MAHSO

MARKET AREA HEALTH SYSTEMS OPTIMIZATION

National Planning Strategy

Mental Health Residential Rehabilitation Treatment Programs

March 2021

Table of Contents

Executive Summary

The Department of Veterans Affairs (VA) Market Area Health Systems Optimization (MAHSO) effort developed 96 draft market assessments in the 18 VA Veteran Integrated Service Networks (VISNs) to produce opportunities for the design of high-performing integrated delivery networks. These market assessments were required by the VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018.

These market assessments will culminate with a National Realignment Strategy that will present Veterans Health Administration's (VHA's) plan for the future of VA health care, enabling Veterans to access the right high-quality care in the right location. Recommendations from the market assessments will be finalized and submitted by the Secretary of VA to the presidentially appointed Asset and Infrastructure Review (AIR) Commission for consideration. The AIR Commission will submit its recommendations to the President for review and approval, prior to them sending to Congress for review and approval.

This Mental Health Residential Rehabilitation Treatment Program (MH RRTP) National Planning Strategy establishes a consistent set of guidelines that will help to develop the opportunities that are specific to MH RRTP services. Using comprehensive VA data, the guidelines can facilitate improved alignment of MH RRTP capacity and capabilities with the evolving needs of Veterans.

The VHA Chief Strategy Office (CSO), committed to working with offices across the organization to create programs and services that best serve Veterans, developed the MH RRTP National Planning Strategy in consultation with the MH RRTP Section within the Office of Mental Health and Suicide Prevention.

MH RRTP Overview

MH RRTPs are part of the broader mental health continuum within VA, related to but distinct from VA acute inpatient mental health care and VA outpatient services such as outpatient substance use treatment. MH RRTP's mission is to "provide timely, state-of-the-art, high quality residential and treatment services for Veterans with mental health and substance use disorders that are often complex and co-occur with medical conditions and psychosocial needs such as low income, unemployment and homelessness." [1]

MH RRTP is an umbrella term that encompasses several programs including:

- General Domiciliary (GEN DOM)
- Domiciliary Substance Use Disorder (DOM SUD)
- Domiciliary Posttraumatic Stress Disorder (DOM PTSD)

- Domiciliary Care for Homeless Veterans (DCHV)
- Compensated Work Therapy – Transitional Residence (CWT-TR)

At the end of Fiscal Year (FY) 2020, there were 115 VA Medical Centers (VAMCs) with MH RRTP related programs and 7,742 total MH RRTP beds across VA. [2] In VA's 96 markets, 72 have at least one MH RRTP. MH RRTP demand is projected to decrease approximately 15.1% between 2017 and 2027, from 2,124,589 Bed Days of Care (BDOC) to 1,803,105 BDOC, though there are variations within program types. [3] The distribution of MH RRTPs across the nation varies in number of programs, beds, and mix of specialty programs. While all VISNs have at least one MH RRTP, there are gaps within certain areas.

Currently, program offerings differ by scope, scale, and geographic distribution, with some VISNs over-capacity and some under-capacity relative to future Veteran enrollee demand projections and identified concerns with timely access to residential treatment. The distribution and utilization of MH RRTP services needs to be optimized to maximize timely access to care for Veterans.

Resulting Planning Guidelines and Thresholds

Planning guidelines and thresholds inform products of the market assessment process. The rationale for establishing VA planning guidelines and thresholds are rooted in the belief that quality of care or patient safety may be compromised when a service falls below identified measures.

The key planning priorities that have guided the development of the planning guidelines and thresholds for MH RRTPs are to increase access, align capacity with projected demand, and ensure quality and performance across programs.

The MH RRTP National Planning Strategy developed quantitative and qualitative planning guidelines and thresholds across demand, supply, access, quality, and other applicable domains for each service type. Planning guidelines and thresholds for the five MH RRTPs are collectively designed to support access by ensuring the full continuum of program types in every VISN, balancing capacity with demand at the VISN and/or market level, and ensuring access within a 120-minute drive time of enrollee population centers.

A summary of the primary demand planning guidelines is as follows:

MH RRTP Planning Guidelines

Service	Primary Planning Guideline
Geography	Minimum of one of each program type per VISN. Additional programs may be added based on 120-minute drive time and/or demand criteria listed below.
GEN DOM, DOM SUD, DOM PTSD, and DCHV	• **Open**: Minimum projected FY 2027 VISN Average Daily Census (ADC) of 17.0 • **Maintain/Resize/Modernize/Replace**: Minimum projected FY 2027 ADC of 13.6 • **Relocate Program:** Projected FY 2027 ADC is <13.6 • **Partner (AA/Federal/CCN)**: Projected FY 2027 ADC is <13.6
CWT-TR	• **Open**: Minimum Projected FY 2027 VISN ADC of 8.5 • **Maintain/Resize/Modernize/Replace**: Minimum projected FY 2027 VISN ADC of 8.5 • **Relocate Program**: Projected FY 2027 ADC is <8.5

Future Program Planning

The four-step process for revisiting MAHSO draft opportunities describes how MH RRTP-specific market assessment opportunities will be reviewed and updated, if necessary:

1. Review Phase 1-3 market assessment data and MH RRTP opportunities
2. Apply MH RRTP planning guidelines
3. Update/Create MH RRTP opportunities
4. Review and finalize opportunities with VA Leadership

The National Planning Strategy guidelines and thresholds will be used to ensure that capital planning is matched to Veteran demand and a sound, consistent set of recommendations is established to inform the development of the National Realignment Strategy. The planning guidelines will also inform future quadrennial market assessments and other long-range planning exercises.

1. Program Overview

1.1 Program Mission

The Mental Health Residential Rehabilitation Treatment Program (MH RRTP) is a vital component of Veterans Affairs (VA) mental health continuum of care, sharing its broader mission to promote, protect, and restore the mental health and well-being of Veterans. Within this broader mandate, MH RRTP's specific mission is to "provide timely, state-of-the-art, high quality residential and treatment services for Veterans with mental health and substance use disorders that are often complex and co-occur with medical conditions and psychosocial needs such as low income, unemployment and homelessness." [1]

The vision of the program is to maximize timely Veteran access to high-quality MH RRTP services by ensuring every Veteran Integrated Service Network (VISN) has a full range of MH RRTPs that are ideally located, distributed, and sized to meet future demand where Veterans reside and that optimize staffing, sustainability, and cost effectiveness. [4]

The MH RRTP provides a comprehensive range of services addressing mental health, substance use, posttraumatic stress disorder (PTSD), homelessness, and unemployment that are not widely available in the private sector, leading to limited community options. However, geographic distribution of MH RRTPs is uneven across the nation, with some VISNs over-capacity and some under-capacity relative to future Veteran enrollee demand projections and identified concerns with timely access to residential treatment. The distribution and utilization of MH RRTP services needs to be optimized to maximize timely access to care for Veterans.

2. Current State Overview

2.1 Demographic and Programmatic Distribution Analysis

Background

VA's current MH RRTP traces its roots to the original Domiciliary Care program, the National Home for Disabled Volunteer Soldiers, which grew out of legislation in the late 1860's to provide housing for disabled soldiers following the Civil War. Once VA was established in 1932, the National Homes were converted to Domiciliary Care to provide services to economically disadvantaged Veterans. In 1995, Psychosocial Residential Rehabilitation Treatment Programs were developed to provide structure and support for rehabilitation for Veterans with behavioral health issues, including a variety of mental health, substance use, and psychosocial issues such as homelessness and unemployment. In 2005, Domiciliary Care programs were integrated with Psychosocial Residential Rehabilitation Treatment Programs under the Office of Mental Health and Suicide Prevention and in 2010 both programs were combined into a single system of residential care to become VA's MH RRTP. [5]

Mental Health Continuum of Care and Eligibility

While MH RRTPs are part of the broader mental health continuum within VA, they are distinct from VA acute inpatient mental health care, VA outpatient services, such as outpatient substance use treatment, and VA extended care, such as Community Living Centers. MH RRTPs provide comprehensive supervised treatment and therapeutic services to Veterans with mental health diagnoses that often co-occur with existing psychosocial stressors and medical concerns. According to Veterans Health Administration (VHA) Directive 1162.02, to be eligible for admission to MH RRTPs, Veterans seeking recovery must: [5]

- "Be assessed as not meeting criteria for acute inpatient mental health or medical admission;
- "Be assessed as requiring a level of care higher than outpatient care, or outpatient care is not available or accessible;
- "Be assessed as having identified mental health, addiction, psychosocial, or medical rehabilitation and treatment needs requiring the services, structure, and support of a mental health residential treatment environment;
- "Be assessed as not an imminent risk of harm to self or others;
- "Be capable of self-preservation (ability to protect one's self from harm) and basic self-care (able to independently complete activities of daily living such as bathing, dressing without assistance, take medications, etc.)"; and
- For Domiciliary Care for Homeless Veterans (DCHV) programs, "the Veteran must also be homeless or at risk for homelessness or lacking a stable lifestyle or

living arrangement that is conducive to the Veteran's goal of recovery. ***NOTE****: This should be a consideration, but is not a requirement, for other bed sections*."

