Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

Report No. 10-04085-203

June 22, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

As directed in Public Law 110-387, the VA Office of Inspector General (OIG) conducted a follow-up review to evaluate any improvements made or problems remaining since completion of a comprehensive 2009 review of residential mental health care facilities of the Veterans Health Administration (VHA). The results of that inspection were published in the June 25, 2009 report, *Healthcare Inspection Review of Veterans Health Administration Residential Mental Healthcare Facilities* (OIG report number 08-00038-152). In the 2009 report, we issued 10 recommendations based on identified areas of concern. The OIG conducted the present inspection in order to ascertain VHA's progress in carrying out recommendations from the 2009 report and to evaluate whether improvements have occurred or deficiencies remain in these areas. Our inspection consisted of 3 components: (1) onsite inspection at 20 VHA Mental Health Residential Rehabilitation Programs (MH RRTP) sites (2) review of 907 medical records of MH RRTP patients treated at these 20 sites, and (3) relevant document review.

Results

We found significant interim progress in meeting recommendations: that VHA review residential program utilization, resource allocation, and distribution; that a staff member is present on each floor and unit of each residential program; that VHA develop formal guidelines for residential program mental health clinician staffing; that clinicians document a medical screening preceding admission, and for inclusion of OEF/OIF/OND (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) special emphasis programming/activities.

We found moderate progress regarding: the presence of either a formal policy or consistent informal mechanism for capturing and addressing missed appointments for MH RRTP patients; and documentation of a progress note and prescriber's order for patient safe medication management. We found mild-moderate interim progress regarding the provision of minimum programming hours 7 days per week-4 hours per day; and limiting dispensing of prescribed narcotics to up to 7 days for safe medication management for residential program patients (although overall compliance for this item was high-94%).

We found little interim progress for: ensuring contact with patients during the time interval between acceptance into an MH RRTP program and program start.

Although VHA met the requirement to develop core mental health clinical staffing guidelines, on this inspection we also reviewed actual staffing at MH RRTP programs visited. We found this to be an area of concern which is newly addressed in the

recommendations section. On this inspection we also reviewed whether MH RRTP patients were assessed for occupational dysfunction, and if present whether they were referred to vocational rehabilitation services. We found that patients were assessed, but based on program size and urban-rural status there were differences in the percentage referred. In light of the emphasis on a recovery based model, this area of concern is also newly addressed in the recommendations.

Table 1 summarizes the findings of the present inspection. Color coding for each item reflects an integrated OIG assessment of progress within the context of overall compliance. Of note, although we estimated 94% (high) compliance with limiting dispensing of narcotics to up to 7 days, and improvement since the previous review in 2009 (89%), in light of the substantive nature of this issue, the item is shaded red.

ISSUE	2011 OIG Review	2009 Review
VHA Review of MH RRTP Program Model Utilization, Resource Allocation, and Distribution	**Met**	Newly Recommended in 2009 Report
OEF/OIF/OND Programming	**70%**	26%
Contact During Interval Between MH RRTP Program Acceptance and Program Start	**73%**	74%
Medical Screening Preceding Admission	**89%**	54% (PRRTP) -77% (DRRTP)
Minimum Program Hours 7 Days per Week-4 Hours per Day	**70% of programs**	55% of sites
Formal Guidelines for Mental Health Clinician Staffing	**Met**	Newly Recommended in 2009 Report
Staff Member Presence on Each Floor and Unit	**97% of Programs** **95% of Programs**	Newly Recommended in 2009 Report
Limit Dispensing of Narcotics to up to 7 Days for Safe Medication Management Patients	**94%**	89%
Prescriber's Order for Safe Medication Management (SMM) and Progress Note Assessing SMM	**61%** **41-96%(depending on program size and urban-rural status)**	45% 82%
Formal Policy or Consistent Informal Mechanism for Capturing and Addressing Missed Appointments	**82%**	Newly Recommended in 2009 Report

Table 1. Summary of findings for each issue compared with relevant findings from 2009 OIG review.

Recommendations

We recommended that the Under Secretary for Health:

(1) Ensure that VISN Directors ensure contact between MH RRTP staff and/or engagement in MH treatment for patients in the interim between their acceptance into and actual participation in a MH RRTP.

(2) Ensure that VISN Directors ensure that MH RRTPs document a medical screening prior to MH RRTP admission.

(3) Ensure that VISN Directors review whether MH RRTP patients assessed as having occupational dysfunction are referred to vocational rehabilitation when indicated and desired by the patient.

(4) Ensure that the Office of Mental Health Services (OMHS) examines barriers to provision of weekend programming and provides further guidance to MH RRTPs regarding programmatic expectations during the weekend.

(5) Ensure that VISN Directors ensure that MH RRTPs meet or exceed VHA's core minimum staffing requirements.

(6) Ensure that VISN Directors ensure that MH RRTPs comply with the MH RRTP Handbook regarding limiting of residential patient self-administration of controlled substances to a 7-day supply during the last third of a patient's anticipated residential program stay.

(7) Ensure that VISN Directors ensure documentation of a provider's order and clinical note related to MH RRTP assessment for safe medication management.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health

SUBJECT: Healthcare Inspection – A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs

Purpose

As directed in Public Law 110-387, the VA Office of Inspector General (OIG) conducted a follow-up review to evaluate any improvements made or problems remaining since completion of a comprehensive 2009 review of residential mental health care facilities of the Veterans Health Administration (VHA). The results of that inspection were published in the June 25, 2009 report, *Healthcare Inspection Review of Veterans Health Administration Residential Mental Healthcare Facilities* (OIG report number 08-00038-152). In the 2009 report, we issued 10 recommendations based on identified areas of concern. The Acting Under Secretary (at the time of issuance) agreed with the findings and recommendations and provided an improvement plan.

The OIG conducted the present inspection in order to ascertain VHA's progress in carrying out recommendations from the 2009 report and to evaluate whether improvements have occurred or deficiencies remain in these areas. Additionally, from the medical record review component of this inspection, we determined documented housing arrangement (e.g., temporary grant-per-diem, return to own home) and vocational status for patients discharged from mental health residential rehabilitation treatment programs (MH RRTP) during the time frame of our review.

Background

VHA MH RRTPs 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. MH RRTP programs are intended to focus on Veterans' needs, abilities, strengths, and preferences. Categories included in MH RRTP include; Psychosocial Residential Rehabilitation Treatment Programs (PRRTP), Substance Abuse Residential

Rehabilitation Treatment Program (SARRTP), Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program (PTSD-RRTP), Domiciliary Residential Rehabilitation Treatment Programs (DRRTP), Domiciliary Care for Homeless Veterans (DCHV), and Compensated Work Therapy/Transitional Residence (CWT/TR).

MH RRTPs intend to identify and address goals including rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to facilitating treatment and intervention for specific medical conditions, mental illness, substance use, and psychosocial stressors. Focus on patient strengths, abilities, needs, and preferences rather than on illness and symptoms is a core MHRRTP objective.

MH RRTPs may provide treatment within the program itself (all inclusive residential model), or patients in MH RRTPs may participate in an intensive regimen of outpatient services (supportive residential model), which are then augmented by the MH RRTP component of care (supportive residential model). The residential component is intended to emphasize incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. In an all inclusive residential model, staff dedicated to the MH RRTP provide virtually all treatment and rehabilitative services to patients in the program. In a supportive residential model, a supportive residential component is provided while patients receive intensive outpatient treatment from providers in other mental health programs (e.g., intensive outpatient substance use program, PTSD clinic).

