

## INTENSIVE COMMUNITY MENTAL HEALTH RECOVERY SERVICES

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook outlines the requirements for the provision of Intensive Community Mental Health Recovery (ICMHR) Services within the VHA Mental Health Services.
- 2. SUMMARY OF MAJOR CHANGES:** This is a new Handbook, which incorporates requirements for Mental Health Intensive Case Management (MHICM), Rural Access Network for Growth Enhancement (RANGE), and Enhanced Rural Access Network for Growth Enhancement (E-RANGE) care as outlined in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics. It provides a single policy for these similar programs and guidance for future programs.
- 3. RELATED ISSUES:** VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics.
- 4. RESPONSIBLE OFFICE:** Mental Health Services (10P4M) and the Office of Patient Care Services (10P4) are responsible for the contents of this Handbook. Questions may be directed to Dan Bradford, MD, MPH at 919-286-0411, ext. 7151 or [daniel.bradford@va.gov](mailto:daniel.bradford@va.gov).
- 5. RESCISSIONS:** VHA Directive 2006-004, VHA Mental Health Intensive Case Management (MHICM), is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of January 2021.

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Under Secretary for Health

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## INTENSIVE COMMUNITY MENTAL HEALTH RECOVERY SERVICES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides policy and procedures for VHA's Intensive Community Mental Health Recovery (ICMHR) Services for Veterans with serious mental illness (SMI) and significant functional impairment as a part of the mental health continuum of care. **AUTHORITY:** 38 U.S.C. § 2031.

### 2. BACKGROUND

a. Serious mental illness is a significant problem among Veterans. For example, in 2010, the Department of Veterans Affairs (VA) provided care for 241,976 Veterans diagnosed with psychosis at an estimated cost of 5.4 billion dollars. Assertive Community Treatment (ACT) is the most well-known, evidence-based treatment approach for providing intensive case management to persons with SMI. Provision of ACT to individuals with SMI meeting ACT fidelity criteria has consistently been shown to reduce inpatient mental health hospitalization, improve patient satisfaction with care, increase housing stability, and improve treatment retention.

b. Mental Health Intensive Case Management (MHICM), Rural Access Network for Growth Enhancement (RANGE), and Enhanced Rural Access Network for Growth Enhancement (E-RANGE), collectively referred to as ICMHR Services are adaptations of ACT for Veterans with SMI served by the VHA mental health system.

c. To date, ICMHR Services have provided clinical community-based case management services to Veterans with SMI, severe functional impairment, and high inpatient mental health unit utilization, in coordination with existing community and VA services. Program elements have been distinguished from usual case management and traditional mental health services by the following characteristics:

- (1) A high staff-to-Veteran ratio, with multiple visits per week as needed;
- (2) Clinical case management provided by an interdisciplinary team where all members of the team are available to provide for the Veteran;
- (3) Interventions occurring primarily in the community rather than in office settings;
- (4) Availability maintained, around the clock when feasible, for ICMHR Services over a prolonged period as clinically indicated.

d. ICMHR Services are cost-effective interventions, despite the high resource intensity associated with them. When the ICMHR Services elements have been rigorously maintained (i.e., appropriately high frequency and intensity of services, low caseloads, ACT-informed team structure) and when the service is offered to Veterans in the defined target population, reductions in utilization of interventions, including inpatient mental health units, outpatient clinics, emergency rooms, and others have more than offset ICMHR Services costs. Additionally, according to data collected by the Northeast Program Evaluation Center (NEPEC), ICMHR Services are associated with

improvements in satisfaction with mental health services, housing independence, quality of life, and mental health symptoms.

e. Evaluations by NEPEC indicate compelling evidence for the effectiveness of the intervention with Veterans who experience psychotic symptoms; ICMHR Services may also be useful for Veterans who experience significant impairments in independent and community functioning as a result of severe affective disorder, severe post-traumatic stress disorder (PTSD), or other serious mental illnesses.

f. VHA's Mental Health Services (MHS) and the NEPEC in the Office of Mental Health Operations (OMHO) have collaborated in the development and management of ICMHR Services since their inception. These programs have been defined in VHA Directive 2006-004 (VHA Mental Health Intensive Case Management (MHICM)) and are recognized as important elements in the continuum of mental health care as detailed in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics.

g. NEPEC has produced comprehensive annual reports that document adherence of ICMHR Services to VHA policy, identify outliers, and document clinical outcomes using standardized and other accepted measures.

h. Consistent with the transformation of all VHA mental health services to a recovery orientation and with the alignment of the ICMHR Services under the Psychosocial Rehabilitation and Recovery Services (PSR&RS) Section of VHA MHS, ICMHR Services will likewise transform to fully implement practices and principles of psychosocial rehabilitation and recovery. In this way, ICMHR Services will help Veterans with SMI to achieve success in a broader array of self-defined and recovery-oriented domains.

### 3. SCOPE

This Handbook establishes procedures for ICHMR Services to meet the needs of Veterans with serious mental illnesses and to develop new services as supported by the needs of the Veteran.

