**Department of
Veterans Affairs**

VHA PROGRAM GUIDE 1103.3

MENTAL HEALTH PROGRAM GUIDELINES
FOR THE NEW VETERANS HEALTH ADMINISTRATION

**Office of Patient Care Services
Mental Health Strategic Healthcare Group (116)
Veterans Health Administration
Washington, DC 20420**

FOREWORD

Guidelines as set forth in this document are published to improve the care for a large and often complex group of veteran patients. These Guidelines reflect what the Veterans Health Administration (VHA) is capable of doing now and suggest directions for future program development, particularly in response to the revolutionary changes accompanying the Journey of Change. The Department of Veterans Affairs (VA) operates a large, diverse healthcare system that must adapt, create, lead, and innovate, or it will not meet the needs of veterans of future decades. VA strongly encourages the creation of new, evidence-based, innovative programs, organizations of clinical services, and alliances with, and input from, community organizations, as it moves from a predominately hospital-based system to one based in, and serving the entire veteran community.

This organization of mental health services, based on the concept of an integrated continuum of care should be incorporated into the regular VA planning process at all levels. If additional resources are required to provide necessary services, requests should be incorporated into the planning process at the Veterans Integrated Services Network (VISN) level.

These are guidelines. None of the programs listed are mandated at this time. It is strongly encouraged to use the enclosed definitions, Decision Support System (DSS) Identifiers, Treating Specialty Codes, and Consolidated Distribution Report (CDR) Accounts at all sites so that we can share meaningful information among medical centers and across Veteran Integrated Service Networks (VISNs).

Thomas V. Holohan, M.D., FACP
Chief, Patient Care Services Officer

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MENTAL HEALTH PROGRAM GUIDELINES FOR THE NEW VETERANS HEALTH ADMINISTRATION

1. INTRODUCTION AND OVERVIEW

a. **Authorization**

(1) "The mission of the veterans healthcare system is to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services. To accomplish this mission, the Veterans Health Administration (VHA) needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice." (Kizer, Journey of Change, 1997)

(2) "Each eligible (enrolled) veteran will have access to a comprehensive, integrated, continuum of high quality effective mental health services by the year 2002." (Mental Health Strategic Healthcare Group (MHSHG), 1997.)

(3) Within the context of the dramatic transformation of VHA as anticipated in Dr. Kizer's Vision for Change, and authorized by Public Law 104-262**,** the Eligibility Reform Act of 1996**,** this document reflects:

(a) A new integrated continuum of mental health services providing continuity of care.

(b) A major shift from an inpatient focus to that of residential treatment and community-based services.

(c) An innovative approach to organizing, planning, providing mental health care by uncoupling patient treatment and rehabilitation modalities from the settings with which they are traditionally associated.

(d) A framework for integrating the specialized knowledge of mental health into primary care.

(e) Healthcare decision-making at the facility and Veterans Integrated Service Network (VISN) level.

(f) Accountability through providing national workload definitions, methods for data capture, and measures of costs and outcomes.

b. **Purpose**. The purpose of this program guide is to:

(1) Provide current program guidelines for mental health professionals, planners, and administrators.

(2) Reflect changes involving current best practice in mental health care as VHA moves into the next century.

(3) Define levels of care.

(4) Stimulate innovative and evidence-based approaches for clinical care.

(5) Reflect requirements regarding "capacity" contained within the Veterans Healthcare Eligibility Reform Act of 1996.

(6) Provide a template for individual patient treatment planning.

(7) Provide definitions and a crossover to VHA's new Decision Support System (DSS) methodology.

2. GUIDELINES FOR PROVIDING MENTAL HEALTH SERVICES

a. **Principles for Organizing Mental Health Care.** Quality primary and specialty mental health care can be provided to veterans under a variety of organizational structures, including the traditional professional services model, a product and/or service line (Charns et al, 1998) model, or a combination of these and other models. In developing an efficient structure for the delivery and monitoring of quality mental health care in VHA, organizational structures need to:

(1) Promote inter-professional collaboration in leadership, planning, and the monitoring of mental health program performance**.**

(2) Provide for a cost-effective**,** seamless continuum of mental health treatment programs.

(3) Support a continuity of care to meet both the primary care and specialty mental health care needs of patients while mindful of the patient's involvement in treatment decisions.

(4) Acknowledge the need for discipline specific involvement in the recruitment and evaluation of the practice of mental health professionals, including the oversight of training and research activities.

(5) Include contributions from patients and patient advocate groups in planning and evaluating mental health care delivery.

(6) **Reference.** Charns MP, Parker V, Wubbenhorst W. Clinical Service Lines In Integrated Healthcare Delivery Systems, for Industry Advisory Board, Center for Health Management Research, 1998.

b. **Principles for Program Planning**

(1) **Definition of Program and Program Elements**. In the context of reorganization of clinical programs to focus on patients' needs, a useful definition of a program is "an integrated, comprehensive and cost effective continuum of care for veterans provided under a single administrative structure." Program elements make up the total program. Under this definition, all program elements at a single Department of Veterans Affairs (VA) medical center, for instance, would be considered as a single program if administered as a single program. If program administration were at a consolidated VA Healthcare System or a VISN level, then the larger unit would be considered a "program." The word, "program," is also used for some program elements organized under a single administrative structure and for some settings where an integrated treatment regimen is indistinguishable from the setting (e.g., day treatment center).

NOTE: *In the past programs tended to be defined, at least in part, by funding sources. If there were separate sources of funding for inpatient and outpatient program elements at the same facility, these might be listed as two programs whereas if these program elements had the same funding source, they would be seen as a single program.*

(2) **Organizational Structures**. Organizational structures involved in planning mental health services, whether at the facility or VISN level, need to:

(a) Identify programs and program elements in a manner consistent with local organizational structures as well as national priorities;

(b) Create plans based on veteran populations rather than existing programs or facilities;

(c) Reflect diversity and creativity in program development;

(d) Partner with other service providers in planning;

(e) Involve patients and patient representatives in the process;

(f) Consult clinical practice guidelines where they are available;

(g) Include, or provide access to, the often multiple sources of expertise required to treat patients with comorbidities; and

(h) Encourage the evaluation of programs and outcome measurements of delivery systems.

NOTE: *Comorbidities in veteran populations pose a problem for program planning. Terms such as "dual diagnosis" and "Mentally Ill Chemical Abusers (MICA)," that have surfaced nationally over the last decade reflect the growing realization that not only veterans, but many*

other individuals with a mental disorder have, in addition, one or more other disorders that complicate not only individual treatment planning but organization of programs. Special funding by diagnosis or circumstance (e.g., substance abuse or elderly) in the past has compounded the problem by putting artificial barriers to clinicians faced with real patients presenting simultaneously with, for instance, a substance use disorder, post-traumatic stress disorder (PTSD), and depression. Under new funding and allocation systems, VHA now has the opportunity to remedy that situation.

c. **Principles for Providing Quality Mental Health Care**

(1) **Mental Health Providers**. Mental health providers should strive to:

(a) Maximize each patient's functional independence;

(b) Make ongoing quality mental health care available in the most appropriate location based on the patient's medical and functional condition;

(c) Provide an integrated continuum of care including access to long-term care when needed;

(d) Advocate for the needs of patients;

(e) Involve patients, their families, and other caregivers in shared decision-making;

(f) provide continuity of care and a knowledgeable treatment team through case management (or care management) and primary care approaches; and

(g) Use evidence-based treatment guidelines where available and appropriate (see App. B).

(2) **The Continuum of Care.** VHA is committed to providing an integrated, comprehensive and cost effective continuum of care for veterans with mental disorders.

(a) Program elements along a continuum of care should be driven by needs of the patients and their families rather than by traditional bed levels or funding sources.

(b) Patients should move among the components of the continuum as is clinically appropriate, with minimal disruption in treatment, and in a manner which facilitates positive treatment outcomes.

(c) Veterans within and across VISNs should have equal access to all levels of care within the continuum.

(d) Treatment of all patients with mental health problems should be provided by appropriately trained, credentialed, and privileged clinicians and should be managed to assure continuity of care.

(e) Treatment provided by VA should reflect state-of-the-art care as documented in the empirical literature and clinical treatment guidelines and should be provided in a cost-effective manner.

(f) Treatment outcomes should be monitored and serve as a basis for improving care.

(g) Evaluations of VA's mental health service delivery and outcomes should benchmark results with comparable non-VA healthcare systems.

(h) During reorganizations of clinical services, primary emphasis should be placed on the development of an accessible continuum of care for all patients with mental disorders.

(i) When developing admission and readmission policies care should be taken to distinguish between the intensity of services necessary to address the clinical problem and the setting (i.e., ambulatory, residential, partial hospital, inpatient**,** etc.) most appropriate for the patient.

(j) Case (care) management is an effective tool and should be utilized to assure that patients receive all necessary services throughout the continuum in a timely and coordinated manner.

(3) **Mental Health and Primary Care.** Mental Health Primary Care should be made available to veterans with significant mental disorders.

(a) Definition of Primary Care. Primary Care is the coordinated, interdisciplinary provision of comprehensive healthcare including intake, initial assessment, health promotion, disease prevention, emergency services, management of acute and chronic biopsychosocial conditions, referrals for specialty, rehabilitation, and other levels of care, follow-up**,** overall care management, and patient and caregiver education.

(b) Rationale. As described in The Prescription for Change, VA has adopted primary care as a fundamental emphasis for the delivery of healthcare to veterans (Kizer, 1995). Mental health care is the primary focus of healthcare for a substantial proportion of patients in the public and private healthcare system (Regier, et al, 1978). For many other healthcare patients with undetected psychiatric problems, mental health services, although often overlooked, can also reduce the risk and intensity of medical illness and the extent and cost of medical care services (Friedman, et al, 1995).

(c) Models. There is no one correct way to address mental health primary care delivery. It is a tenet of primary care that there be continuity of care across service delivery sites and across episodes of care, ensuring that there is coordination of care, and that patients do not "fall through the cracks" as can happen in a fragmented care system. Four models are evolving for the provision of mental health primary care, each of which can be adapted to fit specific sites, resources, and goals (see VHA Program Guide 1103.2).

1. **Mental Health Primary Care Teams**. One model involves mental health primary care teams in which the mental health providers (psychiatrists, psychologists, psychiatric nurse practitioners, psychiatric social workers, etc.) serve as the primary care provider, and the mental health team as the primary care team. Mental health primary care teams can promote "seamless" continuity of care across different types of treatment settings. For example, teams combining clinicians formerly separated on inpatient units and in subspecialty outpatient clinics now follow patients across the multiple episodes of care required for dual or multiple mental health conditions (Ronis, et al, 1996). Double-boarded psychiatrists (e.g., psychiatry plus family practice, internal medicine, or geriatrics), specialists in addiction medicine, nurse practitioners and physician assistants may provide the primary medical coverage for their cohort of patients. In some cases, internists or family practitioners are members of mental health primary care teams, just as mental health clinicians are members of medical teams. The team provides all primary care functions, such as health screens, vaccinations, etc.

2. **Dual Team Membership**. In some facilities, mental health primary care teams have linkages with medical primary care teams, and patients have membership on both teams. For this model to be effective excellent communication is required between teams. A single care manager on the mental health team may help bridge the gap.

3. **Mental Health Participation in Medical Primary Care Teams.** A third model involves mental health providers, i.e., psychiatrists and psychologists, psychiatric social workers, clinical chaplains, and clinical nurse specialists. These serve as regular members of medical primary care teams. Both outpatient and inpatient care can be covered by mental health membership on medical primary care teams.

a. Mental health professionals have for many years offered such services as:

(1) Assistance with diagnosis of behavioral disorders and symptoms that can affect health status,

(2) Adaptation to illness, and

(3) Compliance with treatment regimens and treatment services.

b. Examples are psychological methods of pain management, cardiac risk reeducation, behavioral methods of smoking cessation, and patient and family education to enhance coping with chronic illness (Sobel, 1995).

c. Mental health clinicians in primary care settings may perform a variety of tasks. Examples are:

(1) Developing a protocol for screening patients for depression or patients who have mixed somatic and psychological symptoms;

(2) Providing brief evaluation and treatment;

(3) Referral of more complex cases to mental health specialty services; and

(4) Providing education to patients, primary care staff, and other caregivers on identification and management of mental disorders. (Blumenthal, et al, 1995).

4. **Traditional Consultation and Liaison**. Alternatively, mental health clinicians may serve as specialty consultants, the more traditional form of mental health involvement in primary care, derived from consultation and/or liaison approaches developed in healthcare delivery over the past 40 years. Mental health consultation to medical providers requires familiarity with medical syndromes, the psychological features that can be modified to enhance medical care outcomes and reduce medical care costs, and methods of communication that are responsive to medical providers.

(d) Comprehensive Healthcare. Comprehensive healthcare implies addressing the multiple comorbidities found increasingly in the veteran population.

(e) References

1. Blumenthal D, Mort E, Edwards J. "The Efficacy of Primary Care for Vulnerable Population Groups." Health Services Research, 30: 253-73, 1995.

2. Friedman, R, Sobel, D, Myers, P, Caudill, M. "Behavioral Medicine, Clinical Health Psychology, and Cost Offset," Health Psychol. 14: 509-518, 1995.

3. Kizer, K: Prescription for Change. Department of Veterans Affairs, 1995.

4. Regier, DA, Goldberg, ID, Taube, CA. "The De Facto U.S. Mental Health Services System: a Public Health Perspective," Arch Gen Psychiatry. 35: 685-693, 1978.

5. Ronis DL, Bates EW, Garfein AJ, Buit BK, Falcon SP, Liberzon I. "Longitudinal Patterns of Care for Patients with Posttraumatic Stress Disorder," J Trauma Stress. 763-781, 1996.

6. Sobel, D. "Rethinking Medicine: Improving Health Outcomes with Cost-effective Psychosocial Interventions," Psychosom Med. 57: 234-244, 1995.

7. VHA Program Guide 1103.2, Provision of Primary Care Services for Mental Health Clinicians, Oct. 31, 1997.

(4) **Case (Care) Management.** Case (care) management should be made available when indicated.

(a) Definition. Case (care) management is a strategy for coordinating and integrating care among providers and systems in order to achieve optimal client outcomes, reduce costs, enhance quality, and promote continuity across the healthcare continuum (Laura Miller, 1997). In the mental health care area, use of case management with high risk populations of veterans can enhance continuity of care, accessibility to care, accountability in provision of care, efficiency through maximizing utilization of resources, and optimal patient functioning.

(b) Clinical Use. Virtually all clients of mental health services can benefit from basic case management. Case management can be viewed along a continuum, with different levels of management used with different groups of patients, based on the needs of the patients and the intensity of services provided. Case management is a flexible, fluid process that changes as the needs of the patient change. So while a patient may require comprehensive or intensive case management in the beginning, stabilization of symptoms and enhanced functioning may lead to need for a less intense level.

(c) Basic Case Management**.** All case management includes some form of basic functions or activities. Basic case management incorporates many functions of routine clinical work, but is distinguished by its focus on coordination of services and continuity of care. Functions include:

1. Outreach and identification of appropriate clients;

2. Assessment of medical and psychosocial problems, spiritual injuries, and current strengths and weaknesses;

3. Treatment planning, where goals, specific interventions to achieve them, and methods to address outcome are specified;

4. Linkage with other providers and services as needed and coordination of care among them;

5. Follow-up and monitoring of outcome, with modifications of treatment plan as necessary; and

6. Advocacy for the client in obtaining access to services.

(d) Dimensions of Case Management. Case management is applied in various ways in mental health settings. It is tailored to meet the needs of specific client groups and service settings by varying the additional activities provided by case managers and the way in which case management is provided. Some dimensions that can be varied include focus, time frame, intensity (caseload), setting, availability, and frequency (Willenbring, 1991; 1994). ***NOTE:*** *Ranges noted are for illustration purposes and not to be taken literally.*

Dimension	**Range**
Focus	Narrow ---------- Comprehensive
Time Frame	Time limited ---------- Indefinite
Intensity (Caseload)	1:100 ---------- 1:10
Setting	Office ---------- Community
Availability	Office Hours---------- 24 hours/day 7 days/week
Frequency	Monthly ---------- Daily

(e) Models of Case Management. Some common models used in mental health are listed as follows. This list is not exclusive; models should be individualized for specific settings and client populations (see subpar. 2b(4)(f)).

1. "**Door to Door" Case Management**

a. Basic case management functions, usually in institutional settings.

b. Time-limited, usually brief.

c. Narrow focus on discharge or disposition planning.

d. Usually facility-based, daily or non-daily contact.

e. Target Clients. Those in transition from inpatient or partial hospital settings.

2. **Primary Therapist**

a. Basic case management functions.

b. Additional functions include crisis intervention and supportive psychotherapy.

c. Usually comprehensive in form, indefinite, moderately intense (a ratio of 1:30-50) and office-based.

d. Target Clients: Most mental health clients.

3. **Medical Care Management**

a. Basic case management functions.

b. Provided by physician or nurse.

c. Normal focus on medication management and physical health.

d. Usually less intensive (a ratio of 1:50-150), less frequent (monthly to quarterly), indefinite in length, and office-based, but could include home visits.

e. Target Clients: All mental health patients.

NOTE: *For the purposes of capturing workload, these first three are classified under standard case (care) management.*

4. **Intensive Case Management**

a. Basic case management functions.

b. Additional functions include: crisis intervention, coping skills training, vocational rehabilitation, and community readjustment.

c. Comprehensive, intensive (a ratio of less than 1:20), community-based, 24-hour-per-day availability, indefinite.

d. Examples include: Assertive Community Treatment (ACT), Intensive Psychiatric Community Care (IPCC), and Strengths Model Community Case Management (Rosenheck, 1998; Rosenheck, 1998).

e. Target Clients. Severe psychiatric illness, at risk for frequent or lengthy hospitalizations.

5. "**Dual Disorder Case Management**"

a. Basic case management functions.

b. Similar to intensive case management.

c. Incorporates both mental health and addiction treatment foci.

d. Target Clients: Patients with both severe and persistent mental illness and addictive disorders.

6. **High-Risk Case Management**

a. Basic case management functions.

b. Focused on reducing utilization and cost for high-risk patients.

c. May be either narrow or broad in focus, time-limited (e.g., inpatient only) or indefinite.

d. Emphasizes gatekeeper perspective more than facilitator of service access.

e. Target Clients. High utilizers, especially those using inappropriate or expensive services

(f) References

1. Corporate Strategy on Case Management. Department of Veterans Affairs, VHA Atlanta Network. VHA Headquarters, September 1997.

2. Laura Miller, Chair, VHA Work Group on Case Management. Draft Strategy on Case Management. Department of Veterans Affairs, VHA Headquarters, 1997.

3. Muesser KT, Bond GR, Drake RD. "Models of Community Care for Severe Mental Illness: A Review of Research on Case Management," Schizophrenia Bulletin. 1997.

4. Rosenheck RA, Neale M, Leaf P, Milstein R, Frisman L. "Multi-site Experimental Cost Study of Intensive Psychiatric Community Care," Schizophrenia Bulletin. 21; 129-140, 1995.

5. Rosenheck RA and Neale MS. "Cost effectiveness of Intensive Psychiatric Community Care for High Users of Inpatient Services," Archives of General Psychiatry. 55; 459-466, 1998.

6. Rosenheck RA and Neale MS. "Inter-site Variation in the Impact of Intensive Psychiatric Community Care on Hospital Use," American Journal of Orthopsychiatry. 68(2); 191-200, 1998.

7. Willenbring ML, Ridgely MS, Stinchfield R, Rose M. "Application of Case Management in Alcohol and Drug Dependence: Matching Techniques and Populations," Department of Health and Human Resources (DHHS) Publications. No. (ADM) 91-1766. Rockville, Maryland: Government Printing Office, 1991.

8. Willenbring ML. "Case Management Applications in Substance Abuse Disorders," Journal of Case Management. 1994.

(5) **Psychosocial Rehabilitation.** Psychosocial Rehabilitation is an essential component to mental health care**.**

NOTE: *Psychosocial interventions are a part of nearly all mental health treatments and are used in most settings and programs. The many psychotherapies, vocational counseling, case management and adjunctive therapies (milieu treatment) are examples of generic psychosocial treatments. Psychosocial Rehabilitation in contrast, is a special type of psychosocial intervention that focuses more on patients' strengths and functioning than treatment of symptoms. It has received increasing support nationally as an effective method of rehabilitating patients with disabilities resulting from mental illness with particular emphasis on functional status. (Bertolote, 1996; Gittleman, 1997; IAPRS, 1994; Liberman, 1988; Mueser, 1997.)*

(a) Purpose. The primary goal of psychosocial rehabilitation is to expand the capacities of individuals with disabilities, thereby improving their quality of life and diminishing reliance upon more resource intensive forms of treatment, such as prolonged inpatient care. Psychosocial Rehabilitation services play a role throughout the continuum of care for the special emphasis veteran, both through the process of normalization and the increase in self-confidence which will enable the veteran to enter into more difficult challenges in life's experiences (see VHA Clinical Guidelines, 1997).

(b) Therapeutic Work. A primary modality in Psychosocial Rehabilitation is the use of therapeutic work. The adjunctive application of work experience serves to strengthen gains made in treatment, and is of critical importance to the rehabilitation (or habilitation) process. Further, when vocational and residential rehabilitation treatments are provided concurrently in a coordinated effort, clinical outcomes are significantly enhanced.

(c) Residential Rehabilitation. Another major approach to Psychosocial Rehabilitation is the inclusion of residential rehabilitation settings. This approach provides a 24-hour supportive, therapeutic treatment setting for patients with multiple and severe psychosocial skill deficits related to their psychiatric disorder. These settings utilize the residential therapeutic community of peer and professional support, with a strong emphasis on increasing personal responsibility to

achieve optimal levels of independence upon discharge to independent or supportive community living.

(d) Planning Psychosocial Rehabilitation. The development of opportunities for Psychosocial Rehabilitation at each facility should be based upon the populations being served and their needs. The broad scope of Psychosocial Rehabilitation services would include a determination of a veteran's social and economic level of functioning, independent living skills, vocational needs, assets, and available housing options. Services available at any facility should take into account this assessment, as well as an assessment of available community options.

(e) References

1. Bertolote J, Saraceno B, edts. Psychosocial Rehabilitation: A Consensus Statement. Initiative of Support to People Disabled by Mental Illness. Division of Mental Health and Prevention of Substance Abuse, World Health Organization (WHO). Geneva: WHO, 1996.

2. Gittleman M, "Psychosocial Rehabilitation for the Mentally Disabled: What have we learned?" Psychiatric Quarterly. 68(4), 393-406, 1996.

