Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Review of
Veterans Health Administration
Residential Mental Health Care Facilities

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VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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Contents

Executive Summary

Introduction

As directed in Public Law 110-387, the VA Office of Inspector General (OIG) conducted a review of residential mental health care facilities, including domiciliary facilities, of the Veterans Health Administration (VHA). As part of the review, the OIG was directed to assess the availability of residential mental health care facilities in each Veterans Integrated Service Network (VISN); the supervision and support provided in VHA residential mental health care facilities; the ratio of staff members to patients at residential mental health care facilities; the appropriateness of rules and procedures for the prescription and administration of medications to patients in residential mental health care facilities; and the protocols at residential mental health care facilities for handling missed appointments.

The review consisted of all VHA residential mental health care facilities and employed three components for information gathering: a web based information request, onsite inspections, and medical record reviews. In December 2008, an information request was sent to all VA medical centers for completion by affiliated residential program managers. A stratified sample design was used to select a probability-based random sample of 20 VHA residential treatment sites for onsite inspection. VHA residential treatment sites were stratified based on program types. The 20 sample sites resulted in 51 programs of VHA residential treatment. From February 23–March 6, 2009, 6 teams of OIG inspectors conducted onsite visits. For medical records review for compliance with VHA policies relevant to the objectives of this inspection, a probability-based random sample of 50 patients were drawn from lists of all patients admitted to residential treatment programs during FY 2008 within each of the 20 sites visited. For sites with less than 50 admissions during FY 2008, all patients admitted to the program during FY 2008 were included. In total, 933 medical records were reviewed.

Results

- Each VISN except VISN 19 has at least 1 general mental health residential rehabilitation treatment program (MH RRTP). Specialized post-traumatic stress disorder (PTSD) residential programs are available in all VISNs except for VISNs 15, 18, and 22; specialized substance use residential programs are available in all VISNs except VISN 22. Domiciliary Care for Homeless Veteran (DCHV) programs are available in all VISNs. Compensated Work Therapy-Transitional Residence (CWT-TR) beds are available in all VISNs except VISNs 2, 19, and 22. We concluded that not all VISNs had programs in the 5 residential program categories presented. In addition, we found that not all residential programs

include special emphasis programming for Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

- While we consider screening an essential component of the admissions process, only 9 of 20 sites visited had appropriate policies for screening for all programs at that site. In addition, based on chart review, we estimated 74 percent of VA residential program patients placed on waiting lists were contacted or engaged in treatment while awaiting placement. To ensure continuity of clinical monitoring of this vulnerable population, it is essential that residential programs also maintain contact with and/or ensure interim assessment for veterans awaiting placement into residential programs.

- All 20 sites visited, excluding CWT-TR programs, had a staff member present in each building on all shifts. All sites had policies requiring annual monitoring of staff competencies. Based on medical record review, we estimated that 57 percent of patients at programs with policies on contraband had contraband searches performed on admission. The current Domiciliary Residential Rehabilitation Treatment Program (DRRTP) and Psychosocial Residential Rehabilitation Treatment Program (PRRTP) handbooks do not contain guidance for programs on when and under what circumstances contraband searches are indicated, appropriate, and at what frequency. The draft MH RRTP Handbook does, however, require regular and random searches.

- At sites visited, medical screening varied based on program type. Clinical treatment programming meeting VHA standards was provided on weekends at 4 of 20 sites visited. Based on patient records review, we estimated that post-discharge monitoring was not evident in 29 percent of VA residential patient records.

- We could not find specific staffing ratio standards for similar residential facilities from relevant non-VHA accrediting bodies. At a minimum, all sites should have at least one staff member available during each shift, on each separate wing, and on each floor of residential programs. In the absence of external staffing ratio standards for this unique set of programs, we also believe that VHA should develop more specific staffing guidance as it pertains to patient monitoring and supervision by nursing and affiliated staff.

- In terms of medication issues, we estimated that 11 percent of VA residential program Self Medication Policy (SMP) patients on narcotics received more than a 7-day supply of medication. Based on medical record review, an estimated 55 percent of VA residential program SMP patients had no documentation of an order for SMP nor was there consistent documentation of appropriate instruction regarding the SMP process.

- Participation in rehabilitative treatment requires adherence to clinical appointments. Clinicians and program staff should monitor adherence. During site visits we found variation between programs and between sites in monitoring and re-scheduling missed appointments.

Recommendations

Recommendation 1: We recommended that the Acting Under Secretary for Health should ensure that VHA program officials review the utilization, resource allocation, and distribution of general residential, PTSD focused, substance use focused, DCHV, and CWT programs.

Recommendation 2: We recommended that the Acting Under Secretary for Health should ensure that VISN Directors include programming specific for OIF/OEF veterans in residential programs.

Recommendation 3: We recommended that the Acting Under Secretary for Health ensure that VISN Directors should make sure that residential program managers ensure that patients on waiting lists are periodically contacted and/or engaged in treatment while awaiting placement in a residential program.

Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.

Recommendation 5: We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that minimum programming requirements are met 7 days per week.

Recommendation 6: We recommended that the Acting Under Secretary for Health should further develop formal guidelines for mental health clinician staffing by mental health discipline for programs using an all-inclusive staffing model and for programs using a residential type clinical staffing model.

Recommendation 7: We recommended that the Acting Under Secretary for Health should require the presence of at least one staff member on each separate wing and floor of residential programs on all shifts.

Recommendation 8: We recommended that the Acting Under Secretary for Health ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.

Recommendation 9: We recommended that the Acting Under Secretary for Health ensure that all patients on self medication have a documented order for self-administration.

Recommendation 10: We recommended that the Acting Under Secretary for Health ensure that missed appointments by residential program patients should be captured, addressed, and case managed in a uniform manner.

Comments

The Acting Under Secretary agreed with the findings and recommendations and provided an appropriate improvement plan. See Appendix C (on page 31) for the full text of his comments. We will follow up on the implementation of all action plans until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
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Introduction

Purpose

As mandated in Public Law 110-387, the VA Office of Inspector General (OIG) conducted a review of residential mental health care facilities, including domiciliary facilities, of the Veterans Health Administration (VHA). As part of the review, the OIG was asked to assess the availability of residential mental health care facilities in each Veterans Integrated Service Network (VISN); the supervision and support provided in VHA residential mental health care facilities; the ratio of staff members to patients at residential mental health care facilities; the appropriateness of rules and procedures for the prescription and administration of medications to patients in residential mental health care facilities; and the protocols at residential mental health care facilities for handling missed appointments.

Background

A. Program History

The Domiciliary Care Program was initially established by legislation in the late 1860s to provide a home for totally disabled volunteer soldiers of the Civil War. Referred to as the National Home for Disabled Volunteer Soldiers, the program initially accepted veterans with a service-connected disability sufficient to prevent them from earning a living. In the late 1880s, the population served was expanded to "disabled by age, disease or otherwise." In the latter years of the 19th century, vocational training was provided. Gradually, the homes became institutions for the aged and infirmed.

In 1930, the homes became part of the Veterans Administration, and by 1960 there were 18 domiciliary facilities with 1,000 beds each. At the time, residents were provided bed, board, and incidental medication. Most were disabled to the degree that they could not support themselves, and only a fraction ever left.

In 1983, the VA's Chief Medical Director issued a letter indicating that a domiciliary program should be considered a distinct component of VA's continuum of medical care programs, which provide medical care including rehabilitation for eligible ambulatory veterans. The goal became to provide care and rehabilitation to veterans with medical impairments or disabilities to facilitate their ability to return to the community, recognizing that some would continue to require domiciliary care for an indefinite period.

In parallel with this paradigm shift, two types of domiciliary care were implemented. The health maintenance domiciliary was envisioned as a residence for a small number of eligible veterans in need of long-term institutional care, similar to the original domiciliary concept. The biopsychosocial domiciliary was to provide rehabilitative care to assist patients in returning to non-institutional community living.

During the 1980s, domiciliary programs began admitting patients with psychiatric illness including post-traumatic stress disorder (PTSD), substance use[1] disorders, and schizophrenia, as well as homeless veterans, resulting in the need for integration of the domiciliary program and the provision of medical care.

Psychosocial rehabilitation, job training, therapeutic services, and psychological support became integral facets of the domiciliary setting. Domiciliary residents have been expected to be ambulatory, to perform activities of daily living independently or with minimal assistance, and to be mostly capable of medication self-management. Management of chronic and sub-acute medical illness has typically been provided through traditional appointments at VHA outpatient clinics.[2]

In 1995, VHA established the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) for veterans with mental illness or addictive disorders who require additional structure and support to address multiple and severe psychosocial deficits including homelessness and unemployment. The focus of PRRTP care has been gradually shifting from symptom reduction to a rehabilitative approach to affect increased functional status and improved quality of life. The Office of Mental Health Services within the Office of Patient Care Services has been responsible for administration of the PRRTP.