As of the 3rd quarter of FY 2010, there were 237 active MH RRTP programs at 104 VHA locations with approximately 8,457 operational beds. The following table documents MH RRTP utilization for FY 2008-2010.

	2008	2009	2010
Discharges	33,251	34,598	38,974
Cumulative Occupancy Rate	79.6%	79.0%	81.7%
Average Length of Stay (LOS)	63.3	65.4	63.4

Table 2. MH RRTP discharges, average cumulative occupancy rate, and average LOS for FY 2008-2010.

VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program* (December 22, 2010) provides procedures and reporting requirements for Mental Health Residential Rehabilitation Programs. The Handbook details substantive elements for MH RRTP's with respect to several areas including program structure, staffing requirements, admission, screening, treatment planning, suicide risk assessment, medication management, and access and services for woman veterans among others.

In the 2009 OIG review we recommended that the Acting Under Secretary for Health:

1. Ensure that VHA program officials review the utilization, resource allocation, and distribution of general residential, PTSD focused, substance use focused,

(Domiciliary Care for Homeless Veterans (DCHV) , and Compensated Work Therapy (CWT) programs.

2. Ensure that VISN Directors include programming specific for OIF/OEF/OND veterans in residential programs.

3. Ensure that VISN Directors require residential program managers to ensure that patients on waiting lists are periodically contacted and/or engaged in treatment while awaiting placement in a residential program.

4. Ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.

5. Ensure that VISN Directors require that (at least) minimum programming requirements are met 7 days per week

6. 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.

7. Require the presence of at least one staff member on each separate wing and floor of residential programs on all shifts.

8. Ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.

9. Ensure that all patients on self medication have a documented order for self-administration of medication, and documented instruction regarding medication self-administration.

10. Ensure that missed appointments by residential program patients are captured, addressed, and case managed in a uniform manner.

VHA Handbook 1162.02 conceptually addresses several of these recommendations. The following inspection evaluates VHA's "on the ground progress" in carrying out these recommendations and in attending to the areas of concern intrinsic to each recommendation.

Scope and Methodology

We reviewed VHA Handbook 1162.02 (*Mental Health Residential Rehabilitation Treatment Program)*, and VHA Handbook 1160.01 (*Uniform Mental Health Services in VA Medical Centers and Clinics)* and interviewed former and present VA Mental Health Residential Rehabilitation leadership with the Office of Mental Health Services at VA Central Office. We conducted a pilot onsite visit at the Hampton, Virginia VAMC.

A stratified sample design was used to select a probability-based random sample for onsite inspection. VHA MHRRTP sites were stratified based on bed size (small-50 beds or fewer, medium-51-126 beds, large-126 or more beds) and by urban versus rural status. Twenty locations were randomly sampled. In total, there were 50 MH RRTPs affiliated with these 20 locations.

While onsite we interviewed program staff and informally spoke with program participants. We reviewed programming calendars for February and March 2011 looking for evidence that at least a minimum of 4 hours of programming was offered 7 days per week, and for indication of some OEF/OIF/OND veteran specific programming. After discussion of program calendars with staff, for further validation, we then selected 5 medical records of patients presently in each MH RRTP at the time of the visit and reviewed these patient records for involvement in at least 4 hours of treatment or therapeutic programming per day. We observed program staffing and visited each building that houses an MH RRTP looking for the presence of staff or an alternate safety monitoring mechanism on each wing and floor of each MH RRTP at the selected location. We also reviewed each site's missed appointment policies and interviewed staff regarding mechanisms used to monitor, address, and case manage missed appointments.

For medical records review, a probability-based random sample of 50 patients was drawn from lists of all unique patients admitted from September 1, 2010, through December 30, 2010, to MHRRTPs at the 20 sites selected for onsite visits. For locations with less than 50 admissions during FY 2010, all patients admitted to MHRRTP's at the site were included. OIG healthcare inspectors reviewed a total of 907 patient medical records for evidence of compliance with recommendations and/or elements from VHA Handbook 1162.02 regarding admission screening; documentation of contact with veterans waiting more than 7 days to start a MHRRTP; medical screening; assessment of occupational function/dysfunction and vocational rehabilitation referral; documentation of suicide assessment as part of the biopsychosocial assessment; assessment for the ability to be in the safe-medication program and presence of an accompanying clinician's order; and duration of narcotic prescriptions for patients on a safe-medication program. In addition, we reviewed documentation of vocational status and type of housing arrangements noted in the discharge plan.

Additional document inspection included: review of safe medication policies for each location; review of required nursing-hours-per patient day (certified time sheets for each shift on 3 separate days); written staffing plans with roster by name and position title for all program staff; and a labor map for psychologists, psychiatrists, social workers, primary care physicians; physician assistants, and/or nurse practitioners assigned full or part time to MHHRTPs at each location.

We conducted the review in accordance with *Quality Standards for Inspection* and *Evaluation* published by the Council of the Inspectors General.

Results and Conclusions

Issue 1. Review by VHA of the Utilization, Resource Allocation, and Distribution for each MH RRTP Program Model.

MH RRTPs provide residential rehabilitative and clinical care to veterans with a wide range of problems or needs. MH RRTP bed types include: Domiciliary Residential Rehabilitation Treatment Programs (DRRTP), DCHV, Health Maintenance Domiciliary, General Domiciliary or Psychosocial Rehabilitation Treatment Programs (PRRTP), Domiciliary PTSD (Dom PTSD) or Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Programs (PTSD-RRTP), Domiciliary SA (Dom SA) or Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP), and CWT-Transitional Residence (TR) programs.

Those VAMCs that have a MH RRTP may have 1 or more MH RRTPs at one site, or separate programs in separate locations. In addition, within an MH RRTPs there may be special tracks or designated beds. For example, there may be a PTSD track or substance use track located with a general domiciliary program.

MH Residential Rehabilitation leadership reported that MH RRTP utilization, resource allocation, and bed distribution are tracked by the VA Northeast Program Evaluation Center (NEPEC) on a quarterly basis. This information is sent to VISN leadership and directly to facility MH RRTP managers. We obtained and reviewed the MH RRTP quarterly bed reports, quarterly reports by MH RRTP bed type, VISN and facility level stoplight reports (based on cumulative occupancy rates, and related notes for FY 2010. Quarterly reports indicate: (1) the number of operational beds for each program model-type at MH RRTP locations, (2) the cumulative average daily census for each program, (3) the cumulative occupancy rate, (4) the number of beds under development or construction at each location for each model type, and (5) the name and contact information for program coordinators at each site.

Cumulative occupancy and cumulative average daily census data provide program managers and VA leadership with information to enhance decision making regarding utilization, resource allocation, and bed distribution. The additional notes include miscellaneous information on bed status changes (e.g., “they anticipate additional beds for TBI as soon as construction to accommodate these beds is completed”), observations regarding changes in occupancy rates, conversions from 1 model bed type to another (e.g., from General PRRTP to PTSD PRRTP), and observations regarding anomalies noted in the data reported to NEPEC (e.g., “VISN submitted copy of previous information from December 2009 making it unclear if the information is correct”).

Each VISN except VISNs 19 and 21 have General MH RRTP operating bed types. Dom PTSD or PTSD-RRTP bed types are present in each VISN except for VISN’s 15, 18, and

22 which is unchanged since the June 2009 OIG report. However, the VA Eastern Kansas Health System, Topeka in VISN 15 does run a specialized inpatient stress disorders unit. Dom SA or SARRTP and DCHV bed types are operating in all VISN's. CWT-TR beds operate in all VISN's except for VISN's 9, 19, and 22 (compared with VISN's 2, 19, and 22 at the time of prior OIG report).

