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(Veterans Health Administration)

Chapter 9, Criteria and Standards and Program Planning Factors

Appendix 9H, Criteria and Standards for VA Intermediate Care Programs

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CRITERIA AND STANDARDS FOR VA INTERMEDIATE CARE PROGRAMS

1. BACKGROUND

a. Authority to establish Intermediate Medicine as a section of Medical Service was issued in Information Bulletin 10-110, 1959. The Bulletin described the Intermediate Medicine patient as "one who has completed his acute phase of illness but has not reached maximum hospital benefit and requires medical services by a physician on a more or less daily basis with attendant laboratory and X-ray use for a protracted period" and other support services, usually provided in a hospital setting.

b. The Intermediate Medicine system in the VHA (Veterans Health Administration) can be divided into essentially two major sub-systems: programs in medical centers which at one time were designated as VA (Department of Veterans Affairs) psychiatric hospitals, and programs in medical centers with a GM&S (General Medical and Surgical) history. The primary distinction between the two types of Intermediate Medicine programs can be found in the patient mix and the clinical programs or practice patterns typical of each sub-system. Program and patient mix differences exist even between facilities belonging to the same hospital category.

c. After a thorough nationwide review of Intermediate Medicine in 1987 and 1988, as well as from previous VHA reviews, two facts were readily apparent:

(1) Since 1959, Intermediate Medicine has evolved into a heterogeneous patient care program that needs to be defined to assure its emergence as a legitimate hospital level of care.

(2) Appropriate program planning factors are required to accomplish this objective.

2. PURPOSE

a. The purpose of M-9, chapter 9, appendix 9H, is to provide criteria and standards to assist:

(1) In the revision of existing Intermediate Medicine Units as bona fide hospital patient care programs, and

(2) In the planning and development of new Intermediate Care programs.

b. As medical care technology changes, planning criteria and standards will be changed as well. M-9, chapter 9, appendix 9H, will be revised, if necessary, every other budget year. Exceptions to the established guidelines, criteria and standards may be granted during the review process. The strongest justification for granting exceptions would be based on factors supporting quality patient care based on quantitative data.

NOTE: *The word* **"must"** *is used only when the observance of a condition is mandatory, and* **"should"** *when the observance is strongly recommended.*

3. DEFINITIONS

The definitions included in M-9, chapter 9, appendix 9H, were taken from VA

publications, or were supplied or approved by appropriate VA Central Office Clinical Service Chiefs.

a. **Criteria.** Criteria are defined as measurable characteristics of a health service.

b. **Standards.** Standards represent a quantitative and/or qualitative value or level of achievement by which one may judge the effective functioning of a health care program.

c. **Level of care criteria.** Level of care criteria are statements of intensity of clinical interventions, expressed as services ordered and provided.The services must be medically required, of a type which, in the light of the patient's medical condition, can be provided safely only in the inpatient hospital setting, and cannot be provided safely in an alternate and less costly setting.

d. **ICU (Intensive Care Unit)**

(1) Medical/surgical/psychiatric ICUs are designed for acutely ill patients with potential for recovery. ICUs require maximum skilled nursing, monitoring and medical resources.

(2) Acute medical/surgical and psychiatric units are designed for the diagnosis and treatment of acute and sub-acute illnesses with state-of-the-art secondary and tertiary diagnostic and treatment modalities.

e. **Intermediate Care**

(1) Intermediate Care is designed as a time-limited program for patients:

(a) With either an uncertain prognosis (Patients with a terminal illness have a recognized prognosis for deterioration.), or

(b) With a recognized prognosis for improvement, and/or

(c) With a definite need for physical restoration or psychiatric rehabilitation services which are best provided in a hospital setting, or

(d) With a condition or conditions that require transitional care if medically indicated.

(2) Intermediate Care may be organized as a combined medical/surgical and psychiatric program or it may be organized as individual service units in the respective bed services: Intermediate Medicine, Intermediate Psychiatry, Intermediate Surgery, Intermediate Neurology, or Intermediate Rehabilitation Medicine.