Domiciliary programs were administered by the VHA Office of Geriatrics and Extended Care, which ultimately became part of the Office of Patient Care Services. In 2005, domiciliary programs became integrated in the Office of Mental Health Services within the Office of Patient Care Services. An April 2006 VHA Handbook 1162.02[3] updated standards and procedures for the VHA Domiciliary Residential Rehabilitation and Treatment Program (DRRTP). In October 2006 VHA Handbook, 1162.03[4] provided updated procedures and reporting requirements for the PRRTP bed level of care.

Over time, the patient population and clinical objectives of the DRRTP and PRRTP programs have been converging; in 2005 administration for the domiciliary program was moved to the Homeless and Residential Rehabilitation and Treatment Services section of the Office of Mental Health Services.

Because of the converging patient populations, and therapeutic and rehabilitative goals of the DRRTP and PRRTP programs, the Office of Residential Rehabilitation and Treatment Programs section of the Office of Mental Health Services has been in process

[1] Substance use (SU) or substance abuse disorder (SUD) is the term currently used by VHA for what was previously termed "substance abuse" (SA). Occasionally the terms or their acronyms are used interchangeably.
[2] Office of the Medical Inspector Report, *Domiciliary Care Program*, Veterans Health Administration, February 2003.
[3] VHA Handbook 1162.02, *Domiciliary Residential Rehabilitation and Treatment Program*, Mental Health Service (116), April 3, 2006.
[4] VHA Handbook 1162.03, *Psychosocial Residential Rehabilitation Treatment Program (PRRTP)*, Mental Health Service (116), October 19, 2006.

of developing a handbook that unifies the DRRPT and PRRTP programs under a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) bed level of care and specifies a common set of procedures and reporting requirements relating to VHA residential programs. This process has been ongoing for 1 year and 9 months. Care models to be included in the MH RRTP bed level of care will be General DRRTP, General PRRTP, Domiciliary Care for Homeless Veterans (DCHV), Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program (PTSD-RRTP), and Compensated Work Therapy-Transitional Residence (CWT-TR).

B. Level of Inpatient Care

Mental health services within VHA include a continuum of levels of care with increasingly intensive and more restrictive support systems. Acute inpatient psychiatric hospitalization on a locked unit is the highest level of intensity and the most restrictive environment. Some VHA facilities have sub-acute inpatient beds or intermediate psychiatry beds for patients who are less symptomatic than at the time of acute admission but are not ready for discharge. These beds are usually located near or integrated within an acute psychiatry unit. For example, on a 20-bed unit, 5 beds, or a particular wing might be designated for use as sub-acute beds.

On the other end of the mental health care spectrum is traditional ambulatory outpatient mental health clinic services. Other levels of outpatient care include intensive outpatient treatment services programs and partial or day hospital programs that entail a minimum of 3 hours per day of care at least 3 days per week. For patients with psychotic disorders and serious mental illness, Mental Health Intensive Case Management and Assertive Community Treatment programs represent more intensive levels of outpatient care aimed at promoting functioning within the community and preventing acute hospitalization or institutionalization.

With the shift toward community based outpatient care over the past 15 years and away from traditional acute inpatient settings, residential rehabilitation programs have become increasingly prominent in the continuum of VHA mental health care and care for homeless veterans. Residential programs provide a care setting for patients who cannot effectively utilize care on an outpatient basis because of homelessness, distance from a VA Medical Center, or lack of a stable living environment.

Residential programs provide a 24-hour therapeutic setting for veterans utilizing professional and peer support in a structured, environment. Residential programs aim to provide rehabilitative and clinical care to address a range of problems experienced by eligible veterans. Issues encountered include medical, psychiatric, and substance use related conditions; homelessness; and problems that are social, vocational, and educational in nature.

Depending on the program, services available at a given residential rehabilitation program may range from assessment and diagnosis; individual and group counseling; case management; work therapy; vocational counseling; living and social skills training; occupational and recreational therapy; peer support and self-help groups; couples counseling; medication management; and individual and/or group psychotherapy.

Although residential beds are designated as inpatient beds, they are not acute inpatient psychiatry or intermediate inpatient psychiatry beds. The quasi-inpatient nature of residential program beds necessitates trying to balance the paternalistic structure and safety of an inpatient unit with promoting recovery, increased independence, and community re-integration within a less restrictive treatment setting.

Given the somewhat unique nature of VHA residential programs, in terms of number of programs and extent of services, it would be difficult to find a comparable analogue to VHA residential rehabilitation programs in adult non-VA healthcare settings. Some state and community mental health facilities provide residential treatment on a smaller scale to more specific patient populations, for example patients with serious mental illness (SMI) or emotionally disturbed or at-risk teens. In the private sector, many of the available adult residential programs are focused on treatment of substance use and co-morbid mental health issues. However, access or length of treatment at some private programs may be limited by financial constraints.

C. Types of DRRTP and PRRTP Programs

Although somewhat of a moving target, due to additions and/or changes in programs and number of beds, at the time of this inspection there were 103 VHA sites with residential rehabilitation programs (DRRTPs or PRRTPs). In total there were 232 programs and 8,584 operating beds at these sites. We did not include the small number of offsite residential houses in these totals.

There are different models or sub-types of residential care. These include:

- General Domiciliary Programs.
- Substance Abuse Domiciliary Programs.
- PTSD Domiciliary Programs.
- Domiciliary Care for Homeless Veterans (DCHV) Programs, which provide time-limited residential treatment to homeless veterans with significant health care and social-vocational deficits.
- General Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs).
- PTSD Residential Rehabilitation Programs (PRRPs).
- Substance Abuse Residential Rehabilitation Treatment Programs (SARRTPs).

- Compensated Work Therapy Transitional Residency Programs (CWT-TRs), which are available to veterans enrolled in VHA with priorities 1–6.

In addition, there are a few residential programs with unique and innovative foci such as military sexual trauma and non-mental health medical domiciliary care.

At any given site there may be one or more sub-types of DRRTP programs. In addition there may be a mix of DRRTP and PRRTP programs and program sub-types. For example, one VA medical center that we visited had a General DRRTP located in one building and 2 different types of PRRTPs located on separate floors of a different building. On the other hand, another site might have DRRTPs and no PRRTP programs or vice versa. Moreover, there may be tracks or programs within programs, such that a facility may have a general domiciliary program that includes beds dedicated to a PTSD track and a substance use track. Furthermore, although the focus may be less specific or intense, patients with a common set of problems including medical, psychiatric, PTSD, substance use, and homelessness are also treated in general DRRTP and PRRTP program settings to provide flexibility based on local population needs.

While many residential programs are onsite at a VA medical center, some are located offsite. For example, the North Texas VAMC administrates residential facilities located in Dallas, and Bonham, Texas.

Within residential facilities, there are two basic models for clinical treatment. In the all inclusive model, staff are dedicated specifically to the residential program and provide most treatment and rehabilitative services for the veterans residing in these beds. This model may be suited for programs with a specific treatment focus such as a PTSD focused program that utilizes a combination of individual and group evidence-based psychotherapies.

In the supportive residential model, staff provide a supportive structure while treatment is accessed through higher intensity use of existing medical center outpatient programs such as the outpatient clinics, intensive outpatient substance use programs, and day treatment programs. A patient residing in an unstable environment and in need of intensive, several days per week, outpatient mental health treatment may benefit from the supportive milieu and structure that would facilitate access to and adherence with treatment. For some patients, continuity is maintained by having patients seen by their usual therapist at the medical center's outpatient clinic during participation in a residential program.

Residential treatment, rehabilitation, and programming may range from relatively short term (e.g., 30 days) with a targeted focus to comprehensive rehabilitation lasting greater than a year. At some sites patient may move from one program to another. For example, a patient with substance use issues, schizophrenia, and homelessness might first complete a residential stay at a facility's SARRTP program and then might be transferred to the

facility's general domiciliary program to work on a longer term health, social and vocational rehabilitation issues.

Scope and Methodology

We interviewed leadership for the VA Central Office, Office of Mental Health Services, Office of Residential Rehabilitation and Treatment Programs. We initially conducted pilot visits to residential programs at 2 VA sites (Orlando, FL and Montrose, NY). We reviewed VHA handbook 1162.02 (*Domiciliary Residential Rehabilitation and Treatment Program*), VHA handbook 1162.03 (*Psychosocial Residential Rehabilitation Treatment Program*), VHA handbook 1108.03 (*Self-Medication Program),*[5] and VHA handbook 1160.01 (*Uniform Mental Health Services in VA Medical Centers and Clinics*).[6]

Our inspection consisted of 3 parts: (1) a web-based information request, (2) onsite inspections, and (3) medical record reviews.

In late December 2008, an information request focused on access, staffing, supervision, programming, medication policies, and missed appointment policies was sent to all VA medical centers for distribution and completion by their affiliated residential program managers. Ninety-two of 103 VHA residential facility sites completed the information request.

A stratified sample design was used to select a probability-based random sample for onsite inspection. VHA residential treatment program sites were stratified based on three program types: DRRTP, PRRTP or both. Twenty locations were randomly sampled; they resulted in 51 programs of VHA residential treatment. Overall, these 20 locations had 1,766 operational residential treatment beds.