3. International Association of Psychosocial Rehabilitation Services (IAPSRS). An Introduction to Psychiatric Rehabilitation. Columbia, MD, 1994.

4. Liberman R. edt. Psychiatric Rehabilitation of Chronic Mental Patients. Washington; American Psychiatric Press, 1988.

5. Mueser K, Drake R, Bond G. "Recent Advances in Psychiatric Rehabilitation for Patients with Severe Mental Illness." Harvard Review of Psychiatry. 5(3), 123-137, 1997.

6. VHA Clinical Guidelines: Management of Persons with Psychosis, Module L, on Psychosocial Rehabilitation (initial publication, June 13, 1997). ***NOTE:*** *This is available at VHA libraries and on the VA Intranet, Mental Health website (http//:vaww.mentalhealth.med.va.gov).*

d. **Principles for Individual Patient Treatment Planning**

(1) **Designing a Treatment Plan**

(a) There are two often related, but independent decisions, which need to be made when designing a treatment plan for a patient, the:

1. Kind and intensity of therapeutic modalities the patient requires, and

2. Level of professional supervision or institutional structure the patient needs to reside in while receiving the set of interventions.

(b) This approach of dividing the decision process into two independent factors will be used throughout this document.

(c) While VHA encourages flexibility and innovation in delivery of services, based on the immediate needs of patients, accountability to the funding system requires:

1. Nationally agreed upon levels of care and both traditional and newer program elements that address specific populations, settings, or modalities;

2. Accurate recording of treatment; and

3. Accurate documenting of the settings and treatment events for tracking costs and possible reimbursement from third party payers and, for those disabled by mental illness, for tracking VHA's capacity for providing appropriate treatment.

4. The following table gives examples of Intensity of Therapeutic Interventions (on the vertical axis) and of Levels of Therapeutic Milieu (on the horizontal axis). ***NOTE:*** *The examples are not to be considered limiting.*

Intensity* and Levels of VA Mental Health Care
<- Levels indicate degree of supervision or structure->

Inten-sity*	Level 1 Community (Outpatient)	Level 2 artial Hospitalizatio (Day Programs)	Level 3 Residential (Treatment) Settings	Level 4 Professional Care Setting (Medium Level Staffing)	Level 5 Highly Staffed Hospital Setting
Low	Less than 1 hour per week. No case management beyond primary care referrals. Periodic Medication reviews.		Non-professional supervision. No clinical services associated. No formal structure. Clinical oversight no more than monthly.	Maintenance of self-care. Primary supervision at L.P.N. level. Partially structured milieu. Emphasis on rehabilitation for group or independent living.	Diagnosis or evaluation or procedures requiring high staffing.
Moderate	1 - 8 hours per week or more for work programs. Basic case management Psychotherapy Routine clinic care.	2 - 8 hours per week. Supportive activities with case management.	24 hour supervision. Moderately structured daily milieu. Basic case management.	Nursing care with R.N. supervision. Moderately structured daily milieu. Plan highest functional level. Secured or securable setting. Rehabilitation focus.	R.N. supervision. Treatment plan with specific goals. Brief respite, medication stabilization. Crisis stabilization.
High	9 - 15 hours per week or more for work programs. Intensive case management	9 - 15 hours per week. Structured groups or activities Ongoing to prevent hospitalization	24 hour, on-site supervision. Highly structured daily milieu. Active case management. Specific rehabilitation goals.	Skilled nursing care with R.N. supervision. Treatment plan with specific goals. Highly structured milieu. Community reentry goal. Focus on symptom stabilization.	R.N. supervision. Treatment plans with specific goals. Evaluation and stabilization of major symptoms.
Very High	Over 15 hours per week. Crisis management. stabilization. Intensive case management	Over 15 hours per week. Structured groups, activities all week and or weekends. Time limited to stabilize. Crisis Management	24 hour professional or paraprofessional supervision. Highly structured milieu. Intensive case management. Rehabilitation plan with specific functional goals	Skilled nursing care, R.N. supervision. Supervision by specially trained staff. Highly structured milieu. Focus on symptom reduction. Community reentry goals.	R.N.supervision. Locked unit,. seclusion rooms, and or restraints. Evaluation and stabilization of severe symptoms. Specially trained staff.

* Intensity indicates hours of active professional treatment

(2) **Intensity of Therapeutic Interventions.** This dimension can be measured primarily by the number of hours of professional intervention required for treatment or rehabilitation, in

addition to that required to supervise patients where they spend their evenings, nights, and weekends. Intensity levels from low to high depicted in the preceding chart are arbitrarily placed along a theoretical continuum and the examples described are only for guidance in treatment planning.

(3) **Level of Therapeutic Supervision or Structure.** This dimension also represents a theoretical continuum from independent, unsupervised living in the community to a locked seclusion room in a highly staffed hospital setting. Staffing levels per patient or hours of care supervision required in maintaining the patient's activities of living are suggested measures, but are also depicted as examples for treatment planning only. These levels are seen as being independent of length of stay in order to free up clinicians and patients alike to move from one level to another, depending upon their specific needs for the day. More than one level may be provided at a given setting. Definitions of Levels of Therapeutic Supervision or Structure are suggested as follows:

(a) Level 1. Community and/or Outpatient. Patients (and/or families) provide food, housing, transportation, and other life management activities independently. Treatment services are provided on an "as needed" basis from clinics, home, or community-based settings, and they may range from periodic assessment for health maintenance to intensive case management services designed to avoid admission to residential or inpatient care.

(b) Level 2. Partial Hospitalization. Patients (and/or families) can provide food, housing, and transportation during evenings and possibly weekends, but require additional structure during the day. Treatment services of varying intensity are provided in supervised settings, often using group structures or activities. This level may provide an alternative to residential or hospital care, provide a transitional setting, or provide day respite for caregivers.

(c) Level 3. Residential Treatment Settings. Patients are unable to manage independent living and/or require additional structure at least during evenings, possibly weekends, and at most 24 hours a day, but with minimal staffing supervision. Treatment intensity varies but often has a rehabilitation focus, emphasizing or enhancing personal responsibility, management of disabling symptoms, or vocational deficits. Professional and/or peer support is available. Settings may be located in community settings, within a Domiciliary or in distinct units at a medical center.

(d) Level 4. Medium Level Professional Care Setting. Patients require 24-hour care with a moderate level of staff supervision. Treatments vary in intensity from emphasis on maximizing quality of life, to providing a rehabilitation focus in preparation for more independent living, to providing a step-down from high level hospital care prior to returning home. Interdisciplinary nature of staffing depends upon individual patient goals. This may be provided in community, nursing, or hospital settings.

(e) Level 5. High Level Hospital Setting. Patients require 24 hour, professionally supervised care. Treatment intensity varies from emphasis on stabilization to specialized interdisciplinary treatment services providing comprehensive evaluation, stabilization, and reduction and/or management of severe or complex symptoms.

NOTE: *Appendix C describes alternative levels of care, as defined by the other healthcare organizations.*

(4) **Principles Regarding Planning Patients' Living Arrangements**. With the move from hospital to residential and community-based treatments, facilities have increased the range of residential alternatives to traditional hospital beds. Some patients who have been in an institutional setting for long periods have, in response to new medications, rehabilitation modalities, and changing attitudes, been able to move to alternative settings. While the principles listed apply to any treatment planning, they become more important as institutionalized patients move to new settings. The following issues should be addressed as part of the planning process:

(a) Patient preferences;

(b) Patient's financial resources;

(c) Patient's coping skills and decision-making capacity;

(d) Need for structured settings;

(e) Patient's spiritual resources and connection with faith community;

(f) Perceived change, plus or minus, of quality of life;

(g) Extent of family support system, including extended family and/or friends;

(h) Impact on therapeutic and social alliances forged in current treatment setting; and

(i) Geographical location, including safety, transportation, access to shopping, social supports.

(5) **Principles when Families are Involved in Living Arrangements**

(a) Pay attention to family dynamics.

(b) Strive to prevent misunderstandings and unrealistic expectations.

(c) Assess effect on family members of:

1. Financial responsibilities,

2. Proximity of family to the residential setting, and

3. Need for respite care if appropriate.

3. SPECIAL POPULATIONS

a. The Eligibility Reform Act of 1996

(1) **Public Law 104-262.** Public Law 104-262, the Veterans Healthcare Eligibility Reform Act of 1996, § 1706(b)(1), requires that VA "…*maintain its capacity* to provide for the specialized treatment and rehabilitation needs of *disabled veterans* (including those with spinal cord dysfunction, blindness, amputations, and *mental illness*) within distinct programs or facilities…that are *dedicated to the specialized needs* of those veterans in a manner that (A) affords those veterans reasonable access to care and services…and (B) ensures that overall capacity…is not reduced below the capacity …nationwide…as of October, 1996." [*Emphases added*].

(2) **Definition of Disabled Veterans with a Mental Illness.** As a result, the Policy and Forecasting Office (105D), with consultation from MHSHG (116) at VHA Headquarters, has defined those veterans with a mental illness who are disabled by (serious) mental illness as those who currently or at any time during the past year have a diagnosed mental disorder of sufficient duration to meet criteria as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), other than V codes, which results in a disability.

(a) Disability. A disability is defined as a functional impairment that substantially interferes with or limits one or more major life activities, including basic daily living skills, instrumental living skills, and/or vocational and educational activities. ***NOTE:*** *This definition corresponds to one contained in the Federal Register vol. 58, No 96, dated May 20, 1993.*

(b) Functional Impairment. Starting with fiscal Year (FY) 1998, the disabled mentally ill population is defined as those veterans who have attended a mental health treatment setting who have a Global Assessment of Functioning (GAF) score below a specific number (such as "50") (see VHA Dir. 97-059).

(3) **Subgroups.** The "Report to Congress on Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitation Needs of Disabled Veterans," of May 1, 1997, defines the overall group of disabled mentally ill veterans into two main groups: those diagnosed with a Serious Mental Illness (SMI) and those diagnosed with PTSD. The SMI group includes three subcategories:

(a) Veterans who suffer a disability as a result of a diagnosed DSM-IV substance abuse disorder;

(b) Homeless veterans who have a disability as a result of mental illness, and

(c) All other SMI veterans who have a disability as a result of a diagnosed DSM-IV mental illness.

(4) **Comorbidities.** There are many obvious diagnostic overlaps among these groups, but because subspecialty expertise is needed to provide the special care needs in each subcategory, data are collected for each group independently.

(5) **Specialized Programs.** Specialized programs for each of the subgroups can be identified at the local level by use of specific DSS identifiers (previously called stop codes and specific specialty bed codes which are listed throughout subparagraph 4d and App. D).

(6) **Capacity.** VA's capacity to treat SMI veterans is measured by:

(a) Workload, defined as the total number of individual veterans receiving treatment in specialized psychiatric services annually.

(b) Annual expenditures (for FY 1997 and 1998 only) on specialty mental health care (total dollars spent on mental health inpatient, outpatient, and residential services, including identified mental health programs located in VA Domiciliaries). Starting in FY 1999, expenditures will play a progressively lesser role and outcomes will become the primary mechanism to assure that quality, functional status, and customer satisfaction are maintained and improved. ***NOTE:*** *The development of reliable and meaningful outcome measures is in process.*

(c) Reasonable access is currently defined as timeliness of access. This is being monitored by the percentage of veterans discharged from psychiatric inpatient settings who received outpatient specialty mental health services within 30 days of hospital discharge. ***NOTE:*** *An additional measure of market share to indicate access will be developed.*

(7) **Special Emphasis Programs.** Twelve Special Emphasis Programs (SEPs) are defined as central to VA's mission. Four SEPs, directed to the four patient subgroups noted in the preceding, are as follows:

(a) Homeless Veterans Treatment and Assistance Programs;

(b) PTSD Programs;

(c) SMI Veterans Programs; and

(d) Substance Use Disorder Programs.

(8) **Resulting Mandate**. Since the Eligibility Reform Act requires the Secretary of Veterans Affairs to maintain the overall capacity to provide care for these subgroups of disabled veterans, and the SEP Directive identifies VHA's special commitment to programs to provide care for them, it falls upon all facilities to identify the programs and accurately record the workload achieved in their behalf. The remainder of this Program Guide is designed to assist in those efforts.

(9) References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), 1994.

2. Report to Congress on Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitation Needs of Disabled Veterans," of May 1, 1997.

b. **Veterans Diagnosed with a Serious Mental Illness**

(1) **Background**

(a) Definition

1. The capacity legislation defines two groups of veterans diagnosed with a SMI: a larger group composed of all veterans disabled by any mental illness except PTSD and a smaller subgroup which consists of those from the larger group remaining when patients with a primary diagnosis of substance use disorder and/or those who are homeless are removed. In this section, it is the smaller subgroup of SMI veterans, many of whose members have a severe and persistent major mental illness (SPMI), who are addressed.

2. It is also important to distinguish the SMI veteran group, defined by the capacity legislation, from a smaller group, called Chronically Mentally Ill (CMI), which is currently defined by the Veterans Equitable Resource Allocation system (VERA) as one of the "special groups" of patients qualifying for a larger allocation of funds than the "basic groups." CMI veterans (approximately 32,000, as of FY 1997), qualify essentially as having a psychosis, having been hospitalized "over 90 days" in one of the previous 5 years, and still receiving treatment. VERA does not recognize "SMI" veterans and the overlap between these two groups has no fiscal consequences. Furthermore the VERA system may change significantly over the next few years.

(b) Cost to VHA. The Northeast Program Evaluation Center (NEPEC) Mental Health Report Card documents inpatient costs alone for general psychiatry in FY 1997 of $1.354 billion. All Mental Health program costs were $1.948 billion of which $555.9 million were reported as mental health outpatient costs (National Mental Health Program Performance Monitoring System (NMHPPMS), 1997, Table 6-2).

(c) Prognosis. In many VA as well as non-VA mental health systems, the great majority of SMI veterans can and do live in the community receiving supportive counseling, medications, and/or rehabilitation as required by their needs and symptoms and reflected by their strengths. The degree of residential support and structure they require may change as individual circumstances, symptoms, and patients' self-confidence vary. In some locations, however, community services are still not available and the enormous growth and visibility of homeless mentally ill (HMI) over the last 2 decades is evidence that alternatives to institutional care have not been adequately developed or funded.

(2) **Principles for Providing Quality Treatment**. Principles for providing quality treatment to SMI veterans are described in subparagraph 2c.

(3) **Treatment Guidelines.** Evidence-based treatment guidelines are recommended for all treatment services (VHA Clinical Guidelines, 1997).

(4) **The Continuum of Care for SMI Veterans**

(a) Professional interventions range from low intensity case management through outpatient clinic modalities, intensive case management, psychosocial rehabilitation, and crisis management to high intensity treatments seen in hospital settings.

(b) Environmental structures range from independent living, through clubhouses, lodges (Fairweather, 1980), residential care, supportive living settings, half-way houses, residential rehabilitation settings (including Domiciliaries), nursing homes and subacute hospital settings, to acute hospital settings, including psychiatric intensive care units.

(5) **Alternatives to Long-term Psychiatric Hospitalization**

(a) Since the early 1960s, the mental health community has not considered long-term psychiatric hospitalization for patients with a non-responding SMI as a usual or expected method of providing care. VHA still reports over 3700 long-term psychiatric beds, primarily located in selected areas of the country where community standards do not challenge that practice or where academic affiliations are weak. Thus the recent revitalization of VHA provides a special opportunity for an ongoing review of long-term patients, of custodial practices and attitudes, and of the relationships between our rural psychiatric facilities and their often more academically enhanced urban neighbors. Medical literature supports the use of:

1. New, atypical antipsychotic and anti-depressant medications (Marder, 1996; Hirsh, 1995);

2. Intensive outpatient case management (Rosenheck, 1998);

3. Psychosocial rehabilitation (Lehman, 1995);

4. Partial hospitalization and residential care (Bedell, 1989; Knapp, 1993),

5. Community-based treatment (Okin, 1995; Weisbrod, 1980),

6. Emphasis on non-institutional housing and vocational opportunities(Blanch, 1988; Goldmeier, 1977), and

7. Partnerships with community agencies, family and patient advocate groups, and others dealing successfully with SMI patients in their communities (Rogers and Yaskin, 1997).

(b) Those SMI patients, whose illnesses respond poorly to standard treatments, require ongoing care at various intensities and in different settings. These factors depend upon individualized diagnosis, comorbidities, and prognosis as well as access and availability of care, availability of

family or other support persons and groups, vocational opportunities, residential resources in the community, and other socioeconomic factors. The goal for such patients is to minimize the level of institutional structure they require by providing treatments which are of adequate intensity to maintain and improve their level of functioning.

(c) A highly staffed psychiatric hospital setting may be appropriate for patients undergoing regression or recurrence of a psychotic illness, but a less structured setting should be made available as soon as possible to allow the patient to regain as much independence as tolerated.

(d) Even patients with progressive dementing illness generally need differing care intensities and degrees of structure during the course of their deterioration, in the context of a focus on preserving residual independence and quality of life.

(e) Patients with non-dementing mental disorders, in particular, are unpredictable in their potential for remission or partial recovery. A number of factors may impact on their success in moving to levels of care which are marked by less structure. ***NOTE**: For many of these patients, aging characteristically will decrease the intensity of the psychotic process (see Harding et al, 1987).*

1. The continued introduction of new psychotropic medications, particularly the atypical antipsychotic medications and newer anti-depressants, opens further possibilities for those who have not responded to current available medication. Barriers to their use, however, include overly restrictive formularies and failure to consider the total costs of care.

2. Intensive case management such as that provided by VHA's IPCC teams, has been well demonstrated to permit many formerly institutionalized patients to live in the community (see subpar. 2c(4)(f)).

3. Clinicians report that many seemingly regressed schizophrenic patients are acutely aware of the attitudes of staff, family, volunteers, and patients around them and respond to both hopefulness and resignation by those they consider important. Yet there is little systematic or evidenced-based literature to corroborate these observations.

4. The anecdotal literature of the last 30 years has been replete with stories of back-ward patients who recovered and returned home following the advent of a new activity program, a new doctor, a new theory of treatment or rehabilitation, transfer to a new ward or hospital, an exciting research program, or a significant change in family relations such as the death of a parent.

5. These factors appear to have in common the infectious qualities of hope, emotional energy, and of new possibilities.

(f) The enthusiasm and funds that accompanied the community mental health movement in the 60's and 70's, including the availability of partial hospitalization programs and community care, and the continual introduction of new and powerful psychotropic medications, also led to significant shrinking of state and VA psychiatric hospitals. The "reinvention of VA" initiated in the late 1990s has brought those issues again to the foreground. Funding pressures to shorten hospital length of stay

(LOS) and focus on outpatient modalities have played a part in engaging staff to look for alternatives to continued hospitalization for long-stay patients.

(g) The chronic nature of some mental disorders should be clearly distinguished from the patients who suffer from the disorders. It serves no purpose to consider the patients themselves as "chronic," in the sense of untreatable, and not worth the investment of time, money, and emotional energy. The rehabilitation movement, which focuses on patients' strengths and efforts at independent living in spite of their disability, has proven to be a welcome and effective alternative (see subpar. 2c(5)(e)1. and the references in subpar 3b(6)).

(h) Although shrinking, there remains a small but visible group of patients whose illness does not respond to current medications or other interventions and who therefore respond in unpredictable and destructive ways that preclude discharge or placement outside of a hospital or specialized nursing home setting any time now. Such patients need and deserve ongoing treatment in appropriately structured settings during this phase of their illness.

1. The intensity of even a chronic mental illness often changes over months or years, and given time, consistent opportunity, allies, and periodic case reviews, patients may gain the ability and confidence to try a less intensive setting. At times a change of setting, accompanied by staff with new diagnostic and therapeutic perspectives, different expectations, and an environment with new opportunities, may produce unexpected positive results.

2. For some patients fighting against an overwhelming psychotic illness, pressure to be discharged may result in counter pressure and/or regressive behavior, which may be perceived as a "power struggle." These symptoms may diminish when pressure is removed until the illness decreases in intensity and the patient is able to recover at a pace commensurate with the patient's increasing self-control. Sensitivity, encouragement, and being open to opportunity are proper staff attitudes toward such patients. Staff members should keep open the continued possibility that many patients can and do improve over time and should not be deprived of the opportunity to attain greater self-determination.

(i) Without a sense of therapeutic optimism, no program is likely to be very helpful. Active efforts to engage the patient in symptom recognition, self-management, and treatment, will improve the possibility of recovery and demonstrate to staff and patients alike that positive change is possible. Staff commitment to progress over time is fundamental for effective long-term recovery.

(6) References

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(d) Goldmeier J, Shore MF, Mannino FV. "Cooperative Apartments: New Programs in Community Mental Health," Health and Social Work. 2(1), 120-139,1977

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c. **Veterans Diagnosed with a Substance Use Disorder**

***NOTE**: The term "substance abuse" has been replaced by "substance use disorder" within the clinical and scientific community. Since VHA's older acronyms and DSS Identifiers (stop codes) do not fit the new nomenclature, this document will use the terms interchangeably at times.*

(1) **Background**

(a) History. In the early 1970s, Congressional recognition of the extent of substance abuse in the active military services led to major funding of substance abuse programs throughout both the Department of Defense (DOD) and VA. Substance use disorder programs are now authorized throughout the integrated continuum of care and should be available at all VA facilities.

(b) Cost to VA. In FY 1997, 24 percent of all inpatients discharged from VA medical centers had a primary or secondary diagnosis of substance use disorder. These patients accounted for 28 percent of the total number of bed days of care provided. Approximately 35 percent of inpatients with substance use disorder diagnoses were treated by substance use disorder units, 39 percent by psychiatric units, and 34 percent by medical-surgical units (Piette, et al, 1997).

(c) Treatment Works. The scientific literature is unequivocal in documenting that treatment of substance use disorder improves clients' outcome on a variety of measures. Such measures include duration and amount of substance use, employment, family status, and legal status. (McLellan et al, 1996; Hubbard et al, 1989; Rice et al, 1991).

(d) Nature of Illness**.** Substance use disorder is a chronic, recurring disorder much like diabetes, hypertension, or asthma. Expecting a "complete cure" for a substance use disorder is no more realistic than expecting total and permanent symptom elimination for these other illnesses.

(2) **Principles for Treatment and Rehabilitation of Veterans with a Substance Use Disorder.** As with other medical illnesses, VA is committed to providing equal access to a high quality, integrated, comprehensive, and cost effective continuum of care for veterans with substance use disorders including monitoring of outcomes to increase effective care (see subpar. 2c).

(3) **The Substance Use Disorder Continuum of Care.** A comprehensive, cost effective continuum of services should be available to all veterans within a VISN (see VHA Program Guide 1103.1, 1996).