(a) **The Medical Intermediate Care Patients**

1. Medical Intermediate Care patients may or may not be acutely ill. They often suffer from chronic, severe, and sometimes unstable medical conditions:

a. COPD (Chronic Obstructive Pulmonary Disease),

b. Diabetes mellitus,

c. CVA (Cerebral Vascular Accidents),

d. Terminal illness and other conditions that are usually complicated by advanced age; or

e. General physical infirmity; or

f. The presence of a secondary medical or psychiatric condition; or

g. a combination of all.

2. The common characteristic shared by all Intermediate Medicine patients is the presence of a specific clinical condition which does not require acute care but does require hospital care, usually for 60 days or less, after which the patients can be discharged home or transferred to a non-hospital level of long-term or ambulatory care.

(b) **The Psychiatric Intermediate Care Patient**

1. Psychiatric Intermediate Care patients often:

a. Suffer from intractable or chronic psychiatric conditions,

b. Exhibit abnormal behavior, and/or

c. May be neurologically handicapped.

2. These patients manifest:

a. Disruptive or other unacceptable behavior,

b. Random yelling, and

c. Wandering.

3. In addition to the psychiatric condition, these patients may also require medical or minor surgical treatment.

4. Psychiatric Intermediate Care patients share the common clinical characteristic that their condition does not require acute psychiatric care but nevertheless does require hospital services, usually for 90 days or less, after which the patient can be discharged home or transferred to a lower level long-term or ambulatory care.

f. **Psychiatric Intermediate Care Programs**

(1) **Special Focus Programs**

(a) This category includes many specialized care units found in the larger VA facilities. Included are those providing focused treatment and rehabilitation for:

1. Certain assaultive patients,

2. Brain damaged patients,

3. AIDS (Acquired Immunodeficiency Syndrome) patients,

4. PTSD (Post-traumatic Stress Disorder) patients, or

5. Substance abuse patients.

(b) Length of stay is a reflection of the special emphasis.

(2) **Specialized Treatment Programs**

(a) Often patients require a special setting if they need training in:

1. Social skills,

2. Group living,

3. Reentry,

4. Discharge planning, and

5. Community survival skills.

(b) Examples are:

1. A Psychiatric Convalescent/Intensive Discharge Planning (step-down) Unit, or

2. A program involving training in community living.

(c) The long-term psychiatric patient, usually suffering from a major mental illness, often needs help with:

1. Housing,

2. Finding appropriate food, and

3. Understanding the nature of his illness and the need for continued medications.

(d) Family members and caretakers also need help in understanding their roles in providing a stable post-hospital environment. These patients can use special assistance in planning their discharges, often on a unit designed for that which has been incorporated within existing ward programs.

(3) **Night Hospital.** A form of partial hospitalization for patients who are unable to move directly to an outpatient status is a program called a night hospital.

(a) Patients in a night hospital program are to be off the ward during the day either in:

1. A compensated work program,

2. Community college or vocational education program, or

3. A day treatment center.

(b) Patients should be on self-medications in preparation for outpatient status.

(c) Day staffing is minimal.

(d) A program conducted evenings and weekends involves:

1. Group therapy and counseling regarding work or school problems,

2. Problems in social interaction on or off the ward,

3. Discharge planning,

4. Budgeting, or

5. Development of social and leisure time skills.

(e) The program should be time-limited but may be integrated with a sheltered workshop or rent payment program to provide gradual but continued incentives for the patient to make the move out of the hospital. For example:

1. CWT (Compensated Work Therapy), and

2. TR (Therapeutic Residences).

g. **Geriatrics And Extended Care**

(1) **Extended Care.** Extended Care organizationally or functionally refers to a group of treatment programs or treatment facilities that provide restorative or maintenance rehabilitative health care and necessary social services for usually (but not necessarily) 90 days or more. Extended care facilities are: NHCUs (Nursing Home Care Units) and Domiciliaries but exclude Intermediate Care patients or units.

(a) **NHCU**

1. An NHCU is a specialized health care facility designed to care for patients who require skilled nursing care and supportive personal care. Nursing home placement is justified by a patient's need for:

a. Long-term nursing supervision,

b. Observation and care by an interdisciplinary team, and/or

c. Long-term maintenance programs and supportive health services.

