

## DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT PROGRAM

- 1. PURPOSE.** This Veterans Health Administration (VHA) Handbook establishes procedures for the Domiciliary Residential Rehabilitation and Treatment Program (DRRTP).
- 2. SUMMARY OF CHANGES.** This is a new handbook establishing the administrative procedures for the DRRTP.
- 3. RELATED ISSUES.** VHA Directive 1162 (to be published).
- 4. FOLLOW-UP RESPONSIBILITY.** The Office of Mental Health Services (116), Homeless and Residential Rehabilitation and Treatment Services, is responsible for the contents of this handbook. Questions may be directed to the Associate Chief Consultant, Homeless and Residential Rehabilitation Treatment Services at (202) 273-8446.
- 5. RESCISSIONS.** Manual M-5, Part IV, dated December 6, 1999, is rescinded.
- 6. RE-CERTIFICATION.** This VHA handbook is scheduled for re-certification on or before the last working day of April 2011.

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## **DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT PROGRAM PROCEDURAL HANDBOOK**

### **1. PURPOSE**

This Veterans Health Administration (VHA) handbook converts and updates procedures, and standards regarding Department of Veterans Affairs (VA) Domiciliary Residential Rehabilitation and Treatment Program (DRRTP) activities.

### **2. BACKGROUND**

a. The Domiciliary Care Program is VA's oldest health care program. Initiated through legislation passed in the late 1860's, the Domiciliary's purpose was to provide a home for disabled volunteer soldiers of the Civil War. Domiciliary care was initially established to provide services to economically disadvantaged veterans, and it remains committed to serving that group. The Domiciliary has evolved from a "soldiers' home" to become an active clinical rehabilitation and treatment program for male and female veterans. Domiciliary care is an integral component of VHA's continuum of health care services.

b. The DRRTP mission is to provide coordinated, integrated, rehabilitative, and restorative clinical care in a bed-based program with the goal of helping eligible veterans achieve and maintain the highest level of functioning and independence possible. Domiciliary care, as an integral component of VHA's continuum of health care services, is committed to providing the highest quality of clinical care in a coordinated, integrated fashion within that continuum.

c. DRRTP provides a type of care without which veterans could be forced into inappropriately intensive and expensive care, receive fragmented or inadequate care, or go entirely without needed care.

d. In 2005, DRRTP became fully integrated with other residential rehabilitation and treatment programs of the Office of Mental Health Services. These residential care programs include Compensated Work Therapy –Transitional Residence Programs (CWT-TRs), Psychiatric Residential Rehabilitation and Treatment Programs (PRRTPs), and VA's Homeless Providers Grant Per Diem Program (GPD). With DRRTP now located with the Office of Mental Health Services, it is expected that recovery-based programming will be developed or expanded to address the needs of male and female veterans with serious mental illness.

### **3. DEFINITION OF THE DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT PROGRAM**

DRRTP provides residential rehabilitative and clinical care to eligible veterans who have a wide range of problems, illnesses, or rehabilitative care needs which can be medical, psychiatric, vocational, educational, or social.

#### **4. CHARACTERISTICS OF DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT**

Historically, DRRTP has provided a range of psychosocial rehabilitation services to veterans with mental health, substance abuse, and medical problems to improve their functional abilities. DRRTP has the following characteristics; it:

- a. Provides clinical care in a supportive, therapeutic milieu which fosters veterans' functional independence and mutual support. The peer community is used in a conscious, purposeful manner to facilitate social, psychological, and behavioral change.
- b. Offers care by a DRRTP interdisciplinary team(s) that coordinates and integrates services with the medical center and community resources.
- c. Includes all resources involved in the veteran's care, and includes the veteran in developing, integrating, and coordinating a comprehensive and individualized treatment plan. This plan includes the veteran's goals, strengths, needs, abilities, and preferences.
- d. Utilizes multiple therapeutic and rehabilitative activities that are designed to produce positive outcomes in the goals of the veterans served.
- e. Offers the potential for treatment and rehabilitation to veterans with a wide-range of problems, illnesses, and areas of dysfunction in an atmosphere which is safe, secure, and homelike.
- f. Ensures that veterans' mental health, substance abuse, medical, educational, vocational, and social needs are identified and addressed appropriately.
- g. Provides optimal opportunities for veterans to participate in medical center and community activities to foster independence.
- h. Ensures that discharge planning takes place in a timely manner and that follow-up care and access to medical center and community supports are facilitated.
- i. Differs from hospital or nursing home level of care as veterans in DRRTP do not require bedside nursing care and generally are capable of self-care.

