

**MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE  
PROCEDURES HANDBOOK FOR SPECIFIC PROGRAMS**

- 1. REASON FOR ISSUE:** This handbook is issued to provide procedures to specific Department of Veterans Affairs medical facility mental health programs.
- 2. SUMMARY OF CONTENTS:** This handbook provides procedures which have the maximum flexibility provided within the scope of existing Federal statues and regulations, for administrating the following mental health programs: Community-based Psychiatric Residential Treatment for Homeless Chronically Mentally Ill (HCMI) Veterans, Substance Abuse Contract Programs, Psychiatric Residential Rehabilitation and Treatment Program (PRRTP), and the Vocational and Rehabilitation Services Program.
- 3. RESPONSIBLE OFFICE:** The Office of Patient Care Services, Mental Health and Behavioral Sciences Service is responsible for the contents of this Veterans Health Administration (VHA) Handbook.
- 4. RELATED ISSUES:** None.
- 5. RESCISSIONS:** None.
- 6. RECERTIFICATION:** This document is scheduled for recertification on or before the last working day of February, 2001.

S/ by Thomas Garthwaite, M.D. for  
Kenneth W. Kizer, M.D., M.P.H.  
Under Secretary for Health

Distribution: **RPC: 1303 is assigned.**  
FD

Printing Date: 3/96

March 27, 1996

VHA HANDBOOK 1103.1

Department of  
Veterans Affairs

## **MENTAL HEALTH PROGRAMS**

**Mental Health and Behavioral Sciences Service**

**Procedures Handbook for Selected Programs**

**COMMUNITY BASED PSYCHIATRIC RESIDENTIAL TREATMENT FOR HOMELESS  
CHRONICALLY MENTALLY ILL (HCMI) PATIENTS**

**SUBSTANCE ABUSE CONTRACT PROGRAMS**

**PSYCHIATRIC RESIDENTIAL REHABILITATION AND TREATMENT PROGRAMS (PRRTP)**

**VOCATIONAL AND REHABILITATION SERVICES**

**Veterans Health Administration  
Washington, DC 20420**

## FORWARD

This handbook provides procedures for administering the following mental health programs: Community-based Psychiatric Residential Treatment for Homeless Chronically Mentally Ill (HCMI) Veterans, Substance Abuse Contract Programs, Psychiatric Residential Rehabilitation and Treatment Program (PRRTP), and the Vocational and Rehabilitation Services Program.

The Department of Veterans Affairs (VA) policy provides for Community-based Psychiatric Residential Treatment for HCMI veterans by contracts with non-VA service providers for HCMI veterans, including those who are nonservice-connected. Legislation originally provided by Public Law (Pub. L.) 100-6 and extended by Pub. L. 101-237 authorizes VA to contract with non-VA community based Residential Programs for chronically mentally ill veterans who are homeless. The VA is authorized to contract for such care and treatment and rehabilitative services with non-VA halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment programs for eligible veterans suffering from chronic mental illness disabilities (including substance abuse).

VA was authorized to conduct a Substance Abuse Contract Pilot Program from 1980 through 1997, utilizing contracts for care and treatment and rehabilitative services in non-VA halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment settings. Title 38 United States Code (U.S.C.) 1720A (a)(1) provides: "The Administrator (Secretary of Veterans Affairs), in furnishing hospital nursing home care, and domiciliary care and medical and rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment settings of eligible veterans suffering from alcohol or drug dependence or abuse disabilities."

Veterans Health Administration (VHA) Manual M-2, Part X, Chapter 3, authorizes a new level of bed-care, Psychiatric Residential Rehabilitation Treatment Program. (PRRTP). PRRTP is defined as a structured and supervised, 24 hour-a-day, therapeutic setting which embodies strong treatment values with peer and professional support

Title 38 U.S.C. authorizes a Vocational and Rehabilitation Service Program by the assignment of patients to a comprehensive therapeutic milieu, either real or simulated, designed to provide clinical and residential support, skills training, job readiness, money management, independent living skills, vocational counseling, and job placement.

Overall clinical and administrative responsibility for these programs at the VHA Headquarters level is provided by the Mental Health and Behavioral Sciences Service. The medical center Director has the responsibility of designating team members and ensuring transportation is available for evaluation and follow-up. The organizational placement at the medical center is determined by the Chief of staff. The responsible Service Chief appoints the Program Coordinator, as appropriate. The medical center Contracting Officer has the final responsibility for negotiating and consummating contracts with suitable provisions.

**CONTENTS**

**MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE  
PROCEDURE HANDBOOK FOR SELECTED PROGRAMS**

**CHAPTER**

1. PROCEDURES FOR COMMUNITY BASED PSYCHIATRIC RESIDENTIAL  
TREATMENT FOR HOMELESS CHRONICALLY MENTALLY ILL PATIENTS
2. PROCEDURES FOR SUBSTANCE ABUSE CONTRACT PROGRAMS
3. PROCEDURES FOR PSYCHIATRIC RESIDENTIAL REHABILITATION AND  
TREATMENT PROGRAMS
4. PROCEDURES FOR VOCATIONAL AND REHABILITATION SERVICES

**CONTENTS**

**CHAPTER 1. PROCEDURES FOR COMMUNITY-BASED PSYCHIATRIC  
RESIDENTIAL TREATMENT FOR HOMELESS CHRONICALLY  
MENTALLY ILL VETERANS**

| <b>PARAGRAPH</b>  | <b>PAGE</b> |
|---|-------------|
| 1.01 Scope .....  | 1-1         |
| 1.02 Definitions .....  | 1-1         |
| 1.03 Methods of Process .....   | 1-2         |
| 1.04 Contracts .....  | 1-3         |
| 1.05 VA Minimum Standards .....   | 1-4         |
| 1.06 Pre-Award Survey .....   | 1-6         |
| 1.07 Subsequent Surveys .....   | 1-8         |
| 1.08 Guidelines for Selecting Veterans for Residential Treatment Referral ..... | 1-9         |
| 1.09 Per Diem Rates and Census .....  | 1-10        |
| 1.10 Quality Improvement .....  | 1-10        |
| 1.11 References .....   | 1-11        |

## CHAPTER 1. PROCEDURES FOR COMMUNITY-BASED PSYCHIATRIC RESIDENTIAL TREATMENT FOR HOMELESS CHRONICALLY MENTALLY ILL VETERANS

### 1.01 SCOPE

a. The number of homeless Americans has been reportedly growing during recent years. About 30 percent of adult homeless individuals are believed to be veterans, with approximately 50 percent of these being veterans of the Vietnam Era. Of the total homeless population, at least 60 percent are believed to have a psychiatric disorder, including alcohol or other drug abuse problems.

b. While it is acknowledged that many of the chronic mentally ill may require life-long support, the goal of improving their level of functioning and their degree of integration into the community is valid and attainable for a significant number.

c. Eligible veterans include those who are homeless and have a chronic mental illness or who, on a limited basis, are being furnished hospital, domiciliary or nursing home care for a chronic mental illness.

d. The priority for such care and services would be in the following order:

(1) Veterans with a service-connected chronic mental illness disability,

(2) Veterans with any service-connected disability, and

(3) Veterans with nonservice-connected disability unable to defray the expenses of necessary care (see M-2, Pt. X, Ch. 3).

*NOTE: While some of the Homeless Chronically Mentally Ill (HCMI) veterans may be receiving care in Department of Veterans Affairs (VA) medical centers, domiciliaries, or nursing homes, most are not. To provide outreach services to these HCMI veterans, VA treatment teams have been and are established to conduct direct outreach to homeless veterans and to collaborate with existing homeless coalitions, task forces, and other service providers in the communities.*

### 1.02 DEFINITIONS

a. **Community-based Psychiatric Residential Treatment for HCMI Veterans.** Contracted non-VA halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment settings for eligible veterans have been developed to meet the needs of many citizens for a residential treatment environment addressing the causes and/or effects of homelessness. These treatment and rehabilitative programs provide transitional support for eligible veterans prior to reentry into community life. Residents at such programs learn self-help skills by assuming personal responsibilities, improve social skills through program activities and, in some cases, develop vocationally by involvement in volunteer training and/or work programs. Eligible veterans include those who are homeless and have a chronic mental illness or who, on a limited basis, are being furnished hospital, domiciliary or nursing home care for a chronic mental illness.

b. **Halfway House (HWH).** A community HWH is defined as a community-based, peer group oriented, residential setting which provides food, lodging, and supportive services for

persons with a chronic mental illness disability. Licensing requirements vary considerably from state to state, and HWHs may be found which are licensed as boarding homes, board and care facilities, intermediate care facilities and, most desirable, as halfway houses per se.

c. **Therapeutic Community (TC)**. In the context of this chapter, a TC is a residential treatment setting with a social organization of patients and personnel within a specially structured program which:

- (1) Utilizes a family-like authority system;
- (2) Promotes the resident's psychosocial functioning within acceptable social bounds which recognize the norms of community life; and
- (3) Helps the residents assume increasing responsibility for their own rehabilitation and that of their fellow patients.

*NOTE: Such programs have often been specialized for the rehabilitation of chronic drug abusers.*

d. **Psychiatric Residential Treatment Center (PRTC)**. A PRTC is a free standing setting or complex of settings that provides domicile and health-related services, along with personal and/or protective care for psychiatric patients. Such residents do not require hospital level care, but require a level of care which exceeds that provided in a community residential care setting. Normally there are ancillary arrangements for the provision of clinical services, including medical, psychiatric, social and rehabilitative services and a full range of psychiatric treatment.

e. **Homelessness**. Public Law (Pub. L.) 100-77 defines a homeless individual as a person who lacks a fixed, regular, and adequate night time residence, including any such person residing in institutions, emergency shelters, or other facilities meant for the homeless.

### 1.03 METHODS OF PROCESS

a. VA treatment teams are established to make direct outreach contacts with homeless veterans and to collaborate with existing homeless coalitions, task forces and service providers in the community.

(1) The treatment team members working in the shelters, in the streets, and with community residential treatment programs with which the VA has developed contracts, act as case managers for HCMI veterans

(2) VA case managers assist in the development and maintenance of clinical records established by both the VA medical center and the non-VA residential treatment program.

b. Individual treatment plans and discharge summaries must be maintained by the Non-VA Residential Treatment Program on each veteran outplaced under contract. Within 1 month of a veteran's discharge from a Contract Program, the program will provide the VA medical care facility with a copy of the veteran's treatment plan and discharge summary for incorporation into the veteran's VA medical record.

c. All community-based visits are recorded and monitored separately in designated HCMI Program stop codes and are included in the VA medical center's workload reporting.

d. A multidisciplinary VA team consisting of a social worker, nurse, an engineering service safety officer and, as appropriate, other designees of the VA medical center Director must conduct a survey of the Residential Treatment Community Health Care Program prior to the award of a contract.

e. Referral for medical follow-up may be made to another VA medical center or to a VA outpatient clinic when the distance between the residential treatment center, or other compelling circumstances, would make follow-up by the authorizing medical center impractical.

(1) When two or more VA facilities place patients in the same residential treatment center, those VA facilities may work out arrangements by which needed VA follow-up services are furnished without regard to which facility initially made the placement.

(2) Current law calls for providing case management services to program beneficiaries, and defines case management to include follow-up, while veterans are receiving treatment in a Non-VA Residential Treatment Program at VA expense.

f. Patients who graduate from the HCMI Program will be afforded follow-up care through the VA medical center in accordance with their ability to meet the eligibility criteria applied to non-homeless veterans. Those veterans not eligible for VA follow-up will be referred to community resources.

#### 1.04 CONTRACTS

Contracts will be sought with community-based programs which both meet the standard and desire to furnish care to VA-referred veterans. Appropriate medical center personnel will advise the medical center Director of known suitable programs.

a. Contracts entered into under current legislation authority will cite Title 41 United States Code (U.S.C.) 25(c)(5) and 38 U.S.C. 620(C), as the negotiation authority. These contract actions are exempt from Commerce Business Daily synopsis in accordance with VA Acquisition Regulations (VAAR) 806.302-5(c); this exemption does not affect the justification and approval requirements outlined in VAAR 806.303.

b. Medical center Directors are responsible for:

(1) Designating the appropriate individuals to:

(a) Serve as members of the Contracting Officer's negotiating team, and

(b) Develop proposed contracts.

(2) Ensuring appropriate clinical and administrative participation in the selection and placement of patients;

(3) Issuing authorizations and processing invoices;

(4) Inspecting settings;

(5) Coordinating the follow-up of patients; and

(6) Maintaining a file of all current contracts.

c. The medical center Contracting Officer negotiates and consummates contracts with suitable community-based programs.

d. The medical center Contracting Officer is responsible for negotiating and consummating contracts with suitable programs.

(1) Special effort will be made to secure contracts which include within the per diem rate, room, meals, a degree of supervision, and the other necessary services as described in the contract.

(2) Therapeutic services should be provided by the residential treatment center or complex; however, those not included that may be deemed necessary for the population should be supplied by linkages with other community providers, through other separate contracts, sharing agreements, and/or collaborative arrangements, or by the VA medical center.

e. Payment for residential treatment settings is made on a monthly basis, for services rendered.

(1) Acquisition and Materiel Management Service (A&MMS) and Medical Administration Service (MAS) will coordinate the payments.

(2) Coordinator, HCMI Program, is responsible for informing MAS when a veteran's treatment under the Contract Program has been terminated.

f. Personnel costs will be charged to Veterans Health Administration (VHA) Control Point "HCMI/Personnel Services" (808) and contract costs will be charged to Control Point "HCMI/Contracts and All Other" (809).

### 1.05 VA MINIMUM STANDARDS

Contractors under this program must meet the following VA standards, based on regulations promulgated by Title 38 Code of Federal Regulations (CFR) Section 17.53b:

a. **Legal**

(1) Both residential and ambulatory care settings must meet:

(a) The standards of the Life Safety Code (National Fire Protection Association (NFPA) #101);

(b) The fire and safety code imposed by the State law; and

(c) City, State, and Federal requirements concerning licensing and health codes.

(2) All residential treatment settings must be licensed as required for the particular setting under State or Federal authority.

b. **Accreditation and Licensing**. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is evidence of internal quality assurance mechanisms and is desirable, but is not required. Where applicable, the residential treatment setting must have a current occupancy permit issued by the authority having jurisdiction.

c. **Privacy Act**. The notification and contract clauses entitled "Privacy Act Notification," as specified in Federal Acquisition Regulations (FAR) 52.224-1 and 52.224-2, shall be incorporated into this contract by the contracting officer.

d. **Basic Services**. Basic Services will include:

- (1) A supervised environment which will be staffed on a 24-hour basis;
- (2) Board and room;
- (3) Laundry facilities for residents to do their own laundry; and
- (4) Therapeutic and Rehabilitative Services including:
  - (a) Structured activities; i.e., resident participation in group sessions dependent upon resident preference and the VA case manager and residential treatment setting staff recommendations;
  - (b) A variety of group activities, including physical activities, as appropriate;
  - (c) Health and personal hygiene maintenance;
  - (d) Monitoring of medications, if necessary;
  - (e) Supportive social service, in collaboration with the case managers, VA or other community resources;
  - (f) Professional counseling as required, including emphasis on self care skills, adaptive coping skills and, as appropriate, vocational counseling, in collaboration with VA program or community resources;
  - (g) Opportunities for immediate learning and/or development of responsible living with a goal of achieving a more adaptive level of psychosocial functioning;
  - (h) Support for an alcohol and/or drug-free lifestyle; and
  - (i) Opportunities for:
    1. Learning, and internalizing knowledge of the illness and/or recovery process;
    2. Improving social skills; and
    3. Improving personal relationships.

e. **Records and Reports**

(1) An individual clinical record will be developed with the assistance of the HCMI staff and maintained by the residential treatment staff on each veteran outplaced under this contract.