The eligibility criteria that apply to Compensated Work Therapy – Transitional Residence (CWT-TR) admission includes: [5]

- The process must be coordinated between the CWT and the CWT-TR programs, as these services "must be integrated to meet the Veteran's employment and rehabilitation needs";
- "Veterans must be engaged in CWT services, including but not limited to vocational assistance, transitional employment, or supported employment"; and
- "Veterans must be assessed as independent under the MH RRTP Safe Medication Management Program" where Veterans are "able to learn and practice safe management of their medication regimens in order to achieve independent medication administration."

Additionally, authority and eligibility for MH RRTP services are governed by Federal statute and regulation (Title 38 United States Code (U.S.C.) 1710, 2032, 8110 [6]; Title 28 Code of Federal Regulations (C.F.R.) 17.46, 17.47, 17.48). [7] Efforts are currently in progress to align VA's Domiciliary Care authority and regulations to meet the needs of today's Veterans requiring intensive, time-limited residential treatment for mental health and substance use disorders often co-occurring with medical and psychosocial needs such as homelessness and unemployment. Specifically, 38 U.S.C. § 1710(b) currently establishes an income limitation that requires higher level of approval for Veterans who exceed this minimum income level. [6] Further, 38 U.S.C § 2043(a) establishes a limit on the number of homeless domiciliary programs that can be established, limiting the flexibility that VA has to align resources in areas where Veterans may require access to DCHV. [8] Legislative proposals to address both concerns were submitted as part of the Fiscal Year (FY) 2022 VA Budget.

MH RRTP Services and Specialties

As outlined in VHA Directive 1162.02, MH RRTP is an umbrella term that describes the range of programs that encompass mental health residential treatment in VA. MH RRTPs provide "a 24/7 structured and supportive residential environment as part of the rehabilitative treatment regime" utilizing both professional and peer supports. [9] The following programs are currently designated as MH RRTPs: General Domiciliary (GEN DOM), Domiciliary Substance Use Disorder (DOM SUD) programs, Domiciliary Posttraumatic Stress Disorder (DOM PTSD) programs, DCHV programs, and CWT-TR programs. [4]

- **GEN DOMs** consist of general programs that may include specialized tracks for Veterans with mental health and substance use disorders and other psychosocial needs, such as homelessness and unemployment. Specialty programs to treat serious mental illness (SMI) fall within the GEN DOM bed section.

- **DOM SUD** programs provide a residential level of care tor Veterans with SUDs. To be admitted, Veterans must not be at risk for severe withdrawal or require inpatient medical management for treatment of withdrawal.
- **DOM PTSD** programs provide a residential level of care to Veterans with PTSD and include programs to treat Veterans who have experienced Military Sexual Trauma (MST).
- **DCHV** programs provide a time-limited residential level of care to homeless Veterans with social-vocational and health care deficits. Homeless Veterans may also be treated in GEN DOMs or specialized programs as needed.
- **CWT-TR** programs are not targeted to any specific mental health population. They provide TR services and offer therapeutic work-based residential rehabilitation services that are designed to facilitate successful community integration.

MH RRTP services must have the capability to provide equivalent services to women Veterans and provide an environment that maintains women Veterans' safety and privacy. Additionally, MH RRTPs must have the capability to treat all Veterans who have been diagnosed with a Serious Mental Illness (SMI). [5] Each VA Medical Center (VAMC) must provide MH RRTP services either locally through the VAMC, on a regional basis through agreements with other VA facilities, or through the community care network.

Demographics and Disease Prevalence

Mental illnesses—particularly PTSD, SUD, depression, and anxiety—are disproportionately high among Veterans [10]; therefore, timely access to high-quality mental health services is a top priority of VA. In 2019, 3.9 million Veterans had a mental health condition and/or SUD. [11] Mental health conditions may be influenced by a range of factors including, race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location. Social determinants of health such as "interpersonal, family, and community dynamics, housing quality, social support, employment opportunities, and work and school conditions" may also affect risk for developing a mental health concern and/or outcomes associated with mental health conditions. [12] Below are descriptions of disorder prevalence and demographics specific to the Veteran population.

- ***SUD:*** In 2019, 1.9 million Veterans had been diagnosed with a SUD. [11] The National Institute of Drug Abuse reported that SUDs among Veterans are linked to exposure to combat and that 25.0% of Veterans returning from Afghanistan and Iraq showed signs of a SUD. [13] Additionally, the opioid epidemic has affected Veterans. Opioid misuse is defined as heroin or prescription pain reliever misuse. In 2019, 595,000 Veterans (2.9% of the total population) were reported with opioid misuse. [11]

- ***PTSD:*** Major drivers of combat-related PTSD among Veterans include the combat situation itself as well as the political situation surrounding the war, location, and nature of the enemy. VA reports prevalence rates of PTSD among Veterans that vary by service era. In a given year, 11.0% to 20.0% of Iraqi Freedom and Enduring Freedom Veterans and 12.0% of Gulf War Veterans experienced PTSD. [14] Further, data suggest Vietnam Veterans have a 30.0% lifetime prevalence of PTSD. [14]
- ***MST:*** National data indicates that when screened by a VA provider, 33.0% of women Veterans and 2.0% of male Veterans responded "yes" that they experienced MST. [15] It is important to note that the total number of male Veterans with MST is higher than that of women Veterans due to disproportionate numbers of male Veterans (~90.0%) and women Veterans (~10.0%). [16] According to the National Academy of Medicine, women Veterans with a history of MST are nine times more predisposed to develop PTSD compared to women Veterans who had no history of sexual trauma. [17] Similarly, male Veterans who screened positive for MST were more predisposed to develop PTSD (52.5%) versus male Veterans that had no history of MST (31.8%). [18] Veterans who have experienced MST may also be diagnosed with PTSD, SUD, and depression and other mood disorders.
- ***Homelessness:*** As of January 2017, on any given day, an estimated 40,056 Veterans experienced homelessness in America. [19] Two-thirds of those homeless Veterans were staying in shelters or transitional housing programs, while the other one-third were unsheltered. [19] While there are Veterans experiencing homelessness in every state, the states with the highest prevalence of Veteran homelessness are California and Florida. [19]

***Co-occurring Disorders*:** The challenges of mental illnesses, SUDs, PTSD, and homelessness often co-occur and require comprehensive, coordinated care. The 2019 National Survey of Substance Abuse Treatment Services census (field period March 2019- December 2019) reports that 73.0% of VA enrollees in treatment were diagnosed with co-occurring substance use and mental disorders. [20] 27.0% of Veterans in VA care diagnosed with PTSD also have a SUD. [21] "Almost 20.0% of Veterans returning from Iraq and Afghanistan suffer from PTSD, depression or traumatic brain injury which predisposes one to substance abuse." [22]

Fiscal Year 2019 Veteran Characteristics

The below data comes from the North East Program Evaluation Center (NEPEC). NEPEC conducts program evaluation and data analyses related to VA clinical programs. [23]

In FY 2019, most of the Veterans that received care across all MH RRTPs were white (65.8%), male (91.8%), and divorced/separated/widowed (49.1%). Of Veterans who

were discharged from a MH RRTP during FY 2019, the majority (89.8%) had a SUD diagnosis, 51.3% had a PTSD diagnosis, and 17.8% had a SMI diagnosis. Further, 74.6% of the Veterans had co-occurring disorders as evidenced by the presence of a SUD and an additional diagnosis of SMI, PTSD, depression, or personality or anxiety disorder. The high prevalence of co-occurring conditions among Veterans served by the MH RRTPs highlights the need for all MH RRTPs to provide comprehensive, Veteran-centered services able to address co-occurring conditions.