Prior to visits to these 20 sites, OIG inspectors reviewed patient lists, waiting lists, policies and procedures for each program, and staff training folders. From February 23–March 6, 2009, 6 teams of OIG inspectors conducted visits to the 20 residential treatment sites. Inspectors interviewed the Director of Mental Health, Program Directors, nursing and other staff, and patients at each site. Inspectors reviewed program staffing, conducted environment of care rounds, and inspected patient rooms for compliance with medication safety policies. Table 1 in Appendix A lists the sites and programs visited.

For medical records review, a probability-based random sample of 50 patients were drawn from lists of all patients admitted to residential treatment programs during FY 2008 within each of the 20 sites visited. For sites with less than 50 admissions during FY 2008, all patients admitted to the program during FY 2008 were included.

[5] VHA Handbook 1108.03, *Self-Medication Program (SMP)*, Pharmacy Service (119), March 15, 2005.
[6] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, 116 – Mental Health Service, September 11, 2008.

OIG inspectors reviewed patient medical records from each of the 20 sites for compliance with VHA policies (VHA handbook 1162.02 and 1162.03) regarding the admission process, including screening and waiting lists; documentation of required clinical assessments; treatment planning; compliance with self-medication requirements; contraband and passes; and discharge planning. In total, 933 medical records were reviewed. Among these 57 were in a general DRRTP program and 208 in a general PRRTP program, 197 in a DCHV program, 25 in a PTSD program (DRRTP or PRRP), 332 in a substance abuse program (DRRTP or PRRTP), 77 in a CWT-TR program, and 37 in other programs.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

Issue 1: The Availability of Care in Residential Mental Health Care Facilities in Each VISN

We evaluated the availability of care in residential mental health care facilities in each VISN. We ascertained the number and location of residential programs in each VISN; the types/sub-types of residential programs and corresponding operating beds available in each VISN, the availability of residential treatment for women; the time from presentation to screening for admission to residential programs; and the time from presentation to occupying a bed in residential programs.

A. Program Capacity

The Table 2 in Appendix B lists the number of residential programs, program sub-types, and available beds in each VISN. For this analysis all general residential programs are combined and referred to as Mental Health Residential Rehabilitation Treatment Programs (Gen MH RRTP). All PTSD focused programs are combined (PTSD), as are all substance use programs (SA). Compensated Work Therapy programs are referred to as CWT-TR in Table 2. Data was initially obtained from the December OIG web based information request. The results were then compared with an October 2008 internal VHA Office of Residential Rehabilitation and Treatment Programs roster. Data pertaining to the facilities that did not respond to the OIG information request and any discrepancies between information request data and the October 2008 VHA roster were reconciled by calling the facility program leadership and staff to verify results.

Although program emphasis differs by program model or sub-type, in any given program there may be overlap of patient diagnoses and therapeutic options. For example, a patient with PTSD and substance use might be treated in a PTSD residential program, a general domiciliary program or a SARRTP program depending on the relative prominence of symptoms and other psychosocial issues. In addition, some facilities may have special tracks within a general MH RRTP. For example, one residential program does not designate itself as a specialty residential program but has a PTSD track and an Independent Living Skills track within the general program. In some circumstances, patients who live and receive care in one VISN may be referred to or opt for care at a residential program in another VISN. Further, we are aware that some specialized PTSD programs admit referrals from Department of Defense facilities.

Each VISN except VISN 19 has at least 1 general MH RRTP. Specialized PTSD residential programs are available in all VISNs except VISNs 15, 18, and 22 and specialized substance use residential programs are available in all VISNs except VISN 22. DCHV programs are available in all VISNs. CWT-TR residential programs are available in all VISNs except VISNs 3, 19 and 22.

Three facilities indicated having specialized residential programs or tracks focused on military sexual trauma, and 1 program indicated having a "women's domiciliary."

All but 4 of the 92 facilities responding to the OIG information request reported having residential program beds available for female veterans. The median was 8 beds per facility. Thirty-two percent of these facilities had beds available for female veterans that were located on a separate wing or floor from male patients. All other facilities reported that female beds were located on the same floor or wing as male patients.

During our onsite visits we noted that all female rooms were able to be locked by the patient. Some facilities used electronic key cards. The VHA Office of Mental Health Services reported ongoing efforts to have electronic key card access in place for women veteran rooms in all residential treatment programs, though functioning standard locks are acceptable.

From the OIG information request, 3 sites reported having a separate wing or floor for OIF/OEF veterans and 24 of 92 respondent sites indicated inclusion of special emphasis programming dedicated to OIF/OEF veterans.

Conclusion

Not all VISNs had programs in the 5 residential program categories presented. In addition, not all residential programs include special emphasis programming for OIF/OEF veterans.

Recommendation 1: We recommended that the Acting Under Secretary for Health should ensure that VHA program officials review the utilization, resource allocation, and distribution of general residential, PTSD focused, substance use focused, DCHV, and CWT programs.

Recommendation 2: We recommended that the Acting Under Secretary for Health should ensure that VISN Directors include programming specific for OIF/OEF veterans in residential programs.

B. Screening for Admission and Time to Beginning of Treatment

Interpretation of data pertaining to waiting times to screening and program admission necessitates discussion of caveats and limitations to the data. Patients admitted from an inpatient acute care unit on which they have already been screened and evaluated may have less of a wait time before occupying a residential bed than patients referred from other sources. Some specialized programs use a cohort approach whereby a group of patients start and end their stay in the residential program at the same time. The average wait time for patients waiting to start the next cohort is dependent on when in the cohort cycle a new application is received. Further we would anticipate that less specialized

programs (general MH RRTP's) would have lesser waiting times and that highly specialized programs (MST) may have greater waiting times. Another factor impacting wait times is the bed capacity and average length of stay in a program.

In some situations, a bed may be available but a patient may opt to wait to occupy a bed till a later, specified date for various psychosocial reasons (e.g., veteran waiting for activated reservist spouse to return home from tour of duty, pending legal issues).

Table 3 indicates average reported length of time from initial application for admission to completion of the screening process for PTSD, substance use, and DCHV residential programs obtained from the OIG information request. Percentiles are cumulative.

	PTSD	SUD	DCHV
Within 24 hours	3%	26%	17%
< 3 days	14%	54%	46%
< 1 week	54%	79%	80%
< 2 weeks	84%	90%	90%
< 1 month	89%	92%	93%

Table 3. Average reported length of time from initial application to screening for PTSD, SUD and DCHV residential programs.

Table 4 indicates the average reported length of time from completion of the screening process to when a patient occupies a bed in the treatment program for PTSD, substance use, and DCHV program as reported by information request respondents. Percentiles are cumulative.

	PTSD	SUD	DCHV
Within 24 hours	6%	10%	12%
< 3 days	9%	21%	27%
< 1 week	12%	50%	49%
< 2 weeks	38%	67%	66%
< 1 month	62%	84%	88%

Table 4. Average reported length of time from completion of screening to occupying a bed for PTSD, SUD, and DCHV residential programs.

Screening Policy

During the onsite visits, we found that 9 of the 20 sites visited had a policy for all programs at that site that describes the screening process for admission to residential

programs. At the other sites, approximately one-third of individual programs had a policy that addressed the screening process.

Waiting Lists and Follow-Up Pending Start of Program

Programs at 12 of 20 sites visited maintained a waiting list for admission to residential programs. Medical record review indicated that estimated 26 percent of VA residential program patients were placed on a waitlist prior to admission. VHA handbook 1160.01 requires that patients on waiting lists for residential programs are followed during the time from screening to admission to ensure they are receiving outpatient treatment in the interim. Of the patients who had been on a wait list for more than 7 days, we estimated that 74 percent of them were followed clinically from the time of screening to admission. We estimated that for 64 percent of these patients had a documented interim care plan. Table 5 displays the estimated percent of days on wait list who were placed on a wait list and for whom we were able to determine days on the list.

Days on Wait List	Estimated Percent of VA Residential Program Patients
1– 7	32
8–14	24
15–21	13
22–28	9
29–35	2
36–42	2
Over 42	18

Table 5. Estimated percent of VA residential program patients placed on wait list by waiting days, based on 189 sample patients.

Referral of Patients Not Meeting Program Eligibility Requirements

We ascertained whether patients who did not meet admission criteria to residential programs were referred for other VHA mental health treatment. We found that 6 of 20 sites did not maintain a list of patients screened who did not meet program requirements. From the 14 sites with patients who did not meet admission criteria, we selected 5 patients (or all if less than 5) from each site and reviewed their medical records. For some programs there were less than 5 patients on the list. Of the total of 105 patients selected, 89 percent were referred to other mental health treatment within the VA facility.

Patients Residing In Residential Programs for Greater than 1 Year

From the OIG information request, approximately 25 percent of sites reported having at least one patient who has been at the facility for more than one year. During our onsite visits we found that 4 facilities had at least one program with one or more residents who have resided at the facility for greater than one year. In total there were 13 veterans who

had resided at these facilities for more than 1 year. At least 3 of these patients were in need of ongoing residential support. Two of these patients had non-mental health related chronic medical conditions.