(a) The Residential Treatment Program must comply with the requirements of the "Confidentiality of Certain Medical Records" (38 U.S.C. 7332), and the "Confidentiality of Alcohol and Drug Abuse Patients Records" (42 CFR, Part II) when appropriate, and shall be part of the contract.

(b) All case records will be maintained with such security and confidentiality as required, and will be made available on a need-to-know basis to appropriate VA staff members involved with the treatment program of the veterans concerned.

(c) The clinical record maintained by the non-VA residential treatment program will include:

1. Reasons for referral;
2. Essential identifying data relevant to the veteran and veteran's family;
3. Data relating to the veteran's admission, to include the targeted individual goals for constructive changes which are to be attained during the veteran's stay at the residential treatment setting;
4. Record or log of medical prescriptions issued by physicians;
5. Reports of periodic reevaluation by program staff, to include any measures of movement toward rehabilitation goals; and
6. Final summaries on each veteran who leaves the program, to include a description of beneficial changes realized during the residential period, reasons for leaving, the veteran's future plans, and, if possible, follow-up locator information.

(2) In addition to the clinical record maintained by the non-VA residential treatment staff, a consolidated health record (CHR) will be maintained in the local VA Mental Health Outpatient Program for each veterans in contract placement and those seen by ongoing outreach efforts. These records will meet the standards required by the Psychiatry Service. All community-based visits will be recorded and monitored separately for reporting purposes for the duration of the project and will be included in the VA medical center's workload reporting.

(3) VA case managers will assist in the development and maintenance of clinical records established by both the VA medical center and the residential treatment setting. **NOTE:** *Most VA HCMI Programs have two to three person outreach teams whose members serve as case managers and who are VA employees.*

(4) The non-VA residential treatment program will provide copies of each veteran's treatment plan to the VA medical center when it is completed. Treatment plans may be completed by VA HCMI teams on VA forms if treatment planning is conducted with inclusion by contract setting staff. The program will send a copy of the final summary to the VA medical center within 1 month of the veteran leaving the setting.

f. **Staffing.** Sufficient staff must be provided (i.e., in numbers and position qualifications) to carry out the policies, responsibilities, and therapeutic activities of the residential treatment program.

(1) In residential treatment settings there must be, as a minimum, a full-time staff member or designee available for emergencies 24-hours-a-day, 7-days-a-week.

(2) In those instances where a supervised residential setting is linked to a geographically distinct rehabilitation and/or socialization day program, sufficient staff must be provided to staff the necessary therapeutic activities to ensure a meaningful integration of these efforts with those provided in the residential setting. **NOTE:** *VA inspection teams are expected to evaluate the*

*residential treatment setting's ability to consistently ensure the presence of staff capable of providing those services required under the terms of the contract.*

## 1.06 PRE-AWARD SURVEY

**NOTE:** *The pre-award survey is the survey to be made prior to awarding the contract.*

a. A multidisciplinary VA team consisting of a social worker, nurse, an engineering service Safety Officer, and other designees of the VA medical center Director that may be deemed necessary, should conduct a survey of the residential program prior to the award of a contract. Residential settings to be utilized will be restricted to community-based, peer group oriented settings that provide food, shelter, and therapeutic services in a supportive environment.

b. The Safety Officer will inspect the setting for conformity to the current Life Safety Code and submit the findings to the chairperson of the team. The other members of the team will focus on an assessment of the quality of life within the residential treatment settings, giving particular attention to the following indicators:

(1) General observation of residents indicates that they maintain an acceptable level of personal hygiene and grooming.

(2) The setting is conducive to social interaction and the fullest development of the resident's rehabilitative potential. It is preferably in a central location, near public transportation, and not too far from areas which provide employment.

(3) Appropriate organized activity programs which reflect a high level of activity in the setting or in the linked settings.

(4) There is evidence of program-community interaction. **NOTE:** *This may be demonstrated by the nature of scheduled activities, or by information about resident involvement with community activities, volunteers, local consumer services, etc.*

(5) Staff behavior and interaction with residents convey an attitude of genuine concern and caring.

(6) Adequate meals are provided in a setting which encourages social interaction; nutritious snacks between meals and bedtime are available.

(a) The addition of nutritious snacks to the requirements for board is particularly indicated for HCMI patients. Many of these patients are either undernourished or have developed poor eating habits or both, because of their chronic psychiatric disorder, including alcohol and/or drug abuse behaviors.

(b) The local VA medical center dietitian may consult with the initial inspection team and the team making subsequent assessments, in evaluating not only the printed menus but the patients' satisfaction with meals and the actual consumption of food offered.

(7) Treatment and discharge planning reflect a team assessment of health, social and vocational needs and the involvement of residents' families (when indicated) and appropriate community resources in resolving problems and setting goals.

(8) There is documented evidence of the program's commitment to the implementation of the VA Patient's Bill of Rights (38 CFR, Section 17.34a).

c. The report of Pre-Contract Survey, (to include all reports from team members), with demonstrated cost basis for per diem, and other recommendations, will be submitted through the Veterans Integrated Service Network (VISN) Director's Offices to Mental Health and Behavioral Sciences Service (MH&BSS) in VHA Headquarters for review and approval prior to awarding a contract. When VHA Headquarters approvals are provided, the VA medical center may complete contract arrangements with the community setting.

(1) Preliminary to inspecting each setting and performing each survey of patient care, the team leader will:

(a) Contact the person in charge of the non-VA setting to arrange the date and time of inspection.

(b) Review the report of most recent previous inspection, if any, and discuss with the Chief, MAS, medical center Contracting Officer, and the Chief, Social Work Service, any problems or irregularities which they may have encountered earlier in dealing with the setting.

(c) Review terms of any existing agreement.

(2) A formal report of each inspection will be prepared and forwarded to the medical center Contracting Officer. In accordance with normal contract administrative practices, the following actions can be expected to ensue:

(a) The non-VA program (potential contractee) will be advised of the findings of the inspection team.

(b) In the event deficiencies have been noted, the non-VA program will be given a reasonable time to take corrective action and to notify the contracting officer that the corrections have been made.

(c) Any unsatisfactory conditions noted during a follow-up visit to a residential treatment setting with which the VA has a contract will be reported in writing to the Contracting Officer through the VA medical center Director. In already existing contracts, satisfactory corrections must be made in a reasonable time. When this is not done, the Contracting Officer will consult with the concerned officials so that suitable arrangements can be made to discharge or transfer patients and terminate the contract.

(d) The original copy of the inspection report and pertinent correspondence will be filed in the contract file.

d. Contracts will not be awarded until noted deficiencies have been eliminated.

e. All contracted programs, as an explicit part of the contract, have agreed and warranted that they neither maintained nor provided for dual or segregated patient residential settings on the basis of race, creed, color, or national origin. As a part of each inspection, special attention will be given to evaluating compliance with this requirement. If, during the course of the inspection, an unresolved discrimination complaint arises or maintenance of segregated residential settings has been observed, a report will be forwarded to the VISN Director (10N\_\_). The report will contain pertinent facts and observations with a description of action taken to correct this situation. A copy of the report will be given to the Contracting Officer.

## **1.07 SUBSEQUENT SURVEYS**

Subsequent surveys of the residential treatment setting must be made on a yearly basis by a multidisciplinary team including such hospital personnel as the Director considers necessary to ensure that the setting provides quality care in a safe environment. As site visits are accomplished by VA program personnel, attention will be directed to the adequacy of veterans' records, and include a spot checking of records to ensure contractor invoices accurately reflect the veteran's length of stay.

### **1.08 GUIDELINES FOR SELECTING VETERANS FOR RESIDENTIAL TREATMENT REFERRAL**

a. Veterans eligible for the Residential Program are those who are identified as being HCMI. This may include veterans with a service-connected chronic mental disorder (who must be accorded highest priority), veterans with any service-connected disability, or veterans with a nonservice-connected disability. These veterans should be identified by the treatment teams working in the community, in shelters, in missions, or in the streets.

(1) For the purposes of the Residential Program, the veterans initially will be selected from those HCMI in the community rather than those currently residing within VA medical and domiciliary facilities. *NOTE: The Residential Program is designed particularly to assist those chronically mentally ill who are actively homeless in the community.*

(2) Technical (clinical) guidance, patient selection and associated coordination will be provided by the project coordinator who will be supervised by the Chief of the appropriate service in these patient care parameters.

(3) The VA case manager will coordinate the veteran's:

- (a) Identification,
- (b) Determination of eligibility,
- (c) Psychiatric and medical workup,
- (d) Residential treatment placement, and

(e) Evaluation of the veteran's progress in rehabilitation after placement into the Non-VA Contract Program.

b. Selection for placement in Residential Treatment Setting

(1) All veterans placed in residential treatment should be capable of self-preservation. In an emergency situation, the patient should have sufficient:

- (a) Capacity to recognize physical danger;
- (b) Judgment to recognize when such danger requires immediate exit from the group residence;
- (c) Capacity to follow a prescribed route of exit; and
- (d) Physical mobility to accomplish such exit.

(2) The veteran patients will be identified by the VA case manager and/or treatment teams as being HCMI; this includes chronically mentally ill veterans and those with alcohol and/or substance abuse disorders who are homeless.

(a) All such eligible veterans will be provided a clinical assessment, with a physical exam and laboratory studies if indicated, and confirmation of chronic mental illness by a VA mental health professional.

(b) Such evaluations will be done either on an outpatient basis or through a brief hospitalization depending on the circumstances. *NOTE: More prolonged hospitalizations will be avoided unless dictated by the patient's clinical needs.*

(3) The patient's VA eligibility (i.e., veteran status) will be determined by MAS as expeditiously as possible. This may be done in the community with the assistance of the VA case manager (e.g., at a shelter) or at the VA medical center, if necessary. Optimally, eligibility will be determined prior to the medical and/or psychiatric workup. *NOTE: No patient will be placed in a residential treatment setting before that veteran's eligibility is verified.*

c. After outplacement into a residential treatment setting, therapeutic and rehabilitative services will ordinarily be provided by non-VA staff in the contracted programs, although VA staff may assist with therapeutic services.

(1) In some cases, VA may complement the Residential Treatment Program with added treatment services, such as participation in VA outpatient programs or with community providers.

(2) In the cases of complexes of non-VA community health care settings, it is imperative that all components of the community healthcare and residential treatment settings be inspected by the VA team prior to approval of the contract, as is required for an integrated primary site.

(3) Each of the community settings identified in the complex as contract recipients, will be subject to the requirements for contracting, safety, and record keeping described in other parts of this document as applying to contractees.

### **1.09 PER DIEM RATES AND CENSUS**

a. Length of stay at VA cost will be initially authorized for up to 6 months, depending upon the needs of the patient as mutually determined by the:

- (1) Patient,
- (2) Residential treatment staff, and
- (3) VA HCMI treatment team.

b. The Chief of the responsible service may recommend an additional 6 months of contract-supported residential treatment with the Chief of Staff's approval with such funding as is authorized. This authorization may be delegated as appropriate by the Chief of Staff.

### **1.10 QUALITY IMPROVEMENT**

a. Residential treatment settings shall make documented information available to the VA, as deemed necessary to:

- (1) Conduct utilization review audits for the mandated national evaluation study,
- (2) Verify quality of patient care for veterans,
- (3) Ensure confidentiality of patient record information, and
- (4) Determine the completeness and accuracy of financial records. *NOTE: The comprehensive program monitoring and evaluation study mandated by law will draw part of its data from the residential treatment settings.*

b. Assessment of treatment outcome at periodic intervals may be of value to case manager teams. Veterans provided placement in residential treatment or other care settings under this program, may be included in VA program follow-up activities as part of the continuing support and monitoring of the quality of care by the contracting VA facility. Such visits will be recorded as community-based visits and tracked in the same manner as the other outreach visits.

c. Should a patient referred to a residential care setting be absent in an unauthorized manner, payment for services for that veteran to the residential treatment setting may be continued for a period of 2 days, provided there is an active outreach attempt on the part of the residential treatment setting staff to return the veteran to the Residential Care Program and a strong likelihood that the patient will return.

## 1.11 REFERENCES

- a. Pub. L. 100-6.
- b. Pub. L. 100-237.
- c. Pub. L. 100-77.
- d. Title 38 U.S.C. 620 (C).
- e. Title 38 U.S.C. 7332.
- f. Title 41 U.S.C. 25 (c)(5).
- g. Title 38 CFR 17.
- h. Title 42 CFR Part II.
- i. FAR 54.
- j. VAAR 806.
- k. NFPA # 101, Life Safety Code.
- l. M-2, Part X, Chapters 3.

**CONTENTS**

**CHAPTER 2. PROCEDURES FOR SUBSTANCE ABUSE CONTRACT PROGRAMS**

| <b>PARAGRAPH</b>  | <b>PAGE</b> |
|---|-------------|
| 2.01 Purpose .....  | 2-1         |
| 2.02 Definitions .....  | 2-1         |
| 2.03 Program Management Responsibilities .....                  | 2-1         |
| 2.04 VA Standards for Contracting .....                         | 2-3         |
| 2.05 Patient Records .....                                      | 2-4         |
| 2.06 Staffing .....   | 2-5         |
| 2.07 Criteria for Establishing Contracts - Program Survey ..... | 2-5         |
| 2.08 Patient Referral .....                                     | 2-9         |
| 2.09 Per Diem Rates and Census .....                            | 2-10        |
| 2.10 Assessment of Treatment Outcome .....                      | 2-11        |
| 2.11 Program Reporting Requirements (RCS 10-0105) .....         | 2-11        |
| 2.12 References .....   | 2-11        |

## CHAPTER 2. PROCEDURES FOR SUBSTANCE ABUSE CONTRACT PROGRAMS

### 2.01 PURPOSE

This chapter describes the use of Contract Community Halfway Houses, Therapeutic Communities, Psychiatry Residential Treatment Centers and other community-based treatment settings for eligible veterans suffering from alcohol and/or drug dependence (see M-2, Pt. X, Ch. 3).

### 2.02 DEFINITIONS

a. **Substance Abuse Contract Programs.** Halfway houses, therapeutic communities, and psychiatric residential treatment programs were established to fill the needs of many patients for a residential environment intermediate between the hospital and the home. Through utilization of such modalities, many individuals may now be discharged from hospital status in a significantly shorter time while others are provided a specialized, substance-free, social environment and, in some cases, temporary detachment from their homes as transitional support prior to reentry into family and community life. Residents in such programs learn self-help skills through assuming responsibility for their rooms, household chores, and, in many cases, obtaining employment in the community. This occurs while living and working with others who have common problems

b. **Halfway House (HWH).** A community HWH or recovery home for alcohol and/or drug dependence treatment is defined as a community-based, peer group oriented, residential setting which provides food, lodging, and supportive services in a substance-free environment for persons involved in a recovery process. Licensing requirements vary considerably from state to state. HWHs may be found which are licensed as boarding homes, board and care facilities, intermediate care facilities, recovery homes, and as HWHs per se.

c. **Therapeutic Community (TC).** For purposes of this chapter, a TC is a therapeutic milieu of patients and personnel within a specially structured setting which:

- (1) Utilizes a family-like authority system,
- (2) Promotes the resident's psychosocial functioning within acceptable social bounds which recognize the norms of community life, and
- (3) Helps the residents assume increasing responsibility for their own rehabilitation and that of their fellow patients. *NOTE: Most often such programs are specialized for the rehabilitation of chronic drug abusers.*

d. **Psychiatric Residential Treatment Setting.** A free-standing setting that provides domicile and health-related services, personal and/or protective care for psychiatric patients, including those with substance abuse disorders. Such residents do not require hospital level care. Often there are ancillary arrangements for the provision of medical, psychiatric, social and rehabilitative services and a full range of psychiatric treatment.

