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Healthcare Inspection

Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs

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Washington, DC 20420

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Executive Summary

In the joint explanatory statement to accompany the fiscal year (FY) 2015, Omnibus Appropriations Bill, “Consolidated and Further Continuing Appropriations Act, 2015,” Congress requested the VA Office of Inspector General (OIG) conduct a broader review of the operations and effectiveness of VA substance abuse inpatient rehabilitation programs. Specifically, the OIG was asked to report back on: (1) The current number of VA inpatient rehabilitation programs, (2) the annual number of veterans who participate and their average length of treatment, (3) the average length of time for VA treatment compared to that of non-VA residential treatment programs, (4) the rate of recidivism for both types of programs, (5) the process used to refer patients to VA inpatient treatment, (6) the degree of supervision of patients in VA programs and how often drug tests are performed, and (7) how well mental health and substance abuse treatment are integrated for veterans with comorbidities.

Background

According to the *Diagnostic and Statistical Manual of Mental Disorders*, a diagnosis of substance use disorder (SUD) is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. SUDs are diagnosed when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Recovery from SUDs is often wrought with ups and downs and at times interrupted by periods of relapse. Relapse, however, does not signal treatment failure, as is often believed. Like other chronic illnesses, relapse indicates that further treatment should be considered or the current treatment plan needs adjustment. Substance addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.¹

Results of Review

1. Number of Residential Substance Use Treatment Programs

- The Veterans Health Administration (VHA) has 63 VA residential substance use treatment programs, 43 Substance Abuse Residential Rehabilitation Treatment Programs (SA RRTPs) and 20 Domiciliary Substance Abuse Programs (DOM SAPs).

2. Annual Number of Veterans Who Participate in SA RRTPs and DOM SAPs and their Average Length of Treatment

- During FYs 2012, 2013, and 2014, SA RRTPs and DOM SAs treated 13,818, 14,826, and 15,306 unique patients, respectively, representing a 10.7 percent increase over this timeframe.

¹ Relapse rates for drug addiction are similar to those of other well-characterized chronic illnesses. National Institute on Drug Abuse Web site. <http://www.drugabuse.gov/publications/addiction-science/relapse/relapse-rates-drug-addiction-are-similar-to-those-other-well-characterized-chronic-ill> Last Updated July 2008. Accessed on June 22, 2015.

- Data compiled by VHA's Northeast Program Evaluation Center (NEPEC) indicated a residential substance use treatment program median length of stay of 31 days for FYs 2012–2014. Our review of a sample of electronic health records (EHRs) of patients who were admitted during the first week of FY 2015, was consistent with the NEPEC data and found a median length of stay of 28 days.

3. *VA Residential Substance Use Treatment Average Length of Stay (ALOS) Compared to Non-VA ALOS*

- The median length of stay for VA residential substance use treatment programs was 31 days and was similar to the median length of stay of 37 days in discharge data that the Substance Abuse Mental Health Services Administration (SAMSHA) collects from the states.
- The mean length of stay for VA programs was 36.2 days and the average length of stay for a large, private non-profit residential substance use treatment provider that shared its data with us was 25.9 days. Comparison may be limited as there may be significant differences between the populations served.

4. *Rate of Recidivism for VHA and Compared to Non-VHA Entities*

- Readmission rates in isolation do not sufficiently provide a comprehensive assessment of program outcomes, and utilization of additional complementary and long-term outcomes measures should be considered.
- The average 30-day post-discharge readmission rate from VA residential treatment programs for FY 2012–2014 was 7.2 percent in the NEPEC data. From our EHR review of a patient cohort, we produced comparable numbers.
- Readmission rates at 30 days post-discharge for VA residential substance use treatment programs was considerably lower than found in New York State Medicaid data, but due to differing treatment and regulatory environments and intrinsic operational factors, one must be cautious in generalizing the Medicaid data to VA programs.
- We reported on readmission rates at 180 days for VA residential substance use treatment programs. A large, private residential substance use treatment entity provided readmission rates at 1 year for the private, non-profit provider. However, in addition to the difference in time frames, the private provider's rates were based on readmission to the provider's substance use residential treatment programs only whereas the VA data is based on readmission to any VA residential programs thus limiting apples to apples comparison.

5. *Process Used To Refer Patients to VA Substance Use Residential Treatment*

- For approximately one-third of the 63 programs, admission dates are primarily on a first-come first-served basis. The other programs apply varying prioritization factors superimposed on an underlying first-come first-served paradigm. For the two-thirds of programs utilizing prioritization factors, consideration is made

concerning the treatment setting from which the patient is being referred, for example an inpatient detoxification, acute mental health unit.

6. *Degree of Supervision of Patients in VA Residential Substance Use Treatment Programs and How Often Drug Tests are Performed*

- Eighty-eight percent of patients in our sample averaged at least one urine drug screen (UDS) per week, while 40 percent averaged two UDS per week.
- We found deficiencies with VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, December 2010, (MH RRTP Handbook) compliance in terms of having at least the minimum of one staff member per unit / wing/ floor, 24-hour-per-day, 7-days-per-week core staffing assigned at all times; consistent documentation of required twice-daily bed checks; full documentation of completion of every 2-hour rounds; and not having closed-circuit television (CCTV) cameras in treatment areas.
- We identified opportunities to enhance guidance to and consistency across programs and to further strengthen processes to check patient bags for contraband after patients return from passes; clarifying how CCTV is to be used or monitored and how often staff should check camera/monitor function; documenting the patient's condition during twice daily bed checks; and the availability of naloxone in program areas.

7. *How Well Mental Health and Substance Abuse treatment are Integrated for Veterans with Comorbidities*

- We evaluated whether individualized treatment plans addressed ongoing assessment and treatment of comorbid mental health conditions. We found inconsistent inclusion of measurable treatment objectives for comorbid mental health conditions.
- We observed aftercare appointments for comorbid mental health conditions were seldom documented in discharge related progress notes.

We made 10 recommendations.

Comments

The Under Secretary for Health concurred with the findings and recommendations. (See Appendix B, pages 47–53, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.



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Purpose

As requested in the Joint Explanatory Statement to accompany the fiscal year (FY) 2015 Omnibus Appropriations bill, “Consolidated and Further Continuing Appropriations Act, 2015,”² the VA Office of Inspector General (OIG) conducted a broad review of the operations and effectiveness of VA substance abuse inpatient rehabilitation programs.

The specific request stated:

“Due to questions about VA residential substance abuse treatment in Miami, Florida, that have been raised by the VA OIG (Report No. 13-03089-104, March 27, 2014), the OIG is requested to conduct a broader review of the operations and effectiveness of VA substance abuse inpatient rehabilitation programs and report back to the Committees by August 1, 2015, on the following: the current number of VA inpatient rehabilitation programs; the annual number of veterans who participate and their average length of treatment; the average length of time for VA treatment compared to that of non- VA residential treatment programs; the rate of recidivism for both types of programs; the process used to refer patients to VA inpatient treatment; the degree of supervision of patients in VA programs and how often drug tests are performed; and how well mental health and substance abuse treatment are integrated for veterans with comorbidities.”³

The OIG report⁴ referenced by the Congress was an OIG Office of Healthcare Inspections’ review in response to the unexpected death of a patient in the substance abuse residential rehabilitation treatment program (SA RRTP) at the Miami VA Healthcare System. The patient’s autopsy results indicated that the death was a result of acute cocaine and heroin toxicity and our review identified concerns related to supervision and monitoring of patients in the Miami SA RRTP.

Background

A. Defining Substance Use Disorders

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5),⁵ is the most current manual used by clinicians and researchers to classify mental disorders. DSM-5, published in 2013, replaced the terms substance abuse and substance dependence with substance use disorder (SUD).

According to the DSM-5, a diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.⁶ SUDs are diagnosed when the recurrent use of alcohol and/or drugs causes clinically and functionally significant

² Congressional Record. Congress.gov Web site. <https://www.congress.gov/congressional-record/2014/12/11/house-section/article/H9307-1> Published December 11, 2014. Accessed June 22, 2015.

³ *ibid.*

⁴ Healthcare Inspection: *Unexpected Death in a Substance Abuse Residential Rehabilitation Treatment Program*, Miami VA Healthcare System, Miami, Florida, Report No. 13-03089-104, March 27, 2014.

⁵ American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), Washington, D.C.

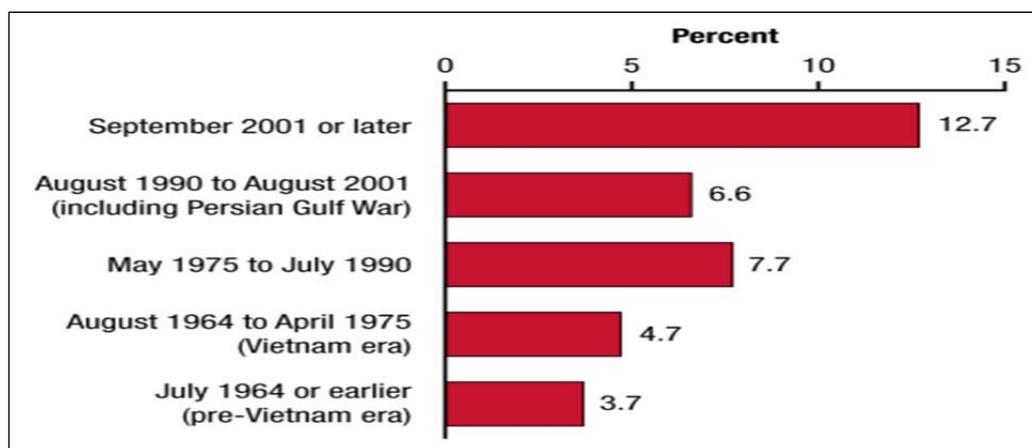
⁶ *ibid.*

impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The level of severity of an SUD diagnosis is defined as mild, moderate, or severe and is determined by the number of diagnostic criteria met.

B. Rates of Substance Use

According to the 2013 National Survey on Drug Use and Health, 1.5 million veterans aged 17 or older (6.6 percent of this population or 1 in 15) had a SUD in the past year. Among all Americans, aged 17 or older, the rate was about 1 in 11, or 8.6 percent. Substance use rates broken down by military service era demonstrate significant variance. For veterans serving September 2001 or later, the rate of SUDs was higher than all other veteran groups and the general American population at 12.7 percent. (See Figure 1 below)⁷

Figure 1: The Percent of SUD Among Veterans Aged 17 or Older, by Service Era⁸



Source: *The Substance Abuse Mental Health Services Administration, 2013*

C. Comorbid Mental Health Conditions

According to VA, approximately one-third of Veterans admitted to Veterans Health Administration (VHA) residential substance use treatment programs had a co-occurring post-traumatic stress disorder diagnosis (PTSD), 11% had a co-occurring affective disorder, and 12% had other serious mental illness diagnoses.⁹ In FY14, 37.6 percent of VA patients diagnosed with a confirmed mental health diagnosis also received a SUD diagnosis. VA administrative data reflects that more than a third of patients with mental health diagnoses have a comorbid¹⁰ substance use diagnosis. The VHA Mental Health

⁷ The CBHSQ Report, National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration Web site. http://www.samhsa.gov/data/sites/default/files/report_1969/Spotlight-1969.html. Accessed May 7, 2015.

⁸ *ibid.*

⁹ As per correspondence from VHA MH RRTP program leadership, July 16, 2015.

¹⁰ Comorbidity describes two or more disorders or illnesses occurring in the same person that can occur at the same time or one after the other.

Residential Rehabilitation Treatment Program (MH RRTP) Handbook also specifically outlines the components of an integrated, dual diagnosis¹¹ treatment program.¹²

D. Impact of SUDs

SUDs have substantial negative consequences on mental and physical health, work performance, housing status, and social functioning.¹³ A Centers for Disease Control and Prevention (CDC) analysis showed that 38,329 people died from drug overdoses in the United States in 2010.¹⁴ According to the National Institute on Alcohol Abuse and Alcoholism, nearly 88,000 people (approximately 62,000 men and 26,000 women) die from alcohol-related causes annually, making it the third leading preventable cause of death in the United States.¹⁵

SUDs are also financially costly. Hundreds of billions of dollars are spent on costs related to health care, crime, and lost work productivity in the United States (Table 2).¹⁶

Table 1: Financial Cost of Substance Use in America

Substance	Health Care	Overall
Alcohol	\$25 billion	\$224 billion
Illicit Drugs	\$11 billion	\$193 billion

Source: National Institute on Drug Abuse, 2015

E. Natural History of Addictive Illnesses, Relapse, and Recovery

Historically, substance addiction was considered to only impact those with poor will power or moral character. However, significant strides have been made in the understanding of addiction and SUDs. Drug and alcohol addiction are now believed to be a complex disease process, much like heart disease. SUDs change the brain. The changes make it difficult to stop substance using behavior, even for individuals desiring to stop.¹⁷

According to the National Institute of Drug Addiction (NIDA),

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is

¹¹ As per the National Alliance on Mental Illness definition, dual diagnosis is a term used for when someone experiences a mental illness and a substance abuse problem simultaneously.

¹² VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

¹³ Substance Use Disorder Queri Website <http://www.queri.research.va.gov/sud/>. Accessed on June 22, 2015.

¹⁴ Opioids drive continued increase in drug overdose deaths. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html Updated February 20, 2013. Accessed on June 22, 2015.

¹⁵ Alcohol Facts and Statistics. National Institute on Alcohol Abuse and Alcoholism Web site. <http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics> Published March 2015. Accessed on June 22, 2015.

¹⁶ Trends and Statistics. National Institute on Drug Abuse Web site. <http://www.drugabuse.gov/related-topics/trends-statistics>. Last update January 2015. Accessed on June 22, 2015.

¹⁷ McLellan, A. Have we evaluated addiction treatment correctly? Implications from a chronic care perspective *Society for the Study of Addiction to Alcohol and Other Drugs Addiction* (2002) vol. 97, 249–252.

*considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.*¹⁸

The Substance Abuse Mental Health Services Administration (SAMHSA) defines recovery as: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”¹⁹ Within the construct of recovery is the notion that recovery is non-linear. In other words, recovery does not have a tidy beginning and end point. It is wrought with ups and downs and at times interrupted by periods of relapse.

Chronic illnesses, such as drug and alcohol addiction, asthma, and heart disease, can be managed successfully. Chronic illnesses often have periods of relapse and relapse rates for SUDs are comparable to those seen in patients suffering from type 1 diabetes, asthma, and hypertension. Patients with chronic illness may experience challenges with treatment and medication adherence. Relapse, however, does not signal treatment failure, as is often believed. Like other chronic illnesses, relapse indicates that further treatment should be considered or the current treatment plan needs adjustment. Substance addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.²⁰

F. SUD Treatment in VA

VHA has a variety of options for SUD treatment. For the purpose of this report, we reviewed residential substance use treatment programs. Levels of care in VHA that serve patients with mental health and/or substance use issues include:

- **Inpatient Units**: Provide acute, in-hospital care for patients experiencing urgent mental health or medical symptoms, including detoxification.
- **MH RRTP**: Provide time-limited residential rehabilitation and treatment to Veterans with mental health and substance use disorders, co-occurring medical concerns, and psychosocial needs including homelessness and unemployment. Residential programs have a longer length of stay and lower staffing levels than inpatient care. VHA SA RRTPs and Domiciliary Substance Abuse Programs (DOM SAPs) fall within the residential level of care.
- **Intensive Outpatient Treatment Programs (IOPs)**: Provide at least 3 hours per day of treatment services on at least 3 days per week. This includes partial

¹⁸ The Science of Drug Abuse and Addiction: The Basics. National Institute of Drug Abuse Web site. <http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics> Last updated September 2014. Accessed on June 22, 2015.

¹⁹SAMSHA announces a working definition of “recovery” from mental disorders and substance use disorders, SAMSHA Web site. <http://www.samhsa.gov/newsroom/press-announcements/201112220300> Published December 22, 2011. Last update June 3, 2014. Accessed on June 22, 2015.