Conclusion:

While we consider screening an essential component of the admissions process, not all programs visited had appropriate policies for screening. To ensure continuity of clinical monitoring of this vulnerable population, it is essential that residential programs maintain contact with and/or ensure interim assessment for veterans awaiting placement into residential programs.

Recommendation 3: We recommended that the Acting Under Secretary for Health ensure that VISN Directors should make sure that residential program managers ensure that patients on waiting lists are periodically contacted and/or are engaged in treatment while awaiting placement in a residential program.

Issue 2. Supervision and Support Provided in VHA Residential Mental Health Care Facilities

A. Supervision

We considered supervision to include physical supervision; reporting of adverse events; environment of care; physical security; and policies regarding handling of emergencies, passes, and contraband. We divided the analysis of support into patient evaluation and therapeutic programming during residential treatment.

Supervision

The DRRTP handbook requires at least one staff at all times in each building, including night shifts while the PRRTP handbook requires 24 hour, 7 days-per-week, onsite supervision. Neither handbook provides specific guidelines regarding supervision. The draft MH RRTP Handbook does provide guidance regarding physical supervision.

During the onsite visits, excluding CWT-TR programs, all sites had a staff member present in each building on all shifts. At 16 of 19 sites (one site with only a CWT-TR program), a staff member was present (includes nursing staff, health technicians, domiciliary assistants) on all shifts for each floor with residential program beds.

All 20 sites reported having a policy defining annual competencies required by staff and the frequencies by which those competencies are evaluated. OIG inspectors reviewed training files for 3 employees at each site. In aggregate, we found competencies up to date in 58 of 60 folders reviewed.

In the OIG information request, we asked how often staff make rounds to patient's rooms to check on their well being. Seventy-eight percent of program respondents reported making rounds at least once per shift. Fourteen percent reported making hourly rounds.

Environment of Care and Security Monitoring

In general, sites visited appeared relatively clean and well maintained though austere. We found a local policy for after hours security at 16 of 20 sites, with a wide range of practices employed. Security cameras were in place at 19 of 20 facilities. At 3 sites, the security cameras did not record, at 1 site only the external doors were monitored, and at 1 site a video monitor was non-functional. One site had 52 motion activated cameras that monitored all entrances and hallways.

Policies for Emergency Management

All 20 sites had a written emergency policy guiding how to handle psychiatric and medical emergencies, and fires and environmental emergencies. To further explore staff readiness, a health technician was interviewed at each site. The health technicians at 19 of 20 sites were able to reasonably articulate the policies for handling psychiatric, medical, and fire or environmental emergencies.

Polices Regarding Passes

Off ground passes give residential program patients an opportunity to interact with people other than those in the program, to visit with and/or work on relationships with family, to practice skills learned in a real world environment, and to gradually transition toward discharge to the community. In addition, patient and family feedback upon return from pass provides clinical staff with an opportunity to gauge function in a less structured environment. On the other hand, passes provide an opportunity for patients to bring contraband items back to the residential setting.

Based on medical records reviewed, we estimated that 18, 30, and 33 percent of patients at sites with only DRRTP programs, sites with only PRRTP programs, and sites with both, had gone on pass at some point during their residential stay.

At 18 of 20 sites visited, residential programs had well defined criteria that veterans must meet to receive an off grounds (weekend day pass). We found a wide variation in policies from program to program. For example, 1 program required patients to be in the program at least 8 days before granting a pass, another program required 30 days, and 1 substance use program did not grant passes at all.

Drug Screens

At least 1 program at all sites visited had a urine drug screen/breathalyzer policy. At 5 sites, policies required obtaining a urine drug screen or breathalyzer when patients return from pass.

In the OIG information request, 60 percent of programs responding to this question (99 of 164) reported performing a select number of random urine drug screens at least weekly.

Policies Regarding Contraband

At most of the 20 sites visited, individual patient handbooks listed prohibited items and informed patients of the possibility of contraband search on admission and at random throughout program participation. Programs at 18 of 20 sites had policies regarding contraband searches. Thirteen of the 18 sites with contraband polices had a policy requiring a search for contraband at the time of admission. At 15 sites, policies included a standard operating procedure regarding contraband searches. Program staff at the sites we visited reported regularly conducting contraband searches on admission. Based on medical record review, we estimated that 57 percent of VA residential program patients had a contraband search at time of their admission for sites with a policy regarding contraband searches.

Conclusions:

All sites visited, excluding CWT-TR programs, had a staff member present in each building on all shifts. All sites had policies requiring annual monitoring of staff competencies. Based on medical record review, we estimated that 57 percent of VA residential program patients had a contraband search at time of their admission for sites with a policy regarding contraband searches. The current DRRTP and PRRTP handbooks do not contain guidance for programs on when and under what circumstances contraband searches are indicated, appropriate, and at what frequency. The draft MH RRTP Handbook does, however, require regular and random searches.

B. Support

Patient Assessment

The DRRTP handbook requires that as part of assessment all veterans must receive and have documented an interdisciplinary assessment as part of the integrated patient assessment that serves as the basis for creating a plan of treatment or rehabilitation. One element of the integrated patient assessment, an initial medical clearance by a physician or qualified health care provider, is required prior to admission. As part of the integrated assessment the DRRTP handbook requires a complete history and physical examination be completed within 7 days from admission unless a patient has had a documented exam

within the previous 30 days; and a psychosocial assessment completed within 14 days of admission. The DRRTP handbook requires a comprehensive treatment plan be developed and documented within the first 2 weeks of admission. The PRRTP handbook requires documentation of a history and physical, comprehensive biospychosocial assessment, and an individualized treatment plan but does not indicate a timeframe for performance.

We estimated that 77 percent of medical records for sites with only a DRRTP program documented a medical screening prior to admission. For sites with only PRRTP programs, 54 percent documented medical screening prior to admission, and for sites with both DRRTP and PRRTP programs, 70 percent of records documented a medical screening. Although the requirement pertains to DRRTP programs, overall 69 met the requirement.

We estimated that 96 percent of medical records at VA sites with only DRRTP programs indicated performance of a history and physical examination before or within the 7th day after admission. For 80 percent of patients this occurred on the date of admission. For sites with only PRRTP programs and for sites with both DRRTP and PRRTP programs, history and physical examination was performed prior to the 7th day for 92 percent of patients.

For biopsychosocial assessments, at sites with only DRRTP programs, we estimated that 98 percent of medical records documented completion prior to or within the first 14 days after admission. Comparable estimates were found for sites with only PRRTP programs and for sites with both DRRTP and PRRTP programs.

For comprehensive treatment planning, approximately 92 percent of patient records indicated completion before or within the first 14 days of admission at sites with only DRRTP programs. Similar estimates were found for sites with only PRRTP programs and for sites with both DRRTP and PRRTP programs.

Treatment Programming

Residential treatment programs are expected to provide a minimum of 4 hours per day, 7 days per week of clinical treatment programming (including recreational therapy). All 20 sites visited provided at least 4 hours of treatment programming from Monday to Friday. Programs at 4 sites did not meet this minimum threshold on Saturdays and at 5 sites on Sundays.

For the 20 sites visited, we asked about the availability of specific evidence-based treatments for PTSD for patients in residential treatment programs, whether provided in the program in an all-inclusive model, or at an outpatient clinic providing mental health treatment to residential patients. Table 5 summarizes the availability of cognitive

processing therapy (CPT), prolonged exposure therapy (PE), and a less specific form of cognitive behavioral therapy (CBT) for PTSD.

PTSD Psychotherapy	Number of Sites
CPT	14
PE	7
CBT	17

Table 6. Number of sites visited at which evidence-based psychotherapies for PTSD were available to residential treatment patients.

We also asked about the availability of evidence-based interventions for substance use in residential treatment programs. For the 20 sites visited, motivational interviewing was available for residential program participants at 14 sites, 12 step facilitated counseling at 16 sites, substance use focused cognitive behavioral therapy at 15 sites, contingency management at 6 sites, and opiate agonist[7] therapy at 6 sites.

Aftercare

Aftercare (ensuring provision of Domiciliary Program and other VA and community resources after discharge from DRRTP care) is required in the DRRTP handbook. From the medical record review, we estimate 80 percent of discharged patients had discharge plans documented in the medical record. For sites with only DRRTP programs, 79 percent of records had a documented discharge plan. For all sites overall, for those records with a documented discharge plan, 87 percent of the discharge plans included the name of a follow-up provider, 87 percent included date of follow-up, and 72 percent included the phone number for the follow-up clinician. Although some discharges are irregular (e.g., the patient has failed to adhere to the rules and regulations of the program, or the patient requests to leave before treatment goals are met), we note that VHA policies continue to require a documented discharge plan with provider contact information.

Overall, evidence of post-discharge monitoring by program staff was found in 71 percent of charts.

Conclusion:

At sites visited medical screening varied based on program type. Clinical treatment programming meeting VHA standards was provided on weekends at 4 of 20 sites visited. Post-discharge monitoring was estimated not evident in 29 percent of patient records reviewed.