(a) Primary Care. Substance Use Disorder Programs should be involved in the primary care of patients. Specific arrangements will vary from setting to setting. In some situations, the program itself will provide the primary care; in others, it will coordinate with designated primary care providers.

(b) Special Patient Populations and/or Comorbidities. All substance use disorder programming should be sensitive to the needs of special populations including the homeless,

ethnic minorities, women, geriatric patients, and patients with PTSD and other psychiatric comorbidities, human immunodeficiency virus (HIV) infection and other medically compromised patients, and with a spinal cord injury.

(c) Components Within a Continuum. The following components should be readily accessible to all veterans when indicated:

1. Early identification and intervention;

2. Assessment, triage, and referral;

3. Acute stabilization and detoxification (including inpatient hospital services as medically and psychiatrically necessary);

4. Rehabilitation services on an outpatient basis and/or on a residential basis for those patients in need of such a setting;

5. Other outpatient care, encompassing continuing care, monitoring and relapse prevention; and

6. Opioid substitution treatment (e.g., methadone maintenance therapy) and other drug therapies (e.g., long-acting methadone substitutes, etc.) as they are approved for use, in combination with psychosocial services.

(d) Services Within a Continuum**.** Depending on the patient's stage of recovery and clinical needs, the following services should also be provided or arranged in the intensity and frequency dictated by a comprehensive individualized treatment plan:

1. Medical services,

2. Psychiatric evaluation and care (including medication management),

3. Family education and counseling,

4. Domestic violence assessment and treatment,

5. Educational, vocational and employment services,

6. Social and independent living skills training,

7. Relapse prevention skills training,

8. Housing services, and

9. Self-help groups.

(e) Service Settings within a Continuum. Service settings within the continuum are:

1. Ambulatory (including intensive outpatient).

2. Partial hospitalization.

3. Residential settings, such as Substance Abuse Residential Rehabilitation Treatment Programs (SARRTPs), Substance Abuse Compensated Work Therapy Transitional Residences, Domiciliary Care Programs, and halfway houses.

***NOTE**: Each VISN should have available specialized, formal programming to meet the needs of patients requiring residential rehabilitation, veterans in need of comprehensive vocational and rehabilitation services, and those who are often more difficult to treat because of being dually diagnosed with a substance use disorder and another mental illness.*

4. Subacute rehabilitation in a hospital setting.

5. Acute hospital care.

(g) Treatment Guidelines. Evidence-based treatment guidelines are recommended for all treatment services. Examples can be found in Module S of the Major Depressive Disorder (MDD) Guidelines published in February 1997 and in Module C of the Psychosis Guidelines, published June 13, 1997 (see App. B).

(h) Outcome Monitoring. VHA Headquarters (116B), the Program Evaluation Resource Center (PERC) at Palo Alto VA Medical Center, and the Center of Excellence in Substance Abuse Treatment and Education (CESATE) at Philadelphia and Seattle VA Medical Centers, in conjunction with other facilities and VISNs, have developed a standardized national outcome monitoring system using the Addiction Severity Index (ASI) and GAF. These ratings are now required for all veterans receiving specialized treatment for substance use disorder.

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d. **Veterans Diagnosed with Post Traumatic Stress Disorder (PTSD)**

(1) **Background**

(a) Extent of the Problem. The best estimate of the number of Vietnam veterans suffering from PTSD is found in the National Vietnam Veterans Readjustment Study (NVVRS) (Kulka, et al, 1988). It shows that 15.2 percent of male Vietnam Theater Veterans, i.e., 479,000 out of 3.1 million, suffer from PTSD. Only 20 percent of these veterans had ever received care for their PTSD. Another 479,000 had PTSD between the war and the time of the survey but no longer were symptomatic. NVVRS also described PTSD in 8.5 percent of female theater veterans (610 of 7200). Two studies of Persian Gulf War veterans, one involving over 4500 veterans and the other involving over 2,000 veterans, identified from 9 to 10 percent of these veterans as having PTSD symptoms. PTSD ranked first in frequency among the nine problem areas assessed in the Vet Centers population (Rosenheck, et al, 1992). Of women veterans seeking care from special Woman's Veterans Stress Disorder Treatment Teams, 12 percent were exposed to enemy fire, but 63 percent reported physical harassment and 43 percent reported rape or attempted rape during military service. Fifty percent of women veterans seen by the Woman's Stress Disorder Teams met criteria for PTSD (Fontana et al, 1997).

(b) Cost to VA. In FY 1994, expenditures for specialized PTSD programs (those originally funded from Congressionally mandated appropriations and monitored by NEPEC) were $40,655,000. This figure does not include any local support for these programs nor does it include data from locally developed and funded programs (Rosenheck and Fontana, 1996). In addition to these direct costs, there are indirect costs to VA and to society in terms of substance use disorder treatment, lost wages, and incarceration that are not easily measured.

(c) Treatment Works. Positive treatment outcomes for PTSD have been documented for VA's inpatient and outpatient PTSD programs and Vet Centers. Improvements are noted in PTSD symptoms as well as in significant quality of life parameters such as employment, family, and legal status. However, the nature of treatment appears to require a specific expertise. Selected psychotherapeutic and psychopharmacological approaches can be effective for PTSD. (Blake, 1993; US GAO, 1996; Meichenbaum, 1994; Rosenheck et al, 1996 and 1997.)

(d) Nature of Illness

1. PTSD is an anxiety disorder essentially described as:

"…the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death

or serious injury; or other threat to one's physical integrity; or witnessing an event that involves death, injury or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (American Psychiatric Association, 1994).

2. The person's response involves fear, helplessness, or horror. Characteristic symptoms include re-experiencing the trauma; avoidance of stimuli associated with the trauma, numbing of responsiveness and persistent symptoms of increased arousal. The effects of war zone trauma have been demonstrated to be long lasting and severe. Thus for these veterans, the most common stressor for PTSD is war zone stress, including both combat and dealing with mass casualty situations (Scurfield RM, 1993; Kulka et al, 1990). Also included may be other non-war zone military experiences such as the crash of a military aircraft or sexual assault.

(e) Clinical Complexity of VA Patients (Comorbidities). Veterans who are treated for PTSD in VA have significant complicating features, including;

1. Comorbid anxiety disorders such as panic disorder and general anxiety disorder;

2. Depressive disorders, which are found in the 16 percent to 20 percent range even in non-treatment seeking Vietnam veteran populations;

3. Substance use disorder, with an incidence reported from 58 percent to 80 percent in veteran treatment populations; and

4. General medical disorders. Because of the aging of the veteran population, and because of the implication of PTSD in the development or exacerbation of certain internal medical disorders, assessment and treatment of patients with PTSD should include a particular focus on the presence and management of physical disorders (VHA Treatment Guidelines, MDD, Module A, 1997).

(2) **Principles of Treatment and Rehabilitation of Veterans Suffering from PTSD**

(a) VA is committed to providing an integrated, comprehensive, and cost-effective continuum of care for veterans with PTSD and its associated comorbidities (see subpar. 2c).

(b) It is widely acknowledged that optimal treatment of PTSD requires specialized knowledge and skill. Accordingly, PTSD treatment is optimally delivered by specialized teams whose work is primarily focused on treating veterans with PTSD.

(3) **The PTSD Continuum of Care.** The entire continuum of clinical services may not be present in a single facility, but should be easily accessible by all patients treated within a VISN. Some components of the continuum may be provided in coordination with neighboring VISNs. Services provided should be based on the individual patient's clinical needs; not all patients will require the entire continuum of services. Patients should move among the components of the continuum as is clinically appropriate, with minimal disruption in treatment, and in a manner which facilitates positive treatment outcomes.

(a) Components of a Continuum. The following components in this continuum should be readily accessible to all veterans:

1. Early identification and intervention.

2. Assessment, triage, and referral.

3. Acute stabilization and intervention (including hospitalization, as necessary).

4. Treatment and rehabilitation; short-term or long-term (greater than 30 days) on an outpatient or residential basis for those patients in need of such a setting.

5. Other outpatient care, encompassing continuing care, monitoring, and relapse prevention for those with substance use disorder comorbidity.

(b) Services Within a Continuum. Depending on a patient's stage of recovery and clinical needs, the following services should also be available in the intensity and frequency dictated by a comprehensive individualized treatment plan:

1. Medical services;

2. Psychiatric care for PTSD and non-PTSD comorbid diagnoses, including medication management;

3. Family education and counseling;

4. Domestic violence assessment and treatment;

5. Educational, vocational and employment services, including Compensated Work Therapy (CWT);

6. Social and independent living skills;

7. Relapse prevention skills training for patients with substance use disorder comorbidity; and

8. Housing assistance encompassing Health Care for Homeless Veterans (HCHV), placement assistance, and Domiciliary services.

(c) Service Settings within a Continuum. A spectrum of treatment options needs to be preserved for veterans with PTSD. Outpatient settings should maximize accessibility, expertise, and clinical efficacy. Staff should have the capacity to address the severity, chronicity, complexity, and comorbidities associated with PTSD. There is a small core of patients for whom treatment in an intensive inpatient or residential setting is a medical necessity. There are times when a patient whose primary problem is PTSD may also require other psychiatric services in

addition to those found in specialized PTSD settings. Examples include emergencies such as suicidal behavior, which may require care on a general psychiatric unit; or specialized substance use disorder treatment needed before PTSD care is initiated, or during the course of treatment. Service settings within the continuum include:

1. **Ambulatory Care**. Ambulatory care, including PTSD Clinical Teams (PCTs); PTSD Day Hospital; or Day Treatment Centers; Women's Stress Disorder Treatment Teams, and Vet Centers.

2. **Residential Care**. Residential care (including PTSD Residential Rehabilitation Programs, CWT/Transitional Residences and Domiciliaries and

3. **Hospital Care.** Hospital care, including acute stabilization and treatment, evaluation and brief treatment, general psychiatric care, intensive psychiatric treatment, and the specialized care found within a Specialized Inpatient PTSD Unit (SIPU).

(d) Primary Care. A primary care PTSD program link should be established that provides appropriate medical services for veterans with PTSD because of the association of stress disorders with other medical disorders and because the PTSD population is aging. Primary care services may be coordinated in a variety of ways, such as providing mental health clinicians on medical primary care teams or providing medical clinicians on mental health primary care PTSD teams. Designating liaison staff between the two is another alternative. These approaches promise to promote increased efficiency of overall healthcare by improving outcomes, reducing medical costs and improving patient satisfaction.

(e) Special Veteran Populations. All PTSD treatment programs should be sensitive to the special needs of their patients including issues of homelessness, substance use disorder, physical disabilities, HIV positive status, and other medically compromising conditions. In addition, treatment programs should be responsive to the special needs of elder veterans, members of ethnic minority groups, and female veterans. PTSD symptoms in older combat veterans may first appear after they retire from their life's work.

(f) Practice Guidelines Practice guidelines for PTSD are available within Module P, MDD Guidelines available at VHA medical libraries and the intranet, http://vaww.mentalhealth.med.va.gov (see App. B).

(4) **Outcome Monitoring**. VHA Headquarters (116), and VA's NEPEC, in conjunction with facilities and the VISNs, have developed a standard national outcome monitoring system including GAF and performance measures for the PTSD SEPs. These include both population outcome measures and program outcome measures. Such measures will assist in evaluating the effectiveness of treatment.

(5) **References**

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e. **Homeless Mentally Ill Veterans**

(1) **Background and Definition**

(a.) History. VA's homeless programs were initiated in 1987 with the passage of Public Law 100-6. The law created the Homeless Chronically Mentally Ill (HCMI) Veterans Program which gave VA authority to establish clinical teams to address the needs of homeless veterans and to contract with community-based organizations for the provision of residential care. Services were broadened and additional sites were funded and, although HCMI remained the core of these programs, in 1993, the term HCHV was adopted to serve as a broader title. HCHV is sometimes used interchangeably with HCMI but generally it is used to reflect augmented program designs

and services and to reduce the stigma that may be associated with the "chronically mentally ill" title. Subsequent legislation and increased Congressional appropriations, as well as additional collaborations with other Federal, state, and local agencies, and non-profit organizations, have created an expanded and diverse mix of treatment and assistance programs for homeless veterans that varies with each site dependent on local need and ingenuity. In a statement before the Committee on Veterans Affairs' Subcommittee on Health, on June 17, 1998, the Under Secretary for Health identified medical services and other support to homeless veterans as VHA's fifth mission (in addition to general medical care, education, research, and support to DOD).

(b) Current Programs. Currently, VA offers a wide array of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible. In fact, VA is the only Federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans and their dependents, VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. Many of VA's homeless programs operate under the auspices of HCHV. Other VA initiatives that provide services to homeless veterans were established by subsequent public laws, encouraged by parallel efforts of complementary VA mental health programs, or set up through collaborations with other federal agencies. Key VA programs that provide services for homeless veterans are outlined as follows:

1. HCMI Veterans Program: outreach, assessment, case management and community-based contracts for housing.

2. Domiciliary Care for Homeless Veterans (DCHV) Program: outreach, assessment, treatment planning, service delivery, outplacement, and after care.

3. CWT/TR: vocational development and work therapy linked to community-based residential living;

4. Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) Program: case management in the community and HUD assisted independent living.

5. Supportive Housing (SH): case management in the community and independent living.

6. Social Security – VA Outreach (SSA-VA): outreach and social security benefits assistance.

7. Veterans Benefits Administration (VBA) – VHA Collaborative Initiative: outreach and veterans benefits assistance.

8. Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans: National assessment, coordination, and planning of services for homeless veterans.

9. VA Homeless Providers Grant and Per Diem Program: assistance for community providers in creating and operating supportive services.

(c) Extent of the Problem. It has been estimated that one-third of all homeless adults and 40 percent of homeless men are veterans of the United States armed forces (Rosenheck et al, 1994) and that on any given night there are approximately 250,000 homeless veterans living in shelters or on the streets of American cities. Perhaps twice as many veterans may experience homelessness over the course of a year. Many other veterans are considered at risk because of their poverty, lack of support from family and friends, and precarious living conditions in inexpensive hotels or in overcrowded or substandard housing.

(d) Patient Characteristics. Almost all homeless veterans are male (about two percent are female) and the vast majority are single. Homeless veterans tend to be older and more educated than homeless non-veterans (Rosenheck and Koegel 1993). A majority of veterans seen in the HCHV programs in Fiscal Year (FY) 96 were judged to have a serious psychiatric or substance use disorder problem. Just under one-half had a serious psychiatric problem (i.e., psychosis, mood disorder, or PTSD) and three-fourths were described as dependent on alcohol and/or drugs. Roughly 55 percent were African American or Hispanic (Kasprow et al, 1997).

(e) Cost to VA. In FY 97, VA spent a total of $93.1 million on programs specifically for homeless veterans. In addition to these direct costs, there are additional associated costs. VA continues to treat homeless veterans in its acute inpatient units. The FY 96 End-of-Year Survey of Homeless Veterans in VA Acute Inpatient Programs (Seibyl et al, 1997) revealed that 13.5 percent of all veterans hospitalized in acute care described themselves as homeless at the time of their admission. Additionally, the study reported that 7.5 percent of these patients in acute care were objectively homeless, residing in shelters, the streets, and similar locations prior to their admission.

(f) Treatment Works. The core programs of VA's Homeless Treatment and Assistance programs are monitored by the VA's NEPEC. Data from these monitoring efforts demonstrate the success of specific courses of treatments designed to address the cause and/or effects of homelessness. Additionally, the literature suggests that successfully reaching the homeless populations at times requires nontraditional techniques and practices. It has been shown that there are unique dynamics of and within the homeless population. The homeless veteran has specific needs. These needs can be addressed by VA's continuum of care, consisting of a diverse mix of community-based services.

(g) Nature of Illness. Homelessness itself is not an illness, however, the causes and effects of homelessness can be. Causes of homelessness may include mental illnesses such as depression or psychosis; substance use disorder; or personality disorders. A veteran may be homeless because of a lack of education or job training. Confounding this issue is the fact that mental illness could also be an effect of homelessness. Other effects of homelessness include physical problems; diseases or infections; social isolation; and criminal complications. An accurate assessment as to the causes versus the effects of homelessness is an important part of evaluating the homeless veteran and formulating a successful treatment plan.

(2) **Principles for Treating Homeless Veterans Disabled by Mental Illness**

(a) VA is committed to providing an integrated, comprehensive, and cost-effective continuum of care for homeless veterans disabled by mental illness (see subpar. 2c).

(b) Caregivers should recognize that HMI veterans may not seek treatment because of their isolation, distrust of VA, or unwillingness to pursue services. These veterans should be targeted and contacted through various means of assertive outreach to and within the community.

(c) VA staff, actively collaborating with other Federal, state, county, city, and nonprofit community services agencies dealing with homeless persons, should develop resources to form a network of services for homeless veterans. Collaborating groups could include advocacy organizations such as homeless rights groups, coordinating bodies such as homeless coalitions, or service providers such as homeless shelters and drop-in centers. At times VA may provide the leadership to create these collaborations for an entire community.

(d) Intervention should focus on establishing rapport and a trustful relationship with the homeless veteran and addressing practical needs, as the veteran perceives them. Services should be made available in a non-threatening location where the veteran is comfortable.

(e) Assessment should focus not only on the causes but the effects of homelessness in order to develop an accurate treatment plan that meets the needs of the veteran.

(f) Treatment should include active case management for veterans who are literally homeless, on the streets or in shelters, as well as for those placed in community-based residential settings.

(g) In many cases, only after the environment has been stabilized will homeless mentally ill veterans be willing to address issues regarding their emotional lives and relationships.

(h) With the closure of many VA inpatient substance use disorder and psychiatry beds, access by homeless veterans to transportation for outpatient services has become an issue of increased importance. Outreach, case management and residential treatment efforts should be sensitive to the needs of homeless veterans regarding transportation to other government services, community referrals, VA facilities, and community treatment providers**.** Staff should ensure that homeless veterans are physically and economically able to keep their scheduled outpatient visits. Discussions regarding transportation should be documented in the patient's record.

(3) **Continuum of Care for HMI**

(a) Components of a Continuum: The following components should be readily accessible to all veterans, when clinically indicated and available:

1. Assertive community outreach to those veterans living on streets and in shelters who otherwise would not seek assistance.

2. Residential rehabilitation options such as placement in community settings contracted by VA, community settings under partnership or collaborative agreements with VA, supportive housing arrangements through the HUD-VASH initiative, VA Domiciliary care programs, and CWT/TR's.

3. Long-term, sheltered, transitional assistance with case management, employment assistance, and community linkage, moving towards permanent housing.

(b) Services Within a Continuum. Depending on the patient's causes and/or effects of homelessness and clinical needs, the following services should be available:

1. **Outreach.** Outreach is the engagement of the veteran in community locations (shelters, soup kitchens, parks, bus or train stations, and on the streets);

2. **Intake Assessment.** Intake assessment is the clinical evaluation of the veteran and the determination of eligibility for services followed by referral to needed medical treatment for physical and psychiatric disorders, including substance use disorder;

3. **Community Case Management.** Community case management is the direct services or linkage, referral, or other assistance for veterans not currently in residential settings or inpatient care;

4. **Psychiatric and Medical Examination.** The psychiatric and medical examination are the evaluations conducted at the VA medical center, on an inpatient or outpatient basis;

5. **A Comprehensive Individualized Treatment Plan**. A comprehensive individualized treatment plan dictates the intensity and frequency of services; ***NOTE**: This treatment plan, however, may not be formulated and/or followed in the traditional manner given the sometimes unpredictable nature and hard to reach character of the population.*

6. **Initiation of Treatment Intervention**. Initiation of treatment intervention is the contact which especially focuses on the acute needs of the veteran, and often involves stabilization of the veterans' psychiatric and/or medical condition;

7. **Residential Treatment**. Residential treatment means contracts with community-based residential treatment facilities and halfway houses, and/or sharing agreements with community-based provider organizations for brief to intermediate lengths of stay and/or VA owned and operated residential rehabilitation programs, such as HCMI CWT/TRs; and

8. **Continuing Case Management.** Continuing case management is the oversight of services provided while in residential treatment and assistance with or follow-up to support re-entry into the community.

(4) References

(a) Kasprow WJ, Rosenheck RA, and Chapdelaine J. Healthcare for Homeless Veterans Programs: Tenth Progress Report. West Haven, CT: Northeast Program Evaluation Center [Report to Congress], 1997.

(b) Rosenheck RA, Frisman LK, and Chung A. "The Proportion of Veterans Among the Homeless," American Journal of Public Health. 84(3): 466-468, 1994.

(c) Rosenheck RA and Koegel P. "Characteristics of Veterans and Non-veterans in Three Samples of Homeless Men," Hospital and Community Psychiatry. 44: 858-863, 1993.

(d) Seibyl CT, Rosenheck RA, Sieffert D, and Medak S. Fiscal Year 1996 End of Year Survey of Homeless Veterans in VA Inpatient Programs. West Haven CT: Northeast Program Evaluation Center, 1997.

f. **Elderly Veterans with Psychogeriatric Problems**

NOTE: *Elderly veterans with psychogeriatric problems, i.e., psychogeriatric patients, are not specifically included as special populations under the* Eligibility Reform Act *or as requiring a Special Emphasis Program. They are included in these Guidelines, however, because they do require special programming and medical care.*

(1) **Definitions**

(a) For the purpose of this document, psychogeriatric patients are defined as those with a psychiatric disorder who are age 60 or older. Younger individuals in the age range 50 to 60 years who have early-onset dementia or other clinical presentations common to psychogeriatric patients also are included as are elderly patients for whom legal and ethical issues of competency arise.

(b) Typical psychogeriatric patients include those with depression, dementia, anxiety, psychosis, and/or memory disorder; the frail elderly with multiple medical and psychiatric comorbidities; the aging chronically mentally ill; and elderly patients with cognitive and behavioral problems arising from a variety of sources. In many instances, the patient populations appropriate for psychogeriatric programs will overlap considerably with existing geriatric programs, such as Geriatric Evaluation and Management (GEM) Programs, dementia units, as well other established geriatric medicine programs, and will be well served by collaborating rather than mutually exclusive programs**.**

(c) Psychogeriatric programs may be conceptualized in two tracks that reflect the needs of two psychogeriatric patient groups. These are "psychogeriatric," and "medical-psychogeriatric."

1. Psychogeriatric programs are intended to serve those who, following appropriate medical and psychiatric evaluation, are seen primarily to be physically healthy, or to have relatively stable, chronic medical conditions, and require ongoing evaluation and treatment of psychiatric disorders.

2. Medical-psychogeriatric programs are intended to serve those who, following appropriate medical and psychiatric evaluation, are found to need simultaneous evaluation and active treatment of both psychiatric and medically unstable conditions.