#### **5. ESTABLISHMENT OF A DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT PROGRAM (DRRTP)**

a. A proposal to establish DRRTP care at a given site, whether by new construction, re-designation, and/or conversion of existing space, must be submitted to, and approved by, the Director of Residential Rehabilitation and Treatment Services, Office of Mental Health Services, in conformance with VHA Directive 1000.1 and VHA Handbook 1000.1. A proposal to establish Domiciliary Care at a site must include plans to ensure compliance with standards as identified in current VHA policy. Under usual circumstances, forty beds are considered the

minimum size for any DRRTP. **NOTE:** *Fewer than forty beds are not considered to be cost-effective based on the need for certain core staffing. Proposals for smaller Domiciliaries will be considered and evaluated according to reasonable clinical rationale and the apparent ability to provide effective, efficient care within the context of the clinical model, resources, and other proposed parameters.*

b. The feasibility of renovation, re-designation, and/or conversion of unused or under-utilized inpatient care beds and/or buildings to a Domiciliary Residential Rehabilitation and Treatment facility must be fully explored. Proposals for new construction may be made only if the potential for renovation or redesign is not available at a lower cost.

**NOTE:** *Proposals for new construction must adhere to the requirements in VA Handbook 7610 (312).*

c. All proposals are required to:

(1) Identify veteran populations to be served. Demographic and other population changes having implications for DRRTP need to be recognized and addressed. For example, increasing numbers of veterans needing and receiving care in these programs for psychiatric and substance dependence problems must be acknowledged, as should the growing need for programs addressing issues pertinent to the frail elderly and to women.

(2) Plan programs to meet identified needs.

(3) Include plans for integration of medical, psychiatric, substance abuse, and dental care.

(4) Include plans for serving special populations such as women veterans, seriously mentally ill, substance abusers, and the chronically homeless.

(5) Include staffing levels and patterns.

(6) Identify resources needed to achieve the desired goals and objectives to accommodate both male and female veterans on-site or in the community.

(7) Include start-up and recurring costs.

(8) Identify the space that will be utilized.

d. All proposals must recognize the paramount importance of creating DRRTPs that emphasize the provision of care in a safe, secure, and sober environment. Accordingly, attention must be paid to issues of facility security, control of veteran and non-veteran ingress and egress, infection control, disaster plans, procedures for the detection of weapons, drug and alcohol use, and the provision of appropriate medical care.

e. Plans must include effective communications systems to ensure that assistance can be immediately sought and readily provided in case of emergency. Such systems must be attentive

to both personnel (numbers, types, proximity of staff or other support personnel) and technological issues (reliable means to communicate, even in extreme circumstances).

f. All proposals need to address academic affiliations, as well as any prospective roles of DRRTTP, or any associated medical center staff, in training, education, and research.

g. All proposals for the creation of DRRTTPs that include Domiciliary Care for Homeless Veterans (DCHV) Programs, or proposals for the establishment of a DCHV Program within an existing DRRTTP (see par. 18), must support and complement other VA initiatives targeted to homeless veteran populations and must be integrated with existing coalitions of public agencies and volunteer organizations working with the homeless.

## 6. RESPONSIBILITIES

a. **Director, Residential Rehabilitation and Treatment Programs, Office of Mental Health Services.** The Director of Residential Rehabilitation and Treatment Programs is responsible for:

- (1) Directing and overseeing DRRTTPs nationally.
- (2) Chairing and leading the Domiciliary Field Advisory Board (DFAB) in all of their activities.
- (3) Assisting facilities with recruitment of qualified candidates for leadership of DRRTTPs.
- (4) Assigning a mentor for the appointed Chief, DRRTTP, drawn from a pool of experienced DRRTTP Chiefs.

b. **DFAB.** DFAB, appointed by the Under Secretary of Health, works collaboratively with the VHA Central Office program office to:

- (1) Implement the recommendations of the Office of the Medical Inspector (OMI) and Patient Care Service (PCS), National Task Force reports, and other activities related to DRRTTP.
- (2) Monitor DRRTTPs to ensure:
  - (a) Quality of care,
  - (b) Compliance of programs with standards in this Handbook,
  - (c) Clinical alignment of programming with current clinical evidence, and
  - (d) Safety and security.
- (3) Provide mentoring and education for DRRTTP Chiefs.

c. **Veterans Integrated Services Network (VISN) Director.** The VISN Director is responsible for compliance with all standards in this handbook by all DRRTPs in the VISN.

d. **Medical Center Director.** The medical center Director is responsible for appointing a Chief, DRRTP, responsible for the efficient, effective operation of all aspects of the program. Chiefs must be drawn from the ranks of established clinical disciplines; specifically, physicians, psychologists, social workers, nurses, or physician assistants.

e. **Chief, DRRTP.** The Chief, DRRTP is responsible for all aspects of a comprehensive program of clinical care and for the efficient, effective operation of the domiciliary including:

(1) Completing, within the first year of assignment, the Training Program established by the Director of Residential Rehabilitation and Treatment Programs.

