

## MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive describes the procedures and reporting requirements for the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) bed level of care.

**2. SUMMARY OF MAJOR CHANGES:** This directive is a revision of VHA Handbook 1162.02. The content has been revised and streamlined as follows:

a. The revision provides updated information regarding changes to treating specialty codes. Treating specialty codes for Substance Abuse Residential Rehabilitation Treatment Program, Posttraumatic Stress Disorder Residential Rehabilitation Treatment Program, and Psychosocial Residential Rehabilitation Treatment Program were eliminated, requiring these programs to use the equivalent Domiciliary treating specialty codes 85, 86, and 88.

b. The term Program Manager will be the national designation for the program leaders. The term Domiciliary Chief can continue to be used by medical facilities where it has been historically utilized.

c. Models of care have been eliminated (all-inclusive and supportive).

d. Information on Nursing Practice and Nurse Staffing Methodology has been included to assist medical facility directors, nurse executives, and Program Managers to determine the number and type of nursing staff and the 24 hours day / 7 days a week staff required by MH RRTPs to provide adequate safety security and supervision of MH RRTPs.

e. Suicide risk screening and assessment have been added.

### 3. RELATED ISSUES:

a. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

b. VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorders, dated March 7, 2012.

c. VHA Directive 1160.03 Programs for Veterans with Posttraumatic Stress Disorders, dated November 16, 2017.

d. VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated July 1, 2011.

e. VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011.

f. VHA Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers, July 1, 2011.

**4. RESPONSIBLE OFFICE:** The Office of Mental Health and Suicide Prevention (10NC5) is responsible for the contents of this directive. Questions regarding the contents of this directive are to be referred 202-461-4193.

**5. RESCISSIONS:** VHA Handbook 1162.02, dated December 22, 2010, is rescinded.

**6. RECERTIFICATION:** This VHA directive is due for recertification on or before the last working day of July 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE  
UNDER SECRETARY FOR HEALTH:**

/s/ Renee Oshinski  
Acting Deputy Under Secretary for Health for  
Operations and Management

**NOTE:** *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

**DISTRIBUTION:** Emailed to the VHA Publications Distribution List on July 16, 2019.

**CONTENTS**

**MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM**

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS ..... 2

4. POLICY ..... 4

5. RESPONSIBILITIES ..... 4

6. TRAINING ..... 11

7. RECORDS MANAGEMENT ..... 12

8. REFERENCES..... 12

APPENDIX A

CORE CLINICAL PROCESSES A-1

APPENDIX B

CORE CLINICAL PROGRAMMING REQUIREMENTS .....B-1

APPENDIX C

STAFFING, STAFF COMPETENCIES AND TRAINING REQUIREMENTS ..... C-1

APPENDIX D

COMPENSATED WORK THERAPY - TRANSITIONAL RESIDENCE..... D-1

APPENDIX E

CORE ADMINISTRATIVE REQUIREMENTS, ACCREDITATION, SAFETY AND SECURITY, AND PROGRAM MONITORING AND EVALUATION.....E-1

APPENDIX F

SAFE MEDICATION MANAGEMENT ..... F-1

APPENDIX G

NURSING PRACTICE AND 24 HOURS PER DAY/7 DAYS PER WEEK COVERAGE IN MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAMS G-1

## MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM

### 1. PURPOSE

This Veterans Health Administration (VHA) directive provides national policy for clinical and administrative procedures for the Mental Health Residential Rehabilitation Treatment Program (MH RRTP). **AUTHORITY:** Title 38 United States Code (U.S.C.), 1710, 2032, 8110; Title 38 Code of Federal Regulations (CFR) 17.46, 17.47, 17.48.

### 2. BACKGROUND

a. The Domiciliary Care Program is VA's oldest health care program. Established through legislation passed in the late 1860's, the purpose of the National Home for Disabled Volunteer Soldiers was to provide a home for soldiers of the Civil War. After the VA was established in 1932, the National Homes were converted to domiciliary care to provide services to economically-disadvantaged Veterans, and they remain committed to serving that group. VA established the Psychosocial Rehabilitation Treatment Program (PRRTP) bed level of care in 1995. This distinct level of mental health residential care served Veterans with mental illnesses or addictive disorders who required additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary Care programs became integrated with the PRRTPs under Mental Health Services. In 2010, the Domiciliary Care programs and PRRTPs were merged into a single system of residential care to become MH RRTPs.

b. VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013, categorizes the MH RRTP as residential care and distinguishes such care from VA outpatient, inpatient care (acute and extended psychiatry, medicine, rehabilitation and surgery beds), and VA institutional extended care Community Living Centers (CLCs). MH RRTPs also include the Compensated Work Therapy-Transitional Residence (CWT-TR) which is designed for Veterans participating in Compensated Work Therapy and who are in the process of transitioning to successful independent community living (See Appendix D for specific information about CWT-TR). The MH RRTP provides a 24-hour therapeutic setting utilizing professional and peer supports. MH RRTP beds are officially classified as domiciliary beds in the VA Bed Control System. As a 24-hour bed service, common bed procedures used in inpatient and CLC settings are also utilized in residential programs unless otherwise specified in this directive. These common bed procedures include admission and discharge, absences, passes, dietetics, medication orders, consults, etc. **NOTE:** See VHA Handbook 1907.01, *Health Information Management and Health Records*, dated, March 19, 2015, and VHA Handbook 1163.02, *Therapeutic and Supported Employment Services Program*, dated July 1, 2011, for more information about Compensated Work Therapy. CWT is designed to provide services to Veterans who want treatment to address employment and vocational rehabilitation goals and help them overcome barriers to employment due to mental or concurrent physical illness.

c. The primary goal of the MH RRTP is to provide treatment and rehabilitation services to Veterans who have mental health and substance use disorders that are often complex and co-occur with medical concerns and psychosocial needs, such as employment and housing. This is accomplished through the provision of services designed for improving functional status, sustaining treatment and rehabilitation gains, recovery, community integration, and breaking the cycle of recidivism.

### 3. DEFINITIONS

a. **Advanced Practice Provider.** An Advanced Practice Provider is a general title used to describe individuals who have completed the advanced education and training that qualifies them to manage medical problems and prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical pharmacists, clinical pharmacy specialists, clinical nurse specialists, psychiatric mental health nurse practitioners, nurse practitioners, and physician assistants.

b. **Authorized Absence.** An authorized absence is the absence of a resident, approved by the medical provider and involving an overnight stay from a MH RRTP. The authorization must include any necessary orders for medications, specific instructions to the Veteran and the expected duration of the absence. An example of an authorized absence is a week-end pass; authorized absences generally do not exceed 96 hours. ***NOTE:*** See Appendix E, Core Administrative Requirements, for more information regarding authorized absences.

c. **Discharge.** A discharge is the termination of a period of inpatient or RRTP care through formal release of the patient.

d. **Hoptel.** Temporary lodging facility, other than a VA Fisher House, located at a VA medical facility. ***NOTE:*** See VHA Directive 1107, VA Fisher Houses and Other Temporary Lodging, dated March 10, 2017, for information about these services.

e. **Licensed Independent Practitioner.** A Licensed Independent Practitioner is an individual, as permitted by law and the organization, who provides care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization.

f. **Mental Health Residential Rehabilitation Treatment Program.** Mental Health Residential Rehabilitation Treatment Program (MH RRTP) is the umbrella term for the array of programs and services that comprise mental health residential care. The term MH RRTP refers to those programs currently designated as Domiciliary RRTPs which may include Domiciliary Care for Homeless Veterans, Domiciliary Substance Use Disorder Programs, Domiciliary Posttraumatic Stress Disorder (PTSD) Programs, General Domiciliary Programs (General DOM), and Compensated Work Therapy (CWT) – Transitional Residence (TR).

g. **Passes.** Passes are approved absences of patients participating in therapeutic and rehabilitative activities programs away from the medical center without staff during day or evening hours. Such passes range from granting patients the privilege of leaving

the medical facility grounds during specified hours for self-help activities and participation in community related activities such as job search, self-help meeting attendance, and other activities related to the care plan. Passes do not require a provider order. Passes may be granted by the interdisciplinary recovery team. **NOTE:** *Passes are not the same as authorized absences.*

h. **Patient.** A patient is the recipient of services who is assigned to a be in a VA medical facility. Patients in residential treatment are referred to as residents.

i. **Patient Pending Bed Placement List.** The Bed Management Solution (BMS) Patient Pending Bed Placement (PPBP) List is a system that allows VA medical facility Bed Flow Coordinators and other staff to track and manage patient placement including any change in status to properly assess bed demand against current availability. Patients requiring a bed may be located in the Emergency Department awaiting admission, scheduled admissions, surgery patients requiring an inpatient bed, patients in other VA hospitals, patients in community hospitals, home, etc. Use of the PPBPL is integral to effective bed management within a VA medical facility. It provides an essential flow tool to identify when care is needed, how long it has been pending, and the ability to assist in identification of potential opportunities for improvement to expedite care.

j. **Residential Care.** As defined in VHA Handbook 1006.02, residential care is defined as encounters between Veterans and providers within the VA health care system that require an overnight stay in residential bed sections. Each point of service receives a residential care rating within the VHA site classifications based on the services provided at that location. Although some residential care is also classified as extended care, two programs are specifically classified as “residential care” in the site classification: Residential Rehabilitation and Domiciliary Care (all residential rehabilitation programs are types of domiciliary care). Residential care is distinct from VA outpatient, inpatient (acute and psychiatry, medicine, rehabilitation and surgery beds), and institutional extended care (CLCs).

k. **Serious Mental Illness.** Serious mental illness refers to a mental, behavioral, or emotional disorder (excluding cognitive and developmental disorders and disorders due to a general medical condition), as defined in VHA Directive 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008. Serious mental illnesses include mood disorders, anxiety disorders, Posttraumatic Stress Disorders, psychotic disorders, Substance Use Disorders, dementia, and other cognitive disorders.

l. **Treatment Track.** A treatment track is defined as specialized treatment provided to a subset of Veterans within the residential program who receive the same or similar intensive treatment and rehabilitative services. Tracked programs are on par with specialty bed sections or programs in terms of staffing, programming, and other clinical resources. A treatment track must offer a minimum of 4 hours of intensive treatment and rehabilitation services comparable to those offered in the diagnosis-specific bed

sections or, for tracks for which there is not a comparable bed section, specifically focused to the identified sub-population being treated.

m. **Unauthorized Absence.** This term is used to describe the status of patients who absent themselves from VA care without approval of the MH RRTP medical provider or the interdisciplinary recovery team and their condition renders discharging not appropriate. ***NOTE:*** See Appendix E, *Core Administrative Requirements*, for more information regarding unauthorized absences.

#### 4. POLICY

It is VHA policy to provide residential treatment and rehabilitation services to Veterans who have complex mental health and substance use disorders, that these services are built around each Veteran's treatment goals, and that those goals are reached through the provision of services designed to promote recovery by improving functional status; to sustain treatment and rehabilitation gains, and to encourage community integration.

#### 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for overseeing the development and implementation of VA MH RRTP.

c. **VHA Central Office, National Mental Health Director, Residential Rehabilitation Treatment Programs Office of Mental Health and Suicide Prevention.** VHA Central Office, National Mental Health Director, Residential Rehabilitation Treatment Programs Office of Mental Health and Suicide Prevention (OMHSP), is responsible for:

(1) Developing national policy and procedures for MH RRTPs.

(2) Monitoring MH RRTPs to ensure operational practices and clinical services provided remain consistent with current standards of care and remain an effective component of the broader continuum of mental health care.

(3) Developing and analyzing program monitoring and outcome data in collaboration with the Northeast Program Evaluation Center (NEPEC), which is funded by and reports to the Office of Mental Health and Suicide Prevention.

(4) Providing policy and operational consultation and guidance to Veterans Integrated Service Networks (VISN) and VA medical facilities for the development and operation of MH RRTPs.

(5) Leading the MH RRTP Field Advisory Board (FAB), which advises the National Mental Health Director, MH RRTP on policy, procedures, and issues related to the residential programs.

(6) In conjunction with the Technical Assistant, VISN Mental Health Lead, and medical facility leadership, reviewing all MH RRTP bed and program change requests and providing consultation and recommendations to program, VA medical facility, VISN, and VHA leadership.

(7) Developing responses to inquiries from internal and external stakeholders through established processes for communications.

d. **Director of Northeast Program Evaluation Center.** The Director of the Northeast Program Evaluation Center (NEPEC), located at the VA Connecticut Healthcare System at West Haven, is responsible for providing national program evaluation of the MH RRTPs, and for overseeing NEPEC staff. NEPEC staff lead the evaluation efforts for the MH RRTPs and are the primary point of contact for the Quarterly Bed Occupancy Report and the Annual Program Review. The MH RRTP program evaluation process also includes an annual review of program workload and costs and adverse events by the NEPEC staff.

e. **MH RRTP Field Advisory Board Chair.** The MH RRTP Field Advisory Board (FAB) Chair is responsible for providing assistance to the Office of Mental Health and Suicide Prevention with strategic guidance that includes insight, ideas, and solutions into MH RRTP clinical and administrative program operations with a focus on program accountability. The FAB consists of a diverse group of subject matter experts that collaborate with and advise the MH RRTP's senior managers and staff on best practices associated with MH RRTP services. Best practices may comprise guidance on a variety of projects and issues to enhance patient care and evaluate performance, through data collection and analysis and monthly reporting on new projects that affect positive changes for MH RRTP programs and Veterans. In addition to an advisory role, the FAB supports the establishment of MH RRTP projects and assists in the development of project deliverables.

f. **Technical Assistants, Office of Mental Health and Suicide Prevention.** Technical Assistants (TAs) are responsible for collaborating with all OMHSP program office areas in matters pertaining to the implementation of mental health services and initiatives, and providing consultation and technical assistance to the networks, facility mental health leads, facility program leads, and frontline staff as needed.

g. **VISN Director.** Each VISN Director is responsible for ensuring:

(1) Inclusion of MH RRTP capacity data, which is provided by the Office of Policy and Planning, in the VISN's healthcare utilization gap analysis process when completed.

(2) MH RRTPs are operated in compliance with this directive.

(3) VISNs have residential treatment programs able to meet the needs of women Veterans and Veterans with a serious mental illness (SMI), PTSD, military sexual trauma (MST), substance use disorder (SUD), and homelessness either through specific bed sections, programs, or treatment tracks in residential programs.

(4) Veterans who require a residential level of care have timely access to residential treatment as medically necessary and that treatment meets Veterans' needs for specialized residential, intensive mental health treatment, and rehabilitation services.

(5) All VA medical facilities with MH RRTPs have implemented Bed Management Solution (BMS) for all MH RRTP beds to include use of the Patient Pending Bed Placement List to track Veterans pending admission to a MH RRTP. BMS supports VA's commitment to maintain a real-time inventory of all VHA beds, their respective statuses and a list of patients waiting for beds at the VA medical center, VISN and National level. **NOTE:** See VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, dated November 28, 2017.

h. **VISN Mental Health Lead.** Each VISN Mental Health Lead is responsible for:

(1) Ensuring all MH RRTPs within the VISN are involved in program monitoring, evaluation, and data collection activities to allow for sufficient oversight and coordinating and reviewing related reports, assessments, evaluations, and follow-up actions for implementing VHA policy and procedures.

(2) Ensuring that the MH RRTP coordinates and integrates services for homeless Veterans in collaboration with the Network Homeless Coordinator.

(3) Acting as a liaison between OMHSP, VISN and facility leadership, mental health leadership, and MH RRTP leadership.

(4) Communicating significant adverse events or program changes, including changes in mission, number of beds, or number of staff to the National Mental Health Director, MH RRTP, OMHSP.

(5) Reviewing and updating annually the VISN MH RRTP Strategic Access Plan to ensure timely access to residential treatment as medically necessary, and that treatment meets Veterans' needs for specialized residential, intensive mental health treatment and rehabilitation services.

i. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring core staffing requirements are met or exceeded based on Veteran needs and the staffing requirements detailed in Appendix C, Core Staffing Requirements, and Appendix D, Compensated Work Therapy (CWT) - Transitional Residence (TR) of this directive.

(2) Ensuring the VA medical facility has implemented BMS for all MH RRTP beds to include use of the Patient Pending Bed Placement list to track Veterans pending residential admission.

(3) Ensuring Veterans who require residential treatment have access as medically necessary to specialized residential, intensive mental health treatment, rehabilitation services, and emergency treatment. **NOTE:** See *Priority Access in Appendix A of this directive and VHA Handbook 1160.01 for further details.*

(4) Ensuring quality services are being provided that comply with VHA policy and procedures; specifically, ensuring that there is a program manager, clinical staff, and support staff.

(5) Ensuring special attention is given to address the unique needs of special populations, including women Veterans.

(6) Ensuring the completion of all mandated reporting, monitoring, and accreditation requirements in accordance with established timelines and requests from facility, VISN, and OMHSP.

(7) Providing a safe, well-maintained, and appropriately furnished residential environment that is staffed to support and enhance the recovery efforts of the Veteran and addresses the unique environmental and safety needs of women Veterans, in accordance with VHA Directive 1850.05, VHA Interior Design Operations and Management Program, dated September 22, 2017, and VHA Directive 1330.01, Appendix A, dated February 2017.

(8) Ensuring there is private space for Veterans to visit with significant others and children at designated times.

(9) Ensuring consultation with OMHSP prior to bed or program changes as outlined in current VHA bed control policy and current VHA program restructuring policy. **NOTE:** See *VHA Handbook 1000.01 Inpatient Bed Change Program and Procedures, dated December 22, 2010, and VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.*

(10) Providing appropriate support and resources to ensure the MH RRTP is able to accomplish its stated mission, goals, and objectives.

(11) Maintaining compliance with VA and accrediting body environment of care standards, including, but not limited to Life Safety Codes (LSC), space criteria, safety, security, privacy, and emergency planning and preparedness.

(12) Ensuring that a MH RRTP operating in the community is following the procedures in this directive, is providing safe, efficient, and effective services comparable to an on-station program, and is complying with applicable zoning requirements, building permit requirements, and other similar requirements.

j. **Nurse Executive/Associate Director, Patient Care Services.** The Nurse Executive/ Associate Director, Patient Care Services is responsible for overall nursing practice at the VA medical facility. Nursing leadership responsibilities include the following:

(1) Ensuring sufficient nursing services are dedicated to the MH RRTP to meet the increasing acuity of Veteran needs and complexity.