***NOTE**: Identification of programs as "psychogeriatric" and "medical-psychogeriatric" should not be interpreted as a requirement to create competing programs or restrict access exclusively but only to remind clinicians that the populations are somewhat different. At many VA medical centers, there will not be sufficient demand to establish both types of programs. Patients who need simultaneous medical and psychiatric evaluation and treatment may be accommodated in the most appropriate setting that offers appropriate medical and mental health staff resources.*

(d) Psychogeriatric patients often move from one level of care to another. In order to ensure effective, high-quality diagnosis and treatment, psychogeriatric services should provide both a continuity of providers who know the patient and are responsible for integrating the patient's services and an integrated range of available program elements.

(e) Hospital stays of relatively brief duration may be needed to provide respite for family members or other caregivers, thus extending the period of time that the patient may be maintained at a less restrictive level of care; e.g., at home with outpatient treatment.

(2) **Interdisciplinary Approach.** Because of characteristic medical and psychosocial comorbidities, exemplary geriatric mental health care requires an interdisciplinary team approach that incorporates the perspectives of the full range of healthcare professionals. While some providers may be assigned to a specific clinical team, others may be available as part of an extended team through consultation or specific clinic visits.

(3) **Special Issues**

(a) There are a number of special issues to be considered in developing mental health services for older veterans. These include:

1. Special attention to the physiology of aging.

2. The presence of multiple physical and mental comorbidities, including substance use disorder, which may be diagnosed or undiagnosed.

3. Associated socio-cultural and psychosocial problems and spiritual injuries, such as bereavement and social isolation.

4. Special issues of geriatric psychopharmacology.

5. Under-utilization of mental health services and the need for outreach.

6. The crucial role of the older patient's family or other social support system.

7. Issues of patient mix (e.g., mixing elderly with younger psychiatric patients, or mixing demented with non-demented patients).

8. Psychogeriatric assessment issues including neuropsychological testing.

(b) These issues are discussed in detail in VHA Program Guide 1103.22, Integrated Psychogeriatric Patient Care.

(4) **Staffing Considerations**

(a) Owing to the national shortage of a staff with psychogeriatric training and experience, generically trained care providers must be aware of the need for seeking specialized consultation so that treatment and/or rehabilitation planning and provision of care adequately consider each patient's unique needs. Access to expertise on aging is crucial. Staffing in psychogeriatric programs varies as a function of patient mix, program design, and availability of staff with specialized training in working with older patients. In the ideal medical center climate, core staff in a psychogeriatric program should include a:

1. Geriatric psychiatrist,

2. Geriatrician,

3. Psychiatric social worker with training and/or a special experience in gerontology,

4. Clinical nurse specialist or nurse practitioner with training in psychiatric nursing and geriatrics and/or gerontology, and a

5. Geropsychologist or psychologist with training in gerontology.

(b) Members of other disciplines can provide valuable assistance either as core team members or through liaison arrangements. In particular, the Health Care Finance Administration (HCFA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that a pharmacist evaluate the drug therapy of geriatric patients. A clinical chaplain with special training in gerontology can also be helpful, where available**.** In addition, psychogeriatric programming can benefit considerably from the assistance of volunteers willing to elicit patients concerns in conversation or to serve as an escort for appointments or errands.

(c) In community based programs, the needs for staffing will take into consideration the numbers of patients, the intensity of their symptoms, and the availability of community resources, caregivers, and volunteers.

NOTE: *The education of staff should be carefully planned and up to date. Moreover, all staff members need to be trained in the management of elderly patients.*

(5) **The Psychogeriatric Continuum of Care**

(a) Environmental Structures or Settings. Environmental structures or settings range from homes with support from family members, to retirement centers with access to special care if needed; other community residential care settings; outpatient clinics and day treatment settings; VA or state Domiciliaries; VA, state, or private nursing homes with psychogeriatric settings; and intermediate to highly staffed hospital settings.

(b) Professional Interventions. Professional interventions range from outreach and education of patients, their families, community agencies and nursing homes, to case management including crisis management by phone or in person, and consultation, evaluation, treatment, and follow-up for veterans in various settings, including moderate to intensive treatment and rehabilitation in special clinics and hospital settings.

(6) References

(a) VHA Program Guide 1103.22, Integrated Psychogeriatric Patient Care, March 26, 1996.

(b) Van Stone W. "Veterans Affairs Medical Centers and Services for the Psychogeriatric Patient." In Kaplan HI and Sadock BJ, Comprehensive Textbook of Psychiatry/VI, vol 2. pp. 2629-2631, 1995.

g. **Providing Services to Veterans Living in Rural Areas**

***NOTE**: Veterans living in rural areas are not specifically included as special* populations *under the Eligibility Reform Act or as Special Emphasis Programs under VHA Directive 96-051. They are included in these Guidelines, however, because they do require special programming to provide access to medical care.*

(1) **General Principles to Consider**

(a) Most rural clinicians need to be generalists competent to treat all the basic general psychiatric problems seen in VA practice. Functions performed in urban settings at mental health clinics and by PTSD clinical teams and outpatient substance abuse teams need to be combined in any rural clinic. Inpatient units need to function the same way with many rural programs having to combine acute psychiatry, inpatient substance use disorder detoxification and stabilization, PTSD rehabilitation, and longer term care all in one unit.

(b) Willingness and comfort in doing telephone therapy is essential for both clinicians and patients. Using telemedicine equipment for interviews from isolated emergency rooms also has occurred and is desirable where feasible.

(c) Traveling clinics are often desirable, particularly where competent mental health providers in rural sites are rare. VA staff members need to find ways to provide direct services to remote towns and population clusters. Local armories, grange halls, service clubs, and veteran's halls usually are willing to let VA use their space at no charge if VA clinicians are willing to travel to that site to extend services.

(d) Coordination of care activities with Vet Centers, Indian Health Service, DOD, the Department of Health and Human Services (HHS), community mental health centers, state mental health, and other federal and state agencies is desirable. Often scarce resources can be pooled in joint clinics to provide more effective and cost efficient treatment systems.

(e) Availability of lodger beds is a useful option making it possible for veterans to come for outpatient care from distant sites. Coordination of appointments between all clinical services treating veterans from distant locales, i.e., beyond 50 miles, is highly desirable.

(2) **Guidelines for Using Tele-Mental Health Technology**

(a) Definition.: Tele-mental health is the use of communications technologies to provide and support mental health care when distance separates the participants.

(b) Activities. Tele-mental health activities include both the use of the telephone for mental health service and the use of videoconferencing or interactive television technologies for providing or supporting mental health services.

(c) Telephone Use in Mental Health Services

1. The use of the telephone for communication with patients is an integral part of quality mental health care. The use of the telephone for clinical purposes can range from psycho-educational support to crisis evaluation and intervention and may include a follow-up contact with a patient following hospital discharge. The information obtained and provided using the telephone in clinical decision making should be integrated with information obtained from prior contacts and assessments and incorporated within the patients' records.

2. Telephone liaison care programs are available to provide information, guidance and direction for patients (see VHA Program Guide 1120.1, 1997.)

3. The use of interactive voice response (IVR) and automated response systems is being evaluated to define further its role in clinical assessment and follow-up.

(d) Internet Access in Mental Health Services

1. The Internet and World Wide Web can serve as a valuable educational resource for providers, patients and families. Providers and facilities should maximize its educational use. Access to the Internet will increasingly provide patients and families with additional specific education and information regarding their condition.

2. There is a growing recognition of potential adverse effects related to use of the Internet, including the potential for misinformation and unsound advice. (Jadad, 1998.)

3. Patients may also have questions regarding mental health services identified as available using the Internet. Patients should be advised regarding the limitations of these activities in treatment or assessment decisions.

(e) Videoconferencing and Tele-Mental Health

1. The use of two-way teleconferencing or tele-mental health for assessment and management of mental health conditions has been rapidly increasing. Clinicians are referred to a resource document for Telepsychiatry via Videoconferencing (American Psychiatric Association (APA) Committee, 1998). Most tele-mental health activities are conducted using compressed digital videoconferencing equipment. Most activities have used 384 Kilobytes per second (Kbps) or higher bandwidth transmission, though transmission at 128 Kbps using desktop equipment appears suitable for an increasing number of clinical applications.

2. The use of tele-mental health services should be directed towards increasing the availability and access to services for patients in areas where geographic barriers exist. Tele-mental health service delivery should facilitate and complement already existing mental health service delivery processes.

3. Tele-mental health services generally require a team approach involving a provider located at a distance from the location of the patient and provider team members at the remote end. The team process should be coordinated to maximize the benefit to the patient.

4. Patients should be fully advised and give informed consent regarding the nature of the activity, limitations, possible adverse reactions or contraindications, confidentiality issues, and alternatives to this intervention, just as if the contact were direct.

5. Documentation of assessments, consultations, and clinical decisions should be fully integrated within the medical record. Provisions should be made for emergency or crisis management situations, which clearly identify responsibilities for management of the clinical interventions.

6. Videoconferencing is useful in facilitating joint team conferences between inpatient and outpatient facilities as well as providing consultative support for education of residents and staff. Family support groups and visitation can also be facilitated using videoconferencing systems.

7. Technical consultation and support from Information Resource Management (IRM) are essential in maintaining quality of videoconferencing capabilities and implementation of this capability.

8. Ongoing evaluation of tele-mental health services is essential to continue to identify appropriate uses, cost-benefits, and outcomes associated with this method of service.

(3) **References**

(a) APA Committee on Telemedical Services. APA resource document on telepsychiatry via videoconferencing, 1998. Internet at http://www.psych.org/pract_of_psych/tp_paper.html.

(b) Jahad AR, Gagliardi A. “Rating Health Information on the Internet,” JAMA. 279:611-614, 1998.

(c) VHA Program Guide 1120.1. Telephone Liaison Care, March 25, 1997.

h. **Special Issues for Women and Other Minority Veterans**

(1) **Women Veterans.** Women veterans are recognized as one of the special emphasis populations. As such, VHA is committed to maintain the overall capacity to provide programs to care for women veterans, including provision of high quality mental health care.

(a) Women veterans seeking VA mental health care often have unique needs compared to a primarily male patient population. These include:

1. Privacy, safety, and comfort in all VA settings;

2. A significant peer group of fellow women veterans in group treatments and in hospital and residential settings;

3. Access to counseling and treatment for sexual harassment and abuse before, during and after military service;

4. Access to gender-specific care and other woman-related services, such as eating disorder clinics; and

5. Special considerations regarding minor aged children.

(b) Sexual trauma services should be available at each facility and are present at over 60 Readjustment Counseling Centers, i.e., Vet Centers, nationwide.

(c) In addition to general mental health services available to women veterans in all VHA inpatient and outpatient settings, VHA provides six inpatient units designated specifically for women and four women's stress disorder teams.

***NOTE**: A Task Force chaired by the Director, Center for Women Veterans, Director, Women Veterans Health Program and the Associate Consultant for PTSD, MHSHG, has begun work on Mental Health Guidelines for Women Veterans.*

(2) **African-American Veterans**. African-American veterans often have special issues regarding cultural differences and experiences in the military that are often not understood by the majority population. Sensitivity to such issues and involvement of African-American staff in planning and treatment may help to alleviate some of these issues.

(3) **Latino Veterans.** The growing Latino minority, especially in areas of the country with large Latino populations, also has cultural needs that require special attention during treatment planning. Most veterans, having served in the armed forces, speak excellent English, however communication with friends and relatives may require bilingual staff to communicate and understand both the words and the cultural issues.

(4) **Native-American Veterans.** At locations near large Indian reservations VHA has a growing number of programs focusing on providing treatment for Native American veterans. Service in the armed forces has been part of a long and honorable warrior tradition in many Native American cultures. Outreach to Native American veterans requires sensitivity to the wide range of cultural differences within their many populations, as well as to issues faced by those who are primarily assimilated within the majority culture. Asian and/or Pacific Islander veterans also share special issues described in the Matsunaga Study (NCPTSD, 1997).

NOTE: *Broad categories like "African American, Latino, and Native American," cover a rich variety of subgroups within each category who may or may not share common attitudes about mental illness and healthcare. In truth, the same can be said of the "majority" population. Our goal is to better understand and meet the needs of members of these diverse populations and of all the unique individuals we serve.*

(5) **Reference.** National Center for Post-Traumatic Stress Disorder (NCPTSD) and National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR): Matsunaga Vietnam Veterans Project. February, 1997.

4. PROGRAM ELEMENTS AND SETTINGS

a. Overview

(1) **Journey of Change.** The Journey of Change envisions innovations in providing medical care including new modalities, settings, and interventions. This paragraph shifts from the more theoretical focus presented in paragraphs 1 through 3, to practical, nuts and bolts suggestions on transforming innovative ideas into the definitions and data collection conventions required by the Eligibility Reform Act (see subpar. 3a) and prudent business practice. The following programs, program elements, and settings are defined in the context of the need for a common vocabulary and common data code definitions. ***NOTE:*** *See subpar. 2b(1) for the definition of "program" and "program element." DSS Identifiers, formerly called "stop codes," are defined in Appendix D, but are subject to change. Local administrative services should have the latest publications.*

(2) **Admission to Mental Health Care**

(a) The process of admission to care varies widely among VA medical centers and clinics reflecting their differing size, mission, location, community practice norms, and their relationship to academic and other non-VA resources. For each patient seeking medical care, the following issues must be addressed in a flexible manner:

(1) Eligibility determination,

(2) Acuity issues,

(3) A safe place for assessment,

(4) Availability of records and/or information from family or referring agencies,

(5) Referral for care of often multiple comorbidities, and

(6) Access to beds and/or alternative resources.

(b) Patients already enrolled into a primary care team or who have access to a case manager clearly have an advantage over patients who must negotiate the admission "system" by themselves.

(c) Practitioners and administrators have devised special programs, procedures, and settings in addition to the traditional emergency or admission room, that are relevant to patients' entry into mental health practice. The following are examples:

1. Telephone consultation and triage services available 24-hours a day (VHA Program Guide 1120.1);

2. Mental health admission, triage, and outreach teams that may see patients first to provide crisis or other appropriate intervention before formal eligibility is confirmed; and

3. The 23-hour (up to 48-hour) observation bed, available when a period of time is needed for a patient to stabilize before making a more thorough assessment.

(d) Procedures also exist for reviewing patients' psychiatric and medical status with a transferring facility's clinical staff to ensure that:

1. The patient's mental health problems are clearly understood and within the capabilities of the receiving facility to manage (VHA Program Guide 1120.1, Telephone Liaison Care), and

2. That the patient is medically and psychiatrically stable enough to be safely transferred.

b. **General Mental Health (Seriously Mentally Ill Veterans)**

NOTE: *All of the following program elements qualify as "specialty settings" for patients designated as disabled by a serious mental illness under the Eligibility Reform Act. They are available for all psychiatric patients.*

(1) **Mental Health Primary Care Teams**

(a) Mental Health Primary Care Teams represent a new way to provide across the board care for veterans with a mental illness (see subpar. 2c(3)). Teams may follow their patients throughout the mental health continuum and across diagnostic groups and provide whatever intensity of intervention is clinically indicated. If administered as one organization, this qualifies as a program.

Mental Health Primary Care Teams

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

NOTE: *Intensity (of therapeutic interventions) and Levels (of therapeutic milieu, supervision or structure) are described in more detail in subparagraph 2d and following pages.*

(b) Since primary care team members see patients in all possible settings, it is important in capturing costs to use DSS Identifiers associated with those settings. Patients seen by a primary care team who are not seen in another setting or program element, as described in this paragraph, should be coded under DSS 531 (MH Prim Care individual) or 563 (MH Prim Care group). If patients are provided specialty substance use disorder, PTSD, or homeless treatment by team members, DSS Identifiers for those specialties should be used (see subpars. 4c, 4d, or 4e respectively).

NOTE: *The following program elements are listed in order of the five levels of settings presented in the Figure in subparagraph 2d(1)(c)4., starting with the least intensive environmental structure to the highest, in order to make comparisons with non-VA mental health sectors easier (see App. C). The accompanying diagrams for each program and/or element indicate that VHA's mental health programming does not neatly fit those categories. Definitions of DSS identifiers sorted by number are found in Appendix D.*

(2) **Community Based Clinics.** Community-based outpatient clinics (CBOCs), mobile clinics, and veterans outreach centers are increasingly used to provide mental health care nearer the veteran's home.

Community-Based and/or Satellite Clinics

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Mental health issues should be addressed at all CBOCs. Mental health professionals at smaller CBOCs need regular access to mental health specialists usually available at larger VA facilities through administrative links, scheduled telemedicine contacts, face-to-face consultation visits, or other arrangements in order to maintain their proficiency.

(b) Mental health workload at these clinics may be captured using the same codes as those used at Mental Health Clinics.

(3) **Mental Health Clinics (MHCs)**

Mental Health Clinics

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

NOTE: *Shading of different intensities across the Levels continuum suggests that treatment teams may follow patients across levels of care to differing degrees.*

(a) MHCs are the basic outpatient settings within the mental health care delivery system. MHC staff provide primary and specialty mental health care for patients whose mental health problems can be resolved and stabilized within the community, and essential aftercare for patients following a period of hospitalization. Some MHCs may provide medication clinics or other services for patients enrolled in partial hospitalization or residential treatment programs (lightly shaded area).

(b) The MHCs are designed to provide direct services including the entire range of modern mental health assessment and treatment modalities.

(c) Examples of special modalities that may be found within MHCs are:

1. Crisis intervention,

2. Admission triage teams,

3. Family therapy,

4. Special programs for Prisoners of War (POWs) or PTSD patients,

5. Substance use disorder and dual-diagnosis treatment,

6. Primary ambulatory medical care for psychiatric patients, and

7. Case Management.

(d) MHCs may locally be named psychiatric outpatient clinics, primary mental health care clinics or whatever name is clinically appropriate for patient care.

(e) With respect to VERA and the requirement to maintain "capacity" within Public Law 104-262, however, the MHC codes (502 MHC indiv. or 550 MHC group) should be used for general mental health services performed in any mental health outpatient clinic setting. Encounter forms initiated at each visit to a clinic capture the diagnosis and identity of the provider.

(f) DSS Identifiers for Psychiatry (509 indiv., and 557 group), or Psychology (510 indiv., and 558 group) are better restricted to other settings where primarily psychiatry or psychology services are rendered. Examples might be emergency rooms, or special behavioral health clinics. Psychiatry consultation (DSS 512) would be appropriate in medical or other settings outside of the MHC**.**

(g) Specialty PTSD clinics within MHCs should use DSS 516 and DSS 562, (PTSD group, and PTSD individual, respectively);

(h) Specialty substance use disorder clinics within a MHC should use 513 (Substance Abuse, individ), and 560 (Substance Abuse, Group).

(4) **Standard Case Management**

NOTE*: A diagram does not accompany programs or program element definitions where the description in text is sufficient.*

(a) Categories. Subparagraph 2c(4) of this Program Guide describes organization of standard case management into three general categories:

1. "Door to Door" case management.,

2. Primary therapist., and

3. Medical care management.

(b) Since standard case management services are provided in most outpatient and many inpatient settings and are generally integrated into basic medical or mental health care, DSS identifiers associated with the workload are those appropriate for the setting. Currently, the case management services are captured under a wide range of Current Procedural Terminology (CPT) codes including the Evaluation and Management codes for medical conference, 99361 and 99362; and telephone call, 99371-99373. (American Medical Association (AMA), 1997). CPT codes change frequently and updated manuals must be sought from VA medical administrative services or libraries.

(5) **Intensive Community Case Management (ICCM)**

Intensive Community Case Management

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) This program, a modification of the "community crisis teams" and ACT provided at some VA and non-VA mental health settings, brings high intensity, interdisciplinary, professional supervision to severely psychiatrically disabled patients residing in a variety of community settings, e.g., family homes and apartments, community residential care, and in psychiatric and general nursing homes. Many VA facilities are offering a well-researched version (see subpar. 2c(4)(e)7.), monitored out of the NEPEC, called IPCC.

(b) Aspects of Intensive Community Case Management (ICCM) Teams that help prevent clinical deterioration that often leads to re-hospitalization are:

1. Provision of medication maintenance,

2. Behavioral intervention,

3. Family counseling,

4. Crisis intervention services, and

5. Community-based rehabilitation.

(c) The programs are relatively resource intensive and should be seen primarily as an alternative to long-term hospital care.

(d) Hours of professional contacts per patient may range from 5 to 21 hours per week.

(e) DSS identifiers for NEPEC-supported IPCC teams only are 552 (IPCC community) and 546 (IPCC telephone). Other ICCM visits and telephone contacts are to use the new DSS Identifiers 564 (Intensive Comm. Case Mgt.) and a 147-564 credit pair to capture the telephone calls.

(f) Reference. AMA. CPT 98: Physicians' Current Procedural Terminology, p. 39, 1997.

(6) **Day Treatment Centers (DTCs)**

Day Treatment Centers

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) DTCs are designed to maintain psychiatric patients with severe and persistent mental illness at relatively stable levels of functioning within the community using a rehabilitation focus that facilitates independent living. DTCs offer a wide range and intensity of professional interventions within a moderately structured setting as much as 6 to 8 hours a day.

(b) These programs provide:

1. A supportive learning environment for patients having chronic, severe psychiatric illnesses; difficulties with community adjustment; interpersonal relations; and vocational or educational problems.

2. A setting permitting patients to remain within their social and family environment while receiving treatment, or to participate in a residential rehabilitation program that provides a structured, therapeutic living environment to reinforce day treatment interventions.

3. Cost-effective alternatives to repeated or prolonged hospitalizations.

4. Improvement of the quality of life.

5. Maximum social and vocational rehabilitation.

(c) Patients in DTCs often have had long and/or multiple periods of hospitalizations and need continued monitoring of their general health and medication needs. Patients in DTCs may receive treatment in this setting 3 to 5 days per week or more and may continue for months or years**.** ***NOTE:*** *Less intensive or lower level alternatives should periodically be considered.*

(d) Some DTCs:

1. Offer services on weekends;

2. May work closely with intensive case management teams or hospital-based rehabilitation programs;

3. Develop special programs for psychogeriatric patients;

4. May work with CWT or other supported/therapeutic work programs;

5. May work in conjunction with Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs) to develop psycho-educational skills to be practiced in the residential setting then transferred into independent living.

(e) DSS identifiers for DTCs include 505 (DTC individual) and 553 (DTC group). Exceptions would be psychogeriatric Day Hospitals, which would use DSS 578 (Psychoger Day Program).

(7) **Day Hospital Programs**

Day Hospital Programs

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Day Hospitals are the most labor-intensive ambulatory psychiatric care programs. They provide a moderate, specialized degree of structure that falls between full hospitalization or residential rehabilitation programs and the more traditional models of ambulatory care.