Programmatic Distribution Analysis

In VA's 96 markets, 72 have at least one MH RRTP. At the end of FY 2020, there were 115 VAMCs with MH RRTPs and 7,742 total MH RRTP beds across VA. [1] Table 1 summarizes key MH RRTP statistics by program at the national level:

Table 1: *Key MH RRTP Statistics*

Program	Number of Programs (Q4 FY 2020)	Number of Beds (Q4 FY 2020)	Combined Average Daily Census (Cumulative Occupancy) (Q4 FY 2019)	Average Bed Days of Care (FY 2019)
GEN DOM	53	2,499	1,844.5 (72.4%)	52.5
DOM PTSD	46	777	573.0 (74.9%)	47.3
DOM SUD	68	1,873	1,485.0 (81.8%)	32.3
DCHV	44	2,045	1,544.3 (74.8%)	81.4
CWT-TR	41	548	378.0 (70.8%)	110.9
Total	**252**	**7,742**	**5,835.0**	**49.3**

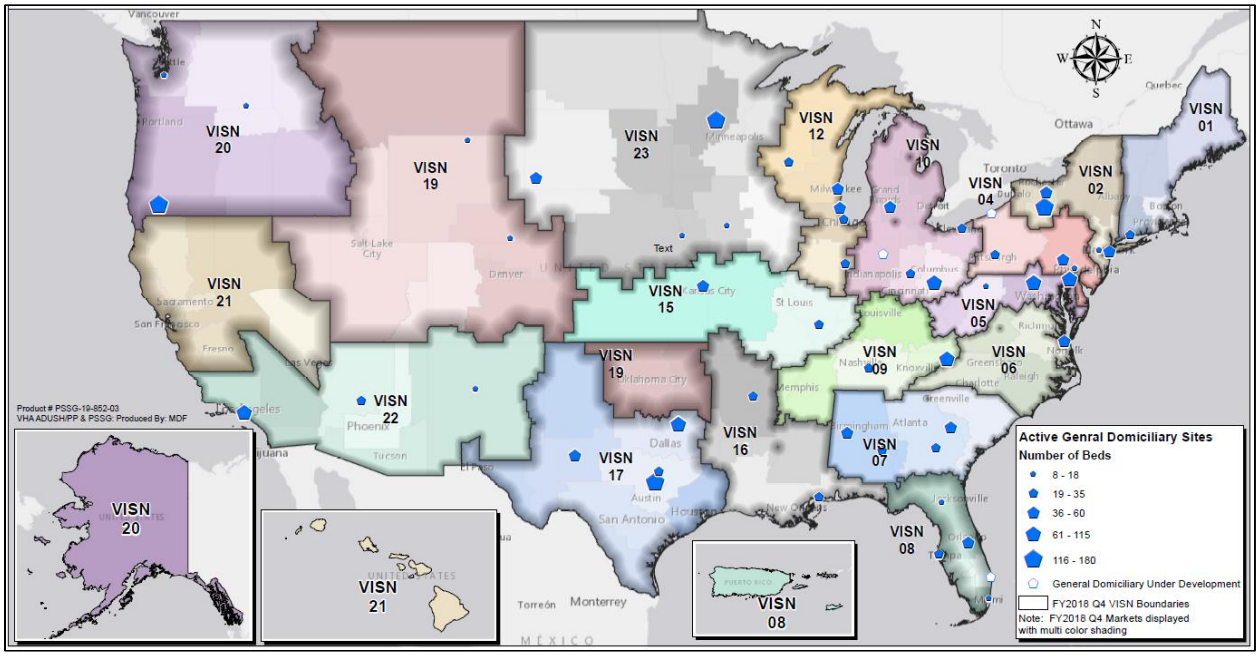
Source: MH RRTP FY 2020 Annual Program Review National Data Report Northeast Program Evaluation Center (NEPEC); Northeast Program Evaluation Center (NEPEC) FY 2019 'Closeout' Summary Workbook

Note: *Data for FY 2020 was significantly impacted by the pandemic and as such does not reflect the typical status of utilization of MH RRTP resources in VHA. Given that, FY 2019 data for ADC and ALOS are provided.*

As noted in Section 1 and illustrated in Figures 2-4 and Table 2, the distribution of MH RRTP services varies across the country: [1]

- **GEN DOM:** The greatest concentration of GEN DOMs is in the Eastern United States, particularly the Northeast and mid-Atlantic regions. Figure 1 illustrates the distribution of GEN DOM sites based on FY 2018 fourth quarter (Q4) data.

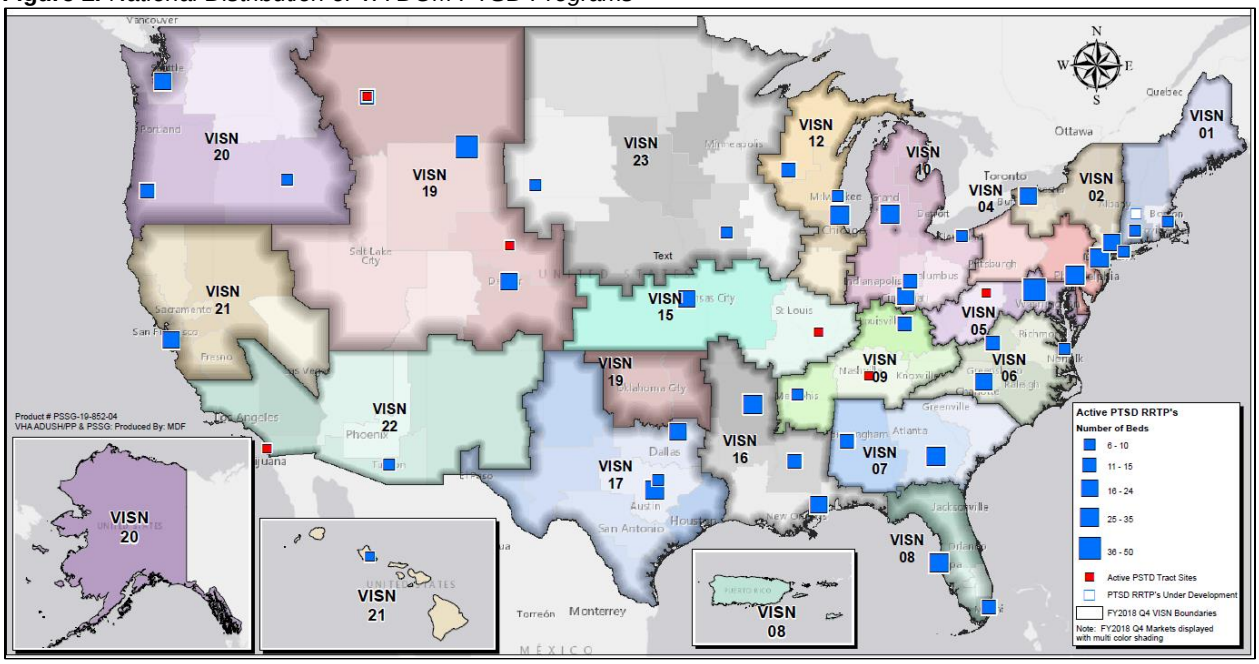
Figure 1: *National Distribution of VA GEN DOM Programs*



Source: Pre-Decisional Deliberative Document - Program Office National Report 2020

- **DOM PTSD:** DOM PTSD programs are geographically more distributed than GEN DOM programs, with large concentrations in the Eastern and Southern United States. Figure 2 illustrates the distribution of DOM PTSD sites based on FY 2018 Q4 data.