Conclusion

In conclusion, documentation review indicates that VHA program officials are engaged in ongoing review of the utilization, resource allocation, and distribution of general residential, PTSD focused, substance use focused, DCHV, and CWT programs. VHA tracks outcome measures (e.g., housing status, incarceration, employment status) for certain residential programs at 30 days post discharge. Although ongoing follow-up becomes more challenging as time horizons increase, VHA should consider utilizing a longer time frame and explore broadening the set of outcome measures as part of the MH RRTP evaluation process.

Issue 2. Special Emphasis Programming for OIF/OEF Veterans

At the 20 sites visited for our review, there were a total of 49 MH RRTP programs. CWT-TR programs offer therapeutic work-based residential rehabilitation services designed to facilitate successful community integration. In general, the main focus of the CWT-TR programming day consists of participation (on-site or off-site) in compensated work therapy which is not targeted to a specific veteran or mental health population. We therefore excluded the 12 CWT-TR programs from our analysis in this section of the report. For non-CWT, MH RRTPs, 100% had at least 1 OEF/OIF/OND veteran within the 2 months prior to our visit. From documentation and interview we found evidence of OEF/OIF/OND specific programming at 70% of the programs visited. This is improved compared with the 26% of programs with inclusion (different methodology) of special emphasis programming for OEF/OIF/OND veterans during our 2009 inspection.

Conclusion

Depending on the program focus and location, the number of OEF/OIF/OND veterans served by each particular MH RRTP varies throughout the system. Special emphasis programming may be impractical for programs that infrequently serve OEF/OIF/OND veterans but are a relevant component of the program of care for those MH RRTP's that are regularly accessed by recent, returning veterans. Inclusion of OEF/OIF/OND special emphasis programming in MH RRTP's significantly increased since our prior inspection.

Issue 3. Contact with and Engagement in Treatment for Patients on Waiting Lists for Residential Programs

After screening and acceptance for admission to residential programs, some patients may begin program participation shortly following acceptance into the program, while other patients may experience a time delay between the time of acceptance and actually starting treatment in a MH RRTP. The time lag may be patient initiated (e.g., veteran taking college classes desires to wait until end of semester to begin program) or facility specific (e.g., lack of an available bed at time of acceptance, cohort model for PTSD track with each new cohort of patients starting at six week intervals).

To ensure continuity of clinical monitoring of this vulnerable population during the period between acceptance into and starting treatment in a residential program, prudence dictates that residential programs maintain contact with and/or ensure interim assessment for veterans awaiting placement into residential programs. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* notes that facilities must ensure that 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, and/or utilizing waiting periods to provide pre-group preparation to enhance the experience and benefits of group treatment.

OIG inspectors reviewed a statistically representative sample of 907 medical records of patients treated in MH RRTPs during FY 2010 at the 20 sites visited. Figure 1 depicts the relative frequency of times between MH RRTP acceptance and start for patients.

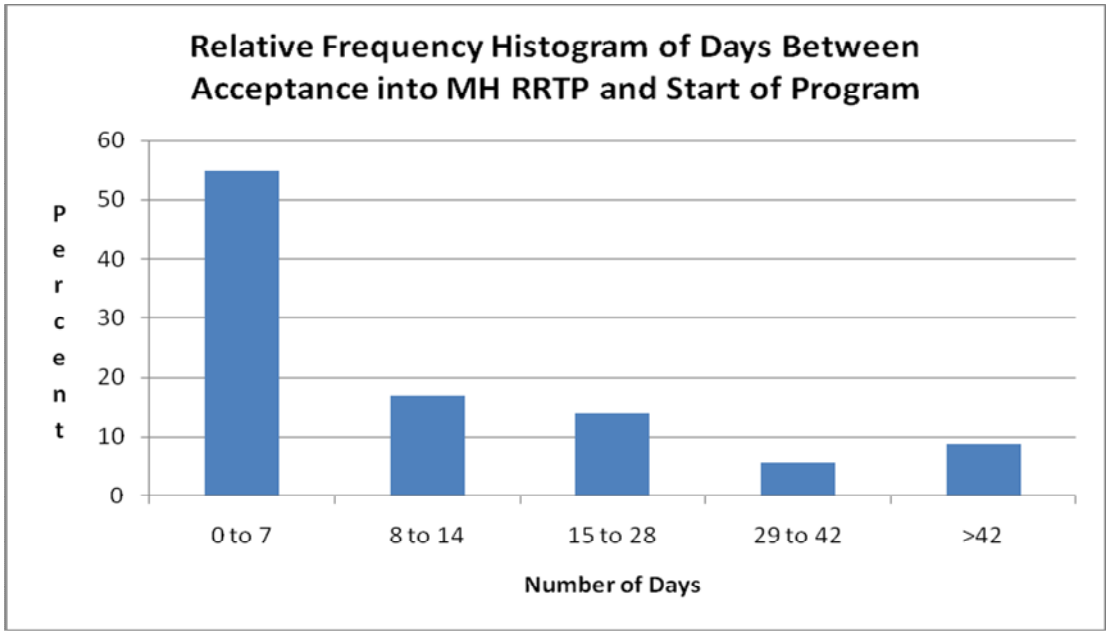


Figure 1. Relative frequency of times between acceptance and start in MH RRTP.

Based on results from our sample, we estimated the mean number of days from acceptance to start for MH RRTP patients was 14.6 days [95% Confidence Interval (CI) of 9.02-20.12 days].

In order to evaluate the presence and nature of clinical monitoring for patients waiting to start in a residential program, we focused on patients for whom the time between acceptance into and beginning formal participation in a MH RRTP was greater than 7 days. We estimated that 45.1 percent of the patients began MH RRTP participation greater than 7 days after program acceptance.

For VHA MH RRTP patients starting a MH RRTP 7 days or more after program acceptance, we estimated that overall there was interim phone or similar contact for 73% (CI 53.50-86.31) of these patients. Table 3 indicates estimates of the percentage of VHA MH RRTP patients starting a MH RRTP 7 days or more after program acceptance who had a mental health visit (in person or telehealth) during the relevant time frame by MH RRTP program size (small, medium, large) and facility urban-rural status. The data is presented by strata instead of an overall composite because a statistically significant difference was observed for small programs based on urban-rural status, and for small-urban programs compared to medium-urban and large-urban programs.

	Estimated Percentage
Small-Rural	59.6 (CI 41.19-75.59)
Small-Urban	97.1 (CI 86.21-99.43)
Medium-Rural	67 (CI 34.62-88.58)
Medium-Urban	74 (CI 66.05-80.59)
Large-Rural	72.8 (CI 61.54-81.73)
Large-Urban	31.4 (CI 6.13-76.20)

Table 3. Percentage estimates of patients starting MH RRTP 7 days or more after program acceptance who had a mental health visit during the interim time frame by program size and urban-rural status.

Table 4 depicts the estimated percentage of VHA MH RRTP patients who began participation at least 7 days after program acceptance, and had documentation in the record of either a mental health visit (in-person or via telehealth) or interim phone or other contact with the program prior to starting a residential program by program size and urban-rural status. A statistically significant difference was noted for small programs based on urban-rural status, and for small-urban programs compared with large-urban programs.

	Estimated Percentage
Small-Rural	76.8 (CI 63.93-86.07)
Small-Urban	99.3 (CI 92.87-99.94)
Medium-Rural	88 (CI 71.70-95.53)
Medium-Urban	90 (CI 63.09-97.94)
Large-Rural	78.2 (CI 67.16-86.35)
Large-Urban	51.1 (CI 25.30-76.39)

Table 4. Percentage estimates of patients starting MH RRTP 7 days or more after program acceptance who had either phone contact or a mental health visit during the interim time frame by program size and urban-rural status.