### 2.03 PROGRAM MANAGEMENT RESPONSIBILITIES

a. Contracts will be sought with selected providers which desire to furnish care to Department of Veterans Affairs (VA)-referred veterans and which meet VA standards. Appropriate medical center personnel will advise the medical center Director of suitable settings known to them.

b. Medical center Directors are responsible for designating members of a Residential Program evaluation team and ensuring that transportation is available for evaluation and patient follow-up. Team members are responsible for:

- (1) Ensuring appropriate administrative participation in the placement of patients,
- (2) Issuing authorizations and processing invoices,
- (3) Inspecting settings,
- (4) Coordinating the follow-up of patients,
- (5) Assisting in the development of contracts, and
- (6) Recommending approval, disapproval or termination of contracts.

c. The medical center Contracting Officer has final responsibility for negotiating and consummating contracts with suitable providers.

(1) Special effort will be made to secure contracts which include within the per diem rate, the cost of a room, meals and the cost of routine medical care, and other necessary services.

(2) If this is not possible, the contract must specify those services and/or supplies which are not included in the per diem rate.

(3) Per diem will generally be paid for the day of admission or the day of discharge from the program, but not both (see subpar. 2.09c).

(4) Copies of contracts with new providers (that is, the provider has not previously been approved to participate in the Alcohol and Drug Halfway House Program) should be forwarded through the Veterans Integrated Service Network (VISN) Director (10N\_\_), and the Chief Network Officer to the Office of Patient Care Services (10N/111C1E).

(5) A concurrent copy of the contract should be forwarded directly to the Associate Director for Addictive Disorders (111C1E).

d. The Chief, Alcohol, Drug, or Combined Substance Abuse Program, is responsible for:

- (1) Clinical selection and placement of patients in contract settings ;
- (2) Monitoring patient care during contract placement; and
- (3) Monitoring the patient after discharge from the Contract Program.

(4) In VA medical facilities lacking an Alcohol and Drug, or Substance Abuse Treatment Program, the medical center Director is responsible for designating a service as responsible for Contract Program clinical activities.

(5) A clinician from this service will be assigned responsibility for clinical selection and placement of patients and monitoring of patient care during contract placement. Ideally, this function will be assigned to the clinician(s) who have the major responsibility for treatment of such cases.

e. Responsibility for medical follow-up may be referred to another VA medical center or VA outpatient clinic (VAOPC) when:

- (1) The distance between the placing medical center and the Contract Program is significant;
- (2) Follow-up by the authorizing medical center is deemed impractical; or
- (3) Other compelling circumstances are present.

*NOTE: When two or more facilities place patients in the same contract setting, follow-up services may be exchanged by mutual agreement.*

f. All patients in HWH, TCs, and Psychiatric Residential Treatment Settings will be followed by VA staff for a minimum of 1 year starting with their date of discharge from the Contract Program.

- (1) Information collected should include data on:
  - (a) Reason for discharge from the Contract Program,
  - (b) Employment,
  - (c) Recurrence of substance use,
  - (d) Hospital readmission, and
  - (e) Reason for readmission.

(2) Both VA and Contract Program staff should cooperate fully with all evaluation requests from the Program Evaluation and Resource Center (PERC) located at the VA Medical Center, Palo Alto, CA.

#### **2.04 VA STANDARDS FOR CONTRACTING**

a. Standards for contracting include the provision of social rehabilitative as well as health-related services with support and guidance toward the goal of independent living. The setting must meet the following VA standards:

- (1) All Contract Programs must be licensed under State or Federal authority.
- (2) All buildings must conform to the requirements for applicable residential and board and care, and the general chapters of the latest edition of the Life Safety Code, National Fire Protection Association (NFPA) Standard No. 101.
- (3) All local and state fire safety requirements and licensing standards must be met for "Board and Care" type occupancies or the occupancy type the setting is designated as by the local fire safety officials.
- (4) The contract setting must have a current occupancy permit issued by the authority having jurisdiction, where applicable.

b. The clauses Privacy Act Notification (Federal Acquisition Regulation (FAR) 52.224.1) and Privacy Act (FAR 52.224.2) shall be incorporated into the contract.

c. Services of community residential settings standards include:

- (1) A supervised alcohol and drug-free environment;
- (2) Provision of continued substance abuse treatment of a patient while in residence. This may be provided by the halfway house staff or by arrangement with a VA medical facility or community treatment source. Treatment may be provided by:
  - (a) Staff licensed as mental health professionals or certified as substance abuse counselors; or
  - (b) Personnel who are supervised weekly, on a face-to-face basis, by such licensed or certified professionals.
- (3) An active affiliation with a self-help programs, Alcoholics Anonymous (A.A.), Narcotics Anonymous (N.A.), etc.;
- (4) Staffing on a 24-hour basis and at least one live-in staff member;
- (5) Nutritionally adequate and acceptable meals, appropriately designed dining rooms, and resident participation in menu planning and food preparation activities;
- (6) Laundry facilities for residents to do their own laundry;
- (7) Structured activities; i.e., resident participation in group sessions will depend upon resident preference and VA substance abuse residential program staff recommendations;
- (8) A variety of group activities, including physical activities, as appropriate;
- (9) Health and personal hygiene maintenance;
- (10) Monitoring of medications;
- (11) Social work and community support services;
- (12) Psychological counseling, nutrition counseling, and vocational rehabilitation counseling;
- (13) Opportunities for the development of skills for responsible independent living;
- (14) Support for an individual's desire for sobriety and an alcohol and drug-free lifestyle; and
- (15) Opportunities for:
  - (a) Learning and internalizing knowledge of illness and the recovery process,
  - (b) Upgrading social skills, and
  - (c) Improving personal relationships.

## **2.05 PATIENT RECORDS**

a. An individual patient record will be maintained by the Contract Program staff on each veteran admitted under this contract. It will include the following:

- (1) Reasons for referral;
  - (2) All essential identifying data relevant to the resident and the resident's family, including a socio-cultural and vocational assessment;
  - (3) Data relating to the patient's admission, including targeted goals for constructive changes to be attained during the residential rehabilitation episode, and the anticipated length of stay;
  - (4) Copies of all medical prescriptions issued by any physician, including orders, if any, for medications to be taken and/or diets to be followed;
  - (5) Reports of periodic reevaluation by program staff, including measures of movement toward rehabilitation goals, with particular focus on the attainment of self-help skills; and
  - (6) Final summaries on each resident who leaves the program, including:
    - (a) A description of beneficial changes realized during the residential period,
    - (b) Reasons for leaving,
    - (c) The resident's future plans, and
    - (d) Follow-up information.
- b. The community Contract Program must comply with the requirements of the "Confidentiality of Alcohol and Drug Abuse Patient Records" (Title 42 Code of Federal Regulations (CFR), Part II) and the "Confidentiality of Certain Medical Records" (Title 38 United States Code (U.S.C.) 7332). The contract will include:
- (1) All case records to be stored in a secure setting and confidentiality maintained as required.
  - (2) Records which must be made available on a need-to-know basis to appropriate VA staff members involved with the treatment programs of the veterans concerned.
- c. Periodic administrative and fiscal reports will be provided to VA as required. This includes provision of patient follow-up data and responding to evaluation requests from the PERC.

## **2.06 STAFFING**

- a. Sufficient staff must be provided in numbers and position qualifications to carry out the policies, responsibilities, and services of the program.
- b. In residential settings there must be, at a minimum, a full-time administrative staff member, or staff designee, on duty or residing on the premises who is available for emergencies 24-hours-a-day, 7-days-a-week.
- c. VA inspection teams are expected to evaluate the contractor's ability to consistently ensure the presence of staff capable of providing those services required under the terms of the contract.

## **2.07 CRITERIA FOR ESTABLISHING CONTRACTS - PROGRAM SURVEY**

a. A multidisciplinary VA team consisting at a minimum of a physician, a social worker, psychologist, dietitian, nurse, safety officer, and a contracting officer, will conduct an initial assessment of the program to assess appropriateness of the program for a contract. One member of the team should be designated as team coordinator by the medical center Director. *NOTE: Awarding of contracts is contingent upon a positive assessment of the program by the survey team.*

(1) The Program Survey (to include all reports from team members) with recommendations will be submitted to the Chief Network Officer (10N/111C1E) through the VISN Director (10N\_\_) for review and approval, prior to awarding a contract. The VISN Director will forward the contact with recommendations regarding approval/disapproval and any other relevant issues. A concurrent copy will be forwarded to the Associate Director for Addictive Disorders (111C1E).

(2) Preliminary to making each inspection of a setting, the team leader will:

(a) Contact the person in charge of the non-VA program to arrange the date and time of inspection.

(b) Review the report of most recent inspection, if any, and discuss with the Chief, Medical Administration Service (MAS), medical center Contracting Officer, and the Chief, Social Work Service any problems or irregularities which they may have encountered earlier in dealing with the setting.

(c) Review terms of any existing agreements.

(3) A formal report of each inspection will be prepared and forwarded to the medical center contracting officer. In accordance with normal contract administrative practices, the following actions can be expected to ensue:

(a) The setting will be advised of the findings of the inspection team.

(b) In the event deficiencies have been noted, the setting will be given a reasonable time to take corrective action and to notify the contracting officer that the corrections have been made.

(c) Any unsatisfactory conditions noted during a follow-up visit to a contract setting will be reported in writing to the Contracting Officer through the medical center Director. In already existing contracts, satisfactory corrections must be made in a reasonable time. When this is not done, the contracting officer will consult with the concerned officials so that suitable arrangements can be made to discharge or transfer patients and terminate the contract.

(d) The original copy of the inspection report and pertinent correspondence will be filed in a contract file maintained by the medical center.

1. Copies of all new contracts, modifications and terminations and any other significant data pertaining to the contract setting will be maintained by the medical facility and will be ready available to external reviewers (such as VISN Director and Veterans Health Administration (VHA) Headquarters site teams).

2. One copy of contracts with new settings (that is, the setting has not previously been approved to participate in the Alcohol and Drug Halfway House Program) should be forwarded through the VISN Director (10N\_\_) to the Chief Network Officer and Office of Patient Care

Services (10N/111). A concurrent copy should be forwarded directly to the Associate Director for Addictive Disorders (111C1E).

b. Residential programs to be utilized will be restricted to community-based, peer group oriented settings that provide food, shelter, and service in a supportive, non-alcohol drinking and/or non drug abusing environment (i.e., abstinence).

c. The Safety Officer will inspect the setting for conformity to the current Life Safety Code and submit the findings to the coordinator. The setting must meet applicable fire, safety, and sanitation standards.

d. The setting should be located in attractive surroundings conducive to social interaction and the fullest development of the resident's rehabilitative potential. It is preferable for the setting to be in a central urban location, near public transportation, and not too far from areas which provide employment.

e. The clinical members of the team will focus on an assessment of the quality of care provided by the setting and the quality of life within the residential setting, giving particular attention to the following critical indicators:

(1) Continued involvement of the patients in active substance abuse treatment.

(2) Policies and procedures for handling psychiatric emergencies are congruent with clinical standards, and are compatible with VA medical facility operating procedures.

(3) General observation of residents indicates that they maintain an acceptable level of personal hygiene and grooming.

(4) Appropriate organized activity programs during waking hours (including evenings) reflect a level of activity in the setting consistent with therapeutic rehabilitation principles.

(5) There is evidence of setting-community interaction. *NOTE: This may be demonstrated by the nature of scheduled activities or by involvement of other than setting staff with the residents.*

(6) Staff behavior and interaction with residents convey an attitude of genuine concern and caring.

(7) The setting demonstrates a commitment to constant upgrading of knowledge and skills of staff through provision of documented training programs which respond directly to the resident's treatment needs.

(8) Appetizing and nutritionally adequate meals are provided in a setting which encourages social interaction. Nutritious snacks between meals and bedtime are available for those requiring additional food as medically indicated.

(a) The contract setting's attention to the residents' nutrient requirements is particularly important for alcohol or drug dependent patients. Many of these patients are either undernourished or have developed poor eating habits because of the addiction.

(b) The dietitian on the initial inspection team will determine if the setting has policies and procedures in place to ensure assessments of residents' nutrient needs are conducted by appropriately trained clinical staff.

(c) The contract setting must also assure evaluations are done to determine residents' satisfaction with meals. During the initial inspection, the dietitian will:

1. Evaluate printed menus,
2. Evaluate the settings used for food preparation in regards to sanitation and safety, and
3. Determine the actual consumption of food offered.

(9) If urine screening or other procedures are required, data will be developed to indicate the extent to which VA will be expected to provide these services.

(10) Treatment and discharge planning reflect a team assessment of health, social, and vocational needs, and the involvement of residents' families and appropriate community resources in resolving problems and setting goals.

(11) There is documented evidence of the setting's commitment to the implementation of the Patient's Bill of Rights.

f. All contract programs, as an explicit part of the contract, have agreed and warranted that they neither maintain nor provide for dual or segregated patient settings on the basis of race, color, religion, or national origin (FAR 52.222-26) and are nondiscriminant in services provided beneficiaries VA Acquisition Regulation (VAAR) 85227170). As a part of each inspection, special attention will be given to evaluating compliance with this requirement. If, during the course of the inspection, an unresolved discrimination complaint arises or maintenance of segregated settings has been observed, a report will be forwarded to the VISN Director (10N\_\_). The report will contain pertinent facts and observations with a description of action taken to correct the situation. A copy of the report will be given to the Contracting Officer.

g. Subsequent assessment of the setting must be made at least every 2 years by a multidisciplinary team including such medical enter personnel as the Director considers necessary to ensure that the setting provides quality care in a safe environment. Attention will be directed to the adequacy of veterans' records and will include spot checking to ensure that contractor invoices accurately reflect the veterans' length of stay.

h. The contractor shall certify willingness to:

(1) Make documented information available to the VA, as deemed necessary to conduct utilization review audits;

(2) Verify quality of patient care for veterans;

(3) Ensure confidentiality of patient record information;

(4) Complete program evaluation studies; and

(5) Determine the completeness and accuracy of financial records.

i. Mutual use of contracts is authorized. The same policy that has been in effect pertaining to mutual use of nursing home contracts is extended to the Contract Program authorized under 38 U.S.C. 1720A, subject to the following restrictions:

(1) For one medical center to utilize the contract of another medical center, the former center must obtain approval from the appropriate program officials in VHA Headquarters to place veterans in such a contracted setting. Requests should be sent through the VISN Director (10N\_\_) to the Chief Network Officer and the Office of Patient Care Services (10N/111C1E). The VISN Director needs to forward recommendations with the request. A concurrent copy of the contract should be forwarded directly to the Associate Director for Addictive Disorders (111C1E).

(2) The Contracting Officer who signed the original (base) contract must execute an SF-30, Amendment of Solicitation/Modification of Contract, extending the use of the contract to another medical center. The SF-30 must specify the procedures by which invoices are to be submitted to the additional setting which will utilize the contract. A copy of the executed SF-30, along with a copy of the base contract, will be forwarded to VHA Headquarters (10N/111C1E) through the VISN Director (10N\_\_) by the contracting officer "utilizing" the base contract of another VA medical center. A concurrent copy should be sent to the Associate Director for Addictive Disorders (111C1E).

(3) VHA Headquarters will provide budget authority to the medical center identified on the SF-30, which is authorized use of the base contract.

(4) Each medical center utilizing the base contract will be responsible for submitting to VHA Headquarters, the quarterly reports required for this Contract Program (see par. 2.11).

**NOTE:** *To ensure stations receive sufficient funding for per diem costs, **under no circumstances** will sharing of such contracts be permitted without specific prior approval of VHA Headquarters (10N/111C1E).*

## 2.08 PATIENT REFERRAL

a. It should be emphasized that the Contract Program is limited to placement of eligible veterans who have recently completed detoxification or other VA medical center level treatment. This program is not to be used to find emergency boarding houses nor temporary residences for veterans awaiting hospitalization.

b. Technical (clinical) guidance, patient selection, and associated coordination will be provided by the Chief, Alcohol, Drug, or combined Substance Abuse Program at the contracting VA medical center. When there is not a substance abuse program at the VA facility, these functions will be provided by the clinician(s) designated in paragraph 2.03d.

c. VA program staff will evaluate the clinical appropriateness of this level of care for the patient before authorizing treatment in a contract setting. Before recommending an extension to the length-of-stay in the contract setting, VA program staff must evaluate the patient's progress towards rehabilitation. Criteria to be used in selection for placement in a residential setting include the following:

(1) All patients placed in contract settings should be capable of self-preservation. In an emergency situation, the patient should have sufficient:

- (a) Capacity to recognize physical danger,
- (b) Judgment to recognize when such danger requires immediate exit from a group residence,
- (c) Capacity to follow a prescribed exit route, and

(d) Physical motility to accomplish such exit.