2. Nursing home care is provided for veterans in

a. VA facilities,

b. The community at VA expense, and

c. State homes.

3. VA nursing homes accept both medical/surgical and psychiatric patients.

4. The development of special psychiatric bed sections in regular VA NHCUs is encouraged.

(b) **Domiciliary Care.** Domiciliary programs represent a segment of the long-term care continuum that provide restorative and a wide-range of health care services.

1. Domiciliary patients are ambulatory and do not require the level of nursing care provided in nursing home care units.

2. MMC (Minimal Medical Care) in VA is a level of clinical intervention and therapeutic structure that is between medical or psychiatric nursing home care and community residential care. It is provided in domiciliaries.

3. Domiciliary care is also provided for veterans in state home facilities.

(2) **Geriatrics.** Geriatrics is defined as the clinical aspects of old age; the care of the elderly.

(a) **Medical Respite Care.** Respite care means hospital or nursing home care which is of limited duration.

1. It is provided in a VA facility on an intermittent basis to a veteran who is suffering from chronic illness and who resides primarily at home.

2. Respite care is furnished for the purpose of supporting the caregiver's role in caring for the chronically ill veteran at home.

(b) **GEM (Geriatric Evaluation and Management) Unit.** A GEM may be an inpatient bed unit, an outpatient clinic unit, or a medical center consultation unit.

1. The goal of a GEM is to improve diagnosis, treatment and placement of older patients with complex medical and other health related problems.

2. A GEM provides:

a. Comprehensive diagnostic and functional assessment,

b. Treatment, and

c. Appropriate placement based on medical needs and socio-economic factors through an interdisciplinary health approach.

(c) **GRECCs (Geriatric Research, Education And Clinical Centers).** GRECCS are organizational entities encompassing a clinical demonstration unit designed to develop, advance and disseminate research, educational and clinical achievements in geriatrics and gerontology.

(d) **Hospice Care.** VA is developing programs which furnish pain management, supportive counseling, and other medical services to terminally ill veterans, as well as supportive and bereavement counseling to their families in various service settings. The hospice concept of care is generally being incorporated into VA medical centers' approaches to the care of the terminally ill; by FY 1993 all VA medical centers will be expected to provide a full range of hospice care.

(e) **HBHC (Hospital Based Home Care).** The program provides primary medical care to veterans with chronic illnesses in their own homes.

1. The family provides the necessary personal care under the coordinated supervision of a hospital-based interdisciplinary treatment team.

2. The team prescribes the needed medical, nursing, social, rehabilitation and dietetic regimens, as well as providing the training of family members and the patient.

(f) **ADHC (Adult Day Health Care).** Adult Day Health Care is a therapeutically oriented ambulatory program that provides health maintenance and rehabilitation services to veterans in a congregate setting during daytime hours.

1. ADHC in VA is a medical model of services, which in some circumstances may substitute for nursing home care.

2. VA continues a program of contracting for ADHC services at VA medical centers.

(g) **Community Residential Care**

1. The residential care home program is for veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable support system (e.g., family, friends) to provide the needed care. It provides residential care, including:

a. Room,

b. Board,

c. Personal care, and

d. General health care supervision

2. All homes are inspected by a VA multidisciplinary team prior to incorporation of the home into the VA program and annually thereafter.

a. Care is provided in private homes that have been selected by VA, at the veteran's own expense.

b. Veterans receive monthly follow-up visits from VA health care professionals.

g. **Physical Medicine And Rehabilitation.** This service is responsible for providing treatment facilities and rehabilitation therapy to patients requiring physical rehabilitation.

(1) The patients receive intensive rehabilitation care that is provided under the immediate direction of a physiatrist and may include multiple prescribed therapies, as:

(a) Kinesio therapy,

(b) Physical therapy,

(c) Occupational therapy,

(d) Vocational rehabilitation,

(e) Educational rehabilitation, and

(f) Speech therapy.