²⁰Relapse rates for drug addiction are similar to those of other well-characterized chronic illnesses. National Institute on Drug Abuse Web site. <http://www.drugabuse.gov/publications/addiction-science/relapse/relapse-rates-drug-addiction-are-similar-to-those-other-well-characterized-chronic-ill> Last Updated July 2008. Accessed on June 22, 2015.

hospitalization programs, day treatment programs, and outpatient-clinic based programs.²¹

- SUD Treatment Outpatient Clinics: Provide ambulatory services for initial and continuing outpatient care to patients with SUD (other than those engaged in a regulated opioid treatment program) either independently or in conjunction with other mental health programs. Treatment is designed to provide full-range of clinically indicated treatment and rehabilitation services for patients with SUD.
- SUD-PTSD Team or Specialist: An SUD specialist serves as a contributing member of each facility's PTSD team or service. Integrated or coordinated concurrent treatment of PTSD and SUD is considered an evidence-based practice. This can be achieved either by having staff capable of providing PTSD care within the SUD program, having SUD care within a PTSD program, or through coordinating concurrent care between programs.²²
- Opioid Treatment Programs: Outpatient programs for patients with chronic opioid dependence in which patients are treated with opiate agonists²³ such as methadone, or partial agonists such as buprenorphine.
- SUD Care in General Mental Health Clinic Settings: Ambulatory care in a general mental health clinic setting for patients with stabilized or low-severity SUD.²⁴

Often, residential treatment programs are confused with acute inpatient hospitalization programs due to the nature of residents living at the program site. However, a true inpatient hospital setting is typically hospital-based, very short term, stabilization oriented, and specific to acute medical and/ or psychiatric needs, such as detoxification or suicidality. SUD programs in the United States and in VHA are typically residential, not acute inpatient hospital-based.

The veteran population often has complex psychosocial issues, making appropriate referral more complicated. The Department of Veterans Affairs and Department of Defense (VA/DoD) guideline²⁵ recommends use of the most recent *Patient Placement Criteria of the American Society of Addiction Medicine (ASAM)*,²⁶ which defines residential levels of care, admission criteria, staffing models, assessment dimensions, intensity, focus on treatment services, and treatment review guidelines.

²¹ VHA Office of Patient Care Services, Office of Mental Health fact sheet, September 2010.

²² VHA Office of Patient Care Services, Office of Mental Health fact sheet, September 2010.

²³ An opiate agonist is a drug that binds to opiate receptors in the brain.

²⁴ VHA Handbook 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, March 7, 2012.

²⁵ Department of Veterans Affairs & Department of Defense (2008). *VA/DoD Clinical Practice Guideline for Substance Use Disorder*. (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM.

http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp Accessed on June 23, 2015.

²⁶ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. (This VHA Handbook is scheduled for recertification on or before the last working day of December 2015.)

Although not required by VHA, the use of ASAM criteria to determine the level of care is the most widely used and comprehensive set of guidelines for placement, continued stay, and the transfer and/or discharge of patients with addiction and co-occurring conditions. ASAM criteria are required in over 30 states.^{27,28} VHA utilizes the VHA MH RRTP Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, for guidance on admissions to SA RRTP and Dom SA programs.²⁹

G. SA RRTPs and DOM SAPs

VHA has two residential treatment program bed types that specialize in the treatment of SUDs: SA RRTPs and DOM SAPs. Both programs provide 24-hour care in safe and therapeutic environments and fall under the larger umbrella of VHA MH RRTPs.

Although SA RRTPs and DOM SAPs share a common emphasis on SUD treatment, they have differences. SA RRTPs are free standing programs that are not attached to a larger or combined MH RRTP structure. DOM SAPs are embedded within a larger MH RRTP structure and may share staffing, programming, beds, and resources with other MH RRTPs.

SA RRTPs and DOM SAPs are designed for veterans who need higher levels of care than outpatient care due to the complexity of their conditions, which may be due to a combination of addiction severity, biopsychosocial co-morbidity, and serious relapse potential at less intensive levels of care or if residing in a home environment that places the patient at high risk for relapse.

SA RRTPs and DOM SAPs can adhere to all-inclusive or supportive models of care.³⁰ In all-inclusive models, staffing must include at least 2 licensed independent providers, with competencies in the delivery of evidence-based psychosocial interventions for SUD. Dedicated staff must be accessible to provide addiction-focused pharmacotherapy. In supportive program models, services from licensed independent providers are generally provided through the outpatient substance use treatment program while the veteran resides at the SA RRTP or DOM SAP.

Consistent with the VA/DoD Clinical Practice Guideline for the Management of Patients with SUDs, SA RRTPs and DOM SAPs must include access to evidence-based psychosocial interventions and addiction-focused pharmacotherapy when indicated. Providing evidence-based psychosocial interventions has been shown to meaningfully improve treatment outcomes, including drug-abstinence, treatment retention, psychosocial functioning, and relapse prevention. Interventions include the Community Reinforcement Approach, Cognitive-Behavioral Therapy and Skills Training,

²⁷ *ibid.*

²⁸ What is the ASAM Criteria? From ASAM Web site. <http://www.asam.org/publications/the-asam-criteria/about/>
Accessed on June 22, 2015.

²⁹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, December 22, 2010.
(This VHA Handbook is scheduled for recertification on or before the last working day of December 2015.)

³⁰ *Ibid.*

Motivational Enhancement Therapy (Motivational Interviewing), and Contingency Management among others.³¹

H. Balancing Personal Accountability and Safety in SUD Treatment

One of the most significant challenges in providing SUD treatment is promoting personal accountability while also ensuring a safe recovery environment. Working to achieve this balance is not unique to VHA. SUD programs outside of VHA also are tasked to implement a safe recovery environment that encourages self-direction. Typically, SUD residential programs are not locked settings and are not held to the same security level as psychiatric acute care hospitals. The VHA MH RRTP Handbook provides guidance on safety and security requirements as well as creating a therapeutic community. It also specifies programmatic requirements such as staffing, supervision, substance use monitoring, and admission screening requirements.

Scope and Methodology

We reviewed both SA RRTPs and DOM SAPs after speaking with the MH RRTP national program office and being informed that the programs are essentially identical. We conducted onsite visits to a statistical sample of 33 VHA residential substance use programs. We reviewed a statistical sample of 100 electronic health records (EHR) of patients who were admitted to a VHA SA RRTP or DOM SAP during the first week of FY 2015. We chose this timeframe to reflect recent care of patients who had likely completed their inpatient stay at the time of our review.

In addition, we reviewed VHA policies and operational data, spoke with VHA MH RRTP program leadership and subject matter experts, collected information on SA RRTPs using an information gathering tool, and conducted structured interviews of facility program managers and staff. In addition, we interviewed individual SA RRTP and DOM SAP leadership and staff.

In seeking comparative data from non-VA programs, we spoke with officials from other government agencies as well as researchers and clinicians in academic, public, and private settings with residential SUD treatment programs. We were graciously provided data from SAMHSA and the Hazelden Betty Ford Foundation's Butler Center for Research. We also obtained data on New York State Medicaid residential substance use treatment program via open source.

We randomly sampled two populations of interest—residential SUD programs that we visited onsite and a recent cohort of patients treated in substance use programs. We conducted onsite reviews to better assess the supervision of patients while in residential substance use treatment programs. We chose a cohort of the patients admitted for the first full week of FY 2015 to assess the care delivered to patients who had recently been in residential substance use treatment.

³¹ Marsch, Lisa PhD, and Dallery, Jessie PhD, *Advances in the Psychosocial Treatment of Addiction: The Role of Technology in the Delivery of Evidence-Based Psychosocial Treatment*, *Psychiatr Clin North Am.* 2012 Jun 35(2): 481–493.

From the sample data, we calculated the 95 percent confidence intervals for our estimate of the population prevalence for select issues of interest. In some cases, we presented the sample data (for example, frequency distribution) as representative for the population of interest. We also presented qualitative impressions of the data, which was difficult to categorize.

Inspection Results

1. Number of VA Residential Substance Use Rehabilitation Programs

We were asked to review the number of VA inpatient residential substance use treatment programs and operational beds.

A. Northeast Program Evaluation Center Data on Number of Programs and Beds

According to Northeast Program Evaluation Center (NEPEC) data for 4th Quarter FY 2014, VHA had 63 programs with a total of 1,702 operational beds that were classified as residential substance use treatment programs. This represented 43 SA RRTPs and 20 DOM SAPs.

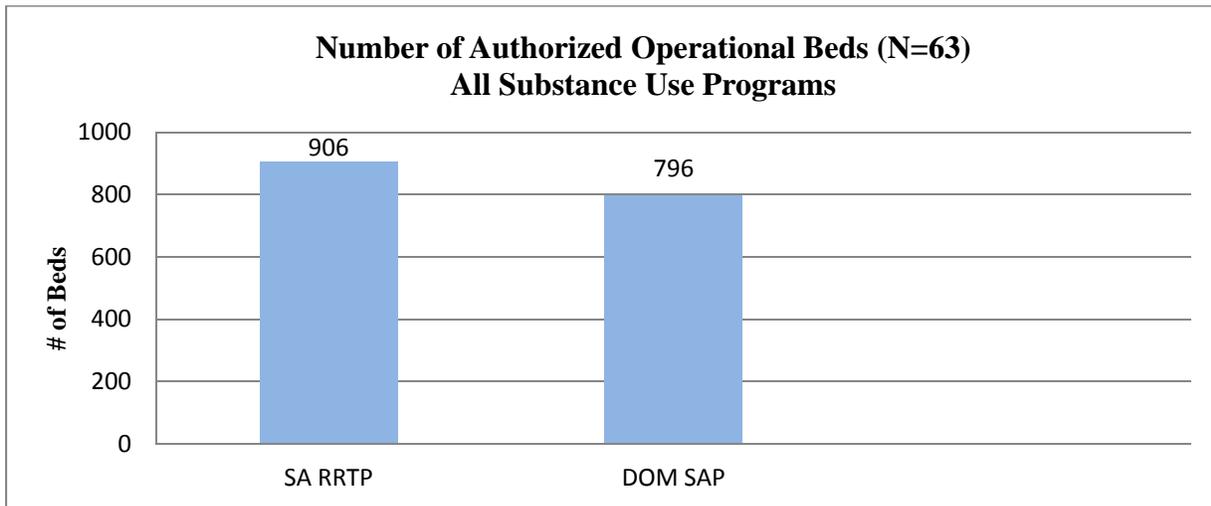
B. OIG Survey Data

In January 2015, we distributed a web-based survey to all VHA facilities to validate the number of SA RRTPs in FY 2013 and/or FY 2014. We achieved 100 percent response and the survey identified 49 self-reported SA RRTPs.

We reconciled the VHA facilities self-reported survey results (49 SA RRTPs) and the NEPEC data (43 SA RRTPs) and determined that 6 respondent programs self-identified as SA RRTPs because those programs admitted patients who needed substance abuse treatment; however, the programs were designated as other types of MH RRTPs. For example, a 16-bed psychosocial RRTP reported utilizing 8 of the 16 beds for substance use treatment.

We determined that that NEPEC data accurately identified VHA’s 43 SA RRTPs and 20 DOM SAPs with 906 SA RRTP beds and 796 DOM SAP beds. (See Appendix A for facility specific operational bed breakdown.)

Figure 2: SA Program Authorized Operational Beds – 4th Quarter FY 2014



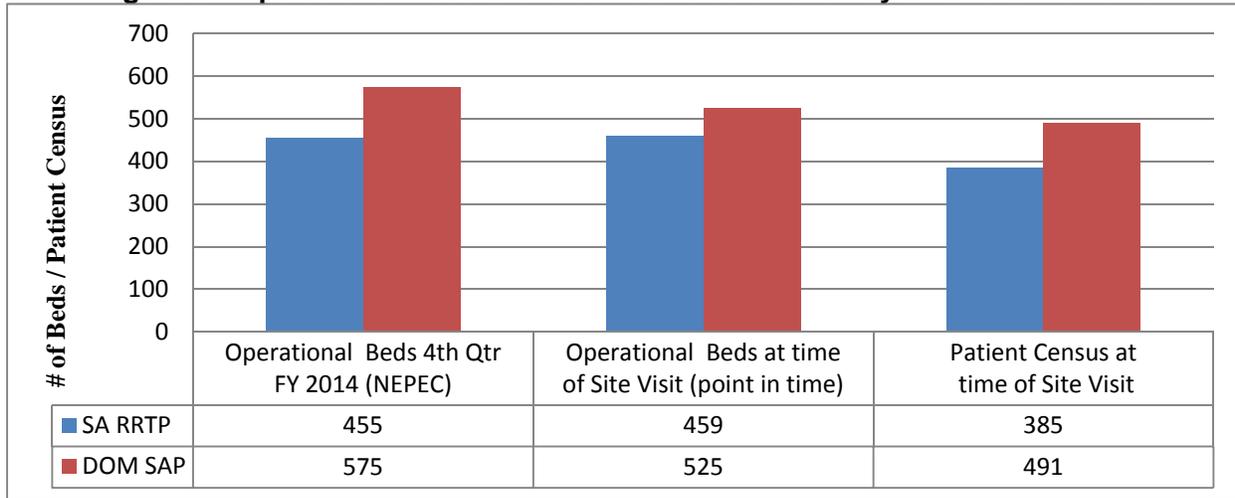
Source: NEPEC

C. Onsite Reviews

From March 2015 through May 2015, we conducted onsite reviews at 33 of the 63 VHA SA RRTPs/DOM SAPs. (See Figure 3 below.) While onsite, we ascertained the number of operational beds and patient census on the day of our visit (point-in-time).

The number of operational beds fluctuated due to additions and/or changes in the programs and the number of beds over time. Examples of these changes included construction requiring the temporary closure or moving of patient beds; adequate staffing concerns; infection control outbreaks; and availability of treating physicians, such as a provider on extended leave.

Figure 3: Operational Beds of the 33 Facilities on the Day of Onsite Reviews



Source: VA OIG

We determined the number of point-in-time SA RRTP operational beds during the onsite reviews was generally consistent with the NEPEC report. However, we found a 50-bed discrepancy in the number of DOM SAP operational beds at one facility. In March, the facility reclassified 50 SA RRTP beds to general domiciliary beds.

2. Annual Number of Veterans Who Participate in Residential Programs

We were asked to look at the annual number of veterans who participate in VA residential substance use programs. To respond to this request, we reviewed the number of unique patients served by a VA substance use program and program occupancy rates.

A. Unique Patients

In FY 2014, the number of unique patients served by a VA residential substance use program was 15,306. The number of unique patients increased 10.8 percent FY 2012–FY2014. (See Table 2 below.)

**Table 2: Number of Unique Patients Served by Residential Substance Use Programs
FY 2012–FY 2014**

Unique Patients FY 2012	Unique Patients FY 2013	Unique Patients FY 2014
13,818	14,826	15,306

Source: NEPEC

B. Occupancy Rates

The VHA MH RRTP Handbook states that the MH RRTP Program Manager is to maintain an 85-percent bed occupancy, and the Handbook provides procedures and reporting requirements for MH RRTPs. Per VHA data, for the fourth quarter FY 2014, the overall occupancy rate for VHA residential substance use treatment programs was 85.4%.

NEPEC occupancy data revealed that 36 (57 percent) of the 63 substance use programs did not meet the 85-percent target occupancy rate during the 4th Quarter of FY 2014. Our onsite point-in-time occupancy data revealed a slightly higher occupancy rate; 15 (45 percent) of the 33 programs we visited did not meet the 85-percent target on the day of our onsite review (see Table 3 below). We note, however, that we did not adjust the point-in-time data for temporary bed closures, construction, or staffing concerns, which might affect the cumulative occupancy rates over time.