[7] Opiate agonist therapy is based on a drug action that mimics the effects of another opiate drug. An example is the therapeutic use of methadone, an opiate agonist used to treat opiate addiction. The two primary clinical applications of opiate agonist pharmacotherapy are detoxification treatment and maintenance treatment.

Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.

Recommendation 5: We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that minimum programming requirements are met 7 days per week.

Issue 3. The Ratio of Staff Members to Patients at Residential Mental Health Care Facilities

According to VHA Handbook 1162.02, each DRRTP must have adequate staffing to provide safe, reasonable, and appropriate clinical care. Exact staffing patterns are determined by each facility's DRRTP Chief based on analysis of veteran population needs, strategic planning considerations, standards established by relevant accrediting bodies, and consultation from senior members of each clinical discipline. Staffing must be sufficient to provide appropriate clinical coverage 24 hours-per-day, 7 days-per-week.

Handbook 1162.03 notes that PRRTPs "may have flexible staffing patterns since, by their residential nature, they are designed to maximize peer support and self-care compared to a traditional hospital bed." Professional staff must be on call by phone, beeper, or radio at all times. At a minimum, the PRRTP residential function is required to have a case manager; medical doctor, physician assistant or nurse practitioner; evening, night, and weekend staff; and a program clerk. For CWT-TRs a current or graduate resident "house manager" may supervise the residence in lieu of staff. At a minimum, house managers and non-professional staff are to be trained to observe resident behavior, facilitate a healthy milieu, coordinate residential activities, ensure safety, and initiate the call for professional staff intervention. House managers are established through the human resources department as "without compensation" employees.

The PRRTP Handbook indicates that for individual programs staffing size and expertise is dependent on the specialized needs and stage in treatment of veterans served. The PRRTP Handbook does not specify required staffing ratios.

Because programs that follow a residential-type model utilize clinicians from outpatient clinics at the affiliated medical center, determining total clinical staff to patient ratios becomes somewhat arbitrary and not directly comparable from program to program. Some programs may have outpatient clinicians who as a specific part of their duties are assigned to see any patients in a facility's residential program (e.g., 0.5 FTE of a psychologist's time). Patients in other programs are seen by their own usual outpatient psychiatrist, therapist, or social worker/case manager in order to promote continuity.

The presence of onsite nursing and affiliated staff, especially during the evening and night, may be a more salient metric of basic physical supervision and patient monitoring.

For the 20 sites visited, we determined the ratio of nursing and affiliated staff (including RNs, LPNs, technicians, and domiciliary assistants) present at each site to the number of beds (capacity). Table 4 summarizes the results. Because CWT-TRs may be staffed by house managers rather than paid VA nursing and affiliated staff, and during the day CWT-TR patients are likely at a work therapy venue and not present in the residence, we calculated the ratios for each site excluding CWT-TR programs. At Oklahoma City, the only residential program is a CWT-TR. The ratio for this site is included in Table 4 based on paid VA nursing and affiliated staff.

Facility	Patient Capacity	Staffing Ratios		
		Day	Evening	Night
West Haven, CT	32	0.22	0.13	0.03
Pittsburgh, PA	84	0.10	0.07	0.06
Battle Creek, MI	95	0.16	0.07	0.07
North Chicago, IL	121	0.03	0.03	0.03
Kansas City, MO	27	0.11	0.07	0.07
Oklahoma City, OK	20	0.20	0.05	0.05
Fort Meade, SD	12	0.25	0.25	0.08
Lyons, NJ	168	0.07	0.05	0.05
Northport, NY	40	0.11	0.06	0.05
Coatesville, PA	229	0.11	0.06	0.03
Clarksburg, WV	21	0.14	0.14	0.10
Asheville, NC	18	0.11	0.06	0.06
Dublin, GA	145	0.07	0.01	0.01
Miami, FL	58	0.10	0.03	0.03
Des Moines, IA	38	0.11	0.08	0.08
Detroit, MI	50	0.12	0.06	0.04
Leavenworth, KS	202	0.10	0.03	0.03
West Los Angeles, CA	296	0.07	0.06	0.04
Gallup, NM	10	0.30	0.15	0.10
Omaha, NE	21	0.10	0.10	0.10

Table 7. Ratio of nursing and affiliated staff to patients by shift for sites visited.

As depicted, the ratios ranged from 0.25 to 0.03 (1:4 to 1:33) for day shift, from 0.25 to 0.01 (1:4 to 1: 100) for evening shift, and from 0.1 to 0.01 (1:10 to 1:100) for night shift.

Because there are more staff members present during the daytime and most mental health clinicians are typically present during dayshift, from a supervision and monitoring standpoint, the nursing and affiliated staff ratios listed under-represent the physical presence of overall staff (licensed mental health clinicians plus nursing and affiliated staff) available for monitoring and supervision during the day shift. At some facilities other staff (e.g., addiction therapists) may be present during part or the entire evening

shift. An additional caveat includes variation in independence levels between patients in different sub-types of programs and from site to site.

In terms of licensed clinical providers, we asked about assignment of specific clinical providers to residential programs. From the OIG information request, 19 percent of site respondents reported having a primary care physician assigned to residential programs. Sixty-three percent reported assigning a nurse practitioner. Seventy percent of respondents reported assigning a psychologist to their domiciliary program(s), and 90 percent assigned a social worker.

We also reviewed the presence of clinical backup on off-hours. During onsite visits we inquired whether there is 24/7 on-call coverage by a psychologist, psychiatrist, or mental health social worker. We requested and inspected the call list for the week of the onsite visits and found on-call clinical backup to be in place at each of the sites.

Conclusion:

We could not find specific staffing ratio standards for similar residential facilities from relevant non-VHA accrediting bodies. At a minimum, all sites should have at least one staff member available during each shift, on each separate wing, and on each floor of residential programs. In the absence of external staffing ratio standards for these unique set of programs, we also believe that VHA should develop more specific staffing guidance as it pertains to patient monitoring and supervision by nursing and affiliated staff.

Recommendation 6: We recommended that the Acting Under Secretary for Health should further develop formal guidelines for mental health clinician staffing by mental health discipline for programs using an all-inclusive staffing model and for programs using a residential type clinical staffing model.

Recommendation 7: We recommended that the Acting Under Secretary for Health should require the presence of a least one staff member on each separate wing and floor of residential programs on all shifts.

Issue 4. The Appropriateness of Rules and Procedures for the Prescription and Administration of Medications to Patients in Residential Mental Health Care Facilities

The DRRTP Handbook (1162.02) does not provide guidance or policies regarding prescription and administration of medications to patients in domiciliary programs. The PRRTP Handbook (1162.03) states that “veterans in PRRTPs are able to learn and practice self-management of their medications in order to achieve independent medication administration.”

The March 2005 VHA Handbook 1108.3, *Self-Medication Program (SMP)*, describes assessment of patients for participation in an SMP. According to the SMP handbook, there should be a written SMP policy for each participating program at each facility. The policy should include guidance in assessing patient suitability for SMP, patient education and compliance, administration and safekeeping of medication, monitoring clinical responses to medications, and reporting adverse drug events.

Prior to each patient's participation in an SMP, a progress note with a provider's order must document that the patient has been assessed and is eligible. Based on the evaluation, patients are assessed as either a semi-independent or independent participant in the SMP. If semi-independent, then the level of independence is sub-categorized into levels I–IV. The SMP handbook provides guidance for dispensing, monitoring, and storage of medications for each level. Monitoring for a semi-independent patient ranges from observing the patient taking their medication to performing periodic counts of a patient's medications.

For some patients, medications will be stored by staff while other patients will store meds themselves. In either case, medications must be stored in locked locations. Keys for locked cabinets or lockers must be unique and not usable in other patient's lockers.

When independent, a patient may receive a 7 to 30 day supply of medication directly from the pharmacy. According to the Self-Medication Handbook, oral controlled substances can be included for self-medication use as determined by individual VA facilities. Controlled substances used in the SMP are to be dispensed in 7 day quantities or less if administered and stored by the patient. In addition, controlled substances must be inventoried every 72 hours as per VHA Handbook 1108.1.

VHA Handbook 1160.0, *Uniform Mental Health Services in VA Medical Centers*, finalized in September 2008, notes that facilities must ensure full compliance with Mental Health Residential Rehabilitation Program Safe Medication Management (SMM) procedures, and that VHA Handbook 1108.3 *Self Medication Program* does not apply to MH RRTPs. This change was put into effect in part, to facilitate easier access to treatment in residential programs for patients with both mental health and ongoing substance use issues. However, because the unified MH RRTP handbook is awaiting issuance, the MH RRTP Safe Medication Management Procedures would not yet be in effect, and therefore uniform guidance is presently absent.

Medication Administration Policies

At 18 of 20 sites visited, program policies did not exclude admission of patients on narcotic medications. At 1 site, there was an exclusion policy for a CWT program, and at another site there was an exclusion policy for a substance abuse focused program.

Quantity of Medications Dispensed

All programs at 18 of the 20 sites that we visited allow veterans to participate in an SMP. Programs at 17 of 18 sites provide patients with up to a 30 day supply of non-controlled medications. One program gives up to a 90 day supply.