### 4. DEFINITIONS

a. **National Psychosis Registry.** The Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) maintains the National Psychosis Registry (NPR). The NPR is an ongoing registry of all Veterans diagnosed with psychosis (defined by SMITREC as including schizophrenia, schizoaffective disorder, bipolar disorders, and other non-organic psychoses) who have received VHA services (inpatient or outpatient) from 1988 to the present. SMITREC distributes facility-specific data regarding the number of Veterans seeking VHA services on the NPR on at least an annual basis. This information can be found at: [http://vaww.va.gov/HSRDCOMPUTERSUPPORT/annarbor-hsrd/index\\_smitrec.htm](http://vaww.va.gov/HSRDCOMPUTERSUPPORT/annarbor-hsrd/index_smitrec.htm).

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

b. **Psychosocial Rehabilitation.** Psychosocial rehabilitation is the term used within VHA that is synonymous with psychiatric rehabilitation, which the Psychiatric Rehabilitation Association (PRA) defines as promoting “recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives.” PRA notes that rehabilitation services must be collaborative, person directed, individualized, evidence-based, and an essential element of any health care system.

c. **Recovery.** Recovery is identified as the “single most important goal” for the mental health service system in *Transforming Mental Health Care in America, Federal Action Agenda: First Steps* (SAMHSA, 2005). VHA endorses the definition of “recovery” as described by the Substance Abuse and Mental Health Services Administration (SAMHSA), which describes recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Through the Recovery Support Strategic Initiative, SAMHSA has delineated 4 major dimensions that support a life in recovery:

(1) **Health.** Overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way.

(2) **Home.** A stable and safe place to live.

(3) **Purpose.** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

(4) **Community.** Relationships and social networks that provide support, friendship, love, and hope.

d. **Serious Mental Illness (SMI).** Specifically in the context of ICMHR Services, serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder that meets Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria (excluding cognitive and developmental disorders and disorders due to a general medical condition) and meets all of the following criteria:

(1) Single unremitting episode of symptoms or with frequently recurring and/or prolonged episodes of symptoms;

(2) Symptoms result in impairments in mood, thinking, family or other interpersonal relationships, behavior (often resulting in socio-legal consequences), and/or self-care which substantially interfere with or limit major life activities; and

(3) The impact of these symptoms results in a functional impairment equivalent to a Global Assessment of Functioning (GAF) score of 50 or below. **NOTE:** Recovery is a prominent goal of care for Veterans with SMI regardless of diagnosis or GAF score.

e. **Community Integration.** Community integration is “the opportunity to live in the community and to be valued for one’s uniqueness and abilities, like everyone else.”

(Salzer, M.S., & Baron, R.C. (2006). Community integration and measuring participation. Philadelphia, PA: University of Pennsylvania Collaborative on Community Integration. Available online at <http://tucollaborative.org/>).

f. **Shared Caseload.** In the Evidence-Based Practices toolkit on ACT published by SAMHSA, the concept of shared caseload is defined as: “Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.” In addition to providing for continuous service by team members known to the Veteran, sharing of caseloads provides enrolled Veterans with access to the expertise of each discipline on the interdisciplinary team, as well as to specific competencies various team members have in delivering additional evidence-based and recovery-oriented practices.

g. **Rural.** This Handbook uses the VA’s Office of Rural Health definition of “rural”:

(1) **Urban Area.** Any block or block group having a population density of at least 1,000 people per square mile.

(2) **Rural Area.** Any non-urban or non-highly rural area.

(3) **Highly Rural Area.** An area having less than (<) 7 people per square mile.

## 5. MISSION, VISION, AND VALUES

VHA is committed to providing personalized, proactive, and patient-centered health care services. As a recovery-oriented program, ICMHR Services embrace VHA’s commitment through the following:

a. **Mission.** ICMHR Services support VHA’s mission to “Honor America’s Veterans by providing exceptional health care that improves their health and well-being.” To that end, the specific mission of ICMHR is to provide Veterans with a serious mental illness with intensive recovery-oriented mental health services that enable them both to live meaningful lives and in the community of their choosing. Services should assist Veterans in defining and pursuing a personal mission and vision based on their identified strengths and self-chosen values, interests, personal roles, and goals. ICMHR Services fully embrace and incorporate the core principles of psychosocial rehabilitation and recovery in all interactions, interventions, and program development.

b. **Vision.** In support of VHA’s Vision that health care services be patient-centered, all Veterans served by ICMHR Services will achieve their goals and live a meaningful life in the community and environment of their choice through ready access to recovery-oriented and community-based services and supports. Veterans served by ICMHR Services will fully integrate into their communities.

c. **Values.** ICMHR Services fully support VA's Core Values (Integrity, Commitment, Advocacy, Respect, and Excellence) through the following program-specific values:

(1) All individuals have the capacity to engage fully in the recovery process.

(2) All individuals have the capacity to learn and grow. Veterans with serious mental illness can participate in meaningful, self-determined community roles such as those assumed in school, work, personal relationships, and in recreational, spiritual, or volunteer activities. ICMHR Services help to facilitate an enhanced quality of life for each Veteran served.