(2) Ensuring education and mandatory competency development are maintained for nursing staff in MH RRTPs.

(3) Providing oversight, management, and accountability for medication management in collaboration with the MH RRTP Nurse Manager.

(4) Collaborating with the MH RRTP Nurse Manager and Program Manager in identifying and addressing organizational/systems processes to improve Veteran outcomes.

(5) Ensuring the use of professional standards of care and practice to evaluate nursing practice.

(6) Collaborating with the Program Manager to ensure that nursing is included in decisions related to the design of space that will enable safe and efficient delivery of nursing care including design of appropriate space for nursing staff, safe medication rooms, automated medication dispensing systems and Bar Code Medication Administration equipment that meets quality standards for administration of medications and documentation.

(7) Collaborating with the MH RRTP team to ensure there are clear policies for off-station programs as to how emergencies and other situations are handled given the unique needs of these patients and programs.

(8) Collaborating with the Program Manager to obtain input regarding nursing operations such as 24/7 coverage, planned and unplanned leave, performance reviews and other operational activities.

(9) Collaborating with the facility Mental Health Lead and/or the MH RRTP Manager to ensure completion of the MH RRTP Nurse Manager performance evaluation.

k. **Chief of Pharmacy.** The Chief of Pharmacy is responsible for the provision of clinical and distributive pharmacy services within a VA medical facility which includes overseeing the professional practice for all clinical pharmacists within the facility to include those assigned to the MH RRTP. Oversight responsibilities include, but are not limited to: medication distribution, safety, security and regulatory oversight compliance, competency assessment, functional statements, patient care responsibilities, scope of practice recommendations, and professional practice evaluations for clinical pharmacists with a scope of practice.

I. **Program Manager.** The Program Manager is responsible for:

(1) Managing all clinical and administrative operations of the MH RRTP to ensure the safe, efficient, and effective provision of rehabilitation and treatment services. Given the scope of responsibility, the Program Manager must be labor mapped to reflect administrative time consistent with FTE requirements specified in this directive (i.e. 1.0 FTE equals 100 percent administrative and 0.5 equals 50 percent of time is administrative.) **NOTE:** See *Appendices A through G for specific contextual responsibilities.*

(2) Ensuring collaboration and integration of treatment and rehabilitation services with Nursing, Mental Health, Primary Care, Pharmacy, Social Work, Homeless and other specialty services with staff matrixed to the residential program. The Program Manager must have direct supervision authority for all staff assigned to the MH RRTP. In locations where licensed staff report to a professional service line, the Program Manager will retain administrative supervision to ensure appropriate program operations and conformance with local and national policies and procedures. Administrative supervision entails direct input into leave requests and performance evaluations completed by the primary supervisors of non-MH RRTP staff that provide services in the MH RRTP.

(3) Maintaining a minimum cumulative bed occupancy rate of 85 percent.

(4) Ensuring Veterans pending admission receive a point-of-contact during that waiting period. **NOTE:** See *VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.*

(5) Ensuring use of BMS to track Veterans pending admission using the Patient Pending Bed Placement List and the Bed Board to monitor bed availability.

(6) Ensuring the MH RRTP is operated in compliance with all applicable VHA policies and procedures.

(7) Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to the MH RRTP.

(8) Developing partnerships with internal and external stakeholders to facilitate outreach, access, and discharge planning.

(9) Developing and implementing a plan to ensure safety, security, and privacy procedures follow the requirements specified in this directive. All safety, security and/or privacy deficiencies must be reported to facility leadership for correction within time frames designated by the facility.

(10) Ensuring the implementation of measurement-based care in accordance with OMHSP policies. **NOTE:** See *Appendix A for more information regarding Measurement-based care.*

(11) Coordinating with Clinical Pharmacist or Clinical Pharmacy Specialist, the Nurse Executive and the Patient Safety Manager to implement Safe Medication Management (SMM) as specified in this directive. **NOTE:** *VHA Directive 1108.03, Self-Medication Programs (SMP), dated November 28, 2016 does not apply to MH RRTPs.*

(12) Assigning responsibilities to an Assistant Program Manager as necessary.  
**NOTE:** *See Appendix C.*

(13) Collaborating with the Nurse Executive and VA medical facility Mental Health Lead to ensure completion of the MH RRTP Nurse Manager performance evaluation.

(14) Collaborating with the Nurse Manager, facility Staffing Methodology Coordinator, Associate Director for Patient Care Services (ADPCS), and VA medical facility Mental Health Lead to ensure completion of the Office of Nursing Services MH-RRTP Staffing Methodology.

**NOTE:** *The term Domiciliary Chief is expected to be used by VA medical facilities where it has been historically utilized for Domiciliaries operating greater than 100 beds.*

m. **Women Veterans Program Manager.** The Women Veterans Program Manager has agreed to participate in regular environmental rounds in the MH RRTP to ensure the physical and psychosocial privacy of women Veterans. See Appendix B, paragraph 5, Access and Services for Women Veterans.

n. **Nurse Manager.** The Nurse Manager oversees the nursing staff which are present on the MH RRTP unit: Registered Nurses (RNs); Licensed Professional Nurses (LPNs); and depending on the organization, 24/7 non-licensed staff. The Nurse Manager is responsible for:

(1) Ensuring that nurses in the MH RRTP attain established medical and mental health nursing competencies and monitor nursing related outcomes.

(2) Ensuring that nurses deliver comprehensive and effective nursing care within an interdisciplinary recovery team concept.

**NOTE:** *See Appendix G, paragraph 2, Nursing Practice and 24/7 Staffing in Mental Health Residential Rehabilitation Treatment Programs for specific responsibilities.*

o. **Mental Health Treatment Coordinator.** The Mental Health Treatment Coordinator (MHTC) is responsible for ensuring that each Veteran has continuity throughout their mental health care and affords the Veteran an enduring Point of Contact (POC), especially during care transitions. The MHTC serves as a clinical resource for the Veteran and for other staff and will generally be a member of a Veteran's assigned outpatient general mental health team except under certain circumstances.

p. **Domiciliary Assistants/Social Science Assistants.** Domiciliary Assistants/Social Science Assistants are the non-licensed staff that are responsible for

providing 24/7 supervision of the units. See Appendix C, *Core Staffing Requirements*, for further detail regarding responsibilities.

q. **Interdisciplinary Recovery Team.** The Interdisciplinary Recovery Team is comprised of the various disciplines, listed below, that are responsible for participating in the assessment, planning, and/or implementation of a Veteran's care. **NOTE:** *The Case Manager is not discipline-specific. The Chaplain's level of involvement may vary by facility and when involved is an important member of the interdisciplinary recovery team. See Appendix C for descriptions of core staff roles and full descriptions for those not described here.*

(1) **Case Manager.** The staff member assigned to coordinate the Veteran's care while admitted to the program. **NOTE:** *Various disciplines may be designated to provide case management services as determined by scope of practice.*

(2) **Chaplain.** Provides spiritual assessments and pastoral counseling.

(3) **Psychiatric Provider.** Doctor of Medicine (MD), Doctor of Osteopathy (DO), Psychiatric Mental Health Nurse Practitioner (PMHNP).

(4) **Psychologist.**

(5) **Admissions/Transitions Coordinator.**

(6) **Social Worker.**

(7) **Medical Provider.** Doctor of Medicine (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).

(8) **Registered Nurse.**

(9) **Clinical Pharmacist (CP) or Clinical Pharmacy Specialist (CPS).**

(10) **Employment and Vocational Services Staff.**

(11) **Peer Support Specialist.**

(12) **Dietician.**

(13) **Recreation Therapist.**

## 6. TRAINING

a. The following training is required for all MH RRTP Managers and other staff in addition to recommended training targeted to their role and assigned to their learning plans:

(1) Suicide Risk Management for Clinicians (Refresher) (TMS VA 29376).

(2) Suicide Risk Management Training for Clinicians (TMS VA 6201).

(3) S.A.V.E. (Signs, Asking, Validating, Expediting and Escorting) Refresher Training (TMS VA 30535).

(4) Prevention and Management of Disruptive Behavior (PMDB). Every employee in VHA is required to complete the levels of PMDB training corresponding with the assessed Workplace Risk Level assigned to the work location. All employees are required to complete Level 1 VA TMS 7831 which is one-time only. Level 1 TMS 16699, is the annual refresher of 7831. Other PMDB courses are required every two years. See facility website for information regarding training.

b. OMHSP has developed and made available specialized training for new Program Managers that includes presentations and additional resources on various topics that enhance the skills of staff. These are in addition to other required training for VHA employees. See the link to the MH RRTP Training portal on the MH RRTP SharePoint: <https://vaww.portal.va.gov/sites/OMHS/mhrrtp/training/default.aspx>. **NOTE:** *This is an internal VA Web site not available to the public.*

## 7. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be directed to the facility Records Manager or Records Liaison.

## 8. REFERENCES

a. Public Law 105-116.

b. 38 U.S.C. 1710, 2032, 7301(b), 8110.

c. 21 CFR 1300, 1301, 1304, 1305, 1307, 1317.

d. 38 CFR 17.46, 17.47, 17.48.

e. 38 Code of Federal Regulations (CFR) 7301(b).

f. VHA Directive 1000.1, Program Restructuring and Inpatient Bed Change Policy, dated April 15, 2005.

g. VHA Directive 1003.04, Patient Advocacy Program, dated February 7, 2018.

h. VHA Directive 1002, Bed Management Solution (BMS) For Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 20, 2017.

- i. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- j. VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees, dated December 22, 2017.
- k. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.
- l. VHA Directive 1101.04, Medical Officer of the Day, dated February 6, 2019.
- m. VHA Directive 1107, VA Fisher Houses and Other Temporary Lodging, dated March 10, 2017.
- n. VHA Directive 1108.02, Inspection of Controlled Substances, dated November 28, 2016.
- o. VHA Directive 1108.03, Self-Medication Program, dated November 28, 2016.
- p. VHA Directive 1108.06, Inpatient Pharmacy Services, dated February 8, 2017.
- q. VHA Directive 1330.01(2), Health Care Services for Women Veterans, dated February 15, 2017.
- r. VHA Directive 1330.02, Women Veterans Program Manager, dated August 10, 2018.
- s. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.
- t. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.
- u. VHA Directive 1850.05, VHA Interior Design Operations and Management Program, dated September 22, 2017.
- v. VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011.
- w. VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010.
- x. VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.
- y. VHA Directive 1108.01, Controlled Substances Management, dated May 1, 2019.
- z. VHA Handbook 1108.05 Outpatient Pharmacy Services, dated June 16, 2016.
- aa. VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorders (SUD), dated March 7, 2012.

bb. VHA Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers, dated July 1, 2011.

cc. VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Program, dated May 9, 2017.

dd. VHA Handbook 1330.03, Maternity Health Care and Coordination, dated October 5, 2012.

ee. VHA Handbook 1601A.06, Applications and Copayments for Extended Care Services, dated November 10, 2015.

ff. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

gg. American Psychiatric Nursing Association  
(<https://www.apna.org/i4a/pages/index.cfm?pageid=3334>).

hh. Disposal of Controlled Substances, Final Rule-Drug Enforcement Administration Diversion 79 Federal Register 53520  
([https://www.deadiversion.usdoj.gov/fed\\_regs/rules/2014/2014-20926.pdf](https://www.deadiversion.usdoj.gov/fed_regs/rules/2014/2014-20926.pdf)).

ii. National Fire Protection Life Safety Code (<https://www.nfpa.org/101>).

jj. Substance Abuse and Mental Health Services Administration,  
(<https://www.samhsa.gov/>).

## CORE CLINICAL PROCESSES

### 1. SCREENING PROCESS

a. Veterans may apply directly for Mental Health Residential Rehabilitation Treatment Program (MH RRTP) services or be referred from other programs, both within and outside the Veterans Health Administration (VHA). As Veterans applying for MH RRTP admission generally face significant barriers to treatment access, MH RRTPs must take steps to reduce barriers to treatment. The screening process must consider the circumstances of each Veteran and determine how the program can meet the individual Veteran's needs.

b. Screening with an admission decision must be completed within 7 business days of the referral. Referrals for residential treatment must be documented through formal consults within the Computerized Patient Record System (CPRS). **NOTE:** *All Veterans screened for admission for a MH RRTP must have workload documented in a screening clinic with the stop code 596 and corresponding clinical documentation in CPRS. Data related to stop codes are extracted by NEPEC from administrative files.*

c. A single screening determines whether a Veteran is appropriate for admission to any of the facility's MH RRTPs. The Veteran must be screened for admission to MH RRTP by a team of staff members who are capable of assessing their medical and mental health stability and their suitability for admission to any of the facility's MH RRTPs. At a minimum, the screening team must include a licensed mental health professional and a medical provider.

d. The screening team will collect all necessary information to make an admission decision based on information from the medical record and Veteran interview and will not utilize a paper application that is required to be filled out by the referral source or by the Veteran. Programs may use a short paper application for Veterans being referred from an outside agency that does not have access to the VHA electronic consult such as Vet Centers or when the screening team does not have access to another agency's medical records such as active duty service members. To facilitate access, screenings are conducted on all normal business days. The screening decision by one MH RRTP screening team is sufficient for determining admission to any of the facility's MH RRTPs.

e. As part of the screening process, Veterans must receive a health care screening by a licensed physician, nurse practitioner, or physician's assistant prior to admission that indicates areas of ongoing treatment and potentially urgent medical needs that would prevent admission to the MH RRTP. The health care screening does not need to occur in person and the medical portion of the screening may be completed through review of medical records or through collection of information provided directly from the Veteran. Completion of pre-admission laboratory tests is not required and is to be completed after the Veteran is admitted.

f. Veterans accepted for MH RRTP admission must be provided information about the circumstances, expectations, and any limitations of the program to which they are to

be admitted, ensuring that they are fully aware of their responsibilities and any restrictions imposed by the program. This information must be provided in advance of admission to enable the Veteran to make an informed decision and at the beginning of rehabilitation and recovery.

g. Once accepted for admission, Veterans must be provided a tentative admission date by a designated member of the screening team, given a point-of-contact during the waiting period prior to admission (if any), and added to the Patient Pending Bed Placement List in Bed Management Solution (BMS). Veterans must remain on the list until admitted, or until no longer in need of a residential level of care based on the Veteran's preference, or until the Veteran's pre-admission circumstances warrant re-assessment that precludes admission. **NOTE:** See VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, dated November 28, 2017, and VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, dated August 14, 2009.

## 2. TRANSPORTATION

Veterans accepted for admission sometimes face barriers to accessing treatment at a MH RRTP due to transportation issues. In accordance with current travel procedures, a Veteran may be eligible for travel under one of several transportation regulatory authorities. The majority of Veterans may be eligible under General Authority for Inter-Facility Transport which is used when transporting a Veteran from one VA or authorized non-VA facility to another to receive VA care not available at the sending facility. Under this authority, the sending institution assumes full responsibility for the patient during travel, including the appropriate services needed to accomplish a safe transfer. Facilities are encouraged to work together to share in the cost of transportation as MH RRTPs are considered VISN resources. **NOTE:** See VHA Directive 1094, *Inter-Facility Transfer Policy*, dated January 11, 2017.

## 3. ADMISSION PROCESS

a. Veterans seeking admission must complete VA Form 10-10EC, Application for Extended Care Services, at <https://vaww.va.gov/vaforms/medical/pdf/vha-10-10EC-fill.pdf>, prior to admission as Veterans admitted to a residential level of care may be subject to co-pays for extended care services. **NOTE:** See VHA Handbook 1601A.06, *Applications and Copayments for Extended Care Services*, dated November 10, 2015.

b. Veterans under court-ordered treatment are appropriate for MH RRTP care, but a court's order cannot override a program's otherwise valid admission decision to not admit the Veteran. VA cannot assume responsibility for custody nor guarantee length of stay in the MH RRTP.

c. A written order by a physician, nurse practitioner, or physician assistant is required to admit the Veteran to MH RRTP. **NOTE:** See VHA Handbook 1907.01, *Health Information Management and Health Records*, dated March 19, 2015.

d. **Admission Criteria.** The Veteran must:

(1) Be assessed as not meeting criteria for acute inpatient mental health or medical admission;

(2) Be assessed as requiring a level of care higher than outpatient care, or outpatient care is not available or accessible;

(3) Be assessed as having identified mental health, addiction, psychosocial, or medical rehabilitation and treatment needs requiring the services, structure, and support of a mental health residential treatment environment;

(4) Be assessed as not an imminent risk of harm to self or others;

(5) Be capable of self-preservation (ability to protect one's self from harm) and basic self-care (able to independently complete activities of daily living such as bathing, dressing without assistance, take medications, etc.); and

(6) For Domiciliary Care for Homeless Veterans (DCHV) programs, the Veteran must also be homeless or at risk for homelessness or lacking a stable lifestyle or living arrangement that is conducive to the Veteran's goal of recovery. **NOTE:** *This should be a consideration, but is not a requirement, for other bed sections.*

**NOTE:** *MH RRTPs that develop additional admission criteria must, through facility leadership and the VISN Mental Health Lead, contact the National Director, MH RRTP, Office of Mental Health and Suicide Prevention, VA Central Office for concurrence.*

e. **Denial of Admission.** Veterans cannot be denied admission to MH RRTPs based solely upon:

(1) Current abstinence or length of current abstinence from alcohol or non-prescribed controlled substances;

(2) The number of previous treatment episodes;

(3) The time interval since the last residential admission;

(4) The use of prescribed controlled substances;

(5) Legal history;

(6) Medical co-occurring conditions not requiring a higher level of care and common medical needs such as the use of portable oxygen, the need for dialysis, use of assistive devices for ambulation, and the need for medical supports not requiring bed-side nursing care;

(7) Recent acute inpatient mental health admission, recent suicidal ideation or attempt or elevated chronic risk of self-harm;

(8) Pregnancy; or

(9) The need for initiation or continuation of pharmacotherapy for opioid use disorders including methadone and buprenorphine, or when prescribed a benzodiazepine.