For patients starting an MH RRTP more than 7 days after acceptance and for whom there was no evidence of an interim mental health visit or phone contact between the program and the patient, we estimated that 5.5% (CI 2.09-13.50) of these patients had a primary care visit during the time between acceptance and program start.[1]

For MH RRTP patients for whom there was no evidence of interim phone contact or a mental health visit, the time frame from acceptance to start was 8-14 days for 38.2%, 15-28 days for 33.1%, 29-42 days for 13.1% patients, and greater than 42 days for 15.6% patients.

For MH RRTP patients for which there was a greater than 7-day time frame between acceptance and program start, we looked for evidence of a plan of care until actual program admission. In our 2009 review, we estimated documented presence of an interim plan of care for 64% of patients for whom there was a greater than 7-day time frame between acceptance and program start. Table 5 depicts the estimated percentage of MH RRTP patients with documentation of an interim plan of care by program size and urban-rural status. A significant difference is noted for small-urban versus small-rural programs; for large-urban versus large rural programs; and for small-rural versus large rural programs.

[1] The few patients who were on a VA inpatient unit during the time frame between acceptance into a residential program and participation in the MH RRTP program, were included as having had contact and a mental health visit while waiting to start the program.

	Estimated Percentage
Small-Rural	76.8 (CI 66.90-84.44)
Small-Urban	97.1 (CI 86.21-99.43)
Medium-Rural	43.9 (CI 20.08-70.90)
Medium-Urban	88.3 (CI 58.51-97.59)
Large-Rural	56.3 (CI 45.78-66.23)
Large-Urban	91.2 (CI 84.31-95.26)

Table 5. Estimated percentage of MH RRTP patients starting a program 7 days or more after program acceptance for whom there was documentation of an interim plan of care by program size and urban-rural-status.

Conclusion

We estimated that for MH RRTP patients with a more than 7 day gap between program acceptance and actual start in a program, 73% had phone contact with the MH RRTP; 31.4-97.1% (depending on program size and urban-rural status) were engaged in a mental health treatment visit; and 51.1-99.3% (depending on program size and urban-rural status) had either phone contact or were engaged in a mental health treatment (outpatient or inpatient) visit. This is essentially unchanged since the 2009 OIG review during which we estimated that overall 74% of patients with a more than 7 day gap were followed clinically from the time of screening to actual admission.

Of note, we estimated that for the sub-group of MH RRTP patients with a greater than 7 day interval between acceptance and program start and for whom there was no evidence of phone contact or a mental health visit, the time frame between acceptance and program start was greater than 28 days for approximately 28.7% of these patients.

Recommendation 1: We recommended that the Under Secretary for Health ensure that VISN Directors ensure contact between MH RRTP staff and/or engagement in MH treatment for patients in the interim between their acceptance into and actual participation in a MH RRTP.

Issue 4. Documentation of Medical Screening Preceding Admission

VHA Handbook 1162.02 (the MH RRTP Handbook) notes that veterans need to be screened for MH RRTP admission by staff capable of assessing their medical and psychiatric stability and their suitability for admission to the program. In addition, the

MH RRTP Handbook states that "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."

From medical record review, we estimated that 95.7% (CI 88.41-98.50) of medical records for MH RRTP patients had a screening note for the MH RRTP and 88.8% (CI 81.21-93.60) documented a medical screening prior to admission.

The MH RRTP Handbook requires that veterans receive a comprehensive biopsychosocial assessment that is documented within 5 working days of admission to a residential program. The assessment includes multiple elements (e.g., living situation, family history, military history and trauma screening). Consistent with a rehabilitation model focused on improvements in function and quality of life, an assessment for occupational dysfunction and employment services is to be completed as part of the biopsychosocial assessment so that identified needs can be addressed in the rehabilitation plan. If needed, a referral for additional vocational rehabilitation and employment services may then be completed as part of the initial rehabilitation plan.

We estimated that for 92.9% (CI 84.88-96.85) of MH RRTP patients, the biopsychosocial assessment included an assessment for occupational dysfunction. For MH RRTP patients with documentation of occupational dysfunction in the biopsychosocial assessment, table 6 indicates the percentage estimated to have been referred to vocational services by program size and urban-rural status.

	Estimated Percentage
Small-Rural	56.1 (CI 39.37-71.49)
Small-Urban	32.7 (CI 12.72-61.88)
Medium-Rural	97.4 (CI 97.00-97.67)
Medium-Urban	50.4 (CI 27.37-73.30)
Large-Rural	46.9 (CI 41.20-52.73)
Large-Urban	79.7 (CI 66.02-88.79)

Table 6. Estimated percentage of MH RRTP patients with occupational dysfunction documented in the biopsychosocial assessment that were referred to vocational services by program size and urban-rural status.

A significant difference is noted between medium size programs based on urban-rural status; between large size programs based on urban-rural status; for medium-rural

programs compared to small-rural and large-rural programs; and between small-urban and large-urban programs.

At one facility, all MH RRTP patients with 100% disability are referred to vocational rehabilitation services. As a result, there were an additional 15 patients whose biopsychosocial assessment did not include an assessment for occupational dysfunction, but who were also referred to vocational rehabilitation services.

As per the MH RRTP Handbook, patients screened for admission to an MH RRTP are to be assessed for suicide risk. In addition, upon admission, all patients to an MH RRTP are to be screened again for suicide risk. Assessment of hopelessness, depression, suicidal thoughts, plan, ideation, and intention should also be ongoing through the program including at the time of treatment plan reviews, at times of particular concern (e.g., change in provider, life change etc), and prior to discharge. For this review, we ascertained whether a suicide assessment was included in the biopsychosocial assessment. We estimated that for 100% (CI 99.82-99.99) of MH RRTP patients, a second suicide assessment was included in the biopsychosocial assessment or a contemporaneous chart note.

Conclusion

From medical record review, we estimated that 95.7% of medical records for MH RRTP patients had a screening note for the MH RRTPs and 88.8% documented a medical screening prior to admission. This represents significant improvement compared with our prior review in which documentation of medical screening ranged from 54 to 77 percent depending on historical program type.[2] However, because of the substantive nature of this issue further progress is recommended. We estimated that for 100% of MH RRTP patients, a suicide assessment was included in the biopsychosocial assessment or a contemporaneous chart note. We estimated that for 92.9% of MH RRTP patients, the biopsychosocial assessment included an assessment for occupational dysfunction. For MH RRTP patients with documentation of occupational dysfunction in the biopsychosocial assessment we estimated that depending on MHRRTP program size and urban-rural status there was significant variation as to whether these patients were referred to vocational services. Considering the recovery and rehabilitative focus of MH RRTP programs, we believe this warrants further consideration and analysis by VHA.

Recommendation 2: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs document a medical screening prior to MH RRTP admission.

[2] VHA Handbook 1162.02 unifies procedures and reporting requirements for all residential programs under the MH RRTP bed level of care. Prior to issuance, procedures for Domiciliary programs (DRRTP's) and Psychosocial Residential Rehabilitation programs (PRRTP's) were addressed under two separate handbooks, reflecting the historical organizational backgrounds from which DRRTP's and PRRTP's initially developed.

Recommendation 3: We recommended that the Under Secretary for Health ensure that VISN Directors review whether MH RRTP patients assessed as having occupational dysfunction are referred to vocational rehabilitation when indicated and desired by the patient.