(b) These programs are designed to:

1. Assist the veteran in avoiding full hospitalization and to allow the veteran to maintain community ties.

2. Provide intensive diagnostic and treatment services to patients following inpatient care to allow shortened lengths of stay and a more rapid return to the community.

3. Provide rapid evaluation, crisis intervention, transitional treatment, and further stabilization of psychiatric conditions in order to prevent rehospitalization.

4. Provide therapeutic services to:

a. Seriously mentally ill patients (see subpar. 3b) in crisis;

b. Patients with medical and/or surgical impairments who are having difficulty adjusting to the limitations imposed by their illnesses; and

c. Veterans with PTSD and/or substance use disorder problems as comorbidities.

(c) Patients who benefit from Day Hospitals include those with few previous significant mental health problems whose condition has been precipitated in part by situational crisis.

(d) Following a period of intense treatment in Day Hospitals patients may receive additional, less intense treatment in MHCs, or may be prepared to return to full independent living.

(e) Day Hospitals may:

1. Be used for initial evaluation of patients applying for psychiatric care;

2. Work closely with intensive psychiatric community care teams; and/or

3. Have a psychogeriatric emphasis.

(f) DSS identifiers for Day Hospitals are 506 (DH individual) and 554 (DH group). Exceptions would be Psychogeriatric Day Hospitals, which would use DSS 578 (Psychoger Day Program).

(8) **Community Residential Care (CRC)**

Community Residential Care

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) The CRC Program offers residential care, including room, board, and limited personal care and supervision (often including supervision of medications depending upon individual state laws) to veterans who do not require hospital or nursing home care, but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide needed care.

1. This program, originally designated as "Foster Care," began in the 1950s as a community reentry program for psychiatric patients no longer in need of acute hospital care.

2. Although the CRC Program has been expanded to include general medical and surgical patients, nearly 75 percent of the 11,000 veterans currently enrolled in the program have primary psychiatric diagnoses.

(b) The patient must essentially be capable of performing activities of daily living (ADL) with minimal, or no assistance, exhibit socially acceptable behavior, and not be a threat to self or others.

1. Care is provided at the veteran's own expense in private homes or state-licensed private care facilities inspected and approved by VA, but chosen by the veteran.

2. The veteran generally receives follow-up visits approximately monthly from VA social workers and other healthcare professionals as indicated, and is an outpatient of the local VA medical centers.

(c) DSS Identifier for contacts with CRC patients in their settings is 503 (residential care, individual). The DSS identifier, 121 (Res Care FU), will be not credited for SMI capacity determination or for 30 day post discharge follow-up measures.

(9) **Community-based Residential Treatment Settings**. These non-VHA operated settings include psychiatric half-way houses, structured therapeutic group homes, and community-based residential treatment facilities.

(a) They are designed to provide transitional therapeutic experiences for patients who have just been discharged from VA psychiatric inpatient settings. In these settings veterans may consolidate gains acquired in the hospital and further prepare themselves for full reentry into the community.

(b) In contrast to PRRTPs, these settings are generally owned by private entrepreneurs, non-profit groups, or veterans organizations; they generally provide room and board plus access to mental health treatment programs.

(c) Sometimes VA staff may be directly assigned to provide or augment care.

(d) Except for VA contract half-way houses for drug and alcohol abusers, and HCMI contracts, the veterans generally must pay rent from their own funds.

(e) Since patients at this level are considered outpatients, the same DSS identifiers would apply as other outpatients. ***NOTE:*** *An exception is half-way houses on VA grounds that are counted as beds. These are assigned a Treating Specialty* Code *75.*

NOTE: *Psychiatric Night Hospitals, often described as a form of partial hospitalization, are best considered under the PRRTP category if administered by a VHA facility.*

(10) **Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs)**

Psychosocial Residential Rehabilitation Treatment Programs

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

NOTE*: PRRTPs include residential rehabilitation for other diagnostic groups discussed in the other specialty sections following.*

(a) Program Description. PRRTPs (VHA Dir. 10-95-099, and ch. 1) represent a bed level of care within the psychiatric continuum that is separate from inpatient hospital beds. These residential beds provide a 24-hour therapeutic treatment setting for acute patients with multiple and severe psychosocial skill deficits related to their psychiatric disorder. PRRTPs utilize the residential ”therapeutic community” of peer and professional support, with a strong emphasis on increasing personal responsibility to achieve optimal levels of independence upon discharge to independent or supported community living.

(b) Location. PRRTPs may be established either on VA medical center grounds or in VA-owned or leased space in the community. Regardless of their location, PRRTP beds are counted as VA beds, and must be reflected in the associated VA medical center’s Gains and Loss (G&L) statement along with Nursing Home care Units (NHCUs) and Domiciliaries.

(c) Treatment Services. Veterans in PRRTPs generally participate in an intensive regimen of outpatient services, such as substance use disorder, PTSD or general psychiatric treatment, day treatment programs, or vocational rehabilitation. These outpatient services are then augmented by the residential component of the program that emphasize self-care and personal responsibility. Rehabilitation goals generally addressed in PRRTPs include, but are not limited to:

1. Social and independent living skill development,

2. Community survival skills, vocational rehabilitation,

3. Nutrition,

4. Shopping,

5. Medication management,

6. Patient and family education, and

7. Acquiring appropriate housing.

(d) Staffing. These bed sections are minimally staffed, since, by their residential (versus hospital inpatient) nature, they are designed to maximize peer support and self-care. Professionals, para-professionals, trained volunteers, non-professionals, and/or “senior” residents may provide 24-hour per day, on-site supervision. Regardless of the type of on site staffing a member of the professional PRRTP staff must be on call by radio, telephone, or beeper, at all times, and clear channels of communication with VA medical center on-call staff must always be maintained.

NOTE: *In PRRTPs where the primary focus of the program is diagnosis-specific residential treatment such as PTSD or Substance Use disorder, professional or para-professional staff may be required for accreditation purposes.*

(e) Workload documentation. Workload for PRRTP residential services that are not tailored to a specific psychiatric diagnosis are reported by Bed Days of Care, using Treating Specialty Code 25.

NOTE: *PRRTPs are somewhat similar to Domiciliaries in that they both seek to provide the best possible care in the least restrictive and most cost-effective setting. Both provide a structured therapeutic environment that addresses the psychosocial needs of patients, and may utilize the ambulatory care system for the provision of care. Unlike the Domiciliaries whose function is to provide a comprehensive biopsychosocial rehabilitation and/or long-term health maintenance, PRRTPs are extended rehabilitation programs designed exclusively for the care of the chronically mentally ill, and are supervised by clinicians with expertise in treating the specific mental illness involved.*

(11) **Mental Health Services Within VA Domiciliaries**

(a) Domiciliaries provide 24-hour supervision by professional and/or paraprofessional staff. Each Domiciliary patient has an identifiable interdisciplinary team and a treatment plan with concrete functional objectives.

(b) Some Domiciliaries offer specialized mental health programs of psychosocial residential rehabilitation services that are similar in nature and design to those described for PRRTPs. Domiciliaries tend to offer a broader range of biopsychosocial rehabilitation services than most PRRTPs.

(c) In contrast to PRRTPs, general Domiciliary settings (without specialized rehabilitation programs) may offer a structured therapeutic environment that may be appropriate for psychiatrically disabled (and often aging) veterans for whom community living is not a reasonable clinical expectation.

(d) Workload documentation. Workload for Domiciliary mental health services that are not tailored to a specific psychiatric diagnosis is reported by Bed Days of Care, using Treating Specialty Code 85.

(12) **General Compensated Work Therapy-Transitional Residences (CWT/TR)**

(a) General CWT/TRs are work-based residential rehabilitation programs that are not tailored to the treatment of patients with a specific psychiatric diagnosis. The CWT/TR model is unique to other VA-operated residential programs in that participants contribute (using their CWT earnings) to the cost of operating and maintaining their residential units and are generally responsible for the planning, purchase, and preparation of their own meals and other “household" activities.

(b) Workload for General CWT/TR residential services is reported by Bed Days of Care, using Treating Specialty Code 39.

NOTE: *Outpatient services performed by staff not costed to any of the preceding described general psychiatric residential programs should be reported using the DSS identifiers appropriate to the site and interventions.*

(13) **Nursing Home Care.** VA NHCUs, contract community-based nursing homes, and state-operated veterans nursing homes in which VA participates through a grant program, all treat veterans with complex medical and functional limitations who also have psychiatric and/or behavioral disorders. These programs are administered centrally by VHA's Geriatrics and Extended Care Strategic Healthcare Group. With the exception of designated Psychogeriatric Sections in VA NHCUs (see psychogeriatric program elements, subpar. 4f), there are no centrally defined mental health programs in VA nursing homes.

(14) **Medical - Psychiatric Sustained Treatment and Rehabilitation Units** (previously "STAR I")

NOTE: *Sustained Treatment and Rehabilitation (STAR) programs were introduced in the Mental Health Manual (M-2, Part X) of 1993 as an alternative to undifferentiated long-term psychiatric wards that often offered little potential for discharge or rehabilitation. The designation of STAR levels I, II, and III, have been discontinued. The STAR levels have redesignated in more appropriate terminology as seen in the following paragraphs.*

Medical and/or Psychiatric STAR Units (previously "STAR I")

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Patents in this setting have long-term medical, neurological, and psychiatric disorders that interact in such as way as to make care in traditional long-term psychiatric or nursing home settings problematic. An emphasis on rehabilitation potential and on individual assets should be included.

NOTE: *Patients who can be treated in less restrictive environments should not be maintained in hospital beds.*

(b) Treating Specialty Code 89 will be used to identify all bed and assigned staff costs.

(15) **Community Reentry STAR Program** (previously "STAR II")

Community Reentry STAR Program

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) This program is appropriate for SMI patients who may have adjusted to a hospital environment, but have marked deficits in social-functional skills and poor judgment. They may have potential for discharge to residential or community-based outpatient programs following an intensive psychological, social and vocational evaluation, and functional skills training program with a rehabilitation focus**.**

(b) Generally, these psychiatric patients should have no significant medical problems requiring high level hospitalization; however, they may lack basic self-care skills required for participation in psychosocial residential rehabilitation or intensive supportive living community-based programs. The emphasis should be on patient self-help and self-care as opposed to staff caregiving.

(c) Community Reentry rehabilitation programming may occur, as appropriate, outside of a specific ward area and may be available to patients from more than one ward. Both programming and rehabilitation staff may follow patients as they move from hospital beds to less structured living settings in the community.

(d) Treating Specialty Code 89 will be used to identify all bed and assigned staff costs.

(e) Workload for patients discharged from Community Reentry inpatients programs and followed on an outpatient basis should be reported using DSS identifiers appropriate to the setting.

(16) Skilled Psychiatric Nursing STAR Unit (previously "STAR III")

Skilled Psychiatric Nursing STAR Unit

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) This program element offers skilled psychiatric nursing care for patients with chronic, refractory, partially stabilized, major psychiatric or organic brain disorders who no longer require intensive treatment, are not actively suicidal or chronically assaultive, are medical stable, and do not meet the requirement for ADL deficiencies associated with a NHCU setting. Periodic reassessments at least every 6 months, including potential for rehabilitation, and trials on alternative settings are recommended.

(b) Treating Specialty Code 89 will be used to identify all bed and assigned staff costs.

(17) General Psychiatry, Subacute and/or Rehabilitation Settings

General Psychiatry, Subacute and/or Rehabilitation Settings

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Psychiatric rehabilitation programs represent a group of specialized programs designed for SMI patients that are of higher intensity and shorter duration than the Community Reentry STAR program, but the distinction may disappear over time. Eligible patients require:

1. Training or relearning in social skills,

2. Group living,

3. Reentry,

4. Discharge planning, and

5. Community survival skills, etc.

(b) The SMI psychiatric patient often needs help with:

1. Housing,

2. Shopping,

3. Consuming appropriate food, and

4. Understanding the nature of the individual's illness and the need for continued medications.

(c) Family members and caregivers also need help in understanding their roles in providing a stable post-hospital environment.

(d) Treating Specialty Code 92 will be used to identify all bed and assigned staff costs.

NOTE: *In smaller psychiatric services, these programs may be incorporated within existing ward programs.*

(18) **Continued Extensive Psychiatric Care (CEPC)**

Continued Extensive Psychiatric Care

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) The CEPC, a long-term program requiring a high staffing level, is authorized in recognition of a relatively small group of psychiatric patients found primarily in the larger, predominately psychiatric medical centers who require a high level of staffing because their behavior is such that it cannot be managed on a STAR level program and they are too disruptive and unresponsive to remain for long on a general psychiatric ward or Psychiatric Intensive Care Unit (PICU). All patients on CEPCs should have a thorough diagnostic review, trial on newer medications, and possibly a periodic trial in alternative settings.

(b) Treating Specialty code 89 will identify all costs associated with this program.

(19) **General Psychiatric Hospital Unit**

General Psychiatric Hospital Unit

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) General Psychiatric Wards offer thorough, comprehensive, psychiatric evaluation, diagnosis, and treatment in a highly structured hospital environment for new patients requiring

hospital-level structure, as well as for patients experiencing recurrence of illness who cannot be assessed, or treated, at a lesser level of care.

(b) The primary objective is to provide an intensive care setting with a shift to a less intensive level of care as soon as clinically appropriate. All or parts of such units should be securable in order to accommodate involuntary patients and patients who are temporarily out of control or at risk of harming themselves or others.

(c) Treating Specialty Code 93 will be used for all costs.

(20) **Psychiatric Intensive Care Units (PICUs)**

Psychiatric Intensive Care Units

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) The PICU offers smaller size, increased staffing, security (safe, quiet seclusion rooms), and more specialized clinical expertise than a general psychiatric ward. A PICU may be physically within or adjacent to a traditional admitting or general psychiatric ward.

(b) Patients admitted to this level of care will have the most severe behavioral problems including:

1. High suicide risk,

2. Assaultiveness,

3. Severe agitation,

4. Disorganized behavior secondary to psychosis,

5. Confusion, or

6. Other severe psychiatric disorders.

(c) Psychiatric patients presenting with such symptoms may be rapidly stabilized on such a unit, obviating the need for transfer to a long-term or more secure facility often some distance away.

d) Treating Specialty code 93 will also be used for all program costs.

(21) **Summary of Reporting Codes for SMI Programs**

Seriously Mentally Ill	DSS* ID #	CDR** Account		Seriously Mentally Ill	DSS ID #	Spec Codes	CDR Account
Community/Outpatient			**II**	**Partial Hospitalization**			
Telephone, General Psych	527	2780	6)	Day Treatment, Individual	505		2311
Mental Health Primary Care Team, Indiv.	531	2331	6)	Day Treatment,Group	553		2310
Mental Health Primary Care Team, Group	563	2330	7)	Day Hospital, Individual	506		2311
Psychiatry, Consultation	512	2311	7)	Day Hospital,Group	554		2310
Psychiatry MD - Individual	509	2311	**III**	**Residential Settings**			
Psychiatry - Group	557	2310	8)	Mental Health Residential			
Psychology, Individual	510	2311		Care, Individual	503		N/A***
Psychology, Group	558	2310	10)	PRRTP		25	1711
Mental Health Clinic, Individual	502	2311	11)	Mental Health, Domiciliaries		85	1510
Mental Health Clinic, Group	550	2310	12)	CWT-TR)		39	1717
Intensive Comm Case Management			**IV**	**Professional Care**			
(ICCM)	564	2311	14)-16)	STAR Units		89	1316
Telephone, ICCM (pair)	147-564	2780	17)	Psychiatry Rehab Settings		92	1311
IPCC, Community Visit	552	5117	18)	CEPC		89	1311
Telephone, IPCC	546	2780	**V**	**High Staffed Hospital**			
			19)	General Psychiatric Ward		93	1310
			20)	PICU		93	1310

* See Appendix D for definitions listed by DSS Identifier numbers.
** CDR refers to the Cost Distribution Report used to allocate staffing costs.
*** Not applicable to CDR; Automated Medical Information System (AMIS) segment J-19 is used by CDR currently for workload

c. **Substance Use Disorder Services, Program Elements, Settings**

NOTE: *The term "substance abuse" has been replaced by "substance use disorder" within the clinical and scientific community. Since VHA's older acronyms and DSS Identifiers do not fit the new nomenclature, this document will use the terms interchangeably at times.*

(1) **Substance Use Disorder Treatment Clinics**

(a) Substance Use Disorder Clinics (formerly Substance Abuse Treatment Programs or "SATPs") provide settings for outpatient care to patients with substance use disorders. Both initial and ongoing interventions may be undertaken in a clinic setting. Treatment is designed to provide the full-range of treatment and rehabilitation services for patients with substance use disorders, including:

1. Detoxification.

2. Treatment of the psychological and behavioral aspects of addiction.

3. Opioid substitution treatment, methadone maintenance therapy and other drug therapies (e.g., levo-alphacetylmethadol (LAAM), etc.) as they are approved for use, in combination with psychosocial services. ***NOTE:*** *Methadone Maintenance Programs will meet the requirements outlined in Title 21 Code of Federal Regulations (CFR) 310.305, and M-2, Part VII, Paragraph 3.03.*

4. Vocational and other rehabilitation services.

(b) Outpatient care emphasizes the development of social and vocational skills and the abstinence necessary to successfully remain in the community.

(c) DSS identifiers include 513 (SA indiv), 560 (SA group), and 523 (opioid maint).

NOTE: *SATPs also were formerly called Alcohol Dependence Treatment Programs (ADTPs) or Drug Dependence Treatment Programs (DDTPs). Both alcohol an drug use disorders are now described under the "substance use disorder" designation."*

(2) **Intensive Outpatient Substance Use Disorder Treatment** (formerly Substance Abuse Day Treatment Center and/or Day Hospital)

(a) A setting for substance use disorder interventions that can provide structured activities 3 or more hours per day, 3 days a week at a minimum.

(b) The DSS identifier for this program element is 547 (Intensive Substance Abuse Treatment).

(3) **Substance Use Disorder Residential Programs**

(a) Substance Abuse Residential Rehabilitation Treatment Program (SARRTP). A SARRTP is a PRRTP (see subpar. 4b(1)(c)) residential setting focusing on treatment of patients with substance use disorder problems.

NOTE*: Treating Specialty Code for SARRTP services is 27.*

(b) Domiciliary based Substance Use Disorder Treatment Programs. Domiciliary based Substance Use Disorder Treatment Programs provide residential services focusing on treatment and rehabilitation of substance use disorder problems in a Domiciliary setting.

NOTE: *Treating Specialty Code for Domiciliary Substance Use Disorder services is 86.*

(c) Substance Abuse CWT/TR (S/A CWT/TR). A S/A CWT/TR is a work-based residential rehabilitation program tailored to the treatment of patients with substance use disorders. The CWT/TR model differs from other VA-operated residential programs in that participants contribute (using their CWT earnings) to the cost of operating and maintaining their residential units and are generally responsible for the planning, purchase and preparation of their own meals, and other "household" activities. CWT/TRs are a special class of PRRTPs that focuses on rehabilitation of substance use disorder problems within a work and living setting.

NOTE: *Treating Specialty code for S/A CWT/TR is 29.*

NOTE: *Outpatient services performed by staff not costed to any of the above described Substance Use Disorder Residential programs should be reported using the DSS identifiers appropriate to the site and interventions.*

(d) Community-based contract residential facilities.

(e) Cooperative agreements with other community providers.

(4) **Substance Use Disorder Subacute Rehabilitation Settings**. Patients receiving care in hospital-based, clinically managed Substance Use Disorder Rehabilitation Settings will be given Treating Specialty Code 84 (Psychiatry-Substance Abuse Intermediate Care).

(5) **Inpatient Substance Use Disorder Settings.** ***NOTE:*** *All acute, hospital-based, medically managed substance use disorder settings use Treating Specialty Code 74.*

(6) **Summary of Reporting Codes for Substance Use Disorder Programs**

	Program Name	**DSS***	**Spec**	**CDR****
		ID #	**Code**	**Account**
c.	**Substance Abuse Services, Program elements / Settings**			
1)	Substance Abuse, indiv	513		2316
1)	Substance Abuse, home visit	514		2316
1)	Telephone, Substance Abuse	545		2780
1)	Substance Abuse, Group	560		2316
1)	Substance Use Dis./PTSD teams	519		2317
1)	Opioid Substitution	523		2316
2)	Intensive Substance Abuse Treatment (formerly Day Hosp.).	547		2316
3)a)	SARRTP		27	1713
3)b)	S/A CWT/TR		29	1715
3)c)	Domiciliary-based S/A program		86	1511
4)	Hospital-based Rehabilitation		84	1312
5)	Inpatient ward		74	1313

*See Appendix D for definitions listed by DSS Identifier numbers
** CDR refers to the Cost Distribution Report used to allocate staffing costs.

d. **PTSD Services, Program Elements, Settings**

(1) **Vet Centers.** Implemented by VA in 1979, readjustment counseling for psychological war trauma is provided through a nationwide system of 206 community-based counseling facilities known as Vet Centers. The Vet Centers were the first VA service program to systematically treat PTSD in returning war veterans. Vet Centers have line authority to and are administered by the Readjustment Counseling Service (RCS). As provided at the Vet Centers, readjustment counseling features a non-hospital community setting, a varied mix of social

services, extensive community outreach and referral activities, psychological assessment and counseling for war-related experiences to include PTSD, and family counseling when needed. Initially restricted to Vietnam veterans, current law has extended eligibility for Vet Center services to any veteran who has served in the military in combat operations during any period of armed hostility. All Vet Centers are minimally required to screen and refer veterans with military-related sexual trauma. In 1993, VHA allotted 34 Full-time Employee Equivalent (FTEE) for this purpose, and RCS hired specially trained counselors to provide sexual trauma counseling. VA mental health and primary care are also available at some Vet Centers through collaborative arrangement with the VA medical centers. Such collaborative arrangements include the out-stationing of VA health care providers at some Vet Centers on regular recurring schedules, and the installation of telemedicine technology at some other Vet Centers.

***NOTE**: Vet Centers have a workload accountability system independent of the DSS Identifier (stop code) system used by VA medical centers. VA medical center staff seeing patients in Vet Centers should use the DSS identifier and CPT codes most appropriate to the services rendered, as if they were in a traditional VA setting.*

(2) **Subclinics for PTSD.** Subclinics for PTSD within existing MHCs or community clinics, where clinical expertise in treatment of PTSD is available, should use DSS 516 and DSS 562 (PTSD group, and PTSD indiv., respectively).