(2) Patients who need a slower integration into the community, perhaps requiring a low-skilled job and some help finding a room with cooking privileges;

(3) Alcohol or drug abusing veterans who, because of health problems, may experience particular difficulty in reentry into the community, and may need additional time and support in order to be self-sustaining;

(4) The alcohol or drug abusing veteran who has an unsatisfactory home environment may need more time to stabilize the changes made in the inpatient unit before living autonomously or returning home; and

(5) The semi-stable individual who has considerable ego strength and some environmental support but who is in crisis and needs a brief stay in a residential setting and requires a therapeutic milieu.

d. Patients placed in residential settings require monitoring and follow-up services consistent with VA discharge planning policy as explicated in M-2, Part XII, Chapter 2. Accordingly, Social Work Service will:

(1) Monitor the patients' adjustment at regular intervals,

(2) Involve VA program staff in discussion/resolution of significant problems, and

(3) Provide consultation to service providers consistent with the VA treatment plan.

e. Selection for placement in a non-VA Outpatient Treatment Program applies to veterans who have available residential support and/or employment in a location sufficiently distant from a VA treatment facility that participation in a VA outpatient treatment program is not feasible. Such outplacement should reflect sufficient prior collaborative planning with the non-VA programs to ensure continuity of treatment activities and general endorsement of VA treatment goals.

## 2.09 PER DIEM RATES AND CENSUS

a. To the degree that any savings are generated by lower per diem rates, census may be adjusted to accommodate placement of additional veterans so long as VA facilities remain within their resource allocation for the Substance Abuse Contract Program.

b. Length-of-stay at VA cost will be limited to 60 days. In exceptional cases, a waiver allowing up to 30 additional days may be authorized by the medical center Chief of Staff on the recommendation of the appropriate clinical program official, subject to availability of funds as determined by Fiscal Service. Additional contract funds will not be allocated for placement of veterans at this level of care for post-medical center treatment of alcohol or drug abuse disorders beyond the 90th day.

c. Medical centers are advised that when they negotiate contracts, they should specify that they will pay per diem for the day of a patient's admission to the setting or the day of the patient's discharge, but not both. Usually, reimbursement will be for the day of admission. When necessary to obtain a contract with an outstanding community program, payment may be made for both the admission and discharge date. *NOTE: It is expected that this option will be rarely used.*

d. Contract costs are to be charged to VHA cost center 8361 "Alcohol and Drug Treatment and Rehabilitation."

## **2.10 ASSESSMENT OF TREATMENT OUTCOME**

Assessment of treatment outcome at periodic intervals is expected of all substance abuse programs. Veterans provided placement in residential or other care settings under the Substance Abuse Contract Program are included in VA substance abuse program follow-up activities as part of the continuing support and involvement of the contracting VA (see subpar. 2.03e).

## **2.11 PROGRAM REPORTING REQUIREMENTS (RCN 10-0105)**

A quarterly report, Use of Contract Community Half-way Houses, Therapeutic Communities and Other Community Based Treatment Settings for Eligible Veterans Suffering from Alcohol and/or Drug Dependence (Reports Control Number (RCN) 10-0105), is required. Details may be found in M-2, Part X, Chapter 4, subparagraph 4.05b, and Appendix 4B.

## **2.12 REFERENCES**

- a. Title 38 U.S.C. 1720.
- b. Title 38 U.S.C. 7332.
- c. Title 38 CFR Section 17.
- d. Title 42 CFR Part II.
- e. FAR 52.
- f. VAAR 852.227-170.
- g. NFPA # 101, Life Safety Code.
- h. M-2, Part X, Chapter 3 and 4.

**CONTENTS**

**CHAPTER 3. PROCEDURES FOR PSYCHIATRIC RESIDENTIAL  
REHABILITATION AND TREATMENT PROGRAMS**

| <b>PARAGRAPH</b>          | <b>PAGE</b> |
|---------------------------|-------------|
| 3.01 Purpose .....        | 3-1         |
| 3.02 Background .....     | 3-1         |
| 3.03 Scope .....          | 3-2         |
| 3.04 Physical Plant ..... | 3-2         |
| 3.05 Implementation ..... | 3-2         |

## CHAPTER 3. PROCEDURES FOR PSYCHIATRIC RESIDENTIAL REHABILITATION AND TREATMENT PROGRAMS

### 3.01 PURPOSE

Psychiatric Residential Rehabilitation and Treatment Programs (PRRTPs) give Department of Veterans Affairs (VA) medical centers the option of establishing a new, more flexible clinical and/or administrative program category in response to changing patient characteristics and needs.

a. As the veteran population is aging, there are increasing numbers of Seriously Mentally Ill (SMI) veterans coming to VA for help, with additional problems of mixed substance abuse and/or Post-traumatic Stress Disorder (PTSD) often complicated by lack of residence and/or social support.

b. Many VA programs have developed a more specialized focus in areas such as PTSD treatment, sobriety maintenance, social and/or vocational skills training, discharge readiness, and therapeutic work, that do not require the 24-hour-a-day supervision characteristic of hospital-based treatment.

*NOTE: During the past decade, other public and private mental health care systems (e.g., the Massachusetts Mental Health Center, the Southwest Denver Comprehensive Mental Health Center), facing similar changes in the needs of their patients, have developed a broad range of alternative types of bed-based care to complement acute psychiatric inpatient treatment.*

### 3.02 BACKGROUND

a. This program provides support to SMI veterans engaged in extended rehabilitation programs for substance abuse, PTSD, or other psychiatric disabilities. Such veterans, while seriously impaired and requiring 24-hour-a-day supervision and peer support, must be stabilized and capable of sufficient independent action to participate. Since the early 1950's, the VA has been a national leader in the development of alternatives to psychiatric hospitalization for the SMI patients. In recent years there have been notable changes in the SMI veteran population and in the specialized programs VA offers to them. PRRTPs give VA medical centers the option of converting existing medical center programs or using existing contract program resources (i.e., Alcohol and Drug Halfway House Program or HCMI contract funds) to establish this new clinical/administrative program category.

*NOTE: This shift of emphasis may result in provision of care to greater numbers of patients, or greater rehabilitation intensity or duration to a similar number of patients. There are no new funds currently available for converting existing beds to this new bed category. New Cost Distribution Report (CDR) accounts and bed section codes in the Patient Treatment File (PTF) have been established for administrative purposes:*

b. All PRRTP patients are required to participate in at least 20 hours per week of specified therapeutic or rehabilitative activities. Toward the end of an episode of PRRTP treatment, some veterans may be allowed to work at community jobs instead of participating in formal treatment activities, but the PRRTP will not be used as a simple substitute for community housing. Any VA medical center seeking to establish a PRRTP must complete a standardized program proposal. Submissions will go through the Veterans Integrated Services Network (VISN) Director for review by a joint committee of Veterans Health Administration (VHA) Headquarters officials. PRRTPs are expected to be cost-neutral overall due to reduced costs for

building maintenance, medical and nursing staff and an increased investment in rehabilitation personnel.

### 3.03 SCOPE

a. **Program.** This new level of bed care, PR RTP, is defined as a structured, 24-hour-a-day therapeutic treatment setting which embodies strong treatment values with peer and professional support to CMI veterans in need of extended rehabilitation and treatment see M-2 Pt. X, Ch. 3, par. 3.08, regarding further information about this program).

b. **Patients.** The program may provide support to SMI veterans engaged in extended rehabilitation programs for substance abuse, PTSD, or other psychiatric disabilities. Such veterans, while seriously impaired and requiring 24-hour-a-day supervision and peer support, must be stabilized and capable of sufficient independent action to participate.

c. **Activities.** Therapeutic and vocational activities may take place either in the residence, in the community, or in other medical center premises. All PR RTP patients are required to participate in at least 20 hours per week of specified therapeutic or rehabilitative activities. Toward the end of an episode of PR RTP treatment, some veterans may be allowed to work at community jobs instead of participating in formal treatment activities, but the PR RTP will not be used as a simple substitute for community housing.

d. **Medical and Support Services.** Arrangement for administration of medication and other medical care may vary from program to program according to the needs of individual veterans. In some cases, veterans may manage their medication on their own. In others, a staff member will be responsible for administering daily medication. Meals can be prepared by the veterans themselves, under supervision, or by professional dietetic staff members associated with a residence. In some PR RTPs, especially those on medical center grounds, veterans may be allowed to eat in the patient dining room. Similar flexible arrangement may be allowed for laundry, housekeeping, and for setting maintenance and repair.

e. **Staffing Levels.** Staffing levels will vary depending on the clinical population being treated and whether some part of the treatment is provided directly by staff of another VA program (e.g., a day hospital, Compensated Work Therapy (CWT) Program, or Substance Abuse Unit).

### 3.04 PHYSICAL PLANT

a. A PR RTP may be established in any one of four settings:

- (1) A suitable building or residence on VA medical center grounds;
- (2) A VA owned dwelling in the community;
- (3) Community space leased by VA; or
- (4) Community space donated by a non-profit corporation for use by VA.

b. A PR RTP will have no specified number of beds; bed size is determined by local needs and cost considerations.

### 3.05 IMPLEMENTATION

Any VA medical center seeking to establish a PRRTTP will be asked to complete a standardized program proposal. The specific format of the proposal has been designed by Mental Health and Behavioral Sciences Service (MH&BSS) in collaboration with the Veterans Integrated Service Network (VISN) Directors and the Boston Development Center.

a. Submissions will go through the VISN Director for review by a joint committee of VHA Headquarters officials.

b. New CDR accounts and bed section codes in the PTF have been established for administrative purposes:

| CDR Account | Program PTF   | Treating Specialty Code |
|-------------|---|-------------------------|
| 1711.00     | PRRTTP (not otherwise specified)  | 25                      |
| 1712.00     | PRRP (PTSD Residential Rehabilitation Program)  | 26                      |
| 1713.00     | SARRTP (Substance Abuse Residential Rehabilitation Treatment)                                   | 27                      |
| 1714.00     | HCMI CWT/TR (Homeless Chronically Mentally Ill Compensated Work Therapy/Transitional Residence) | 28                      |
| 1715.00     | SA CWT/TR (Substance Abuse Compensated Work Therapy Transitional Residence)                     | 29                      |

c. Periodic reports on the clinical characteristics of patients treated in PRRTTPs, their use of VA services, their clinical outcomes, and the cost of their care will be submitted to MH&BSS; this includes an annual narrative (see App. C).

**CONTENTS**

**CHAPTER 4. PROCEDURES FOR VOCATIONAL  
AND REHABILITATION SERVICES**

| <b>PARAGRAPH</b>  | <b>PAGE</b> |
|---|-------------|
| 4.01 Definition .....   | 4-1         |
| 4.02 Scope .....  | 4-1         |
| 4.03 Vocational and Rehabilitative Specialty Programs .....   | 4-3         |
| 4.04 Veterans Industries and CWT (RCN 10-0656) .....  | 4-11        |
| 4.05 Veterans Industries, CWT, and Transitional Residences (VI/CWT/TR) Program .....                      | 4-22        |
| 4.06 Incentive Therapy (IT) Program .....   | 4-27        |
| 4.07 Vocational Rehabilitation Case Management Program .....  | 4-28        |
| 4.08 References .....   | 4-30        |
| <b>APPENDICES</b>   |             |
| 4A Sample Contract for Compensated Work Therapy and Guidelines<br>for Completing the Contract .....       | 4A-1        |
| 4B Sample Memorandum of Understanding for Compensated Work Therapy .....                                  | 4B-1        |
| 4C Sample Format for Compensated Work Therapy (CWT)/Therapeutic (TR)<br>Preliminary Site Evaluation ..... | 4C-1        |

## CHAPTER 4. PROCEDURES FOR VOCATIONAL AND REHABILITATION SERVICES

### 4.01 DEFINITION

The Vocational and Rehabilitation Services (V&RS) Program consists of comprehensive evaluation and assessment of veterans' vocational, avocational, and educational needs, as well as therapeutic training and rehabilitation. It endeavors to provide comprehensive and integrated services which may include, but are not limited to any of the following elements:

- a. Vocational evaluation and testing,
- b. Vocational case management and counseling,
- c. Vocational rehabilitation therapy,
- d. Compensated Work Therapy (CWT),
- e. Incentive Therapy (IT),
- f. Independent Living Skills Training, and
- g. Therapeutic Residences (TRs).

### 4.02 SCOPE

#### a. Treatment Objectives

(1) There are two major treatment tracks for those veterans served by the V&RS Program:

- (a) Veterans whose primary treatment objectives include employment or training; and
- (b) Veterans whose treatment objectives are of a therapeutic or rehabilitative nature.

(2) The objective for the employment or training track is to provide instruction and experience of a vocationally significant nature to achieve competitive employment and/or entry into training and/or educational pursuits.

(a) The work conditions, whether actual or simulated, are designed to provide an objective means by which to measure and develop work capacity as well as assess emotional adjustment.

(b) Training and educational pursuits are addressed by:

1. Educational assessment and testing,
2. Remedial and developmental instruction,
3. Guidance counseling, and
4. Assistance in utilizing other Department of Veterans Affairs (VA) educational benefits as well as State vocational programs.

(3) For those veterans or others for whom employment or training is not a realistic goal, treatment objectives would include:

- (a) Increasing self worth,
- (b) Pursuing a means of self actualization,
- (c) Improving both physical and mental capabilities,
- (d) Decreasing social isolation,
- (e) Assisting in maintaining functional level, and
- (f) Channeling interest and energies into socially acceptable patterns.

b. **Program Organization and Management**

(1) Overall clinical and administrative responsibility at Veterans Health Administration (VHA) Headquarters level is provided by Mental Health and Behavioral Science Service (MH&BSS). The organizational placement at the medical center level may vary according to the case mix and resources at that medical center. It will operate under the direction of the Chief, Psychology Service, Rehabilitation Medicine Service, Domiciliary Care Service, Psychiatry Service, or as designated by the Chief of Staff.

(2) The responsible Service Chief may appoint a V&RS Program Coordinator. This individual should serve as a focal point for organizing, implementing and evaluating V&RS programs.