Issue 5. Meeting Minimum Programming Requirements 7 days Per Week-4 Hours per Day

VHA Handbook 1162.02 notes that "MH RRTP policy requires a minimum of 4 hours per day of treatment or therapeutic activities, 7 days per week. Programs must provide therapeutic activities in the evening and on weekends. While the use of appropriate passes that are directly related to the accomplishment of the Veteran's treatment and rehabilitation goals is encouraged, programs may not place all residents on pass for the weekend as a means of meeting the programming goal or due to lack of staffing availability. Evening and weekend activities must have a direct relationship to assisting the Veterans in meeting treatment and rehabilitation goals."

Because therapeutic work-based rehabilitation services encompass most of the programming day for CWT-TR programs and this handbook requirement is not applicable to CWT programs, we excluded these programs from our analysis for this section of the report.

From documentation review and on-site interview, we found that although 95 percent of programs visited met minimum programming requirements on weekdays, 70% of MH RRTPs visited were providing at least 4 hours per day of treatment or therapeutic activities on weekends. This represents mild-moderate improvement compared with our finding (55%) in the 2009 report.

To further explore and validate provision of at least the minimum number of programming hours, while on-site we randomly selected 5 medical records of patients presently in each MH RRTP at the time of the visit and reviewed these patient records for involvement in at least 4 hours of treatment or therapeutic programming per day on the Sunday, Tuesday, and Saturday of the week preceding our visit and queried staff with relevant follow-up questions as indicated. At 2 sites we looked at an additional 5 charts, and at 1 site we looked at a total of 5 charts rather than for each program at the site. In total 178 charts were reviewed on-site for involvement in 4 hours of programming 7 days per week.

Documentation and follow-up discussions regarding this random sample of patient charts also supported meeting of minimum programming requirements during the week but not reliably on weekends. Forty-seven percent of charts supported patient participation in programming 7 days per week. Depending on the program, this number may reflect patient participation in weekend programming but lack of supportive documentation; availability of programming opportunities but variable patient participation; or lack of

weekend programming. Because this on-site patient chart sample was random but not a statistically representative sample, this result cannot be projected beyond the sample of programs and sites visited.

Conclusion

MH RRTPs visited were found to provide at least the minimum number of programming hours on weekdays but only 70% of the programs visited met this requirement 7 days per week. This represents mild to moderate improvement compared with our findings (55%) findings of our previous review.

Recommendation 4: We recommended that the Under Secretary for Health ensure that OMHS examines barriers to provision of weekend programming and provides further guidance to MH RRTPs regarding programmatic expectations during the weekend.

Issue 6. Formal Guidelines for Mental Health Staffing by Clinical Discipline

In the 2009 OIG review of residential mental health programs, we recommended that VHA develop formal guidelines for mental health clinician staffing by mental health discipline for residential programs. Appendix A of the MH RRTP Handbook delineates core staffing requirements for MH RRTPs by number of beds consistent with the spirit of the IG recommendation.

The minimum core requirements are intended to maintain adequate staffing to provide safe, appropriate clinical care. For the sites visited during the present inspection, we reviewed the staffing requirements, allocated staffing, and actual staffing for non-CWT MH RRTPs at the 20 sites visited.

For MH RRTPs (other than CWT-TR) we reviewed staffing for the following clinical disciplines: 24/7 coverage; primary care physician, physicians assistant, or nurse practitioner for coverage of non-mental health medical and wellness issues; psychiatrist; psychologist; nurse; and social worker. Table 3 depicts the percentage of non-CWT programs visited that met core minimum staffing requirements per bed size based on actual staffing for the clinical disciplines reviewed. For example, a program with 41-50 beds is required to have 2 social workers providing services to patients in the program. A program utilizing 2.5 social worker full time equivalents (FTE) would meet the requirement, while a program utilizing 1.5 FTE would not.

Position	Percent Meeting Requirement Based on Actual FTE
24/7 Coverage Staff	92%
MD/PA/NP	73%
Psychiatrist	68%
Psychologist	49%
Nurse (RN or LPN)	84%
Social Worker	65%

Table 7. The percentage of non-CWT MH RRTP programs that met core staffing requirements for select clinical disciplines at site visited.

Sixteen percent of programs visited met requirements for all of the clinical disciplines reviewed. Most programs met staffing requirements for 24/7 coverage staff. In general, MH RRTPs at the sites visited had difficulty meeting core staffing requirements for psychiatrists, psychologists, and social workers. While the percentage of programs meeting core staffing requirements for an RN or LPN and for a primary care physician/physician's assistant/nurse practitioner was greater it still deviated from the expected core staffing requirement.

During our visits we also noted that less than half the programs visited met additional minimum requirements for vocational specialty staffing. One program did not have a nurse, and therefore did not accept patients who cannot self-administer their own medications.

There were 12 CWT-TR programs located at 10 of the 20 sites visited by OIG inspectors. Consistent with the structure of CWT-TR programs, staffing focus differs from and is more fluid compared with other MH RRTPs. In addition, CWT's can utilize house managers (non-paid former/recent participants) to help address participant needs. CWT-TR staff functions include program manager, care manager, program clerk, physician/nurse practitioner/physician's assistant, program evaluation, and other functions for CWT-TR programs visited. Because more than 1 of these functions can be performed by the same staff member, we focused on total minimum required FTE in comparison to total allocated FTE. Overall, inspectors found corresponding staffing arrangements for 9 of the 12 CWT-TR programs.

Conclusion

The 2009 OIG residential review recommended that VHA develop formal guidelines for mental health clinician staffing by mental health discipline for residential programs. Appendix A of the MH RRTP Handbook delineates core staffing requirements for MH RRTPs by number of beds consistent with the spirit of the IG recommendation

During the present review, 16% of programs visited met requirements for all of the clinical disciplines reviewed. Most programs met staffing requirements for 24/7 coverage staff. However many programs did not meet core staffing requirements for psychologists, psychiatrists, social workers, RN or LPN and for a primary care physician/physician's assistant/nurse practitioner. In addition, we also noted that many programs did not meet requirements for vocational specialty staffing. Considering the recovery and rehabilitative focus of MH RRTPs, we believe this warrants further consideration and analysis by VHA.

Recommendation 5: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs meet or exceed VHA's minimum core staffing requirements.

7. Staff Member Presence on Each Separate Unit and Floor

The VHA MH RRTP Handbook states that MH RRTPs "must have adequate staffing to provide safe, effective, and appropriate clinical care…Since onsite supervision of MH RRTPs is required 24/7, an employee must be physically present on the unit at all times that Veterans are present." The Handbook further specifies that in MH RRTPs with multiple floors or buildings, a staff person must be physically present on each floor in each building. "For buildings where there is more than one unit on a floor, a centralized staff person may cover both units only if there is open and clear access to each unit and staff can view and hear the operation of both units." If there is more than one unit on a floor and a physical barrier, a staff person must be present on each unit.

During on-site visits, OIG inspectors went to each unit and floor of each MH RRTP to ascertain whether staff were physically present; and if not, whether programs were utilizing an alternative monitoring mechanism. For non-CWT MH RRTPs, we found staff present on each floor for 97% of MHRRTPs. On floors with more than one unit, staff or an adequate monitoring mechanism (e.g., staff situated between 2 highly visible units) were present on each unit for 95% of programs visited.

At one site, there is a women's program that is housed in a separate building. In the evening staff are placed on the 2nd floor where all bedrooms are located. The building is locked at all times. A camera is positioned to monitor the front door of the first floor. However, the camera/monitor was broken at the time of the OIG visit. Documentation indicated a work order had been placed.