(2) Implementing, integrating, and coordinating a full range of therapeutic and rehabilitative programs to provide effective and efficient services.

(3) Selecting and assigning staff in accordance with the needs of the veterans and respective programs.

(4) Defining programmatic and clinical competencies, in conjunction with respective clinical discipline leaders, for all staff and:

(a) Establishing procedures for assessing those competencies, and

(b) Ensuring the remediation of any failure by staff to fully attain all minimum competencies.

(5) Clearly defining program missions so that they are consistent with the overall DRRTP mission.

(6) Ensuring that DRRTP emphasizes veteran mutual respect and support, as exemplified by the Therapeutic Community model.

(7) Ensuring that DRRTP is responsive to local need, circumstances, and resources.

(8) Providing quality care in a safe environment.

(9) Ensuring that the broadest possible definition of Domiciliary Residential Rehabilitation and Treatment is applied and that veterans who are eligible and appropriate for Domiciliary Residential Rehabilitation and Treatment care are not excluded.

(10) Ensuring that all programs provide comprehensive, integrated, and coordinated clinical care utilizing an interdisciplinary team model.

(11) Establishing procedures for the ongoing monitoring and evaluation of the effectiveness of all program activities.

- (12) Conducting staff performance appraisals if appropriate.

## 7. TYPES OF DOMICILIARY RESIDENTIAL REHABILITATION AND TREATMENT PROGRAMS

- a. A wide variety of services addressing a broad range of problems can be appropriate for the Domiciliary Residential Rehabilitation and Treatment setting which is ideal for creative and flexible programming. It is not limited by specific diagnoses or specific classes or groups of diagnoses.

- b. Although the goal for each veteran is a return to the community, admission need not be restricted based on the anticipated duration of the need for care.

- (1) Any programs, areas of particular programmatic emphasis, or specialized approaches to care must be designed:

- (a) Within the framework of overall Domiciliary Residential Rehabilitation and Treatment care, and

- (b) For effective coordination with other programs and services, both within and outside the Domiciliary.

- (2) The ultimate goal is the effective and efficient coordination and integration of services. While being able to serve a broad range of veterans, Domiciliary Residential Rehabilitation and Treatment generally does not include 24-hour nursing care. *NOTE: However, this is to be determined by the needs of the residents served.*

- (3) Admission only for housing or shelter does not fall within the definition of Domiciliary Residential Rehabilitation and Treatment.

*NOTE: Lodging of veterans where admission is not planned, or the establishment of Hoptel beds within or in close proximity to domiciliary beds, is not recommended.*

- c. Conceptually, bio-psychosocial rehabilitation and health maintenance are the two types of care offered in Domiciliary Residential Rehabilitation and Treatment.

- (1) **Bio-psychosocial Rehabilitation.** Bio-psychosocial rehabilitation consists of those clinical interventions and services rendered with the purpose of effecting, to the extent possible, remediation of medical, psychological, social, educational, and vocational impairments essential to improving health and restoring the veteran to a level of independent functioning and self-care. Bio-psychosocial rehabilitation may be appropriate for veterans with a wide variety and diverse patterns of rehabilitation needs including, but not limited to, homeless veterans (see par. 18).

*NOTE: Congress has recognized a need to care for homeless veterans and to ameliorate the causes of their homelessness. All Domiciliary models are considered appropriate for the provision of care to homeless veterans (see par. 18).*

(2) **Health Maintenance.** Health Maintenance consists of those clinical interventions and services required to prevent or delay, to the extent possible, deterioration in functional and/or health status. Health maintenance may be short or long term, depending on the veteran's clinical status and need, and expected clinical course.

d. In both types of care, interdisciplinary Domiciliary Residential Rehabilitation and Treatment teams use clinical interventions to build on the strengths of the veteran, enhance quality of life experiences, maximize potential for independent functioning, and return the veteran to living in the community.