(2) These services may be provided in a Rehabilitation Service bed or by consultation in another bed service.

h. **Intermediate Care Rehabilitation (Restorative Care)**

(1) Intermediate Care rehabilitation is restorative care. It differs from acute bed service rehabilitation in scope and in intensity. Acute rehabilitation is always comprehensive in nature, involving both physical and behavioral rehabilitation.

(2) Intermediate Care restorative care represents the application of focused treatment for a specific problem. For example, only physical therapy may be needed and applied to improve a specific physical disability. Patients may be transferred from an acute bed service to Intermediate Care to receive continued rehabilitation therapy to improve or compensate for a specific disability or deficit. Intermediate Care restorative care is provided only in Intermediate Care beds.

3. OBJECTIVES

Intermediate Care programs in VA have a three-fold operational objective:

a. Provide a sub-acute hospital level of care;

b. Offer educational activities in cooperation with affiliated academic institutions; and

c. Assist research activities aimed at developing new or improved methods of patient care.

4. INTERMEDIATE CARE PROGRAM

a. A general description of Intermediate Care Units includes:

(1) Intermediate Care patients have available to them primary, secondary and tertiary care services.

(a) The primary care services provided in Intermediate Care may include transitional or convalescent care and respite care when medically indicated.

(b) While in transitional status, Intermediate Care patients may need secondary and tertiary care services usually provided on consultative basis by an acute care service.

(c) Transitional care also relates to the provision of services which are medically necessary to facilitate patient transfer to a non-hospital community resource and may

include intensive discharge planning, or coordination with:

1. Nursing homes,

2. Residential care homes,

3. Outpatient treatment centers,

4. HBHC,

5. Public health nursing services,

6. Day care centers,

7. Vocational rehabilitation agencies, or

8. An independent living environment.

(d) Transitional care also includes patient teaching and family instructions to care for discharged patients.

(e) Normally, discharge plans are completed during the period of acute care hospitalization. If discharge planning cannot be completed while the patients are in an acute care unit, the patients may be transferred, if medically necessary, to Intermediate Care to complete discharge planning.

(2) Respite care may be provided in Intermediate Care if the medical center has no other facility for this purpose.

(3) **Standard**

(a) The Intermediate Care program must assure a systematic, comprehensive approach to assessing, planning for, and meeting patient needs.

(b) Written policies and procedures must outline responsibilities, implementation, coordination, and evaluation of Intermediate Care.

(4) **Standard.** The Intermediate Care written policies and procedures should include, but are not necessarily limited to:

(a) Defined admission criteria and process;

(b) Defined assessment process;

(c) Defined patient monitoring process;

(d) Discharge planning criteria;

(e) Transfer of information criteria and process, and

(f) Defined participation in the hospital Quality Assurance program, as well as any regional or national quality assurance evaluation.

b. **Special Intermediate Care Program Activities**

(1) All hospital services are available to Intermediate Care patients. However, many special services are also provided in Intermediate Care units and may be organized as special clinical activities.

(2) The following list of special diagnostic and treatment activities is not mandatory nor an exhaustive listing of such services which may be available for Intermediate Care patients:

(a) GEMs/geriatric evaluation functions

(b) Intermediate care restoration activities:

1. Musculoskeletal

2. Neurovascular

3. Cardiovascular

4. Cardiopulmonary

5. Arthritis

6. Post surgical

(c) Hospice units

(d) Intermediate care psychiatry:

1. Dementia program

2. PTSD

3. Social skills training

4. Substance abuse treatment

(e) Respite care

(3) **Standard.** A physician-directed ITT (Interdisciplinary Treatment Team) should be available to provide advice concerning the admission, treatment and placement of Intermediate patients.

(4) **Standard.** Special clinical programs must have:

(a) Admission criteria;

(b) Program content criteria consistent with national guidelines (i.e., GEMs, TBI (Traumatic Brain Injury), AIDS) care; and

(c) Discharge criteria.

(5) **Standard.** GEMs or functions should be available to Intermediate Care patients to ensure that geriatric patients are treated efficiently and placed appropriately once evaluation is completed.