**NOTE:** *Veterans may be denied admission to residential care only when they do not meet admission criteria as defined by this directive.*

(10) When a Veteran is not accepted for care, the Veteran, referring provider, the Veteran's Mental Health Treatment Coordinator (MHTC), and the Suicide Prevention Coordinator (SPC), when appropriate, must be provided information by a member of the MH RRTP screening team as to the reasons for non-acceptance, and these reasons must be documented by the Transitions Coordinator (or by designated member of the screening team) in the Veteran's health care record. If the Veteran's circumstance cannot be accommodated by the program, the MH RRTP admissions coordinator (as defined in Appendix C, paragraph 3.b.(8)) must participate in planning for alternative services within the medical facility's, VISN's, or VHA's mental health continuum of care and document the alternate treatment arrangements made. **NOTE:** *If the Veteran does not have an assigned MHTC, then the Veteran is referred to Mental Health for one to be assigned.*

(11) Veterans accepted for admission must be given a point-of-contact during the waiting period prior to admission (if any). **NOTE:** *The provisions of VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009, apply to all MH RRTPs.*

(12) As a rule, Veterans are admitted to the program in the order in which they are screened or accepted. Exceptions may be made at the discretion of the Program Manager or designee based on clinical circumstances indicating Veteran's needs require a higher priority admission.

f. Veterans referred for residential treatment have been identified as needing a higher level of care beyond outpatient mental health. As such, it is critical that admissions occur as quickly as possible. **NOTE:** *MH RRTPs must not be used as a simple substitute for community housing or as VA lodging or Hoptel facility. Additionally, since VA lodging or Hoptel facilities do not provide the necessary structure, programming, and support, they are not an appropriate alternative or replacement for a MH RRTP.*

g. **Priority Access.** Priority access to a MH RRTP must occur within 72 hours from screening to admission.

(1) This time frame is critical for Veterans who are in an unsafe living situation, unsheltered homeless Veterans, and Veterans whose symptoms are significantly impacting activities of daily living and increasing their risk for adverse outcomes.

(2) Certain bed sections by the nature of the care provided would be considered more likely to provide care for Veterans with urgent needs (e.g., Domiciliary Substance Use Disorders programs, DCHV). For other programs, the determination of urgency will be based on the individual needs of the Veteran and documented at the time of screening.

(3) In some instances, Veterans presenting for admission to a program may be receiving care in another setting (acute inpatient mental health) or be unable to engage in residential treatment immediately due to other circumstances (i.e., incarceration). In these instances, Admissions/Transitions Coordinator or a staff member designated by the Program Manager must facilitate a warm handoff to a staff in the other setting, utilizing communication and coordination of care between these settings to reduce the likelihood of the Veteran being lost to care.

(4) Some Veterans, based on their personal preference, will request an admission date greater than 72 hours from the time of the screening, which is acceptable when emergent medical or mental health needs, including appropriate housing, are met.

(5) All other Veteran admissions must occur on the earliest date available after screening.

(6) Any Veteran with a scheduled wait time of greater than 30 calendar days must be offered alternative residential treatment or another level of care that meets the Veteran's needs and preferences at the time of screening. Alternative residential treatment may include a referral to a program in the community, another program within the VISN, or another program in another VISN. Outpatient treatment options while awaiting residential disposition should be discussed with the Veteran.

(7) Some Veterans, based on their personal preference, will request an admission date greater than 30 days from the time of the screening, which is acceptable when emergent medical or mental health needs, including appropriate housing, are met.

#### **4. ORIENTATION PROCESS**

Each Veteran served must receive an orientation at the time of admission that considers the Veteran's presenting condition and the type of services provided, is understandable to the person served, and is documented in CPRS. The Program Manager ensures that assigned Veterans complete the orientation, which is conducted by MH RRTP staff. Staff from services that support the MH RRTP, such as Environmental Management Service, VA Police Service, may participate in conducting the orientation classes. The orientation must be consistent with accrediting body standards and at a minimum, the orientation must include:

- a. Review of resident handbook.
- b. Review of program rules that have been determined by program staff.
- c. Complaint and appeal procedures.

- d. Ending (Sexual) Harassment training.
- e. Suicide Prevention training.
- f. Behavioral expectations to include safety, dignity, respect, racial sensitivity, etc.
- g. The program's health and safety policies regarding use of tobacco products, illegal or legal substances, prescription medications, alcohol and over-the-counter medications, weapons brought into the program, emergency exits or shelters, fire suppression equipment, and first aid kits.

## 5. ASSESSMENT PROCESS

Upon admission to an MH RRTP bed, all Veterans must receive a comprehensive, interdisciplinary assessment completed by qualified staff that considers the Veteran's strengths, needs, abilities, and preferences for care. This assessment must collect an adequate amount of information to develop an appropriate plan of care and to subsequently provide clinically appropriate and safe services. The assessment process includes the following:

a. **History and Physical Examination.** A complete History and Physical examination (H&P) by a licensed physician, nurse practitioner, or physician's assistant is required and must address any physical findings or medical problems that have an impact on the Veteran's current treatment. Active problems are to be included in the H&P and the CPRS Active Problem List is to be updated by the medical provider, when needed.

(1) Timeframes for completion of H&Ps (to include updates) need to be established based on current accreditation standards, but must be completed no more than 7 business days after admission. ***NOTE: Staff are educated on the current standards by the local Quality Management Office (QMO) about Joint Commission standards. The Commission on Accreditation of Residential Facilities (CARF) holds monthly national calls with programs to discuss the standards.***

(2) For Veterans with a physical completed in VA outpatient primary care or VA inpatient hospitalization (e.g., acute psychiatry) within the last 30 days, or transferring from one MH RRTP to another MH RRTP, an updated H&P is sufficient if there have not been any significant changes in the Veteran's medical status.

(3) Pregnancy tests are required at admission for female veterans unless there is existing VA documentation of hysterectomy or long-acting birth control measures. ***NOTE: A female Veteran may refuse a pregnancy test; however, the provider must account for possibility of pregnancy and make adjustments in care to reduce risks.***

(4) A Veteran remaining in the MH RRTP for one year or longer must be given an annual examination, to include mental status.

(5) Given the heightened risk for hepatitis C among patients with SUD, hepatitis C testing must be offered to all Veterans in MH RRTPs, with an antibody test (or documentation of recent testing) and confirmatory testing done for viremia if the hepatitis C antibody is positive. More information on hepatitis C can be found at <http://vaww.hepatitis.va.gov>. **NOTE:** *This is an internal VA web site not available to the public.*

(6) Routine Human Immunodeficiency Virus (HIV) testing must be offered to all Veterans in MH RRTP. HIV screening is recommended for Veterans at least once, and testing must be offered at least annually for Veterans with on-going risk factors. Verbal consent is required prior to HIV testing, written information material regarding HIV must be provided to patients, and documentation of consent is required in the medical record, as required by VHA Handbook 1004.01. More information on HIV, including patient education materials can be found at <http://vaww.hiv.va.gov>. **NOTE:** *This is an internal VA Web site not available to the public.*

b. **Comprehensive Biopsychosocial Assessment.** A comprehensive biopsychosocial assessment, to include an interpretive summary based on the assessment data, must be completed and documented in CPRS within 7 business days of admission by a Licensed Independent Practitioner (LIP). The assessment process includes the preparation of a written interpretive summary that is based on the assessment data, identifies any co-occurring disorders, and is used in the development of the individualized recovery plan.

c. **Measurement-Based Care.** Assessment is an individualized process that begins at the time of screening and continues until discharge. Principles of measurement-based care (MBC) must inform assessment procedures with assessments used to guide decision-making regarding development of the recovery plan and any necessary changes to treatment and rehabilitation during the course of the residential admission. **NOTE:** *See VHA Measurement Based Care Share Point <https://vaww.portal.va.gov/sites/OMHS/omhostrongpractices/MBC>. This is an internal VA Web site not available to the public.*

(1) To ensure consistency across mental health settings of care and support development of a “shared language” across VHA staff and among Veterans, four core measures were selected for use within VHA. **NOTE:** *The specific measures can be found at various links found on the VHA Measurement Based Care SharePoint. Please see the link provided at 4.c above:*

(a) Brief Addiction Monitor – Revised or Intensive Outpatient Program (BAM-R or BAM-IOP).

(b) PTSD Checklist 5 (PCL5).

(c) Patient Health Questionnaire – 9 item (PHQ9).

(d) Generalized Anxiety Disorders – 7 item (GAD7).

(2) MH RRTPs must incorporate the use of these core assessments based on the presenting clinical needs of the individual Veteran. It is not expected that all four measures would be administered to all Veterans admitted for residential treatment, and additional measures may also be used based on locally identified needs.

**NOTE:** *Domiciliary SUD and Domiciliary PTSD programs and tracks are expected to administer the BAM-R or BAM-IOP and PCL5, respectively, given their specialty focus. Veterans with co-occurring SUD and PTSD are expected to complete both the BAM-R or BAM-IOP and PCL5.*

(3) Selected measures must be administered within 7 calendar days before or after admission, and within 7 calendar days prior to discharge.

(4) Given the variability across programs in length of stay, programs are expected to establish local criteria for ongoing administration of assessments during the Veteran's treatment episode consistent with standards for MBC to evaluate progress in meeting recovery plan objectives and to inform appropriate changes to the Veteran's recovery plan.

(a) It is recommended that for programs with average lengths of stay greater than 30 days, assessment instruments are administered, at a minimum, every 30 days.

(b) For programs with shorter lengths of stay, alternate versions of certain measures may be used to support Veteran-centric monitoring during treatment with the primary version only administered at admission and discharge (i.e., BAM-IOP).

(c) MH RRTPs must use Mental Health Assistant (MHA) directly or other tools that have been designed to ensure capture of data within the Mental Health VistA file in order capture and document Veteran reported outcomes for the purposes of MBC.

d. **Suicide Risk Assessment and Prevention.** MH RRTP managers must ensure a constant awareness among staff and residents for the potential of Veteran suicide, as delineated in VHA Directive 1071, Mandatory Suicide Risk and Prevention Training for VHA Health Care Providers, dated June 27, 2014. When a comprehensive suicide risk evaluation (CSRE) is required, the Veteran must be assessed by a VHA health care provider, and the assessment must include a determination of whether to admit the Veteran to a higher level of patient care.

(1) A CSRE must be completed within 7 calendar days admission to a MH RRTP. The CSRE is required by accreditation standards to document risk and protective factors and history of suicidal ideation, intent, plan, and attempts. If a CSRE has been previously completed with the Veteran, an updated, abbreviated version of the CSRE can be completed that updates only those risk and protective factors that may have changed, the clinical impression of acute and chronic risk, and the interventions and mitigation plans as clinically indicated.

(2) A screening for suicide risk must be completed:

(a) At the time of screening for admission. **NOTE:** *This may be different than the time of the actual admission.*

(b) Within 24 hours of admission. **NOTE:** *If the CSRE is completed within 24 hours of admission a screening for suicide risk is not required.*

(c) At the time of treatment plan reviews;

(d) Within 24 hours prior to discharge. **NOTE:** *If the CSRE is completed within 24 hours of discharge a screening for suicide risk is not required. In addition, if a Veteran drops out of treatment without seeing or contacting staff, or other clinical factors preclude the completion of the suicide risk screening, the last screening for suicide risk should be reviewed and that review documented in the medical record*

(e) At any other time, there is a particular concern (such as undergoing medication changes, return to use, irregular discharge, denial of admission, provider changes, trauma, loss, or other major changes in circumstances).

**NOTE:** *When Veterans are screened for admission to the MH RRTP while admitted to an acute inpatient mental health unit, a screening for current risk for suicide may not be required as the Veteran would have received an appropriate screening and assessment for suicide risk during admission to the inpatient unit. However, if a screening has not been completed within the last 7 days, screening for suicide risk must occur during the MH RRTP screening for admission.*

(3) When a screening for suicide risk is positive, a CSRE must be completed with appropriate interventions/mitigation plans implemented as clinically indicated.

(4) An updated CSRE must be completed with all Veterans within 7 days prior to discharge and is expected to incorporate interventions and mitigation plans expected to be in place following discharge. **NOTE:** *If a Veteran drops out of treatment without seeing or contacting staff or other clinical factors preclude the completion of the CSRE, the last screening for suicide risk must be reviewed and that review documented in the medical record.*

(5) Processes must be in place that allow for monitoring for changes in suicide risk within 7 days of the start of the pass or authorized absence from the program. It is recommended that monitoring be completed within 48 hours prior to a Veteran leaving on pass for those Veterans that have not routinely left the program. Monitoring may include completion of a screening for suicide risk, review of the CSRE and/or completion of an updated CSRE.

(6) Screenings for suicide risk and the CSRE must be conducted utilizing current VHA standards for suicide risk screening and assessment.

(7) If a Veteran is deemed to be at risk for harm to self or others, immediate measures must be taken to ensure the Veteran's safety. The Veteran must remain in

the presence of a VHA staff member until additional assessments and if clinically indicated additional interventions and mitigation strategies can be put in place.

(8) The Suicide Prevention Coordinator, or designee at the appropriate VA medical facility must be contacted by the provider for any Veteran assessed at moderate or high acute risk. **NOTE:** See *VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide* (<https://www.healthquality.va.gov/guidelines/MH/srb/>) for information about these risk classifications.

(9) Communication about current suicide risk and all identified interventions and mitigation strategies documented in the CSRE must be shared with the MH RRTP interdisciplinary recovery team, including the Program Manager and 24/7 staff. When clinically indicated, a suicide risk safety and recovery plan must be developed, or if already in place updated, with the Veteran and reviewed periodically during the residential admission. The safety and recovery plan must be documented in the Veteran's clinical record in CPRS and must be updated prior to discharge by a provider, in collaboration with Veteran's assigned case manager.

(10) All Veterans admitted to the MH RRTP must receive suicide prevention gate-keeper training within seven days of admission to the program [e.g., modified Operation S.A.V.E. training (Signs, Asking, Validating, Expediting and Escorting) and VA A.C.E. materials (Asking, Caring, Expediting and Escorting)]. Education must include how to access help if they feel suicidal or are concerned for the safety of other Veterans admitted to the program. Completion of the education is documented in CPRS by either Suicide Prevention staff or a RRTP staff member who conducted the patient health education.

(11) Suicide Risk Screening and Assessment must be included in the mandatory annual competency assessment for all members of the interdisciplinary recovery team and 24/7 staff in every MH RRTP. Staff members must know how to refer Veterans and get immediate assistance from other mental health providers for Veterans identified at risk. Refresher training is required if a staff member does not meet this competency. MH RRTP staff coordinates the program's suicide prevention procedures in collaboration with the facility's Suicide Prevention Coordinator. **NOTE:** See *VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008. Additional resources related to suicide prevention can be found at the following link: <http://vaww.mentalhealth.va.gov/rc-suicideprevention.asp>. This is an internal VA Web site not available to the public.*

e. **Nursing Assessment.** The nursing assessment must be completed by the Registered Nurse within 24 hours of admission. **NOTE:** *A nursing assessment is not required in the CWT-TR program.*

f. **Employment and Vocational Services Screening and Assessment.** The screen for employment and vocational services must be completed by the Licensed Independent Practitioner as part of the biopsychosocial assessment with identified

needs addressed in the rehabilitation plan. If the Veteran needs additional vocational rehabilitation services, a referral to employment and vocational rehabilitation services must be completed by the Vocational Rehabilitation Specialist (VRS) as part of the initial rehabilitation plan. A consult to Therapeutic and Supported Employment Services or Homeless Veterans Employment Services must be made if barriers to employment are present due to mental illness or concurrent physical illness, and support with obtaining or maintaining employment is indicated. In some cases, a referral to a non-VA employment program, in lieu of or in addition to VA employment services, may be the most helpful and the reasons for this referral and outcomes should be documented. If the Veteran's vocational needs, employment goals, or the level of supports needed are unclear, a consult for further assessment should occur.

**g. Safe Medication Management Assessment.** Safe Medication Management (SMM) assessments must be completed as required in Appendix F, Safe Medication Management.

## **6. RECOVERY PLANNING AND TREATMENT SERVICES DOCUMENTATION**

a. The recovery planning process is designed to assist each Veteran incorporate identified strengths, needs, abilities, and preferences into the plan. This planning process is done in each MH RRTP by an interdisciplinary recovery team with the Veteran a full partner in the process.

b. An individualized recovery plan must be developed and completed by the assigned case manager in collaboration with the interdisciplinary recovery team. The plan must include specific goals; measurable objectives such as reduction in symptoms, improved health and well-being, ability to secure meaningful employment and so on; targeted dates for completion; and a designated responsible individual to address each goal. A suicide risk safety plan must be included, as appropriate. The interdisciplinary recovery team must identify the criteria and process for each Veteran's transition and discharge, and must document information in the overall plan of care and services. The goal is to better support the Veteran's progress.

c. Timeframes for developing and updating plans are defined by local requirements and standards of practice and depend on the emergent needs of and the care, treatment, or services sought by the individual served. The Veteran's strengths, needs, goals, and action plans are identified utilizing information obtained through the assessment process and includes direct input from the Veteran and from the Veteran's family or significant others, as available and appropriate. VHA providers beyond the MH RRTP who are currently involved in the Veteran's care need to be included in the planning process whenever feasible.

d. Interdisciplinary recovery team meetings will be conducted with the Veteran present, as appropriate. Timeframes to accomplish the goals established by the Veteran will be identified and monitored. The interdisciplinary recovery team conducts reviews throughout the Veteran's stay, consistent with local requirements. Reviews can

also be requested by the Veteran, a team member, or another provider involved in the Veteran's care.

## 7. DISCHARGE AND TRANSITION PLANNING

a. Discharge and transition planning for each Veteran starts at the time of admission. Discharge/transition planning is a process by which the Veteran identifies personal needs for continuing recovery, care, treatment, and services after leaving the program.

b. Discharge and transition planning should be addressed at each interdisciplinary recovery team meeting with the Veteran. The Veteran is involved in the discharge planning process as well as all members of the treatment team. Programs should include the Mental Health Treatment Coordinator in the discharge planning process

**NOTE:** See *VHA Handbook 1160.01*.

c. Staff is responsible for ensuring that access barriers to continuing outpatient care (e.g., distance, transportation, scheduling) are reduced or eliminated. Staff must ensure that the Veteran is scheduled to be seen by a mental health provider within 7 calendar days of discharge. The appointment must be scheduled with the Veteran notified of the appointment prior to discharge. The Veteran must be introduced to and continuing needs reviewed with the receiving outpatient clinician in person, by phone, or by video conferencing prior to a planned discharge to ensure a seamless transition.

d. Discharge planning should follow a clear process that includes the use of a discharge planning checklist or template, which is created by the Program Manager, in consultation with staff. The checklist should include, but is not limited to, the following elements:

(1) Outpatient follow-up plans, with a copy to Veteran.

(2) Verified appropriate safe housing. MH RRTPs may not discharge to unsheltered homelessness. Veterans will only be discharged to a shelter when there is no other option or when this is the Veteran's preference.