(3) ICMHR Services are individualized, person-centered, and strengths-based and promote hope, responsibility, and personal empowerment.

(4) ICMHR Services are holistic, providing assistance to Veterans across all desired areas of life, including personal wellness and health.

(5) In interactions in the community and through the VHA health care system, ICMHR Services team members address stigma, labeling, and discrimination related to mental health and, in particular, related to serious mental illness. ICMHR Services team members embrace the mantra of "all advocacy, all the time."

(6) ICMHR Services team members show uncompromising respect for Veterans and their families in all interactions, evidenced by the words used, the attitudes demonstrated, and the expectations held for Veterans reaching the goals of their choosing.

(7) Veterans have the right to direct their own treatment through development of a recovery-oriented treatment plan. ICMHR Services team members work with Veterans and collaborating staff to maximize Veterans' autonomy in healthcare settings, to direct their own affairs, and to participate as citizens of their communities.

(8) ICMHR Services are provided in a way that recognizes and respects the Veteran's cultural values and norms. Cultural differences, ethnic differences, and religious or spiritual beliefs are not limiting factors in the provision of ICMHR Services.

(9) ICMHR Services teams recognize family members and other natural supports as vital contributors to the Veteran's recovery. With the consent of the Veteran, family members and other natural supports are involved in the Veteran's treatment planning and recovery.

(10) ICMHR Services continually strive to improve the services they provide, utilizing both evolving best practices and program-level outcomes to guide changes in service delivery.

## 6. PROGRAM ELEMENTS

a. **Target Population.** ICMHR Services are intended to provide necessary mental health treatment and support for Veterans who meet all of the following criteria:

(1) **Diagnosis of a Serious Mental Illness.** Based on the definition in subparagraph 5.d., the primary target population for ICMHR services is Veterans severe psychosis, severe mood disorders, or severe PTSD whose functional status is severely impaired. To maintain an overall emphasis on services for Veterans with psychosis and bipolar disorder, programs are expected serve a minimum proportion (75% for MHICM programs and 65% for RANGE and E-RANGE programs) of Veterans meeting the diagnostic criteria established for the National Psychosis Registry. Once these targets have been reached, Veterans with other diagnoses and similar impairments in functional status may be enrolled in ICMHR services. Other conditions such as Mild Traumatic Brain Injury (mTBI), substance use disorders, or personality disorders may coexist as secondary diagnoses. While ICMHR Services are not designed to serve Veterans who have these accompanying diagnoses as the primary problem for which services are required, these diagnoses do not exclude Veterans from ICMHR Services. ICMHR Services can be provided simultaneously with treatment for accompanying diagnoses, with ICMHR Services staff working to assure coordination, non-duplication of services, and linking of all services to an overall recovery-oriented treatment plan.

(2) **Inadequately Served.** Veterans served by ICMHR Services are inadequately served by conventional clinic-based outpatient treatment. They are unable to maintain successful and stable community integration through the use of these conventional services, even with augmented services such as Psychosocial Rehabilitation and Recovery Centers (PRRC).

(3) **High Resource Use.** High resource use includes frequent hospital use, defined by over 30 days of inpatient mental health unit care (the combined total of VA and non-VA hospital days) or 3 or more episodes of mental health hospitalization over the past year. Veterans who meet all other criteria for admission, but do not have frequent hospital use, may be considered appropriate for ICMHR Services when other indicators of high resource use or high vulnerability—including, but not limited to, frequent emergency department visits, frequent contacts with law enforcement, frequent use of crisis support services, or frequent contact with emergency responders—consistently impair their ability to maintain adequate housing or community function. However, Veterans who meet the inpatient mental health unit care criterion must be given priority consideration.

(4) **Clinically Appropriate for Outpatient Status.** The positive aspects of ICMHR Services must not be used to justify moving Veterans to a community-based model who would be better served by inpatient care. Veterans who are more appropriately managed clinically on inpatient mental health units need to remain in the inpatient setting.

b. **Enrollment in ICMHR Services.** ICMHR Services teams provide an evaluation for service participation for Veterans who are referred to or who personally request ICMHR Services. Referrals and ICMHR Services team responses must be documented using the consult procedure in CPRS. The process of evaluation for ICMHR service participation must be guided by the following principles:



(1) Each referral needs to be considered on an individual basis for enrollment, giving the greatest possible consideration for participation in the program to Veterans who have needs that have not been met by traditional services.

(2) Veterans who otherwise meet the definition of the target population for ICMHR Services cannot be denied service participation based solely upon the length of current abstinence from alcohol or non-prescribed controlled substances, the use of prescribed controlled substances, the number of previous treatment episodes, legal history, homelessness, personality disorder, or previous treatment non-adherence. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity. Because ICMHR Services provide unique clinical services for Veterans with serious mental illness, ICMHR Services teams need to make every possible effort to enroll referred Veterans who meet the definition of the target population who desire ICMHR Services. While respecting the Veteran's right to refuse specific treatment options, ICMHR Services teams need to exert additional efforts to reach out to those who initially are reluctant to enroll to ensure that they make an informed decision.