(3) **Sexual Trauma Counseling.** Sexual Trauma Counseling is available at various outpatient settings. DSS 524 (Active Duty Sex Trauma) should be used to document workload if <u>any</u> of the trauma occurred during active military duty and DSS 589 (Non-Active Duty Sex Trauma) should be used if the trauma occurred <u>entirely</u> apart from active duty.

(4) **PTSD Clinical Teams (PCTs).**

PTSD Clinical Teams (PCTs)

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) PCTs are psychiatric outpatient clinics specializing in the treatment of veterans with PTSD. PCTs provide a specialized focus for outpatient care of patients with PTSD, particularly those who have not previously received specialized care. These treatment teams are responsible for:

<u>1</u>. Providing direct clinical care and integrating treatment offered in Vet Centers, general hospital (inpatient and outpatient) programs, and special PTSD units in order to ensure continuity of care for all veterans;

2. Providing consultation and liaison to general psychiatry units, medical, and surgical units;

3. Supervising educational programs on PTSD; and

4. Monitoring utilization patterns of patients with PTSD.

(b) DSS Identifiers for PCTs are 540 (PCT, individual) and 561 (PCT, group).

(5) **Women Veteran Stress Disorder Treatment Teams.** Women Veteran Stress Disorder Treatment Teams were established in FY 1993. These teams, modeled after PCTs, provide ambulatory care and consultation liaison services for women veterans, in particular, those who have been victims of sexual assault or harassment. ***NOTE:*** *The DSS Identifier is 525 (women's stress).*

(6) **Substance Use PTSD Treatment Programs (SUPTs).** SUPTs are specialized outpatient components of substance use disorder treatment programs that are dedicated to the treatment of veterans with substance use disorders and PTSD. Nine VA medical care facilities have SUPT programs activated in FY 1991. ***NOTE:*** *At this time, it appears preferable to establish substance use disorder treatment capability within all specialized PTSD programs.*
NOTE: *The DSS Identifier is 519 (Substance Use Disorder/PTSD Teams).*

(7) **Day Hospitals for PTSD.** Day Hospitals for PTSD provide a specialized form of care to veterans that falls between full hospitalization and the more traditional models of ambulatory care. These programs are characterized by intensive treatment of patients for fixed periods of time (3 to 6 weeks). Modeled after general mental health Day Hospital programs, they are designed to offer an intensive alternative to inpatient services to reflect VHA's greater emphasis on outpatient care. ***NOTE:*** *The DSS Identifier for PTSD Day Hospitals is 580, including both individual and group treatments.*

(8) **Day Treatment Centers for PTSD.** Day Treatment Centers for PTSD focus more on ongoing supportive services for veterans with chronic PTSD symptoms. ***NOTE:*** *The DSS Identifier for PTSD Day Treatment is 581, including both individual and group treatments.*

(9) **PTSD Residential Rehabilitation Programs (PRRPs)**. PRRPs are residential rehabilitation programs for treatment of veterans with PTSD. The general goal of PRRPs is to provide a semi-structured therapeutic environment before full community re-entry. Rehabilitation efforts involve continuing PTSD treatment, sobriety maintenance efforts, where indicated, and efforts directed at securing employment and at establishing housing and support systems in the community.

NOTE: *The Treating Specialty Code for PRRPs is 26.*

(10) **Domiciliary based PTSD Treatment Programs.** Domiciliary based PTSD Treatment Programs provide residential services focusing on treatment of PTSD in a Domiciliary setting. ***NOTE****: The Treating Specialty Code for Domiciliary-based PTSD programs is* ***88.***

(11) **PTSD CWT/TR.** PTSD CWT/TRs are work-based residential rehabilitation programs (also PRRTPs) tailored for the treatment of patients with PTSD. The CWT/TR model differs from other VA-operated residential programs in that participants contribute (using their CWT earnings) to the cost of operating and maintaining their residential units and are generally responsible for the planning, purchase and preparation of their own meals, and other "household" activities.

NOTE*: The Treating Specialty Code for PTSD CWT/TR is 38.*

NOTE: *Outpatient services performed by staff not costed to any of the above described PTSD residential programs should be reported using the DSS identifiers appropriate to the site and interventions*

(12) **Specialized Inpatient PTSD Units (SIPUs**). SIPUs are inpatient psychiatric treatment programs with a typical bed capacity of 25-30 and an average length of stay of 60-90 days. SIPUs offer comprehensive treatment aimed at resolution of war-related problems, resumption of personal development, restoration of ability to deal with close relationships, social participation, employment, and other aspects of productive living. ***NOTE:*** *There are relatively few of these specialized programs throughout the country and referrals for care may be necessary. The Treating Specialty Code for SIPUs is 79.*

NOTE: *PTSD and Substance Use Disorder (PSUs) Programs. PSUs were inpatient programs designed to provide treatment for veterans with the comorbidities of PTSD and Substance Use Disorders. Since PSUs are few in number and Clinical Guidelines recommend that all PTSD programs address relevant comorbidities, PSUs are discontinued as separate entities and may be subsumed under the SIPU category.*

(13) **Evaluation and Brief Treatment PTSD Unit (EBTPU).** EBTPUs are short-term acute PTSD inpatient programs with five to fifteen beds. Average length of stay is expected to be about 10 to 20 days. It is expected that patients completing treatment in an EBTPU will receive follow-up care in a PCT, Vet Centers, or Mental Health Clinic PTSD team or module. Because of its limited number of beds, an EBTPU is not expected to be a free standing unit, but rather, a component of an existing inpatient psychiatry unit. Program evaluations have shown EBTPUs to be the most efficient and customer friendly form of inpatient care for PTSD.

NOTE*: The Treating Specialty Code for EBTPUs is 91.*

(14) **Summary of Reporting Codes for PTSD Programs**

	Program Name	**DSS***	**Tr Spec**	**CDR****
Prog #	**PTSD (Post Traumatic Stress Disorder)**	**ID #**	**Code**	**Account**
All	Telephone/PTSD	542		2780
2)	PTSD Group	516		2310
2)	PTSD Individual	562		2311
3)	Active Duty Sex Trauma	524		2311
3)	Non-Active Duty Sex Trauma	589		2311
4)	PCT Post Traumatic Stress-Individual	540		2313
4)	PCT-Post Traumatic Stress, group	561		2313
5)	Women's Stress Disorder Teams	525		2311
6)	Substance Use Disorder/PTSD teams	519		2317
7)	PTSD Day Hospital	580		2310
8)	PTSD Day Treatment	581		2310
9)	PRRP (PTSD Residential Rehabilitation Program)		26	1712
10)	Domiciliary-based PTSD program		88	1512
11)	PTSD CWT/TR		38	1716
12)	SIPU (Specialized Inpatient PTSD Unit)		79	1314
13)	EBTPU (Evaluation & Brief Treatment PTSD Unit		91	1315

*See Appendix D for definitions listed by DSS Identifier numbers
** CDR refers to the Cost Distribution Report used to allocate staffing costs.

e. **Health Care For Homeless Veterans (HCHV) Programs**

NOTE: *All veteran patients who are homeless should have a "V-code" 60.0 for "lack of housing" included as part of their diagnosis (Commission..., 1991). Staff associated with Homeless Veteran programs should particularly insure that a V 60 code is included in the medical record.*

(1) **Homeless Chronically Mentally Ill (HCMI) Program**

(a) The HCMI Program staff:

1. Seek out homeless mentally ill and substance abusing veterans;

2. Assess the veterans multidimensional problems; and

3. Assist the veterans in obtaining comprehensive care, including community-based residential treatment.

(b) In compliance with Public Law 100-322, VA contracts with non-VA community-based Psychiatric Residential Treatment Programs to obtain the residential treatment component of the HCMI Program.

(2) **VA Supported Housing (VASH) Programs**. ***NOTE****: The DSS identifier is 522 (HUD/VASH).*

(a) In VASH Programs, VA clinicians provide ongoing case management and other needed assistance to homeless veterans in permanent housing.

(b) There are two types:

1. In the VA- HUD VASH Program, a joint initiative with HUD, VA staff at participating medical centers provide assistance to homeless veterans in permanent housing obtained with specially-designated HUD rental assistance vouchers.

2. In non-HUD VASH programs, the permanent housing is obtained through partnerships with veterans service organizations and others that provide the housing component through local collaborations with public housing authorities. *NOTE: The DSS identifier for both types of programs is 522 (HUD=VASH).*

(3) **Social Security Administration (SSA) - VA Joint Outreach Initiative**

NOTE: *SSA-VA Joint Outreach Initiative is a pilot project with SSA, in which HCHV Program staff coordinate outreach and benefits certification with SSA staff to increase the number of veterans receiving SSA benefits and to otherwise assist in the veteran's rehabilitation.*

(4) **HCMI CWT/TR**. HCMI CWT/TR is a VA owned and operated work-based residential rehabilitation program focusing on the problems of HCMI patients. Participants contribute (using their CWT earnings) to the cost of operating and maintaining their residential units.

NOTE*: The Treating Specialty Code is 28.*

(5) **Domiciliary Care Programs.** Domiciliary Care Programs for homeless veterans are a rapidly expanding and effective addition to VA care.

NOTE: *The Treating Specialty Code for general Domiciliary programs is 85. (V code 60 for "lack of housing" should be included in the discharge diagnosis.)*

(6) Reference: Commission on Professional and Hospital Activities. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Annotated. Ann Arbor, 1991, p. 952.

(6) Summary of Reporting Codes for Homeless Programs

	Program Name	DSS*	Spec	CDR**
Level,		**ID #**	**Code**	**Account**
Prog #)	**HCHV (Health Care for Homeless Veterans) Programs**			
1)	Telephone/Homeless Mentally Ill	528		2780
1)	Telephone/HUD-VASH	530		2780
1)	HCHV/HMI	529		2312
1)	Community Outreach to Homeless Vets by Staff Other Than HCHV and DCHV Programs	590		2319
2)	HUD VASH	522		2318
3), 4)	HCMI/TR		28	1714
6)	Domiciliary-Homeless		85	1510

*See Appendix D for definitions listed by DSS Identifier numbers.
** CDR refers to the Cost Distribution Report used to allocate staffing costs.

f. **Services and Program Elements for Elderly Veterans with Psychogeriatric Problems**

(1) **Concept of Clinical Teams.** Psychogeriatric team care is conceptualized as bridging levels of care and working within and between existing clinical services rather than having particular unit or clinic attachments. Diagnostic evaluation, treatment recommendations, and case management on a direct or consultative basis may be appropriate when resources are limited. Since most elderly patients with problems such as depression or dementia are treated outside of a specialized psychogeriatric setting, a skilled team of consultants to seek them out and provide direct or indirect evaluation and treatment can be a valuable resource to primary care and other non-mental health specialty providers.

(2) **Psychogeriatric Integrated Care Teams (PICTs)**

Psychogeriatric Integrated Care Teams (PICTs)

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) PICTs may initiate services primarily with psychogeriatric patients at the medical center at all levels of care and may follow discharged inpatients with active case management, education of caregivers, home visits, and consultation in the community, using a primary care

approach. Consultation accessed via telephone or television is an additional option. PICTs should identify clinical areas where high numbers of elderly patients are receiving care and actively reach out to patients and clinicians in these areas to provide education, consultation, and, where appropriate, primary care services.

(b) PICTs bring evaluation and treatment services to the psychogeriatric patient rather than bringing the patient to the service. They extend psychogeriatric expertise to programs and settings where limited resources do not permit the addition of assigned FTEE positions.

(c) PICTs may provide a structure for accountability for outcomes of care for older veterans.

(d) If the number of psychogeriatric programs in a medical center is insufficient to meet the need for psychogeriatric care, or if insufficient need exists to justify establishing units at several levels of care, it may be more cost effective and foster higher quality service to have a mobile PICT that serves multiple program needs in a variety of settings.

(e) Because of difficulties the elderly often have in finding adequate transportation and with general mobility, the usefulness of telephone hotlines, crisis management, and case management by phone is particularly worth exploring.

(f) Team members can capture workload for these patients using the three DSS identifiers. 579 (Telephone, Psychogeriatric), 576 (Psychogeriatric Indiv.), and 577 (Psychogeriatric Group).

(3) **Collaboration with Pertinent Geriatrics and Extended Care Programs.** Because of a high prevalence of mental health problems in geriatric patients, facilities are encouraged to assign psychogeriatric mental health professionals to Geriatric Programs, where appropriate, or have them serve as consultants. Examples are:

(a) Home-Based Primary Care (HBPC),

(b) GEM Programs,

(c) Geriatric primary care Clinics,

(d) Acute geriatric units,

(e) NHCUs,

(f) Adult Day Health Care (ADHC),

(g) Hospice Programs,

(h) Respite Programs,

(i) Alzheimer and other Dementia Programs,

***NOTE**: Alzheimer and other Dementia Programs are defined as those outpatient or inpatient programs in which at least 50 percent of patients have a primary diagnosis of dementia (Alzheimer's or other form) and interventions are specific to that group. The remaining patients may be elderly individuals with other types of primarily psychiatric diagnoses in addition to some degree of cognitive impairment, who would benefit from the special focus of the program. Patients may also have medical comorbidities.*

(j) Domiciliaries,

(k) CRC,

(l) Community Nursing Home Programs (CNH), and

(m) State veterans nursing homes and domiciliaries.

(4) **Family and/or Caregiver Support**

(a) Multiple levels of support are needed for caregivers throughout the continuum of care for the identified psychogeriatric patient. In acute and long-term care settings, the caregiver may need practical support to cope with a patient's illness and to become an active member of the care team. Families provide approximately 80 percent of the home healthcare needs of the frail elderly. Their presence and availability as a source of care are important factors in delaying and possibly preventing institutionalization. For caregivers of dementia patients, family burden or "resiliency" is a major factor in the decision to seek institutional care. It is, therefore, essential to provide counseling, education, and practical support to caregivers. Special consideration is required for caregivers with unusual economic and other social needs.

(b) When the team uses the designated DSS Identifiers (see App. D) for psychogeriatric outpatient visits, the workload regarding the family members will be captured within that clinic as a collateral visit.

(5) **Psychogeriatric Primary Care Clinics**. Psychogeriatric primary care clinics are designed to provide direct service including all modalities of modern mental health assessment and treatment short of a day hospital or inpatient hospitalization although team members may follow patients into day settings or community nursing homes. The clinics may provide:

(a) Aftercare following a period of hospitalization, and/or

(b) Primary care for patients who do not require hospitalization.

***NOTE:** DSS identifiers are 576 (psychogeriatric individual) and 577 (psychogeriatric, group).*

Psychogeriatric Primary Care Clinics

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(6) **Psychogeriatric Day Programs**. Psychogeriatric Day programs provide a locus for ongoing health maintenance activities for psychogeriatric patients and a mechanism for sharing the burden of care of the elderly families. ***NOTE:*** *DSS Identifier for psychogeriatric Day Programs is 578. Distinctions between group and individual treatment are made by CPT codes.*

Psychogeriatric Day Programs

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(7) **VHA Domiciliaries.** VHA Domiciliaries as well as state-operated Veterans Domiciliaries, offer care and rehabilitation for many elderly veterans, including some with psychiatric diagnoses.

NOTE: *Other than Domiciliaries, there are no VHA beds at a residential rehabilitation level of care for psychogeriatric patients. CRC, paid for directly by patients to CRC operators, has been a long-standing placement option. The increasing need for supported residences for the elderly, between the home and the nursing home, has given rise to a variety of new, commercial, and non-profit residences that may also be available as placement options. The expansion of home and community-based services, including Home-Based Primary Care and Homemaker and/or Home Health Aide programs, is another approach to meeting the need for supportive care in the community.*

(8) **Psychogeriatric Sections Within VA NHCU**.

Psychogeriatric Sections within VA Nursing Home Care Units

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Psychogeriatric Sections within VA NHCUs are self-contained, distinct sections of a NHCU that are authorized for patients who require nursing home care (i.e., maintenance or restoration of patient's physical functioning in physical activities of daily living) and who also manifest behavioral disturbances that are manageable within the context of a nursing home with staff skilled in behavioral interventions**. S**taff should include both geriatric and psychiatrically prepared nurses. Supervision remains centrally under Geriatrics and Extended Care Strategic Heathcare Group.

(b) These special sections may be securable to prevent patients from wandering away or harming themselves unescorted outside of the facility. ***NOTE****: Workload is recorded under treatment specialty codes for NHCUs.*

(9) **Medical - Psychogeriatric Sustained Treatment and Rehabilitation Units** (Previously STAR-I)**.**

NOTE: *Most psychogeriatric patients requiring inpatient care will be seen in brief-stay programs. Patients may subsequently progress through various levels of care as their psychiatric and medical conditions warrant.*

Medical - Psychogeriatric STAR Units

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(a) Patients may include elderly intermediate medicine patients, formerly designated psychiatric and medically infirm (PMI), who may require lengthy to indefinite lengths of stay with the goal of enhancing quality of life and augmenting acceptable levels of behavior, rather than that of rapid discharge to the community. Involuntary patients may be accepted. These units may also serve hospice patients.

(b) Until appropriate VHA or community alternatives are available, medical centers may offer such settings with an emphasis on rehabilitation and maximizing self-care and quality of life. ***NOTE:*** *The Treating Specialty code is 89.*

(10) **Skilled Psychogeriatric STAR Nursing Units** (previously STAR III). Skilled Psychogeriatric Nursing Units should be considered when care in a psychogeriatric section in a NHCU is not an option due to lack of access or eligibility. They may remain within a Psychiatry Service bed section, but when appropriate, a nurse with appropriate training may administer the program. ***NOTE****: The Treating Specialty code is 89.*

Skilled Psychogeriatric STAR Nursing Units

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(11) **High Intensity (Brief Stay) Psychogeriatric Evaluation Settings.** Most psychogeriatric patients requiring high intensity hospital level treatment will be seen in brief-stay programs focusing on evaluation and stabilization of usually multiple medical and psychiatric problems. When patients do not require the high level supervision associated with a hospital setting, alternatives, including home care, assisted living, residential settings, community residential care, and elder settings offering a range of support services, may be considered. Special attention to identifying alternatives to hospital level care while negotiating the admissions process will prevent high intensity evaluation settings from being compromised by disposition problems. ***NOTE****: The treating specialty code is 93.*

High Intensity Psychogeriatric Evaluation Settings

	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(12) **Summary of Reporting Codes for Psychogeriatric Programs**

	Psychogeriatric Programs	DSS*	Treating	CDR**
		ID #	Spec Code	Account
2) 5) 6)	Telephone, Psychogeriatric	579		2780
2) 5)	Psychogeriatric Clinic, Individual	576		2311
2) 5)	Psychogeriatric Clinic, Group	577		2310
6)	Psychogeriatric Day Programs	578		2310
7)	VHA Domiciliaries		85	1520
8)	Psychgeriatric Section of NHCU		80	1420
9)	Med/Psychogeriatric STAR I		89	1316
10)	Psychoger. Nurse Unit STAR III		89	1316
11)	Psychogeriatric Brief Stay		93	1310

*See Appendix D for definitions listed by DSS Identifier numbers.
**CDR refers to the Cost Distribution Report used to allocate staffing costs.

g. **Psychosocial Rehabilitation Program Elements**

(1) **Psychosocial Rehabilitation.** Psychosocial Rehabilitation services play a role throughout the psychiatric continuum of care except at the most acute stages of crisis stabilization. The following program offerings describe services available to all psychiatric patients that are not otherwise described in broader or more specialized program descriptions (e.g., Day Treatment, Substance Use Disorder programming, etc.).

Psychosocial Rehabilitation Program Elements					
	Level 1	Level 2	Level 3	Level 4	Level 5
Intensity	Community	Partial	Residential	Professional	High staff
↓	Outpatient	Hospital	Treatment	Care Setting	Hospital
Low					
Moderate					
High					
Very High					

(2) **The Psychosocial Rehabilitation Continuum of Care**

(a) CWT/Veterans Industries (VI). The CWT/VI Program may be identified by its two major components: Workshop and Transitional Work, although numerous variants exist. This is a "work for pay" program that remunerates assigned veterans for work performed for industry. Funds for patient payments are secured though contracts developed by program staff, and are not considered to be appropriated funds. Basic program types include:

1. **Transitional Work**. In keeping with current practices in rehabilitation, a place-and-train modality exists, by which veterans work in actual industry settings, and are usually paid on hourly basis for work performed. This process is known as environmental normalization. In

some cases, veterans may work in Transitional Work settings at federal agencies, including VA. One innovative method uses the veteran CWT participants as members of a Veterans Construction Team (VCT) that provides services including major construction projects at a number of VA medical centers.

2. **Sheltered Workshop**. In this setting, staff members secure piecework operations from industry for completion by veterans. Participants are paid on a production basis for work performed. Work in sheltered environments ranges from repetitive, lower level jobs such a collating, stapling, etc., to resource intensive tasks using state-of-the-art manufacturing and packaging equipment. This modality works well with the chronic, seriously mentally ill to stabilize and habilitate them. With younger, employment-bound individuals, the workshop can serve to assess and provide a vehicle to improve basic worker traits and habits in a highly structured environment. CWT workshops vary greatly, depending upon local economic conditions and available resources (space, utilities, transportation and personnel). Workshops may be located either on facility grounds or in a community setting. ***NOTE:*** *The DSS Identifier for CWT/VI is 574.*

(b) Incentive Therapy (IT). Participation in IT results in a token level of remuneration, limited to one half of the current federal minimum wage, to veteran participants providing direct services to their medical centers. This program is usually endorsed most strongly at neuropsychiatric facilities as a placement modality for veterans with chronic, disabling psychiatric conditions that preclude their being able to function in more demanding situations. In some cases, it is used as a situational assessment tool prior to placement in CWT Transitional Work opportunities, or as a training modality, whereby veterans train under the supervision of VA personnel to learn specific job skills prior to placement in Transitional Work settings. Examples of this supervision would include, but not be limited to: Nursing Assistant, Environment Management Worker, Dietetics Aide, Groundskeeper, and Office Assistant. ***NOTE:*** *The DSS Identifier for Incentive Therapy is 573.*

(c) Therapeutic Printing Plants (TPP). The TPP is authorized to provide veterans with therapeutic activities in the graphic arts field. These exist at a limited number of stations due to the cost of equipment and supplies and the level of technological sophistication required. In some settings, CWT will become involved with screen and limited printing operations that are not a part of TPP operations. ***NOTE:*** *DSS identifiers 573, 574, or 575 should be used for Therapeutic Printing, depending, respectively, on whether it is operated as an IT, CWT, or non-pay vocational modality.*

(d) Vocational Rehabilitation Therapy (VRT) This non-remunerating activity was established to provide veterans with an avocational setting to decrease isolation and promote socialization. Clinics may offer a wide variety of opportunities: woodworking, graphic arts, machine shop, etc. In some cases, this modality is used with significantly regressed individuals to initiate a therapeutic relationship based upon previous vocational experiences. ***NOTE:*** *The DSS Identifier for VRT is 575.*

(e) CWT/TR. This work-based Psychosocial Residential Rehabilitation Treatment Program (PRRTP) offers a 24-hour therapeutic residential setting for patients involved in Compensated Work Therapy with multiple and severe psychosocial skill deficits. It utilizes peer and professional support, with a strong emphasis on increasing personal responsibility. It differs from the VA-operated residential bed program described elsewhere in that participants contribute (using their CWT earnings) to the cost of operating and maintaining their residences and are responsible for planning, purchase and preparation of their own meals, etc.