Inspectors also noted a program with units whose layout had several pockets that could not be easily monitored by one health tech. This concern was conveyed to program leadership who reported that health techs had increased the frequency of individual patient checks in order to compensate in part for the physical layout.

Ninety-five percent of non-CWT MH RRTPs had an emergency management policy.

For CWT Programs, veterans are engaged in work programs and not generally present in the residential facility during the daytime. The presence of a staff member on each floor and unit is not a requirement for these programs. In the evening, a staff member or a current or graduate resident ("House Manager") acting as a Without Compensation employee may supervise the residence with professional staff available on an emergency and callback basis.

Conclusion

In the 2009 OIG residential program review, we recommended that 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 addition, we commented that VHA should develop more specific staffing guidance as it pertains to patient supervision by nursing and affiliated staff. The MH RRTP Handbook which published subsequent to the 2009 OIG review includes guidance regarding patient supervision, requires that an employee must be physically present on the unit at all times that Veterans are present, and further specifies that in MH RRTPs with multiple floors or buildings, a staff person must be physically present on each floor in each building. During the present review, 97% of programs visited were found to have a staff member present on each floor. Ninety-five percent of programs with multi-unit floors had presence of staff or alternative monitoring arrangements for each individual unit.

Issue 8: Dispensing of Narcotic Self-Medication

With the shift in delivery of mental health care toward a rehabilitative and recovery model, greater emphasis has been placed on skill development aimed at bolstering patients' capacity for self-care, including self-management of medication regimens. Each MH RRTP must develop a local policy for Safe Medication Management (SMM). The MH RRTP Handbook notes that for each patient, the level of medication management must be assessed as dependent, semi-independent, or independent. Veterans are not to be denied access to an MH RRTP based on dependent or semi-independent status or on prescription of controlled medications.

In terms of SMM, dependent patients (level I) require varying levels of medication supervision including direct involvement of nursing for observing and administering medication as per protocol outlined in VHA Handbook 1108.06, *Inpatient Pharmacy Services*. Semi-independent patients (level II) are able to assume partial responsibility for storage, security, and safe administration of medications. Program staff members provide varying degrees of supervision including periodic review of a patient's safe medication practices, visual counts of a patient's medications, and clinical observation of patient response. Patients assessed as independent (level III) are able to assume complete responsibility for the storage, security, and safe administration of medications.

The MH RRTP Handbook dictates that in the last third of a veteran's length of stay and with at least two consecutive reassessments as independent, the independent veteran may be prescribed up to a 7-day supply of controlled substances for self-administration.[3] The MH RRTP Handbook was released after issuance of our prior review of VHA residential mental health care facilities (2009). The present Handbook procedure limiting self-administration of controlled substances to a 7-day supply during the last third of the residential stay represents a significant change from prevailing procedures in practice at the time of our previous OIG residential program review.

To assess whether programs were dispensing more than a 7-day supply of controlled substances to MH RRTP patients for self-administration, we focused on dispensing of narcotic medications. From our review of medical records, we estimated that 12.4% (CI 7.81-19.16) of patients in the sample that were on a SMM program were on a prescribed narcotic. We estimated that for 94.2% (CI 90.65-96.50) of MH RRTP patients on an SMM program who were prescribed a narcotic, the order was for up to 7 days.

Conclusion

New procedures outlined in the MH RRTP Handbook limit self-administration of controlled substances to a 7-day supply during the last third of a patient's residential stay. We estimated that 94.2% of MH RRTP patients on a safe medication management program prescribed a narcotic, had an order for up to 7 days and 5.8% had an order for more than a 7-day supply. This represents improvement compared with our previous review in which we estimated that 11 percent of VHA residential program patients on a self-medication program and who were prescribed narcotics received more than a 7-day supply of medication. Although MH RRTPs were largely compliant with the relevant internal controls set forth in the MH RRTP Handbook, given the nature of this issue, we would expect to see 100% compliance.

Recommendation 6: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs comply with the MH RRTP Handbook regarding limiting of residential patient self-administration of controlled substances to a 7-day supply during the last third of a patient's anticipated residential program stay.

Issue 9: Documented Orders for Medication Self-Administration

A patient's ability to safely manage medications is to be assessed by a physician, physician's assistant, nurse practitioner, clinical pharmacist, clinical nurse specialist or registered nurse upon admission to a MH RRTP. The patient is assessed at that time for independent, semi-independent, or dependent medication management. The MH RRTP Handbook requires that proper documentation include a progress note along with a

[3] All controlled substances must be administered and recorded by licensed staff, except in CWT-TR programs.

provider's order documented in the patient's medical record by the staff member completing the assessment. SMM is to be incorporated into each patient's individual treatment plan and must be reviewed as part of plan updates.

The assessment includes patient knowledge of medication names, dose, security requirements, reason for taking, common side effects, and evaluation of integration of medications into the patient's lifestyle, possible barriers to compliance and learning, and procedures for requesting a change in regimen.

Based on medical record review, we estimated that a provider's order for a patient to be on SMM was present 61.2% (CI 36.51-81.28) of the time. Table 8 depicts the estimated percentage of MH RRTP patients for which there was presence of a progress note documenting assessment of the patient's ability to safely manage medications.

	Estimated Percentage
Small-Rural	96.4 (CI 92.40-98.29)
Small-Urban	87.3 (CI 78.67-92.77)
Medium-Rural	88.9 (CI 68.20-96.78)
Medium-Urban	91.6 (CI 74.18-97.67)
Large-Rural	95.2 (CI 90.80-97.52)
Large-Urban	41.3 (CI 6.00-88.58)

Table 8. Percentage estimates of MH RRTP patients for whom there was presence of a progress note documenting assessment of the patient's ability to safely manage medications by program size and urban-rural status.

A statistically significant difference is noted comparing the relatively low estimated percentage for MH RRTP patients in large-urban programs to the relatively high percentage estimated for MH RRTP patients in large-rural programs.

Conclusion

The MH RRTP Handbook states that proper documentation regarding assessment of a patient's ability to safely manage medications (independent, semi-independent, dependent) includes a progress note along with a provider's order. We estimated the presence of a related provider's order for 61.2% of MH RRTP patients. This represents mild to moderate improvement compared to 45% noted during our 2009 review. We estimated presence of a relevant progress note for 41.3-96.4% of MH RRTP patients depending on program size and urban-rural status. Excluding large-urban programs presence of a progress note documenting assessment of the patient's ability to safely

manage medications was moderately improved compared to an overall composite rate of 82% found during our 2009 review.

Recommendation 7: We recommended that the Under Secretary for Health ensure that VISN Directors ensure documentation of a provider's order and clinical note related to MH RRTP assessment for safe medication management.

Issue 10: Tracking and Management of Missed Appointments

During the 2009 OIG residential program review, we found significant variation in how and to what extent residential programs monitor and re-schedule missed appointments.

For the present review, we ascertained on-site whether programs had a policy and/or mechanism in place to monitor for and to re-schedule missed patient appointments. Capturing and addressing missed appointments facilitates treatment adherence and continuity and may help optimize benefit derived by patients participating in an MH RRTP.

We reviewed formal missed appointment policy documents (if existent) and discussed with staff mechanisms by which missed appointments are captured and addressed. Eighty-two percent of programs had either a formal documented policy regarding missed appointments or a consistent informal mechanism (e.g., daily log followed by documentation in a medical record progress note).

Conclusion

Eighty-two percent of programs visited had either a formal written policy or articulated a consistent informal practice for capturing and addressing missed appointments. The extent and mechanism by which MH RRTPs capture and address missed appointments appears variable and inconsistent across sites.