At all but one site, programs limited dispensing of narcotics to a 7-day supply. At the one site whose only program is a CWT-TR program, narcotics were not always issued for only 7 days nor was there a supply limit for other medications.

From the medical record review, for prescriptions filled during the 30 days prior to the OIG review, we estimate that 12 percent of patients had been prescribed a narcotic medication, and among these patients 11 percent were prescribed a supply of more than 7-days.

We identified the potential for patients to receive greater than a 30 day supply of non-narcotic or a 7-day supply of narcotic medication from VA providers who treat patients outside of the residential program. For example, at 1 site a patient had orthopedic surgery while in a residential program. Post-operatively the patient was given a prescription for narcotic pain medication (60 tablets). Initially, there was no indication that residential program staff were aware that the patient had filled this prescription. In the DRRTP, PRRTP, and Self-Medication handbooks we could not find guidance on medication reconciliation for similar circumstance.

Storage of Medications

OIG staff inspected a sample of patient beds at all 20 sites, 140 patient beds in total, to assess compliance with the individual program's self-medication policy in terms of secure storage of medication. In addition, we asked each vet whose room we inspected whether nurses had discussed the SMP with them. We found that 93 percent (130 of 140 patients) kept medications secured as per policy. Two sites accounted for 8 of the 10 beds in non-compliance with the storage policy. We found that all 140 veterans were reasonably able to articulate understanding of SMP policy.

Documentation of Providers Assessment for SMP

Based on medical record review, we estimated that 45 percent of VA residential program patients had documentation of orders for an SMP. Overall, we estimated that 82 percent of patients with an SMP had documentation that the patient received instruction regarding the SMP process.

Conclusion:

For VA residential program patients we estimated that 11 percent of SMP patients on narcotics received more than a 7-day supply of medication. Fifty-five percent of SMP

patients had no documentation of an order for SMP nor was there consistent documentation of appropriate instruction regarding the SMP process.

Recommendation 8: We recommended that the Acting Under Secretary for Health ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.

Recommendation 9: We recommended that the Acting Under Secretary for Health ensure that all patients on self medication have a documented order for self-administration of medication, and documented instruction regarding medication self-administration.

Issue 5. Protocols at Residential Mental Health Care Facilities for Handling Missed Appointments

We were asked to review the protocols at residential mental health care facilities for handling missed appointments. On the OIG information request, 63 percent of respondent sites reported having a policy for how to handle missed appointments.

Of the 20 sites visited, 16 had at least one program that uses an all inclusive model of care in which patients go to groups and other appointments within the residential program. Nine facilities had at least one program using the residential model in which a patient resides within the therapeutic milieu of the residential program but goes to appointments at VHA clinics outside of the program.

During the onsite visits we found that at 8 facilities, if a patient misses a treatment related mental health appointment, the appointment is simply re-scheduled with no concomitant action or consequence; and at 7, the appointment is re-scheduled and the patient is counseled by staff about maintaining appointments. The other 5 facilities employed different processes for re-scheduling. At one facility rehabilitation technicians review a list of missed appointments, call the veteran to discuss reasons (e.g. possible relapse), and help the veteran re-schedule. At another facility with a substance use program, the veteran is counseled and given a homework assignment, and if absent more than twice, then dismissal from this program is considered. Patients in the CWT-TR program at this same facility are encouraged by staff to re-schedule but the patient is responsible for doing the re-scheduling.

We ascertained during site visits, if and how a program manager and program staff are notified if a veteran misses a mental health appointment. Each site has multiple programs, and therefore there may be more than one process at each site. For 9 programs, we found that staff or case managers proactively review the patient appointment list for adherence. At 7 programs, an email is sent to program staff regarding missed appointments. Nineteen programs are called by the clinician or clinic staff with whom the patient was supposed to have the appointment. For 6 programs,

clinicians from the clinic with whom the appointment was missed notify the patient, and it is the patient's responsibility to notify the program staff of the missed appointment. At 2 programs, letters are sent by clinicians to the program manager. Other variants included one program for which the missed appointment is flagged in the computerized patient record system and a program in which staff reviews appointment compliance during treatment team meetings.

To facilitate continuity with patient's primary care providers, at 19 of the 20 sites visited, primary care providers are notified of patient participation in a MH RRTP program. Similar to mental health appointments, most programs either re-schedule appointments or re-schedule and counsel veterans regarding missed appointments. One CWT-TR program adds the primary care physician as an additional signature to program admission notes to ensure the primary care doctors awareness of the patient's participation in the residential program. Five programs at the facilities visited consider it the patient's responsibility to notify staff of missed medical appointments, and for at least 1 of the programs no staff is notified.

Conclusion:

Participation in rehabilitative treatment requires adherence to clinical appointments. Clinicians and program staff should monitor adherence. During site visits we found variation between programs and between sites in monitoring and re-scheduling missed appointments.

Recommendation 10: We recommended that the Acting Under Secretary for Health ensure that missed appointments should be captured, addressed, and case managed in a uniform manner.

List of All Recommendations:

Recommendation 1: We recommended that the Acting Under Secretary for Health should ensure that VHA program officials review the utilization, resource allocation, and distribution of general residential, PTSD focused, substance use focused, DCHV, and CWT programs.

Recommendation 2: We recommended that the Acting Under Secretary for Health should ensure that VISN Directors include programming specific for OIF/OEF veterans in residential programs.

Recommendation 3: We recommended that the Acting Under Secretary for Health ensure that VISN Directors should make sure that residential program managers ensure

that patients on waiting lists are periodically contacted and/or are engaged in treatment while awaiting placement in a residential program.

Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.

Recommendation 5: We recommended that the Acting Under Secretary for Health ensure that VISN directors make sure that minimum programming requirements are met 7 days per week.

Recommendation 6: We recommended that the Acting Under Secretary for Health should further develop formal guidelines for mental health clinician staffing by mental health discipline for programs using an all-inclusive staffing model and for programs using a residential type clinical staffing model.

Recommendation 7: We recommended that the Acting Under Secretary for Health should require the presence of a least one staff member on each separate wing and floor of residential programs on all shifts.

Recommendation 8: We recommended that the Acting Under Secretary for Health ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.

Recommendation 9: We recommended that the Acting Under Secretary for Health ensure that all patients on self medication have a documented order for self-administration of medication, and documented instruction regarding medication self-administration.

Recommendation 10: We recommended that the Acting Under Secretary for Health ensure that missed appointments should be captured, addressed, and case managed in a uniform manner.

Appendix A

Location and Programs Visited During OIG Onsite Inspections

LOCATION	VISN	PROGRAM SUB-TYPES
West Haven, CT	1	Gen PRRTP, CWT-TR
Lyons, NJ	3	Gen PRRTP, PRRP, DCHV, MST
Northport, NY	3	PRRP, SARRTP
Coatesville, PA	4	DCHV, SA DOM, PTSD DOM
Clarksburg, PA	4	Gen PRRTP, PRRP, SARRTP
Pittsburgh, PA	4	Gen PRRTP, DCHV, SA DOM, CWT-TR
Asheville, NC	6	SARRTP
Dublin, GA	7	Gen DOM, SA DOM, PTSD DOM, DCHV, Women's DOM
Miami, FL	8	Gen PRRTP, PRRP, SARRTP
Battle Creek, MI	11	PRRP, SARRTP, Gen DOM, CWT-TR
Detroit, MI	11	DCHV
North Chicago, IL	12	PRRP, SA DOM, DCHV, CWT-TR
Kansas City, MO	15	SARRTP, CWT-TR
Leavenworth, KS	15	Gen PRRTP, DCHV
Oklahoma City, OK	16	CWT-TR
Gallup, NM	18	Gen PRRTP
West Los Angeles, CA	22	Gen DOM, DCHV
Des Moines, IA	23	PTSD DOM, SA DOM, DCHV
Fort Meade, SD	23	Gen PRRTP, CWT-TR
Omaha, NE	23	Gen PRRTP, SARRTP

Table 1. Location and Programs Visited During OIG Onsite Inspection

Gen PRRTP = General Psychosocial Residential Rehabilitation Treatment Program
Gen DOM = General Domiciliary
PRRP = PTSD Psychosocial Residential Rehabilitation Treatment Program
SARRTP = Substance Use Psychosocial Residential Rehabilitation Treatment Program
PTSD DOM = PTSD Domiciliary Program
SA DOM = Substance Use Domiciliary Program
DCHV = Domiciliary Care for Homeless Veterans Program
CWT-TR = Compensated Work Therapy-Transitional Residence Program