## 8. REQUIRED PROGRAM ELEMENTS

DRRTPs, and programs within them, may vary considerably in terms of which services are provided within the Domiciliary and which are provided to domiciliary veterans elsewhere in the medical center (or even outside the medical center). Certain basic or minimum standards apply to Domiciliary Residential Rehabilitation and Treatment care in all instances; they are clinical programs and must utilize a broad range of therapeutic and rehabilitative modalities, clinical disciplines, and experience. Program activities must include, but not necessarily be limited to:

a. **Outreach.** Outreach is the identification and development of effective linkages between Domiciliary Residential Rehabilitation and Treatment staff, medical center personnel, other VA resources, and community-based services and programs.

b. **Screening.** Screening is the evaluation of veterans for appropriateness for Domiciliary Residential Rehabilitation and Treatment care (see subpar. 10a).

c. **Treatment and/or Rehabilitative Services.** Treatment and/or rehabilitative services are the provision of clinical services and are intended to help the veteran achieve the highest possible level of functioning and independence (see par. 13).

d. **Discharge Planning and/or Implementation.** Discharge planning and/or implementation requires the coordination and utilization of VA and community-based social and health support services, housing, employment, education and training, and financial resources.

e. **Aftercare.** Aftercare is ensuring provision of Domiciliary Program and other VA and community resources to veterans after discharge from Domiciliary Residential Rehabilitation and Treatment care to promote successful community adaptation.

## 9. PROGRAM STAFFING

DRRTP, as a defined clinical care entity, must have adequate staffing to provide safe, reasonable, and appropriate clinical care.

a. Each DRRTP must be staffed by an interdisciplinary clinical team or teams of health care professionals. Appropriate supporting administrative and clerical staff must be provided to allow for efficient operation.

b. Exact staffing patterns are determined by the Chief, DRRTP, based on:

(1) An analysis of the veteran populations served and their defined needs;

(2) Strategic planning considerations;

(3) Standards established by the relevant accrediting bodies; and

(4) Consultation from the senior member of each respective clinical discipline involved in staffing DRRTP.

c. Staffing patterns and numbers must ensure the safety of the veteran and adequate clinical care. At a minimum, attention to the veteran's medical, social, and psychological needs must be ensured through adequate medical (physicians, physician extenders, nurses), social (social workers), and psychological (psychologists) staffing.

d. Staffing must be sufficient to provide appropriate clinical coverage 24 hours-per-day, 7 days-per-week. Minimum staffing needs to consist of at least one clinical staff at all times in each building, including night shifts. When DRRTP units are housed in more than one building, the level of staffing must be maintained in each building. Staffing for all positions must be adequate to allow coverage, even in times of staff shortage and/or absence.

e. To ensure adequate care, the overall clinical staff-patient ratio must be at least 1:5 for health maintenance programs and 1:3 for bio-psychosocial rehabilitation programs. These staff-patient ratios must involve Full-time Equivalent (FTE) employees assigned to DRRTP.

f. To provide a full range of clinical services, it is necessary to utilize services and providers outside the Domiciliary, and from within and outside of the medical center. For veterans to benefit maximally from the full continuum of care, it is necessary to establish effective and efficient working relationships with these other providers and to have an individualized treatment plan that carefully delineates the integration of planned care.

## 10. PATIENT SELECTION AND ADMISSION

### a. Screening

(1) Policies, procedures, guidelines, and selection criteria must be established to ensure that all applicants for Domiciliary Residential Rehabilitation and Treatment are adequately screened using established veteran selection guidelines and criteria. To prevent delays in access to care, screening must be conducted daily on normal business days.

(a) Veterans may apply directly for Domiciliary Residential Rehabilitation and Treatment or be referred from other programs, both within and outside of VHA.

(b) Direct applicants and veterans applying and/or being referred from programs outside of VHA must be evaluated for appropriateness for admission by DRRTP designated staff.

(c) At the discretion of the Chief, Domiciliary Residential Rehabilitation and Treatment, this screening function may be delegated to the referring program and/or facility. Screening must be conducted in such a manner as to ensure that no veteran is admitted without genuine clinical need(s) and that Domiciliary Residential Rehabilitation and Treatment and/or other resources are adequate to address the identified need(s).

(2) Screening must be inclusive (i.e., when there is doubt as to whether applicants are able to benefit from Domiciliary Residential Rehabilitation and Treatment), the applicants will be given the benefit of the doubt and accepted for care, provided there is no significant associated risk of harm to the applicant, others, or the program. Under no circumstances will veterans be admitted to DRRTP solely for the purpose of shelter or housing. Under no circumstances will veterans be denied admission based on gender. The Chief, DRRTP, is the determining authority for appropriateness for admission to the program.

(a) Eligibility of individual veterans for Domiciliary Residential Rehabilitation and Treatment is determined according to current VHA standards (see Title 38 Code of Federal Regulations (CFR) 17.46, 17.47, and 17.48).