**Table 3: VHA SA RRTP and DOM SA Occupancy Rates
Point-in-Time and 4th Quarter, FY 2014**

	Onsite Review Occupancy Rate (Point-in-Time)	SA RRTP and DOM SAP Cumulative Occupancy Rate Qtr. 4 FY 2014 (NEPEC)
Number of Programs	33	63
# of programs below 85 percent occupancy	15	36
% of programs below 85 percent occupancy	(45%)	(57%)
# of programs meeting target 85 percent	18	27
% of programs meeting target 85 percent	(55%)	(43%)

Source: VAOIG Onsite visits (point-in-time data) and NEPEC (cumulative rate).

3. Average Length of Treatment in VHA SA RRTP and DOM SA Programs

We were asked to report on the average length of treatment for veterans who participate in VHA inpatient substance use rehabilitation programs.

A. NEPEC Average Length of Stay Data

Average length of stay (ALOS) data is the aggregate length of stay in days for patients participating in these programs divided by movements out of the programs (either by

discharge or transfer to another program or treatment venue). The movements out are first identified for a particular fiscal year and then the number of days of stay are calculated. The number of days might include days of stay prior to October 1 and time spent in other bed sections of care. For example, a patient in a PTSD focused MH RRTP is transferred directly to the SA RRTP program without going home, so the hospitalization is one ongoing stay.³²

Bed days of care is calculated by dividing the total bed days of care (BDOC) for patients participating in these programs divided by the total number of completed episodes of care (patient is no longer in the SA RRTP/DOM SAP at end of fiscal year). As a result, ALOS data tends to be longer than BDOC data.

Table 4, below, indicates the national ALOS and the average BDOC for patients admitted to the 63 VHA SA RRTP/DOM SAP bed sections for FYs 2012, 2013, and 2014.

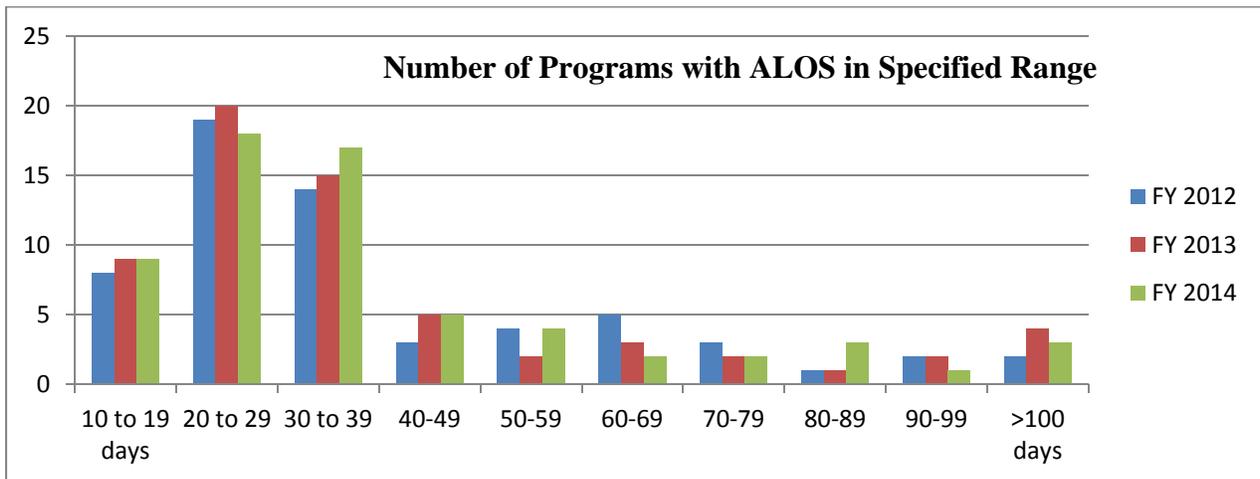
Table 4. ALOS and BDOC for VHA SA RRTPs/DOM SAPs, FYs 2012, 2013, 2014

	FY 2012	FY 2013	FY 2014
Average Length of Stay	34.4	35.7	36.2
Bed Days of Care	32.1	32.6	32.7

Source: *OIG Analysis of VHA NEPEC data.*

The median LOS and BDOC was 31 and 29 days respectively for all 3 years. Figure 4, displays the range and frequency distribution of program ALOS for the 63 VHA SA RRTPs/DOM SAPs.

Figure 4. Frequency Distribution of ALOS among VHA SA RRTPs/DOM SAPs FY 2012-2014³³



Source: *OIG analysis of VHA NEPEC data*

³² Correspondence from National Director, VHA MH Residential Treatment Programs, June 1, 2015.

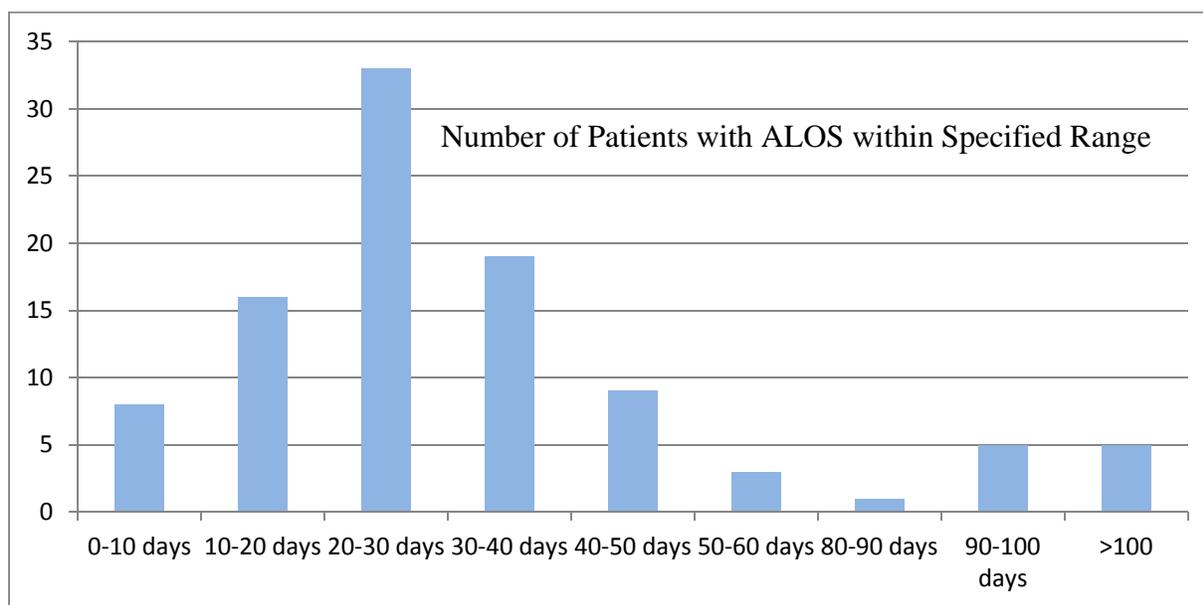
³³ FY 2012 and 2013 data were not available for the Hines facility. The Clarksburg SA RRTP became a general MH RRTP and the Lebanon SA RRTP became a general domiciliary program.

With few exceptions, the program ALOS from year to year was fairly consistent for individual programs. In other words, if a given program’s ALOS was in the 20 to 29 day range in 2012, it was typically in this range for 2013 and 2014. The handful of programs at the shorter end (10–19 days) of the ALOS range and the handful of programs at the longer end of the ALOS range (90–99 or greater than 100 days) were the same programs over the FY 2012–2014 timeframe.

B. OIG Medical Record Review

We reviewed a statistical sample of 100 EHRs of patients who were admitted to a VHA SA RRTP/DOM SAP during the first week of FY 2015. Our analysis found a patient ALOS of 34.6 days with a range of 1 to 41 days. The median patient ALOS was 28. These results are consistent with the NEPEC program ALOS data analyzed earlier in this section.

Figure 5. Frequency Distribution of Patient ALOS from OIG Review of 100 EHRs of Patients Admitted to VHA SA RRTPs/DOM SAPs during the First Week of FY 2015



Source: VAOIG.

4. VA Compared to Non-VA ALOS for Residential Substance Use Treatment

We were asked to report on the average length of time for VA treatment compared to that of non-VA residential substance use treatment program.

We searched for and/or reached out to potential sources of ALOS, readmission rates, and outcomes related data, including governmental entities, non-VA accrediting agencies, and private and non-profit non-VA entities providing residential substance use treatment.

For community based entities, the cost of data collection (in terms of time, money, and perceived opportunity costs) can be a significant barrier to ongoing collection, especially of outcomes data. Other entities collect data, but the data may be proprietary and/or not publicly available. The collection and availability of relevant data enhances residential substance use treatment provider program evaluation efforts, and the ability of the residential treatment community to assess and adopt potential best practices and/or evidence-based innovations.

A. SAMSHA Treatment Episode Data Set

The Treatment Episode Data Set—Discharges (TEDS-D) is a national census data system of annual discharges from substance abuse treatment facilities. State laws require certain substance abuse treatment programs to report all of their admissions and discharges to the state. In all states, treatment programs receiving any public funds are required to provide the data on both publicly and privately funded clients; in some states, programs that do not receive public funds are required to provide data as well. TEDS collects this data from the states on all admissions and discharges of patients aged 12 or older.

TEDS-D is one component of the Behavioral Health Services Information System (BHSIS), maintained by the Center for Behavioral Health Statistics and Quality (CBHSQ), at SAMHSA. TEDS-D records represent discharges rather than individuals, as a person may be admitted to and discharged from treatment more than once. Information on treatment discharges is routinely collected by state administrative systems and then submitted to SAMHSA in a standard format. A sister data system, called the Treatment Episode Data Set—Admissions (TEDS-A), collects data on admissions to substance abuse treatment facilities.³⁴

The most recent year of available TEDS-D data is 2011. The report contains data on median LOS by type of service. The three different types of residential service reported on are short-term residential, long-term residential, and hospital residential.

- Short-term residential treatment is defined as typically 30 days or fewer of non-acute care in a setting with treatment services for substance abuse and dependency.
- Long-term residential treatment is defined as typically more than 30 days of non-acute care in a setting with treatment services for substance abuse and dependence, which may include transitional living arrangements such as halfway houses.
- Hospital Residential Treatment is 24-hour per day medical care in a hospital facility in conjunction with treatment services for substance abuse and dependence, excluding detoxification.

³⁴ Correspondence from Dr. Peter J. Delany PhD, LCSW-C and Alex Stashny, TBS, CBHSQ at SAMSHA, April 29, 2015.

The overall median LOS for short-term residential treatment was 22 days for all 167,113 TEDS-D discharges.

The median LOS for all of the 130,149 patients aged 12 and older from long-term residential treatment was 57 days.

From hospital residential treatment, the median LOS was 7 days for all 5,969 discharges and 11 days among treatment completers. Hospital residential treatment in this context would be the least analogous to the VHA SA RRTP/DOM SAP MH RRTP treatment setting.³⁵

The weighted average among LOS for short-term, long-term, and hospital residential treatment was 36.7 days, which is consistent with the VHA ALOS data for FYs 2012–2014.³⁶

B. Data Collected by Hazelden Betty Ford Foundation's Butler Center for Research

Hazelden's mission is to be a force of healing and hope for individuals, families, and communities affected by addiction to alcohol and other drugs. Founded in 1949, Hazelden has grown into one of the largest private, non-profit alcohol and drug addiction treatment providers with outpatient and residential programs in 13 locations. In 2014, Hazelden merged with the Betty Ford Center.³⁷ The Butler Center for Research is dedicated to improving recovery from addiction by conducting clinical and institutional research, collaborating with other research centers, and communicating evidence-based findings.

Hazelden and the Butler Center provided aggregated (non-patient level) ALOS data for patients discharged from their adult residential programs based in Center City, MN, and in Newberg, OR, for the period January 1, 2014 through April 30, 2015. The ALOS for both programs combined was 25.88 days with a standard deviation of 7.86 days. The ALOS was less than the ALOS for VHA SA RRTPs/DOM SAPs during the most recent years.

Demographically (for example, veteran status including combat status, level of mental health comorbidity, private insurance status, socioeconomic status, housing situation, external supports), the population of patients served in the Hazelden programs may differ from patients served in VHA SA RRTP/DOM SA programs. In addition to potential population differences, we would expect differences in intrinsic operational policies and processes which may also affect ALOS and limit the extent of comparison to VHA.

³⁵ Center for Behavioral Health Statistics and Quality, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS-D), 2011.

³⁶ To facilitate comparison, we used the imperfect assumption that the distributions were not significantly skewed.

³⁷ About the Hazelden Betty Ford Foundation. Hazelden Betty Ford Foundation Web site.

<http://www.hazeldenbettyford.org/about-us> Accessed on June 6, 2015.

C. Research on Length of Stays and Residential Substance Use Treatment

Substance use treatment has generally been conceptualized as a process comprised of two phases. Phase 1 is an initial or primary phase of treatment of substance dependence, detoxification, residential, and in some cases, intensive-outpatient treatment, or, in even fewer cases, standard outpatient treatment services. Phase 2, depending on the level of care received during the primary phase of treatment, involves some form of less intensive and tapered care which can range in duration from a few weeks to up to several years. Evidence in the form of various clinical outcomes from several randomized controlled trials and systematic reviews of the SUD treatment literature clearly demonstrates that, irrespective of treatment modality, treatment affords improvements for the majority of patients and is undoubtedly better than no treatment.³⁸

LOS in substance use treatment has been considered one of the predictors of post-treatment outcomes by way of several, older previous large-scale, multisite studies of treatment effectiveness. In the latest U.S. national treatment evaluation project, the Drug Abuse Treatment Outcomes Study (DATOS), a total of 10,010 patients admitted to 96 programs from 11 cities participated in the project from 1991 to 1993. The sample included patients admitted to publically funded and private long-term residential programs, short-term inpatient programs, outpatient treatment programs, and outpatient methadone maintenance programs. The initial DATOS evaluation project and subsequent studies replicated prior findings that longer lengths of stay were associated with better follow-up outcomes. This general conclusion was found despite considerable variation in how the programs operated, the populations treated, their success in engaging and retaining patients in treatment, and the specific services delivered. Overall, the findings revealed a progressively greater reduction in the likelihood of substance use after long-term residential and outpatient treatment as length of stays increased.³⁹

To investigate the question as to whether longer stays in VHA SA RRTPs is associated with better substance use related outcomes, researchers randomly selected up to 50 new patients from each of 28 randomly selected SA RRTPs (a total of 1,307 patients). The study's goal was to examine if patient and program ALOS were associated with improvement on the Addiction Severity Index (ASI) Alcohol and Drug composite scores. The researchers found that patients in programs with an ALOS greater than 90 days tended to have mental health treatment prior to the index episode of treatment and less severe substance-related symptoms but more homelessness. At follow-up, programs with ALOS longer than 90 days had the least improvement in the ASI Alcohol composite and significantly less improvement than programs with ALOS of 15 to 30 and 31 to 45 days.⁴⁰

³⁸ Proctor, Steven L., Herschman, Philip, Review Article: *The Continuing Care Model of Substance Use Treatment: What Works and When is "Enough," "Enough?"* *Psychiatry Journal*, Volume 2014. [Doi.org/10.1155/2014/692423](https://doi.org/10.1155/2014/692423)

³⁹ Ibid.

⁴⁰ Alex H.S. Harris PhD, Daniel Kivlahan PhD, Paul G. Barnett PhD, John W. Finney PhD, *Longer Length of Stay is Not Associated with Better Outcomes in VHA's Substance Abuse Residential Rehabilitation Treatment Programs*, *The Journal of Behavioral Health Services & Research*, January 2012, Volume 39, Issue 1, pp.68-79.