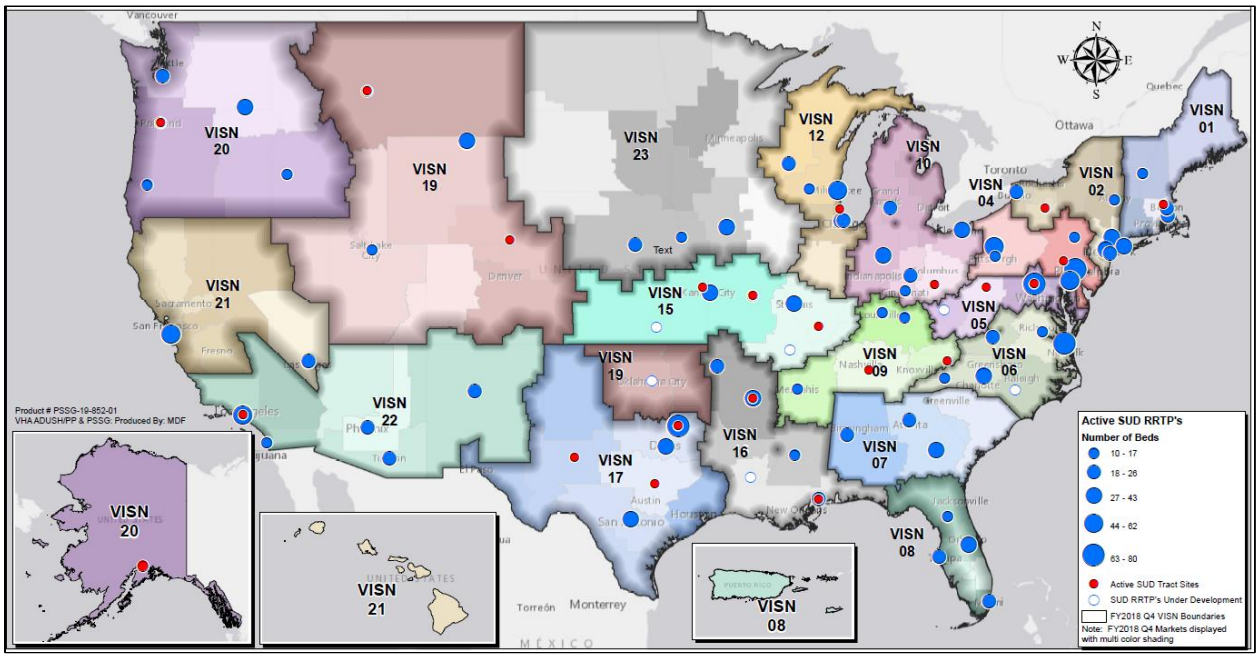
Figure 2*: National Distribution of VA DOM PTSD Programs*



Source: Pre-Decisional Deliberative Document - Program Office National Report FY 2020

- **DOM SUD:** DOM SUD programs have high concentrations in the Eastern, Midwestern, and Southern United States. There are fewer DOM SUD programs in the West. Figure 3 illustrates the distribution of DOM SUD sites based on FY 2018 Q4 data.

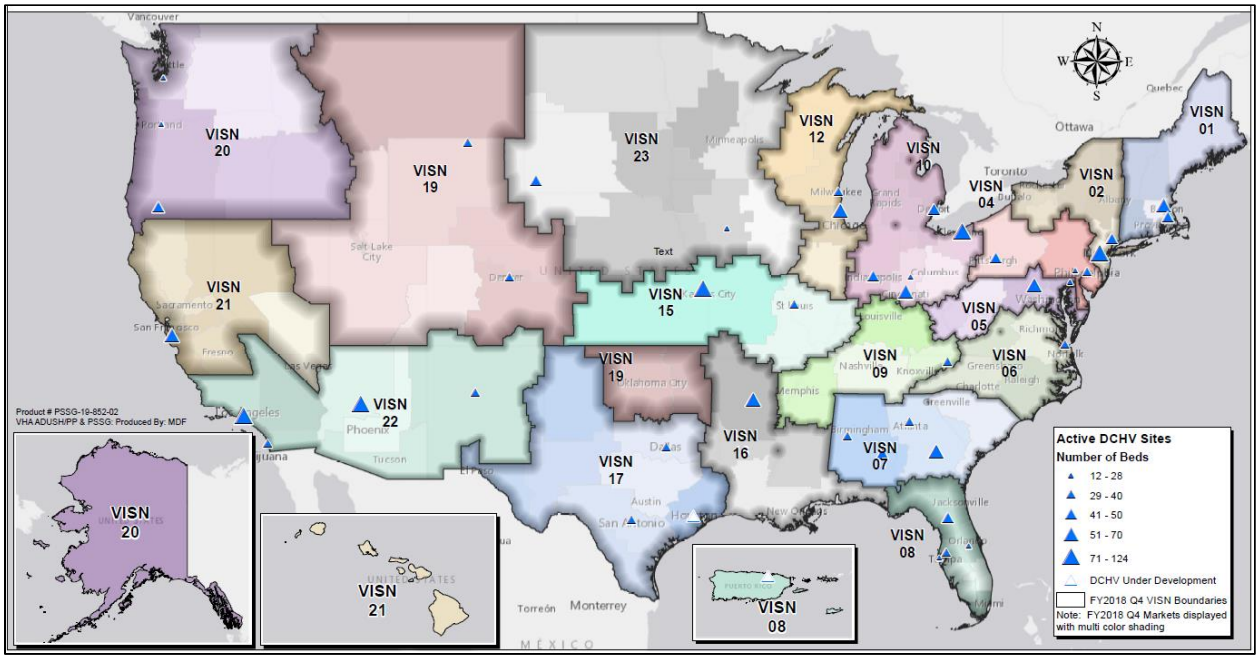
Figure *3:* *National Distribution of VA DOM SUD Programs*



Source: Pre-Decisional Deliberative Document - Program Office National Report FY 2020

- **DCHV*:*** DCHV programs are concentrated on the Eastern and Western United States with few programs between the coasts. Figure 4 shows the distribution of DCHV sites based on FY 2018 Q4 data.

Figure 4: *National Distribution of VA DCHV Programs*



Source: Pre-Decisional Deliberative Document - Program Office National Report FY 2020

- **CWT-TR:** CWT-TRs are concentrated on the east and west coasts with a few programs in the midwestern and southern parts of the U.S. A CWT-TR map is unavailable as it was not created for the original MH RRTP Program Office's report.

The distribution of MH RRTPs across the nation varies in number of programs, beds and mix of specialty programs. The number of beds within each specialty program is displayed in Table 2 by VISN based on the MH RRTP FY 2020 Annual Program Review National Data Report from NEPEC. While all VISNs have at least one MH RRTP, there are gaps within certain areas.

Table 2: *Number of RRTP Beds per Specialty Program by VISN (FY 2020)*

VISN	GEN DOM	DOM PTSD	DOM SUD	DCHV	CWT TR	End of Year Enrollees (FY 2018)
VISN 1	26	14	58	102	91	340,436
VISN 2	266	99	148	135	12	441,948
VISN 4	82	35	158	118	42	401,936
VISN 5	173	50	139	77	31	312,484

VISN	GEN DOM	DOM PTSD	DOM SUD	DCHV	CWT TR	End of Year Enrollees (FY 2018)
VISN 6	40	44	179	20	28	529,429
VISN 7	162	45	72	188	47	616,535
VISN 8	174	42	98	123	0	730,296
VISN 9	135	25	47	35	0	367,640
VISN 10	172	83	141	269	34	661,797
VISN 12	224	33	102	83	49	370,191
VISN 15	70	21	73	135	38	325,871
VISN 16	60	60	95	60	25	421,581
VISN 17	336	51	139	76	28	729,010
VISN 19	25	71	57	70	16	438,725
VISN 20	196	36	95	128	43	443,115
VISN 21	0	43	72	70	21	456,326
VISN 22	150	7	138	294	5	728,188
VISN 23	208	18	62	62	38	417,025
Total	**2,499**	**777**	**1,873**	**2,045**	**548**	**8,732,533**

Source: MH RRTP FY 2020 Annual Program Review Program & VISN Level Data Report Northeast Program Evaluation Center (NEPEC); 2019 Enrollee Health Care Projection Model (EHCPM)

These national patterns in bed distribution indicate the effect of factors such as resource availability, demographic differences, staffing, and approaches to treatment that differ across the nation regarding MH RRTP development.

2.2 Current VA Program Review and Analysis

Reliance

Based on the Base Year (BY)[1*] 2018 VA Reliance Dashboard, the reliance of the Veteran population on MH RRTP care provided by VA is projected to stay consistent, with over 99.0% current and projected VA reliance for GEN DOM, DOM PTSD, DOM SUD, DCHV, and CWT-TR. [23] At this point in time the VA Reliance Dashboard does not capture community care reliance for MH RRTP care given the historically low amount of care sent to the community. It is also difficult to assess how much MH RRTP care is sent into the community using existing methodologies. This high level of reliance is driven by comprehensive VA programs and the lack of available comparable residential treatment options delivered by community providers.