*NOTE: The use of VA Voluntary Service (VAVS) volunteers in V&RS is a local administrative decision. If volunteers are utilized in this section, a thorough orientation should be given the volunteer as to the necessary precautionary measures to be observed with patients.*

(3) Veterans who return to the medical center for outpatient care in either IT or CWT may be provided lunch as a part of the therapeutic treatment program. Many patients who return for therapy do not receive a sufficient income from the program to pay for daily meals. Exceptions could be considered for patients whose income in the therapeutic programs exceed what is considered reasonable by program officials.

c. **Therapeutic Review Board.** A Therapeutic Review Board may be utilized as a resource for developing vocational goals and/or discharge plans. The board provides an interdisciplinary approach to treatment problems for patients having complex, unresolved, and varied rehabilitation problems and for those patients who have reached a plateau in their treatment programs. The board may be used in the referral process for patients to be transferred from a medical setting to a domiciliary.

d. **Referrals.** Patients will be referred to the V&RS Program by means of the Standard Form (SF) 513, Consultation Sheet, for the purpose of comprehensive assessment and evaluation of the potential of the patient and placement into appropriate therapeutic modality.

e. **Progress Notes.** Participants are evaluated by the appropriate professional staff element at regular intervals, but not less often than every 3 months, in order to determine readiness for discontinuance from the program or to adjust the therapeutic regimen. Written reports of such evaluation are to be documented in the participant's medical record, following appropriate Joint

Commission on Accreditation of Healthcare Organizations (JCAHO) and VA standards for documentation.

f. **Relationship with Allied Health Professionals.** Rehabilitation is not exclusively accomplished through activities provided in the V&RS Program, rather, it is accomplished through the combined efforts of all staff having contact with the patient. The treatment team is multidisciplinary in nature. Psychologists, social workers, and vocational rehabilitation therapists assist each other in counseling, testing, planning, evaluation and placement of patients. This cooperation ensures comprehensive rehabilitation planning and treatment, eliminates duplication, and accelerates discharge planning.

g. **Program Evaluation and Quality Assurance.** V&RS is responsible for the continuing analysis, evaluation, and synthesis of therapeutic work programs. The purpose is to lead to improved care, treatment, and rehabilitation of the patient to assure that treatment goals are established and met. As such, the provision of appropriate treatment will be assessed by clinical monitoring in accordance with current JCAHO and VA standards.

h. **Research.** V&RS is strongly encouraged to develop research appropriate to its service provision.

i. **Staff Training, Education, Professional Development and Certification.** The various V&RS disciplines are rapidly growing due to research and the exchange of professional experiences. New forms of therapeutic intervention are regularly evolving. Treatment professionals should participate in continuing education, and where appropriate, achieve state licensure or certification.

j. **Affiliation and Clinical Training Programs.** Clinical training programs provide trained professionals and help VA staff maintain work relations with the schools involved in academic preparation within their disciplines. These students trained at VA medical centers represent a great asset of potential employees to all Veterans Health Administration (VHA) facilities.

#### 4.03 VOCATIONAL AND REHABILITATIVE SPECIALTY PROGRAMS

##### a. **Vocational Evaluation**

(1) Vocational Evaluation is a comprehensive process that systematically utilizes work, either real or simulated, as the focal point for assessment and vocational exploration; the purpose is to assist the person in vocational development and adjustment. Vocational Evaluation incorporates medical, psychological, social, vocational, cultural, and economic data.

(2) The range and scope of the evaluation services should be sufficiently comprehensive to assess or obtain information concerning at least the following:

- (a) Physical and psychomotor capacities;
- (b) Intellectual capacities;
- (c) Pre-vocational skills including the ability to accept supervision, but not limited to:
  1. Appropriate attire,
  2. Attendance and punctuality,
  3. Cooperative working relationships with others, and

4. Adjustment to the changing demands of a work environment, etc.
  - (d) Interests, attitudes, and knowledge of occupational information;
  - (e) Personal, social, military, and work histories;
  - (f) Aptitudes;
  - (g) Achievement; e.g., educational, vocational;
  - (h) Work skills and work tolerance;
  - (i) Job-seeking skills;
  - (j) Identification of work-and nonwork-related needs;
  - (k) Possible employment objectives, which may involve either competitive or noncompetitive employment;
    - (l) The veterans' ability to learn about themselves as a result of the information obtained and furnished through the evaluation experience;
    - (m) Learning style, including understanding and responding to various types of instruction; and
    - (n) Identification of the need for job-site modifications or adaptive equipment when a person's disability may invalidate otherwise standardized procedures.
  - (3) Where a person's disability may invalidate otherwise standardized procedures, appropriate adaptive assessment tools and methods should be used.
  - (4) The length of time a veteran remains in Vocational Evaluation should be individualized to accomplish the veteran's evaluation goals.
  - (5) Evaluation data should be supplemented by personal interviews and behavioral observation.
    - (6) In the vocational evaluation process, veterans should be assessed for job areas based on:
      - (a) Their interests and capabilities,
      - (b) Opportunities in the labor market geographically accessible to the veteran, and
      - (c) Questions asked by the referral source.
    - (7) Based on referral questions and the initial interview, an individualized written plan should be developed with each veteran, which should:
      - (a) Define the scope of the evaluation;
      - (b) Indicate how this will be accomplished; and
      - (c) Be periodically reviewed and modified as necessary.

(8) The Vocational Evaluation Service should ensure that a variety of work settings and tasks are available to sufficiently meet the veterans evaluation needs. It should use two or more of the following techniques based on the specific abilities and needs of veterans served:

(a) Psychometric Tests. If psychometrics are used, the selection, administration, scoring, interpretation, and reporting of all psychological and psychometric tests should be under the supervision of an individual who meets the qualifications as defined by State law and by American Psychological Association standards.

(b) Work Samples. Work samples using either real or simulated work. If work samples are used they should be:

1. Representative of realistic competitive worker traits and/or skills.
2. Established by an analysis of job tasks or traits related to a specific area of work, and should be standardized as to materials, layout, instructions, and scoring.
3. Established and used competitive norms of industrial standards.
4. In an examiner's manual which specifies:
  - a. Its relationship to occupational divisions, worker trait groups, or an appropriate job analysis system;
  - b. Prerequisites; e.g., any specific task requirements which might make administration unfeasible for a given individual;
  - c. The work sample purpose; e.g., specifically what the sample is attempting to assess;
  - d. Materials and equipment used;
  - e. Preparation for testing and the layout of materials;
  - f. Instructions to the person served;
  - g. Instructions for timing, evaluating errors; and scoring, if applicable; and
  - h. Instructions for interpreting scores.

(c) Simulated Job Stations. If simulated job stations are used, the veteran's job performance should be evaluated against competitive industrial standards; e.g., quality, quantity, physical demands.

(d) On-the-Job Evaluation. If on-the-job evaluation is used, each job site should be evaluated as to its appropriateness with regard to:

1. Ability to provide and observe key job elements,
2. Adequate supervision,
3. Appropriate safety,
4. Physical accessibility,

- 5. Transportation accessibility, and
- 6. Competitiveness of work tasks and demands.

(9) For each veteran served in Vocational Evaluation, a written functional evaluation report should be prepared, properly interpreted to the veteran served, and disseminated in a timely fashion to the program manager, referral source, and other appropriate agencies or individuals.

(10) At the completion of evaluation, the goals of veterans served should be expressed as job possibilities in terminology such as job titles or job families related to existing occupations in the community. Where applicable, barriers to training and employment will be fully addressed and alternative goals should be specified.

(11) Equipment used in Vocational Evaluation should sample the skills and abilities required by competitive industry. The selection of equipment should be based on the capability of the veteran served and be suitable to the local job market.

(12) Vocational Evaluation services should be provided by, or be under the supervision of a qualified individual who meets appropriate professional standards, i.e., Certified Rehabilitation Counselor (CRC), Certified Vocational Evaluation Specialist (CVE), Certified Work Adjustment Specialist (CWA), Licensed Occupational Therapist (OTR), etc.

b. **Educational Therapy (ET)**

(1) ET should be considered a vital part of the prevocational and vocational planning in a veteran's career rehabilitation plan. ET utilizes educational materials and methods in the following areas:

(a) Educational assessment and instruction (remedial and developmental), prevocational and vocational evaluation;

(b) Counseling;

(c) Improvement of psychosocial and basic life skills;

(d) Remotivation;

(e) Reality orientation; and

(f) Cognitive rehabilitation and development of avocational interests.

(2) The Educational Therapist directs educational, vocational, and creative activities for patients through a curriculum. The curriculum may include:

(a) High school equivalency programs as the General Educational Development (GED);

(b) Individual preparation and testing;

(c) Commercial subjects, such as typewriting, word-processing, bookkeeping and accounting; and

(d) Academic subjects such as mathematics, English, and social studies.

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

(1) Modalities of VRT (*previously known as Manual Arts Therapy*) provide patient treatment through actual and simulated work situations which are selected from broad fields in industry for their potential to stimulate patient interest and motivation, and provide training and experience. Clinical areas include:

- (a) Graphic arts,
- (b) Horticulture,
- (c) Metal-working,
- (d) Light mechanics,
- (e) Woodworking,
- (f) Painting,
- (g) Electricity,
- (h) Plastics, and

(i) Any number of other activities based upon the patient's vocational and avocational interests and resources available.

(2) The avocational objectives of treatment are stressed to assist the veteran in developing skills and techniques which can be continued after discharge. These skills provide the veteran with meaningful and satisfying use of leisure time through such activities as amateur radio, ceramics, leather, lapidary, etc.

(3) All articles fabricated in rehabilitation activities as byproducts of patient treatment will become the property of the patient, if so desired, unless specifically fabricated for government use, or as a Veterans Industries/Compensated Work Therapy (VI/CWT) contract item. Fabrication and repair of articles for government use may be completed in rehabilitation clinics when appropriate for the patients' treatment program. It will be the responsibility of the Service Chief accountable for the VRT Program to control and schedule flow of such work. Any commitments made concerning completion deadlines for assigned projects must be made with the patients' overall rehabilitation goals in mind.

(4) Many of the clinical areas of treatment currently in use throughout VA health care facilities include, but are not limited to:

(a) **Metal Clinic**. This includes sheet-metal work, welding, machine operations, drafting and blueprint reading, and jig and fixture production use.

(b) **Light Mechanics Clinics**. Included within this general field are small engine repair, automotive tune-up, bicycle repair, and wheelchair repair.

(c) **Woodworking Clinic**. This modality includes drafting and project plan reading, machine operations, carpentry, cabinetmaking, carving, furniture repair, production and use of jigs and fixtures, and various finishing techniques.

(d) **Crafts Clinic**. Patients may work in leather, jewelry, lapidary, art, and ceramics.

(e) Paint Clinic. In this area of treatment, patients can learn brush painting, spray painting, sandblasting, picture framing, glass-cutting and glazing ,and sign painting.

(f) Electricity Clinic. The main activities include radio and television repair, radio communications (amateur radio-CB), kit building, small appliance repair, basic electricity, and basic electronics.

(g) Plastics Clinic. In this relatively new area of treatment, patients can learn how various plastics are formed by hands-on experience in vacuum forming, strip heating, injection molds, extrusion forming and buffing, polishing and finishing techniques.

(h) Photography Clinic. In conjunction with the Graphic Arts Clinic, or as a separate modality, photography provides both fieldwork and darkroom experience.

1. Fieldwork consists of camera settings, film speeds, and photo composition.

2. Darkroom work consists primarily of developing film and print making.

(i) Horticulture Therapy. This modality includes such tasks as mixing soils, digging, propagating, pruning, arranging, and planting.

d. Work Hardening or Work Adjustment Program. Work Hardening or Work Adjustment Programs may be interdisciplinary in nature, and are seen as graded, transitional experiences through which the individual gains insight into the nature of the expectations of the worker role, as attitudes, productivity behaviors, etc. Through these the individual develops physical and emotional stamina necessary for successful integration into the workforce.

e. Therapeutic Printing Plant (TPP)

(1) TPP applies to those printing facilities in VA locations which are used primarily for treatment purposes, and is established on the authority of the Under Secretary for Health and the Joint Commission on Printing and under the direction of MH&BSS, to carry out specific treatment objectives and to acquaint patients with the graphic arts industry. The TPP will conform to the guidelines described in current directives which deal with printing insofar as methods of reproduction and types of equipment are concerned.

(2) Adherence to strict work schedules and deadlines, commonly found in the printing environment, may not be advisable in TPPs because treatment activities should be organized and progress according to a therapeutic schedule. TPPs should not become overburdened with medical center projects. If, in the therapist's professional judgment, a specific patient or patients are capable of functioning under such realistic pressures, the therapist may use these as a segment of the treatment program.

(3) Established deadlines should be a consideration in the treatment process. VHA may align TPPs under VI/CWT and may use the plants as a source of work for patients in the programs. The VI/CWT Programs operating printing plants can enter into agreements with VA facilities locally, or with any other VA facility, to provide printing services.

(4) Work experiences to which veterans will be exposed in the TPP will include:

(a) Letterpress operations which consists of handset typesetting, lockup, press make-ready, press operation, over printing, and distribution of type.

(b) Offset lithography which consists of makeup and layout, making camera ready copy, coldtype composition, darkroom operations, film developing, masking, platemaking, press makeready, and press operation.

(c) Silk screening which includes making hand-cut stencils, photographically made stencils, screen fabrication, adhering stencils to screen, application of ink onto a variety of surfaces, and the appropriate use of the silk screen process.

(d) Collating and binding operations which consist of folding, stapling, trimming, and packaging for delivery.

(e) Other operations may include shearing, punching, plastic spine binding and the recycling of paper into scratch pads.

f. **Job Placement**

(1) Job Placement is a program or service organized to assist veterans to identify, obtain, and/or maintain employment commensurate with their vocational, social, psychological and medical needs, and their abilities. Provided on an organized, planned basis, these services should include, but not be limited to, preparation of the veteran for employment, job development and placement, follow-up, and post-employment services.

(2) As second aspect of Job Placement involves services which are made available to employers to facilitate the successful employment of persons with disabilities.

(3) A written placement plan should be developed for each veteran served in Job Placement. This plan should:

(a) Integrate the results and/or recommendations from other services;

(b) Contain the job objective(s) and the roles and responsibilities of the individual providing placement and the veteran served; and

(c) Specify the length of time in which follow-up contact will be maintained, primarily based on the veteran's needs and motivation.

(4) Employment preparation services should include:

(a) Analyzing pertinent findings from medical, psychological, or prior vocational services and/or work experience.

(b) Counseling regarding the techniques for obtaining and maintaining employment.

(c) Assisting veterans in becoming knowledgeable regarding the impact of employment on disability and other benefits as well as providing information on the means to access such benefits.

(d) Eliciting job preference, salary expectations and needs, insurance needs, transportation needs, and hours and days available to work.

(e) Assisting veterans in becoming knowledgeable about job duties, personnel benefits, rates of pay, employment policies and practices, and the job location prior to job acceptance.

(5) Job development and placement services should include:

(a) Contacting employers and appropriate Federal, State and local employment agencies to develop and/or identify job opportunities for persons with disabilities.

(b) Providing on-site job analysis, consultation, and recommendations for work-site and job modification, when appropriate.

(c) Assisting employers to identify, modify, and/or eliminate architectural, procedural, instructional and/or communication, and/or attitudinal barriers to the employment and advancement of persons with disabilities.

(d) Educating employers about:

1. Various disabilities and resulting vocational implications;

2. Assistive devices;

3. Job accommodations;

4. Services provided by the Job Placement Program;

5. Incentives to the employer; and

6. Current disability-related legislation affecting the employer.

(e) Maintaining communication and coordination with other community agencies and resources.

(f) Maintaining an organized system of recording job openings.

(6) Job Placement should adopt a local policy with regard to the placement of veterans served in businesses with active labor relations disputes.

(7) Follow-up and post-employment services should include:

(a) Initial contact within 1 week with the employed veteran and with the employer, where this is appropriate in consideration of the prior relationship.

(b) The availability of appropriate personnel for the veteran and/or employer during and, if feasible, after regular working hours to provide support services, if requested.

(c) The maintenance and documentation of contact for a reasonable period of time (at least 60 days) to assure adequate job adjustment and retention.

(d) The availability of services, including prevocational placement, for persons who are unsuccessful in maintaining employment.

(8) Veterans referred for job placement services who have not been placed should have their plans reviewed at least every 30 days. Consultation should occur with the veteran, other appropriate professional staff, and/or the referral source to determine if the placement plan should be amended.

(9) Records of veterans who have been placed in outside employment should contain the following information:

- (a) Place of employment,
- (b) Job title,
- (c) Rate of pay and fringe benefits,
- (d) Date on which employment commenced,
- (e) Employment status 60 days following commencement, and
- (f) Name of the immediate supervisor at the work site.

#### 4.04 VETERANS INDUSTRIES AND CWT (RCN\* 10-0656)

\* *Reports Control Number, formerly Reports Control System.*

The terms Veterans Industries (VI) and CWT are interchangeable, with "Veterans Industries" used programmatically and "Compensated Work Therapy" used in therapeutic references.

a. **Objectives.** VI objectives are to:

(1) Reinforce through the use of well-established motivational principles (rewards), modifications to, or development of attitudes, habits, skills and behaviors necessary to attain or maintain a maximum level of social, psychological and physical adjustment.