The continuing care model of substance use treatment can be conceptualized as successful completion of the initial phase of substance use treatment, defined by the ASAM's Patient Placement Criteria as the resolution of the problem(s) that justified admission to the patient's current level of care as indicated by achievement of the specific goals articulated in their individualized treatment plan, generally followed by some form of continuing care, in which patients receive treatment of a lower intensity.⁴¹

An important consideration for VHA MH RRTP programs may be facilitating patient engagement within the continuum of outpatient substance use disorder treatment in addition to emphasizing appropriately individualized lengths of stay in residential substance use disorder treatment.

5. Readmissions Rates

We were asked to report on the rate of "recidivism" for VA residential substance use treatment programs and non-VA treatment programs. Recidivism is terminology often used in a legal setting. Because this report focuses on health care settings, we use the term readmission rate.

A. VHA NEPEC Data

NEPEC compiles readmission rates for MH RRTPs at 14 days, 30 days, and 180 days post-discharge. The readmission rate as collected refers to readmissions from a SA RRTP/DOM SAP to any VHA MH RRTP (not just SA RRTP/DOM SAP) within the indicated time frame. VHA's collection methodology does not give readmission rates to SA RRTPs/DOM SAPs only or to the same SA RRTP/DOM SAP only. The readmission data excludes patients directly admitted from one MH RRTP to another (for example, patients who do not leave the hospital and go directly to the next MH RRTP without being discharged home); for these patients, the whole stay is considered one episode of care. However, if the patient had left the hospital for 24 hours before admission into the next MH RRTP, then the second program admission is captured in the readmission data.

In the context within which NEPEC collects this data, readmission could reflect relapse but could also reflect continued care for substance use and/or co-morbid illness (for example, a patient who completes an SA RRTP and is admitted shortly after to a PTSD focused residential treatment program).

Table 5 depicts rates of readmission following discharge from VHA SA RRTPs and DOM SAPs to any MH RRTP during FYs 2012, 2013, and 2014.

⁴¹ Proctor, Steven L., Herschman, Philip, Review Article: *The Continuing Care Model of Substance Use Treatment: What Works and When is "Enough," "Enough?"* *Psychiatry Journal*, Volume 2014. [Doi.org/10.1155/2014/692423](https://doi.org/10.1155/2014/692423)

Table 5. Rates of Readmission Following VHA SA RRTP/DOM SAP Discharge to Any VHA MH RRTP (including SA RRTPs/DOM SAPs) at 14, 30, and 180 days for FYs 2012–2014

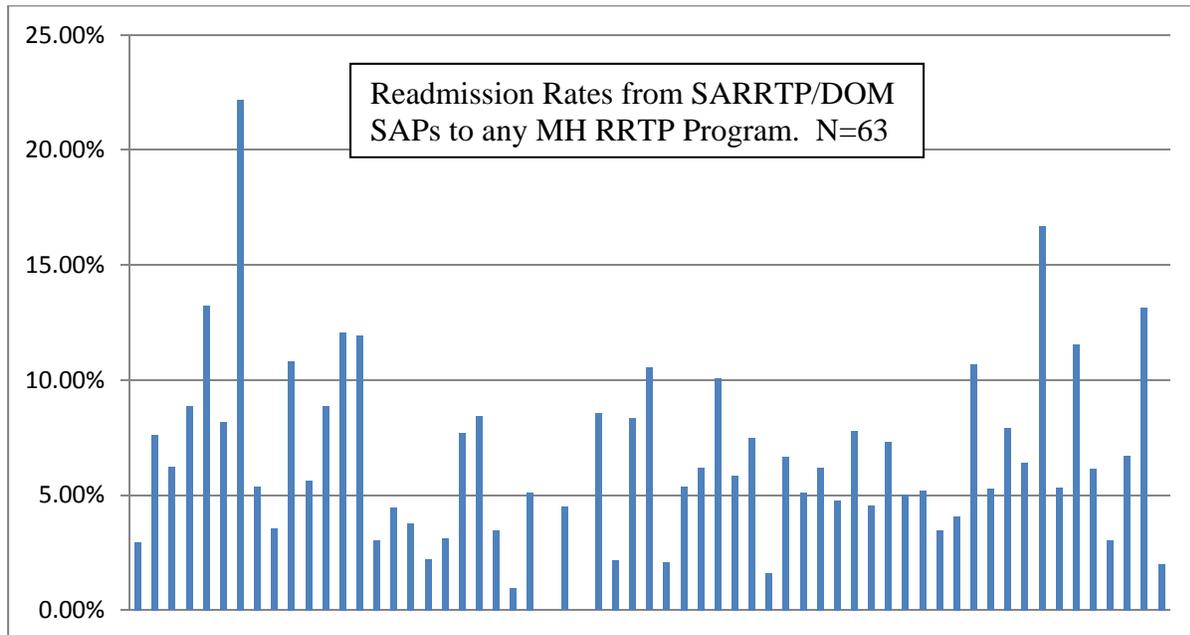
FY	14 days post-DC	30 days post-DC	180 days post-DC
FY 2012	6.62%	8.79%	19.64%
FY 2013	4.27%	5.88%	13.12%
FY 2014	4.68%	6.90%	19.0%

Source: *OIG Analysis of NEPEC data.*

As would be expected, readmission rates increased as the time interval from discharge lengthened.

Among individual programs, for FY 2014, readmission rates from SA RRTPs/DOM SAPs to any MH RRTPs at 30 days post-discharge ranged from 0 percent to 22.1 percent. The plot below displays the distribution of readmission rates among the individual SA RRTPs/DOM SAPs at 30 days post-discharge.

Figure 6. Rates of Readmission for each of the 63 SA RRTPs/DOM SAPs to Other MH RRTPs at 30 Days Post-Discharge



Source: *OIG analysis of NEPEC data.*

NEPEC also compiles data on readmission rates at 14, 30, and 180 days for patients discharged from a SA RRTP/DOM SAP program and subsequently admitted to acute inpatient psychiatry unit beds.

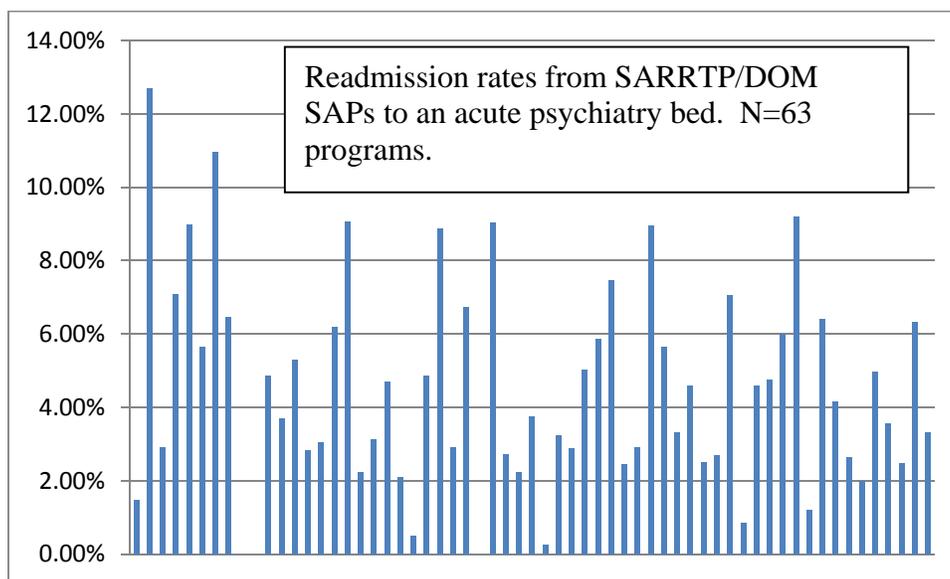
Table 6. Aggregate Readmission Rates from VHA SA RRTPs/DOM SAPs to an Acute Inpatient Psychiatry Unit at 14, 30,180 Days Post-Discharge for FYs 2012–2014

FY	14 days post-DC	30 days post-DC	180 days post-DC
FY 2012	2.22%	4.08%	16.16%
FY 2013	2.31%	4.2%	15.89%
FY 2014	2.66%	4.73%	16.9%

Source: *OIG Analysis of NEPEC data as of July 2015.*

Among individual programs, for FY 2014, readmission from SA RRTPs/DOM SAPs to an acute inpatient psychiatry unit at 30 days post-discharge ranged from 0 to 12.7 percent. Readmission rates could reflect differing program service delivery characteristics or alternatively differences in the complexity of patients served by different SA RRTPs/DOM SAPs.

Figure 7. Rates of Readmission for each of the 63 SA RRTPs/DOM SAPs to an Acute Inpatient Psychiatry Unit at 30 Days Post-Discharge



Source: *OIG analysis of NEPEC data as of July 2015.*

B. OIG Medical Record Review

We reviewed a statistical sample of 100 EHRs of patients who were admitted to VHA SA RRTPs/DOM SAPs during the first week of FY 2015. Because one patient was still admitted at the time of our review, the data reflects 99 patient EHRs. As part of the record reviews, we looked to see if within 30 days of discharge patients were:

- Readmitted to the same or another SA RRTP/DOM SAP
- Readmitted to another VHA MH RRTP
- Admitted to an acute inpatient psychiatry unit
- Had any mental health or substance use related emergency department visits

Table 7. Patient Readmission Rates at 30 Days Post-Discharge from OIG EHR Review of Patients Admitted to VHA SA RRTPs/DOM SAPs the First Week of FY 2015

SA RRTP/DOM SAP (30 days)	Other MH RRTP (30 days)	Acute Psychiatry (30 days)	MH or SA Related ED Visit (30 days)
7.1% (3.4 – 14.3)	3.0% (1.0 – 9.1)	6.1% (2.7 – 13.0)	5.1% (2.1 – 11.7)

Source: VAOIG.

The combined SA RRTP/DOM SAP rate of 10.1 percent was not significantly different from the 30 day post-discharge rate of 7.2 percent from the NEPEC administrative data averaged for FYs 2012–2014. The 6.1 percent readmission rate to an acute inpatient psychiatry unit within 30 days post-discharge was not statistically significantly different from the 4.3 percent readmission rate from the NEPEC administrative data average for FYs 2012–2014.

C. SAMSHA TEDS-D Data Set

We searched for and contacted governmental, accreditation, and private entities regarding readmission rate data.

Although, SAMSHA collects state data regarding substance use related residential program admissions and discharges (TEDS-A and TEDS-D), until the present reporting year, states did not use a unitary identification number for each patient. In other words, if a patient was admitted three times during the year to a residential substance use treatment program in a state, the admission would be captured with three different reference numbers as if it was three different patients instead of repeated use of one number for the patient. As a result, accurate readmission rates could not be calculated. SAMSHA reported having worked with states over the past several years to change this and subsequent to the present reporting year, readmission rate data will be calculable.

D. New York State Medicaid Behavioral Health Organization Data

In 2011, the Governor of the State of New York appointed a Medicaid Redesign Team (MRT) Behavioral Health (BH) Workgroup to develop recommendations for moving behavioral health services into managed care and for restructuring of the Medicaid program “to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.” The New York State Office of Mental Health is collaborating with the Department of Health and Office of Alcoholism and Substance Abuse Services to implement managed care transition in response to the recommendations and guiding principles set forth by the MRT BH Subcommittee.

As an initial phase, behavioral health organizations (BHO) were contracted to manage the high cost fee-for-service behavioral health services through a concurrent review process for fee-for-service inpatient care and to focus on high-quality engagement post

discharge.⁴² The BHO initiative oversees the transition from a fee-for-service to a managed care for Medicaid recipients who receive MH and SUD services in New York State.⁴³

The BHO SUD readmission dataset describes the rate of readmission for SUD inpatient detoxification or chemical dependence inpatient rehabilitation within either 30 or 45 days of the last inpatient SUD discharge for all discharges identified from paid fee-for-service Medicaid claims.

The following table displays year to date statewide readmission rates to the same or other residential substance use treatment programs with 30 and 45 days of discharge for 2010–2012 Quarter 4, 2013 Quarter 3 and Quarter 4, and the 1st 2 Quarters of 2014.

Table 8. Rate of Readmission for SUD Inpatient Detoxification or Chemical Dependence Inpatient Rehabilitation within Either 30 or 45 Days of the Last Inpatient SUD Discharge for All Discharges Identified from Paid Fee-for-Service Medicaid Claims from New York State BHO Data⁴⁴

Days to Readmit	2014 Q1Q2	2013 Q3Q4	2012 Q4	2011 Q4	2010 Q4
30	22%	22.5%	26.8%	32.3%	33.3%
45	25.3%	25.9%	30.3%	36.6%	38%

Source: New York State Office of Mental Health Behavioral Health Organization data.

Demographically, the population served may be more similar to the population served in VHA SA RRTPs/DOM SAPs than would be in private insured residential treatment programs. However, a caveat to comparison is the impression that a substantial amount of treatment in New York is mandated through the courts with requirements for abstinence monitoring. This could be one factor contributing in part to the consistently higher readmission rates.

Of note, if the BHO data is reviewed for other parts of the state, but New York City (for which rates are much higher) is excluded, the rates of readmission for Quarter 1 and Quarter 2 of 2014 was 11.7 percent compared to the VHA rate for FY 2014 (6.9 percent to an MH RRTP or 4.7 percent to an acute psychiatry unit). Overall, as there may be intrinsic operational differences, caution in generalizability of the New York State Medicaid readmission data to SA RRTP/DOM SAP services provided to the VHA’s treatment population would need to be considered.

E. Hazelden Betty Ford Foundation Butler Center for Research

The Hazelden Betty Ford Foundation Butler Center for Research provided aggregated (non-patient level) readmission rate data. Of the patients who attend a Hazelden

⁴² Behavioral Health Managed Care. New York State Office of Mental Health Web site. <https://www.omh.ny.gov/omhweb/bho/>. Accessed on June 8, 2015.

⁴³ BHO SUD Readmission: Beginning 2010. Data.gov Web site. <http://catalog.data.gov/dataset/bho-sud-readmission-beginning-2010>. Accessed on June 8, 2015.

⁴⁴ Ibid.

residential treatment program in a given year, the rate represents the percentages who re-admit to a Hazelden facility for another residential treatment stay within 12 months of discharge. The data does not include readmission to other (non-Hazelden) residential treatment facilities. Residential readmission rates for Hazelden typically range between 6 percent and 9 percent for the year following treatment.

The longest, analogous post-discharge timeframe for which a VHA rate was available was at 180 days and was 19 percent. However, as the data is captured by VHA, this includes readmission to any MH RRTP not just to a SA RRTP or DOM SAP. Additionally, there may also be population and intrinsic operational differences, which impact generalizability of comparison.

F. Residential Substance Use Treatment Readmission Rates and Outcomes

In a recovery-oriented systems model approach to measuring long-term patient outcomes, health care payers are viewed as consumers. Payers track their patients' admissions and identify programs that yield best outcomes, specifically measured by low readmission rates. The model reflects the current shift in non-VHA sectors from fee-for-service to fee-for-performance and the integrated long-term care of patients by emphasizing close monitoring, care management, and linkage to support and aftercare services across the substance use treatment continuum of care.

When a patient relapse occurs, prompt intervention, such as recovery support services or readmission is needed. An integral component is not just having a treatment system supported by recovery support services, but the closeness of interaction between episodes of treatment and relapse prevention services in order to create lengthening periods of abstinence until recovery can be achieved.

One limitation to this evaluative approach is the risk for programs to seek good outcomes by limiting readmission in cases in which readmission to residential treatment is indicated and needed. Over or inappropriate emphasis on low readmission rates has the potential risk for short-changing the path to final recovery.⁴⁵

Readmission rates can paradoxically reflect either inadequate treatment or successful aftercare in which patients with reemerging needs for a more intensive level of care are not lost to follow-up during aftercare. For example, a patient who is concerned he or she may relapse if not readmitted to a residential level of care and a patient who relapses but remains engaged in treatment and is readmitted both increase the readmission rate but are arguably better outcomes than a patient who is discharged, relapses shortly after discharge, and does not engage in any aftercare through VHA or other outpatient or intensive outpatient treatment. The readmission rate would be unchanged, but the patient would be worse off. At the same time, the patient who benefits significantly from residential treatment and successfully engages in aftercare lowers the readmission rate and represents an ideal outcome.