Issue 11: Housing and Occupational Status at Discharge

The MH RRTP Handbook specifies that type of housing and employment status at discharge should be among a list of items (e.g., reason for admission, pending appointments, status of goals) included in MH RRTP discharge summary note. During the medical record review for the present inspection, we looked at housing arrangement and vocational status documented at the time of discharge. The following descriptive results are provided for informational purposes. Figure 2 depicts estimated the post-discharge housing arrangement by relative percentage for MH RRTP patients based on the 816 patients for whom we could find documentation of post-discharge status. For clarification, patients in MH RRTPs transitioning to another MH RRTP on discharge are categorized in figure 2 as temporarily residing in an MH RRTP on discharge from the

first program. These patients would ultimately have other housing arrangements after discharge from the 2nd MH RRTP program.

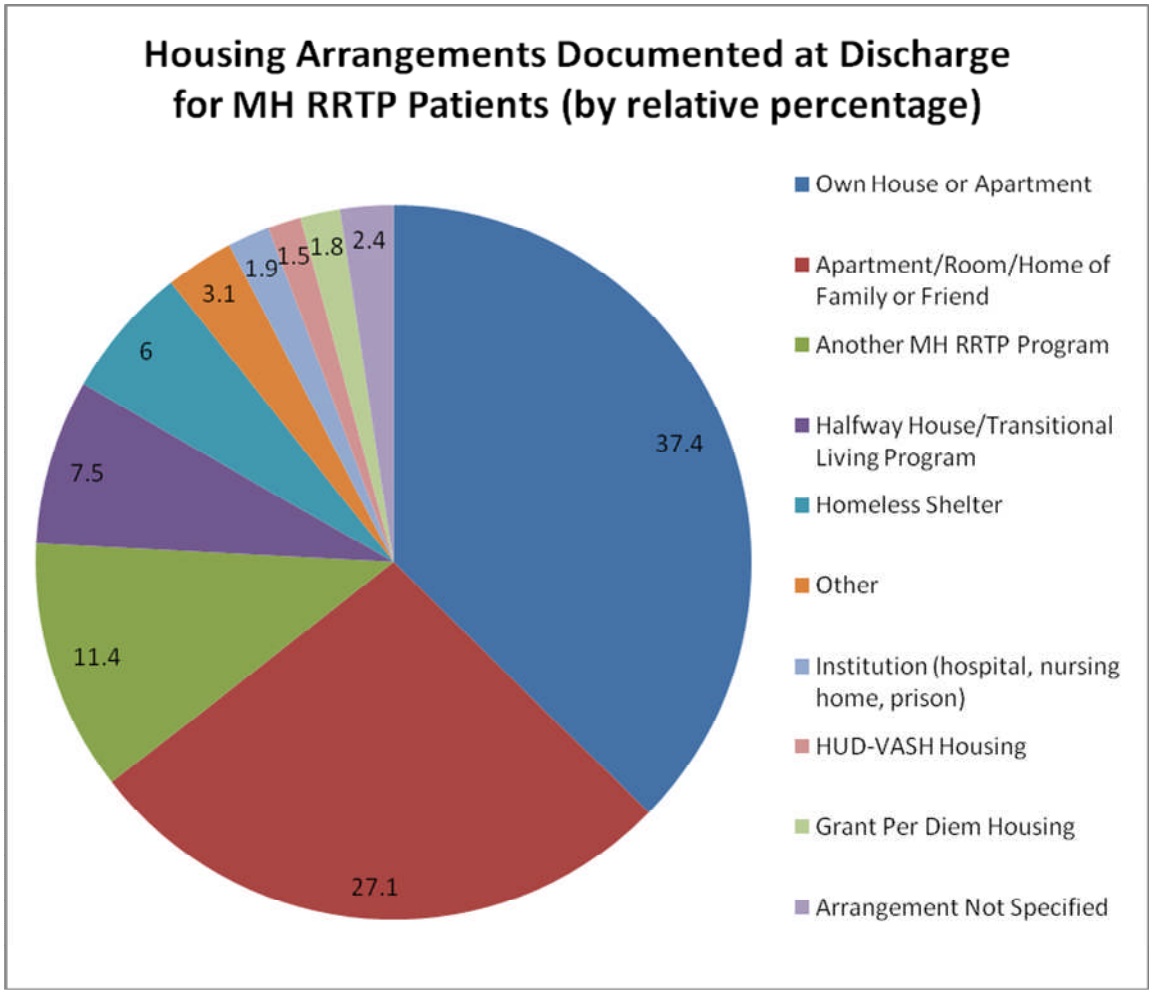


Figure 2. Estimated post-discharge housing arrangements for MH RRTP patients based on 816 patients for whom their was documentation of housing status at discharge.

Figure 3 depicts the estimated vocational status for MH RRTP patients based on the 699 patients for whom we could find documentation at discharge.

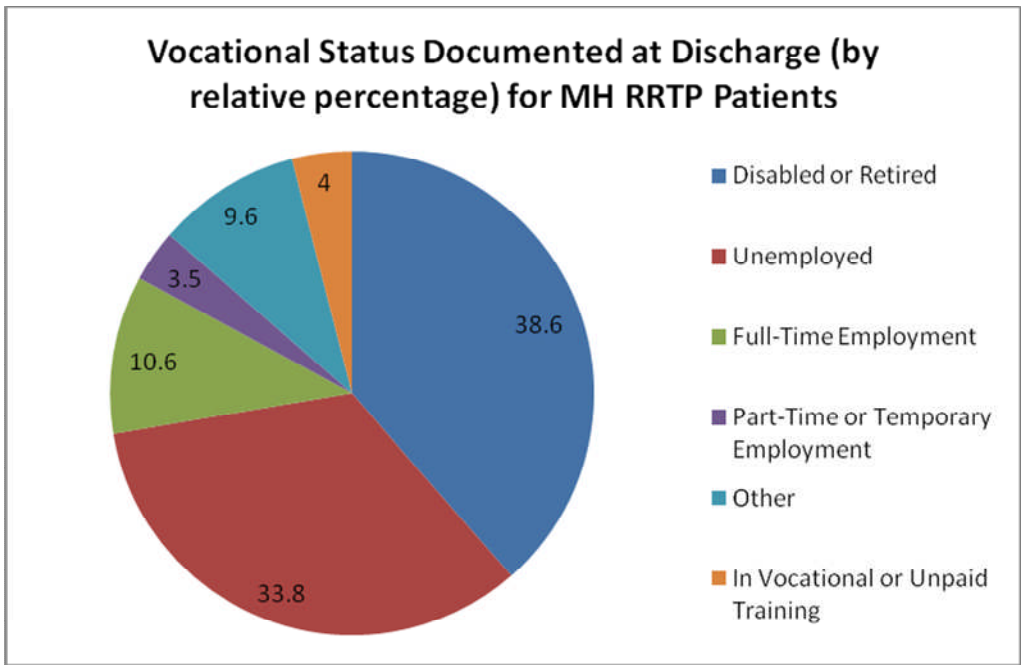


Figure 3. Estimated vocational status at discharge for MH RRTP patients based on 699 patients for whom it was documented.

Conclusion

Based on our sample of patients for who post-discharge housing arrangements were documented in the medical record, we estimated that approximately 37.4% were returning to their own apartment or house and approximately 27.1% were planning to live at the residence of a family member or friend. Approximately 11.4% of MH RRTP patients were transitioning to starting another MH RRTP (e.g., from a substance use focused program to a PTSD focused program). We estimated that 14.1% of MH RRTP patients were employed full-time, part-time or temporarily at the time of discharge.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2011

From: Under Secretary for Health (10)

Subject: Healthcare Inspection – A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the Office of Inspector General (OIG) draft report, and I concur with its recommendations and findings. Providing Veterans with effective residential rehabilitation and treatment is an important component of the Veterans Health Administration's (VHA) continuum of mental health care.