(b) The following issues must be considered when assessing a veteran's ability to benefit from DRRTP care:

1. The veteran's interest in participating in a comprehensive psychosocial rehabilitation program designed around personal goals to improve the quality of the veteran's life.

2. The need to attain the knowledge and skills necessary to restore or achieve appropriate functional independence.

3. The need for ongoing mental health, substance abuse, and/or medical treatment to enhance stability and well-being.

4. The willingness to participate in a supportive, therapeutic community, focused on recovery and empowerment.

5. The ability to accomplish the activities of daily living (ADL) with minimal assistance, which can include the use of a wheelchair or other assistive devices.

6. The ability to reside in a communal setting, without posing a risk or danger to self or others.

(c) Veterans screened and accepted for care must be provided information about the circumstances, expectations, and limitations of DRRTP to which they are to be admitted, in advance of their admission, to enable them to make an informed choice and to participate in the establishment of a treatment or rehabilitation agreement.

(d) Veterans not accepted for care must be provided information as to the reasons for non-acceptance, and these reasons must be appropriately documented in the veteran's health care

record. For veterans who are not accepted, alternative sources of care must be explored and appropriate referrals made to ensure that needed care is provided.

(e) Veterans accepted for care must be given a tentative admission date. Admissions must be scheduled in the most expeditious manner possible.

1. As a general rule, veterans are admitted to the program in the order in which they were screened and/or accepted. Exceptions to this may be made for overriding clinical or other extenuating circumstances at the discretion of the Chief, DRRTP, with appropriate documentation.

2. At either screening or admission, the veteran's strengths, needs, abilities, and interests must be explored within the process of encouraging the veteran to establish goals. General information and rules must be reviewed with the veteran to ensure that the veteran is fully aware of rights, responsibilities, and any restrictions imposed by the program.

## 11. SPECIAL POPULATIONS

It is expected that all DRRTPs will serve special populations including frail elderly veterans, veterans with serious mental illness, veterans who are chronically homeless, veterans with substance abuse problems, veterans with post-traumatic stress disorder, and women veterans. Rehabilitation and Treatment services provided to these veterans must be structured to address their special needs. *NOTE: Coordination of care and linkages with other mental health or primary care resources is essential to ensure good care and a seamless system of care for special populations.*

## 12. INTERDISCIPLINARY PATIENT ASSESSMENT

All veterans admitted to a DRRTP must receive a thorough, comprehensive, interdisciplinary assessment. This assessment may be conducted in a variety of ways, but must include certain basic elements, and address other areas not specified as clinically indicated. The results of the assessment must be integrated into an Assessment Summary. The assessments, and especially the Integrated Assessment Summary, serve as the basis for creating the plan of treatment and/or rehabilitation.

a. **Initial Medical Clearance.** 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 Domiciliary Residential Rehabilitation and Treatment and indicates areas of ongoing treatment and potentially urgent medical needs. The screening must be documented in the veteran's medical record. A written order is required to admit the veteran to DRRTP.

b. **Full Assessment.** Once a veteran has been admitted to the program, a full assessment of the individual must be performed. Those assessments consist of the following:

(1) **History and Physical Examination.** A complete history and physical examination

by a physician or qualified health care provider must be completed within 7 working days of admission, unless the veteran has a documented current (within the previous 30 days) examination. The history and physical examination must be repeated annually. The history and physical examination must address any physical findings or medical problems that have an impact on the veteran's treatment. It must include, but not be limited to, the following:

- (a) Any history of physical abuse or military sexual trauma.
- (b) Infection and communicable diseases, specifically to include the tuberculin skin test or chest x-ray, as indicated.
- (c) Use of alcohol and/or other drugs (including the age of onset, duration, patterns, and consequences of use).
- (d) Types of responses to previous treatment.
- (e) Diagnostic testing, including invasive and non-invasive diagnostic and imaging procedures.
- (f) Identification of psychiatric issues which may require further assessment by Mental Health Service.
- (g) Age appropriate preventive medical screening, such as mammograms, Pap smears, bone mineral density, etc.

(2) **Nursing Assessment.** This needs to be done within 24 hours of admission. The assessment is to include, but is not limited to, the following:

- (a) Height;
- (b) Weight;
- (c) Vital signs, including pain assessment;
- (d) A functional assessment, including ADLs;
- (e) The potential risk for falls;
- (f) The need for medication;
- (g) The ability to self-administer medications, including any limitations, special circumstances, or individual requirements; and
- (h) An evaluation of high-risk behaviors.