⁴⁵ *Creating a New Standard for Addiction Treatment Outcomes*, A Report from the Institute for Behavior and Health, Inc. Rockville, MD. August 2014.

Readmission rates in isolation, therefore, do not sufficiently provide a comprehensive assessment of program outcomes, and the utilization of additional complementary quality, process, and outcomes measures should be considered. Complementary measures might include average wait times for program admission, rate of successful completion of treatment program, periods of patient abstinence and relapse measured by biological monitoring in-treatment and after discharge, utilization of recovery support services, coordination with primary care clinicians, substance related emergency department visits and hospitalizations, substance use related illness, substance use related accidents, and substance use related incarceration among others.⁴⁶

Many MH RRTPs utilize the Brief Addiction Monitor initially around program admission and near program discharge to evaluate patient progress. In for profit, private non-profit, and government health care sectors, collecting and analyzing data for substance use treatment outcomes for the purpose of program evaluation, best practice development, and process improvement can be challenging, time consuming, and entails opportunity costs. VHA presently collects limited data regarding post-discharge outcomes.

6. Process Used To Refer Patients to VHA SA RRTPs and DOM SAPs

We were asked to report on the process used to refer patients to VHA residential substance use treatment.

Per the VHA MH RRTP Handbook, a patients' acceptance for admission must be given a tentative admission date and a point-of-contact during the time period prior to admission (if any).⁴⁷ Admissions must occur in the most expeditious manner as possible. As a general rule, patients are admitted to the program in the order in which they are screened or accepted. Exceptions for prioritization based on other factors and clinical circumstance may be made at the discretion of the MH RRTP manager.

Patients are referred to SA RRTPs/DOM SAPs various ways. These include walk-in; self-referral (patient initiates through other avenues); a formal or informal consultation from mental health or non-mental health providers; through contact with a SA RRTP/DOM SAP admission coordinator; and by direct service area referral, for example, from an Emergency Department, Urgent Care, and an inpatient medical unit on which a patient is receiving treatment for alcohol detoxification. The majority of SA RRTPs/DOM SAPs utilize a formal consult request in the EHR as their primary referral process.

⁴⁶ *ibid.*

⁴⁷VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

A. The Admissions Screening Process

The purpose of the screening assessment includes identification of patient diagnoses; the appropriateness for treatment in a residential treatment program versus another level of care; and, presence of other medical, mental health, and possibly legal issues that may need to be addressed either within the SA RRTP/DOM SAP, another MH RRTP, or by another program or clinic within the medical center (for example, Veterans Justice Outreach program or homelessness programs). Patients with substance use issues often have co-morbid mental health diagnoses. At several medical centers, the screening process often includes concurrent screening for appropriateness for several MH RRTPs. For example, the screening may be done concurrently for appropriateness for both a PTSD MH RRTP and the SA RRTP/DOM SAP.

At some SA RRTPs/DOM SAPs, the screening referral and determination may be completed by one individual within the SA RRTP/DOM SAP while at other programs, the screening and admission determination is made by an interdisciplinary team. The interdisciplinary team may include, but is not limited to a physician, psychiatrist, psychologist, nursing, social worker, addiction therapist, vocational rehabilitation therapist, psychiatric technician, and other mental health staff. The individual provider or the interdisciplinary team complete and record the screening assessment in the EHR.

We found admission screening was completed by an individual at 32 of the sites, a team at 29 sites, and 1 program used both. In the program that used both, if the referral came from an outpatient setting the screening was completed by an individual; if the referral came from an inpatient setting, it was completed by a team. After the assessment of the patient's medical, psychological, and social stability and the appropriateness for treatment is identified, the decision for admittance was made by an individual at 22 programs and as a shared decision by an interdisciplinary team in 41 of the programs.

The screener asks a series of questions and reviews the patient's medical record to gather information so that the admitting individual or team can ensure that the patient is placed in the MH RRTP that best fits the patient's immediate need. MH RRTPs that patients may be admitted to, other than SA RRTPs/DOM SAPs, include MH RRTPs primarily focused on PTSD, Domiciliary care, and Compensated Work Therapy.

B. Inclusion and Exclusion Criteria

The VHA MH RRTP lists common admission inclusion criteria for SA RRTPs. These criteria include:⁴⁸

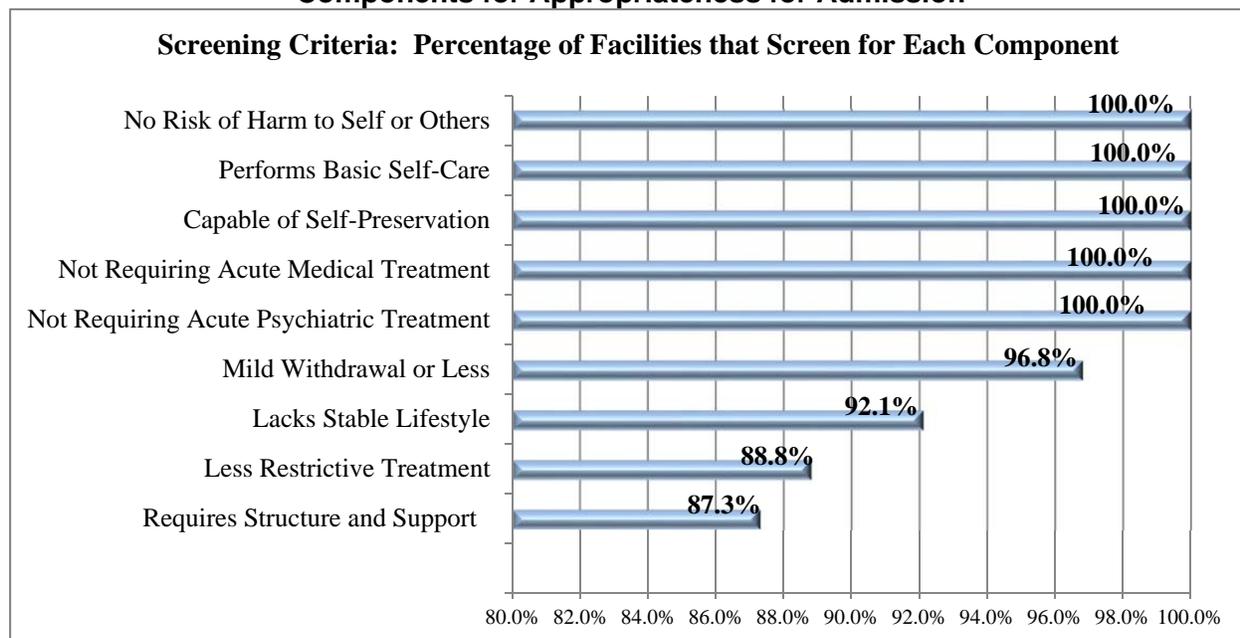
- Patients are assessed as not meeting criteria/requiring acute psychiatric treatment.
- Patients are assessed as not requiring acute medical treatment.

⁴⁸ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

- Patients have tried a less restrictive treatment alternative.
- Patients require the structure and support of a residential treatment environment.
- Patients are not at significant risk of harm to self or others.
- Patients are capable of self-preservation.⁴⁹
- Patients are capable of basic self-care.⁵⁰
- Patients have no more than mild withdrawal symptoms.
- Patients lack a stable lifestyle or living arrangement that is conducive to recovery.
- Patients have identified substance use related treatment and rehabilitation needs.

Because of the nature of the residential treatment level of care, patients participating in MH RRTPs must be agreeable to attending treatment on a voluntary basis and have no need for continuous monitoring. The majority of SA programs utilize the common screening criteria components specified in the VHA MH RRTP Handbook.

Figure 8. Screening Criteria: Percentage of Facilities that Screen the Following Components for Appropriateness for Admission



Source: VA OIG

Essentially, almost all programs utilized the screening inclusion criteria. In the screening process, approximately 90 percent of the programs reported including gender and ongoing pregnancy. Additionally, some adaptation of ASAM criteria is used in the referral process in 38 of the programs to assess level of care needed and whether treatment could be provided in a less restrictive environment.

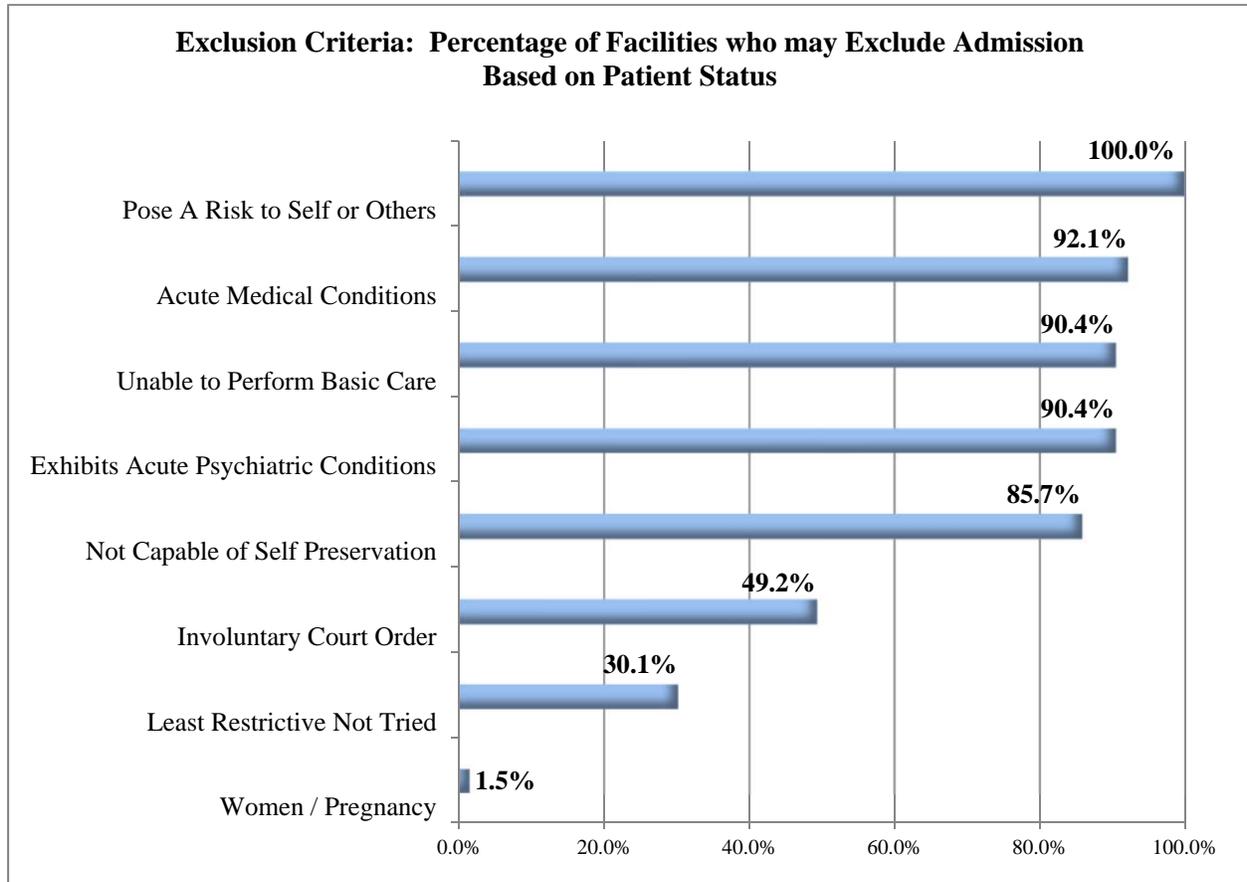
⁴⁹ Self-preservation is the ability to protect oneself from harm or death.

⁵⁰ Self-care is the ability to perform activities of daily living such as bathing, dressing, handling financial matters and household chores.

The VHA MH RRTP Handbook indicates the screening process must consider special circumstances to determine whether the program can meet the individual patient's needs while maintaining the program's safety, security, and integrity.⁵¹

Figure 9 displays the percentage of programs that responded "yes" when asked if the special circumstance listed below might exclude a patient from SA RRTP/DOM SAP acceptance during the screening process.

Figure 9: Possible Exclusion Factors: The Percentage of Facilities that Responded "Yes" When Asked if Special Circumstances Listed May Exclude Acceptance at Point of Presentation



Source: VA OIG

Multiple factors were taken into consideration when determining acceptance or exclusion. The decision to not admit a patient is a clinical decision made in consideration of the interplay of multiple factors. Programs reported that during the screening process, programs try to meet patient clinical needs or to refer them to the appropriate program to meet their needs.

⁵¹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

C. Prioritization of Admission (Program Start) Date

Once patients are accepted for admission, we attempted to ascertain, through a series of structured interview queries, whether the processes SA RRTPs/DOM SAPs utilize for admission are based purely on a first-come first-served basis or involve prioritization based on other factors.

For 19 of the programs, admission dates were primarily first-come first-served based on when the patient was temporally screened and accepted into the program. The other 43 programs applied varying prioritization factors superimposed on an underlying first-come first-served paradigm. One program accepted a female-only patient cohort and admissions were based almost singularly on a first-come, first-served basis. For admission to the program's non-female cohort beds, prioritization factors were considered in addition to first-come, first-served.

Of the programs that admitted patients primarily on a first-come first-served basis, the majority stated that they rarely deviated; however, they would do so if it was clinically indicated and if the patient would likely experience negative consequences if not immediately treated.

For the 44 programs utilizing prioritization factors, consideration was made concerning the setting from which the patient was being referred. If the patient was being referred from an inpatient detoxification setting (VA or non-VA), a VA inpatient medical-surgical unit, or a VA inpatient mental health unit, all 44 stated that impacts the prioritization process and where the patient is placed in the admission queue.

Conversely, more than half of the programs said that whether patients were being referred from their facility, their Veterans Integrated Service Network (VISN), outside their VISN, a non-VA outpatient setting, a DoD provider, or the presence of court ordered treatment had little or no impact, by itself, as to whether patients were prioritized in the admission process.

However, 26 programs identified referral through the Veterans Justice Outreach program as having a moderate or major impact on prioritization for admission.

Table 9, below, summarizes the reported impact of various factors on SA RRTP/DOM SA prioritization for the 44 programs that indicated they used some sort of prioritization process in addition to first-come, first-served status.

Table 9: Ranking of Prioritization: Degree to Which the Following Items Impacts Prioritization for Admission: (N = 44)

Criteria	Number Rated 0 (No Impact)	Number Rated 1 (Mild Impact)	Number Rated 2 (Moderate Impact)	Number Rated 3 (Major Impact)
Referral from Inpatient Setting - Detoxification	0	4	13	27
Referral from Inpatient Mental Health Unit	0	5	15	24
Referral from Inpatient Med/Surgery	2	12	12	18
Referral Special Medical	6	9	15	14
Referral from Non VA Detoxification Program	5	12	16	11
Referral from Veteran Justice Outreach Program	4	14	19	7
Referral from Non-VA Inpatient Setting	5	17	16	6
Referral from Department of Defense	11	13	15	5
Referral Court Ordered	12	16	15	1
Referral from Within Facility	19	7	11	7
Self-Referral	18	11	14	1
Referral from Within the VISN	18	11	14	1
Referral from Outside the VISN	19	16	9	0
Referral Non VA Outpatient Setting	16	23	5	0

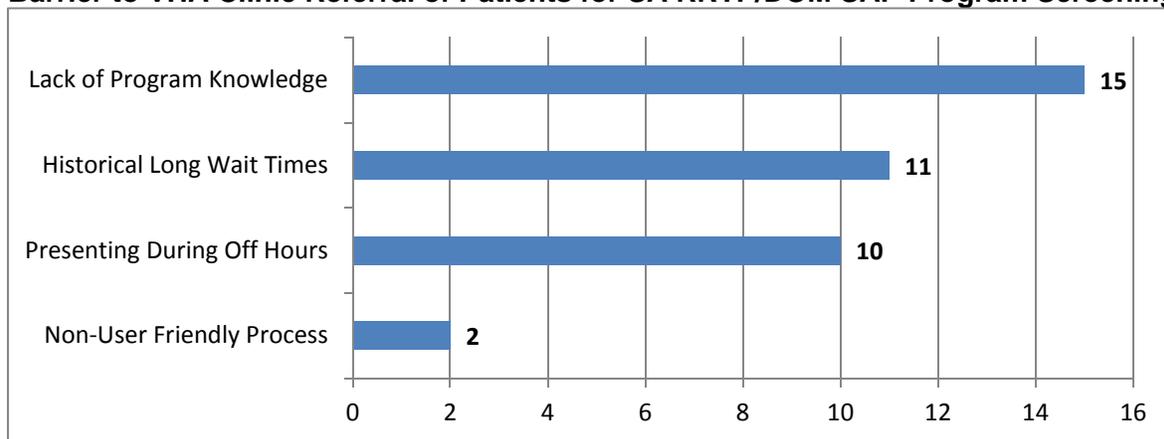
Source: VA OIG

D. Barriers to Referral, Admission, and Discharge

1. Barriers to Referral

We queried program leaders about barriers that may adversely impact SA RRTP/DOM SAP referrals from within the program's facility.