(3) Safety of ICMHR Services team members and of Veterans is a highly important consideration. Because they primarily deliver services in the community, ICMHR Services team members work in settings that cannot be controlled in the same manner as the VA medical facility or clinic. In addition to general considerations of safety in the community, accommodations such as conducting initial evaluation visits in pairs of ICMHR Services team members or in the VA medical facility or clinic may be used to facilitate completion of the evaluation for ICMHR service participation. In support of safe practice while working in the community, ICMHR Services team members must have access to cellular telephones.

(4) When a referred Veteran is not enrolled in ICMHR, the ICMHR Services team must partner (e.g., suggesting alternative services) with the Mental Health Treatment Coordinator (MHTC) or referring provider (if an MHTC has not yet been designated) to help the MHTC ensure that the mental health needs of the referred Veteran are met.

c. **Service Elements.** ICMHR Services are delivered by an integrated, interdisciplinary team. Fidelity to these Service Elements is essential to ensure desired program outcomes and positive results for Veterans. The core treatment elements are:

(1) **Focus on Psychosocial Rehabilitation and Recovery.** ICMHR Services are driven by a recovery-oriented care-planning process that incorporates the Veteran's goals, preferences, and strengths. It includes interventions for building adaptive and social skills, increased self-care, independent living, employment, crisis resolution, and practical problem solving. To address the many facets of psychosocial rehabilitation and to promote Veteran recovery, ICMHR Services teams are encouraged to utilize a variety of professional disciplines (e.g., psychiatrists, psychologists, social workers, pharmacists, mental health counselors, marriage and family therapists, nurses, occupational therapists, kinesiotherapists, recreation therapists, vocational specialists, peer specialists) both as team members and as collateral partners. If not directly represented on the team or in regular team meetings, team members need to routinely collaborate with these professionals and with other related VHA programs such as Compensated Work

Therapy/Supported Employment, Health Care for Homeless Veterans (HCHV), Women's Health, Veterans Justice Outreach, Housing and Urban Development-VA Supportive Housing (HUD-VASH), and Psychosocial Rehabilitation and Recovery Centers (PRRC). In particular, strong partnerships between ICMHR Services teams and PRRCs are important to the continuum of care provided to Veterans with serious mental illnesses. In support of this partnership, a shared recovery plan must be in place for each Veteran simultaneously enrolled in an ICMHR program and the PRRC.

(2) **Focus on Community Integration.** Helping Veterans with SMI to achieve integration into their communities is a major goal of ICMHR Services. Efforts to help Veterans to identify environments in which to live, work, learn, and socialize are based on individual goals and preferences. Consistent with this principle, efforts to promote community integration must emphasize work with individual Veterans over group outings. When desired by the Veteran, assisting Veterans in connecting or reconnecting with family members and other natural supports can be helpful in promoting community integration.

(3) **High Intensity.** ICMHR Services are described as both frequent (i.e., high intensity of service) and clinically intense (i.e., complex clinical encounters).

(a) Veterans are seen frequently (typically 2 to 3 contacts per week) for the delivery of ICMHR Services. This level of service intensity may not be required for the entire time the Veteran receives ICMHR Services, and Veterans may be seen more or less frequently as warranted by their clinical needs at a given time, recognizing that recovery is a non-linear process. Events such as hospital discharges, transitions in living environments, initiation or changes in psychopharmacological treatment, or times of loss often require increased intensity of contact for limited periods of time.

(b) Clinical contacts are anticipated to be complex and typically are face-to-face. At least 1 visit per week must be face-to-face, preferably in the Veteran's home or community. When desired and with the consent of the Veteran, ICMHR Services team members need to have contacts with the Veteran's caregivers, family members, and other natural supports.

(4) **Low Caseloads.** In order to provide intense and frequent contact with Veterans served, ICMHR Services team members must have small caseloads. Caseloads are limited to 7 to 10 Veterans per clinical case manager for RANGE and E-RANGE teams, and 7 to 15 Veterans per clinical case manager for MHICM teams. Logistically, low caseloads are also necessary to allow time for regular travel to Veterans' homes and communities. Caseload ranges are provided to allow for the consideration of the individual level of needs of the Veterans served by the ICMHR Services team. For example, Veterans with complex needs who may experience specific challenges such as homelessness or active substance abuse may have more frequent need of clinical contact than those approaching readiness for a lower intensity of care. When caseloads on ICMHR Services teams approach the specified upper limits, program team leaders must work with local health system leadership to increase staffing.

(5) **Shared Caseloads.** While each Veteran in ICMHR Services has a primary clinical case manager who typically serves as the MHTC, ICMHR programs use shared caseloads so that the Veteran can take advantage of the expertise of each team member and so that the Veteran has consistent access to ICMHR Services, uninterrupted by staff absences.

(6) **Provision of Clinical Case Management Services.** ICMHR Services utilize clinical case management as the primary service modality. Clinical case management focuses on all aspects of the physical and social environment through the utilization of community experiences as in-vivo treatment opportunities (e.g., therapy, skill building) to facilitate Veterans' recovery.