2. As an organization, VHA has worked diligently to provide a consistently high level of residential rehabilitation and treatment for all Veterans. I am pleased with the significant improvements that the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) have made since OIG last reviewed these programs. However, this report provides useful insight into areas of residential rehabilitation and treatment that can be further improved.

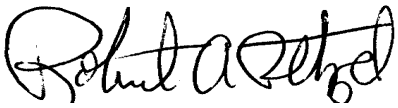
3. As part of this continuous effort, in 2007, the National Leadership Board-Health Systems Committee charged VHA's Office of Mental Health Services (OMHS) with the task of reviewing the current status of care delivery in MH RRTPs in order to improve and enhance services to Veterans. Subsequently, OMHS 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. In May 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. The Handbook was further amended in December 2010 to address issues identified in OIG's

initial MH RRTP report dated June 25, 2009. This Handbook was distributed to the field earlier this year for immediate implementation.

4. In addition, Mathematica Policy Research, Inc., a nationally recognized leader in independent, objective policy research and health care quality improvement, is currently conducting follow-up site visits to MH RRTPs to assess, evaluate and provide consultation on the implementation of the VHA MH RRTP Handbook. A final report is expected in September 2011.

The purpose of this survey is to identify MH RRTPs that need further development to meet policy requirements. Medical centers are required to submit action plans for each item identified by Mathematica that is not in compliance with the VHA MH RRTP Handbook requirements. VHA's Office of Mental Health Operations and OMHS will collaborate to ensure that there is a plan for implementation and progress monitoring in place at each site, as needed.

5. Thank you for the opportunity to review the draft. An action plan to implement the report recommendations is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.



Robert A. Petzel, M.D.

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:

OIG Recommendations

Recommendation 1: We recommended that the Under Secretary for Health ensure that VISN Directors ensure contact between MH RRTP staff and/or engagement in MH treatment for patients in the interim between their acceptance into and actual participation in a MH RRTP.

VHA Comments

Concur

The Office of Inspector General (OIG) review found that 73 percent of Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) were in contact with Veterans that had more than a 7- day gap between screening and admission. To improve in this effort, the Veterans Health Administration's (VHA) Office of Mental Health Services (OMHS) and Office of Mental Health Operations (OMHO) will review and clarify guidelines regarding contact with Veterans waiting for MH RRTP admission on national conference calls with both MH RRTP program managers, and Veterans Integrated Service Network (VISN) and medical center leadership regarding contact with Veterans waiting for admission into a MH RRTP. The message of these national conference calls will emphasize the need for contact between MH RRTP staff and/or engagement in mental treatment for patients awaiting admission and system-wide documentation of such contacts.

In Process September 30, 2011

Recommendation 2: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs document a medical screening prior to MH RRTP admission.

VHA Comments

Concur

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), requires that 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.

OIG found that 96 percent of medical records reviewed had a screening note and 89 percent documented a medical screening prior to admission to the MH RRTP. VHA's OMHS and OMHO will review and clarify guidelines regarding medical screening requirements on national conference calls with MH RRTP program managers and VISN and medical center leadership on national conference calls. The message of these national conference calls will emphasize system-wide documentation of medical screenings prior to a Veterans' admission into a MH RRTP.

In Process September 30, 2011

Recommendation 3: We recommended that the Under Secretary for Health ensure that VISN Directors review whether MH RRTP patients assessed as having occupational dysfunction are referred to vocational rehabilitation when indicated and desired by the patient.

VHA Comments

Concur

The OIG review found that 93 percent of medical records reviewed had an assessment for Occupational Dysfunction and that 59 percent of the Veterans were referred for vocational rehabilitation services. VHA's OMHS and OMHO will review VHA guidelines regarding Occupational Dysfunction requirements on national conference calls with MH RRTP program managers and with VISN and medical center leadership. Discussion during these calls will emphasize VHA's requirement that MH RRTP patients assessed with occupational dysfunction be referred to vocational rehabilitation when indicated and desired by the patient.

In Process September 30, 2011

Recommendation 4: We recommended that the Under Secretary for Health ensure that OMHS examines barriers to provision of weekend programming and provides further guidance to MH RRTPs regarding programmatic expectations during the weekend.

VHA Comments

Concur

The OIG review found that 95 percent of the MH RRTPs provide the minimum number of programming hours on weekdays, but only 70 percent of the programs met this requirement on weekends. A review of 2009 and 2010 Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation surveys of MH RRTP found that approximately 10 percent of programs did not meet this standard.

VHA's OMHS will develop a list of MH RRTPs that were cited by CARF for not meeting this requirement and review and clarify guidelines and identify barriers on national conference calls with MH RRTP program managers. The VHA OMHO will review and clarify guidelines regarding 7 days per week, 4 hours per day of treatment and rehabilitation services on national conference calls with VISN and medical center leadership.

In Process September 30, 2011

Recommendation 5: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs meet or exceed VHA's minimum core staffing requirements.

VHA Comments

Concur

Appendix A of the MHRRTP Handbook includes staffing guidelines that outline minimum core staffing, specialty bed section staffing requirements, and include discipline, full-time equivalent, and staff to bed ratio.

VHA OMHS will review VHA's recommended minimum staffing requirements on national conference calls with MH RRTP program managers to ensure that MHRRTPs are in compliance. The VHA OMHO will review the requirement to meet or exceed the core minimum staffing requirements on national conference calls with VISN and medical center leadership and will review the process for making adjustments to the core minimum staff for MH RRTPs. Each medical center operating an MH RRTP will be required to submit a local written staffing plan as outlined in the MH RRTP Handbook. The staffing plan will outline the core minimum staffing required and note the current full-time equivalent employees (FTEE) by discipline assigned to the unit. The staffing plan will be reviewed and approved by the medical center and VISN Directors and

include an action plan to address any staffing gaps in meeting or exceeding the core minimum staffing requirements.

In Process September 30, 2011

Recommendation 6: We recommended that the Under Secretary for Health ensure that VISN Directors ensure that MH RRTPs comply with the MH RRTP Handbook regarding limiting of residential patient self-administration of controlled substances to a 7-day supply during the last third of a patient's anticipated residential program stay.

VHA Comments

Concur

The OIG review found 94 percent of MH RRTP patients on a safe medication management program prescribed a narcotic, had an order for less than 7 days and 6 percent had an order for more than a 7-day supply. Although MH RRTPs were largely compliant with the relevant internal controls set forth in the

MH RRTP Handbook, given the nature of this issue, OIG is recommending VHA continue to work for 100 percent compliance.

VHA's OMHS and OMHO will review and clarify guidelines regarding limiting controlled medication to a 7-day supply on national conference calls with

MH RRTP program managers, and VISN and medical center leadership to ensure safe medication management.

In Process September 30, 2011

Recommendation 7: We recommended that the Under Secretary for Health ensure that VISN Directors ensure documentation of a provider's order and clinical note related to MH RRTP assessment for safe medication management.

VHA Comments

Concur

On national conference calls with MH RRTP program managers and VISN and medical center leadership, VHA's OMHS and OMHO will review and clarify guidelines regarding the required proper documentation of a provider's order and clinical note related to MH RRTP assessment for safe medication management.

In Process September 30, 2011

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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Appendix C

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