

January 10, 2012

## RE-ENGAGING VETERANS WITH SERIOUS MENTAL ILLNESS IN TREATMENT

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides the procedures to follow to re-engage in treatment Veterans with a serious mental illness (SMI) who have been lost to follow-up care.

### 2. BACKGROUND

a. A quality improvement assessment by the VHA Office of the Medical Inspector (OMI) demonstrated that Veterans with SMI can be re-engaged in treatment and that such efforts can significantly impact the mortality rate for these Veterans. In cooperation with the Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC), the OMI project was able to contact 68 percent of the study population, and 72 percent of those Veterans contacted returned to VA treatment. In addition, there was a significant difference in the mortality rate between those Veterans who returned to care compared to Veterans who did not (0.5 percent versus 6.3 percent). The OMI report outlined several recommendations to extend the results beyond the study.

b. In a memorandum dated December 7, 2010, the Under Secretary for Health accepted the recommendations in the OMI report and authorized their implementation.

#### c. Definitions

(1) **Serious Mental Illness (SMI).** Within the context of this Directive, SMI refers to an American Psychiatric Association Diagnostic and Statistical Manual (DSM) Axis I disorder resulting in significant functional impairment and/or disruption in major activities of daily living. This typically includes schizophrenia and other psychotic disorders, bipolar disorder, major depression, and severe Posttraumatic Stress Disorder (PTSD). Veterans with other DSM Axis I diagnoses may also be included in this domain, usually in conjunction with a DSM Axis V Global Assessment of Functioning (GAF) Scale score of 50 or lower.

(2) **Target Population.** Initially, the target population for this Directive refers to Veterans who have been diagnosed with schizophrenia or bipolar disorder. Upon evaluation of the effectiveness of the program by SMITREC, the target population may expand to other SMI, including major depression and PTSD.

(3) **“Lost to Follow-Up Care.”** “Lost to Follow-Up Care” refers to any living Veteran with SMI who has received outpatient or inpatient care within VHA in the past, but who has not received treatment services for at least 1 year (i.e., no outpatient visit, or an inpatient stay of 2 days or fewer).

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(4) **Re-engaging in Treatment** refers to contacting the Veteran; determining the Veteran's need for mental health, medical, and psychosocial services; and facilitating new appointments for those Veterans who need continued treatment. *NOTE: The expectation is that Veterans are contacted by telephone or in person; however, they may be contacted by letter or other means if those methods fail.*

(4) **Local Treating Facility** refers to the most recent VA medical facility where the Veteran received inpatient or outpatient mental health care.

**3. POLICY:** It is VHA policy that Veterans with SMI who have been lost to follow-up care must be identified on an ongoing basis; that the local treating facility must assess these Veterans' need for continued treatment; and the local treating facility must re-engage the Veterans in treatment as warranted. *NOTE: Accurate contact information must be maintained for Veterans seen in VA health care facilities.*

**4. ACTION**

a. **Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC).**  
SMITREC is responsible for:

(1) Adapting the algorithms used in the OMI project to identify Veterans with SMI who have been lost to follow-up care from the time of the completion of the OMI study. *NOTE: The specific algorithm used to identify Veterans can be obtained by contacting SMITREC.*

(2) Providing the list of Veterans with SMI who have been lost to follow-up care to the Local Recovery Coordinator (LRC) at the Veteran's local treating facility and to the Veterans Integrated Service Networks (VISNs) Mental Health leaders for those facilities. The list is provided through encrypted e-mail.

(3) Developing and implementing a reporting form for the LRCs to complete following their initial contact with the Veterans on their list.

(4) Evaluating the information provided by the LRCs; refining the algorithm and the process of providing lists to the LRCs, as warranted; and providing feedback and assistance to the LRCs to improve the process.

(5) Tracking and reporting on the number of Veterans who:

(a) Return to VA care after being contacted;

(b) Have died;

(c) Are engaged in mental health treatment outside VA; or

(d) Refused VA care or otherwise did not return to VA care during the reporting period.