Figure 10 displays the number of respondents that identified each barrier to referral from VHA outpatient clinics to SA RRTP/DOM SAP treatment. Some programs identified more than one of the barriers presented. Other programs did not identify any barriers.

Figure 10: The Number of Program Managers (N=63) who Identified Each Component as a Barrier to VHA Clinic Referral of Patients for SA RRTP/DOM SAP Program Screening

Source: VA OIG

When discussing barriers that prevent VHA clinics from referring patients, lack of program knowledge was identified by 15 program leaders. Many of the 15 expressed that although they provide education to staff on what the SA RRTP/Dom SAP provides and how to refer to the programs, they continue to get inappropriate referrals or no referrals at all. Clinic staff turnover may contribute to the lack of program knowledge despite the education provided. Only two managers responded that they felt that they have a non-user friendly consult process.

2. Factors Affecting Wait Times for SA RRTP/DOM SAP Admission

In the structured interviews, 24 of the 63 program managers self-reported they had patients waiting over 30 days from screening to admission (starting the program) in FY 2014. The majority of these managers attributed this to supply and demand (not having enough beds to support the population requesting services). Other common reasons cited included:

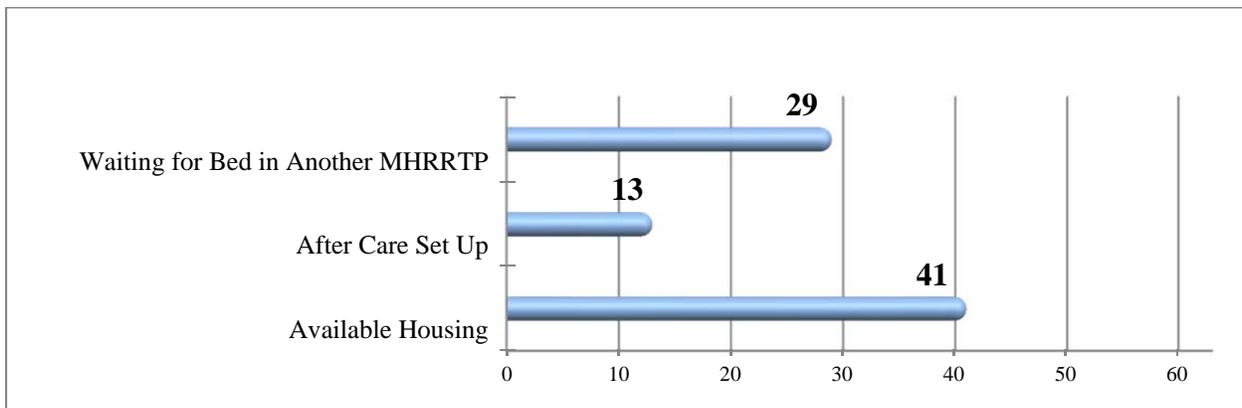
- Staffing issues, for example, staff on extended leave, difficulty recruiting for specialized positions, and timeliness in hiring
- Special medical needs, for example, coordination of opioid replacement, dialysis, and other accommodations to meet the individual medical needs
- Patient's preference date for admission, for example, patients want to wait until after college semester ends to start program and incarcerated patients accepted into program but awaiting release
- Construction issues
- Transportation to the residential program at time of admission and upon discharge
- Inability to locate patients who had been accepted for admission, for example homeless veterans

Nearly half of the program managers reported that staffing did affect timeliness of admission to their SA RRTPs/DOM SAPs in FY 2014. Managers stated that even with staffing shortages, they do the best they can to provide coverage in an effort to minimize the negative impact on patient care. Commonly stated staffing shortages include physicians, psychologists, nurses, social workers, and addiction therapists. A common remark was that the nature of the hiring process itself impedes the ability to fill vacancies timely.

3. Barriers That Delay Program Discharge

In addition, we asked about barriers that may delay program discharge since barriers to discharge decrease availability of program beds for additional or timely admissions. Over half the programs reported available housing and waiting for an available bed in another MH RRTP program were identified as being discharge barriers. Although delaying a patient’s discharge date due to non-substance use treatment related needs is considered veteran centric it can contribute to bed availability delays for another patient waiting for an admission date.

Figure 11: Barriers that Delay Program Discharge: The Number of Program Managers who Identified Each Component as a Barrier to Delay of Program Discharge



Source: VA OIG

Many of the program leaders expressed that they would benefit from more guidance from VHA around data collection and the utilization of data information regarding screening, admissions, and discharge. They also expressed that it would be helpful if all SA RRTP/DOM SA programs collected the same data.

D. VHA SA RRTP/DOM SA Wait Times

VHA completed an internal review on wait times and barriers to access for MH RRTPs. VHA’s review identified many of the same issues and trends that we identified in our structured interviews.

When a VA outpatient visit occurs, the VA clinic uses a three-digit stop code or six-digit Decision Support System identifier (that is, primary stop code with credit pair) to reflect the type of outpatient care and record workload. When a patient is admitted to an

MH RRTP program bed, programs have been asked to enter data into VHA's Bed Management System, software that interfaces with VHA's VistA⁵² system and is used for tracking patient movement, bed status and bed availability.

VHA mandates programs to use the 596 (RRTP Admission Screening) stop code so that VHA can objectively measure actual wait times (rather than self-reported) by calculating the time from use of the 596 stop code to the first day of the patient's participation in an MH RRTP as captured in the Bed Management System.

VHA internal data shows that during Quarter 1 of 2015, facilities had used the 596 stop code for 68 percent of patients admitted to MH RRTPs. Table 10 displays the total percentage of programs that used the mandated 596 stop code for the Quarter 1 of 2015 and the mean and median wait times (date of 596 stop code to date of admission) for SA RRTPs/DOM SAPs.

Table 10. The Percentage of Programs in Q3 and Q4 of 2014 that Used the 596 Stop code

MH RRTP Bed Segment Type ^{††}	Number of Days from Screening Date of First 596 Stop/ Credit to MH RRTP Admission Date [†]	Number of Days from Screening Date of First 596 Stop/ Credit to MH RRTP Admission Date [†]	MH RRTP Bed Segments matched with a 596
	Mean	Median-50 th Percentile	Percentage
SUD MH RRTP	37.2	14	68.4%

Source: NEPEC

National Wait Times for MH RRTP Admissions and by MH RRTP Bed Segment Type Q1 FY 2015^{†, ††, †††}

[†] CWT/TR bed segments excluded.

^{††} Q2 Q4 FY 2014 and Q1 FY 2015 596 Clinic and Credits Stops were included in this analysis.

^{†††} 596 stops that occurred more than 270 days out from the date of admission were dropped from the analysis.

The expectation is that all programs should use the 596 stop code. The wait time mean and median data therefore only represents data for the 56 percent of patients for whom programs were compliant with use of the 596 stop code. The other 32 percent of patients were in programs that were not compliant with the use of this stop code.

7. The Degree of Supervision of Patients in VHA SA RRTPs/DOM SAPs

We were asked to report on the degree of supervision of patients in SA RRTPs and DOM SAPs.

⁵² Veterans Health Information Systems and Technology Architecture (VistA) is used for documenting clinical care and other functions. VistA is an integrated electronic health record information technology system with approximately 200 application packages that share a common data store and internal services.

We obtained information at 33 sites visited including how patients and visitors are managed, management of Closed Circuit TV (CCTV), the completion of bed checks and rounds, management of emergencies, and program staffing. We spoke with program managers and staff and reviewed documentation.

The VHA MH RRTP Handbook states:⁵³

- Program managers are responsible for all clinical and administrative operations to ensure the safe, efficient, and effective provision of rehabilitation and treatment services. Program managers must develop written procedures for detecting contraband brought on the unit.
- Each program needs to secure all entrance and egress doors, and maintain a single point of access utilizing keyless entry and CCTV with recording capability. However, larger programs with multiple residential programming areas may provide more than one entrance and egress. The main entrance to the unit may be open during normal business hours, as long as adequate staff is present to ensure that only authorized patients, staff, and visitors access the unit.
- CCTV may not be installed in areas where treatment or other clinical activities are conducted or in private spaces, such as bedrooms and bathrooms.
- Program staff are to conduct bed checks twice daily, to occur in the morning and night to verify the physical presence of each resident. Additional checks may be warranted based on a patient's circumstances.
- Program staff are required to conduct and document rounds to ensure the safety and security of patients, staff, and visitors. These rounds are every 2 hours of all public spaces, such as hallways, dayrooms, group rooms, stairwells, and community bathrooms.
- The minimum core staffing for each unit/ wing/ floor in the program is six full-time employees to cover the 16 off-tour shifts required for 24-hour-per-day, 7-days-per-week (24/7) coverage. An employee must be physically present on the unit at all times that patients are present on the unit. Additional coverage staff is necessary for units on separate floors or in separate buildings. Coverage staff may be comprised of any combination of Rehabilitation Technicians, Health Technicians, Nurse Aides, Domiciliary Assistants, Peer Technicians, Licensed Practice Nurses, and Licensed Vocational Nurses.

A. *Supervision of Patients*

We reviewed if and how programs track patients in the program areas. At the 33 sites visited, we found all programs had some method to track patients:

- One site used a magnetic board.

⁵³ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

- Two sites tracked patients by attendance (at program activity) roster.
- Thirty sites used a paper sign in/out roster.

Additionally, 32 sites utilized a “pass” system to allow patients to leave program areas, generally for defined time periods such as 24 hours. Also, 14 sites provided patients electronic keys to access the program areas; however, none of the programs used the keys as a means to electronically track patients. Overall, program staff mentioned having a system-wide electronic tracking system, such as an electronic key with recording capacity, would be beneficial especially to eliminate paper-based documentation.

We also reviewed if and how patients were escorted or supervised by VA staff for both on-campus appointments and off-campus appointments. Programs did not generally escort patients to on-campus appointments unless there was an identified patient need. We found one site escorted patients to these appointments. For off-campus appointments, 15 sites provided escorts for appointments. Escorts were generally not provided for medical appointments, if the patient went by VA transportation, and if a family member or trusted individual (such as a clergy member) escorted the patient.

Overall, program staff emphasized escorts would be provided for patients’ on-campus and off-campus appointments, based on clinical assessment and individual patient need.

We also reviewed if and to what extent staff checked patients’ bags on return to program areas. At the 33 sites visited, 28 had staff check bags. We noted that there was no universal standard for how a bag is checked.

- One site checked bags brought in only from off-campus.
- Four sites completed random checks.
- Twenty-three sites checked all bags when patients return to the program areas.

At one site, staff did not check patient bags and instead relied on other patients to check bags. These patients were in the program 2 weeks and completed specific training before being assigned to checked patient bags.

Overall, program staff stated that when checking patient’s bags, it was a balance between safety and creating an environment of trust.

B. Supervision of Visitors

We reviewed if and to what extent facilities allowed visitors, individuals who are non-patients and non-VA employees, in the program areas. At the 33 sites visited, none allowed visitors in patient rooms and 24 allowed visitors to the program areas.

Facilities used various methods, either singularly or in conjunction, to identify and track visitors:

- Seven sites utilized visitor pass or badge.
- Nine sites escorted visitors.

- Eighteen sites utilized a sign-in roster.
- Twenty sites utilized designated visiting hours.
- Twenty-four sites utilized designated visiting areas.

The other nine sites did not allow visitors to the program areas, and some mentioned patients could meet visitors in other areas of the facility, such as the cafeteria.

We also reviewed if and to what extent facilities allowed visitors to bring bags into the program areas and found that 18 sites allowed visitors to bring bags. Of the 18 sites where visitor bags were allowed, staff at 14 sites checked bags. As with patient bags, there was no universal standard for how a bag is checked. Four sites checked bags if they appeared suspicious, while 10 sites routinely checked bags. Of the 14 sites that checked visitor bags, 2 sites used lockers/bins for visitors to store their bags. At one site, staff did not check visitor's bag and instead relied on patients to check bags. These patients were in the program 2 weeks and completed specific training before being assigned to checked visitor bags.

Additionally, one site did not allow visitor bags into the program areas and provided lockers/bins for the visitors to store their bags.

Overall, program staff stated, as with patient bags, it was a balance between creating a therapeutic environment and safety, when checking visitors' bags. Across programs, interviewed program staff were widely enthusiastic about adopting the use of lockers/bins to store visitors' bags to avoid potential introduction of contraband.

C. CCTV

At the 33 sites visited, we found that 31 sites had CCTV with recording capability, while 2 sites had CCTV, but no recording capability. The VHA MH RRTP Handbook has no requirement on how CCTV is to be monitored.⁵⁴ The management of the CCTV process varied from site to site—program staff did not continuously monitor CCTV at some sites; program staff continuously monitored CCTV at some sites; and VA police monitored the CCTV at other sites.

At the time of our site visits, 11 sites had some component of the CCTV system not operational, such as a nonfunctioning monitor or camera. While not a specific VHA MH RRTP Handbook requirement, nine sites documented a daily check of the CCTV to ensure it was operational. We also found that six sites had cameras in treatment areas, which is inconsistent with VHA MH RRTP Handbook requirements.

Overall, based on the site to site variation we observed, it appears unclear to programs if the intent of CCTV with recording capability is to be used for active clinical oversight of patients, security of the program's entrance and egress doors, or for law enforcement purposes.

⁵⁴ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

D. *Daily Bed Checks*

At the 33 sites visited, we found that 30 sites consistently documented completion of the required twice-daily bed checks. Overall, we found the documentation ranged from a simple numerical count to verify patients were physically present to documentation that included not only if the patient was physically present, but also the description of the patient's presentation and activities, such as sleeping or awake and reading. The VHA MH RRTP Handbook requires a physical check but does not mention documentation of patients' condition.⁵⁵ We believe documentation of patient condition could provide useful clinical information for program staff.

E. *2-Hour Rounds*

At the 33 sites visited, we requested documentation of the 2-hour rounds for 3 specific time periods, which included a holiday, weekend, and weekday, and also included day, evening, and night shifts. If the sites were unable to provide documentation, we did not provide credit for the check.

We found that 21 sites completed 2-hour rounds as required, while 12 sites missed or did not have full documentation (all 12 times for each of the 3 days reviewed) of the 2-hour rounds. Four of the 12 sites routinely shredded or destroyed documentation of the 2-hour rounds.

F. *Management of Emergencies*

For the 33 sites visited, all programs had a process to manage medical and behavioral health emergencies. We asked about the availability of specific equipment to treat medical emergencies and found that 11 sites had an emergency code cart⁵⁶ located in the program areas.