(3) **Assessment of Current Emotional and Behavioral Functioning.** The assessment of current emotional and behavioral functioning must be completed within 14 days of admission. The assessment must include, but is not limited to, the following:

- (a) Current emotional and behavioral functioning, including the level of anxiety or fear;
- (b) Maladaptive problem behaviors;
- (c) Circumstances surrounding the current admission;
- (d) A mental status exam, if indicated;
- (e) A statement reflecting competency to handle funds, if indicated;
- (f) Psychological assessments including intellectual, neuropsychological, and personality testing, if indicated; and
- (g) A psychiatric evaluation by a psychiatrist, if indicated.

(4) **Psychosocial Assessment.** A psychosocial assessment must be completed within 14 days of admission; this assessment must include, but is not limited to, the following:

- (a) History of emotional, behavioral, and substance abuse problems;
- (b) Environment and home;
- (c) Use of alcohol and drugs by other family members;
- (d) Leisure and recreation;
- (e) Religion;
- (f) Childhood history;
- (g) Military service history, including any major stressors, illnesses, environmental exposures, or trauma;
- (h) Financial status;
- (i) Social, peer group, and environmental setting from which the individual comes;
- (j) Sexual history;
- (k) Individual's family circumstances;
- (l) Legal issues;

- (m) History of physical or emotional abuse; and
- (n) History of military sexual trauma, if any.

(5) **Vocational and Educational Screening.** Vocational and educational screening with subsequent full assessment when indicated.

(6) **Recreational Screening.** Recreational screening with subsequent full assessment when indicated.

(7) **Additional Screens.** Additional screens with subsequent full assessment when indicated. When an initial screen indicates the need for full assessment, action must be taken to complete the assessment within seven days of the completion of the initial interdisciplinary assessment. These include, but are not limited to, the following:

- (a) Nutritional and/or dietary;
- (b) Spiritual;
- (c) Dental; and

(d) Other areas of more detailed assessment as indicated by the initial multi-disciplinary assessment or subsequent clinical developments or findings.

### 13. TREATMENT PLANNING

A comprehensive plan of treatment, rehabilitation, and/or health maintenance must be developed and documented for each veteran and must be based on the results of the comprehensive interdisciplinary assessment and the resultant Integrated Assessment Summary. The veteran must be an active participant in the process. The plan is to be completed within two weeks of admission. A veteran admitted to a DRRTP with a treatment plan developed in another VHA program must have that plan reviewed and revised as necessary within two weeks of admission. *NOTE: More restrictive timeframes may be established by local policy for any of the preceding, based on local program parameters.* Each plan must show evidence of:

- a. Interdisciplinary input;
- b. The opportunity for the veteran to participate maximally in decisions that affect treatment and rehabilitation;
- c. Individualization of care;
- d. Planning based on the veteran's goals, strengths, assets, and preferences, as well as on the needs, limitations, liabilities, and areas of dysfunction;
- e. Utilization of all available resources, including Domiciliary Residential Rehabilitation and Treatment staff, other VA services, and non-VA and other community resources;

- f. Coordination and integration of care by DR RTP staff;
- g. A review and revision of treatment plans within timeframes consistent with the treatment models employed;
- h. Discharge planning initiated at, or prior to, admission and continuing as a primary focus of treatment;
- i. Documentation in the health care record of all aspects of veteran care; and
- j. An individualized aftercare plan that includes DR RTP staff, and may include other outpatient services of the medical center, as well as other appropriate services within VA or other community-based settings. This is necessary for all regular discharges and, when possible, for irregular discharges.

#### **14. TREATMENT AND REHABILITATIVE SERVICES**

All DR RTP veterans must receive active clinical treatment. This active clinical treatment must involve at least four hours-per-day of planned activity for health maintenance veterans and at least seven hours-per-day of planned activity for bio-psychosocial rehabilitation. The specific clinical services provided need to include, at a minimum:

a. **Medical Care.** In addition to the provision of routine medical care, plans must be in place for addressing emergent medical problems effectively and expeditiously, 24 hours-per-day, 7 days-per-week. If such care is not available through an immediately-adjacent VA medical center, appropriate arrangements must be in place (e.g., including transportation) to provide such ready access to urgent and emergent care, at an appropriate medical facility, in reasonable proximity.

b. **Infection Control.**

c. **Environment.** A therapeutic milieu that includes an environment that is conducive to therapeutic intervention and promotes personal dignity, responsibility, privacy, and consideration of gender.

d. **Vocational and Educational Rehabilitation.** Vocational and rehabilitation services consist of comprehensive evaluation and assessment of veterans' vocational, avocational, and educational needs, as well as therapeutic training and rehabilitation. It endeavors to provide comprehensive and integrated services which may include, but are not limited to, any of the following elements:

- (1) Vocational evaluation and testing;
- (2) Vocational case management and counseling;
- (3) Vocational rehabilitation therapy;

- (4) CWT;
- (5) Supported employment;
- (6) Incentive Therapy (IT);
- (7) Independent Living Skills Training;
- (8) Educational assessment and testing; and
- (9) Remedial and developmental instruction.

e. **Family Involvement.** Involvement of veterans' families and/or other significant persons in their care to the extent feasible and pertinent.

f. **Leisure Time.** Addressing recreational and leisure time needs.

g. **Resources.** Utilization of all available resources.

h. **Aftercare Services.** Aftercare services provided by DRRTTP staff in conjunction with other resources to:

- (1) Foster successful community adaptation;
- (2) Minimize the likelihood of regression; and

(3) Ensure, to the extent possible, that veterans discharged from the program are able to continue to utilize DRRTTP resources as needed.

## 15. AUTHORIZED ABSENCES

Authorized veteran absences must be administered in accordance with VHA policy. Veterans are encouraged to make use of authorized absences for therapeutic and rehabilitative purposes.

a. Veterans on authorized absence, not to exceed 96 hours, are considered bed occupants and their beds are reserved. Veterans granted absences in excess of 96 hours are considered absent bed occupants and their beds are not reserved.

b. While it needs to be utilized only rarely and under unusual circumstances, authorized absence for periods up to 30 days may be granted. An absence cannot extend beyond the due date of the veteran's annual physical examination.

c. When a veteran on authorized absence is admitted to a VA medical center for treatment, the absence is cancelled and the status must be changed to absent-sick-in-hospital (ASIH) or the veteran will be discharged from DRRTTP.

d. Systems of control (e.g., sign-out and sign-in lists) must be designed and implemented to ensure knowledge of the veterans' whereabouts both to:

- (1) Monitor and address individual veteran safety, and
- (2) Ensure the integrity and security of the program living space.

## 16. CHANGE OF CARE SETTING

a. When a veteran's clinical condition becomes such that DRRTP is insufficient or inappropriate to satisfy the treatment needs of that veteran, arrangements must be made, without delay, to move the veteran to an appropriate setting of care.

b. Veterans exhibiting dangerous or uncontrollable behavior must be moved to an acute care, or other, setting for appropriate management and supervision.

c. Transfers from one section or program of a DRRTP to another, or from one domiciliary to another, must be implemented when it becomes evident that such a transfer best serves the treatment needs of the veteran.

## 17. DISCHARGES

a. Discharges are to be given to veterans who have met their rehabilitation and treatment goals, and who have:

- (1) Profited maximally from the DRRTP; and
- (2) Been determined by the DRRTP clinical team to be able to provide adequately for themselves, or be otherwise provided for in the community.

b. Discharge must be given to:

- (1) Clinically stable veterans requesting it (whether present, or in authorized absence status);
- (2) Veterans who remain in ASIH status after 30 days;
- (3) Veterans who are admitted to a Nursing Home Care Unit; and
- (4) Veterans who fail to return from authorized absence.

c. Discharge may be given to veterans who:

- (1) Refuse, neglect, obstruct, or otherwise fail to cooperate with their treatment;
- (2) Interfere with the treatment of others; or

(3) Otherwise disrupt DRRTTP or the therapeutic milieu.

d. Discharge plans must be initiated with veterans at the time of, or prior to, admission to DRRTTP. Veterans must be actively involved in all aspects of discharge planning. Except in the case of emergent discharges, veterans must be kept informed of discharge plans and prospective discharge dates. Discharge plans are to be implemented in such a manner as to maximize both the veteran's level of functioning in the community and the likelihood of success in community adaptation. **NOTE:** *Veterans being discharged because of failure to cooperate with treatment must be offered assistance in obtaining appropriate alternative services.*

## 18. DOMICILIARY CARE FOR HOMELESS VETERANS (DCHV) PROGRAM

The Domiciliary Care for Homeless Veterans (DCHV) Program has been developed to address the complex clinical needs of the large number of homeless veterans.

a. This program provides comprehensive bio-psychosocial rehabilitation, including attention to the broadest possible range of veteran needs (e.g., medical, psychiatric, social, vocational, and spiritual).

b. The goal of the program is the earliest possible return to functional independence and health for each veteran treated and the facilitation of independent or semi-independent reintegration into community-based living.

c. Innovation, creativity, and originality are encouraged in program development and implementation. Programmatic flexibility is encouraged to successfully address the unique needs of individual veterans.

d. Clinically-appropriate services are provided primarily through the use of existing domiciliary and medical center care systems. Care management by appropriate interdisciplinary treatment team members is utilized to ensure continuity of clinical care. Each veteran's treatment must be individualized.

e. Care may include, but is not limited to:

(1) Clinical interventions;

(2) Patient education;

(3) Basic living skills;

(4) Vocational assessment and/or counseling;

(5) Social skills training;

(6) Healthy leisure training;

(7) CWT;

(8) Community re-entry skills; and

(9) Housing referral.