(6) Developing a process to provide near-real-time data to the LRCs contacting Veterans with SMI who have been lost to follow-up care.

(7) Providing reports on the outcome of these efforts on an annual basis to facility Directors, VISN Leadership, and the Office of Mental Health Services.

b. **Medical Facility Director.** The Medical Facility Director, or designee, is responsible for ensuring that:

(1) Re-engagement services are provided to Veterans with a SMI who have been lost to follow-up care;

(2) LRCs have an appropriate amount of time allocated to providing re-engagement services and that re-engagement services take precedence over or are provided in lieu of other clinical assignments for the LRC;

(3) Clinic capacity allows for the Veterans to be re-engaged in treatment through this effort within the time criteria specified in subparagraph 4b(2)(c);

(4) Post-contact evaluation forms are submitted to SMITREC in a timely manner;

(5) Program coordinators for VA and community-based outreach programs (including, but not limited to, Suicide Prevention Coordinators and Homeless Program Coordinators) are aware of the program described in this Directive and work cooperatively with the LRCs to re-engage Veterans in treatment;

(6) LRCs are given permission to obtain assistance from other mental health staff, as needed, to perform re-engagement services;

(7) Contact information for Veterans receiving mental health services is updated with each inpatient and outpatient visit;

(8) Completion of administrative requirements for care (e.g., re-enrollment; means testing) does not present a barrier to the Veteran being re-engaged in treatment.

c. **Local Recovery Coordinators (LRC).** According to the memorandum from the Deputy Under Secretary for Health for Operations and Management dated December 8, 2006, LRCs' duties include direct, recovery-oriented clinical services to Veterans with SMI (not to exceed 25 percent of their time). The following re-engagement services are consistent with this expectation. The LRCs are responsible for:

(1) Obtaining and maintaining PKI encryption in order to receive list of Veterans from SMITREC.

(2) Upon receipt of the list of Veterans from SMITREC, initiating re-engagement services to

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contact the Veteran and to assist the Veteran in returning to treatment for mental or physical health care or psychosocial services.

(a) Re-engagement services must involve a direct contact with the Veteran (through a phone call or an in-person visit whenever possible). If the Veteran cannot be contacted directly, a letter may be sent to the Veteran.

(b) Upon contacting the Veteran, the LRC determines the Veteran's need for continued treatment services.

(c) If the Veteran warrants and desires continued mental or physical health care or psychosocial treatment services, the LRC facilitates making an appointment for the Veteran. Appointments are to be within 5 working days of the contact, or at a later date if desired by the Veteran.

(d) The LRC coordinates the Veteran's appointment with the appropriate mental health and primary care clinicians and assists the receiving clinician or team with developing a list of treatment options.

(3) Assisting the receiving clinic, as warranted, with its responsibility to contact the Veteran if the appointment is not kept.

(4) Documenting in the Veteran's electronic health record their efforts to contact the Veteran, the outcome of those efforts, and any services provided, including appointments or referrals that were made.

(5) Completing and submitting the SMITREC contact report for all Veterans who were contacted, as well as the summary report for those who were not able to be contacted.

(6) Submitting these reports to SMITREC through the facility Chief of Mental Health (or equivalent), the facility Director, the VISN Mental Health leader, and the VISN Director.

## **5. REFERENCES**

a. Quality Improvement Assessment: Outreach Services to Schizophrenic and Bipolar Patients Lost to Follow-up care (2010-D-252), December 7, 2010.

b. VHA Handbook 1160.01.

c. "Facility Recovery Coordinators," memorandum from the Deputy Under Secretary for Health for Operations and Management, December 8, 2006.

**6. FOLLOW-UP RESPONSIBILITY:** The Deputy Chief Patient Care Services Officer for Mental Health (10P4M) is responsible for the contents of this Directive. Questions may be addressed to (202) 461-7309.

**7. RESCISSIONS:** None. This VHA Directive expires January 31, 2017.

Robert A. Petzel, M.D.  
Under Secretary for Health

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