1. Workload for CWT/TR residential services is reported by Bed Days of Care with unique Treating Specialty Codes depending upon the subspecialty care being provided (see summary table following subpar. 4g(3)(c)).

2. Outpatient services provided by staff not assigned to the CWT/TR programs should be reported using the DSS identifiers appropriate to the site and intervention.

(f) Non-Specific Clinics. With the increasing use of Psychosocial Rehabilitation to address life skill development, such as job readiness and job survival skills, budget and money management, consumer skills, housing issues, meal planning, etc., non-specific clinics have been established to record psychosocial rehabilitation services that may be delivered outside of specific programs previously described. ***NOTE:*** *DSS Identifiers for Non-Specific Clinics are 532, (psychosocial rehabilitation, individual and 559 (psychosocial rehabilitation, group).*

(3) **Integration of Work Programs**

(a) The following chart is offered to help in the design and development of Psychosocial Rehabilitation Therapeutic Work Programs. It is meant to be descriptive in nature, not prescriptive. Individual sites should have the flexibility to develop programs that will best suit the needs of the veterans, considering available resources.

Veteran Need	CWT	IT	TPP	VRT	CWT/TR
Employment	X				
Independent Living Skills	X				X
Work Hardening	X	X			
Training		X	X		
Evaluation	X	X	X	X	
Avocational Experience			X	X	

(b) Experience has shown that functional level has much to do with success. The table following illustrates common practices:

Modality	Functional Level High	Functional Level Low
CWT Workshop	X	X
CWT Transitional Work	X	

(c) Again, the preceding information is descriptive. For instance, some facilities maintain state of the art Therapeutic Print Plants, requiring a much higher level of functioning than would normally be expected in such an environment.

(4) **Summary of Reporting Codes for Psychosocial Programs**

Psychosocial Rehabilitation Program Elements	DSS* ID #	Treating Spec Code	CDR** Account
Psychosocial Rehabilitation, Individual	532		2315
Psychosocial Rehab, Group	559		2314
Telephone, Psychosocial Rehabilitation	537		2780
MH Compensated Work Therapy (CWT) Group	574		2314
MH Incentive Therapy-Group	573		2314
MH Vocational Assistance Group	575		2314
MH Vocational Assistance Individual	535		2315
Telephone, Vocational Asst.	536		2780
General CWT/TR		39	1717
S/A CWT/TR		29	1715
PTSD CWT/TR		38	1716
HCMI CWT/TR		28	1714

*See Appendix D for definitions listed by DSS Identifier numbers
**CDR refers to the Cost Distribution Report used to allocate staffing costs

COMMON ACRONYMS USED IN THESE GUIDELINES

1. **AA** (Alcoholics Anonymous)
2. **AAC** (Austin Automation Center)
3. **ACT** (Assertive Community Treatment)
4. **ADHC** (Adult Day Healthcare)
4. **ADL** (Activities of Daily Living)
5. **ADTP** (Alcohol Dependence Treatment Program)
6. **AMA** (American Medical Association)
7. **AMIS** (Automated Medical Information System)
8. **APA** (American Psychiatric Association)
9. **ASAM** (American Society of Addiction Medicine)
10. **ASI** (Addiction Severity Index)
11. **CARF** (Commission on Accreditation of Rehabilitation Facilities)
12. **CBOC** (Community-based Outpatient Clinic)
13. **CEPC** (Continued Extensive Psychiatric Care)
14. **CESATE** (Center of Excellence in Substance Abuse Treatment and Education) at Seattle and Philadelphia VA Medical Centers
15. **CFR** (Code of Federal Regulations)
16. **CHALENG** (Community Homelessness Assessment, Local Education and Networking Groups) for homeless veterans
17. **CMI** (Chronically Mentally Ill)
18. **CNH** (Community Nursing Home)
19. **CPT** (Current Procedural Terminology)

20. **CRC** (Community Residential Care)

21. **CWT** (Compensated Work Therapy)

22. **CWT/TR** (Compensated Work Therapy and Transitional Residences)

23. **CWT/VI** (Compensated Work Therapy and Veterans Industries)

24. **DCHV** (Domiciliary Care for Homeless Veterans)

25. **DDTP** (Drug Dependency Treatment Program)

26. **DOD** (Department of Defense)

27. **DOM** (Domiciliary)

28. **DSM-IV** (Diagnostic and Statistical Manual of Mental Illness, 4th Revision, 1994)

29. **DSS** (Decision Support System) for documenting costs and workload for VHA programs

30. **DTC** (Day Treatment Center)

31. **EBTPU** (Evaluation and Brief Treatment PTSD Unit)

32. **FTEE** (Full-time Employee Equivalent)

33. **GAF** (Global Assessment of Functioning) from DSM-IV

34. **GAO** (General Accounting Office)

35. **GEM** (Geriatric Evaluation and Management)

36. **G&L** (Gains and Losses)

37. **HBPC** (Home-Based Primary Care)

38. **HCFA** (Health Care Finance Administration)

39. **HCHV** (Health Care for Homeless Veterans)

40. **HCMI** (Homeless Chronically Mentally Ill) veterans program

41. **HCMI/TR** (Homeless-specific CWT/TR) Programs

42. **HHS** (Department of Health and Human Resources)

43. **HIV** (Human Immunodeficiency Virus)

44. **HMI** (Homeless Mentally Ill)

45. **HUD-VASH** (Department of Housing and Urban Development – VA Supportive Housing) program

46. **IAPRS** (International Association of Psychosocial Rehabilitation Services)

47. **ICCM** (Intensive Community Case Management)

48. **IPCC** (Intensive Psychiatric Community Care)

49. **IRM** (Information Resource Management)

50. **IVR** (Interactive Voice Response)

51. **IT** (Incentive Therapy)

52. **JCAHO** (Joint Commission on the Accreditation of Healthcare Organizations)

53. **Kbps** (Kilobytes per second)

54. **LAAM** (levo-alphacetyl methadol), a long-acting derivative of methadone

55. **LOS** (Length of Stay)

56. **MDD** (Major Depressive Disorder)

57. **MICA** (Medically Ill Chemical Abusers)

58. **MH** (Mental Health)

59. **MHSHG** (Mental Health Strategic Healthcare Group) in VHA Headquarters

60. **NCAIANMHR** (National Center for American Indian and Alaska Native Mental Health Research)

61. **NMHPPMS** (National Mental Health Program Performance Monitoring System)

62. **NEPEC** (Northeast Program Evaluation Center) at West Haven VA Medical Center

63. **NHCU** (Nursing Home Care Unit)

64. **NVVRS** (National Vietnam Veterans Readjustment Study)

65. **OSAT** (Outpatient Substance Abuse Team)

66. **PERC** (Program Evaluation Resource Center) at Palo Alto VA Medical Center

67. **PICT** (Psychogeriatric Integrated Care Team)

68. **PICU** (Psychiatric Intensive Care Unit)

69. **PMI** (Psychiatric and Medically Infirm)

70. **POW** (Prisoner of War)

71. **PRRTP** (Psychosocial Residential Rehabilitation Treatment Program)

72. **PSU** (PTSD and Substance Use Disorder Unit)

73. **PTSD** (Post Traumatic Stress Disorder)

74. **RCS** (Readjustment Counseling Service)

75. **S/A CWT/TR** (Substance Abuse Compensated Work Therapy and Transitional Residence)

76. **SARRTP** (Substance Abuse Residential Rehabilitation Treatment Program)

78. **SEP** (Special Emphasis Program)

79. **SH** (Supportive Housing)

80. **SIPU** (Specialized Inpatient PTSD Unit)

81. **SMI** (Seriously Mentally Ill)

82. **SPMI** (Severe and Persistent Mental Illness)

83. **SSA-VA** (Social Security Administration – VA) outreach program for homeless veterans

84. **STAR** (Sustained Treatment and Rehabilitation)

85. **SUPT** (Substance Use PTSD Treatment) Program

86. **TPP** (Therapeutic Printing Plants)

87. **VA** (Department of Veterans Affairs)

88. **VASH** (VA Supported Housing) programs

89. **VBA – VHA (**Veterans Benefits Administration – Veterans Health Administration) collaborative initiative for homeless veterans

90. **VCT** (Veterans Construction Team)

91**.** **VERA** (Veterans Equitable Resource Allocation) system

92. **VHA** (Veteran Health Administration)

93. **VISN** (Veterans Integrated Service Network)

94. **VRT** (Vocational Rehabilitation Therapy)

MENTAL HEALTH DIRECTIVES AND CLINICAL PRACTICE GUIDELINES FOR MENTAL HEALTH PRACTIONERS

1. **Public Law referred to in these Guidelines**

Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, § 1706(b)(1) referring to the capacity legislation.

2. **Veterans Health Administration (VHA) Directives referred to in these Guidelines**

a. VHA Directive 10-94-100, ”Guidance for the Implementation of Primary Care in Veterans Health Administration,” 1994.

b. VHA Directive 10-95-028, “Designation of Psychogeriatric Sections Within Nursing Home Care Units.” Veterans Health Administration, March 21, 1995.

c. VHA Directive 10-95-099, Psychiatric Residential Rehabilitation Treatment Programs (PRRTP)(RCS 10-0889), October 11, 1995.

d. VHA Directive 96-051, “Veterans Health Administration Special Emphasis Programs,” August 14, 1996.

e. VHA Directive 97-059, “Instituting Global Assessment of Function (GAF) Scores in Axis V for Mental Health Patients,” November 25, 1997.

3. **VHA Program Guidelines for Mental Health Practice**

a. VHA Program Guide 1103.1, “Substance Abuse Treatment: Standards for A Continuum of Care,” Oct 8, 1996.

b. VHA Program Guide 1103.2, “Provision of Primary Care Services for Mental Health Clinicians,” Oct. 31, 1997.

c. VHA Program Guide 1103.22, “Integrated Psychogeriatric Patient Care,” March 26, 1996.

d. VHA Program Guide 1120.1, “Telephone Liaison Care,” March 25, 1997.

4. **Clinical Guidelines referred to in this document**

***NOTE**: VHA Clinical Guidelines are available at VHA libraries and on the VA Intranet, Mental Health website (http//:vaww.mentalhealth.med.va.gov).*

a. VHA Clinical Guidelines: "Clinical Guidelines for Major Depressive Disorder (MDD)," including comorbidities of Substance Use Disorder and Post Traumatic Stress Disorder. Jan 31, 1997, revised March 10, 1998.

b. VHA Clinical Guidelines: "Management of Persons with Psychosis." June 13, 1997.

COMPARATIVE DEFINITIONS OF "LEVELS OF CARE" FOR MENTAL HEALTH SERVICES

1. **Department of Veterans Affairs**
(from VHA Program Guide 1103.3, 1998)

Levels	Mental Health Programs
Level 1	Community / Outpatient
Level 2	Partial Hospitalization
Level 3	Residential Treatment
Level 4	Professional Care Setting
Level 5	Hospital Setting

2. **American Society of Addiction Medicine, Inc. (ASAM)**
(from Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Chevey Chase, Maryland, 1996)

Levels	Adult Admission Criteria	Levels	Detoxification Services
Level 0.5	Early Intervention		
Level I	Outpatient Services	Level 1-D	Ambulatory without Extended On-site Monitoring
Level II.1	Intensive Outpatient	Level 2-D	Ambulatory with Extended On-site Monitoring (Day Hospital)
Level II.5	Partial Hospitalization		
Level III	Residential Services	Level 3-D	Clinically-Managed Residential Detoxification
Level III.1	Clinically-Managed Low Intensity		
Level III.3	Clinically-Managed Medium Intensity		
Level III.5	Clinically-Managed Medium -High Intensity		
Level III.7	Medically Monitored Intensive Inpatient Services	Level 4-D	Medically Monitored Inpatient Detoxification
Level IV	Medically Managed Intensive Inpatient Services	Level 5-D	Medically Managed Intensive Inpatient Detoxification

3. **Commission on Accreditation of Rehabilitation Facilities (CARF)**
(from 1996 Standards Manual and Interpretive Guidelines for Behavioral Health)

Levels	Mental Health Programs	Levels	Alcohol/Drug Programs
1	Case Management	1	Case Management
2	Crisis Management	2	Detoxification Services
3	Outpatient Treatment	3	Outpatient Treatment
4	Partial Hospitalization	4	Community Housing Services
5	Residential Treatment	5	Residential Treatment
6	Inpatient Treatment	6	Inpatient Treatment

NOTE: *Levels range from four to six depending upon the particular emphasis of the organization. VHA's Level 4 is similar to ASAM's Level 4-D or Level III.7. CARF, in contrast, distinguished three outpatient levels within VHA's Level 1. ASAM breaks out three sub-levels within the Residential Treatment category. Criteria from these other organizations may be used within VHA if they are helpful in a given clinical situation.*

CURRENT DSS IDENTIFIERS (STOP CODES) AND COST DISTRIBUTION REPORT (CDR) ACCOUNTS FOR MENTAL HEALTH PROGRAMS

***NOTE**: The following are abstracts from VHA Directive 99-005, VHA 99 Decision Support System (DSS) Outpatient Identifiers (Ambulatory Care Data Capture) dated February, 24, 1999,*

I. ATTACHMENT I to VHA Directive 99-005, VHA FY 99 Decision Support System (DSS) Outpatient Identifiers: Mental Health And Other 500-999 Series

1. Changes in Mental Health Codes Fiscal Year (FY) 99

a. **New Primary DSS Identifiers**

564 Intensive Community Case Management (ICCM)
589 Non-Active Duty Sex Trauma
730 Domiciliary- General Care
731 Psychiatric Residential Rehabilitation Treatment Program (PRRTP)- General Care

b. **New DSS Identifier Credit Pairs**

527564 Telephone – ICCM
510474 Psychology (PSO) Research

c. **Definition changes**

(1) Definition changes have occurred in the following primary stop codes: 121; 503; 505; 506; 509; 520; 524; 531; 532; 550; 552; 553; 554; 563; 574; 580; 581.

(2) Definition changes have occurred in the following credit pairs: 510473, 516726.

d. **Inactive Codes**

501 Inactivated 10/1/94 Homeless Mentally Ill (HMI) Outreach
510475 Research. Use 510-474
574513 Compensated Work Therapy (CWT) and Substance Abuse
999510 PSO-EAP. Optional.

2. Distinctions between Care in the Mental Health Day Hospital and in the Mental Health Day Treatment Center

a. The Department of Veterans Affairs (VA) has two programs intended to provide special support to Mental Health patients to avoid hospitalization.

(1) **Day Hospital.** Day Hospital is a specific acute episode program that is intended to help prevent repeat hospitalizations due to exacerbating mental illness. If a patient has been stable on the outside, but suddenly becomes hallucinatory and uncontrolled on current medications, that patient may be referred to the Day Hospital. It is meant to be used to prevent hospitalization in acute crisis or exacerbations only. Usually patients are not assigned to Mental Health Day Hospital for more than 3-week episodes.

(2) **Day Treatment.** Day Treatment is chronic Mental Health caregiving for outpatients. This is intended to be used for long-term conditions needing support to maintain care or wellbeing on the outpatient side only.

b. In Fiscal Year (FY) 99, the hours and days for the two programs: Day Hospital and Day Treatment were changed to match and to more realistically reflect programs 4 to 8 hours per day, 3 to 7 days per week.

(1) Purpose. The major distinction is that Day Treatment is long-term for continuing care and community maintenance. Day Hospital clinics are prioritized for crisis treatment, transitional care and rehabilitation.

(2) Duration. Duration of episode of treatment typically on average, do not extend beyond 3 to 4 weeks per client per acute episode in a Day Hospital Clinic, unlike Day Treatment care which is expected to go on for months or years.

3. Sexual Trauma Counseling

a. **Stop Code 524 – ACTIVE DUTY SEX TRAUMA COUNSELING.** Stop code 524 is to be used when providing counseling to any veteran who received this type of trauma while on active military duty. These patients may or not, have had sexual trauma as children, or before and/or after active duty. If any sexual trauma occurred during active military duty, this DSS Identifier (524) should be used.

b. **Stop Code 589 – NON-ACTIVE DUTY SEX TRAUMA COUNSELING.** Stop code 589 should be used for patients who have received sex trauma at some time, but not during active military duty. If it occurred during active military duty, stop code 524 must be used. (see Public Law 102-585).

4. Categorization of all Mental Health and Domiciliary (DOM) Stop Codes

a. **Psychiatry (MD)**

509 Psychiatry MD (Individual)
512 Psychiatry Consultation
557 Psychiatry Group

b. **Mental Health**

502 Mental Health Clinic (Individual)
550 Mental Health Clinic (Group)
535 Mental Health Vocational Assistance (Individual)
573 Mental Health Incentive Therapy (Group)
574 Mental Health CWT (Group)
575 Mental Health Vocational Assistance (Group)

c. **Psychology**

510 Psychology (Individual)
510473 Neurospsychology Lab
510474 Psychology Research
510509 Psychology - Psychiatry (PSO-PSI)
558 Psychology (Group)

d. **Special Programs**

529 Health Care for Homeless Veterans (HCHV)/HMI
522 Department of Housing and Urban Development (HUD)-VA Shared Housing (VASH)
523 Opioid Substitute
540 Post Traumatic Stress Disorder (PTSD) PTSD Clinical Team (PCT)-PTSD (Individual)
561 PCT-PTSD (Group)
577 Psychogeriatric Clinic (Group)
576 Psychogeriatric Clinic (Individual)
559 Psychosocial Rehabilitation (Group)
532 Psychosocial Rehabilitation (Individual)
562 PTSD (Group)
516 PTSD (Individual)
516-726 PTSD DOM Aftercare (Group)
524 Active Duty Sexual Trauma
560 Substance Abuse (Group)
513 Substance Abuse (Individual)
513461 Substance Abuse: Alcohol Dependence (Individual)

513469 Substance Abuse: Drug Dependence (Individual)
560461 Substance Abuse: Alcohol Dependence (Group)
560469 Substance Abuse: Drug Dependence (Group)
519 Substance Use Disorder-PTSD Teams
525 Women's Stress Disorder Treatment Teams
589 Non-Active Duty Sexual Trauma

e. **Telephone**

527 Telephone General Psychiatry
527564 Telephone ICCM
528 Telephone Homeless Mentally Ill
530 Telephone HUD/VASH
536 Telephone Mental Health Vocational
537 Telephone Psychosocial Rehabilitation
542 Telephone PTSD
545 Telephone Substance Abuse
545461 Telephone Substance Abuse Treatment-Alcohol Dependence
545469 Telephone Substance Abuse Treatment-Drug Dependence
546 Telephone IPCC
579 Telephone Psychogeriatrics

f. **Off Station**

503 Mental Health Residential Care (Individual)
514 Substance Abuse Home Visit
520 Long Term Enhancement
521 Long Term Enhancement (Group)
552 IPCC Community Visit
564 ICCM
590 Community Outreach to Homeless Vets by Staff other than HCHV and Domiciliary Care for Homeless Veterans (DCHV) programs

g. **Day Programs**

505 Day Treatment (Individual)
506 Day Hospital (Individual)
547 Intensive Substance Abuse Treatment
547461 Intensive Substance Abuse Treatment-Alcohol Dependence
547469 Intensive Substance Abuse Treatment-Drug Dependence
553 Day Treatment (Group)
554 Day Hospital (Group)
578 Psychogeriatric Day Program

579 PTSD Day Hospital
581 PTSD Day Treatment

h. **Primary Care**

531 Mental Health Primary Care Team (Individual)
563 Mental Health Primary Care Team (Group)

i. **Other**

725 DOM Outreach
726 DOM Aftercare Community
727 DOM Aftercare VA
728 DOM Admission Screening Services
729 Telephone Domiciliary
730 Domiciliary-General Care
731 PRRTP-General Care

II. ATTACHMENT J to VHA Directive 99-005, VHA FY 99 Decision Support System (DSS) Outpatient Identifiers: Complete Summary Of October 1, 1998 Active Stop Codes

NOTE: *Only Mental Health Codes are included in this document.*

a. The complete mental health changes, updates, and current status as of October 1, 1998, DSS Identifiers, their short and long definitions, follows in Table F.

b. The following symbols are used throughout Table F:

* Not applicable to CDR. Automated Medical Information System (AMIS) segment J-19 is used by CDR currently for workload.
** Amended use of a DSS Identifier
\+ Changed DSS Identifier description
++ New DSS Identifier
‡ Added or changed DSS Identifier CDR account
\- Inactivated DSS Identifier
ψ Work from these stop codes is always non-billable in Medical Care Cost Recovery (MCCR)

TABLE F. Fiscal Year (FY) 99 Outpatient DSS Identifier Definitions (Effective on Veterans Health Information Systems Technology Architecture (VISTA) Software October 1, 1998).

NOTE: *This document includes only Mental Health codes which start on page J-30 in VHA Directive 99-005.*

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
501-Inactivated 10/1/94 [Use 529]		N/A*	HOMELESS MENTALLY ILL OUTREACH	Records any visit, relating to the care of a homeless chronically mentally ill patient, made to a community-based non-VA facility. May include physician services, psychology services, social services, nursing services and administrative services.
502		2311.00	MENTAL HEALTH CLINIC INDIVIDUAL	Individual evaluation, consultation, and/or treatment by clinical staff trained in mental diseases and disorders. Includes clinical services and administrative services.
503+		N/A*	MENTAL HEALTH RESIDENTIAL CARE - INDIVIDUAL	Records visits to a patient residing in: a community nursing home, a boarding home, a community home, etc. Includes physician, nursing, social work, and administrative services. **(If not residential care related to Mental Health, use 121)**
504 Inactivated 4/1/97 (Use 552)		5117.00	IPCC MEDICAL CENTER VISIT	Only VA medical centers approved to participate in the IPCC (Intensive Psychiatric Community Care) Program may use this code. This records visits of patients and/or their families or caregivers to IPCC staff on the VA medical center grounds or at a VA outpatient clinic. Includes clinical and administrative services provided IPCC patients by IPCC staff. Additional stop codes may not be taken for the same workload.