We also asked if the programs had a specific medication, naloxone,⁵⁷ to treat overdoses. We found that 13 sites had naloxone in the program areas. Staff reported this medication may be readily available outside the program areas, such as an adjacent clinical unit. Six sites reported having naloxone readily available in another area. The remaining 14 sites did not have naloxone on the unit.

We also asked to what extent programs were offering overdose education and overdose kits⁵⁸ to the patients. Twenty nine sites provided overdose education and 16 sites prescribed overdose kits to patients.

⁵⁵Ibid.

⁵⁶ Code cart, sometimes called a crash cart, typically contain emergency equipment and medication to use in case of a life-threatening occurrence.

⁵⁷ Used for the reversal of opioid overdose. Opioid is a type of medication used for pain relief, such as Oxycodone. An opioid is sometimes called a narcotic.

⁵⁸ Generally contain naloxone for the reversal of an opioid (narcotic) overdose.

G. 24/7 Core Staffing

We requested the employee work schedule for the week prior to the onsite visit. Of the 33 sites visited, we report on 1 site for the staffing component of this review separately due to special circumstances. We found that 30 sites had the minimal 24/7 core employees assigned to the unit, and 3 sites that did not; managers stated they were trying to obtain additional staff. Overall, program managers reported utilizing float staff, overtime, and having part-time staff work additional hours to maintain 24/7 coverage.

We looked at the schedule to verify if there was staff for each shift (day, evening, and night) for each unit and found that 32 sites had assigned staff for each shift and unit. The one site on which we report separately has a main patient building and then separate townhomes where patients live and sleep. These townhomes do not have staff in each separate building, and instead, the program relied on CCTV with continuous staff monitoring. This practice does not follow the VHA MH RRTP Handbook requirements.⁵⁹ However, we found there was no formal, documented waiver process for VHA MH RRTP Handbook requirements.

8. Frequency of Drug Testing in VHA MH RRTP Programs

We were asked to report on how often drug tests are performed for patients in VHA residential substance use programs.

We spoke with program managers and staff at the 33 sites visited for onsite inspections to determine if and to what extent patient drug tests were being performed. Additionally, we reviewed a statistical sample of 100 EHRs of patients who were admitted to the programs during the first week of fiscal year 2015.

A. VHA MH RRTP Handbook Requirements

The VHA MH RRTP Handbook⁶⁰ outlines that patients are prohibited from using or possessing alcohol and non-prescribed drugs while residing in the MH RRTP program. To ensure a substance-free environment, patients must agree to alcohol and drug screenings. Abstinence monitoring needs to occur at least weekly in early treatment with frequency modified based on indications of relapse risk and should include testing for abuse and diversion of prescribed controlled medications. Patients are to be randomly tested upon return from passes.

⁵⁹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

⁶⁰Ibid.

B. Onsite Visits

At the 33 sites visited, all programs reported having a drug screening process and completing tests at least weekly. All programs utilized urine drug screens (UDS); 31 utilized breathalyzers.⁶¹

For testing after off-campus passes, one site reported not using off-campus passes. Of the 32 other sites, 27 sites screened patients after return from every pass, and 5 sites randomly screened patients upon return from pass.

Some sites also performed other methods of drug testing, to include Ethyl Glucuronide (EtG)⁶², Blood Alcohol Concentration⁶³, and iCup in various panels.⁶⁴ Additionally, some sites reported testing for steroids and synthetic marijuana.

Overall, the main drug testing methods utilized in the programs were the UDS and breathalyzer.

C. EHR Review

We determined the number of UDS that was performed on patients in our patient cohort sample. To adjust for patient LOS, we looked at the ratio of the LOS in days divided by the number of UDS. A ratio value of 7 would indicate that the patient had been tested once per week, and lower ratio values would indicate more frequent screening. We had one patient who has still not been discharged from the program and included the patient in these calculations using the total number of UDS and days in program to date as the basis of our calculation.

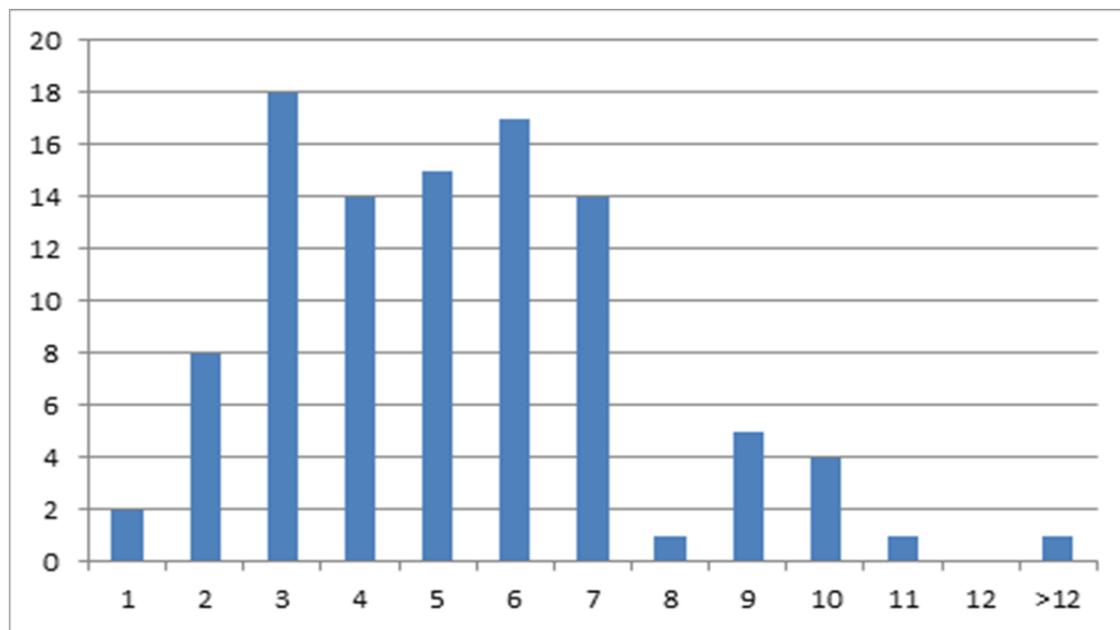
We found that the mean number of the LOS-to-UDS ratio was 5.0. Eighty-eight percent of patients in our sample averaged at least one UDS per week, while 40 percent averaged two UDS per week. The patient with the least amount of testing had been in a program for 36 days and had only 1 urine drug screen.

⁶¹ A device for estimating blood alcohol content from a breath sample.

⁶² EtG is a direct metabolite of alcohol.

⁶³ Testing for the percent of alcohol in a person's blood stream.

⁶⁴ A rapid, one step screening test for the simultaneous, qualitative detection of multiple drugs and drug metabolites in human urine.

Figure 12. Distribution of LOS-to-UDS in Patient Cohort

Source: VAOIG

Overall, with the exception of a few outliers, we found that the frequency of UDS from our record review was consistent with the processes and frequency reported during our onsite reviews.

9. Integration of Mental Health and Substance Use Treatment

We were asked to report on how well mental health and substance abuse treatment are integrated for veterans with comorbidities in VA substance use inpatient rehabilitation programs.

To assess how well treatment for comorbid conditions is integrated, we reviewed the EHRs of a statistical sample of patients admitted to VA SA RRTP/DOM SAP during the first week of FY 2015. We ascertained:

- Whether patients were assessed for comorbid mental health conditions early in admission.
- Whether patients had comorbid mental health diagnoses.
- Were seen by a psychiatrist or psychiatric nurse practitioner during participation in the program.
- Had group therapy encounters related to mental health comorbidity.
- Whether during participation in the SA RRTP/DOM SA program, patients had an individual treatment plan (ITP) with problems, treatment objectives, and goals; whether assessment and treatment of mental health comorbidities was addressed in the ITP; whether the ITP contained measurable objectives regarding assessment and treatment of mental health conditions; and whether

the ITP contained measureable objectives regarding assessment and treatment of substance use related diagnoses.

- Whether patients were offered addiction focused pharmacotherapy. For example, naltrexone which in some patients helps decrease cravings for opiates.
- Whether peer recovery groups or supports were incorporated into programming.
- If a patient had comorbid mental health diagnoses, documentation of post-discharge aftercare arrangements.

A. Assessment for Comorbid Mental Health Conditions Early in Admission

We found that for 97 percent (95% CI: 91.0 – 99.1) of the records reviewed, an assessment for comorbid mental health conditions was documented early in admission.

B. Presence of Comorbid Mental Health Diagnoses

Seventy-eight percent (95% CI: 68.7 – 85.2) of the patients had comorbid mental health diagnoses. The remaining 22 percent (95% CI: 14.8 – 31.3) had substance use diagnoses only or a remote history of a non-active mental health diagnosis.

C. Seen by a Psychiatrist or Psychiatric Nurse Practitioner While in the Program

Ninety percent (95% CI: 82.2–94.6) of patients were seen by a psychiatrist or psychiatric nurse practitioner during their participation in the SA RRTP/DOM SA program. Being seen by a psychiatrist or psychiatric nurse practitioner appeared common.

D. Group Therapy Addressing Mental Health Comorbidity

We found across the system, that during their participation in SA RRTP/DOM SA programs, patients are provided substance use focused, recovery based, relapse prevention, and skills based groups. Examples of skills based groups include mindfulness, stress tolerance, emotional regulation, and groups focusing on interpersonal effectiveness. Skills based groups are applicable and used as part of the treatment for a wide range of mental health conditions in addition to substance use. We found that skills based groups were almost always provided as part of patients' programming.

In addition to skills based groups, qualitatively we also looked for evidence of specialized groups focused specifically on comorbid mental health and substance use, for example, co-morbid illness group and Seeking Safety. Alternatively, we looked to see if non-substance use, mental health focused groups had been incorporated into programming provided to patients.

Seeking Safety is an example of a specialized group focused on integrated care. It is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for use in group or individual therapy and for use in a

variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation.⁶⁵

From the EHRs reviewed, it appeared that few patients with active co-morbid diagnoses were offered specialized groups specifically focused on either integrated treatment of mental health and substance use diagnoses or focused on mental health diagnoses, like depression or PTSD. Whether patients participated in these types of groups initially depended on their having a co-morbid diagnosis requiring treatment. For those with a co-morbid diagnosis, the availability of programming and the provision of specialized integrated groups seemed most related to the SA RRTP/DOM SAP to which they were admitted rather than the patient's individual clinical presentation. In other words, it appeared that some programs incorporate specialized groups focusing on integrated treatment of co-morbid conditions and substance use, while many facilities defer specialized group therapy for other mental health conditions to sequential participation in either another MH RRTP (such as a PRRP-a PTSD focused MH RRTP) for after completion of treatment in the SA RRTP/DOM SA program or to treatment in the outpatient clinic following discharge.

E. Individualized Treatment Planning

The VHA MH RRTP Handbook states, “an individualized rehabilitation or treatment plan must include specific goals, measurable objectives, targeted dates for completion, and a designated responsible individual for addressing each goal. This planning process is done in each MH RRTP by an interdisciplinary team of staff with the Veteran a full partner in the process.” The patient's interdisciplinary team conducts periodic reviews throughout the Veteran's stay.⁶⁶

We assessed whether patient EHRs contained documentation consistent with an individualized treatment plan including problems, treatment goals, and objectives during the time frame of patient participation in the SA RRTP/DOM SAP program. We found documentation of an ITP in 83 of 100 patient records. Six of these 17 patients without documentation of an ITP left either against medical advice or via irregular discharge (asked to leave by program) within a few business days after admission. Reasons included refusal to stop using substances while in the program, not returning from pass, initiating a physical altercation with another patient, among others. When adjusted for these patients, 88.3 (95% CI: 79.9–93.5) percent of patients had a documented ITP. Since an average SA RRTP/DOM SAP stay is typically 4 or more weeks in length, after adjusting for against medical advice and irregular discharges, we expected to see an ITP in 100 percent of the relevant EHRs reviewed.

We then evaluated whether patients' active comorbid mental health diagnoses were addressed in the ITP. Qualitatively, inclusion of these elements in the ITP was highly variable and when included, objectives were often vague.

⁶⁵ Seeking Safety. SAMSHA's National Registry of Evidence-based Programs and Practices Web site. <http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139>. Last updated 1/28/2014. Accessed on June 11, 2015.

⁶⁶ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

While ITPs essentially addressed patients' substance use related issues, the comprehensiveness of ITPs was highly variable, especially in terms of the inclusion of measureable goals and objectives as opposed to vague goals, for example, "will participate in SA RRTP program."

F. Addiction Focused Pharmacotherapy

For some patients with chronic opioid dependence, treatment with an opioid agonist such as methadone or buprenorphine/naloxone, may be indicated.

Naltrexone is an alternative to opioid agonist treatment for opioid dependent patients who are highly motivated and have psychosocial support. Naltrexone blocks the effects of opiates. In some studies it has shown to decrease cravings/desire to take opiates or drink alcohol.

For some patients with alcohol dependence, the medications naltrexone, disulfiram, or acamprosate may reduce the amount of drinking, risk of relapse, number of days drinking, or cravings as an adjunct to addiction focused counseling. For other patients, these medications may not be indicated or may not be effective.⁶⁷ A few studies have indicated benefit for some patients with the use of the anticonvulsant topiramate to reduce heavy drinking and relapse.

If patients were dependent on alcohol or opiates, we looked to see if there was consideration or discussion in the progress notes regarding indication or not for possible use of adjunctive addiction focused pharmacotherapy. We found documentation in the EHRs for 29 percent (95% CI: 20.8–39.2) of patients with alcohol and/or opiate dependence. For some patients, these medications were offered shortly before discharge rather than earlier in the program.

G. Peer Recovery Groups or Support Services

Peer support is assistance provided by a person who shares commonalities with the patient population. "Peer support is an intervention that leverages shared experience to foster trust, decrease stigma and create a sustainable forum for seeking help and sharing information about support services and positive coping strategies."⁶⁸ In a formalized peer-to-peer setting, the peer providing support has received some training and has access to more intensive support services. VHA employs peer support technicians.

We found documentation indicating incorporation of peer support groups or services in 65 percent (95% CI: 55.0–73.8) of the EHRs reviewed.

⁶⁷ Department of Veterans Affairs & Department of Defense (2008). *VA/DoD Clinical Practice Guideline for Substance Use Disorder*. (Version 2.0 – 2009) Washington, DC: The Management of SUD Working Group, The Office of Quality and Performance, VA & Quality Management Directorate, United States Army MEDCOM. http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp Accessed on June 17, 2015.

⁶⁸ Defense Centers of Excellence for Psychology and Traumatic Brain Injury, *Best Practices Identified for Peer Support Programs*, January 2011.

H. *Documentation of Post-Discharge Aftercare Arrangements for Mental Health Conditions*

We reviewed whether patients with co-morbid mental health diagnoses had appointments scheduled at the time of discharge. The analysis was complicated by the presence of several (19) irregular discharges (for example, patients leaving AMA, not returning from pass, or being asked to leave program for repeatedly not agreeing to abstain from substance use while in program) among the EHRs reviewed. For these patients, aftercare cannot always be arranged contemporaneously, depending on the circumstance surrounding the irregular discharge.

Qualitatively we observed that among the records for patients who were not irregularly discharged, comorbid mental health aftercare appointments were seldom documented in discharge related progress notes. In some instances, despite the lack of documentation in discharge related progress notes, we found a subsequent progress note for a visit in the outpatient mental health clinic shortly following discharge. On the other hand, we almost always found progress notes indicative of aftercare or aftercare arrangements for substance use related issues shortly following discharge.

Conclusions

VHA SA RRTPs and DOM SAPs play an integral role in providing residential substance use services along the continuum of VHA substance use treatment.

In this report, we review residential substance use treatment program elements requested in the Omnibus legislation. Moving forward, optimizing data collection and evidence-driven program evaluation would enhance VHA efforts for program refinement.