(7) **Coordination of Services.** As the "fixed point of clinical responsibility" for each enrolled Veteran, ICMHR Services team members work to enhance overall health care quality both by direct provision of mental health services and by coordinating health care and social service needs across the entire VHA system and beyond. ICMHR Services team members work to assure timely access to general medical care services for both routine and acute visits, assist Veterans in receiving recommended preventive services, and assist Veterans in accessing and adhering to recommended general medical treatments (within the clinical privileges or the scope of practice of each professional).

(8) **Flexibility and Community Orientation.** Most services are provided in community settings and include collaboration with available support systems (e.g., family members, landlords, employers, etc.) whenever possible and with the consent of the Veteran. Flexibility of ICMHR Services team members is critical in order to respond to the anticipated and ongoing as well as unanticipated and acute needs of Veterans. ICMHR Services team members may need to adjust their schedules throughout the course of any given day in response to Veterans who are in crisis, especially when support persons and resources in the community are unavailable and to adjust for weather, traffic, and other situational demands related to providing community-based services to vulnerable persons. Local team leaders and facility mental health leaders must have plans and systems in place to accommodate a high degree of flexibility and to ensure the integrity of the program and safety of team members and Veterans.

(9) **Focus on Advocacy and Supporting Veteran Autonomy.** ICMHR Services team members seek to elicit and document Veterans' preferences for clinical care during potential episodes of diminished decision-making capacity and to identify, when desired by the Veteran, individuals who need to be consulted about clinical care decisions on behalf of the Veteran at these times. The ICMHR Services team members advocate for the Veteran during these times and work with other health care providers and the Veteran's designated surrogate decision maker to ensure that the treatment(s) chosen balance the Veteran's wishes, or best interests if the Veteran's wishes are unknown, with the Veteran's safety. ICMHR Services team members provide education on Advanced Directives and assistance to Veterans who wish to complete them.

(10) **Clinical Responsibility.** The ICMHR Services team is identified as being a "fixed point of clinical responsibility," providing continuity of care for each Veteran across treatment settings for the duration of the Veteran's participation in ICMHR Services. This responsibility lasts as long as necessary based on the Veteran's needs and preferences.

**(11) Use of Psychiatric Medications.**

(a) Appropriate use of psychiatric medications is among the evidenced-based tools which can be used to support recovery in Veterans with SMI. Each team must have a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment as a dedicated team member for at least 20 percent time. Availability of a primary prescriber of psychiatric medications with time dedicated to the ICMHR Services team, including attendance at regular team meetings, assures that use of psychiatric medications is recovery-oriented, person-centered, and team-based. While most Veterans served by ICMHR Services would transfer psychopharmacological care to the ICMHR Services team's primary prescriber, a small number of Veterans may be better served by their relationship with a prescriber in another program. Consideration of this arrangement will be on a case-by-case basis. Within their appropriate clinical privileges or scopes of practice, all ICMHR Services team members can contribute to optimal implementation of use of psychiatric medications.

(b) ICMHR Services staff should assist Veterans in increasing their ability to take prescribed psychiatric medications independently. However, some Veterans will at times require increased levels of support with psychiatric medications, and such support (including administration of injectable medications) may often ideally be provided in the community. ICMHR Services must work with local facility administration to develop local policies, which allow ICMHR Services team members to support Veteran use of psychiatric medications in the community in a manner that is consistent with local scopes of practice for each discipline and their associated licensure.

**(12) Delivery of Additional Evidence-based and Recovery-oriented Practices as Part of Intensive Community Mental Health Recovery Services.** To fully facilitate recovery, Veterans served by ICMHR Services teams must also have access to additional evidence-based and recovery-oriented practices. While linking Veterans to providers who are skilled in particular practices beyond the ICMHR Services team may be necessary in some cases, provision of these practices in the community directly by ICMHR Services team members is ideal, as this approach takes best advantage of Veterans' community environment to tailor services to individual needs and to help Veterans build skills in the settings where they will be applied. To that end, ICMHR Services teams must work to develop competence among team members in multiple established evidence-based and recovery-oriented practices for Veterans with SMI. Examples of some practices that may be provided in the context of community visits include:

- (a) Illness Management and Recovery,
- (b) Wellness Recovery Action Planning,
- (c) Motivational Interviewing, and
- (d) Cognitive Behavioral Therapy.

(13) **Use of Federal Vehicles.** Provision of ICMHR Services requires use of Federal vehicles for the delivery of community-based services, including times when Veterans may ride with VA clinical staff in Federal vehicles. Clinical staff must be medically cleared and trained before transporting Veterans in Federal vehicles pursuant to VHA Directive 2008-020. Each use of Federal vehicles in the delivery of ICMHR Services must be documented in the clinical chart, with clear linkage established to specific items in the Veteran's recovery plan. Part of that plan must include efforts to help the Veteran progress over time towards independence in transportation, when possible.