(3) Verified travel or pick-up arrangements.

(4) Review of medication recommendations with appropriate supply of medications, including naloxone if clinically indicated.

(5) Development or update of the suicide risk safety plan, when appropriate.

e. Regardless of the Veteran's discharge status, the approach to discharge and transition planning remains the same.

(1) The Veteran must be involved in the discharge planning process. All discharges, including irregular discharges, should be completed during regular business hours to ensure appropriate resources are available to support the Veteran's transition to the community. VA medical facilities must have procedures and resources

in place to address Veteran behaviors, including substance use, that ensure the safety of Veterans and staff until discharge occurs during regular business hours. Resources might include the need for Veteran monitoring in another unit or the Emergency Department when a risk assessment determines the Veteran cannot be safely managed in the MH RRTP.

(2) The Veteran must be provided clear information regarding discharge. Continuity of VA and non-VA services for medical, substance use and other mental health needs are arranged. This information includes decisions regarding the setting and frequency of ongoing treatment and community recovery activities.

(3) An assessment of dangerousness and overall mental health stability must be made by the provider and appropriate action taken. **NOTE:** *Dangerousness is defined as being potentially a danger to self or to others.*

(4) If the Veteran does not have permanent housing, the case manager, in collaboration with the interdisciplinary recovery team, facilitates arrangements for transitional or temporary housing in collaboration with Homeless Veteran Services.

(5) A member of the interdisciplinary recovery team must provide the Veteran with a copy of the Veteran's current medication list, the name and contact number of the primary care provider, a list of pending appointments, and all other information in support of the on-going treatment of medical, substance use, and mental health issues.

(6) The interdisciplinary recovery team must document in the medical record the Veteran's contact information following discharge.

(7) If a Veteran refuses to participate in discharge and transition planning or if a Veteran drops out of treatment without seeing or contacting staff, a member of the interdisciplinary recovery team enters a discharge note with as much of the preceding information as possible. In addition, that staff member must address, based upon the last known information, whether the Veteran may be at significant risk of harm to self or others. MH RRTP staff designated by the Program Manager or other supervisor will contact the Veteran for follow-up and follow local procedures for initiating a welfare check.

(8) Possible reasons for discharge must be documented in either policy or program handbook and provided to Veterans so they are clearly aware of these expectations upon admission to the program. The criteria for discharge and transition generally depend upon the following:

(a) The Veteran has accomplished the goals as defined in the recovery plan and is prepared for community re-entry with identified resources for after discharge.

(b) The Veteran requires treatment beyond program resources and is to transition to another level of care.

(c) The Veteran requests to leave before treatment goals are met.

f. Veterans must be advised, prior to discharge, of the process that must be followed for the Veteran to appeal a discharge decision. This includes how to access the Patient Advocate. **NOTE:** *For further information about Patient Advocates, please see VHA Directive 1003.04, Patient Advocacy Program, dated February 7, 2018.*

g. **Irregular/Unplanned/Against Medical Advice Discharges.** There are circumstances when the interdisciplinary recovery team may take unilateral action to irregularly discharge a Veteran prior to program completion. These circumstances, which are at the discretion of the interdisciplinary recovery team, include but are not limited to activities that present safety or security concerns for the residential unit such as physical violence, theft, possession of a weapon, or distribution of illicit substances, failure to return from authorized absence or pass, leaving without approval, and demand to discharge while undergoing disciplinary measures.

(1) Any communication about irregular discharges should include all interdisciplinary recovery team members, the Veteran's MHTC, VA Police, and the facility SPC. The MHTC and, where relevant, the SPC have responsibilities for the Veteran's treatment across episodes of care. Their inclusion in treatment planning is necessary to ensure that treatment is Veteran-centric. **NOTE:** *In accordance with VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016, there is no requirement for the Veteran to sign the VA Form 10-5345 (Request for and Authorization to Release Medical Records or Health Information) to release verbal information to VA Police. Veterans must be informed that VA Police will be notified in the event of a Veteran missing from the unit or being discharged irregularly.*

(2) When a Veteran experiences an unplanned, Against Medical Advice (AMA) or an irregular discharge, an in-person follow-up appointment must be offered and scheduled to occur within 24 hours of discharge, with a second appointment scheduled within 7 days of discharge. When a Veteran is unable or unwilling to attend an appointment in person, a telephone appointment may be offered and scheduled. See Appendix E of this directive for additional information related to irregular discharges.

(3) Processes must be in place to ensure notification of facility leadership of all unplanned or irregular discharges.

**NOTE:** *Patients who request release, or whose medical or legal eligibility for care no longer exists, will be given regular discharges.*

## 8. DISCHARGE SUMMARY

a. The MH RRTP medical provider responsible for the patient's care must enter a discharge order and must complete and sign the discharge summary, which is completed consistent with requirements in VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015, external accreditation standards (such as Joint Commission or the Commission on Accreditation of Residential Facilities), and facility by-laws.

b. A copy of the discharge summary must be sent to the Veteran's primary care provider by the MH RRTP provider.

c. The case manager must prepare a discharge note within 4 business days. See Appendix C of this directive for additional information regarding staff responsibilities.

## CORE CLINICAL PROGRAMMING REQUIREMENTS

### 1. RECOVERY ORIENTATION

Services and care provided in Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) are to be recovery-oriented. Recovery-oriented services are person-centered (versus program-centered), focused on functioning and community participation (versus symptoms), and strengths based (a growth model versus a maintenance model). All work is collaborative with the Veteran having control of the recovery plan and goals. **NOTE:** See *Substance Abuse and Mental Health Services Administration (SAMHSA) Web site*, <https://www.samhsa.gov>.

### 2. PROGRAMMING INTENSITY

Programming and length of stay must be individualized to each Veteran's needs and preferences and provide a minimum of 4 hours of therapeutic programming per day, including evenings and weekends. Specialty programs and tracks must provide a minimum of 4 hours of diagnosis-specific treatment and rehabilitation in addition to other clinical services targeted to co-occurring psychosocial needs. While group treatment is a common delivery format for a variety of services, residents should have the opportunity to meet individually with providers as clinically indicated. Individualized programming must be delivered using a model of care that facilitates the Veteran being able to participate in core evidenced-based psychotherapeutic groups as well as psychoeducational groups, complementary therapies, self-help and other activities that meet individual needs and interests.

a. A minimum of 4 hours of programming per day during the week must be staff-led. It is expected that most programs will provide more than 4 hours per day during administrative hours (Monday through Friday) especially the specialty bed sections or tracks. Larger programs must have sufficient programming to ensure availability of a minimum of 4 hours per day for all Veterans with group sizes that are consistent with Centers for Medicare and Medicaid standards for process groups (no more than 12 persons) and educational groups of a manageable size to allow for discussion and interaction among participants. **NOTE:** See *Center for Medicare and Medicaid Services* (<https://www.cms.gov/>). *This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.* On weekends, at least one hour per day of programming must be staff-led. In the evening and on weekends, programs must provide appropriate therapeutic activities that have a direct relationship to assisting the Veterans in meeting treatment and rehabilitation goals. While the use of appropriate passes that are directly related to the accomplishment of the Veteran's treatment and rehabilitation goals is encouraged, programs may not place all residents on pass for the weekend as a means of meeting the programming goal or due to lack of staffing availability.

b. Treatment, rehabilitation, and psychosocial programming may range from relatively short-term care of limited focus, (e.g., less than 30 days and targeted primarily towards diagnosis-specific treatment and symptom management) to long-term,

comprehensive rehabilitation (e.g., more than 30 days with a full-range of psychosocial services, such as life-skills training, social learning, vocational rehabilitation therapy, etc.). **NOTE:** See VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, dated September 11, 2008, for further information about the range of treatment options.

c. Military Sexual Trauma (MST)-related mental health care must be available for all Veterans as clinically indicated during their residential stay. Care may be provided by staff working directly in the program or through engagement with outpatient mental health clinics providing such care.

### 3. INTEGRATED CARE

Co-occurring mental health and substance use disorders, as well as other medical concerns, must be addressed as part of the Veteran's recovery plan during the Veteran's residential stay. Care for Veterans in all MH RRTPs must be delivered using an integrated care model that allows for concurrent treatment of co-occurring conditions. Care should be taken to reduce or limit routine sequential admissions across bed sections.

### 4. MONITORING AND RESPONDING TO SUBSTANCE USE

a. At the time of admission, residents must be informed that using or possessing alcohol and non-prescribed drugs is not permitted while participating in the MH RRTP, and be provided with information about the policies and procedures related to substance use monitoring.

(1) MH RRTPs must be able to monitor for possible substance use by Veterans during their residential admission.

(2) To ensure a substance-free environment, residents must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their recovery plans. Procedures include urine drug screening.

(3) Abstinence monitoring must occur at least weekly in the first 30 days of treatment, with frequency modified based on indications of relapse risk, and must include testing for abuse and diversion of prescribed controlled medications. All residents must be tested upon return from pass with consideration given to the length and timing of the pass to determine when the testing is completed.

(4) Monitoring procedures must include direct observation by nursing staff or same gender staff, or by other procedures deemed sufficient to ensure that samples are not adulterated (e.g., temperature strips, urine creatinine levels, modified space for urine drug screen collection, etc.) and to promote rapid preliminary feedback (e.g., breathalyzer), with laboratory confirmation available for disputed results. Decisions about direct observation of urine drug screens must be informed by clinical factors that

may indicate a need to use alternate procedures designed to ensure that samples are not adulterated.

(5) All MH RRTPs must have routine urine toxicology screening and confirmatory testing available for the following substances: amphetamines, methamphetamines, benzodiazepines, cocaine, methadone, marijuana, oxycodone, opiates, and buprenorphine. MH RRTPs must have capacity for second-tier selective screening for less-common or newer substances of abuse (i.e. synthetic cannabinoids, fentanyl) using existing contracts available through pathology and laboratory medicine.

(6) Veterans who do not adhere to this monitoring policy must have careful review of their appropriateness for residential care by the Program Manager and staff and may be subject to discharge from the residential program.

b. All MH RRTPs must have procedures in place for responding when a Veteran presents to the unit intoxicated or under the influence of a substance. Procedures include medical assessment as appropriate and other measures to ensure the safety and security of the Veteran. These procedures are developed locally by the Program Manager.

c. The MH RRTP may not require automatic or immediate discharge when a Veteran reports substance use, is found to be intoxicated, or has a positive urine toxicology screen. Whenever possible, first consideration should be to retain the Veteran in treatment so that the Veteran's treatment needs can continue to be met. All MH RRTPs should have procedures in place, developed by the Program Manager, to respond to substance use that allow for active changes to the recovery plan as appropriate while directly engaging the Veteran in this process. When there are concerns with safety and security of the residential environment, such as continued active substance use, or where there is involvement of the legal system due to contraband on the unit, the Veteran may be discharged. Whenever a decision is made to discharge a Veteran from the residential program by reason of substance use, continuing VA and, if appropriate, community care services for medical, substance use disorders, and other mental health concerns must be arranged and documented by the care manager or a designated member of the treatment team.

## 5. ACCESS AND SERVICES FOR WOMEN VETERANS

a. **Mental Health.** MH RRTP services must be provided to women Veterans to the same extent as provided to male Veterans at each facility. ***NOTE: Plans for new residential programs or renovations to existing space must support a 20 percent minimum utilization rate for women Veterans.***

(1) Each program must ensure that gender-sensitive treatment and rehabilitation services are provided meeting the needs of women Veterans, especially in the areas of serious mental illness (SMI), sexual trauma, homelessness, eating disorders, reproductive health, and intimate partner violence. ***NOTE: See VHA Directive 1330.01, Health Care Services for Women Veterans, dated February 15, 2017; VHA Handbook***

1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, dated September 11, 2008.

(2) Women Veterans must have access, 5 days a week, to a female clinician for individual treatment as clinically indicated.

(3) The Program Manager and staff are responsible for addressing gender-related issues in a manner that ensures safety and security within mixed gender groups.

**b. Environment of Care Considerations for Women Veterans.**

(1) MH RRTPs must maintain and adjust environments to support women Veterans' dignity, respect, privacy and safety. Physical and psychosocial privacy must be provided to women Veterans. **NOTE:** *The Women Veterans Program Manager (WVPM) must participate in regular environmental rounds with special emphasis on improving privacy and security. See VHA Handbook 1330.02, Women Veterans Program Manager, dated August 10, 2018.*

(2) MH RRTPs must provide:

(a) Locking bedrooms and bathrooms (including showers) for female Veterans.

(b) Facilities with 40 or more residential treatment beds must establish a separate and secured unit or wing for women Veterans. Facilities with fewer than 40 beds are strongly encouraged to establish a separate and secured area for women Veterans; if this is not possible, rooms for women Veterans should be located nearest to staff. In locations with multiple units or programs, beds for women Veterans may be consolidated across bed sections (program types) into one separate space for women Veterans. **NOTE:** *In certain circumstances, women Veterans may prefer to remain on a mixed-gender unit. In these instances, this preference can be considered when a bedroom is available that meets safety and security requirements.*

(c) When a separate unit or wing is established, care must be taken to ensure that women Veterans are able to actively participate in all aspects of care including all therapeutic activities associated with the program for which they have been admitted.

(d) Separate space for women Veterans on the unit for leisure activities and down time (e.g., day room or lounge).

(e) Gender-specific personal care and hygiene products.

**c. Medical Care for Women Veterans.** As part of the continuity of care for women Veterans, a trained provider must be available wherever a woman Veteran presents for care. **NOTE:** *Medical care for women Veterans should be in compliance with VHA Directive 1330.01. If there are additional specific health issues, contact the Women's Health Medical Director or Women Veteran Program Manager. See VHA Directive 1330.02, Women Veterans Program Manager, dated August 10, 2018.*

d. **Pregnant Women Veterans.** MH RRTPs must accommodate women who are pregnant or lactating. Pregnancy cannot be the sole factor for denying admission. MH RRTPs should work in collaboration with the facility's Maternity Care Coordinator to ensure conformance with VHA Handbook 1330.03, Maternity Health Care and Coordination, dated October 5, 2012. Special attention must be paid to ensuring a viable discharge plan prior to delivery. **NOTE:** *MH RRTP Managers, in collaboration with Women's Health, must plan and develop procedures for responding to the emergent medical needs for women who are pregnant.*

e. **Preventive Care for Women Veterans.** Preventive care must be available to women Veterans admitted to a MH RRTP. Preventive services for women Veterans must include but is not limited to age and risk appropriate screening for breast, and cervical cancer and osteoporosis screening. Screening for intimate partner violence and military sexual trauma must be completed as part of preventive care, with connection to recommended services in the case of a positive screen. See VHA Directive 1330.01, Health Care Services for Women Veterans, dated February 15, 2017.

## **6. ACCESS AND SERVICES FOR VETERANS WITH SERIOUS MENTAL ILLNESS**

a. All MH RRTPs must have the ability to serve Veterans who have been diagnosed with SMI. Services provided should allow these Veterans to fully participate in the therapeutic process, which values their strengths, needs, abilities and preferences.

b. Some Veterans enrolled in MH RRTPs will meet admission criteria for Psychosocial Rehabilitation and Recovery Centers (PRRC) or Intensive Community Mental Health Recovery (ICMHR) programs. When the Veteran chooses to participate in PRRC, the Veteran must be given the option to participate in PRRC while they are simultaneously enrolled in the MH RRTP program. However, the choice of where to get services (e.g. whether at a PRRC, RRTP, or specialty RRTP or a combination of services) must be Veteran-driven (See VHA Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers, dated July 1, 2011). When a Veteran chooses to participate in an ICMHR program as part of the discharge planning process from the MH RRTP program, a warm hand off must be arranged in advance of the MH RRTP discharge date (See VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated May 9, 2017).

c. In addition to the opportunity to participate in PRRC while enrolled in MH RRTP, Veterans must have access to evidence-based treatment, which should include: Wellness Recovery Action Plan, Illness Management and Recovery, Social Skills Training, and Integrated Dual Diagnosis Treatment. Veterans must also have access to psychiatric support and pharmacotherapy as clinically indicated (See VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated July 1, 2011).

d. Veterans with a SMI who desire competitive community employment should be referred for Compensated Work Therapy (CWT) Supported Employment services. Vocational rehabilitation staff's time should be dedicated to the provision of vocational

and educational services to assist the Veterans in meeting their employment goals (See VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program dated July 1, 2011).

## 7. SERVICES FOR VETERANS ADMITTED WITH SUBSTANCE USE DISORDERS

a. Over 85 percent of Veterans admitted to an MH RRTP have a Substance Use Disorder (SUD) diagnosis. Given the high rates of SUD diagnoses among Veterans served by the MH RRTP, all residential programs must have capacity to address SUD-related treatment needs.

b. Veterans assessed as meeting the criteria for ambulatory withdrawal management consistent with the VA-Department of Defense (DoD) Clinical Practice Guidelines ([www.healthquality.va.gov](http://www.healthquality.va.gov)) may be admitted to an MH RRTP as part of a plan to provide treatment and rehabilitation for SUD. These Veterans must meet the admission criteria for a MH RRTP and be willing to participate in ongoing treatment and rehabilitation as part of the residential continuum of care. Veterans at low risk for complications, with mild withdrawal, or who would otherwise be managed as outpatients, can be managed in residential treatment programs providing medically monitored detoxification. Medical monitoring includes nursing, medical support, and the use of evidenced-based monitoring tools (e.g. CIWA-R).

c. MH RRTPs are not an appropriate level of care for Veterans who are at moderate to severe risk of withdrawal. These Veterans require medically managed withdrawal on an acute inpatient bed section where there is 24/7 nursing care and daily physician visits.

d. The current VA-DoD Clinical Practice Guideline for the Management of SUD ([www.healthquality.va.gov](http://www.healthquality.va.gov)) must guide the provision of SUD treatment for Veterans admitted to any MH RRTP.

e. A minimum of two evidence-based psychosocial interventions for SUD must be offered by SUD specialty care bed sections. Cognitive behavior therapy for SUD is required as one of the two evidenced-based practices. See Mental Health SharePoint for information on Evidence Based Practices, <http://vaww.mentalhealth.va.gov/ebp/index.asp>. **NOTE:** *This is an internal VA Web site not available to the public.*

f. Addiction-focused pharmacotherapy for alcohol, opioid, and tobacco use disorders must be offered, unless contraindicated. When clinically indicated, Veterans diagnosed with an opioid use disorder or those assessed at risk for an opioid overdose must be offered a prescription for naloxone at the time of admission and at discharge.

g. During the residential stay, program clinical staff must promote:

(1) Access to a variety of ongoing mutual-help groups both on-site and in the community (e.g., Alcoholics Anonymous, SMART recovery, peer support, and other spiritual or religious groups).