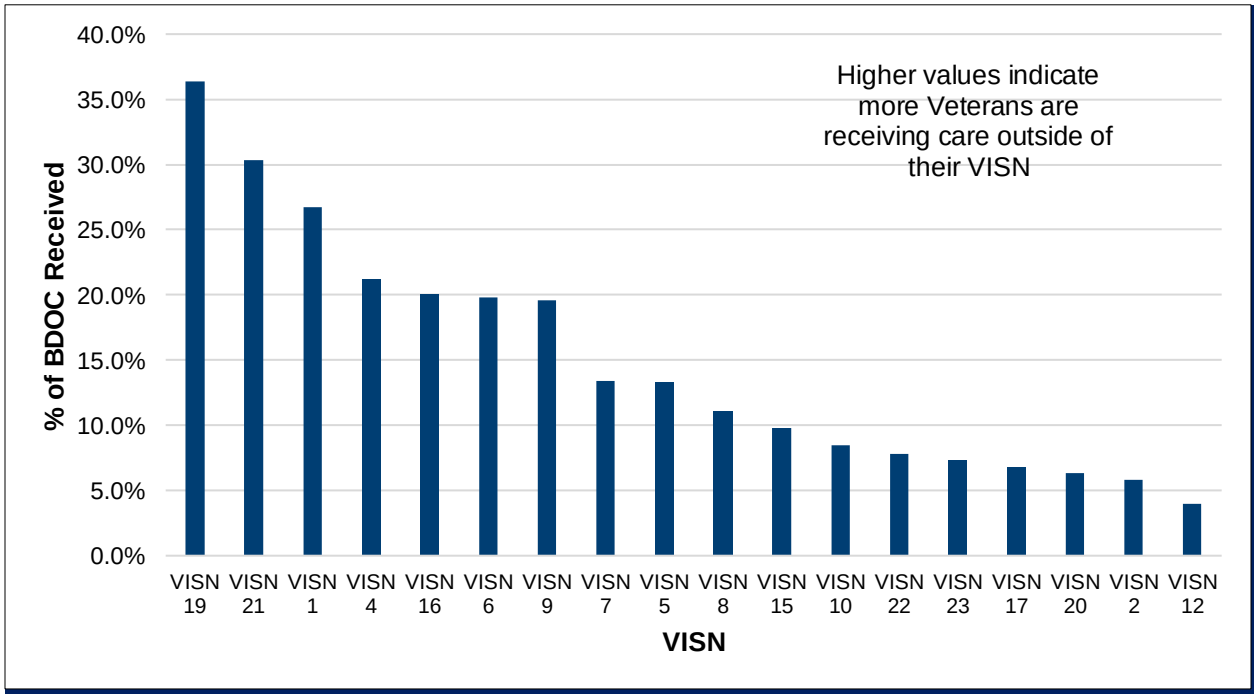
[*] The base year (BY) is the first (or index) year of a series of years in a projection model upon which the projection is based.

Geographic Utilization

Due to the distribution of MH RRTP facilities across the country, each VISN experiences different utilization patterns with how Veterans within VISN boundaries pursue MH RRTP care. Based on a MH RRTP facility's location in relation to a Veteran's residence, a Veteran may leave their VISN boundaries to seek MH RRTP care in another VISN. For example, over 20.0% of the MH RRTP BDOC within FY 2018 for Veterans living within VISN 1, VISN 4, VISN 19, and VISN 21 occurred in programs outside of the VISN's boundaries. [1] These utilization patterns suggest Veterans travel across VISN boundaries to access MH RRTP facilities and that MH RRTP facilities within their VISN are not ideally located.

Figure 5 provides an overview of the amount of MH RRTP care, measured in BDOC, that Veterans received in facilities located outside of their VISN of residence. The percentage of BDOC received by Veterans outside of their VISN ranged from 4.0% to 36.4%, indicating discrepancies in MH RRTP access within VISN boundaries. [1] Within VISN 1, VISN 19, and VISN 21 this may be due to the low number of programs available to serve a large geography as well as the geographic distribution of programs. These data indicate a need to better distribute MH RRTP services within and across VISNs to improve Veteran access.

Figure 5: *Percentage of BDOC: Veterans Receiving Care Outside of VISN of Residence (FY 2018)*



Source: Department of Veterans Affairs BY 2018 Mental Health Residential Rehab Morbidity Summary of Users and Utilization by Residence and Treatment Location

Staffing

MH RRTPs have specific staffing descriptions and requirements that can be referenced in VHA Directive 1162.02 Appendix B. [5] Each MH RRTP must have a written staffing plan based on national requirements outlined within VHA Directives as well as adjustments for scenarios that may require additional staff beyond the minimum core staffing levels. However, meeting staffing requirements can be a challenge, particularly in more rural settings.

At a minimum, MH RRTPs are required to have adequate staff to ensure safe operation of the program with an emphasis on an interdisciplinary team that includes mental health, nursing, social work/case management, medical, pharmacy, and peer support disciplines. Based on discussions with the MH RRTP Program Office, staff levels are based on a floor of 20 beds as staffing below these levels would not be adequate to provide necessary clinical care and ensure safe program operation. Each MH RRTP must align specialty staff based on the number of specialty beds assigned to specific bed sections. Staff may be assigned directly to a MH RRTP or there can be outpatient staff that are resourced into MH RRTPs. If a MH RRTP is staffed from outpatient specialty staff, it is expected they will be involved in screening, assessment, and the recovery planning process for patients. Field interviews with leading MH RRTPs indicate a clear operational advantage for dedicated vs. shared staffing.

Despite the existence of dually assigned staff, the expectation is that all staff should have experience treating Veterans with SMI, SUD, PTSD, and co-occurring medical conditions. It is also expected that they will be involved in screening, assessment, and the recovery planning process for patients. Finally, due to MH RRTPs' requirement to provide supervision 24/7, staffing plans stipulate that a MH RRTP must have at a minimum one employee physically present within the unit with auditory and visual awareness of the unit whenever Veterans are present. [5]

Each MH RRTP must align specialty staff based on the number of specialty beds assigned to specific bed sections and specialty track programs. [5]

- PTSD specialty staff must provide primary assessments, education, and group and individual psychotherapy.
- SUD specialty staff must provide primary assessments, education, group and individual counseling, and SUD specific pharmacotherapy.
- SMI specialty staff provide SMI-related assessments, education, and group and individual counseling.
- Homeless and vocational staff provide vocational rehabilitation including employment skills services, education on finding and maintaining housing, financial skills training, and individual and group counseling.

Given the uniqueness of the CWT-TR program, there are additional factors which may also influence CWT-TR staffing numbers including the number and distribution of beds, the location and type of residential facility, travel distances, transportation logistics, utilization of house managers, and skills of the staff. The staffing model for CWT-TR is distinct from that of the Domiciliary bed sections as it does not require 24/7 staffing and specific nurse staffing as CWT-TRs are typically staffed by house managers who reside in the home. CWT-TR programs with 10 or fewer beds must staff their programs as though they have 10 beds. Staffing for 10 bed programs is the minimum staff needed to maintain a safe and effective program. Table 5 in Appendix B provides the minimum staffing guidance for CWT-TR programs based on the number of beds within a program. [5]

MH RRTPs may need to adjust the staff (within the disciplines discussed above) to meet the needs of their program and the Veterans they serve.

Tele-Modalities/Virtual Components

Given the advancement of virtual care modalities, MH RRTPs have expanded telehealth to augment existing care and fill gaps in staffing. While in-person interaction is often preferred as it is the traditional method of care, a psychiatrist or other clinician can provide consultations virtually. Telehealth and VA Virtual Video Connect has increased facilities' ability to leverage available staff at other VA sites to help alleviate staffing challenges and is particularly helpful within rural areas where staffing pools are more limited. The COVID-19 pandemic has driven a large increase in telehealth.