* Not applicable to CDR; AMIS segment J-19 is used by CDR currently for workload.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
505+		2311.00	DAY TREATMENT - INDIVIDUAL	Records individual patient visit for ongoing treatment and rehabilitation services, of patients with mental health and psychogeriatric disorders, who require clinical assistance and support up to 4 to 8 hours per day, 3 to 7 days per week for continuing care and community maintenance. Day treatment clinics serve patients who are less acutely ill, would likely have longer lengths of stay and require less intensive staffing than found in a day hospital setting. Includes clinical and administrative services.
506+		2311.00	DAY HOSPITAL - INDIVIDUAL	Records individual patient visits for evaluation, treatment, and/or rehabilitation of patients with mental health disorders, that require intensive diagnostic and treatment services up to 4 to 8 hours per day, 3 to 7 days per week. Is typically prioritized along the lines of crisis treatment, transitional care, and rehabilitation as opposed to continuing care and community maintenance. Day hospital clinics serve patients who are often severely and acutely ill at time of referral, and the individual's length of stay is time-limited. Includes clinical and administrative services
507- Inactivate 4/1/97 (Use 513)		2316.00	DRUG DEPENDENCE - INDIVIDUAL	Records patient visits for individual evaluation, consultation, follow-up, and treatment provided by a facility's formal Drug Dependence Treatment Program. Includes clinical and administrative services.
508- Inactivate 4/1/97 (Use 513)		2316.00	ALCOHOL TREATMENT - INDIVIDUAL	Records patient visits for individual evaluation, consultation, follow-up, and treatment provided by a facility's formal Alcohol Dependence Treatment Program. Includes clinical and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
509+		2311.00	PSYCHIATRY - MD INDIVIDUAL	Records individual patient visit for the purpose of evaluation, follow-up, and treatment provided by a physician trained in mental, emotional and behavioral disorders. May prescribe medications. Includes physician and administrative services.
510		2311.00	PSYCHOLOGY - INDIVIDUAL	Records individual patient visit for the purpose of evaluation, follow-up, and treatment provided by a psychologist trained in mental, emotional and behavioral disorders. Includes clinical services and administrative services.
	510473+		NEURO PSYCHOLOGY LAB	Records the individual patient visit for the purpose of neuropsychological assessments performed by a specially trained psychologist in neuropsychological evaluations. Assessments usually are performed in a designated lab setting.
	510474++ψ		PSO RESEARCH	Records the individual patient visit for evaluation, follow-up, treatment involved in a research protocol under the direction of Psychology Service
	510475- Inactivated 10/1/98.		RESEARCH	Use 510-474
	510509		PSO-PSI	
512		2311.00	PSYCHIATRY CONSULTATION	Records patient consultation with a physician trained in mental, emotional and behavioral disorders. Includes physician and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
513		2316.00	SUBSTANCE ABUSE - INDIVIDUAL	Records patient visits for individual evaluation, consultation, follow-up, and treatment provided by a facility's formal Substance Abuse Treatment Program, including the Substance Abuse CWT/ Transitional Residence (TR) Program. Includes clinical and administrative services. If the program is exclusively for alcohol-dependent clients, use 513-461. If the program is exclusively for drug-dependent clients, use 513-469. If the program is for generic substance abuse (drug and alcohol), use 513 alone - without a secondary DSS Identifier.
	513461	2316.00	INDIVIDUAL SUBSTANCE ABUSE: ALCOHOL DEPENDENCE	Records patient visits for individual evaluation, consultation, and follow-up treatment provided by a facility's formal Substance Abuse Treatment Program, including the Substance Abuse CWT/TR Program. Includes clinical and administrative services. For a program exclusively treating alcohol-dependent clients.
	513469	2316.00	INDIVIDUAL SUBSTANCE ABUSE: DRUG DEPENDENCE	Records patient visits for individual evaluation, consultation, follow-up, and/or treatment provided by a facility's formal Substance Abuse Treatment Program, including the Substance Abuse CWT/TR Program. Includes clinical and administrative services for clients with drug dependence. For a program exclusively treating drug-dependent clients.
514		2316.00	SUBSTANCE ABUSE - HOME VISIT	Records visit by VA staff to patients with history of alcohol and drug abuse. The visit is accomplished in the patient's residence. Includes clinical services and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
515-Inactivated 4/1/97 (Use 574)		2311.00	CWT/TR-HCMI	CWT/TR visits by outpatients who are in CWT/TR programs which were funded by HCMI. These visits reflect the CWT work component as well as the independent living skills training and treatment of this comprehensive community re-entry program.
516		2310.00	PTSD - GROUP	Records consultation, treatment, and/or follow-up provided to more than one individual. Treatment is provided to those patients with post traumatic stress disorder (PTSD). Includes clinical services and administrative services. This activity does not take place through a designated PTSD clinical team (PCT).
	516726+		PTSD DOM-AFTERCARE-GROUP	Records consultation, treatment, and/or follow-up to more than one individual with a post traumatic stress disorder. Includes clinical and administrative services provided to discharged DOM patients by Psychiatry staff. This activity does not take place through a designated PCT.
517 Inactivated 4/1/97 (Use 574)		2316.00	CWT/ SUBSTANCE ABUSE	Compensated work therapy visits by outpatients who are in a substance abuse program which has been enhanced to support CWT.
518-Inactivated 4/1/97 (Use 574)		2316.00	CWT/TR - SUBSTANCE ABUSE	CWT/TR visits by outpatients who are in CWT/TR programs which were funded by substance abuse. These visits reflect the CWT work component as well as the independent living skills training and treatment of the comprehensive community re-entry program.
519		2317.00	SUBSTANCE USE DISORDER/PTSD TEAMS	Approved VA Medical Centers Only. Records visit to a treatment team designed to treat substance use disorders (drug and alcohol) in conjunction with PTSD. Includes clinical services and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
520+		2311.00	LONG-TERM ENHANCEMENT - INDIVIDUAL	For use by approved long term psychiatric care hospitals. Provides Individual outpatient support for maintenance in the community of chronic mentally ill veterans with a history of institutional dependence.
521		2310.00	LONG-TERM ENHANCEMENT - GROUP	For use by approved long term psychiatric care hospitals. Provides group outpatient support for chronic mentally ill patients to continue living in the community.
522		2318.00	HUD-VASH	Records visits by staff of the HUD-VASH program for homeless veterans and families of these veterans. Workload should reflect activity related to permanent housing as well as caring for formerly homeless veterans in permanent housing. Includes physician services, psychology services, social services, nursing services, rehabilitation services, and administrative services.
523		2316.00	OPIOID SUBSTITUTION	Outpatient treatment of opiate dependent clients by OPIOID substitution, including methadone maintenance, by the facility's formal substance abuse program. Includes clinical services and administrative services.
524+ψ		2311.00	ACTIVE DUTY SEX TRAUMA	Records patient visit for appropriate care and services to a veteran for a psychological injury, illness, or other condition determined to be the result of a physical assault, battery, or harassment of a sexual nature, while serving on active military duty. Services include clinical and administrative services. (Public Law 102-585)
525ψ		2311.00	WOMEN'S STRESS DISORDER TREATMENT TEAMS	Records contacts with veterans seen by Women's Stress Disorder Treatment teams at officially VA Central Office designated VA Medical Centers.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
526-Inactivated 4/1/97		2780.00	TELEPHONE/ SPECIAL PSYCHIATRY	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical and/or professional staff assigned to the special psychiatry service. Includes the administrative and clinical services. **Provisions of Title 38 United States Code (U.S.C.) Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus (HIV), or sickle cell anemia are strictly confidential and may not be released or discussed unless there is a written consent from the individual.
527ψ		2780.00	TELEPHONE/ GENERAL PSYCHIATRY	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the general psychiatry service. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is a written consent from the individual.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
	527564 ++ψ		TELEPHONE – ICCM	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the ICCM program. Includes administrative and clinical services. NOT to be used for telephone contacts with the New England Program Evaluation Center (NEPEC)-supported Intensive Psychiatric Community Care (IPCC) teams. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia, are strictly confidential and may not be released, discussed unless there is written consent from the individual.
528ψ		2780.00	TELEPHONE/ HOMELESS MENTALLY ILL	Records patient consultation or medical care management, advice, and/or referral provided by staff funded through the Health Care for Homeless Veterans (HCHV) programs (except for those programs assigned to other specific stop codes, such as the HUD-VASH program) to homeless veterans with mental and or substance abuse disorders, or to family members of these veterans. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia are strictly confidential and may not be released or discussed unless there is a written consent from the individual.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
529		2312.00	HCHV/HMI	Records any visit provided by clinical staff funded through a HCHV program (except for the programs with specific stop codes, such as the HUD-VASH program) to Homeless Chronically Mentally Ill (HCMI) veterans with mental and/or substance abuse disorders or family members of such veterans.
530ψ		2780.00	TELEPHONE/ HUD-VASH	Records patient consultation or medical care management, advice, and/or referral provided by telephone staff of the HUD-VASH program to homeless veterans who are being case-managed in the HUD-VASH program, or who are being screened for placement, and to family members of these veterans. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual.
531+		2331.00	MENTAL HEALTH PRIMARY CARE TEAM - INDIVIDUAL	Records individual care provided to patients assigned to a Mental Health Primary Care Team, characterized by a coordinated interdisciplinary approach consisting of; (a) intake and initial needs assessment; (b) health promotion and disease prevention; (c) management of acute and chronic biopsychosocial conditions; (d) access to other components of health care; (e) continuity of care; and, (f) patient and non-professional care giver education and training. Includes clinical, ancillary and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
532+		2315.00	PSYCHOSOCIAL REHABILITATION INDIVIDUAL.	Records individual services provided to aid veteran's successful community re-entry, i.e., case management, advocacy, counseling, social and living skills development, interviews, etc. (For use by Psychosocial Rehabilitation Programs and other programs where more specific DSS Identifiers do not exist).
535		2315.00	MH VOCATIONAL ASSISTANCE - INDIVIDUAL	Records individual patient visit for vocational testing, assessment, guidance, counseling, or hands-on treatment provided by Vocational Rehabilitation (Voc Rehab) Therapy programs for veterans with psychosocial rehabilitation needs.
536ψ		2780.00	TELEPHONE/ MH VOCATIONAL ASSISTANCE	Records vocational services provided via telephone for veterans with psychosocial rehabilitation needs.
537ψ		2780.00	TELEPHONE/ PSYCHOSOCIAL REHABILITATION	Records services provided via telephone to aid veterans' community re-entry, i.e., case management, advocacy, counseling, social and living skills development, interviews, etc. (For use by psychosocial rehabilitation programs where more specific DSS Identifiers do not exist).
540		2313.00	PCT POST - TRAUMATIC STRESS INDIVIDUAL	Records consultation, evaluation, and/or follow-up provided to a patient with a diagnosis of post traumatic stress syndrome. Treatment is provided by a specialty multidisciplinary PTSD Clinical Team (PCT).

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
542ψ		2780.00	TELEPHONE/ PTSD	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the PCT. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential, and may not be released, discussed unless there is a written consent from the individual.
543-Inactivated 4/1/97		2316.00	TELEPHONE/ ALCOHOL DEPENDENCE	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the alcohol dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential, and may not be released, discussed unless there is a written consent from the individual.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
544-Inactivated 4/1/97		2316.00	TELEPHONE/ DRUG DEPENDENCE	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential, and may not be released, discussed unless there is a written consent from the individual.
545ψ		2780.00	TELEPHONE/ SUBSTANCE ABUSE	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the substance abuse treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential, and may not be released, discussed unless there is a written consent from the individual.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
	545461ψ	2780.00	TELEPHONE SUBSTANCE ABUSE TREATMENT - ALCOHOL DEPENDENCE	Use for Alcohol Dependence Treatment Phone Calls. Using the full definition for 545.
	545-469ψ	2780.00	TELEPHONE SUBSTANCE ABUSE TREATMENT - DRUG DEPENDENCE	Use for Drug Dependence Treatment Phone Calls. Using the full definition for 545.
546ψ		2780.00	TELEPHONE/IPCC	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special psychiatry service. Includes administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual.
547		2316.00	INTENSIVE SUBSTANCE ABUSE TREATMENT	Records visits for intensive substance abuse services provided by substance abuse treatment program staff. Treatment program is usually an interdisciplinary outpatient program designed for substance abuse clients based upon day hospital, day treatment, psychosocial rehabilitation models (may include outpatient detoxification). Patients generally are expected to participate in a program of 3 or more hours per day, 3 days a week at a minimum.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
	547461		INTENSIVE SUBSTANCE ABUSE TREATMENT-ALCOHOL DEPENDENCE	Use only for an intensive substance abuse treatment program exclusively treating alcohol-dependent clients. (See the full definition for DSS Identifier 547.)
	547469		INTENSIVE SUBSTANCE ABUSE TREATMENT - DRUG DEPENDENT	Use only for an intensive substance abuse treatment program exclusively treating drug-dependent clients. (See the full definition for 547.)
550+		2310.00	MENTAL HEALTH CLINIC (GROUP)	Records services assigned to a group of outpatients by any clinical specialty assigned to the Mental Health Clinic.
551-Inactivated 4/1/97		5117.00	IPCC COMMUNITY CLINIC/ DAY PROGRAM VISIT	Only VA medical centers approved to participate in the IPCC Program may use this code. This records visits with patients and/or their families or caregivers to IPCC staff at identified IPCC satellite clinics, IPCC storefronts, or IPCC offices not on the VA medical center grounds or at a VA outpatient clinic. Includes clinical and administrative staff. Additional stop codes may not be taken for the same workload.
552+		5117.00	IPCC COMMUNITY VISIT	Only VA medical centers approved to participate in the IPCC program may use this code. This records visits with patients and/or their families or caregivers by IPCC staff at all locations not on the VA medical center grounds, at a VA outpatient or at IPCC satellite clinics, IPCC storefronts or IPCC offices. Includes clinical and administrative services provided IPCC patients by IPCC staff. Additional stop codes may not be taken for the same workload.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
553+		2310.00	DAY TREATMENT-GROUP	Records treatment to a group of patients with mental health and psychogeriatric disorders, for ongoing and rehabilitation services. Patients require clinical assistance and support up to 4 to 8 hours per day, 3 to 7 days per week for continuing care and community maintenance. Day treatment clinics serve patients who are less acutely ill, would likely have longer lengths of stay and require less intensive staffing than found in a day hospital setting. Includes clinical and administrative services.
554+		2310.00	DAY HOSPITAL-GROUP	Records treatment to a group of patients for evaluation, treatment, and/or rehabilitation of patients with mental health disorders, who require intensive diagnostic and treatment services up to 4 to 8 hours per day, 3 to 7 days per week. Day hospital clinics are typically prioritized along the lines of crisis treatment, transitional care, and rehabilitation as opposed to continuing care and community maintenance. Patients are often severely and acutely ill at time of referral, and the individual's length of stay is time-limited. Includes clinical and administrative services.
555-Inactivated 4/1/97		2316.00	DRUG DEPENDENCE - GROUP	Records patients visits for group follow-up, treatment, and evaluation by a facility's formal Drug Dependence Treatment Program. Includes clinical and administrative services.
556-Inactivated 4/1/97		2316.00	ALCOHOL TREATMENT - GROUP	Records patient visits for a group follow-up, treatment, and evaluation by a facility's formal Alcohol Dependent Treatment Program. Includes clinical and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
557		2310.00	PSYCHIATRY - GROUP	Records treatment, follow-up provided to a group of patients by a physician trained in mental, emotional and behavioral disorders and may prescribe medications. Includes physician services and administrative services.
558		2310.00	PSYCHOLOGY - GROUP	Records treatment, follow-up provided to a group of patients by a psychologist trained in mental, emotional, and behavioral disorders. Includes psychologist services and administrative services.
559		2314.00	PSYCHOSOCIAL REHABILITATION GROUP	Records group services provided to aid veterans' successful community re-entry, i.e., case management, advocacy, counseling, social and living skills development, interviews, etc. (for use by psychosocial rehabilitation programs where more specific DSS Identifiers do not exist).
560		2316.00	SUBSTANCE ABUSE - GROUP	Records patient visits for group follow-up, treatment, evaluation by a facility's formal Substance Abuse Treatment Program. Includes clinical and administrative services.
	560461	2316.00	GROUP SUBSTANCE ABUSE: ALCOHOL DEPENDENCE	Records patient visits for group follow-up, treatment, and/or evaluation by a facility's formal Substance Abuse Treatment Program. Includes clinical and administrative services. For a program exclusively treating alcohol-dependent clients.
	560469	2316.00	GROUP SUBSTANCE ABUSE: DRUG DEPENDENCE	Records patient visits for group follow-up, treatment, and/or evaluation by a facility's formal Substance Abuse Treatment Program. Includes clinical and administrative services. For a program exclusively treating drug-dependent clients.
561		2313.00	PCT-POST TRAUMATIC STRESS GROUP	Records group therapy provided to patients with diagnosis of PTSD. Treatment is provided by specialty multidisciplinary PTSD Clinical Team (PCT).

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
562		2311.00	PTSD - INDIVIDUAL	Records consultation, evaluation follow-up, and/or treatment provided to an individual with PTSD. This activity does not take place through a designated PTSD clinical team. Includes clinical and administrative services.
563+		2330.00	MENTAL HEALTH PRIMARY CARE TEAM - GROUP	Records care provided to a group of patients assigned to a Mental Health Primary Care Team characterized by a coordinated interdisciplinary approach consisting of: (a) intake and initial needs assessment; (b) health promotion and disease prevention; (c) management of acute and chronic biopsychosocial conditions; (d) access to other components of health care; (e) continuity of care; and (f) patient and non-professional care giver education and training. Includes clinical and administrative services.
564++		2311.00	INTENSIVE COMMUNITY CASE MANAGEMENT (ICCM)	Records visits with patients and/or their families or caregivers by ICCM staff at all locations. Includes and administrative services provided ICCM patients by ICCM staff. NOT to be used for visits to NEPEC-supported IPCC teams. (See 552.)
573		2314.00	MH INCENTIVE THERAPY-GROUP	Records patient visit for, or work activity in, the Incentive Therapy Program provided by Psychology, Psychiatry, Social Work, Domiciliary or any other service other than Physical Medicine and Rehabilitation Service (PM&RS). This is a rehabilitation program provided under 38 U.S.C. 618(A), which authorizes assignment of patients to various in-hospital work situations. Pay scale is up to one-half minimum wage. This program is supported by medical care funds.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
574+		2314.00	MH COMPENSATED WORK THERAPY (CWT) GROUP	Records patient visit for evaluation for, or work activity in, the CWT/Veterans Industries (VI) Program provided by Psychology, Psychiatry, Social Work, Domiciliary or other service other than PM&RS. Involves work subcontracted from and paid for by public and/ or private organizations including the Federal government. Patients are paid, based on productive capabilities, from the Special Therapeutic and Rehabilitation Activities Fund (STRAF) account at the VA facility.
	574513 – Inactivated 10/1/98	2314.00‡	MH CWT/ SUBSTANCE ABUSE	Records CWT patient visits by outpatients who are in a Substance Abuse Program that was enhanced to support CWT. Included here are evaluations for, and work activity in, the CWT/Veterans Industries Program provided by Psychology, Psychiatry, Social Work, Domiciliary or other service other than PM&RS. Involves work subcontracted from, and paid for, by public and/or private organizations including the Federal government. Patients are paid, based on productive capabilities, from the STRAF account at the VA facility.
575		2314.00	MH VOCATIONAL ASSISTANCE GROUP	Records patient visit for vocational testing, assessment, guidance, counseling, or hands-on treatment provided by the Vocational Rehabilitation Therapy Program provided by Psychology, Psychiatry, Social Work, Domiciliary or any other service other than PM&RS.
576		2311.00	PSYCHO-GERIATRIC CLINIC, INDIVIDUAL	Records individual evaluation, consultation, and/or treatment by clinical staff in a designated psycho-geriatric outpatient clinic. Includes clinical and administrative services.
577		2310.00	PSYCHO-GERIATRIC CLINIC, GROUP	Records treatment, evaluation, and/or rehabilitation provided to a group of patients in a designated psycho-geriatric clinic. Includes clinical and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
578		2310.00	PSYCHO-GERIATRIC DAY PROGRAM	Records all patient visits in a local or nationally designated psychogeriatric day program for ongoing treatment and rehabilitation of psychogeriatric disorders. Includes clinical and administrative services.
579ψ		2780.00	TELEPHONE/ PSYCHO-GERIATRICS	Records patient consultation of medical care management, advice, and/or referral provided by telephone contact between patient or patient's relative, caregivers, and the clinical and professional staff assigned to a designated psychogeriatric program. Includes administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism, or alcohol abuse, infection with HIV, or sickle cell anemia are strictly confidential and may not be released or discussed unless there is a written consent from the individual.
580+		2310.00	PTSD DAY HOSPITAL	Records psychiatric treatment to an individual or group of patients diagnosed with post traumatic stress disorders, who require intensive diagnostic and treatment services up to 4 to 8 hours per day, 3 to 7 days per week. PTSD day hospital clinics typically are prioritized along the lines of crisis treatment, transitional care, and rehabilitation as opposed to continuing care and community maintenance. Patients are often severely and acutely ill at time of referral, and the individual's length of stay is time-limited. Includes clinical and administrative services.

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
581+		2310.00	PTSD DAY TREATMENT	Records therapeutic psychiatric outpatient services to an individual or a group of patients diagnosed with PTSD, who require clinical assistance and support up to 4 to 8 hours per day, 3 to 7 days per week for continuing care and community maintenance. Patients in day treatment are less acutely ill, would likely have longer lengths of stay, and require less intensive staffing than those found in a day hospital setting.
589++		2311.00	NON-ACTIVE DUTY SEX TRAUMA	Records patient visit for appropriate care and services to a veteran for a psychological injury, illness or other condition determined to be the result of a physical assault, battery, or harassment experienced during childhood; any pre-active and post- active duty status (Not On Active Duty). Services include clinical and administrative services. (Public Law 102-585.) If Trauma occurred on Active Duty, use 524.
590		2319.00	COMMUNITY OUTREACH TO HOMELESS VETS BY STAFF OTHER THAN HCHV AND DCHV PROGRAMS	Records outreach services to veterans carried out by VA Staff other than designated staff of the HCHV or DCHV programs.

***NOTE**: The following code is not used for documenting outpatient care. It is to capture inpatient workload for the Event Capture system, where implemented.*

DSS ID NUMBER	DSS ID PAIR	CDR ACCT	DSS ID NAME	DESCRIPTION
731++		N/A*	PRRTP - GENERAL CARE -	The use of this code is optional and should only be used for those facilities who desire to identify residential care products via ECS. (Do not use for scheduling or cost purposes)

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