(2) Individualized services tailored to Veterans' continuing care needs following residential treatment through linkage to SUD services and other behavioral health and medical services that support long-term health and well-being. **NOTE:** *Other addiction-focused psychosocial interventions may be found at Appendix C of the VA-DoD Clinical Practice Guideline for the Management of Patients with SUD.*

h. Sites must make naloxone available on the residential unit for emergency use by staff in the event of an overdose on the unit. Appropriate staff training in recognizing signs of a possible overdose and procedures for use of naloxone during a suspected overdose must be documented in the Veteran's medical record and in Issue Briefs that are submitted to leadership. **NOTE:** *Additional resources may be found on the Opioid Overdose Education and Naloxone Distribution (OEND) SharePoint site: [vaww.portal2.va.gov/sites/mentalhealth/OEND/default.aspx](http://vaww.portal2.va.gov/sites/mentalhealth/OEND/default.aspx). This is an internal VA Web site not available to the public.*

## 8. SERVICES FOR VETERANS ADMITTED WITH POSTTRAUMATIC STRESS DISORDER

a. Domiciliary PTSD and PTSD treatment tracks provide a safe, supportive, and structured environment for Veterans diagnosed with PTSD and co-occurring disorders. Veterans who meet the diagnostic criteria for PTSD or who have a significant trauma-related readjustment problem are eligible for admission to the PTSD residential services. Co-occurring mental health treatment for symptoms related to an experience of MST must be available to all Veterans in residential care. Active duty Servicemembers requiring residential treatment for trauma-related adjustment problems are eligible for care in PTSD residential programs if they receive prior TRICARE authorization.

b. PTSD treatment must facilitate independence, self-determination, and enhanced coping. Programs must offer access to evidence-based psychotherapy for PTSD treatment, such as cognitive processing therapy and prolonged exposure therapy, as well as evidence-based pharmacotherapy as described in the VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress. See [www.healthquality.va.gov](http://www.healthquality.va.gov). A minimum of two evidence-based psychosocial interventions for PTSD must be offered by PTSD specialty care bed sections. Family psycho-education should be offered if indicated. See Evidence-Based Psychotherapy <http://vaww.mentalhealth.va.gov/ebp/index.asp>. **NOTE:** *This is an internal VA Web site not available to the public.*

c. Conditions which co-occur with PTSD (e.g., chronic pain, SUD, Traumatic Brain Injury (TBI), affective disorders) must be concurrently addressed during residential treatment. Treatment for co-occurring SUD must occur concurrently, either through

**July 15, 2019**

**VHA DIRECTIVE 1162.02  
APPENDIX B**

staff embedded in Dom PTSD, a PTSD-SUD Specialist, or through care from a specialized SUD program.

**STAFFING, STAFF COMPETENCIES AND TRAINING REQUIREMENTS****1. STAFFING**

Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) must have adequate core staffing to provide safe, effective, and appropriate clinical care. Written staffing plans must be developed at each MH RRTP based on national policy requirements including this directive and factors affecting minimum core staffing levels. Services may be provided by either dedicated staff assigned to the MH RRTP or by staff assigned to other outpatient medical programs. Each MH RRTP must be staffed by:

a. An adequate number and mix of staff to provide effective clinical outcomes and supervision to ensure a safe, secure environment in accordance with the core minimum staffing requirements in this directive.

b. Staff who have completed required annual Prevention and Management of Disruptive Behavior training.

c. An interdisciplinary clinical team or teams of health care professionals and paraprofessionals with the training and expertise needed to provide interventions designed to meet the Veteran needs.

d. Staff with competencies to treat Veterans with Serious Mental Illness (SMI), Substance Use Disorder (SUD), Posttraumatic Stress Disorder (PTSD), and co-occurring medical conditions.

e. Supporting administrative and clerical staff that allow for efficient operations, to include scheduling of clinical encounters. Depending on program size, an administrative officer may be included to assist the Program Manager with administrative functions.

f. Since onsite supervision of the MH RRTP is required 24 hours per day, 7 days per week, an employee must be physically present on the unit at all times that Veterans are present on the unit.

g. In MH RRTPs with multiple floors, pods, units, wings, or buildings, a staff person must be physically present in each distinct area of the building to ensure auditory and visual awareness of the space.

h. Facility mental health management must identify appropriate staff to be on call by radio, telephone, or pager at all times.

**2. FACTORS AFFECTING MINIMUM CORE STAFFING**

The following factors must be considered when developing the written staffing plan as increased staffing above the core minimum may be necessary:

a. Length of Stay. Programs with shorter lengths of stay will experience greater admissions, discharges, and bed turnover rates, which may increase staff workload.

b. Number of beds. MH RRTPs with 20 or fewer beds must staff the units at the 20-bed level; this is considered the minimum staff necessary to maintain a safe and effective program.

c. Distribution of beds (one unit or a program with multiple wings, floors, pods or buildings).

d. An appropriate level and mix of nursing staff on each shift to address medication management, other medical needs of the Veterans, and monitoring of the unit. See Appendix G.

e. Location and type of residential facility (travel distance, transportation, logistics and support).

f. Client demographics (diagnosis, acuity, gender, etc.).

g. Cultural maturity of program (strength of peer support, degree of “built-in” programming structure, experienced use of policies and procedures, staff turn-over, experienced program manager, etc.).

### 3. CORE STAFFING REQUIREMENTS

a. Mental Health (MH) Residential Rehabilitation Treatment Programs (RRTP) are required to maintain adequate staffing to provide safe, appropriate clinical care. When permanent positions (full or part-time) are vacant, arrangement for discipline-specific services must be arranged and maintained until the position is filled.

b. The staffing pattern for disciplines, at a minimum, must contain the following staff positions:

(1) **Program Manager.** All MH RRTPs with greater than 30 beds must have a full-time Program Manager dedicated to the administrative operation of the program. Programs under 30 beds must have a 0.5 manager dedicated to administrative operations.

(2) **Assistant Program Manager.** MH RRTPs with 100 or more beds require an Assistant Program Manager to provide administrative back-up for the program manager and to support clinical supervision of staff assigned to the program.

(3) **Nursing.** The number and mix of nursing staff must be determined by established Office of Nursing Service (ONS) Nursing Staffing Methodology for MH RRTPs. See <https://vaww.vha.vaco.portal.va.gov/sites/ONS/Workforce/SM/Resources/Shared%20Documents/Forms/AreaMHRRTTP.aspx>. *This is an internal VA Web site not available to the public.*

(4) **24-hour-per-day, 7-days-per-week (24/7) Coverage Staff.** 24/7 staff are responsible for monitoring the unit's safety and security, including health and welfare inspections, rounds, contraband prevention, monitoring the whereabouts of Veterans, and maintaining staff situational awareness throughout the unit in conformance with requirements of this directive. Clinical providers may augment the day shift supervision duties when not providing group or individual services to residents. In addition to covering evening, night, and weekend shifts, 24/7 staffing must be allotted to regular business hours to ensure 24/7 supervision of the unit.

(5) **Physician Assistant (PA), Nurse Practitioner (NP).** Provides medical care including admission orders, history and physical (H&P) exams, discharge orders, sick call, and medication orders. Coordinates referrals and oversees continuity of medical care. In addition to the core medical staff assigned to the program, each facility must provide after-hours medical coverage for both emergent and non-emergent resident needs on evenings, nights and weekends. Each facility will develop written procedures for the provision of after-hours medical support. The procedures are developed in accordance with VHA Directive 1101.04, Medical Officer of the Day, dated August 30, 2010 or current policy. The Program Manager participates in the development of these procedures in consultation with VA medical facility leadership.

(6) **Psychiatrist (Doctor of Medicine (MD), Doctor of Osteopathy (DO), Psychiatric Mental Health Nurse Practitioner (PMH-NP).** Provides mental health care including medication management, assessments, referrals, and crisis intervention. These disciplines may also provide components of the medical care including the medical history and physical examination required for MH RRTP admission. Providers are expected to have the necessary credentials to provide support for addiction-focused pharmacotherapy.

(7) **Psychologist.** Provides psychological assessments and psychotherapeutic interventions (group or individual). May provide case management and support for admission and discharge planning.

(8) **Admissions/Transitions Coordinator.** Facilitates and participates in the screening and admissions process. Assists case managers with discharge/transition planning efforts, including aftercare and follow-up referrals. FTE level may need to be increased based on bed turnover rate.

(9) **Social Worker.** Provides psychosocial assessment, case management, group and individual counseling, and discharge planning.

(10) **Employment and Vocational Services Staffing.** Provides vocational and employment-related assessments, education, group and individual counseling, job development, and placement. This position is usually matrixed from Therapeutic Supported Employment Services (TSES) or Homeless Employment Services. Core minimum staffing level is based on providing initial assessment and goal development. Additional FTEE are required for programs with vocational and employment tracks.

(11) **Peer Support Specialist.** Provides peer support, mentoring, and counseling. (See VHA Handbook 1163.05, Psychosocial Rehabilitation and Recovery Services Peer Support, dated July 1, 2011).

(12) **Recreation Therapist.** Provides treatment services, assessments, and therapeutic recreation activities.

(13) **Dietician.** Provides nutritional assessments, counseling, and education.

(14) **Clinical Pharmacist or Clinical Pharmacy Specialist.** Provides medication assessments, counseling, and education as outlined by the safe medication management policy. In some instances, a clinical pharmacy specialist may service as the primary prescriber for a Veteran admitted to the MH RRTP.

(15) **Medical and Program Support Assistant.** Provides ward clerk, scheduling, evaluation support, and administrative functions.

(16) **Case Manager.** Coordinates and provides care within scope of practice for Veterans assigned, from admission to discharge, and serves as the primary point of contact in the interdisciplinary recovery team. Disciplines may vary and is dependent upon the type of staffing. Case management may include screening, intake, individual and group counseling, collecting urine drug screens, referrals, collateral contacts, recommending passes, discharge planning, completing admission and discharge note.

c. MH RRTPs may be required to adjust the number of specific disciplines to reflect the mission of the program and the needs of the Veterans served. Where special circumstances warrant, medical centers may request an exception to the staffing plan. Written requests for an exception must be submitted by the medical center through the VISN to the National Mental Health Director, MH RRTP, Office of Mental Health and Suicide Prevention (OMHSP), Department of Veterans Affairs (VA) Central Office. The request for the exception must describe the medical center's intent for providing appropriate level and intensity of services, milieu security and access to appropriate services utilizing the requested staffing plan.

#### **4. MINIMUM STAFFING REQUIREMENTS**

MH RRTPs must maintain the following Minimum Core Staffing based on the number of beds:

## Minimum FTEE by Number of Beds

Position per Number of Beds	Less than (<) 20	21-30	31-40	41-50	51-60	61-80	81-99	100-125	126 - 150	150 - 175	176 - 200
Chief or Manager	0.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant Chief or Clinical Manager	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0
PA or NP	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.6	1.9	2.2	2.5
Psychiatrist, MD/DO, Psychiatric MH Nurse Practitioner	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Psychologist	0.5	0.8	1.0	1.0	1.4	1.8	2.0	2.6	3.0	3.6	4.0
Admissions/ Transitions Coordinator	0.5	0.5	0.5	1.0	1.0	1.0	1.0	1.5	1.5	2.0	2.0
Social Worker	1.0	1.2	1.6	2.0	2.4	3.2	4.0	5.0	6.0	7.0	8.0
Employment and Vocational Services Staff	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Peer Tech	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Recreation Therapist	0.5	0.5	0.5	0.5	0.5	1.0	1.0	1.5	1.5	2.0	2.0
Dietician	0.2	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.2	1.4	1.6
Clinical Pharmacist/ Clinical Pharmacy Specialist	0.3	0.3	0.5	0.5	0.6	0.75	1.0	1.0	1.2	1.4	1.6
Medical or Program Assistant	0.5	0.8	1.0	1.3	1.5	2.0	2.5	3.1	3.8	4.4	5.0

**NOTE:** Programs over 200 beds must contact the National Mental Health Director, MH RRTP, OMHSP, VA Central Office for directions on developing a staffing plan by using a combination of bed columns. Nursing FTEE levels must be determined using the Nurse Staffing Methodology for MH RRTPs; see Appendix G, Nursing Practice of this directive. Currently 6.0 FTE is the minimum 24/7 coverage staff necessary for a single, unobstructed unit to cover the sixteen off-tour shifts. Total 24/7 staffing requirements will be determined by the physical configuration of the unit and the nursing model.

## 5. SPECIALTY BED SECTION STAFFING REQUIREMENTS

a. Specialty bed sections (SUD Domiciliary, PTSD Domiciliary) and specialty treatment tracks as previously defined in paragraph 3, Definitions, of this directive, for SUD, PTSD, and SMI require additional specialty staff beyond the core staffing requirements. **NOTE:** *Specialty staff may cross multiple disciplines when providing specialty treatment, including, but not limited to: Addiction Therapists, Registered Nurses (RNs), Psychologists, Psychiatrists, Social Workers, Vocational Rehabilitation Specialists, Licensed Marriage and Family Therapists, and Licensed Professional Counselors.*

b. Each MH RRTP must base the number of specialty staff on the number of specialty beds assigned to the bed section or “track”. Staff providing the care may be assigned directly to the RRTP or may be outpatient staff matrixed to the MH RRTP. The outpatient specialty staff is expected to be fully-participating members of the MH RRTP treatment team including the screening, assessment, and recovery planning process.

(1) PTSD specialty staffing provides primary PTSD-related assessments, education, group, and individual psychotherapy. (See VHA Handbook 1160.03).

(2) SUD specialty staffing provides primary SUD-related assessments, education, group and individual counseling, and SUD specific pharmacotherapy. (See VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorders (SUD), dated March 7, 2012).

(3) SMI specialty staffing provides primary SMI-related assessments, education, group, and individual counseling. (See VHA Directive 1160.01 and VHA Handbook 1163.03).

(4) Psychosocial Rehabilitation staffing provides primary housing, vocational rehabilitation, and employment services including assessment, education, individual and group counseling. (See VHA Directive 1160.01).

### c. **Minimum Specialty Staffing Requirements Based on the Number of Beds.**

For other specialty bed sections or tracks such as those for Military Sexual Trauma (MST) related care, Traumatic Brain Injury (TBI), or pain treatment, facilities must utilize the minimum specialty staffing requirements listed below to determine the minimum staffing required.

<b>Position per Number of Beds</b>	<b>&lt;20</b>	<b>21-30</b>	<b>31-40</b>	<b>41-50</b>	<b>51-60</b>	<b>61-80</b>
PTSD Dom Specialty Staff (bed section or track)	2.0	3.5	5.0	6.0	7.0	8.0
SUD Dom Specialty Staff (bed section or track)	2.0	3.5	5.0	6.0	7.0	8.0
Seriously Mentally Ill (SMI) Specialty Staffing	2.0	3.5	5.0	6.0	7.0	8.0
Psychosocial Specialty Staffing (Homeless and/or Vocational)	1.0	2.0	2.5	3.0	3.5	4.0

## COMPENSATED WORK THERAPY - TRANSITIONAL RESIDENCE

### 1. DESCRIPTION

The Compensated Work Therapy-Transitional Residence (CWT-TR) programs are designed for Veterans whose rehabilitative focus is based on CWT and transitioning from this level of care to successful independent community living. **NOTE:** See *VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011, for information regarding the vocational therapy requirements for CWT.* Ongoing outpatient support is provided for diagnosis-specific conditions, as addressed in the Veterans' individualized treatment plans.

### 2. TARGET POPULATION

The CWT-TR Program was originally implemented and funded with two target populations in mind: the Veteran diagnosed with severe Substance Use Disorder (SUD) who frequently relies on institutional care, and the Veteran who is homeless and diagnosed with mental health concerns who under-utilizes VA services. During the initial demonstration phase of CWT-TR, this psychosocial rehabilitation model generally limited the targeted Veteran in these populations to Veterans for whom full-competitive employment was an expected outcome. VA leadership has since expanded the CWT-TR target population to include Veterans diagnosed with PTSD and Veterans with serious mental health disorders and concomitant vocational deficits. The growing number of homeless women Veterans is considered a population that warrants special focus. Additionally, this expanded authority encourages use of the model for program design and development that maximizes the functional status of Veterans whose level of disability may preclude full employment. The primary objectives for these Veterans are greater independence, improved social status, reduced hospitalization, and community work based on their needs, abilities, strengths, and desires. **NOTE:** *This expanded authority is derived from Public Law 105-116.*

### 3. REFERRALS

CWT-TR referrals are from VA inpatient and outpatient programs, self-referrals, community referrals, mail-in applications, and referrals from the Homeless Programs. Known or suspected medical problems that require care must be identified in the referral. Veterans referred to care must be engaged in the rehabilitation process as soon as possible after admission to the program and must be ready to be involved in work therapy. **NOTE:** See *VHA Handbook 1163.02.*

### 4. FINANCIAL MANAGEMENT ELEMENTS

a. 38 U.S.C. 2032 authorizes VA to charge Veterans a program fee to cover the cost of room and board, utilities, and housing maintenance for housing provided as part of CWT-TR. **NOTE:** See <https://www.gpo.gov/fdsys/granule/USCODE-2009-title38/USCODE-2009-title38-partII-chap20-subchapIV-sec2032>. *This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.*

b. Money for program fees is derived from a Veteran's earnings obtained by working in VA's CWT Program, community employment positions, or other income sources. Program fees are charged primarily to foster increased responsibility of Veterans for their recovery, and only secondarily to defray the cost of maintaining the houses. Veterans are not considered renters. Each resident, other than the House Manager(s), is required to pay a TR program fee to cover costs associated with operational expenses, during the resident's period of occupancy. These funds must be deposited in a sub-account of the local General Post Fund (GPF) and used only to support the expenses associated with the management and operations of the TR residences. If revenues (program fees) of a residence do not meet the expenses, resulting in an inability to pay actual operating expenses, the medical center of jurisdiction must provide the funds necessary to return the program to fiscal solvency.

c. Each CWT-TR Program is required to justify the amount of the program fee charged to Veterans. To do so, the CWT-TR Program Manager develops a projected operating budget on an annual basis. On a semi-annual basis, the CWT-TR Program Manager is required to compare the actual program revenues and expenses with the projected budget. If revenues or expenses are over or under projections by more than 5 percent, the Program Manager must adjust the program fees to ensure financial stability. To meet this requirement, the VA medical facility's Chief Financial Officer must provide to the CWT-TR Program Manager a quarterly CWT-TR Budget Report, which contains a beginning balance, total revenues, expenses by cost center, and the ending balance of the CWT-TR GPF account.