Some MH RRTPs have gone even further and leveraged computer-based modules as part of the treatment process to help education and treatment of Veterans. However, technology adoption has not been consistent across MH RRTPs and is left to the discretion of local programs to determine what is needed to meet patient needs. Barriers to technology integration include interoperability issues with electronic health records and other technology platforms. Additional technology, such as the use of iPads, help collect patient outcome data and the use of virtual reality is often utilized for augmenting patient therapy. [4]

Key Planning Metrics

There are several key planning metrics in areas of demand, supply, and operations. These metrics are covered in detail in Section 4 and include:

- **Bed Days of Care (BDOC):** Non-cumulative BDOC is calculated by FY length of stay (LOS) minus prorated leave and pass days.
- **Projected MH RRTP BDOC:** The amount of projected MH RRTP BDOC needed within a geographic area, such as within a VISN or market.

  - **Sourced from the MH RRTP Demographic and Diagnosis-Based Demand (3D) Model:** Projects BDOC independent of historical utilization patterns and any potential limitations due to supply (see appendix D.)
  - **Sourced from the Enrollee Health Care Projection Model (EHCPM):** Projects BDOC within the context of underlying constraints that affect current and future workload (see appendix D.)
- **Operating Beds:** The number of official operational beds as specified by the VA Bed Control aligned to a MH RRTP by bed section (GEN DOM, DOM SUD, DOM PTSD, DCHV, and CWT-TR). Actual operating bed counts may be lower than official operational bed counts due to staffing constraints, reduced demand, or renovation plans.
- **Average Daily Census (ADC)**: The average number of Veterans in an MH RRTP bed per day calculated by BDOC divided by calendar days per year.
- **Occupancy rate**: The percentage of official operational beds that are occupied, calculated cumulatively from the beginning of the FY.
- **Average Length of Stay (ALOS):** The average duration of stay in days.
- **Admits per User:** The average number of admissions per year per unique of MH RRTP services.
- **Wait Time for Admission:** The time in days between initial screening (as indicated by health factors present in the National MH RRTP Screening template) and actual admission by bed section to a MH RRTP.

Access

Improving access is a primary goal of MH RRTP leadership. The key access measure utilized is wait time, measured in days, from screening to program admission. Additional metrics include the number of Veterans waiting for placement and the percent denied admission. The national median wait time has historically ranged from 15-18 days when averaged across programs; however, median wait times vary by program type. [1] Since MH RRTPs are not available within every VA market, there may be access challenges based on drive time to available and appropriate MH RRTP services.

NOTE: *Median wait time was used prior to FY 2019 to address significant outliers in the data due to the necessary business rules. Changes in data capture beginning in FY 2019 have allowed for more accurate capture of average and median wait times using available health factors from the MH RRTP National Screening template.*

Table 3 displays average and median wait time data from FY 2019 through Q4 and the number of Veterans on wait lists for MH RRTPs, highlighting the magnitude of access issues.

Table 3: *Wait Times and Pending Admissions (FY 2019 Q4)*

Program	Average Wait Time (Days)	Median Wait Time (Days)
GEN DOM	14	8
DOM PTSD	27	19
DOM SUD	16	8
DCHV	17	8
All Bed Sections (Excluding CWT-TR)	**17**	**9**

Source: NEPEC MH RRTP Wait Time Data Pull for FY 2019

Current national policy requires that Veterans be admitted as quickly as possible following screening with alternative treatment options including possible care in the community offered when a bed is not available within 30 days of screening. Further, national policy defines priority admission for those Veterans whose treatment needs require more immediate admission, such as unsheltered homeless, recent suicidal ideation, or overdose risk which requires admission within 72 hours. [5] Under MISSION Act requirements, MH RRTPs fall under the Extended Care category and are not subject to drive time or appointment wait time standards. However, separate regulatory standards mandate MH RRTP appointment wait time standards of 72 hours for emergent care and 30 days for non-emergent care. [4] The MH RRTP Program Office has undertaken several initiatives to improve access including a focus on right-sizing bed placement, developing and disseminating reports on access measures at the facility level, and standardizing admission criteria at the national level. Access measures and criteria are discussed further in Section 4.

Quality and Measurement

Accreditation

The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation standards place MH RRTPs among the leading facilities nationwide, which is described in more detail in the commercial accreditation section. All MH RRTPs must be accredited under TJC Behavioral Health Standards Manual and attain and maintain accreditation under the CARF Behavior Health Standards Manual - Residential Treatment standards. Additionally, all CWT-TR programs must be accredited under CARF Behavioral Standards-Community Housing: Psychosocial Rehabilitation standards. All new programs must attain accreditation within 18 months of opening. [5] Among other benefits, achieving accreditation from TJC and CARF communicates to the community that the MH RRTP not only meets the quality standards as laid out by both organizations but ensures continued compliance with industry standards for health care operations and quality.

The NEPEC conducted a review of VHA's Homeless Programs' outcome data and found that Veterans "in CARF-accredited homeless programs achieved improved housing and successful discharge rates; and veterans with substance abuse disorders and serious mental illness had improved outcomes compared to those in these programs before CARF accreditation." [24]

Measurement- and Evidence-Based Care

VA has demonstrated proven effectiveness in its MH RRTPs and has leading initiatives in implementation of evidenced-based treatment (EBT) and measurement-based care (MBC). Assessing MH RRTP quality overall or relative to community providers is challenging due to the lack of standardized and mandated measures shared between VA MH RRTPs and programs in the community.

VA has been an early adopter of measurement- and evidence-based care (EBC) to improve mental health care quality. In order to provide a framework to understand the overall quality of care, VA launched a MBC initiative. The utilization of MBC can help track patient outcomes and drive clinical decisions regarding effective treatment protocols and shared timelines. [1] The initiative provides guidance on both the specific tools to use and when and how they are to be utilized. The initial phase of MBC has focused on the use of four specific tools all of which are widely used in the mental health field: [5]

- Brief Addiction Monitor – 17 items (BAM-R or BAM-IOP)
- PTSD Checklist – 20 items (PCL-5)
- Patient Health Questionnaire – 9 items (PHQ-9)
- Generalized Anxiety Disorders – 7 items (GAD-7)

The data is collected at admission, during care, and at discharge and is used to give providers information that can be utilized to tailor treatment to Veterans' individual needs and to help them advance through treatment. To date, nearly all MH RRTPs are employing some or all the above tools, though the level of utilization varies and remains an ongoing effort. [4]

VA has made a concerted effort across the organization to implement EBC. Specifically, clinical practice guidelines are used to improve patient care as a solution to reduce variations in care and have been developed in several areas relevant to clinical services provided by MH RRTPs. These clinical practical guidelines are based on review and assessment of the published research and include: [25]

- Assessment and Management of Patient at Risk for Suicide
- Major Depressive Disorder
- PTSD
- SUD

The MH RRTP Program Office promotes the use of EBTs and tracks the availability of specific EBTs by location. Common EBTs include Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Cognitive Processing Therapy, and Medication for Opioid Use Disorder.

The systematic use of EBC is a differentiator for VA versus community care. For example, 99.2% of MH RRTPs offer pharmacotherapy for opioid disorder. [26] This compares to community residential treatment programs offering 31.0% and 34.0% buprenorphine or naltrexone, respectively, which are two of the most effective medications for treatment of opioid use disorders. [27] Only two states require the use of EBC in SUD residential treatment. [27]

Discharge Measures [1]

In addition to the MBC initiative, VA tracks discharge metrics focusing on four key measures: 1) discharges to permanent housing; 2) negative discharges and reason for discharge such as rule violation or against medical advice; 3) employment status; and 4) program completion rates.

VA further tracks a variety of post-discharge metrics including post-discharge readmission rates to acute inpatient mental health and MH RRTPs (to any MH RRTP and to the same MH RRTP type as the discharging program) at 14, 30, 120, and 180 days. VA also monitors several measures of outpatient continuing care engagement including mental health outpatient use and visit type at 14, 30, 120, and 180 days, as well as the number of outpatient visits by type and any changes to the Veterans high-risk suicide flag status.

Admits per User and Average Length of Stay

Though not traditional quality measures, Admits per User and ALOS are both factors considered by the 3D Projection Model and can offer insights into the quality of care provided in MH RRTPs.

A MH RRTP site where there are a high number of Admits per User may infer a higher rate of Veterans being readmitted to a program. While there are numerous potential causes, a higher readmission rate may indicate quality issues such as premature discharge or lack of follow up care with discharged patients. Alternatively, it may simply indicate differences not related to program quality such as higher comorbidities in the patient population or lower treatment compliance.