(2) Create a realistic noninstitutional working environment conducive to the development of work tolerance and effective learning of appropriate work habits and skills in preparation for successful reentry into the community.

*NOTE: All veterans participating in the VA clinically authorized CWT treatment modality are patients and are not to be considered "employees" for any purpose. As such, they are not entitled to Office of Worker's Compensation Program (OWCP) coverage. As part of the program, VA will provide medical treatment, care and transportation for medical treatment as a result of injuries suffered while performing duties under a CWT contract. Any further recourse for such injuries, including loss of income (if any) and permanent injuries, must be handled either through the Federal Tort Claims Act process or compensation which may be payable under Title 38 United States Code (U.S.C.) Section 1151.*

b. **Purpose**

(1) The purpose of a CWT Program is to provide a rehabilitation program for inpatients and outpatients. The major component is a work regimen with monetary incentives derived from contracts with private industry, state or local government, or arrangements with Federal entities (including VA or other sources outside VA).

(a) Reimbursements to participants in the program are related to their production.

(b) Every effort is to be made to create a realistic work environment).

(2) It is essential that earnings be commensurate with wages paid in the community for essentially the same quality and quantity of work and that payment to the patient be prompt and at regular intervals. Although industrial business practices are utilized to simulate usual working conditions, therapy is the objective. Veterans who have been identified as having potential for

employment should be given special consideration in the development of a work program which will specifically focus on a vocational rehabilitation treatment plan.

c. **Relationship with Community Rehabilitation Settings.** VA CWT programs may be in direct competition with community rehabilitation settings for essentially the same kinds of work contract. To ensure that this competition is healthy, not destructive, it is necessary that open, active lines of communication be maintained with community resources. Often contracts can be shared or referred to a more appropriate community setting, resulting in good will and positive community relations. Program personnel are encouraged to participate in local community rehabilitation organizations.

d. **Criteria for Establishing Veterans Industries Programs.** Criteria for establishing VI Programs include:

(1) A sufficient number of medical center and/or domiciliary patients, inpatients, and outpatients who would benefit therapeutically and could support the necessary commitments for contracts in the community.

(2) Availability of patients on an inpatient and/or outpatient basis for a sufficient period of time to make a VI Program feasible. In most instances, at least 30 days involvement by individual patients would be considered a minimum.

(3) Sufficient contract potential in the community to support VI.

(4) Availability of adequate VI work and storage space.

(5) Adequate resources to institute a program.

e. **General Policies and Requirements.** Only one VI Program is authorized at each health care facility. The program may consist of more than one activity, such as:

(1) **Basic In-house Workshop**

(a) VI has most often taken the form of the traditional sheltered workshop. Staff members actively solicit subcontract work from industry and bring it into the medical center setting for completion. The participants are paid on a piece rate basis for work performed. Work contracted most often is assembly, collating and/or bulk mailing, fabrication, and/or packaging. ***NOTE: There are settings involved with contracts requiring the use of sophisticated equipment. Contracts utilizing such equipment have the advantage of also providing the veteran with skills which are directly transferable to the industry setting.***

(b) This form of programming has undergone radical changes within the past several years. The changing veteran population has necessitated a multi-level program which addresses the needs of the:

1. Aging veterans,
2. Younger employment-bound veteran,
3. Homeless,
4. Chronically mentally ill, and
5. Substance abusers.

(2) Supported Employment

(a) Programs are encouraged to develop work-sites in community industry and/or government settings. Supported employment sites afford patients the opportunity to demonstrate clinical gains made during the course of therapy. Direct supervision is provided by employees of the industry. VA clinicians will visit the job sites, and provide site supervision on an "as needed" basis.

(b) Veterans participating in such placements are not considered as employees of the participating industry; rather, they are participating in a VA clinically authorized therapeutic modality. As such, injuries incurred on the job site (with the exception of when the company is negligent, or fails to provide safe working conditions) are not covered by Workmen's Compensation, but are considered to be the same as if the veteran were injured during the course of treatment at the VA. Companies could be held liable when patient injuries are the result of negligence or failure to provide safe working conditions.

(3) Token Reinforcement. Token reinforcement is designed primarily for those veterans for whom the attainment of industry standard for production purposes is considered unachievable. An example of this would be breaking work down into amounts which the veteran can realistically expect to complete within a relatively short period; work lots which normally need be turned in quantities of 1,000 might be broken into lots of 100. Instead of paying every 2 weeks, a payment of canteen books may be paid on completion of the new lot size. *NOTE: The possible variants in this modality are limited only by the imagination of the clinician.*

(4) Residential Care. Other community VI Programs include providing projects in community placement homes under the Social Work Service Residential Care Program, as appropriate.

f. Patient Earnings

(1) Earnings by participants in VI are not considered income in relationship to the nonservice-connected VA pension.

(2) Earnings from VI are considered taxable. Earning that exceed \$600 annually will be reported to the patient and to the Internal Revenue Service via form 1099 miscellaneous, not later than January 31 of each year. VI/CWT Program Managers will advise patients of these provisions upon entry into the program.

(3) Fair Labor Standards Act, Title 29 Code of Federal Regulations (CFR) Chapter V, Part 525, wage guidelines should be followed in paying participants.

(4) In order to pay participants, a system of work measurement should be maintained that:

(a) Applies managerial techniques such as, time studies, work sampling, etc., to specific work situations;

(b) Determines the level of performance required for qualified, competent workers to accomplish a work task; and

(c) Understands the work environment.

(5) Reimbursement for work is to be monetary and not payment in kind.

- (6) When possible, a piece-rate system of reimbursement should be used.
- (7) Hourly wages and work performance should be reviewed periodically in relation to the community wage rates and productivity of the patient. Based on reviews, wages should be adjusted accordingly.
- (8) The pay period should be, if possible, every 2 weeks.
- (9) Payment to patients should be based on individual performance, not group.
- (10) Wages should be based on work performed during the pay period and should not be delayed based on payment to the VI/CWT Program.
- (11) It is preferable for patients to receive a written statement for the pay period including; pay, hours worked, deductions, and net pay. This especially important for patients in Therapeutic Residence (TR) Programs.

g. **Program Management and Organization**

- (1) A VI/CWT Program Manager will be designated by the Chief of Staff on the recommendation of the service chief responsible for the program. The Program Manager will be the best qualified individual available in terms of experience, education and/or interest regardless of service affiliation. This person would have a working knowledge and the ability to participate as part of a multidisciplinary team.
- (2) The nature of VI/CWT requires support and involvement from other hospital services. Successful work experiences dictate that patients have adequate uninterrupted work time. This may require that time schedules for medications, physicians' rounds, group therapy, etc., be modified and/or scheduled around work time in order to support patients' rehabilitation goals. Necessary support and interaction from various services include, but is not limited to:
  - (a) Close relationship with the responsible treatment team in regard to patient status and functioning, and supervision for those patients with psychological or sociopathic problems that are not stabilized.
  - (b) Coordination of the treatment plan with the medical center Case Manager for those veterans to have a vocational rehabilitation treatment plan and with staff of the Vocational Rehabilitation and Counseling Division in the Veterans Benefits Administration (VBA).
  - (c) Transportation for patients, materials, finished products, and vehicles for other VI activities.
  - (d) Periodic review of financial activity to be conducted by the VA health care facility, Fiscal Service, with report made to the facility Director and the Program Manager. These review procedures will be developed locally in accordance with the nature of the VI Program.
  - (e) Guidance in matters under the jurisdiction of Acquisition and Material Management Service (A&MMS) pertaining to contracts and inventory systems for VI contract materials.
- (3) A Coordinating committee should be established at each medical center and may include the VI/CWT Program Manager, VBA Case Manager, Chiefs of A&MMS, Fiscal Service, and Engineering Service. **NOTE:** *Representatives of community organizations may be desirable.*

(a) This committee serves to coordinate efforts, identify need for resources, solve problems, and improve communication, helping to establish effective and meaningful community relationships.

1. Meeting frequency should be determined locally.
2. The committee functions will be dependent on community needs and the needs of the medical facility.

(b) Examples of appropriate community members are:

1. Patient representatives and domiciliary patients,
2. Local business organizations, and
3. Veterans organizations.

h. **Financial Management Procedures**

(1) The VA "Special Therapeutic and Rehabilitation Activities Fund," (STRAF) 36X4048 was established in the Treasury of the United State for the purpose of carrying out this specific program. This fund is to be used for receipt of all VI/CWT gross earnings from contractual arrangements. It is designed to cover operational expenses of VI/CWT such as:

- (a) Overhead costs,
- (b) Patient earnings,
- (c) Equipment,
- (d) Supplies,
- (e) Materials,
- (f) Manpower services,
- (g) Contract procurement,
- (h) Advertising,
- (i) Travel,
- (j) Lease of space and/or equipment,
- (k) Renovations and repairs, and
- (l) Other business and program expenses.

(2) All VI/CWT programs (including those medical centers who contract with nonprofit corporations) must report their financial transactions to the STRAF. There are no exceptions.

(3) Use of STRAF funds for staff education and travel is strictly controlled. Requests must be approved by the Director, MH&BSS, VHA Headquarters. Requests for educational and/or travel use of STRAF will be made by memorandum, at least 2 weeks in advance, to the Deputy

Associate Director for Rehabilitation Services (302/111C), VA Medical Center, Hampton, VA 23667, and are to include the following:

- (a) Description of educational endeavor to include travel itinerary and itemized cost,
  - (b) Justification of need,
  - (c) Present balance in STRAF account, and
  - (d) Any significant upcoming expense for which STRAF account will be used.
- (4) One percent of gross contracts will be transferred to VHA Headquarters annually to cover the establishment of new programs, travel, etc.
- (5) The Chief, Fiscal Service, or designee, will review the accounts of any nonprofit corporation under contract to VA. The review will be made within 6 months after the original contract is executed and at least annually thereafter. The review will determine if the nonprofit corporation is maintaining appropriate accounting records. If it is not, the nonprofit corporation will be directed, in writing, to do so by the health care facility director.

i. **Contracting With VA Based Nonprofit Corporations**

(1) Only VA-based nonprofit corporations which were associated with VA VI/CWT programs on the date Public Law (Pub. L.) 95-581 became effective October 21, 1976, will be considered by VA for contractual agreements. *NOTE: This does not include non-VA based nonprofit corporations.*

(2) Terms and conditions of an agreement to be entered between VA and each nonprofit entity will be set out in a contract which must be reviewed and approved by VHA officials with programmatic responsibility for the VI/CWT Program and by the General Counsel. These nonprofit corporations do not include community nonprofit corporations; i.e., Veterans of Foreign Wars, Sheltered Workshops, American Legion, etc. All such contracts must provide that:

(a) Bidding practices must be based upon practices and guidelines recommended by the Commission on Accreditation of Rehabilitation Facilities.

(b) All VA patients will be paid at rates not less than the wage rates specified in the Fair Labor Standards Act, 29 CFR Part 525, relating to employment of handicapped persons.

(c) A statement of the services to be performed by the nonprofit entity is included.

(d) Terms and conditions are to be stated under which the nonprofit entity can retain funds for overhead and operating expenses, including designation of what items constitute such expenses, and a limitation on accumulation of such funds earned from projects where VA patients are involved.

(e) Provision for assessing liability is included in connection with loss of, or damage to goods and materials which comprise or are used in connection with VI/CWT projects, and for assessing liability for damage.

(3) The VA may secure any service from a nonprofit corporation that VA would provide in a VI/CWT Program operated exclusively as a VA program. This would include, but is not limited to:

- (a) Procurement services,
- (b) Production supervision,
- (c) Bookkeeping and accounting services,
- (d) Use of space and equipment, and
- (e) Transportation of goods, materials, and patients performing services away from the VA facility.

(4) No funds may be accrued by the nonprofit corporation through VA patients working as part of the VI/CWT Program in a nonprofit corporation.

(5) No VA employee may serve in any capacity for any nonprofit entity with which VA contracts in connection with the VI/CWT Program. VA employees may not serve as officers or members of boards of directors of nonprofit entities with which the VA has contracts.

(6) VA employees may function only as therapists in regard to patients participating in VI/CWT projects. **NOTE:** *The contract will describe how VA personnel are to be involved.*

(7) In each contract, nonprofit corporations may retain certain funds for expenditures which are subject to prior VA approval and accounted for at the end of the contract, or at the end of the fiscal year if the contract has been in force for all of the fiscal year. These are:

- (a) Staff;
- (b) Equipment, to include:
  - 1. Rental of equipment for the specific contract, including vehicles for transportation, and
  - 2. Expenditures for purchase of equipment authorized by VA, which becomes property of VA.
- (c) Mileage and other expenses incurred for each contract;
- (d) Materials necessary for completion of the contract;
- (e) Insurance expenses directly attributable to VA contract;
- (f) Overhead expenses directly attributable to each contract, such as:
  - 1. Rent,
  - 2. Utilities,
  - 3. Telephones, and
  - 4. Supplies; i.e., general supplies bases on percentage, subject to each contract.

**j. Contract and Agreements for Work to be Performed by VI (excluding VA based nonprofit corporations)**

(1) Contracts and agreements will be negotiated between VI and community businesses or any other appropriate source including VA and other Federal entities to secure appropriate work to be performed by patients in the VI Programs. This is justified as a means to provide treatment necessary to carry out the VA mission. There are generally two types of arrangements for securing VI/CWT work:

(a) Contract agreement with the business and/or buyer of the VI/CWT services and/or commodities. This is the basic agreement under which VI/CWT furnishes services to third parties. It is not subject to the Federal Acquisition Regulations (FAR) and/or Department of Veterans Affairs Acquisition Regulations (VAAR.). The agreement provides rates at which the contractor will reimburse VI/CWT services, and addresses other matters such as which party will be responsible for providing equipment, supplies and space. This agreement should be executed by the VI/CWT Program Manager. *NOTE: It is beneficial and appropriate that the VA contracting office review the agreement for technical sufficiency, particularly its terms regarding use of government property and other services which might require "incidental contracting."* The VA Contracting Officer will participate in pricing negotiations if requested to do so by the CWT official.

(b) Memorandum of Understandings between VI/CWT and VA or other Federal Agencies. This is identical to the basic agreement under which CWT furnishes services to third parties. It is not subject to the FAR and VAAR, and as such, it has been determined that this agreement should be executed by the facility Director, or designee, and the VI/CWT Program Manager. This agreement provides rates at which the VA or other Federal Agency will reimburse VI/CWT for services and/or commodities, and addresses other matters such as which party will be responsible for providing equipment, supplies, and/or space.

(2) The VI/CWT Program Manager, or designee, is responsible for negotiating contracts and agreements through bids following directions contained in subparagraph k. (A sample contract and an agreement which may be used for guidance are in Apps. 4A and 4B.)

(3) Contract Format. The contract must include:

(a) Full specifications for the job to include, but not limited to, materials furnished, quality control limitations, packaging, and storage and delivery arrangements;

(b) Time scheduling, deadlines, delivery dates, etc.;

(c) Manner of payment;

(d) Termination provisions;

(e) Responsibility for risk or loss;

(f) Furnishing of tools and equipment and their maintenance and repair; and

(g) Provisions that the organization with which the contract is made will be responsible for payment of any applicable taxes without involving VA.

k. Guidelines for Bidding on Contracts for VI (excluding nonprofit corporations)

(1) The philosophy of bidding on contracts with industry for the purpose of providing work for a VI/CWT Program must be a competitive process in compliance with provisions of this paragraph.

(2) The basic decision to bid or not to bid takes into consideration the therapeutic benefits to be derived from the work being considered. The bidding process should be considered purely from a business point of view. From this point, business acumen rather than clinical expertise becomes the prime factor. The process of developing a competitive bid will consider the following elements as guidelines:

(a) Secure enough samples of the work to be bid in order to conduct a time study. Obtain a complete description of the work process and establish the best method to complete the task.