## 5. LENGTH OF STAY

A resident's length of stay (LOS) in TR does not usually need to exceed 12 months. Veterans with exceptionally complex psychosocial needs or deficits may require a longer LOS to successfully transition to the community. The LOS must be based on the measurable goals and objectives listed in the rehabilitation plan which is completed by the care manager and recorded in the Computerized Patient Record System (CPRS). While living in a CWT-TR, Veterans must follow the rules and expectations of the house, including participation in cleaning and upkeep of the residence. **NOTE:** *The CWT-TR program may not be used as a substitute for emergency housing.*

## 6. DRUG AND ALCOHOL SCREENING

Residents are prohibited from using or possessing alcohol or illegal drugs while residing in the CWT-TR Program. Residents must, in writing, agree to regular and random alcohol and drug screenings to ensure a substance-free environment, and this agreement must be scanned into CPRS by designated staff. CWT-TR managers must develop written return-to-use protocols to follow when a Veteran relapses. The return-to-use policy must be based on procedures outlined in Appendix B, paragraph 4, Monitoring and Responding to Substance Use.

## 7. ELIGIBILITY

The following eligibility criteria apply to CWT-TR admissions:

a. Admission to the CWT-TR must be a coordinated process between the CWT and the CWT-TR programs, as CWT and CWT-TR services must be integrated to meet the Veteran's employment and rehabilitation needs. The CWT-TR Manager ensures the referred Veteran meets criteria for the program.

b. At the time of admission to a CWT-TR, Veterans must be engaged in CWT services, including, but not limited to vocational assistance, transitional employment, or supported employment to be admitted to CWT-TR. There is no set time after admission that a Veteran must remain in CWT services. Veterans who obtain community employment should remain in the CWT-TR program for the period of time necessary to accomplish the goals and objectives listed in the rehabilitation plan. **NOTE: CWT-TR Programs may not deny admission to Veterans who are unable to work full-time.**

c. Veterans must be assessed as medication independent under the MH RRTP Safe Medication Management Program as outlined in Appendix F of this directive.

## 8. STAFFING AND HOUSE MANAGERS

The CWT-TR residences may be minimally staffed since, by their nature, they are designed to maximize peer support and self-care. However, the safety and welfare of both CWT-TR staff and residents must be the primary consideration. CWT-TRs must maintain a 1:10 staff to bed ratio. When a Veteran is present in the house, on-site supervision of a CWT-TR house is required; a live-in House Manager generally provides this on-site supervision. If the House Manager is not on-site, supervision may be provided by a trained Assistant House Manager. House Managers may be a senior resident or patient, a graduate of the CWT-TR, or a volunteer. Documented training of the House Managers' duties and emergency procedures is required; this training is locally determined. The House Manager's duties must be outlined in a position description and VA staff must regularly assess the House Manager's performance and competencies. The type of professional staffing provided must be determined by the clinical needs of the Veterans served and by standards applied by external accrediting bodies, including the Commission on Accreditation of Residential Facilities and Joint Commission. Medical center management must identify appropriate staff to be on call by radio or telephone at all times. A graduate of CWT-TR, acting as a House Manager, must be established by the CWT-TR manager or the facility Mental Health Chief as a Without Compensation (WOC) employee through Human Resources Management Service.

## 9. APPROVAL, ACQUISITION, CODE REQUIREMENTS, AND MAINTENANCE

a. The CWT-TR Program may operate in a community property that was purchased, leased, or otherwise acquired by VHA, or in space on the VA medical facility grounds. Approval to establish a new CWT-TR residence or expand an existing program requires VA Central Office approval through submission of a Clinical Restructuring Proposal as outlined in VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

b. As prescribed by 38 U.S.C. 2032, in the establishment and operation of CWT-TR residences, VA medical facilities must consult with appropriate representatives of the community in which the housing is established and comply with zoning requirements, building permit requirements, and other similar requirements applicable to other real property used for similar purposes in the community. The residence or facility needs to meet community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located; however, fire and safety requirements applicable to buildings of the Federal Government do not need to apply to such property. **NOTE:** *While Federal fire and safety requirements do not apply to CWT-TR properties, VA medical facilities may choose to follow fire and safety standards from the National Fire Protection Association's Life Safety Code.*

c. Projected costs for property maintenance, repairs, and replacement of furniture and fixtures, must be integrated into the annual CWT-TR budget. Veterans residing in the houses need to accomplish appropriate minor repairs and maintenance. On-station CWT-TR residences are usually maintained by engineering staff, while community properties may be maintained by engineering staff or community contractors. VA medical facility management must conduct annual inspections of CWT-TR residences and budget reviews to ensure plans and funds are in place to appropriately maintain these VA housing resources.

## **10. CORE MINIMUM COMPENSATED WORK THERAPY - TRANSITIONAL RESIDENCE STAFFING REQUIREMENTS AND CONSIDERATIONS**

a. CWT-TR staffing generally describes the direct staff assigned to ensure provision of the residential component of the CWT-TR episode of care. The type of professional staffing provided must be determined by the clinical needs of the Veterans served and by standards applied by external accrediting bodies. CWT-TRs must maintain a 1:10 staff to bed ratio. The CWT-TR direct staffing usually consists of a matrix which provides the following services:

(1) **Program Manager.** Provides administrative program management which may include program reviews, reports, data analysis; financial and facilities management; writes policy and procedures; completes incident reports; develops and conducts outcomes management). **NOTE:** *Some of the administrative duties such as completing reports and data analysis can be assigned to the Care Manager.*

(2) **Care Manager.** Coordinates assessment, screening, treatment, and discharge planning, etc.; provides case management; provides clinical program management which includes service planning, clinical program interface, community services coordination; oversees therapeutic residential group meetings and activities.

(3) **Program Clerk.** Performs clerical functions including processing program bills for payment, etc.

(4) **Psychiatrist (Doctor of Medicine (MD), Doctor of Osteopathy (DO)), Physician Assistant (PA), Nurse Practitioner (NP), Psychiatric Mental Health**

**Nurse Practitioner (PMH-NP).** Writes admission and discharge orders, conducts history and physicals (H&P), completes discharge summaries, etc.

(5) **Program Evaluator.** Collects program data, monitors residents and provides follow-up. **NOTE:** *Duties can be assigned to the Case Manager.*

(6) **Other clinical resources.** Chaplain, Occupational Therapy, Dietitian, and other clinical staff provide independent living skills, and other group meetings and activities.

b. **Factors Affecting CWT-TR Staffing Demands.** The following factors increase the core minimum staffing required for a CWT-TR program. These factors must be considered when developing the written staffing plan.

(1) Number of Beds. CWT-TRs with ten or fewer beds must staff the program at the ten-bed level, as this is considered the floor or minimum staff necessary to maintain a safe and effective program.

(2) Distribution of beds (one or multiple sites).

(3) Location and type of residential facility (travel distance, transportation logistics).

(4) Veteran demographics (e.g., diagnosis, acuity, recovery time).

(5) Cultural maturity of residence (strengths of peer support, degree of built-in programming structure, experienced use of policies and procedures, etc.).

(6) Staff skills, competencies, and cohesiveness.

(7) Type, number, and utilization of House Managers.

**CWT-TR Minimum Staffing Based on Number of Beds**

<b>Position per Number of Beds</b>	<b>Less than 10</b>	<b>11-15</b>	<b>16-20</b>	<b>21-25</b>	<b>25-30</b>	<b>31-35</b>	<b>35-40</b>	<b>40-45</b>
Program Manager	0.2	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Care Manager	0.5	0.8	1.0	1.3	1.5	1.8	2.0	2.3
Program Clerk	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
MD/DO, PA, or Psychiatric MH NP or NP	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Program Evaluator	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
Other Clinical	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8

c. **Staff Tours of Duty and Call Back Coverage.** CWT-TR is a work-based residential rehabilitation program. Veterans are required to work during their TR experience. In most instances (and ideally) these Veterans work day shifts, and interruptions to their work assignments needs to be minimized to the greatest extent possible. Therefore, residential components of the program (e.g., house meetings, individual and group therapy, life skills training,) need to take place in the evening hours (usually between 5:00 p.m. and 8:30 p.m.). Staff tours of duty need to be established primarily to accommodate the needs of the Veterans served and secondarily staff tours of duty. Regular or as-needed Department of Veterans Affairs (VA) staffing for weekend tours need to be planned for and periodically reassessed by the supervisor of the program.

d. **24-Hour Staff Availability.** A member of the TR staff needs to be available for "call-back" at all times. This does not mean that someone must always carry a pager and always be available; however it does mean is that a call tree model needs to be in place. The model allows for communication with a designated TR staff, usually the manager, along with other facility personnel to be contacted in the event of an emergency. This model needs to include appropriate VA medical facility personnel for the instances where no TR staff can be immediately contacted.

e. **Exceptions for CWT-TR Program.** In the CWT-TRs, a current or "graduate" resident may supervise the residence in lieu of staff. House Managers provide 24/7 on-site supervision and are to be provided House Manager training by program staff to observe resident behaviors, facilitate a healthy therapeutic environment (e.g., encourage socialization and participation, and coordinate residential activities), ensure safety, and initiate the call for professional staff intervention. A House Manager who is a former resident must be established as a volunteer with WOC status by the Program Manager, working in conjunction with Voluntary Service and Human Resources. Duties must be clearly outlined in a position description and there must be a regular review of performance and competencies. House Manager training must be documented in administrative program records by program staff along with evaluations of performance by the Program Manager.

**CORE ADMINISTRATIVE REQUIREMENTS, ACCREDITATION, SAFETY AND SECURITY, AND PROGRAM MONITORING AND EVALUATION**

**1. WORKLOAD CAPTURE**

a. Veterans Health Administration (VHA) facilities utilize a variety of software packages to capture outpatient and inpatient delivery of care, including outpatient encounters, inpatient appointments in outpatient clinics, all inpatient professional encounters not captured elsewhere, and all inpatient mental health professional services. **NOTE:** See VHA Directive 1082, *Patient Care Data Capture*, dated March 24, 2015. *Veterans in MH RRTPs are not to be charged residential costs, such as lease expenses, utilities, maintenance, meals, etc., except within the CWT-TR Program.*

b. **Bed Day of Care Workload.** Services provided to Veterans by staff assigned to, and in support of, the MH RRTP residential unit are captured as a “bed days of care” under the following Treating Specialty Codes.

MH RRTP Type	Treating Specialty Code	DECISION SUPPORT SYSTEM MONTHLY PROGRAM COST REPORT IDENTIFICATION#
Domiciliary Care for Homeless Veterans	37	1513
General CWT-TR	39	1717
General Domiciliary	85	1510
SUD Domiciliary	86	1511
PTSD Domiciliary	88	1512

**NOTE:** *Workload typically associated with a bed day includes: collection of urine toxicology specimens, room inspections, rounds, environment of care inspections, checks of personal belongings, bed checks, contraband inspections, medication room checks, provision of meals, provision of general information, and medication administration (i.e. pill line). Care provided by Physicians, Optometrists, Podiatrists, Chiropractors, Psychologists, Psychiatric Mental Health Nurse Practitioners, Nurse Practitioners, Clinical Pharmacists, Clinical Pharmacy Specialists, Clinical Nurse Specialists, Nurse Anesthetists, Physician Assistants, Social Workers and any other clinical staff should not be mapped to these production units. See link to Treating Specialties at the VSSC Website*

*(<http://vharamp.vssc.med.va.gov/VSSCSearch/Pages/results.aspx?k=ramp#k=treating%20specialty>). This is an internal VA Web site not available to the public.*

c. **Residential Workload.** Clinical services provided by residential staff to residents while admitted to a MH RRTP are captured by using stop codes that are associated with individual and group clinics. The clinics must be set up as count clinics, which will allow workload to transmit to Patient Care Encounter. The stop codes used to capture residential workload are 586- Residential Rehabilitation Treatment Program (RRTP)-

Individual and 587- Residential Rehabilitation Treatment Program (RRTP)-Group. Both codes can be used as either the primary stop coded or the credit stop. See the Managerial Cost Accounting Office SharePoint for current list and definitions of stop codes ([http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp)). **NOTE:** *This is an internal VA Web site not available to the public.*

**NOTE:** *Clinical time spent seeing patients in a clinical setting where encounters are completed should be captured by stop codes 586 and 587 and mapped to the associated departments. The cost of the clinician's time is attached to each clinic visit and the utilization is attached to each individual patient record.*

#### d. **Outpatient Workload.**

(1) Services provided by residential staff to an outpatient either prior to or following a residential admission (i.e., screening, aftercare, preadmission contacts, or telephone contacts) must be captured under the following MH RRTP Stop Codes:

- (a) 593- Residential Rehabilitation Treatment Program Outreach Services,
- (b) 596- Residential Rehabilitation Treatment Program Admission Screening Services,
- (c) 597- Telephone/Residential Rehabilitation Treatment Programs,
- (d) 598- Residential Rehabilitation Treatment Program- Outpatient Individual, and
- (e) 599- Residential Rehabilitation Treatment Program -Outpatient Group.

**NOTE:** *See the Managerial Cost Accounting Office SharePoint for current list and definitions of stop codes ([http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp)). This is an internal VA Web site not available to the public.*

(2) Services provided to MH RRTP Veterans by staff in established outpatient clinics (such as Outpatient SUD Clinics, PRRC, PTSD Clinical Team (PCT), Vocational Rehabilitation Therapy (CWT)) are captured as "outpatient visits." These costs are, therefore, captured under the appropriate outpatient stop code for the specific clinic providing services.

## 2. SAFETY AND SECURITY

The physical environment must be designed to promote an individual sense of well-being, optimism, and integration with the surrounding community (as opposed to a hospital- or dormitory-like dwelling). In the design and decoration of the space, a priority needs to be placed on promoting a sense of hope and belief in recovery as well as feeling safety and security. Specifically, Program Managers must:

- a. Create a recovery-oriented, home-like environment of care that is maintained, clean, with comfortable furniture and artwork, and that is able to accommodate

Veterans that require additional assistance for ambulation or other physical disabilities, when necessary.

b. Ensure 24/7 supervision and monitoring of the Domiciliary unit. Staff must maintain situational awareness of common and public areas as well as be able hear what is happening on the unit. Situational awareness must be maintained by regular rounds, throughout the unit, at all times to include bedrooms, by interacting with the residents while on the unit and by use of Closed Circuit Television (CCTV).

c. Except for CWT-TR, each MH RRTP must secure all entrance and egress doors to the unit and maintain a single point of unit access utilizing hotel-like keyless entry restricting access. Each entrance or egress door must be monitored by CCTV. All entrance and egress doors except for the single point of entry must be locked to outside entrance and alarmed to alert staff to an emergency of unauthorized opening. **NOTE:** *MH RRTPs with multiple residential programming areas may provide more than one entrance and egress point utilizing keyless entry and CCTV monitoring.*

d. Use closed-circuit television (CCTV) with recording capability in all public areas, hallways, and at all entrance and egress points. Public areas include entrance and egress points, hallways, stairwells, and general-purpose space such as laundry rooms, kitchenettes, television areas and lounges. **NOTE:** *Programs must prominently display signs alerting Veterans and visitors that they are being recorded. Veterans must be oriented at admission to the purpose of the CCTV and told that the cameras are not monitored 24 hours a day.*

e. Have authority for playback and review capabilities for CCTV. Monitors for CCTV and playback/review capability must be available for staff use to facilitate supervision of the unit.

f. Ensure CCTV is not installed in areas where treatment or other clinical activities are conducted or in private spaces, such as bedrooms and bathrooms. Rooms that are used for both clinical activities and as general-purpose space also are precluded from CCTV monitoring.

g. Ensure all MH RRTPs have locking bedrooms and bathrooms for female Veterans. Installation of locks on all other bedroom and bathroom doors is encouraged.

h. Have documented staff rounds of units (excluding CWT-TR) conducted at a minimum of every 2 hours, and more frequently if deemed clinically appropriate. Rounds must include patient bedrooms and all common spaces, such as hallways, dayrooms, group rooms, stairwells, and community bathrooms, and findings must be documented in rounding sheets that are developed by the programs. Rounds in patient bedrooms may be suspended during sleeping hours at the discretion of the Program Manager, based on clinical needs of the Veterans and an assessment of overall safety and security. **NOTE:** *These rounding sheets are maintained by the program and may be requested by surveyors or OIG.*

i. Have beds checks that occur at approximately 11 p.m. and 6 a.m., conducted by 24/7 staff. These checks must coincide with local daily procedures used to verify the physical presence of each resident and must include documentation of the physical status of the Veteran in a locally developed form. Physical status pertains to location and activity of the Veteran (i.e., "in lounge, watching television"). Based on a local assessment of high-risk behaviors or illness, staff may conduct increased checks on individual Veterans. These checks may take place on any shift, including night time bedroom checks. The results of these bed checks are monitored by the Program Manager and designated staff. **NOTE:** *In CWT-TR Program the House Manager may conduct bed checks.*

j. Implement a system to monitor the location of residents when off the unit or on therapeutic passes such as a daily sign in/out log. The monitoring of visitors must include areas that are accessible to visitors to include the ability to secure visitor belongings.

k. Ensure staff conduct examinations of belongings at the time of admission. Ensure staff randomly inspect belongings upon a Veteran's return from pass and upon return to the unit to prevent the introduction of contraband. Staff may not pat down a Veteran or visitor but may inspect packages, backpacks, jackets, shoes, and other clothing, and may request that Veterans and visitors turn out their pockets.

l. Ensure processes are in place for urine drug screens and breathalyzers to take place at least weekly in the first 30 days of treatment, with increasing or decreasing frequency based on individual Veteran risk of relapse.

m. Ensure daily room inspections of all Veteran rooms are conducted by nurses or 24/7 staff to look for unsecured medications and other safety issues.

n. Implement weekly contraband inspections with a minimum of 10 percent of all rooms, lockers, and drawers inspected each week, to include inspection of common areas. The inspections will be conducted and findings documented by program staff.

o. Complete monthly formal health and welfare inspections on the unit to look for physical environment safety issues that require repair. Formal inspections are full inspections targeting the all areas including bedrooms on a scheduled basis and may include Safety, Environmental Management Service and other departments in the facility. **NOTE:** *Informal inspections may target a subset of rooms/areas and is not scheduled.*

p. Complete an annual safety and security assessment that addresses issues related to environment of care, safety issues, and privacy concerns for residents and staff. **NOTE:** *The criteria for this assessment are established by OMHSP. The reports are sent through the VISN to the Office of Mental Health and Suicide Prevention (10NC5) MH RRTP section for review and discovery of trending national results. The local facility is responsible for addressing any gaps identified in the report.*

q. Ensure suicide risk screening and assessments, if required, are completed by designated VHA providers during residential treatment including at screening, admission, recovery plan updates, discharge, prior to pass, and any time there is a change in mental health status. A positive screening for suicide risk results in an immediate suicide risk assessment with appropriate follow-up. Veterans are provided suicide prevention education during orientation by SPC or designated staff that reviews signs and symptoms and steps to take when feeling suicidal or when recognizing signs and symptoms in other Veterans.

r. Completion of an annual "Culture of Safety Stand-Down" that suspends clinical services for all or part on one day to review safety and security. During the stand down, Veterans, staff, and medical facility stakeholders participate in a variety of safety and security related activities designed to increase awareness, review current policy and procedures, and provide input for improving safety and security.