Appendix B

Residential Programs and Beds by VISN

VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
1	Gen MH RRTP	3	66
1	PTSD	2	20
1	SA	2	34
1	DCHV	2	86
1	CWT-TR	5	105
1	Total	14	311
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
2	Gen MH RRTP	1	30
2	PTSD	1	36
2	SA	4	279
2	DCHV	1	25
2	CWT-TR	1	11
2	Total	8	381
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
3	Gen MH RRTP	2	22
3	PTSD	3	59
3	SA	4	122
3	DCHV	3	195
3	CWT-TR	0	0
3	MST	1	10
3	Total	13	408
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
4	Gen MH RRTP	3	42
4	PTSD	2	41
4	SA	6	165
4	DCHV	3	195
4	CWT-TR	3	42
4	Total	17	485
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
5	Gen MH RRTP	3	200
5	PTSD	1	50
5	SA	2	139
5	DCHV	2	116
5	CWT-TR	3	61
5	Total	11	566

Table 2. Residential Programs and Beds in VISNs 1 – 5

VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
6	Gen MH RRTP	2	84
6	PTSD	1	10
6	SA	5	133/151*
6	DCHV	1	24
6	CWT-TR	1	21
6	Total	10	272/290*
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
7	Gen MH RRTP	3	100
7	PTSD	2	45
7	SA	2	51
7	DCHV	3	156
7	CWT-TR	4	48
7	Women's DOM	1	10
7	Total	15	410
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
8	Gen MH RRTP	4	82
8	PTSD	2	30
8	SA	4	74
8	DCHV	3	80
8	CWT-TR	1	8
8	MST	1	16
8	Total	15	290
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
9	Gen MH RRTP	2	155
9	PTSD	2	25
9	SA	4	127
9	DCHV	1	35
9	CWT-TR	1	25
9	Total	10	367
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
10	Gen MH RRTP	3	154
10	PTSD	2	37
10	SA	3	107
10	DCHV	3	204
10	CWT-TR	1	25
10	MST	1	*Allocated from PTSD
10	PTSD/TBI	1	*Allocated from PTSD
10	Total	14	527

*Richmond VAMC in VISN 6 usually with 23 beds, temporarily with 5 due to construction

Table 2. Residential Programs and Beds in VISNs 6 – 10

VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
11	Gen MH RRTP	1	40
11	PTSD	1	32
11	SA	1	23
11	DCHV	2	100
11	CWT-TR	2	15
11	Total	7	210
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
12	Gen MH RRTP	2	265
12	PTSD	3	63
12	SA	6	182
12	DCHV	2	85
12	CWT-TR	3	32
12	Total	16	627
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
15	Gen MH RRTP	1	25
15	PTSD	0	0
15	SA	2	52
15	DCHV	2	227
15	CWT-TR	3	60
15	Total	8	364
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
16	Gen MH RRTP	1	57
16	PTSD	3	54
16	SA	3	69
16	DCHV	2	110
16	CWT-TR	2	45
16	Total	11	335
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
17	Gen MH RRTP	3	460
17	PTSD	1	40
17	SA	4	270
17	DCHV	2	80
17	CWT-TR	3	33
17	Total	13	883

Table 2. Residential Programs and Beds in VISNs 11 – 17

VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
18	Gen MH RRTP	3	106
18	PTSD	0	0
18	SA	4	74
18	DCHV	2	90
18	CWT-TR	1	9
18	Total	10	279
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
19	Gen MH RRTP	0	0
19	PTSD	2	37
19	SA	2	35
19	DCHV	1	45
19	CWT-TR	0	0
19	Total	5	117
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
20	Gen MH RRTP	2	555
20	PTSD	1	16
20	SA	4	77
20	DCHV	3	121
20	CWT-TR	2	38
20	Total	12	807
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
21	Gen MH RRTP	1	12
21	PTSD	2	62
21	SA	1	52
21	DCHV	1	70
21	CWT-TR	2	22
21	Total	7	218
VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
22	Gen MH RRTP	1	221
22	PTSD	0	0
22	SA	0	0
22	DCHV	1	100
22	CWT-TR	0	0
22	Total	2	321

Table 2. Residential Programs and Beds in VISNs 18 – 22

VISN	PROGRAM SUB-TYPE	NUMBER OF PROGRAMS	BEDS
23	Gen MH RRTP	4	210
23	PTSD	2	17
23	SA	4	80
23	DCHV	2	70
23	CWT-TR	2	29
23	Total	14	406

Table 2. Residential Programs and Beds in VISN 23

Appendix C

Acting Under Secretary for Health's Comments

Department of Veterans Affairs **Memorandum**

Date: June 12, 2009

From: Acting Under Secretary for Health (10)

Subject: **OIG Draft Report, *Review of Veterans Health Administration Residential Mental Health Care Facilities,* Project No. 2008-00038-HI-0005 (WebCIMS 430444)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the OIG draft report on *Review of Veterans Health Administration Residential Mental Health Care Facilities*, and I concur with its recommendations and findings. Providing Veterans with effective residential rehabilitation and treatment is an important component of the continuum of the Veterans Health Administration's (VHA) mental health care, and the report cites valuable opportunities for improvement. As an organization, VHA is working diligently to provide a consistently high level of residential rehabilitation and treatment for all Veterans, including those classified as special populations, by continuously aiming to improve and enhance services.

2. As part of this continuous effort, in 2007 the National Leadership Board-Health Systems Committee charged VHA's Office of Mental Health Services (OMHS) with the task of reviewing the current status of care delivery in Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) in order to improve and enhance services to Veterans. Subsequently, OMHS developed a MH RRTP Transformation Plan, which includes a full review of all MH RRTPs and the development of a unified VHA MH RRTP Handbook. On May 29, 2009, OMHS finalized VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Programs, which establishes the procedures and reporting requirements for the MH RRTP bed level of care (see attached). The Handbook, which also addresses most of the issues identified in your draft report, was distributed to the field for immediate implementation.

3. In addition, Mathematica Policy Research, Inc., a nationally recognized leader in independent, objective policy research and health care quality

Page 2

OIG Draft Report, *Review of Veterans Health Administration Residential Mental Health Care Facilities,* Project No. 2008-00038-HI-0005 (WebCIMS 430444)

improvement, is currently conducting a site survey of all MH RRTPs to assess and evaluate the successful implementation of the Mental Health Residential Rehabilitation Transformation Plan and the VHA MH RRTP Handbook. Through this survey process, OMHS will be able to identify MH RRTPs that need further development to meet policy requirements and ensure that there is a plan for implementation and progress monitoring in place. Mathematica is scheduled to complete the site survey in January 2010 and issue a final report to OMHS in April 2010.

4. Thank you for the opportunity to review the report and provide comments. Attached is VHA's complete plan of corrective action. I would be glad to discuss any concerns or comments you may have about this response or the action plan. If you have any questions, please contact me, or have a member of your staff contact Margaret Seleski, Director, Management Review Service (10B5) at (202) 461-8470.

(original signed by:)
Gerald M. Cross, MD, FAAFP

Attachment

Acting Under Secretary for Health's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

Recommendation 1: We recommend that the Acting Under Secretary for Health should ensure that VHA program officials review the utilization, resource allocation, and distribution of general residential, PTSD focused, Substance Use focused, DCHV, and CWT programs.

Concur

The VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, (Section 12.b-d, Residential Rehabilitation Treatment Programs [RRTP]) states:

- Each Veteran who requires domiciliary care or residential rehabilitation and treatment programs must have timely access to these residential care programs as medically necessary to meet the Veteran's need for specialized, residential, intensive mental health treatment and rehabilitation services.
- Each medical center must provide access to Mental Health Residential Rehabilitation Treatment Program (MH RRTP) services for Veterans who require this type of care. This requirement can be met:
  - On a local basis through the availability of MH RRTP at the facility,
  - On a regional basis through service agreements with other VA facilities, or
  - By sharing agreements, contracts, or non-VA fee basis care to the extent the Veteran is eligible, in community facilities.
- Each Veterans Integrated Service Network must have residential care programs able to meet the needs of women Veterans and Veterans with Serious Mental Illness (SMI), Post-Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), Substance Use Disorder (SUD), Homelessness, and Dual Diagnoses either through special programs or specific tracks in general residential care programs. However, the needs for some types of sub-specialty care (e.g., women with PTSD or Veterans with PTSD and SUD) may be limited, and regional or national resources may be needed.

The Office of Mental Heath Services (OMHS) has reviewed the current utilization, resource allocation, and distribution of MH RRTP beds in each Veterans Integrated Service Network. Based on this review, OMHS has developed policy which it included in the Uniform Mental Health Services Handbook and VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Programs. The Northeast Program Evaluation Center continuously monitors MH RRTP utilization, resource allocation, and distribution, with an OMHS review on a

quarterly basis. Additionally, OMHS continuously monitors allocation of mental health resources through the Technical Assistance for the Implementation of the Uniform Mental Health Services Handbook Process.

Completed May 2009

Recommendation 2: **We recommend that the Acting Under Secretary for Health should ensure that VISN Directors include programming specific for OIF/OEF veterans in residential programs.**

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), (Section 35. c. [4], Establishing a new MH RRTP), requires that all facilities establishing a new MH RRTP develop plans for serving special populations including women, Serious Mental Illness (SMI), Substance Use Disorder (SUD), Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF), traumatic brain injury (TBI), incarcerated, and chronically homeless Veterans. The Handbook requires established programs to implement programming relevant to the diversity of the population served, including services specific for OEF/OIF Veterans. The Handbook also requires the establishment of stakeholder committees to include OEF/OIF Veterans as potential members in order to provide consultation to the MH RRTP program. Office of Mental Heath Services (OMHS) will continue to address the requirements for implementing programming and addressing the needs of OEF/OIF Veterans on national conference calls.