(6) **Standard.** Special expertise in pain control and symptom management for the terminally ill must be available if the unit routinely admits terminally ill patients.

(7) **Standard**

(a) A dementia program should be available to Intermediate Care patients to facilitate diagnosis, treatment, and discharge planning if the unit routinely admits neurologically handicapped patients.

(b) The program should offer structured settings with planned activities. Special emphasis should be on:

1. Patient teaching;

2. Family teaching;

3. Community education; and

4. Medication adjustment.

(8) **Standard**

(a) A Pulmonary Rehabilitation Program must be available if a program admits a significant number of patients in need of ventilator support or other pulmonary care services.

(b) Ventilator dependent patients who are considered in need of maintenance care may be admitted only if other placement is not possible.

(9) **Standard.** Psychiatric restorative care must be available if the program admits a significant number of patients with psychiatric diagnoses.

c. **Organization of the Intermediate Care Units**

(1) **Combined model**

(a) A combined Intermediate Care Unit is an organizational model which incorporates the treatment of all types of Intermediate Care patients:

1. Medical,

2. Surgical,

3. Psychiatric,

4. Neurological, as well as

5. Patients with a combination of medical and psychiatric diagnoses.

(b) The unit should be under the direction of the Chief of Medicine, Psychiatry, Rehabilitation Medicine or Neurology Service depending upon patient mix and resources that are available at a medical center.

(2) **Individual Model**

(a) An Individual Intermediate Care Unit is a service model for the treatment of Intermediate Care patients where each individual bed service takes responsibility for its own Intermediate Care population: Intermediate Medicine, Psychiatry, Rehabilitation Medicine, Neurology or Surgery. This model is best suited for ensuring continuity of care from admission to discharge.

(b) The organizational model selected will depend on:

1. The size of the Intermediate Care patient population;

2. The diagnostic mix of sub-acute care patients; and

3. Local philosophy concerning intermediate Care delivery.

(3) **Standard.** One or a combination of the organizational models may be selected when an Intermediate Care program is established at a VA medical center.

(4) **Standard**

(a) Intermediate Care is organized as an integral part of the VA medical center treatment milieu.

(b) In affiliated medical centers, the Intermediate Care unit should be included in the rotation schedule of appropriate house staff.

d. **Intermediate Care Bed Distribution**

NOTE: *The defined bed unit is probably most efficient when dealing with a larger (30 to 40 patients) homogeneous patient population, i.e., when the average Intermediate Care Daily census closely approximates the average ward size.*

(1) Intermediate Care beds may be operated as one geographic unit or they may be dispersed among acute care nursing units.

(a) A hospital bed is categorized as an Intermediate Care bed if it is located on a formally designated Intermediate Care unit or when it is regularly reserved by designation for patients who meet the admission standards for Intermediate Care.

(b) Dispersed Intermediate Care beds are not the same as "swing beds." ("Swing beds" in this context would mean that the same bed one day is classified as an acute care bed, on another day as an Intermediate Care bed depending on the level of care of its patient occupant.)

(2) The number of Intermediate Care operating beds will depend on patient demand. The authorization to operate an Intermediate Care program or the number of beds to be designated for this purpose must be granted by utilizing the usual clinical and administrative channels delineated in planning guidance.

(3) The establishment of networks of two or more VA facilities with significant referral relationships is strongly urged. The use of networks and appropriate referrals to other VA medical centers with intermediate care programs will enhance both the cost-effectiveness and quality of health services offered to veterans through improved communication and collaboration.

5. INTERMEDIATE CARE ADMISSION STANDARDS

a. **Standard.** Admission of a patient must be on the expectation that the organization's scope of services will meet his needs e.g.:

(1) The patient no longer requires acute care but has significant restorative potential;

(2) The patient needs continued restorative therapy services which need not be completed on acute care units;

(3) The patient needs medical care which is beyond the scope of home care, nursing home care or residential care; or

(4) The patient needs intensive discharge planning.

b. **Standard**

(1) Each patient who is directly admitted to Intermediate Care must have an assessment prior to admission.