d. **Transition to Lower Intensity Services.** ICMHR Services are Veteran-driven and promote increasing the Veteran's independence. Lower intensity services are clinically appropriate for Veterans after they have met their most significant recovery goals and no longer need intensive services to maintain their progress or for those who have embarked on a self-directed plan to achieve goals with less intensive clinical support. Those Veterans who no longer need high-intensity care may be transferred either to standard mental health outpatient care or, in some cases, may continue to be treated by the ICMHR Services team for a limited time at a lower level of service intensity (e.g., fewer than 1 community contact per week). Decisions related to the intensity of care must be made in collaboration with the Veteran and based upon regular review of the Veteran's needs. Given the target population for ICMHR Services, typically no more than 20 percent of an ICMHR Services team's caseload should consist of Veterans receiving low intensity clinical case management. Characteristics of readiness for a lower intensity of care often include the following:

- (1) Clinically stable and not relying on extensive inpatient or emergency services;
- (2) Has met the treatment goals identified in collaboration with the ICMHR Services team;
- (3) Maintaining stable community living in a residence of the Veteran's own choosing, and having the means to sustain this stable housing;
- (4) Unimpeded by the abuse of substances;
- (5) Independently participating in necessary treatments; and
- (6) Expressing a desire to receive less frequent contacts or utilize a different treatment modality.

e. **Staffing of ICMHR Teams.** Adequate staffing for models of ICMHR Services is guided by the number of Veterans served, the severity of impairment of Veterans served, and logistical considerations in offering the type of services provided. Veterans served by ICMHR Services must have access to recovery-oriented clinical case management, psychotherapy, and pharmacological treatment as appropriate for their needs. Staffing of ICMHR Services teams is expected to include multiple disciplines, reflecting the interprofessional nature of psychosocial rehabilitation and recovery-oriented services. ICMHR Services are strongly encouraged to include peer specialists on their teams. In healthcare systems where there is more than one ICMHR Services

team, one of the ICMHR Services team leaders must be designated to assure coordination among teams. Staffing of each type of ICMHR Services team is guided the following:

(1) **MHICM.** MHICM programs must be available to serve Veterans in systems of care where 1,500 or more Veterans are identified on the NPR. The staffing plan for these programs includes a minimum of 4 full-time employee (FTE) clinical case managers and must be adjusted to include additional FTEs as the numbers of Veterans potentially served by the team grows in order to maintain the appropriate staff-to-Veteran ratio (1:7-15). Each team must have a full-time registered nurse and a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) who is a dedicated team member for at least 20 percent time.

(2) **RANGE.** RANGE programs serve Veterans living in less densely populated or rural areas with relatively few Veterans listed on the SMI Registry. The staffing pattern for these programs includes a minimum of 2 FTE clinical case managers and must be adjusted to include additional FTEs as the numbers of Veterans potentially served by the team grows, in order to maintain the appropriate staff-to-Veteran ratio (1:7-10), as clinically indicated by the needs of the Veterans served, or as practically indicated by geographical distance or travel time. RANGE teams must include, as specified for MHICM teams, a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) as a dedicated team member for at least 20 percent time.

(3) **E-RANGE.** E-RANGE are RANGE teams enhanced by a special emphasis on homelessness. The staffing pattern for these programs includes a minimum of 3 FTE clinical case managers and must be adjusted to include additional FTEs as the numbers of Veterans potentially served by the team grows (to maintain appropriate staff to Veteran ratio (1:7-10)), as clinically indicated by the needs of the Veterans served, or as practically indicated by geographical distance or travel time. E-RANGE teams must include, as specified for MHICM and RANGE teams, a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) as a dedicated team member for at least 20 percent time.

f. **Data Recording.**

(1) **Decision Support System (DSS) Identifiers.** Appendix A contains the definitions of the DSS Identifiers (Stop Codes) for the ICMHR workload (546, 552, and 567) as well as the code for general (non-intensive) mental health case management (564) provided by non-ICMHR teams. Intensive case management services provided under Stop Code 552 are the primary determinant of the MHICM Patient Classification within the VHA Veterans Equitable Resource Allocation (VERA) system. For RANGE, RNNX is added to these stop codes. RNNY is added for E-RANGE.

(2) MHS continues to work with the Performance Measurement Program in the Office of Analytics and Business Intelligence and the Office of Mental Health Operations to develop performance indicators, including indicators related to the

ICMHR Services, which may be used in the Executive Career Field (ECF) Performance Contract and other performance measurement systems.

(3) ICMHR Services team members are required to meet all national and local requirements for the timely documentation of their clinical services in the Veteran's electronic health record and for the timely completion of all forms required for the MHICM, RANGE, and E-RANGE performance evaluation and monitoring systems administered by OMHO. ICMHR Services team members must abide by all applicable laws, regulations, and VHA policies related to privacy, confidentiality, and information security.

g. **Accreditation.** Endorsement from external accreditation agencies is an important aspect of ensuring ongoing high quality programming. In connection with this priority, all ICMHR Services must obtain Joint Commission accreditation and maintain the applicable Joint Commission Behavioral Health Standards detailed in the most recent version of the Joint Commission manual. All ICMHR Services with 3 or more clinical team members must obtain accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and maintain adherence to the CARF Behavioral Health Standards, Sections 1 and 2, psychosocial rehabilitation field category, and Case Management program standards. All ICMHR Services must be accredited by the applicable bodies (Joint Commission and CARF) within 2 years of this Handbook being issued or at the time of the next scheduled Joint Commission or CARF accreditation survey for a given facility based on the 3-year accreditation cycle.

h. **Program Quality Monitoring and Improvement Initiatives.** ICMHR Services will maintain service standards consistent with this Handbook, as monitored by MHS and OMHO (described below in Section 7). Additionally, as required by CARF, ICMHR Services will have organized, regular, and planned quality improvement initiatives to systematically improve their services. Quality improvement efforts may also be initiated by MHS and OMHO.