A MH RRTP site where there is a high ALOS for patients relative to the national mean may infer challenges discharging Veterans into environments where they can continue outpatient treatment or have a social support network. A high ALOS may indicate a need to improve discharge planning processes, a lack of resources to support effective discharge, or other operational challenges that should be considered regarding their effect on long term planning.

Clay Hunt Report [28]

The most comprehensive external assessment of the quality of VA's mental health and suicide prevention programs is the annual, independent, third-party evaluation of the effectiveness of VA's mental health programs mandated under the Clay Hunt Suicide Prevention for American Veterans Act of 2015. The 2019 report evaluated a wide range of mental health services including DOM PTSD programs and found that all programs evaluated utilized "valid, reliable, and widely accepted measures of mental health status and symptoms." The report found that those VA mental health programs evaluated "demonstrated an improvement in mental health symptoms or functioning for the Veterans who used them" and that programs were equally effective for males and females. Specific to DOM PTSD programs, the report found:

- Veterans in DOM PTSD programs had significant decreases in PTSD symptoms during residential treatment, although there was a clinically insignificant increase in symptoms following treatment as well as small, but clinically significant increase in substance use four months after discharge.
- For DOM PTSD programs, post discharge care with various VA mental health services was associated with decreased substance use at four-month follow up while Veterans who received non-VA care experienced increased substance use.
- For Veterans who utilized DOM PTSD programs, utilization of inpatient and outpatient mental health and primary services decreased significantly in the year following discharge.

MH RRTP and VA's Fourth Mission

VHA provides emergency management response and disaster relief in times of crisis. The 1982 VA/Department of Defense (DoD) Health Resources Sharing and Emergency Operation Act (P.L. 97-174) initiated VA's authority to provide emergency management response support. This authority was further expanded by the Federal Response Plan in 1992. The creation of these laws led to what would become VA's "Fourth Mission," which is defined as VA's effort "to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts." [29]

During the COVID-19 pandemic, VA provided Fourth Mission support in many communities. This support included placing both clinical and non-clinical staff onsite or at a VA facility, training in infection control measures, and providing personal protective equipment to other health care organizations. The effect of COVID-19 on MH RRTPs is varied, with some facilities temporarily closing or reducing or repurposing beds and some staff temporarily reassigned to other units or facilities including State Veterans homes. Additionally, at times, MH RRTPs support the Fourth Mission by providing bed capacity during times of natural disaster. [4]

2.3 Commercial and Other Federal Provider Trends

There are few commercial offerings that provide the breadth of services comparable to VA, or that integrate into the broader health system in recognition of co-occurring mental health or medical conditions. The overall industry is fragmented, with much variation in licensure, accreditation, and quality measures. The high variability of programs outside of VA makes treatment options even more challenging to identify. The inconsistent nature in program types, quality, licensure, and accreditation, coupled with lack of broader health system integration, often leads to high reliance on VA for these services.

Commercial Trends

Mental Health Residential Treatment Settings

Similar to MH RRTPs, commercial residential treatment settings include "24-hour treatment and support services that provide a safe and structured living environment for individuals that need support before living on their own." [27] Mental health residential settings include community-based supportive housing, group homes, and specialty residential treatment settings. According to the 2017 Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Services Survey, there were approximately 856 organizations providing residential mental health treatment for adults in the United States, and there were about 99,881 people in residential substance use treatment on a given day in the United States. [30]

Mental health residential facilities treat disorders such as depressive and anxiety disorders, bi-polar disorder, SUD, and offer a variety of services to include individual psychotherapy (60.0%), group psychotherapy (65.0%), CBT (58.0%), and psychotropic medications (80.0%). [27] Some mental health residential settings offer programs and services for dual diagnosis individuals that have a psychiatric disorder as well as a co-occurring SUD. Despite the evidence that integrated treatments for mental health and SUD improve patient outcomes, according to a study that sampled 256 programs across the United States, "approximately 18% of addiction treatment and 9% of mental health programs met criteria for dual diagnosis capable services", thus demonstrating that many treatment programs do not provide integrated treatment. [31]

SUD Residential Treatment Settings

SUD residential treatment settings include substance use treatment programs, detoxification, and group homes, while halfway homes and community-based supportive housing also provide SUD treatment but are not equivalent to what is provided at VA. According to the 2017 National Survey of Substance Abuse Treatment Services, there were approximately 3,500 organizations providing residential SUD treatment in the United States. [30] Residential SUD treatment is nonhospital services that are short-term (30 days or less), long-term (greater than 30 days), and/or focused on managing withdrawal/detoxification. [27]

The addiction treatment industry in the United States has changed significantly in recent years due to the opioid epidemic and the Affordable Care Act, and as a result, the demand for addiction recovery services has increased dramatically. Ownership of treatment centers vary from state to state. According to SAMHSA, in 2016, 53.0% of addiction treatment centers were owned by a nonprofit, 35.0% were privately owned, and 11.0% were government owned. [30]

Residential substance use programs have significantly fewer admissions relative to outpatient substance use programs. In 2017, SAMSHA found that residential substance abuse programs only accounted for 17.9% of substance abuse admissions. [30] The largest service setting at time of substance abuse admission was non-intensive outpatient ambulatory programs which made up 48.4% of admissions. [30]

Program Variation

Residential treatment across the United States varies considerably. As noted in the State Regulation of Residential Facilities for Adults with Mental Illness, "there is an absence of a standard nomenclature." [32] Monitoring and licensure are in the hands of each individual State government and within each state there are various program types and program definitions which has been adopted to describe the delivery of care through residential rehabilitation. [32] Examples of program variations state to state and within the same state, are presented in Table 4.

Table 4: *Variations in Program Definitions by State*

State	Program Type	Program Definition
Arizona	Adult behavioral health therapeutic home	"A behavioral health supportive home that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issue and need for behavioral health services" [33]
Arizona	Behavioral health residential facility	"An institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence." [33]
California	"Residential Alcoholism or Drug Abuse Recovery or Treatment Facility"	"Any facility, building, or group of buildings which is maintained and operated to provide 24-hour, residential, nonmedical, alcoholism or drug abuse recover or treatment services." [34]
Texas	"Residential Alcoholism or Drug Abuse Recovery or Treatment Facility"	"Residential services are twenty-four-hour service provided and/or contracted by the department or community center or psychiatric hospital." [35]

Quality

The quality of treatment for mental health and SUD has been a persistent, industry-wide challenge. In 2001, the Institute of Medicine released its seminal report, *Crossing the Chasm: A New Health System for the 21st Century,* which offered broad strategies for the improvement of health care overall. [36] While the strategies gained traction in many areas of health care, mental health treatment lagged, resulting in the release of a new study, *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* [37] The report noted several unique aspects of mental health/SUD that make providing quality programs and measurement of quality more challenging including: stigma against treatment, less developed quality measures and infrastructure, care that spans a range of providers and organizations, the use of coercion into treatment, and a workforce with a range of educational levels.

The report proposed several recommendations around treatment of the whole patient, to include mind and body, greater involvement of patients in their own care, adoption of evidence-based practice, and increased industry efforts to achieve consensus on quality measures. Despite these efforts, the overall quality of mental health care has not improved at the same rate as general medicine. [38] This is due to many widely used mental health measures lacking enough evidence to be used in treatment outcomes and should include a focus on quality of life and recovery in addition to the symptoms themselves. [38] Though there are over 500 existing mental health quality measures to choose from, only 10.0% have been endorsed by the National Quality Forum and 72.0% focus on process measures such as screenings and assessments that may have little bearing on patient outcomes. [38] Furthermore, the commercial mental health care field has been slower to adopt MBC and is “used by fewer than 20.0% of behavioral health clinicians in the United States.” [39] While MBC is used to provide insight into the progress of treatment and ongoing treatment targets of patients, as well as improving patient outcomes, VA takes it a step further and uses MBC to tailor and adjust treatment to the individual Veteran as needed.