(2) The assessment process ensures that the needs of each patient can be met.

c. **Standard.** Patients transferred to Intermediate Care must have appropriate care plans that justify the admission or transfer. At the time of transfer from acute care a patient:

(1) Must have a completed or in progress discharge plan;

(2) Should have an evaluation of his functional status;

(3) Should have medical, psychiatric, dental, nutrition, nursing, social work, and rehabilitation medicine summaries as appropriate;

(4) Must require monitoring by the attending physician as determined by his medical condition and as outlined in clinical program directives.

d. **Standard.** Patients admitted for physical restoration therapy must meet the following admission requirements:

(1) Patients transferred from an acute care ward must have a completed treatment plan which is appropriate to the staff on the Intermediate Care Unit. (A treatment plan is appropriate when the Intermediate Care unit is equipped with the proper amount and mix of resources necessary to implement the prescribed plan.)

(2) The restoration treatment plan must contain specific outcome goals and specific types of restorative services prescribed and the frequency with which therapy will be provided.

(3) Proposed treatment should be completed in 60 days or less as indicated in the treatment plan.

e. **Standard.** Patients admitted for Psychiatric Intermediate Care rehabilitation must meet the following admission requirements:

(1) Psychiatric treatment and monitoring must be provided by a highly skilled ITT under the direction of a physician, preferably, a psychiatrist. (Primary care on Psychiatric Intermediate Care Units should be provided by the attending psychiatrist with medical input provided on a consultation basis rather than vice versa. Participation by internists at interdisciplinary staffing conference and appropriate transfer of patients between medical and psychiatric units should be encouraged.)

(2) Patients transferred from acute care units must have a completed psychosocial rehabilitation plan which is appropriate to the staff in Psychiatric Intermediate Care.

(3) Patients must require frequent daily monitoring by the ITT.

(4) Patients must require monitoring by a physician as determined by the patient's medical condition and as outlined in clinical program directives.

(5) The treatment plan must contain specific outcome goals and specific types of rehabilitation services that are to be prescribed and the frequency with which therapy will be provided.

(6) The proposed treatment should be completed in 90 days or less as indicated in the treatment plan.

6. **DISCHARGE PLANNING STANDARDS**

a. **Standard.** Discharge planning must be an integral part of the patient's treatment plan of care.

(1) Assessment of the potential for discharge of the patient is based on a realistic expectation of discharge.

(2) Estimation of the potential for discharge includes, but is not necessarily limited to evaluation of the following:

(a) The level of independence the patient is anticipated to achieve;

(b) The treatment procedures the patient is expected to require after discharge;

(c) The number of support personnel available at home or outside the organization;

(d) The patient's or the family's financial resources; and

(e) Available community resources.

b. **Standard.** The patient's treatment plan of care should include information that supports the patient's readiness for discharge and the direction, services, and assistance needed from health, social, or welfare agencies after discharge.

7. **OTHER PLANNING STANDARDS**

a. **Standard.** LOS (Length of Stay) in Intermediate Care must be limited:

(1) Generally, to 90 days or less for psychiatric and 60 days or less for all other Intermediate Care patients.

(2) LOS will be reviewed at least every 14 days or more frequently if indicated in the interdisciplinary treatment plan.

(3) Extension beyond each 30-day increment (In Psychiatric Intermediate Care following the 90 day period, in all other Intermediate Care units following the initial 60 day period.) must be justified in writing by the attending physician.

(4) Patients who exceed the maximum permitted LOS will be reviewed by the Service Chief.

b. **STANDARD 2:** The bed sizing methodology for Intermediate Care units will be incorporated in the VA health care planning model.

2.1 The target occupancy rate for Intermediate Care Units is 90 percent.

8. **EDUCATION**

Standard. The educational program must address the needs of all health care professionals who are involved in Intermediate Care including physicians, dentists, nurses, social workers, and the allied health professions.

a. Educational activities for professionals who work on Intermediate Care must be integrated with the facility's medical and allied health education efforts.

b. When a facility is affiliated with a medical school, medical students and residents should be rotated through Intermediate Care as part of the primary special care rotation.

9. **RESEARCH**

Standard. Individual Intermediate Care programs should conduct or participate in research.