## 7. RESPONSIBILITIES

a. **VHA Mental Health Services.** VHA Mental Health Services is responsible for:

(1) Managing the approval process for new ICMHR Services in collaboration with OMHO. When MHS and OMHO have agreed on approval for a new ICMHR Program, MHS will issue a charter letter;

(2) Developing national policy and procedures for ICMHR Services based on relevant laws and regulations, the scientific literature, professional practice standards associated with evidence-based mental health care, and the on-going ICMHR Services-specific evaluation data and reports created by OMHO, the Office of Performance Measurement, and other relevant offices in VHA;

(3) Overseeing the effectiveness of the ICMHR Services in collaboration with OMHO by monitoring workload and outcome data;

(4) Ensuring that ICMHR Services team members are adequately trained and prepared to meet all program standards and the evolving clinical needs of the Veterans served; in close collaboration with the OMHO;

(5) Providing ongoing technical assistance and mentoring for ICMHR Services team members; and collaborating with OMHO in all of these efforts;

(6) Collaborating with OMHO to recommend operational changes as indicated by evaluation and/or scientific data to the Office of the Deputy Under Secretary for Health for Operations and Management, including recommending when any ICMHR Services teams needs to be dropped from the ICMHR program designation because of persistent inability to meet evidence-based fidelity standards, to provide all essential treatment elements, or to comply with data reporting requirements.

**b. The Office Of Mental Health Operations, Northeast Program Evaluation Center.** The Northeast Program Evaluation Center (NEPEC), as an OMHO field-based office for program evaluation in support of VHA mental health programs, is responsible for:

(1) On-going monitoring of all services provided by ICMHR Services teams under the designated Stop Codes through use of the following data collection devices:

(2) Intake data forms are administered by ICMHR clinicians to all Veterans upon admission to ICMHR Services care. These tools document adherence to the eligibility criteria and record baseline data including clinical status, functional impairment, and satisfaction with services.

(3) Follow-up data forms are tools administered to all Veterans by clinicians in ICMHR Services and their respective ICMHR clinicians 6 months after beginning ICMHR treatment, 1 year after program entry, and annually thereafter. These allow for the collection of continuing data to document Veteran progress and delivery of ICMHR service elements.

(4) Completing the annual National Performance Monitoring Report. Each ICMHR team must provide monthly data to NEPEC regarding staffing and service provision. At the end of the fiscal year, teams must provide an annual report, which includes an opportunity to provide a brief narrative that qualitatively documents team events over the year and measures of implementation and fidelity, staffing, and program cost. NEPEC integrates these data (i.e., from monthly and yearly forms and reports) with information from the Administrative Data Files and/or Corporate Data Warehouse stored in the Austin Automation Center into the National ICMHR Performance Monitoring Reports. These electronic reports are distributed to VHA leadership and Veterans Integrated Services Network (VISN) Directors to guide operations and policy development. Further information is available on the NEPEC Web site: <http://vaww.nepec.mentalhealth.med.va.gov>. **NOTE:** *This is an internal VA Web site and is not available to the public.*



(5) Shared oversight of ICMHR Services in collaboration with MHS. This includes, but is not limited to, ensuring that all teams meet the required data collection expectations; ensuring accuracy in the use of relevant stop codes and workload coding; communicating information; and providing technical assistance related to all ICMHR performance measures, monitoring, and capacity targets. In collaboration with MHS, OMHO will also provide consultation to sites that demonstrate an inability to maintain the elements of ICMHR Services as defined in this Handbook. When repeated attempts to assist programs to regain fidelity to the program models are not successful, OMHO and MHS will recommend discontinuing the use of ICMHR Services stop codes.

(6) Ensuring the accuracy and completeness of all data and reports associated with the ICMHR programs;

(7) Collaborating with MHS and other program evaluation centers, particularly SMITREC, to promote the sharing of information pertinent to the ICMHR Services and the Veterans they serve.

c. **The Veterans Integrated Services Network Director.** Each Veterans Integrated Service Network (VISN) Director is responsible for:

(1) Establishing strategies to provide Veterans who correspond to the described target population with access to ICMHR services sufficient to meet their needs.

(2) Supporting fidelity to the ICMHR standards as outlined by VHA policy and as monitored by OMHO.

(3) Assuring identification of one of the facility ICMHR Services team leaders to serve as a VISN ICMHR Services Point of Contact to OMHO and MHS. This individual will provide coordination of ICMHR Services teams and serve as a champion for implementation of this Handbook and other ICMHR Services across each VISN.

d. **The VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Utilizing national DSS identifiers to record ICMHR activity for approved programs.