### 3. PROGRAM LOCATIONS

MH RRTPs are established either on VA medical facility grounds or in community facilities owned, leased, or otherwise acquired by VA.

### 4. PROGRAM FUNCTIONS

a. **Bed Designations.** All MH RRTP beds are designated as official VA Domiciliary beds in the VA National Bed Control System and reported on the Gains and Losses (G&L) statement of the associated VA health care system or medical center. **NOTE:** *To ensure accuracy in capturing workload associated with a bed day, bed sections or wards must be accurately setup by Office of Information and Technology in the medical facility institution file. There are two residential Divisions in the VA Bed Control system, DOM which uses Treating Specialty Codes 37,85,86, and 88 (suffix BU, BV, BX, BW & B1-B4) and PRRTTP which uses Treating Specialty Code 39 (suffix PA-PE). The only program in the PRRTTP Division is the General CWT/TRs which will continue to use the PA-PE suffixes. Transfers between treating specialties within the same division are permitted. Veterans must be discharged and re-admitted between different divisions. See VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.*

b. **Meals.** In most cases, the cost and preparation of meals is the responsibility of the VA medical facility. In many MH RRTPs, especially those on VA medical facility grounds, Veterans eat in a medical facility dining room or in dining areas on the unit. For MH RRTPs that are not on a facility's grounds or in leased facilities, other arrangements may be in place to provide meals for the residents. Where appropriate (for example, in a CWT-TR), preparation of meals in MH RRTPs may be by the Veterans themselves, or by personnel associated with the residence. When Veterans assigned to a MH RRTP (not a CWT-TR) are responsible for their own meals, sufficient staff supervision must be provided to when Veterans engage in direct food preparation to ensure appropriate meal planning, food preparation, sanitation, and safety.

c. **Authorized Absences and Passes.** All periods of absence are to be reported to Health Administration Service to be recorded by the Administrative Officer of the Day in the Patient Treatment File system. See 1601B, Administrative Provision of Veterans Health Care Benefits, 02. Inpatient Care, Chapters 1-9, updated April 18, 2017, or subsequent update, ([https://vawww.vrm.km.va.gov/system/templates/selfservice/va\\_kanew/help/agent/locale/en-US/portal/554400000001031/topic/554400000007358/02-Inpatient-Care](https://vawww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/topic/554400000007358/02-Inpatient-Care)). **NOTE:** *This is an internal VA Web site not available to the public.*

(1) **Granting Authorized Absences and Passes.** Medical providers have the authority to authorize absences which involve overnight stays away from the facility. A period of authorized absence for MH RRTP residents must not exceed 96 hours, except in unusual circumstances, as determined by the medical provider and the Veteran's interdisciplinary recovery team. **NOTE:** *The granting of authorized absences beyond 96 hours is discouraged, however residents in a MH RRTP may be granted a period of authorization not to exceed 30 days.*

(a) The interdisciplinary recovery team may approve day passes. Passes may be used to support the Veteran in obtaining housing, employment, addressing legal and financial issues, as well as developing or sustaining social supports in the community. To maintain bed occupancy, passes allow the resident to be physically present to receive residential care some part of each day but do not include an overnight stay. Use of passes as well as authorized absences must be included in the resident's recovery plan.

(b) One full period of authorized absence may not be immediately followed by another authorized absence.

(c) Residents on authorized absence not exceeding 96 consecutive hours are considered bed occupants, and their beds are reserved. Veterans granted absences for more than 96 hours are considered absent bed occupants; however, programs may elect to hold the bed when contact has been made with the Veteran and a plan has been discussed. When a Veteran on authorized absence is admitted to a VA medical facility for acute treatment, the absence is cancelled, and either the status changed to absent-sick-in-hospital (ASIH), or the Veteran is discharged from the MH RRTP.

(2) **Failure to Return from Authorized Absences or Passes.** MH RRTP residents failing to return from an authorized absence or an authorized pass by the specified time will be placed on Unauthorized Absence. The Veteran will be discharged if efforts to contact the Veteran are unsuccessful, or if the interdisciplinary recovery team determines discharge is warranted. Veterans should not be automatically discharged during evening or night shifts or weekends when at all possible. Details related to failure to return should be documented by 24/7 staff or by a member of the interdisciplinary recovery team in the Computerized Patient Record System (CPRS).

(3) **Unapproved Absences.** MH RRTP residents who absent themselves without approval of the RRTP medical provider or the interdisciplinary recovery team will be

placed on Unauthorized Absence. The Veteran will be discharged if efforts to contact the Veteran are unsuccessful or if the interdisciplinary team determines discharge is warranted. Veterans should not be automatically discharged during evening or night shifts or on weekends when at all possible. Efforts should be documented in CPRS by 24/7 staff or by a member of the interdisciplinary recovery team. **NOTE:** *Residents failing to return by the specified time typically will be released as of midnight the date of the scheduled return in accordance with current policy, however, placing the Veteran on Unauthorized Absence is preferred, pending attempts by staff to contact the Veteran. Attention and consideration must be given to residents who are at risk for injury or harm to oneself or to others. See Policy Manual 1601B: Administrative Provision of Veteran Health Care Benefits 02. Inpatient Care* ([https://vaww.vrm.km.va.gov/system/templates/selfservice/va\\_kanew/help/agent/locale/en-US/portal/55440000001031/topic/55440000007358/02-Inpatient-Care](https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/topic/55440000007358/02-Inpatient-Care)). This is an internal VA Web site not available to the public. See also Appendix A, Core Clinical Components, of this directive.

(4) **Documenting Approval of Authorized Absences and Passes.** Approval of authorized absences and passes must be documented by a member of the interdisciplinary recovery team in the medical record. Documentation for authorized absences includes but is not limited to:

- (a) Any necessary orders for medication (for overnight stays only);
- (b) Specific instructions to the patient; and
- (c) The expected duration of the absence.

(5) **Documenting Returns from Authorized Absences.** Documentation of the return of MH RRTP residents in CPRS will include the following:

- (a) Date and time of return.
- (b) Condition of the resident.

d. **Monitoring Missed Appointments and No-Shows.** The MH RRTP interdisciplinary recovery team will monitor and address missed appointments with the Veteran on an individual basis. Notification of the Case Manager on the same day and follow-up if a Veteran fails to report for a scheduled appointment, group, or planned activity are required. Missed appointments and no-shows are to be documented in the clinical record. **NOTE:** See VHA Handbook 1907.01 and VHA Directive 1160.01.

## 5. STAKEHOLDER COMMITTEE

a. All MH RRTPs must have a committee whose task is to provide information or viewpoints from individual attendees to the MH RRTP in its efforts to meet its mission and serve a full-range of Veterans. Membership in this committee must be voluntary, and may come from the ranks of program alumni, VA mental health service providers, community providers, and Veterans. The attendees may vary from session to session.

b. The committee must meet at least quarterly, and attendance by Program Manager, or a designee, is mandatory. Areas of consideration for the committee may include, but are not limited to: admission criteria, treatment options offered by the program, and alumni or aftercare activities. Minutes of the meeting activities must be maintained by the Program Manager. Suggestions made by the committee must be given full consideration by the Program Manager, who makes the final decision on the implementation of any suggestions.

## 6. ACCREDITATION

All MH RRTPs must be accredited under The Joint Commission Behavioral Health (BH) Standards Manual. In addition, all MH RRTPs must attain and maintain accreditation under the Commission on Accreditation of Rehabilitation Facilities (CARF) Behavioral Health Standards Manual, Residential Treatment (RT) standards for MH RRTPs. All CWT-TRs must be accredited under CARF BH Standards-Community Housing: Psychosocial Rehabilitation standards. New programs must attain accreditation within 18 months of opening. See the Office of Quality Safety and Value SharePoint for the standards (<http://vaww.oqsv.med.va.gov/functions/integrity/accred/accreditation.aspx>). **NOTE:** *This is an internal VA Web site not available to the public.*

## 7. PROGRAM EVALUATION AND MONITORING

a. Outcomes monitoring, to include measures of efficiency, effectiveness, access, wait times, and Veteran satisfaction, must be developed by the Program Manager at each local program as part of quality improvement processes, and must be periodically reviewed for opportunities to improve Veteran outcomes and MH RRTP performance. Additional monitors related to gender, race and ethnicity may also be developed and periodically reviewed. Outcome monitoring processes must include a process for aggregate review of data collected as part of measurement-based care efforts. These reports are submitted to the Office of Mental Health and Suicide Prevention (10NC5) Northeast Program Evaluation Center (NEPEC) and the final reports are posted on the MH RRTP SharePoint for program reference and benchmarking.

b. MH RRTPs must also complete all nationally required reports and to participate in national program evaluation efforts, as appropriate. National mental health reports are reviewed by each facility to identify areas of low performance and develop local action plans to address these areas.

## SAFE MEDICATION MANAGEMENT

Veterans in Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) are able to learn and practice safe management of their medication regimens in order to achieve independent medication administration. Each Program Manager, in collaboration with nursing leadership, pharmacy leadership, and the Patient Safety Manager, must implement Safe Medication Management (SMM) as specified in this directive. **NOTE:** *VHA Directive 1108.03, Self-Medication Programs (SMP), dated November 28, 2016 does not apply to MH RRTPs.*

### 1. ASSESSMENT OF DEPENDENCE LEVELS

a. In MH RRTPs, the level of independence for medication management for each Veteran must be assessed by nursing and the medical provider as dependent, semi-independent, or independent. Veterans who are otherwise appropriate and eligible for admission to a MH RRTP may not be denied access based on assessed medication status (independent, semi-independent or dependent). Veterans also may not be denied based on prescription of controlled medications. All controlled substances must be administered and recorded by licensed staff, except in the Compensated Work Therapy (CWT) - Transitional Residence (TR) Program. Local policy may dictate more restrictive prescribing practices similar to controlled substance for a broader range of medications. Otherwise appropriate and eligible Veterans are not to be denied access to MH RRTPs based on these local prescribing practices.

b. A Veteran's ability to safely manage medications must be assessed by the prescribing medical provider Clinical Nurse Specialist (CNS), or Registered Nurse (RN) upon admission into a MH RRTP. The Veteran must be assessed for independent, semi-independent, or dependent medication management. Proper documentation must include a progress note along with a provider's order. This assessment must be documented in the Veteran's medical record by the staff member(s) completing the assessment.

c. **Safe Medication Management Assessment.** Physical and cognizant assessment as it relates to managing medications includes:

- (1) Integration of medications into the Veteran's lifestyle;
- (2) Potential implications between medications, and diet, and exercise;
- (3) Possible barriers to compliance;
- (4) Possible barriers to learning;
- (5) Risks associated with preconception, pregnancy and lactation;
- (6) Early signs of relapse related to medication efficacy;
- (7) Procedures for requesting a change in medication regimen; and

(8) Appropriateness of issuing Naloxone.

d. **A Veteran May be Assessed as:**

(1) **Dependent.** When assessed as dependent, the Veteran requires additional education and varying levels of medication supervision, which includes direct involvement of nursing for observing and administering each medication. Ideally, there should be sufficient nursing staff to ensure the availability of medication administration on all shifts. The MH RRTP must follow the protocol as outlined in VHA Directive 1108.06, Inpatient Pharmacy Services, dated February 8, 2017 and VHA Handbook 1108.05 Outpatient Pharmacy Services, dated June 16, 2016, which provide specific direction and procedures related to the appropriate storage, handling, and dispensing of medication and supplies for VHA medical center inpatients, including MH RRTP residents.

(2) **Semi-independent.** When assessed as semi-independent, the Veteran is able to assume partial responsibility for storage, security, and safe administration of medications. These Veterans require varying degrees of supervision; professional staff assumes an indirect role in the Veteran's medication management by documenting the results of periodic reviews of Veteran's safe medication practices, a visual count of Veteran's medications, or clinical observations of their responses to medications. The MH RRTP utilizes a combination of services outlined in VHA Directive 1108.06 and VHA Handbook 1108.05 for Veterans assessed as semi-independent. For example, a Veteran assessed as semi-independent may have some medications, including controlled medications, administered by nursing staff while at the same time self-administering other medications.

(3) **Independent.** When assessed as independent, the Veteran is able to assume complete responsibility for the storage, security, and safe administration of medications. Regardless of the Veteran's assessed medication status, including a Veteran assessed as independent, all controlled substances must be administered by nursing staff, with the exception of Veterans in CWT-TR. However, in the last one-third of a Veteran's length of stay and with at least two consecutive re-assessments as independent, the independent Veteran may be prescribed controlled medications up to a 7-day supply for self-administration. The Veteran demonstrates understanding of the purpose of each medication with a general understanding of their common side effects, and can consistently demonstrate independent medication management. The MH RRTP may utilize a combination of services outlined in VHA Directive 1108.06 and VHA Handbook 1108.05, for Veterans assessed as independent.

**Safe Medication Management Levels and Key Functions**

<b>Key Functions</b>	<b><u>Level I</u></b> <b>"DEPENDENT"</b> Zero or limited knowledge or understanding of medical regimen	<b><u>Level II</u></b> <b>"SEMI-INDEPENDENT"</b> Incomplete knowledge of all medication(s)	<b><u>Level III</u></b> <b>"INDEPENDENT"</b> Functional knowledge of all medication(s)
<b>Pharmacy method of dispensing</b>	Individual dose	1-30 day multiple-dose vial of some to all medications	Multiple-dose vial of all medications
<b>Means of medication receipt</b>	Nurse to administer all medication	A combination of Nurse administration and independent dosing	Independent self-administration (except controlled substances)
<b>Monitoring of medication management, education, and documentation of administration</b>	Nurse administration of all medication and documentation of ongoing patient education	Nurse may administer individual dose administration or supervise filling of medication boxes for self-administration of some medications, and document compliance	At least monthly reassessment, clinical monitoring, and documentation of compliance
<b>Patient Education</b>	Reinforcement of education at each dosing	Initial education with periodic review of knowledge	Initial education with periodic review of knowledge
<b>Responsibility for medication storage</b>	Program storage of all medication	Program storage of select medication and patient storage of medications in a locked location	Patient stores own medications in a locked location, except controlled substances
<b>Controlled Substances</b>	Nurse Administration <i>Exception is noted in paragraph 7.a(7) below</i>	Nurse Administration <i>Exception is noted in paragraph 7.a(7) below</i>	Nurse Administration, (except CWT-TR) <i>Exceptions are noted in paragraph 7.a(7) below</i>

e. **Safe Medication Management and the Recovery Plan.** SMM must be incorporated into an individual recovery plan for each Veteran in the MH RRTP and must be reviewed by nursing and the care manager as part of recovery plan reviews. Recovery plans need to identify those Veterans with a past history of high-risk

medication behavior (suicide attempts with overdoses, treatment resistance, etc.) or those prescribed high-risk-alert medications. Due to the increased complexity of MH RRTP Veterans, a pharmacist must be available to participate on the treatment team. The variation in drug distribution and dispensing required to support MH RRTPs requires augmentation of pharmacy staff in order to achieve program goals because Pharmacy will review and verify all medication orders. **NOTE:** *Indicators that pharmacy and provider consultation may be required include: controlled substances, history of medication misuse, high-risk behaviors, and high-risk high-alert, psychopharmacologic, and investigational medications.*

## 2. CLINICAL MONITORING

Clinical monitoring dictated by individual treatment plans must include the Veteran's response to medications.

a. This monitoring must be evaluated and recorded in the Veteran's medical record as defined in the treatment plan at least monthly by the Registered Nurse or prescribing provider. This applies to all Veterans regardless of SMM level. **NOTE:** *Medication monitoring in MH RRTPs is in addition to VA medical facility medication reconciliation policy.*

b. Clinical monitoring must include:

(1) Identification of target symptoms;

(2) Evaluation of the efficacy of the medication on those target symptoms and of any adverse events associated with the use of the medication, including the Veteran's own perception about side effects and efficacy;

(3) Reviewing relevant laboratory results; and

(4) An evaluation of ongoing educational needs and barriers.

c. Medications self-administered by the Veteran must have quality assurance completed on a reoccurring basis, but no less than monthly. This can be accomplished by conducting pill counts or completing systematic review of active medication orders against medications self-administered by the Veteran to assess for correctness. The Registered Nurse (RN) or a Licensed Professional Nurse supervised by a RN or an Advanced Practice Registered Nurse completes this quality assurance process.

d. Licensed staff responsibility for monitoring the Veteran's safe management of medications may range from directly observing and documenting each dose to: observation of a Veteran filling a daily pillbox or counting the medication in the Veteran's possession; clinical monitoring; and documentation of the Veteran's response to the medication. Each Program Manager, and Nurse Manager must define the responsibilities for documentation in accordance with this directive.

e. In cases where a Veteran is assessed as dependent or semi-independent, or is prescribed controlled substances, appropriately-licensed staff must be available to administer or monitor medications for Veterans in the MH RRTP. Veterans' ability to manage their own medications can change throughout their treatment.