Successful treatment outcomes can be defined in a number of ways. Many outcomes measures focus specifically on the quantity and frequency of substance use during a predefined period of time following discharge from alcohol or substance use treatment. However, other measures of life functioning can provide a more complete picture of treatment success. These measures include quality of life, level of functioning in one's career or job, level of involvement with the legal system, and the extent to which a person requires medical care or hospitalization for medical problems associated with alcohol or drug use.

Outcomes used by other entities might include rate of successful completion of treatment program, measures of change in actual substance use, periods of patient abstinence and relapse measured by biological monitoring in-treatment and after discharge, coordination with primary care clinicians, substance use related illness, and substance use related accidents.⁶⁹

⁶⁹ *Creating a New Standard for Addiction Treatment Outcomes*, A Report from the Institute for Behavior and Health, Inc. Rockville, MD. August 2014.

In for-profit, private non-profit, and government health care sectors, collecting and analyzing data for substance use treatment outcomes, can be challenging and time consuming and entails opportunity costs. For this reason, such efforts are typically sparse in private and non-profit sectors. VHA presently collects limited data regarding post-discharge outcomes. Such efforts to ascertain patient reported outcomes may require utilization of clinical informatics.

Moving forward, VHA MH RRTP leadership might consider the cost-benefit tradeoff of incorporating additional quality and outcomes measures for the purposes of program evaluation, best practice development, and process improvement.

The availability of robust screening, process, and outcomes data would allow for standardization of program refinement initiatives, meaningful data sharing to drive collaborative learning among VHA residential substance use treatment programs and with external government and private substance use treatment entities.

Substance use issues, are complex, frequently recurring, and often involve other comorbid mental health and physical conditions. Patient assessment and outcomes measurement in the setting of substance use and mental health issues presents significant challenges beyond those already present with objectively defined measures such as physical parameters, and biological markers. The episodic nature of substance use disorders highlights the significance of systematically accumulating shared clinical information over time and across the continuum of care, as well as the importance of collaborative initiatives to facilitate innovative residential substance use treatment.

Recommendations

Recommendation 1: We recommended that Mental Health Services liaison with internal and external entities regarding standardized data collection from screening processes to core outcome measures to improve program monitoring and by which Mental Health Services can develop collaborative treatment initiatives.

Recommendation 2: We recommended that Mental Health Services ensure system-wide use of the 596 stop code.

Recommendation 3: We recommended that Mental Health Services review the consistency of current processes and provides specific guidance on reducing inflow of contraband into residential substance use treatment programs.

Recommendation 4: We recommended that Mental Health Services consider requiring programs to document patients' physical status in addition to presence when completing physical bed checks.

Recommendation 5: We recommended that Mental Health Services clarify the intent of the requirement for and use of closed circuit television with respect to residential substance use programs.

Recommendation 6: We recommended that Mental Health Services review and evaluate whether reversal agents such as naloxone are readily available at each residential substance use treatment program.

Recommendation 7: We recommended that Mental Health Services encourage more widespread incorporation of programming with a specialized focus on mental health comorbidities.

Recommendation 8: We recommended that Mental Health Services encourage discussion of addiction focused pharmacotherapy with residential substance use treatment program patients.

Recommendation 9: We recommended that Mental Health Services ensure that active mental health comorbidities are addressed in residential substance use rehabilitation treatment program interdisciplinary treatment plans.

Recommendation 10: We recommended that Mental Health Services ensure documentation of post-discharge aftercare appointment arrangements for mental health comorbidities.

VHA Substance Abuse Residential Rehabilitation Treatment Programs

VISN	Station Code	Station Name	Bed Type	# of Operational Beds 4th Quarter FY14 (NEPEC)
1	523	Boston	SA RRTP	20
1	523A5	Brockton	SA RRTP	24
1	405	White River Junction	SA RRTP	14
2	528A8	Albany	SA RRTP	12
2	528	Buffalo	SA RRTP	24
3	630A4	Brooklyn	DOM SAP	22
3	561	East Orange	SA RRTP	30
3	620	Montrose	DOM SAP	42
3	632	Northport	SA RRTP	30
4	529	Butler	DOM SAP	31
4	542	Coatesville	DOM SAP	79
4	646A4	Pittsburgh-Heinz	DOM SAP	15
4	693	Wilkes-Barre	SA RRTP	10
5	613	Martinsburg	DOM SAP	77
5	512A5	Perry Point	SA RRTP	34
6	637	Asheville	SA RRTP	18
6	590	Hampton	DOM SAP	80
6	652	Richmond	SA RRTP	16
6	658	Salem	SA RRTP	26
6	659	Salisbury	SA RRTP	35
7	557	Dublin	DOM SAP	30
7	679	Tuscaloosa	SA RRTP	21
8	516	Bay Pines	SA RRTP	20
8	573	Gainesville	SA RRTP	16
8	546	Miami	SA RRTP	24
8	675	Orlando	DOM SAP	10
9	596	Lexington	SA RRTP	15
9	603	Louisville	SA RRTP	16
9	614	Memphis	SA RRTP	16
10	539	Cincinnati	SA RRTP	17
10	541	Cleveland	DOM SAP	43
10	552	Dayton	DOM SAP	25
11	515	Battle Creek	SA RRTP	20

Appendix A

VISN	Station Code	Station Name	Bed Type	# of Operational Beds
11	610	Marion IN	SA RRTP	30
12	537	Chicago JB	SA RRTP	20
12	578	Hines	SA RRTP	25
12	607	Madison	SA RRTP	12
12	695	Milwaukee	DOM SAP	45
12	676	Tomah	SA RRTP	22
15	589	Kansas City	SA RRTP	28
15	657	St. Louis	SA RRTP	25
16	520	Biloxi	SA RRTP	20
16	586	Jackson	SA RRTP	15
17	549A4	Bonham	DOM SAP	104
17	549	Dallas	SA RRTP	40
17	671	San Antonio	DOM SAP	26
18	501	Albuquerque	SA RRTP	24
18	644	Phoenix	SA RRTP	24
18	678	Tucson	SA RRTP	16
19	660	Salt Lake City	SA RRTP	15
19	666	Sheridan	DOM SAP	23
20	663A4	American Lake	DOM SAP	24
20	531	Boise	SA RRTP	11
20	648	Portland	SA RRTP	10
20	653	Roseburg	DOM SAP	20
20	687	Walla Walla	SA RRTP	28
21	640	Palo Alto	SA RRTP	22
21	640	Palo Alto	DOM SAP	30
22	664	San Diego	SA RRTP	29
22	691	West LA	DOM SAP	62
23	636A6	Des Moines	DOM SAP	8
23	636A4	Grand Island	SA RRTP	18
23	636	Omaha	SA RRTP	14

(Data Source: National Program Evaluation Center - Quarterly Bed Report Q4 FY 2014 7/01/2014 through 9/30/2014)

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 23, 2015

From: Under Secretary for Health (10)

Subj: Healthcare Inspection—Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report, Healthcare Inspection, Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs.
2. I reviewed the draft report and concur with recommendations 1-10. Attached is the corrective action plan.
3. If you have any questions, please contact Karen M. Rasmussen, MD, Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov

(original signed by:)

David J. Shulkin, MD

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1: We recommended that Mental Health Services liaison with internal and external entities regarding standardized data collection from screening processes to core outcome measures to improve program monitoring and by which Mental Health Services can develop collaborative treatment initiatives.

Concur

Target date for completion: June 2016

VHA response: Mental Health Services will convene a workgroup that will include National, Veterans Integrated Service Networks (VISN), facility, and community stakeholders to review current program data collection approaches, develop recommendations for additional measures specific to evaluating program outcomes, and identify the necessary resources to implement a standardized data collection process that can be used to inform development of collaborative treatment initiatives.

To complete this action plan, VHA will submit documentation of:

- A copy of the workgroup findings and recommendations.

Recommendation 2: We recommended that Mental Health Services ensure system-wide use of the 596 stop code.

Concur

Target date for completion: March 2016

VHA response: On July 9, 2014, guidance was sent to the VISNs that specifically outlined requirements for use of the 596 stop code as specified in VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*. This guidance was followed by VISN level calls with all MH RRTP program managers including the Substance Use Disorder (SUD) RRTP managers to review requirements related to monitoring program access. Mental Health Services has established a quarterly report that monitors the percent of residential admissions with an associated 596 screening stop. This information is provided to the program managers and the VISN Mental Health Leads quarterly for awareness and follow-up. During Quarter 2 Fiscal Year (FY) 2015, 79 percent of all Veterans admitted to a MH RRTP had an associated 596 stop code; a 6 percent increase from Quarter 1 FY 2015.

Mental Health Services is working with senior leadership to provide additional guidance to the VISN related to access and wait times that will require development of a VISN

level MH RRTP Strategic Access Plan. VISNs will be required to document use of the 596 stop code by all residential programs. The benchmark for program compliance will be 85 percent of all admissions with a 596 stop code. For sites where concerns have been identified, the VISN plan will require a facility level strategic action plan to ensure compliance that will be monitored by the existing Office of Mental Health Operations (OMHO) Strategic Action Planning process.

To complete this action plan, VHA will submit documentation of:

- Copy of guidance (memorandum) distributed to the sites.
- A copy of the 596 stop code report for two quarters.

Recommendation 3: We recommended that the Mental Health Services review the consistency of current processes and provides specific guidance on reducing inflow of contraband into residential substance use treatment programs.

Concur

Target date for completion: March 2016

Facility response: VHA Handbook 1162.02 provides current guidance on required procedures to reduce the likelihood of contraband being introduced to the residential treatment units. Current guidance includes but is not limited to requirements for the use of secured and centralized access and egress from the unit, locks and alarms on all egress doors, use of closed circuit television (CCTV) to increase situational awareness, weekly health and welfare inspections for detecting contraband, checks for contraband at admission, random bag checks upon return from pass, and daily room checks. Mental Health Services will work in collaboration with VA Police Service and other key stakeholders to review current guidance and to make changes as appropriate.

The Bi-Annual Safety and Security Assessment (BASSA), currently completed by all MH RRTPs, includes specific questions about contraband detection. In order to review the consistency of current processes, the BASSA will be modified to include specific elements of contraband detection to allow Mental Health Services to assess the percent of programs currently implementing each element.

To complete this action plan, VHA will submit documentation of:

- Results of Quarter 1 FY 2016 BASSA.
- Stakeholder recommendations.

Recommendation 4: We recommended that Mental Health Services consider requiring programs to document patients' physical status in addition to presence when completing physical bed checks.

Concur

Target date for completion: December 2015

VHA response: Mental Health Services will review and consider the need for a program requirement of documenting a patients' physical status in addition to presence when completing physical bed checks. Physical status will be defined as location and current activity of the Veteran.

To complete this action plan, VHA will submit documentation of:

- Mental Health Services decision regarding the need for a new documentation requirement.

Recommendation 5: We recommended that Mental Health Services clarify the intent of the requirement for and use of closed circuit television with respect to residential substance use programs.

Concur

Target date for completion: December 2015

VHA response: The intent of CCTV is to improve the safety and security of the residential environment and extend situational awareness by staff of activities occurring on the unit. MH RRTP will develop guidance to clarify both the intent of CCTV and specific requirements for its use and present on the monthly National MHR RTP call.

To complete this action plan, VHA will submit documentation of:

- Copy of guidance presented on the National MHR RTP call.

Recommendation 6: We recommended that Mental Health Services review and evaluate whether reversal agents such as naloxone are readily available at each residential substance use treatment program.

Concur

Target date for completion: June 2016

VHA response: The MH RRTP section within Mental Health Services is committed to advocating for Opioid Overdose Prevention and Education Efforts and in November 2011 issued guidance requiring opioid overdose education for all Veterans admitted to the residential treatment programs with guidance included about the use of naloxone. Since that time, VHA has been a leader in implementing naloxone rescue kits to prevent opioid overdose death with 5600 kits dispensed system-wide to date. The residential treatment programs were among the early adopters of this life saving treatment. In October 2014, additional guidance was sent to the VISNs requiring all residential treatment programs ensure naloxone rescue kits be prescribed, as appropriate, to Veterans with opioid use disorders both during the residential stay and at discharge and that programs review current availability of naloxone on the unit for use by staff.

Mental Health Services will review and evaluate the current level of availability of naloxone on the MH RRTP units.

To complete this action plan, VHA will submit documentation of:

- Copy of the review.

Recommendation 7: We recommended that Mental Health Services encourage more widespread incorporation of programming with a specialized focus on mental health comorbidities.

Concur

Target date for completion: March 2016

VHA response: VHA Handbooks 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, and 1162.02 require provision of services for co-occurring mental health conditions concurrent with SUD treatment. VHA will review data from the MH RRTP Annual Review which identifies clinical services that programs self-identify having provided during the FY and will examine the level at which specialized clinical services for mental health comorbidities are being provided in the SUD RRTPs. VHA will modify the FY 2015 MH RRTP Annual Program Review to expand on existing efforts to monitor provision of clinical services for co-occurring conditions. Finally, VHA will set up a national call devoted to helping programs understand the need for addressing co-occurring mental health and substance use disorders concurrently during the residential stay.

To complete this action plan, VHA will submit documentation of:

- Agenda from National Call.
- Data from the FY 14 MH RRTP Annual Program Review

Recommendation 8: We recommended that Mental Health Services encourage discussion of addiction focused pharmacotherapy with residential substance use treatment program patients.

Concur

Target date for completion: June 2016

VHA response: VHA Handbook 1160.01 requires that appropriate addiction-focused pharmacotherapy be offered and available to all Veterans. The MH RRTP section of the Handbook establishes requirements for the field to provide appropriate addiction-focused pharmacotherapy for Veterans diagnosed with a SUD admitted to a MH RRTP. This requirement will be reinforced during an upcoming MH RRTP National Call. VHA will review current utilization of addiction-focused pharmacotherapy within the MH RRTPs to identify gaps in the service continuum and will develop

recommendations that ensure the availability and utilization of appropriate pharmacotherapy.

To complete this action plan, VHA will submit documentation of:

- Copy of agenda from National Call.
- Copy of review and recommendations from the above review by the National MHR RTP Section.

Recommendation 9: We recommended that Mental Health Services ensure that active mental health comorbidities are addressed in residential substance use rehabilitation treatment program interdisciplinary treatment plans.

Concur

Target date for completion: March 2016

VHA response: VHA will review MH RTP guidance with the SUD-RTP programs for the requirement that existing medical record review processes incorporate documentation of treatment plans for co-occurring mental health conditions during the residential stay. The requirement will be reviewed on the SUD-RTP Quarter 1, FY 2016 call. VHA will conduct a review over Quarter 1 and 2, FY 2016 of SUD-RTP treatment plans to ensure mental health comorbidities are addressed. For facilities that fall below an 80 percent compliance rate, an action plan will be required outlining steps to ensure conformance.

To complete this action plan, VHA will submit documentation of:

- Copy of guidance presented on the National MHR RTP call.
- Results of review.
- Examples of corrective action plans.

Recommendation 10: We recommended that Mental Health Services ensure documentation of post-discharge aftercare appointment arrangements for mental health comorbidities.

Concur

Target date for completion: December 2015

VHA response: Current policy requires that discharge summaries include documentation of all continuing care plans and pending appointments. Further, VHA Handbook 1160.01 establishes the requirement that all Veterans must be provided a mental health appointment within 7-days post discharge from residential treatment. Mental health appointments may include SUD specialty care. These requirements will be reiterated during an upcoming MH RTP National Call. VHA will monitor post-discharge continuing care appointments through the existing metric available within the Mental Health Information System (MHIS). Data is available to and shared with the VISNs and Medical Centers on program specific performance.

To complete this action plan, VHA will submit documentation of:

- Copy of agenda from National Call.
- Quarter 4 FY 2015 data from the MHIS on the post-discharge metric.

Office of Inspector General Contact and Staff Acknowledgments

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