(2) Supporting NEPEC data collection by providing complete monitoring information for ICMHR Services in a timely manner.

(3) Ensuring that ICMHR teams maintain fidelity to program operating principles and evidence-based clinical procedures, as defined in this Handbook. When caseloads on ICMHR Services teams approach the specified upper limits, local health system leadership must increase staffing on current teams or start additional teams to meet the needs of Veterans served.

(4) Ensuring plans and systems are in place to accommodate the high degree of flexibility required for ICMHR staff to be able to respond to immediate Veteran needs as they arise.

(5) Ensuring plans and systems are in place to provide safety for Veterans participating in ICMHR Services and for staff providing ICMHR Services.

(6) Ensuring adequate resources are continuously available to address the needs of the exceptionally vulnerable Veterans served by ICMHR, including:

(a) At least four FTEs who can function as primary clinical case managers for each MHICM team or at least 2 FTEs for each RANGE or 3 FTE employees for each E-RANGE team. Each team must have a psychiatrist (or other professional who is qualified to provide psychopharmacological treatment) who is a dedicated team member for at least 20 percent time. Other requirements for team composition are specified above in sections 6. e. (1)-(3). Each team must include two or more Licensed Independent Providers. Additional team members are required in order to maintain the staff-to-Veteran ratio required in circumstances where the facility has a high number of Veterans on the NPR or where the team is isolated from a VA medical facility that can provide 24-hour coverage and emergency services. Provision must also be made for adequate team leadership (i.e., sufficient administrative time, typically 50 percent for ICMHR Services team leaders) given the intensity of the work; the need for communication and collaboration among team members; the need to ensure staff safety, support, and development; and the completion and submission of all required reports. In healthcare systems where there are multiple ICMHR Services teams, team leaders must collaborate to assure ICMHR Services access and coordination.

(b) Office space for ICMHR team members, preferably in close proximity to each other so they can meet daily to coordinate care.

(c) Adequate support from a Medical Support Assistant to support the ICMHR team in communicating when team members are working in the community, scheduling appointments, and submission of required data forms to NEPEC.

(d) Sufficient numbers of government vehicles (i.e., General Services Administration-leased vehicles) for community-based services and transporting Veterans as described in section 6. c. (13); electronic communication; information technology; and other resources to facilitate safe and efficient delivery of community-based services.

**DECISION SUPPORT SYSTEM (DSS) IDENTIFIERS (STOP CODES) FOR  
INTENSIVE CASE MANAGEMENT**

<b>Decision Support System (DSS) Identifier Number</b>	<b>DSS Identification Name</b>	<b>DESCRIPTION</b>
<p>546 for Mental Health Intensive Case Management (MHICM)</p> <p>For Rural Access Network for Growth Enhancement (RANGE), RNNX must be added to this stop code. RNNY must be added for E-RANGE.</p>	<p>Telephone Intensive Community Mental Health Recovery (ICMHR) Programs</p>	<p>Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or the patient's family members and other natural supports, and clinical, professional staff assigned to the special ICMHR teams (see 552). Includes administrative and clinical services. <b>NOTE:</b> <i>Contact with individuals other than the Veteran is guided by VHA Handbook 1605.1 on Privacy and Release of Information.</i></p>
<p>552 for MHICM</p> <p>For RANGE, RNNX must be added to this stop code. RNNY must be added for E-RANGE.</p>	<p>ICMHR</p>	<p><u>Only VA medical facilities approved to participate in Intensive Community Mental Health Recovery Services monitored by Northeast Program Evaluation Center (NEPEC) may use this code.</u> This records visits with patients and/or their families or caregivers by ICMHR staff at all locations including VA outpatient or ICMHR satellite clinics, ICMHR storefronts, ICMHR offices, or home visits. Includes clinical and administrative services provided to ICMHR patients by ICMHR staff. Additional stop codes may not be taken for the same workload.</p>
<p>567 for MHICM</p> <p>For RANGE, RNNX must be added to this stop code. RNNY must be added for E-RANGE.</p>	<p>ICMHR Group</p>	<p><u>Only VA medical facilities approved to participate in Intensive Case Management programs monitored by NEPEC may use this code.</u> This records group visits with patients and/or their families or caregivers by ICMHR staff at all locations including VA outpatient clinics, satellite clinics, VHA storefront clinics, ICMHR offices, or home visits. Includes clinical and administrative services provided to patients by ICMHR staff. Additional stop codes may not be taken for the same workload.</p>

Decision Support System (DSS) Identifier Number	DSS Identification Name	DESCRIPTION
564	Mental Health Team Case Management	Any case management team that has not been approved as an ICMHR team by VA Central Office may use the 564 stop code to record visits with patients and/or their families or caregivers by members of a mental health case management team performing mental health community case management at all locations. Includes administrative and clinical services provided to patients by team members. ( <u>NOT</u> to be used for visits by ICMHR teams [see DSS Identifier #552], or for case management by individuals who use other stop codes.) Intensive case management codes (above) MUST NOT be used by teams without express authorization from VA Central Office.