(b) Conduct a time study, using the methods and equipment that will be used in the actual production. At least three nonhandicapped people should be used in the study. The purpose of the study is to determine a “standard time.” **Do not use patients in the study, unless you can ensure that their handicap in no way affects their performance on that particular work.**

(c) Determine the local prevailing wage rate for the type of work being considered. *NOTE: Local labor unions, businesses and employment agencies are common sources of accurate information.*

(d) Compute the rate of pay for each unit of work. Example:

|                    |   |                      |
|--------------------|---|----------------------|
| Standard Time      | = | 2.4 units per minute |
| Prevailing wage    | = | \$3 per hour         |
| Cost of labor/unit | = | 2 1/2 cents each     |

(e) After establishing the unit price for direct labor, it is necessary to consider the cost of overhead. Only those costs that accrue from the process of doing business need to be computed. When appropriate, the following expenses may be paid out of the STRAF account

1. Indirect labor, this includes:
  - a. Supervision and administration,
  - b. Contract procurement,
  - c. Clerical and bookkeeping, and
  - d. Labor, material handling, and driver-packing.
2. Materials used up in the normal process of doing business, that cannot directly be charged to a specific contract (i.e., stationery, glue, nails, etc.);
3. Telephone;
4. Transportation, including repairs, fuel, insurance;
5. Insurance, including building, contractors' goods and materials;
6. Dues and fees;
7. Accounting and bookkeeping;
8. Equipment, i.e., used to perform a given contract;
9. Space, but only that portion that is required for the production of work;

10. Utilities, i.e., gas, electric, etc.;

11. Materials that are used directly in the completion of the contract;

12. Quality Assurance **NOTE:** *Careful consideration as to the degree of quality assurance is necessary. The higher the expected quality, the more supervision is required, the higher the cost. Military Standards (MLSTD) 105d and 105e will provide guidance in this area. A 10 percent lot check should be considered minimal; and*

13. Overhead Costs **NOTE:** *The overhead burden should normally not be less than 50 percent of the cost of direct labor; for example, direct labor \$2, overhead \$1, and contract price \$3. In certain instances, the overhead burden will be minimal, making the contract a "loss leader" to open up further contracts with a company.*

1. **Other Contracting Arrangements Related to VI/CWT Program.** There are two other types of contracting arrangements which often arise in the CWT Program:

(a) **Contracts with individuals or firms to locate and arrange for the contracts for the VI/CWT work.** It is legally permissible and has become important to the efficacy of the VI/CWT Program to contract with individuals and firms who find necessary work for the VI/CWT Program. This "finders fee," usually identified as a percentage value of the CWT contract, is a component of the cost of rendering the VI/CWT services and is, therefore, directly costed to the contract. Consequently, the cost of such finders fee is passed on to the buyer of VI/CWT services. If the contract to sell the VI/CWT services cannot be executed, no finders fee is assessed. The "finders fee" contracts are subject to FAR/VAAR, and therefore, must be executed by the Contracting Officer.

1. **Requirements Contracts.** It is expected that all reasonable offers from responsible individuals and/or firms will result in executed contracts. Much like nursing home contracts, no commitment for use is made as these contracts are Requirements contracts as specified in FAR 16.503, and do not include guarantees. Obligation to pay for services is contingent upon the VA medical center's acceptance and ultimate agreement with the firm to which the VI/CWT will provide the service.

2. **Service Contract Act.** These contracts are subject to the Service Contract Act. Contracting Officers should check with the VI/CWT officials to determine the expected job categories.

3. **"Full and Open" Competition.** These requirements are subject to "full and open" competition as provided by the Competition in Contracting Act (FAR Part 6). If it is necessary to enter into a contract immediately in order to avail VI/CWT of an important business opportunity, the Contracting Officer should consider the exceptions to full and open competition provided in FAR 6.302.

4. **Fees.** Fees are generally negotiated as a percentage of the contract value of the VI/CWT work that is brought in by the broker. It is the responsibility of each Contracting Officer to negotiate a reasonable percentage fee. A fee of approximately 15 to 20 percent is considered to be the average rate.

(b) **Contracts for supplies and services necessary for the performance of the VI/CWT Program.** Many of the VI/CWT contracts require the VI/CWT Program to provide supplies, services, lease/purchase equipment and/or leased space incident to the contract performance. These acquisitions of incidental supplies, equipment, space, and services are subject to the FAR/VAAR and will be executed by the VA Contracting Officer. Delegation of leasing

authority by the General Services Administration (GSA) is not required. It is emphasized that the circumstances requiring the contract action in the VI/CWT Program often precludes the time-frames otherwise required by "full and open competition." Although it is expected that competition will be maximized to the extent practical pursuant to FAR 6.101, contracting officers, when appropriate, should use the exception cited in FAR 6.302-2.

m. **Patient Evaluation and Follow-up**

(1) Participants are evaluated and progress report prepared by the appropriate professional staff element at regular intervals, but not less often than every 3 months.

(2) Continuance in the program must be for therapeutic purposes and no individual is to be retained in the program to meet production needs.

(3) The participant is to be discontinued from the VI/CWT Program when any of the following occurs:

(a) Treatment team determines that the participant no longer needs, or will receive no additional benefit from VI/CWT activities.

(b) The participant produces close to industry standard rate for time and quality for a period of 4 consecutive months, with the exception of specialized rehabilitation programs where this would be therapeutically contraindicated.

(c) Participant's production ranges from 50 percent close to the standard time rate for a period of 1 year.

(d) In the case of participants with production consistently below 50 percent of the standard time rate, determination may be made by the appropriate professional element that the participant has achieved a maximum level of functioning in the program, but is potentially employable in the open labor market at other types of employment or is capable of adequate adjustment in a noncontrolled environment.

*NOTE: The preceding criteria may not apply if the appropriate professional staff member determines that continuation in the program is essential to prevent physical and/or social/psychological regression or institutionalization. Such determination should be documented in the clinical record.*

n. **Program Reports and Records**

(1) The basic records that are required are as follows:

(a) Patient treatment records as required by current directives.

(b) Time studies conducted to establish industrial standards should contain the following information:

1. Date of study,
2. Item studies as size of sample,
3. Who conducted the time study,
4. Who participated in the study,

5. Method used in accomplishing work,
  6. Time used by each participant to complete a unit of work, and
  7. Tolerances used and formula used to compute standard time.
- (c) Prevailing Wage Rates Record which contains:
1. Date of original determination;
  2. Sources of information (e.g., Department of Labor, labor unions, employment agencies);  
and
  3. Dates and reasons for changes and periodic reviews.
- (d) Timecard and Payroll Information Record which contains:
1. Name and identification of patient,
  2. Date of pay period,
  3. Dates and hours worked,
  4. Contracts worked on during period,
  5. Piece rate of each task, and
  6. Earnings by day and total for period.
- (e) Shipping, receiving, and inventory documents as required.

(2) An objective evaluation of the therapeutic effectiveness of the program will be devised and data collected and recorded. Written report of analysis of data will be required at regularly scheduled intervals.

(3) Annual Report (RCS 10-0656). The Compensated Work Therapy Report (RCN 10-0656) is a recurring annual report to be submitted to VHA Headquarters by the first working day of November for the preceding fiscal year. This is a combined report (containing information from CWT, IT, and TPP Programs) and should collect data as outlined in M-2, Part X, Chapter 4, subparagraph 4.06.

#### **4.05 VETERANS INDUSTRIES, CWT, AND TRANSITIONAL RESIDENCES (VI/CWT/TR) PROGRAM**

a. **Authorization**. Only VI/CWT/TR Programs authorized by Pub. L. 102- 54 may be established wherein veteran patients pay rent, utilities, and food as part of their therapeutic regimen.

b. **Clinical Overview**

(1) The VI/CWT/TR Program is an extension of the VI/CWT Program, which incorporates supervised living in community-based TRs with therapeutic work. The TRs are designed to

foster the development of environments where substance abuse and/or the homeless chronically mentally ill (HCMI) veterans can develop and practice independent living skills.

(a) When combined with VI/CWT, these veterans are involved in a therapeutic milieu designed to provide:

1. Clinical and residential support,
2. Skills training,
3. Job readiness,
4. Money management,
5. Independent living skills,
6. Vocational counseling, and
7. Job placement.

(b) This affords the opportunity to develop sufficient skills, income and work experience to achieve optimal levels of independence and productivity.

(2) Referrals to the TR Program may be made from any appropriate source, including, but not limited to:

- (a) Substance abuse treatment units,
- (b) Alcohol rehabilitation units,
- (c) HCMI Programs, and
- (d) Domiciliary Programs, etc.

(3) It is recommended that a screening committee be formed to consider admissions to the TR Program. This committee may consist of the TR Program Coordinator and/or staff member, a vocational rehabilitation representative from the VI/CWT Program, a clinical nurse specialist, psychologist, or other appropriate staff.

(4) Admission criteria should be established to include, but not be limited to:

- (a) History of substance abuse and/or chronic mental illness,
- (b) Ability to work full-time in VI/CWT,
- (c) Ability to handle activities of daily living, including self-medication,
- (d) Willingness to sign agreements regarding areas of responsibility in the TR Program, and
- (e) Willingness to participate in random drug testing.

(5) Each veteran in the TR Program will have an individualized treatment plan which includes a comprehensive Vocational Rehabilitation Plan. A TR case manager should be

assigned to work with the veteran and the treatment team in implementing the therapeutic regimen.

(6) In addition to the VI/CWT component, the vocational rehabilitation plan will include job seeking skills, job placement, and any other vocational need, as indicated.

(7) Individual and group counseling will be provided, as indicated. Typical group therapy provided may include:

- (a) Relapse prevention,
- (b) Support systems,
- (c) Family issues,
- (d) Anger and/or stress management, and
- (e) Problem solving, etc.

(8) Independent living training modules or counseling may include such topics as:

- (a) Financial and money management,
- (b) Food purchasing and preparation,
- (c) Acquiring and maintaining living quarters,
- (d) Community living, and
- (e) Community resources, etc.

(9) The VI/CWT/TR Program is committed to continued outpatient support and treatment for the veteran's substance abuse and/or mental illness problems. VA aftercare support, along with community resources are an integral part of each veteran's individual treatment program. VA outpatient care will be provided for any other condition based upon the veteran's eligibility.

(10) Targeted lengths of stay in the TR Program may range from 1 month to 1 1/2 years.

**c. Program Operations**

(1) Each residence will have a house manager who may be a patient, VA staff member, student, volunteer, or other, provided the individual possesses a stable, responsible, caring demeanor (as perceived by staff). House managers may be provided free room and board (does not have to include board), in addition to, or instead of payment for services. House manager responsibilities include:

- (a) Observing and reporting general behavior and mood of residents;
- (b) Reporting problems related to residents, property, and structure of the residence;
- (c) Supervising day-to-day cleaning and maintenance of residence; and

(d) Working with staff to promote an atmosphere in which residents take responsibility for themselves and deal openly with issues related to their living situation and/or rehabilitation.

(2) All residents (except house managers) must:

(a) Participate in therapy as prescribed in their individual treatment plans;

(b) Pay rent, utilities and food costs (primarily from their VI/CWT earnings) during their period of residency; and

(c) Be actively participating in CWT, as described in subparagraph (3).

(3) Patient participation in VI/CWT Programs will be full time, or patients will at least work enough VI/CWT hours in conjunction with going to school or involvement in competitive employment to pay for expenses. During the final phase of living in the TR, patients may transition to competitive employment and pay expenses from their salaries. During this period, patients should be looking for permanent homes.

d. **Operation of Residences.** TRs will either be operated directly by the VA, or through contract with a nonprofit corporation.

(1) Residences operated through contract with a nonprofit corporation will work in conjunction with an existing CWT Program at a medical center.

(2) A contract with a nonprofit corporation may provide for VA services to the corporation including:

(a) Technical and clinical advice,

(b) Supervision of CWT participant activities in the renovation of any therapeutic transitional housing property under contract, including work for possible later sale as a private residence; and

(c) Minor maintenance and/or repair of such property.

e. **Sources of Residences.** TRs may be purchased, leased, or otherwise acquired as follows:

(1) Property acquired as a result of default on a loan made, guaranteed, or insured under 38 U.S.C. Chapter 37;

(2) Property purchased from the Department of Housing and Urban Development (HUD);

(3) Property purchased by a nonprofit corporation through funds by grants and donations; and

(4) Any other property which may be leased, purchased, or otherwise acquired by the Secretary of Veterans Affairs.

f. **Code Requirements for Residences.** Therapeutic Residences must comply with:

(1) All zoning, building and other similar requirements applicable to the real property used for similar purposes in the community. VA representatives should consult with appropriate representatives of the community to ensure full knowledge of community requirements.

(2) All state and community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located. ***NOTE: Fire and Safety requirements applicable to buildings of the Federal government shall not apply***

*to these houses. Rather, these structures must comply with the Life Safety Code for board and care occupancies, i.e., sprinklers for three or more occupants, smoke detectors, self-closing or automatic-closing sleeping room doors, etc., stairwells do not have to be enclosed.*

g. **Housing Selection Procedures.** Selection of residences requires the Coordinator, or designee, to:

- (1) Review VHA Headquarters VI/CWT/TR Preliminary Site Evaluation List for residence selection criteria, see Appendix 4C;
- (2) Review VHA Headquarters site Evaluation Weighted Chart (constraints off and on site, general appearance, and cost factors), see Appendix 4C;
- (3) Meet with local zoning and planning commissions, city officials (mayor, city manager, housing commissions) for legal purposes;
- (4) Meet with community groups and neighborhood groups for public relations purposes;
- (5) Coordinate with contracting officer to obtain lists of VA and HUD foreclosures;
- (6) Coordinate contacts with real estate brokers;
- (7) Narrow selection of homes to a reasonable number for final evaluation (i.e., two to three for each house to be purchased);
- (8) Take the review team consisting of TR Coordinator, Engineer, Safety Officer, Contracting Officer, and others as appropriate, to the residences for the formal site evaluation;
- (9) Ensure that each team member will rate each residence on the Weighted Site Evaluation Chart;
- (10) Total all the evaluations and rank residences in descending order;
- (11) Coordinate with the contracting officer to obtain a lawyer to complete title searches for the top two or three residences;
- (12) Arrange for contracting to accomplish appraisals, radon testing, pest inspections, and boundary surveys for the top two or three residences;
- (13) Submit the rank order to the Director, Land Management Service (184C), VHA Headquarters, who will review the findings and submit the list to the Under Secretary for Health (10), for presentation to the selecting official;
- (14) The selecting official will determine which residences will be purchased;
- (15) The Property Officer will then submit the selected residences to the Department of Justice for approval. When approved, the TR Coordinator and Contracting Officer will be notified of the closing date;
- (16) The Contracting Officer will send all materials to the District Counsel for approval;
- (17) The coordinator will take the engineer through the residence 1 or 2 days before closing and complete the Certificate of Inspection; and

(18) The Contracting Officer, TR Coordinator, and District Counsel (if possible, but not necessary) will be in attendance at the closing.

h. **Housing Renovations.** Housing renovations will normally be required to meet fire and safety requirements which apply to residentially-based programs, Federal Handicapped Accessibility Standards as addressed by VHA Headquarters program officials in MH&BSS, or other modifications as needed.

(1) Engineering Service will normally advise on renovation planning, including completing drafts of drawing for renovations.

(2) The Contracting Officer will then contract for architectural drawing and accomplishment of renovation work.

i. **Residential Furnishings.** Furnishings will be ordered and the Contracting Officer may assist in the storage of furnishings (e.g., contract for temporary trailers, etc.).

j. **Residential Maintenance.** Maintenance of the residences may be accomplished either by the residents, through CWT, by Engineering staff, or through contracts with private companies.

k. **Funding and/or Financial Management Provisions**

(1) All VA residence purchases, (and renovation costs of same) will be accomplished using General Post Funds. Funding requests should be forwarded from the field to the Deputy Associate Director for Rehabilitation Services, (302/111C) VA Medical Center, Hampton, VA 23667.