10. **STAFFING GUIDELINES**

a. **Standard.** The following staffing mix is appropriate for a 30-bed Medical/Surgical Intermediate Care ward. (These staffing guidelines were developed based on a

preliminary understanding of the medical care needs of the hospital level of care intermediate patient. They are subject to verification and revision based on actual patient mix and program design.)

RECOMMENDED RANGE

Type of Staff	Low FTEE	High FTEE
MD Staff	0.5*	3*
House Staff	0	2
PA (Physician's Assistant) / NP (Nurse Practitioner)	1*	1.5*
Dentist	0.1	0.2
RN (Registered Nurse)	**	**
LPN (Licensed Practical Nurse)	**	**
NA (Nursing Assistant)	**	**
MSW (Masters Degree in Social Work)	0.5	2
Dietitian.	0.25	0.5
Psychologist	0	0.5
RMS (Rehabilitation Medical Service) ***	1	4.5
Clerks	1	2
Chaplains	0.1	0.5

* Total MD+PA FTEE= 1.5 or 4.5
** Nurse staffing is to be a function of the applicable staffing guidelines and the prevailing patient mix.
***Includes Recreation Therapy.

b. **Standard.** The following staffing mix is appropriate for a 30-bed Psychiatric Intermediate Care ward.

RECOMMENDED RANGE

Type of Staff	Low FTEE	High FTEE
MD Staff	1*	1.5*

RECOMMENDED RANGE

Type of Staff	Low FTEE	High FTEE
House Staff	0	2
PA/PNP (Psychiatric Nurse Practitioner)	0.5*	1*
Dentist	0.1	0.2
RN	***	***
LPN	***	***
NA	***	***
MSW	1	2
Dietitian	0.25	0.5
Psychologist	0.5	1.5
RMS	1.5**	3**
Clerks	1	2
Chaplains	0.1	0.5

* Total MD+PA FTEE= 1.5 or 2.5
** Includes Recreation Therapy also.
*** Nurse staffing is to be a function of the applicable staffing guidelines and the prevailing patient mix.

11. SPACE GUIDELINES

Standard. Applicable Medical or Psychiatric ward space standards published in H-08-9.

12. QUALITY ASSURANCE MECHANISMS

Standard. The facility quality assurance program must monitor and evaluate the quality and appropriateness of Intermediate patient care on an on-going basis.

13. PROTOCOL FOR SUBMISSION

All proposed initiatives to establish, eliminate or modify Intermediate Care, Intermediate Medicine, or Intermediate Psychiatry units are subject to the Criteria and Standards stated in M-9, chapter 9, appendix 9H.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Chapter 9
Change 14

January 28, 1993

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

2. Principal change is to add Appendix 9P, "Mental Health Criteria and Standards."

3. **Filing Instructions**

Remove	Insert
9-i	9-i
	9P-1 through 9P-26

4. **RECISSIONS:** None.

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

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Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Chapter 9
Change 4

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**

Remove page	Insert pages
iii-iv	iii-iv
9-i through 9-1	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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Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-9
Change 2

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	Insert pages
Cover page through iv	Cover page through iv

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

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Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

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M-9

October 2, 1989

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

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

3. **Filing Instructions:**

Insert pages

Cover page through v
1-1 through 11-3

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

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

Distribution: RPC: 1318 is assigned
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Veterans Administration

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REMARKS

SUBJ: Departmental Manual M-9

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

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

"Planning ~~and Evaluation~~ and Systems Development"

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

3. Thank you for your assistance.

Approved X Disapproved ___

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

2-3-86
Date

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FROM

MARJORIE R. QUANDT
ACMD for Planning Coordination (17A)

1/23/86

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VA FORM MAY 1980 3230 EXISTING STOCKS OF VA FORM 3230, AUG 1976, WILL BE USED. ☆ U.S. G.P.O. 1984-709-228

Veterans Administration

Memorandum

APR 0 3 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 MD

MURRAY G. MITTS, M.D.

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

Approve ✓
Disapprove ___

4/17/84
Date

VA FORM 2105
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