## 19. QUALITY OF LIFE

a. Domiciliary Residential Rehabilitation and Treatment fosters achievement of the highest possible quality of life for all domiciled veterans. This implies, at a minimum:

(1) Appropriate room furnishings in a defined personal space;

(2) A place to park a vehicle;

(3) Some storage space for belongings;

(4) Lockable storage for personal effects and/or possessions in the individual living space;

(5) Encouragement to display personal articles; and

(6) Within limitations of space, arrangement of furniture in a homelike manner to "personalize" the individual living area.

b. Achievement of the optimal level of independence is encouraged and supported at all times, including provision for:

(1) Scheduled and unscheduled activities; and

(2) Time spent in activities outside of the domiciliary or VA medical center.

c. Maintenance of contact with the veteran's family and other aspects of the outside community is supported.

d. A climate that enhances human dignity must be maintained, including provisions for personal privacy. Informed consent is required for all clinical treatments and procedures, as described in Handbook 1004.1. Veterans must be informed of rights and responsibilities, including the right to execute an Advance Directive as described in Handbook 1004.2. **NOTE:** *Handbook 1004.2 provides that disputes concerning the interpretation of an Advance Directive among medical staff and the health care agent or surrogate may be referred to the Ethics Advisory Committee or similar body, Chief of the Service, Chief of Staff, or Regional Counsel through the Chief of Staff. Per the handbook, the specific manner of resolving these types of disputes is to be delineated in local policy.*

e. All policies regarding participation in research programs and/or protocols, including the right to voluntary participation and withdrawal, must be adhered to in the strictest fashion. Veterans are admitted for Domiciliary Residential Rehabilitation and Treatment only if they are in need of such care and not for the sole purpose of participating in a research study.

f. Veterans must have input into Domiciliary functioning through an elected Patient Advisory Council. **NOTE:** *This Patient Advisory Council is an important component of the Therapeutic Community.*

## 20. PROGRAM MONITORING AND IMPROVEMENT

All DRRTPs must establish mechanisms for program monitoring. This must include gathering and utilizing information to ensure quality of care, appropriate programming, and an ongoing process of program improvement. Program improvement must be done in conjunction with other national program evaluation programs (e.g., the Northeast Program Evaluation Center), but not limited to these efforts. All DRRTPs are currently accredited under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for Behavioral Health Care (24-hour settings). DRRTPs who wish to be recognized for state-of-the-art rehabilitative approaches may also choose to be accredited under the Residential Treatment of Commission for Accreditation of Rehabilitation Facilities (CARF).

## 21. REPORTS

a. Report Control Number (RCN) 10-0172, Annual Narrative Report, must be prepared by the facility Chief, Domiciliary Care and submitted, through the medical center Director and via the reporting route dictated by local and Network policy, to the Director, DRRTP, Office of Mental Health Services, VHA Central Office, within 60 days of the conclusion of the fiscal year. This report provides local management and VHA Central Office with current basic information regarding major program elements having administrative or clinical significance for Domiciliary Residential Rehabilitation and Treatment.

b. The report is to be in narrative form and must not exceed ten pages. Charts, tables, and/or graphs may be included, as appropriate, either in the body of the report or as appendices. The report must include:

- (1) A description of DRRTP or, if multiple programs exist in the Domiciliary, each program.
- (2) In the following order, a description of:
  - (a) Program philosophy and/or model,
  - (b) Types of veterans served,
  - (c) Measures of workload,
  - (d) Specific program elements,
  - (e) Staffing, and
  - (f) Outcomes.

(3) An annual safety and security assessment of the Domiciliary with an action plan and timeline for remediation of problem areas.

(4) Any indications of successes, challenges, failures, problems, issues of concern, and the steps taken to resolve them.

## **22. REFERENCES**

- a. Title 38 CFR 17.46(b), 17.47(b)(2), 17.47(c), and 17.47(j).
- b. Title 38 U.S.C. 1710(b).
- c. VA Handbook 7610 (312).
- d. VHA Directive 1000.1.
- e. VHA Handbook 1000.1.
- f. VHA Handbook 1004.1.
- g. VHA Handbook 1004.2.