(2) Rent collections, from VI/CWT earnings, will be deposited into a designated subaccount of the local General Post Fund. These funds will be used to cover all costs associated with the ongoing operation (including utilities) and general maintenance of the residences. It is important that each program be self-sustained by rent collections.

**4.06 INCENTIVE THERAPY (IT) PROGRAM (RCS 10-0656)**

a. **Definition.** IT is a rehabilitation program provided for under 38 U.S.C. 718(a) which authorizes an assignment of patients to various hospital work situations. Since the work is considered of economic benefit to the medical center, the veteran must receive remuneration for the accomplished tasks. Veterans referred to this program are not considered as employees, and are exempt, under 38 U.S.C. 718, from the Fair Labor Standards Act as applied to handicapped employment.

(1) The selection of patients for participation in the IT Program is based upon the physical, psychological and social needs of the patients.

(2) The utilization of monetary incentives in this therapeutic program must meet both of the following requirements:

(a) Work will be assigned based on the patient's treatment and rehabilitation goals.

(b) Work assignments are not to be used strictly to keep patients "occupied" or to provide them with pocket money.

(3) In all medical center and/or domiciliary settings, recommendations for assignment to IT will originate with the ward treatment team or domiciliary team, and will be based on

comprehensive assessment and evaluation of the patient to determine if the individual will benefit from such rehabilitative programs. Final approval of the assignment of recommended patients shall be the responsibility of the Chief of Staff, or such individual(s) as the Chief of Staff may designate.

(4) Position descriptions should be developed by the program supervisor which accurately describe the skills, competencies, and parameters of the assigned jobs being offered at the local facility.

(5) This program may be utilized as a patient assessment tool to evaluate functional levels, rehabilitation needs, and vocational goals of individual veterans. It should be noted that some IT assignments are not particularly conducive to short-term assignments and may not be appropriate for assessment purposes.

b. **Rates of Remuneration**

(1) The maximum remuneration for patients assigned to IV programs shall not exceed 50 percent of the current minimum wage.

(a) On a selective basis, program managers can request a waiver from the Director, MH&BSS, to increase rates beyond one-half of minimum wage. This can be especially beneficial in Domiciliary Programs and on-the-job training programs where patients accept a greater degree of responsibility in their work assignments.

(b) The actual rate to be established will be set in relation to the individual's present functional level. *NOTE: Program supervisors are strongly encouraged to develop wage rates which reflect the skills, effort, and concentration necessary to accomplish the tasks.*

(2) Earnings by participants in IT are not considered income for pension purposes, but may be taxed by the Internal Revenue Service (IRS).

(3) Earnings are taxable; those that exceed \$600 annually will be reported to IRS, using Form 1099 Miscellaneous.

c. **Annual Report (RCN 10-0656)**. The Annual Report for Compensated Work Therapy (Veterans Industries), Incentive Therapy, and Therapeutic Printing Plant Programs (RCN 10-0656), is a recurring annual report to be submitted to Deputy Associate Director of Rehabilitation Services, (302/111C) VA Medical Center, Hampton, VA 23667, by the first working day of November, for the preceding fiscal year. *NOTE: This is a combined report, containing information from VI/CWT, IT, and TPP Programs, and should collect data as outlined in M-2 Part X, Chapter 4.06, and is mandated by 38 U.S.C. Section 1718.*

#### **4.07 VOCATIONAL REHABILITATION CASE MANAGEMENT PROGRAM**

It is VHA policy to provide a Vocational Rehabilitation Case Management Program and an annual reporting system to cover that program.

a. **Background**

(1) **Definition**. Vocational Rehabilitation Case Management (VRCM) is a clinical and an administrative process that provides timely planning and coordinated actions in the delivery of needed rehabilitation services. VRCM is a mechanism for coordinating VHA and VBA with respect to vocational counseling for eligible veterans. This process originates with the initial veteran contact and continues throughout the rehabilitation process.

(2) Organizational Differences. The operation of vocational case management at individual VA facilities will be determined by the patient population, the available medical center resources, and the resources of the community. Consequently, the methods of providing vocational services will vary among VA facilities.

(3) Objectives. The objectives of VRCM are to:

(a) Identify eligible veterans and inform them of available vocational rehabilitation services.

(b) Assess the vocational rehabilitation needs of eligible veterans.

(c) Establish a vocational rehabilitation plan including procedures for follow-up in collaboration with the veteran, the treatment team and other participants involved in the vocational rehabilitation process.

(d) Implement a plan for vocational rehabilitation services which includes the contributions of VHA, VBA, and other Federal, State, and local community resources.

(4) Role of Case Manager. A Case Manager must be prepared to deal with the environment, and must:

(a) Develop and maintain a referral system to ensure that all eligible veterans are given access to available vocational rehabilitation services.

(b) Assist veterans in the development of a vocational and rehabilitation plan by providing for vocational assessment, counseling, training and rehabilitation, job readiness and placement activities.

(c) Inform appropriate treatment teams and services (i.e., providers of veterans' vocational rehabilitation needs) and participate in treatment team and discharge planning for the purpose of implementing appropriate vocational rehabilitation plans.

(d) Serve as liaison to VBA Regional Office for those veterans entitled to vocational rehabilitation benefits for the purpose of insuring that veterans receive needed services from both VHA and VBA.

(e) Serve as liaison to the State vocational rehabilitation service, State job service, and other Federal, State, and community agencies for veterans.

(f) Provide follow-up for veterans who have participated in vocational rehabilitation activities until their needs have been met, the responsibility for rehabilitation has been transferred, or the case is closed.

b. Program Responsibility

(1) The Director, MH&BSS, VHA Headquarters, has overall responsibility for the Vocational Case Management Program.

(2) A VHA Headquarters designated Field Advisory Committee, comprised of professionals with a background in vocational rehabilitation, will serve as a council in providing ongoing consultation to VHA Headquarters.

(3) The medical center Director of each field station will provide at least one full-time or part-time Vocational Case Manager. The individual designated case manager at the medical center should have a:

(a) Background in vocational rehabilitation and the ability to coordinate interdisciplinary activities;

(b) Working knowledge of the physical, mental, social and psychological aspects of disabilities; and

(c) Knowledge of vocational rehabilitation counseling. *NOTE: Exceptions to these qualifications must be reviewed and granted by VHA Headquarters (111C).*

(4) Responsibility for this program will be designated by local medical center management to the service(s) which demonstrate the most interest and expertise in vocational case management activities.

(5) The caseload size and the range of responsibilities may require the assignment of multiple case managers, or other vocational rehabilitation staff.

(6) Specific position descriptions, based on overall task expectations as defined in this Handbook, are the responsibility of each facility.

(7) Case managers are expected to make direct requests for necessary services for which the veteran is eligible, in order to complete the veteran's vocational rehabilitation plan. The management of these requests for services will vary among facilities.

#### **4.08 REFERENCES**

- a. Pub. L. 95-581.
- b. Pub. L. 102-54.
- c. Title 38 U.S.C. Chapter 37.
- d. Title 38 U.S.C. 1718.
- e. Title 29 CFR Chapter 5, Part 525.
- f. Federal Acquisition Regulations (FAR) 6.
- g. M-2, Part X, Chapter 4.

**SAMPLE CONTRACT FOR COMPENSATED WORK THERAPY  
AND GUIDELINES FOR COMPLETING THE CONTRACT**

AGREEMENT BETWEEN

DEPARTMENT OF VETERANS AFFAIRS  
(Medical Center Name and Address (1) )

AND

(Principal's Name and Address (2) )

FOR

(A Brief Statement of what is to be accomplished is written in here) (3) .

This agreement is between the undersigned (Name of Principal) (hereinafter called Principal), and the Department of Veterans Affairs (hereinafter called VA) for the purpose of conducting this agreement.

1. **SCOPE AND OBJECTIVES:** VA will perform the following work (4).
2. **TERM OF AGREEMENT:** VA shall commence subject work or scope on (5 a) and carry on subject work or scope to and including (5 b) . Change in the Federal Minimum Wage will require immediate renegotiation of costs. Overtime hours will be those hours worked in excess of 8 hours a day, or 40 hours a week.
3. **REIMBURSEMENT:** The Principal agrees, subject to the conditions specified herein, to reimburse VA in an amount of (6) after submission of invoice. Payment will be made (7) .
4. **TERMINATION:** this agreement will remain in force during the period stated, unless terminated at the request of either party after 30 days notice in writing.
5. **RISK OF LOSS:** The UNITED STATES shall not be liable for any loss or damage to the Principal's property or expenses incidental to such loss or damage, except that the UNITED STATES shall be responsible for any such loss or damage, not covered by insurance or for which the Principal is not otherwise reimbursed, which is caused by the negligent or wrongful act or omission of a VA employee acting within the scope of his or her employment, but only to the extent permitted by and in accordance with the procedures of the Federal Tort Claims Act.
6. **TOOLS AND EQUIPMENT:** The Principal will provide special tools or equipment required for the completion of this contract. Tools or equipment of a general nature will be the responsibility of VA. Definitions of "special" and "general" will be negotiated. General maintenance to principal owned equipment while on VA premises will be the responsibility of the VA. Repairs will be the responsibility of the Principal. Installation of equipment will be as locally required by regulation and accepted practice (8) .

Chapter 4  
APPENDIX 4A

7. **TAX:** Any Federal, State and local taxes that would be applicable to this agreement shall be the responsibility of the Principal.

UNITED STATES OF AMERICA  
DEPARTMENT OF VETERANS AFFAIRS

\_\_\_\_\_ (2) \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Date)

**Guideline for the Veterans Industries Official in filling in the contract.**

1. Hospital or center address.
2. Principal name and address.
3. Brief of what is to be accomplished.
4. The following list of items should be considered or made a part of the scope of objectives where applicable:
  - a. Drawings, prints, sketches, specifications;
  - b. Samples;
  - c. Tolerances, i.e., on specification in production;
  - d. Quality Control, i.e., limits, levels defects, etc.;
  - e. Inspection, i.e., testing;
  - f. Engineering Service;
  - g. Materials, i.e., furnished by, quantity to be delivered, storage of, material belongs to whom during and after agreement;
  - h. Delivery of finished product, i.e., by whom, delivery of material by whom, shipping out the finished product, or pickup; and
  - i. Packing and/or packaging, i.e., material needed (box-tape-labels, etc.).
- 5a. Date work will start, and
- 5b. Date work will end.
6. Dollar amount to be paid, i.e., per item, work-hour, project, etc.
7. When payment will be made, i.e., weekly, bimonthly, etc.
8. List tools and equipment furnished, etc.

**SAMPLE MEMORANDUM OF UNDERSTANDING  
FOR COMPENSATED WORK THERAPY**

BETWEEN

DEPARTMENT OF VETERANS AFFAIRS, (CITY, STATE)

AND

VETERANS INDUSTRIES/COMPENSATED WORK THERAPY

FOR

(Brief description of what is to be accomplished)

This agreement is between the VETERANS INDUSTRIES/CWT (hereinafter called VI/CWT) and the Department of Veterans Affairs Medical Center (hereinafter called VA) for the purpose of conducting this agreement.

1. **SCOPE AND OBJECTIVES:** VI/CWT will perform the following work: (Schedules of services to be performed and the rates for such services are attached.)
2. **TERM OF AGREEMENT:** VI/CWT will commence subject work on (Date) and carry on subject work to and including (Date).
3. **REIMBURSEMENT:** VA agrees, subject to the conditions specified herein, to reimburse VI/CWT (36x4048 account) in an amount of (Dollar amount, per item, work-hour, etc.) after submission of Bill of Collection. Payment will be made (Bi-weekly, monthly, etc.).
4. **TERMINATION:** This agreement will remain in force during the period stated, unless terminated at the request of either party after 30 days notice in writing.
5. **RISK OF LOSS:** VI/CWT shall not be liable for any loss of or damage to VA's property or expenses incidental to such loss or damage, except that VI/CWT shall be responsible for any such loss or damage (including expenses incidental thereto) resulting from negligence, willful misconduct, or lack of good faith on the part of VI (employees or patients).
6. **TOOLS AND EQUIPMENT:** VA will provide special tools or equipment required for the completion of this contract. Tools or equipment of a general nature will be the responsibility of VI/CWT. Definitions of "special" and "general" will be negotiated. General maintenance to VA owned equipment while on VI/CWT premises will be the responsibility of VI/CWT; otherwise general maintenance will be the responsibility of VA. Repairs will be the responsibility of VA. Installation of equipment will be as locally required by regulation and accepted practice (as specified by local medical center).
7. Title 38 United States Code Section 1718(b), is the authority for this arrangement.

\_\_\_\_\_

UNITED STATES OF AMERICA  
DEPARTMENT OF VETERANS AFFAIRS

\_\_\_\_\_  
VETERANS INDUSTRIES/CWT

By \_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

**SAMPLE FORMAT FOR  
COMPENSATED WORK THERAPY(CWT)/THERAPEUTIC RESIDENCE(TR)  
PRELIMINARY SITE EVALUATION**

Check one.

|  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
| 1. Is property currently vacant or owner occupied?<br>(Must not be any tenants on the property)  | _____      | _____     |
| 2. Is the property outside 100-year flood plains?  | _____      | _____     |
| 3. Does property have minimum acceptable space?  | _____      | _____     |
| 5. Does property have adequate functional utility?<br>sure plumbing and electrical look good.<br>(Make sure water damage is at minimum.)   | _____      | _____     |
| 6. Is the property friable asbestos free?  | _____      | _____     |
| 7. Is the property free of any covenants which might<br>prevent other than residential use? (This is<br>separate and distinct from zoning. The covenants<br>we are interested in are types that are recorded<br>with the sub-division plat at the land and records<br>office of County Court House.) | _____      | _____     |

*NOTE: If all answers are "YES", the property should be evaluated using the "Evaluation Criteria" sheet. If any of the answers are "NO", the property is automatically disqualified.*

**CWT/TR SITE EVALUATION CRITERIA**

**OWNER:**

\_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_

**AGENT:**

\_\_\_\_\_

**EVALUATOR:**

\_\_\_\_\_

**CRITERIA:**

**WEIGHT X VALUE\* SCORE**

(For Example)

7 x 5 = 35

| CRITERIA:   | WEIGHT | X | VALUE* | SCORE |
|---|--------|---|--------|-------|
| <b>1. Off-site Constraints</b>                          |        |   |        |       |
| a. Accessibility to:                                    |        |   |        |       |
| (1) Public transportation                               | 7      | x | ___    | = ___ |
| (2) Shopping and eating establishments                  | 7      | x | ___    | = ___ |
| (3) VA Hospital   | 6      | x | ___    | = ___ |
| b. Surrounding land use, as:                            |        |   |        |       |
| (1) Neighborhood environment                            | 3      | x | ___    | = ___ |
| (2) Existing zoning compatibility                       | 8      | x | ___    | = ___ |
| <b>2. On-Site Constraints</b>                           |        |   |        |       |
| a. General appearance                                   |        |   |        |       |
|   | 6      | x | ___    | = ___ |
| b. Size and accommodation, as in:                       |        |   |        |       |
| (1) Number of bedrooms                                  | 6      | x | ___    | = ___ |
| (2) Number of baths                                     | 5      | x | ___    | = ___ |
| (3) Eating facility                                     | 5      | x | ___    | = ___ |
| (4) Laundry accommodations                              | 3      | x | ___    | = ___ |
| (5) Recreation Space                                    | 2      | x | ___    | = ___ |
| (6) Size of lot   | 2      | x | ___    | = ___ |
| <b>3. Cost Factors</b>                                  |        |   |        |       |
| a. Acquisition of house                                 |        |   |        |       |
|   | 25     | x | ___    | = ___ |
| b. Renovation and improvements<br>(maximum of \$25,000) |        |   |        |       |
|   | 15     | x | ___    | = ___ |
| <b>TOTAL</b>  | 100    | x | ___    | = ___ |

\* Value Score: 0 - Unacceptable, 1 - Bad, 2 - Poor, 3 - Fair, 4 - Good, 5 - Excellent