In addition, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, (Section 23.d, Specialized Post-Traumatic Stress Disorder [PTSD] Services) states that "All VA medical centers and very large community based outpatient clinics (CBOC) must have staff with training and expertise to serve the OEF and OIF population either through an OEF and OIF team or PTSD program staff." The Handbook (Section 12. t, Residential Rehabilitation Treatment Programs [RRTP]) also states that "Based on the MH RRTP's mission and patient demographics, MH RRTP staff must have competencies to meet the individual needs of special populations."

OMHS will continue to develop and refine the continuum of care for OEF/OIF Veterans. At the May 2009 MH RRTP Managers Conference, the Military Liaison Coordinator with the VHA OEF/OIF Outreach Office, provided a general session presentation on the unique approaches in residential rehabilitation and treatment for OEF/OIF Veterans.

Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs and will identify programming currently delivered specifically for OEF/OIF Veterans. OMHS will share this information nationally

with all MH RRTP programs. MH RRTPs assessed as a result of this survey as needing further development to meet the requirements of the VHA MH RRTP Handbook, are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete a site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 3: We recommend that the Acting Under Secretary for Health ensure that VISN Directors should make sure that residential program managers ensure that patients on waiting lists are periodically contacted and/or are engaged in treatment while awaiting placement in a residential program.

Concur

The Office of Mental Heath Services (OMHS) recognizes the importance of maintaining contact with and initiating treatment for Veterans who are awaiting enrollment into Mental Health Residential Rehabilitation Treatment Program (MH RRTP). VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, released in September 2008, emphasizes the need for timely access to residential care programs and requires implementation of processes to provide services to Veterans awaiting placement in a residential program. Specifically, Uniform Mental Health Services Handbook (Section 12. g-i, Residential Rehabilitation Treatment Programs [RRTP]) states that facilities must ensure waits for admission to a MH RRTP do not delay the implementation of care by instituting processes that include:

- Ongoing monitoring and case management of referred patients.
- Provision of treatment as needed to ensure stabilization of target conditions and management of co-morbidities. *NOTE: This may include inpatient care.*
- Utilizing waiting periods to provide pre-group preparation to enhance the experience and benefits of group treatment. Pre-group preparation can be provided on an outpatient basis provided Veterans are in a safe and secure environment.
- Providing appropriate mental health services whenever Veterans awaiting admission to a RRTP have an urgent need for mental health care.
- Maintaining contact with the Veteran until the time of admission to address any urgent mental health care needs that arise whenever there is a gap of greater than 2 weeks for any Veteran accepted into a MH RRTP.

Additionally, VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), (Section 16. e and h, Admission) requires that all Veterans accepted for admission must be given a tentative admission date

and a point-of-contact during the time period prior to admission (if any) and specifies that admission must occur in the most expeditious manner possible. OMHS will review these guidelines regarding access to care and wait lists on national conference calls.

Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as a result of this survey as needing further development to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 4: We recommend that the Acting Under Secretary for Health ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), requires that all Veterans receive a health care screening prior to admission to the MH RRTPs. This screening is in addition to any health or mental health assessments that are required after admission. Specifically, VHA MH RRTP Handbook (Section 16. b. (1). Admission) states: All Veterans must receive a health care screening by a physician or qualified health care provider prior to admission. This screening determines medical appropriateness for the MH RRTP and indicates areas of ongoing treatment and potentially urgent medical needs. Office of Mental Heath Services (OMHS) will review guidelines regarding medical screening requirements on national conference calls.

Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 5: We recommend that the Acting Under Secretary for Health ensure that VISN directors make sure that minimum programming requirements are met 7 days per week.

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), (Section 14. b, Program Structure) requires that all MH RRTPs provide a minimum of 4 hours per day, 7 days a week of treatment or therapeutic activities.

At the May 2009 MH RRTP Managers Conference, Office of Mental Heath Services (OMHS) presented and discussed draft minimum programming requirements in detail. After distribution of the VHA MH RRTP Handbook, OMHS will review minimum program guidelines on national conference calls. Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development as a result of this survey to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 6: We recommend that the Acting Under Secretary for Health should further develop formal guidelines for mental health clinician staffing by mental health discipline for programs using an all-inclusive staffing model and for programs using a residential type clinical staffing model.

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), includes formal staffing guidelines (including guidelines for staffing in Compensated Work Therapy [CWT] Transitional Residences [TR]) for both the All Inclusive Residential Model and the Supportive Residential Model of care offered in MH RRTPs. Staffing guidelines outline minimum core staffing, specialty bed section staffing requirements, and include discipline, full time equivalent, and staff to bed ratio.

At the May 2009 MH RRTP Managers Conference, Office of Mental Heath Services (OMHS) presented and discussed draft staffing guidelines in detail. After distribution of the VHA MH RRTP Handbook, OMHS will review minimum

staffing guidelines on national conference calls. Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPS are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 7: We recommend that the Acting Under Secretary for Health should require the presence of a least one staff member on each separate wing and floor of residential programs on all shifts.

Concur

VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, released in September 2008, requires that facilities ensure the safety and security of Mental Health Residential Rehabilitation Treatment Programs (MH RRTP). Specifically, the Uniform Mental Health Services Handbook (Section 12. o, Residential Rehabilitation Treatment Programs [RRTP]) requires MH RRTPs maintain 24 hour a day, 7 days a week on site-supervision, and that at least one staff member must be physically present on the unit at all times that Veterans are present on the unit.

Additionally, VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), 02 (Section 15. c. 1-3, Staffing Requirements) provides specific language regarding the need for adequate staffing to provide safe, effective, and appropriate clinical care. Specifically, the Handbook requires onsite supervision of MH RRTPs 24 hours a day, 7 days a week, and an employee must be physically present on the unit at all times that Veterans are present on the unit.

At the May 2009 MH RRTP Managers Conference, Office of Mental Heath Services (OMHS) presented and discussed draft guidelines regarding staffing presence on units in detail. After distribution of the VHA MH RRTP Handbook, OMHS will review staffing guidelines on national conference calls. Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the

Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 8: We recommend that the Acting Under Secretary for Health ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), requires that all MH RRTPs develop a local policy for Safe Medication Management (SMM) within the unit. The SMM guidelines require that Veterans are assessed for level of independence in medication management upon admission to the MH RRTP. Additionally, SMM guidelines state that licensed staff, except in Compensated Work Therapy (CWT)-Transitional Residence (TR) Program, must administer and record controlled substances. Within the CWT-TR Program, medication management is based on the SMM Program with a limit of 7-day quantity, or less, for controlled substances.

At the May 2009 MH RRTP Managers Conference, Office of Mental Heath Services (OMHS) presented and discussed SMM guidelines in detail. MH RRTP staff will review SMM guidelines during quarterly conference calls and provide individual consultation to MH RRTPs as needed. OMHS is currently developing web-based training to train all MH RRTP clinical staff on the SMM Program guidelines. Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development to meet the requirements of the VHA MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 9: We recommend that the Acting Under Secretary for Health ensure that all patients on self medication have a documented order for self-administration of medication, and documented instruction regarding medication self-administration.

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), (Appendix C. 4.) states that a Veteran's ability to safely manage the Veteran's medications must be assessed by the independent licensed provider or registered nurse upon admission into an 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.

After distribution of the VHA MH RRTP Handbook, Office of Mental Heath Services (OMHS) will review Safe Medication Management guidelines including provider's orders on national conference calls. Furthermore, Mathematica Policy Research, Inc., is currently conducting a site survey at all MH RRTPs. MH RRTPs assessed as needing further development to meet the requirements of the MH RRTP Handbook are required to submit an implementation plan for requirements specifically identified as needing development. The MH RRTPs are also required to provide quarterly updates on their progress through the Veterans Integrated Service Network Director to the Director MH RRTP. Mathematica is scheduled to complete the site survey in January 2010 and issue its final report to OMHS in April 2010.

In Progress April 2010

Recommendation 10: We recommend that the Acting Under Secretary for Health ensure that missed appointments should be captured, addressed, and case managed in a uniform manner.

Concur

The Office of Mental Health Services will work with facilities to stress the importance of utilizing the existing system in place to capture and address missed appointments.

Planned September 2009

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, M.D. Senior Physician 202 461-4705
Acknowledgments	Donna Giroux, Project Manager Annette Acosta Bruce Barnes Lisa Barnes Gail Bozzelli Shirley Carlile Jennifer Christensen Limin X. Clegg, Ph.D. Melanie Cool Sheila Cooley Marnette Dhooghe Stephanie Hills Kathy King Jennifer Kubiak Nelson Miranda Karen Moore Glen Pickens Wilma Reyes Prabu Selvam Patrick Smith Randall Snow Marilyn Walls

Appendix E

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