### 3. FIRST DOSE MONITORING

MH RRTPs must monitor a Veteran's response to the first dose(s) of a new medication, as clinically indicated. Monitoring must be performed by a licensed nurse, or other appropriate medical provider. **NOTE:** *Appropriate first dose monitoring is determined by the medication and the individual; medical providers responsible for the monitoring may be licensed providers within the MH RRTP or licensed staff in any VHA clinic area.*

### 4. PERIODIC REASSESSMENT OF VETERAN MEDICATION MANAGEMENT.

Assessment of the Veteran's medication knowledge is a process by which a Veteran's ability to accurately and safely manage the medication regimen is determined. Reassessment must take place as deemed appropriate by the medical provider, but at least monthly, and all findings documented in the Veteran's medical record.

### 5. VETERANS' MEDICATION EDUCATION

Veterans education and thorough understanding of prescribed medications are vital to the Veteran's success in managing medication(s).

a. An initial assessment of the Veteran's knowledge of the Veteran's medication(s) must be performed and documented upon admission by the prescribing medical provider or RN.

b. Following an initial assessment of the Veteran's medication regimen, education must be provided by clinical staff for each of these prescribed medications, regardless of the level of Veteran independence. **NOTE:** *The use of learning aids may be beneficial and is encouraged for increased comprehension and compliance with the medication regimen. Examples could include a demonstration of proper metered dose inhaler technique, daily flow sheets of medications and administration times, posters, and the use of an assistive device (e.g., a pill box). Most Veterans on more than three medications per day benefit from the use of an assistive device. The use of an assistive device must not determine the Veteran's level of independence.*

c. Documentation of the Veteran's education by the staff member(s) providing the training must be included in the Veteran's medical record. Such documentation includes:

(1) The name of person providing education;

(2) Education provided;

(3) A demonstrated level of understanding and verbalization by the Veteran; and

(4) An evaluation of a Veteran's learning needs (e.g., barriers, preferred methods of learning, etc.).

(5) Staff must cover the following information when providing Safe Medication Management education to veterans:

(a) The name of each medication;

(b) The risks, contraindications, and common side effects associated with each medication;

(c) The rationale for taking each medication and how each medication works;

(d) The intended benefits, as related to the behavior or symptoms targeted by the medication;

(e) How to administer each medication (such as appropriate frequency, routes of administration, dose);

(f) The importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence;

(g) Potential drug interactions when combining prescription and nonprescription medications, including alcohol, tobacco, caffeine, illegal drugs, and alternative medications;

(h) Potential drug-food interactions to include caffeine and herbals;

(i) Security requirements; and

(j) The availability of financial supports and resources to assist the persons served with handling the costs associated with medications.

d. Veterans with an Opioid Use Disorder diagnosis must be provided with overdose prevention education and are prescribed naloxone kits as appropriate by their providers.

e. MH RRTPs must follow Pharmacy Service policies and conform to Joint Commission and Commission on Accreditation of Residential Facilities standards for medication management. **NOTE:** See Office of Quality, Safety and Value SharePoint (<http://vaww.oqsv.med.va.gov/functions/integrity/accred/accreditation.aspx>). This is an internal VA Web site not available to the public. Related documents supporting the medication management include: VHA Directive 1108.06, VHA Handbook 1108.05, VHA Handbook 1108.01, Controlled Substances (Pharmacy Stock), dated November 6, 2010, and VHA Directive 1108.02, Inspection of Controlled Substances, dated November 28, 2016. VHA Directive 1108.03 does not apply to MH RRTPs.

f. All medications and biologic drugs are stored in a secured location to mitigate risks of drug diversion. **NOTE:** See *Biologics* (<https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm133077.htm>). This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act. The use of automated dispensing devices (e.g. Pyxis, Omnicell, Accudose, etc.) to store medications is highly recommended to maintain accountability, provide safety, and help prevent diversion of controlled substances.

g. The Chief of Pharmacy must define when medications brought into the hospital by patients or their families can be administered. Before use or administration of these medications, the medical provider must review the medications on a case- by- case basis to determine the appropriateness of the medications. **NOTE:** *The Veteran must be informed when medications brought into the hospital are not permitted.*

h. MH RRTPs must participate in the VA medical facility's adverse drug event and medication reporting procedures which include notification of the prescriber by the Chief of Pharmacy in the event of an adverse drug event.

i. When Veterans in MH RRTPs have a length of stay greater than one year, a medical provider must review all medications by the Veteran at least annually.

j. Each Program Manager, in collaboration with nursing leaders and Chief of Pharmacy or designee, must outline procedures for the securing, administration, monitoring, assessment, and education of medications in accordance with VHA policies and accrediting body standards for medication management.

k. All medications managed by the Veteran must be secured in a locked cabinet, drawer, locker, or other acceptable secured means accessible only to the Veteran, the provider with prescriptive privileges, or qualified program staff. Keys or codes must be unique to each Veteran's locked area. Procedures must be in place to address how to assist Veterans who demonstrate difficulty in safely securing medication.

l. Interventions to assist Veterans in understanding the importance of safely securing medications may include, but are not limited to: incentives for demonstrated safe practice, clinical contracts, regular and random room inspections by program staff to ensure safe medication storage, and educational interventions. **NOTE:** *Every effort to ensure a safe environment for Veterans must be emphasized.*

m. The Chief of Pharmacy or designee, in collaboration with Program Manager and Nurse Manager, must develop a process that assures controlled medications prescribed by providers outside of the MH RRTP are not directly dispensed to the individual patient actively enrolled in MH RRTP unless directly specified within the Veteran's care plan (i.e., participation in an Opioid Treatment Program). This may include use of patient electronic record flags or placement of information in the pharmacy profile narrative.

n. Exceptions to Veteran security requirements made for medication(s) that must be stored under secure refrigerated conditions must be in accordance with local policy. Emergency medications such as inhalers, EpiPen® (epinephrine injection), or Naloxone may be maintained by the Veteran either on the Veteran's person or by the bedside.

o. Prescribed multi-dosed topical medications (e.g. shampoos, creams, and ointments) must be maintained by the Veteran in the Veteran's secure storage, unless delineated in local policy.

p. Veterans must agree, in writing, to comply with all MH RRTP security requirements. This agreement must include a statement that the Veteran is responsible for the security of medication(s) in a designated locked area with security code or key issued to the Veteran. **NOTE:** *This agreement is included in the consent to care and signed and scanned into CPRS.*

## 6. MEDICATION RECONCILIATION PROCEDURES

Medication reconciliation procedures are a key element of the SMM assessment. At a minimum, reconciliation should occur upon admission to the unit, any time the medication orders are rewritten or any time the Veteran changes service, setting, provider, or level of case care. Documentation by the prescribing medical provider or RN that reflects medication reconciliation must be included in the Veteran's medical record. Each Program Manager must fully participate in the VA medical facility's ongoing medication management quality improvement and monitoring efforts including medication error reporting. **NOTE:** *See VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011.*

## 7. MEDICATION TRANSPORT

Each Program Manager, in collaboration with the Chief of Pharmacy or designee, must follow established processes regarding a chain of custody process when medications are being transported from the Pharmacy to the MH RRTP.

## 8. ADMINISTRATION OF CONTROLLED SUBSTANCES

a. Each Program Manager, in collaboration with nursing leaders and the Pharmacy Chief or designee, is responsible for ensuring that all controlled substances are administered by an appropriate licensed staff, except in the CWT-TR Program, as outlined in VHA Directive 1108.06 and VHA Handbook 1108.01.

b. Each Program Manager, in collaboration with nursing leadership and pharmacy must:

(1) Implement procedures for the storage, administration, monitoring, and proper disposal of prescribed controlled medications, which meet VHA and accrediting body standards for medication management. See Office of Quality, Safety and Value SharePoint (<http://vaww.oqsv.med.va.gov/functions/integrity/accred/accreditation.aspx>).

**NOTE:** *This is an internal VA Web site not available to the public.*

(2) Make available onsite receptacles for Veteran medication disposal for expired and discontinued medications and comply with the Drug Enforcement Administration Final Rule for Disposal of Controlled Substances, 21 CFR Parts 1300, 1301, 1304, 1305, 1307, and 1317. See the U.S. Department of Justice Drug Enforcement Administration Diversion Control Division Web site (<https://www.deaiversion.usdoj.gov/>). **NOTE:** Receptacles cannot be used to dispose of partial doses or expired unit stock.

(3) Ensure that all providers adhere to Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for prescribing Buprenorphine for Detoxification. See the link to the SAMHSA website (<https://www.samhsa.gov/>).

(4) Ensure that controlled substances administered to Veterans by licensed independent practitioners are managed in accordance with local VA medical facility policy and Handbook 1108.01. **NOTE:** *The medication process is more labor intensive than routine inpatient medication dispensing formats and therefore is not to be utilized to solve staffing or related-workforce issues. VA medical facility Directors must ensure that clinical services, such as pharmacy and nursing are augmented to properly manage this patient population.*

(5) Ensure that Veterans admitted and remaining in the CWT-TR Program are assessed as medication independent. Medication management in CWT-TR Program is based on the SMM Program with a limit of 7-day quantity, or less, for controlled substances.

(6) Ensure that when controlled substances are prescribed to a Veteran residing in a MH RRTP (except for CWT-TR), they are administered as a single dose and monitored by appropriately licensed staff assigned directly to the MH RRTP or by integrated controlled substance administration utilizing medical center clinics, programs, or units.

(7) Exceptions to the controlled substances policy include:

(a) Authorized absences as a means to meet rehabilitation goals, for example: employment, community integration, establishment of relationships with family and friends, and participation in recreational activities. The process for obtaining pass medications and controlled substances must comply with VHA Handbook 1108.05. Medications intended for self-administration when Veterans are on authorized absence must be labeled and dispensed as a prescription(s) by a pharmacist. Controlled substance prescriptions for authorized absences must be limited to a 7-day quantity or less.

(b) Veterans returning from an authorized absence who were provided with pass medications need to be evaluated by licensed staff; medication must be inventoried, and medication use documented in the medical record. Any excess pass medication must be disposed of in compliance with the Drug Enforcement Administration Final Rule for Disposal of Controlled Substances, 21 CFR Parts 1300, 1301, 1304, 1305, 1307, and 1317 to include the use of mail-back envelopes and on-site receptacles.

(c) Veterans in later stages of treatment and preparing for transition to the community with prescribed controlled substances must be assessed at the independent level by the Registered Nurse and medical provider. If the Veteran is deemed independent controlled substances may be dispensed to the Veteran in 7-day quantities, or less. SMM must be continued during this phase of treatment, to include: assessment, re-assessment, monitoring, evaluation, and documentation.

## **9. PRESCRIPTION, OVER-THE-COUNTER (OTC) MEDICATIONS AND HERBAL PRODUCTS**

Medications prescribed by outside providers, OTC medications, and herbal products are permitted in MH RRTP's only after a VHA licensed prescriber has evaluated the Veteran's medical history, medication regimen, and approved the products for use.

**NOTE:** *If a VA medical facility elects to allow the patient to bring OTCs or medications prescribed by outside providers, then it must be defined in local policy and meet all applicable medication management standards to include those defined in VHA Directive 1108.06.*

**NURSING PRACTICE AND 24 HOURS PER DAY/7 DAYS PER WEEK COVERAGE  
IN MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAMS**

This appendix delineates the role, scope, and philosophical foundation of professional Nursing Practice within the Mental Health Rehabilitation Treatment Programs (MH RRTPs), and addresses the role of other staff that provide coverage of the units. Nurses play a very important role in the care and treatment that is provided in MH RRTPs. As the co-occurring conditions of Veterans in MH RRTPs increase and become more complex, the role of nursing has become increasingly critical in the management of Veterans with these conditions.

**1. NURSING PRACTICE**

a. Nursing practice supports the mission of the medical facility by providing state-of-the-art, cost-effective nursing care to veterans as they experience and respond to health and illness. Nurses are accountable for the delivery of comprehensive and effective nursing care within an interdisciplinary recovery team concept. The purpose of nursing is to provide patient care that maximizes self-care and independent functioning, facilitates positive adaptation to changes in health status, and promotes health or slows health deterioration.

b. The Facility Nurse Executive/Associate Director Patient Care Services maintains the responsibility for overall nursing practice and staffing methodology. The Nurse Manager oversees the nursing staff and the nursing care provided within each MH RRTP, and is supervised by either the designated Associate Chief Nurse/Chief Nurse with input from the Program Manager or by the Mental Health Service Line Manager with input from the Program Manager.

c. Nursing within the MH RRTP may consist of the following nursing roles which are present on the MH RRTP unit on a 24/7 (24 hours per day/7 days per week) basis: Nurse Manager; RN Case Manager; RN Admissions Coordinator; Advance Practice RN; Specialized Program RN; Licensed Professional Nurses; and 24/7 non-licensed staff. Nurses on the MH RRTP unit promote mental health through the professional nursing practice process which consists of: assessment; outcome identification; planning; implementation; and evaluation in response to behavioral problems, mental disorders, and comorbid conditions. The MH RRTP professional nurse is familiar with and adheres to the American Psychiatric Nurses Association Psychiatric-Mental Health Nursing: Scope and Standards of Practice 2014 Edition (<https://www.apna.org/i4a/pages/index.cfm?pageid=3342>). **NOTE:** This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.

d. **The Registered Nurse.** The Registered Nurse (RN) performs many functions in the MH RRTP, including the following:

(1) Establishing therapeutic relationships to enhance a trauma-sensitive experience using therapeutic interventions and helps to eliminate barriers to recovery services by incorporating person-first language.

(2) Creating and maintains a safe, therapeutic, recovery-oriented environment in collaboration with Veterans and other healthcare providers.

(3) Assessing and identifying health-related illness using nursing assessments which follow national standards for nursing assessments and local VA mental health nursing assessment policies, including Part B Assessment: Psychiatric Nursing Assessment. The Nursing Assessment must be completed by a RN. The RN may participate in Veteran screening for admission to the program. See resources at this link to the American Psychiatric Nursing Association (<https://www.apna.org/i4a/pages/index.cfm?pageid=3334>).

(4) Providing education and health teaching (individual or group settings) to Veterans regarding: healthcare needs; recovery goals; mental health and substance use problems; treatment regimens; coping skills; relapse prevention; self-care activities; resources; conflict management; problem-solving skills; stress management and relaxation techniques; crisis management; and medications.

(5) Playing a key role in medication management in MH RRTPs and administering medications as ordered by the credentialed provider for monitoring the effectiveness of those medications according to this handbook and facility policy (See Appendix F, Safe Medication Management). Nursing staff must consistently assess and monitor the physical environment to ensure the safety and security of medications.

(6) Developing and monitoring nursing outcomes. The RN is responsible for providing nursing objectives, interventions, and outcomes to help Veterans achieve their treatment goals. Nursing care planning and other nursing interventions must be clearly identified in all documentation in accordance with local practices and procedures.

e. MH RRTPs provide a residential level of care that is different from care delivered on acute inpatient and in Community Living Centers. Veterans in MH RRTPs do not require bedside nursing care and are generally capable of self-care. Nursing staff assigned to MH RRTPs must have the medical and mental health nursing competencies established by Mental Health and Nursing leadership in accordance to local practice and procedures to promote evidenced-based, recovery-oriented nursing practice in these settings.

f. Nursing is critical to ensuring the safety and security of the patients and units of the MH RRTP and it is strongly recommended that nursing be present on the unit on a 24/7 basis. Each MH RRTP is required to have a Nurse Manager FTE who is responsible for the supervision of the unit nursing staff. Local policy will determine the percentage of Nurse Manager FTE based on Veteran needs and other factors, the staffing mix and staffing level derived from the Office Nursing Service Nurse Staffing Methodology (SM) process. **NOTE:** *Some facilities have Dom Assistants/Social*

*Science Assistants that provide 24/7 supervision of the units. Such staff function similarly to Nursing Assistants; however, they typically do not report to Nursing, but to the Program Manager.*

## 2. NURSE STAFFING METHODOLOGY AND 24/7 COVERAGE

a. Medical facility Directors must ensure MH RRTPs maintain adequate staffing to provide safe, appropriate clinical care. The core staffing needs of the programs within each MH RRTP vary based on several factors as no one program is the same due to size, physical layout, location and program structure. Nurse staffing needs must consider:

- (1) Number of beds;
- (2) Distribution of beds (one or multiple units);
- (3) Medication management procedures (nursing staff for administration and monitoring);
- (4) Length of stay (LOS), (shorter LOS increases workload due to increased turnover);
- (5) Location and type of residential facility (travel distance, transportation logistics);
- (6) Veteran demographics (diagnosis, acuity, recovery time, etc.); and
- (7) Cultural maturity of program (strength of peer support, level of other staff support, degree of “built-in” programming structure, experienced use of policies and procedures, etc.)

b. As a result of the complexities of MH RRTP programs and in response VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017, the Office Mental Health and Suicide Prevention collaborated with the Office of Nursing Services (ONS) to develop MH RRTP Staffing Methodology (SM) to address the wide variances of the MH RRTP programs and to ensure safe nurse staffing per SM Directive (See VHA Directive 1351). **NOTE:** *The MH RRTP Directive does not address the methodology that was developed and implemented specifically for MH RRTPs, for related resources see the Office of Nursing Service Staffing Methodology SharePoint (<https://vawww.vha.vaco.portal.va.gov/sites/ONS/Workforce/SM/>). This is an internal VA Web site not available to the public.*

c. Facilities are required to implement the MH RRTP Staffing Methodology and involve the unit leadership and staff to help determine safe staffing levels, as well as variables which may impact staffing. Through the Staffing Methodology process facilities may determine and adjust individual clinical staff to reflect the mission of the program and the needs of the Veterans served in accordance with the staffing methodology directive, program, and nursing outcomes. In accordance with the Directive 1351 and this directive, the staffing pattern for nursing personnel must be

based on common and unit-specific workload indicators such as: unit turbulence (gains, losses, and turnover rate); scope and complexity of services, such as medication management, validated competencies, skill mix, ancillary support, environmental considerations, nursing hours per patient day (NHPPD); and staff replacement calculations. While the Staffing Methodology process applies to nursing staff, other 24/7 disciplines must be considered in determining the need for overall 24/7 staffing if these disciplines provide coverage for the unit.

d. Finally, staffing needs should be individualized to specific clinical settings and should not rely on ranges and fixed staffing models, staff-to-patient ratios, or prescribed patient formulas. The staffing model for MH RRTPs must be flexible, realistic and account for the varying situations and meets the following goals:

- (1) Meets the treatment/recovery and safety needs of the Veterans;
- (2) Provides flexibility that accounts for the variability in geography and unique local conditions;
- (3) Meets Behavioral Health accreditation standards for The Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF), and
- (4) Protects the integrity of nursing care.