There are several innovating international efforts underway to pursue MBC including:

- The World Health Organization’s Assessment Instrument for Mental Health Systems and the International Initiative for Mental Health Leadership. [40]
- The Netherlands has mandated 10 standardized measures for health care reimbursement. [41]
- Australia has mandated standardized mental health outcome measures since 2002 and invested heavily in provider training and engagement. [42]
- The United Kingdom’s National Health Service runs a Benchmarking Network where all mental health providers submit data to benchmark against their peers. The Commission for Quality and Innovation is also implementing a pay-for-performance model in which payments are tied to adequate performance on set quality measures. [43]

There has been little rigorous research on the quality of care provided in residential programs. A 2019 literature review found no systematic reviews of residential care effectiveness. [27] This finding was corroborated by similar findings from a regulation and policy report from the U.S. Department of Health and Human Services. [27] The report further noted that challenges are compounded by the lack of defined mental health/SUD quality measures as well as the difficulty of following this patient population over time. However, there was a 2019 systematic review on the effectiveness of residential treatment services for individuals with SUD that showed moderate quality evidence. Results suggested that best practice rehabilitation treatment integrated mental health treatment and provided continuity of care post-discharge. [44]

Accreditation and Licensure

To address program variation and quality issues, most commercial residential treatment centers are licensed/certified by state departments of health or departments of mental health, while others may be licensed/certified by state substance use agencies. [27] However, not all states require licenses/certification for these facilities. Requirements for state licensure is determined by the state in which the program is located, leading to fragmentation and inconsistency of programs and regulatory processes.

Of the mental health treatment facilities surveyed in the 2017 SAMHSA National Mental Health Services Survey, 72.0% were licensed, certified, or accredited by state mental health authorities, 50.0% by the Centers for Medicare and Medicaid Services, 49.0% by state departments of health, and 35.0% by TJC. [30]

To address payers' and consumers' concerns for person-centered quality and outcomes, single or multiple accreditations may be pursued by a residential treatment program. The most common accreditation bodies are TJC, CARF, and the Council on Accreditation. [27] Unlike MH RRTPs, which are required to attain and maintain accreditation from both TJC and CARF, not all commercial mental health residential facilities are required to be accredited. Approximately one half of the commercial facilities surveyed in the 2017 SAMHSA National Mental Health Services Survey are accredited by TJC (14.6%), CARF (31.8%), or the Council on Accreditation (5.0%). 27

CARF accreditation is known for person-centered standards that emphasize an integrated and individualized approach to services and outcomes. CARF's gold accreditation seal is viewed as a visible symbol of the provider's commitment to continually enhancing the quality of services with a focus on satisfaction of persons served. [45]

On June 1, 2020, CARF and the American Society of Addiction Medicine (ASAM) mobilized the new Levels of Care Certification based on ASAM's widely used residential care criteria. The intent of this new certification is to reshape addiction treatment by providing an independent assessment of a program's ability to deliver evidence-based

addiction treatment consistent with the ASAM Criteria. [46] The ASAM criteria includes five levels of care (Levels 0.5-4) spanning the continuum with specific requirements at each level. Levels include Early Intervention, Outpatient Services, Intensive Outpatient and Partial Hospital Programs, Residential or Inpatient Programs, and Medically Managed Intensive Inpatient Programs. [47] The new certification program is intended to standardize addiction care across the country. While some VA programs integrate ASAM criteria, VA/DoD Clinical Practice Guideline for the Management of SUD does not recommend for or against the use of such criteria for triaging Veterans to services. Overall, VA has implemented an interdisciplinary, multi-dimensional approach to care comparable to that recommended by ASAM and VA's DOM SUD programs provide services that are most aligned with ASAM levels 3.5 and 3.7, Clinically Managed High-Intensity Residential Services and Medically Monitored Intensive Inpatient Services.

Department of Defense (DoD)

The DoD has five Residential Treatment Facilities (Army) or Substance Abuse Rehabilitation Programs (SARPs, Navy) at select Military Treatment Facilities including:

- The Navy Medical Center Portsmouth (Portsmouth, VA) [48]
- The Eisenhower Army Medical Center (Fort Gordon, GA) [49]
- Madigan Army Medical Center (Joint Base Lewis-McChord, WA) [50]
- Naval Medical Center Point Loma (San Diego, CA) [51]
- Fort Belvoir Community Hospital (Fort Belvoir, VA) [52]

These Federal Residential Treatment Facilities function as regional referral centers and primarily serve active duty military. The primary focus of these programs is treating patients with a primary diagnosis of SUD and patients with a SUD/mental health dual diagnosis, including PTSD. This differs from VA which additionally treats patients with a primary or sole mental health diagnosis.

Unlike VA, DoD programs do not incorporate any homelessness or work therapy programs due to the active-duty patient population. The main purpose of these programs is to return soldiers to full active duty and ensure the fitness and military readiness of the military force.

Recognizing the need for consistency, in 2012, VA, DoD, and SAMHSA formed the Interagency Task Force on Military and Veterans Mental Health in an effort to improve access and quality to mental health care for Veterans, service members and their families and to better coordinate efforts. These efforts are not specific to MH RRTPs but do influence relevant research, policies, and quality efforts. The Interagency Task Force has focused on eight priorities: [53]

- Suicide prevention including a memorandum of understanding between VA and DoD, research, and interagency outreach,

- National research action plan with a focus on PTSD, traumatic brain injury, and suicide prevention,
- Joint clinical and outcome metrics including administration of common measures, MBC implementation, and electronic health records alignment,
- Community partnerships including a community provider toolkit and pilot programs,
- Lesbian, gay, bisexual, transgendered, and queer inclusion efforts including a national directive on assessment, outreach, and clinical programs,
- SUD policies and programs with a focus on opioid therapy and pain management, and prescription drug monitoring,
- Sexual assault, sexual harassment, and military sexual trauma policies and practices, and
- Workforce development.

2.4 Current Program Summary

Common industry challenges include balancing capacity with current and future demand, managing admission rates and wait times, optimizing LOS against quality of care, and maximizing bed utilization. However, as a large system of care, VA is uniquely tasked with also distributing MH RRTPs across the country and matching program demand throughout the many markets and VISNs within VA. Additionally, VA must plan, fund, construct, and activate new programs across the various sites of care as necessary.

In the commercial sector, there is a wide variation of settings and organizations across mental health care in the residential setting. Public or privately owned facilities create inconsistencies when it comes to state regulation, licensure, and acceptable means of funding care. Treatment is also highly variable as seen in the commercial sector where a high percentage of facilities utilize psychotropic medications while just over half provide CBT. Similarly, there is inconsistent treatment of patients with dual diagnosis, with few programs meeting the criteria for integrated care.

It is also evident that the slow adoption of EBT and MBC by commercial providers has a direct effect on creating acceptable standards of care. Quality measures are broad which is a limiting factor in the goal of formulating a more distinct model of care. Overall, there are limited studies on the effectiveness of residential mental health and SUD treatment, as well as a lack of widely accepted quality measures to benchmark outcomes. [27]

In summary, there is a need to provide a balanced range of MH RRTP services across all 96 markets. Historically, local facilities would often decide what programs would be built based on local need, current budget, and staffing availability. This method of thinking has been replaced with planning for the needs of VISNs as a whole rather than the needs of a single facility or market. However, despite this renewed focus, MH

RRTPs are inconsistently distributed with capacity not matched to area demand. Further, the commercial market is an unreliable option in terms of breadth and integration of program offerings, quality, accreditation, and payer perspectives. This highlights the importance of MH RRTP planning both nationally and at the VISN and market levels.

3. Leading Practices

3.1 Leading Practices Analysis

There is considerable variation in the commercial sector surrounding the treatment of mental health conditions. Commercial residential rehabilitation is often an aggregate of services and does not necessarily focus on one specific treatment.

There is no current or comprehensive compilation or analysis of state regulation of residential treatment facilities for adults in the United States. Beyond requirements for licensure or certification, the potential regulatory levers include staffing requirements, placement and assessment criteria, and treatment and discharge planning.

The fragmented care and uneven standardization in the commercial sector create a void in the industry for what may be considered a model system of care. In many organizations residential treatment is often under a larger umbrella of mental health services which may also include inpatient care, detox, and intensive outpatient therapy. Therefore, it is difficult to impart a 'leading practice' label for residential treatment to any care center or organization in the commercial market with a high degree of confidence. Instead, these organizations most commonly compare to each of VA's MH RRTP service lines based on their chief focus.

Although many organizations provide services across multiple specialty areas, the organizations below have been identified based on their chief focus. Table 5 lists professional organizations and societies related to each service line with an emphasis on policy advocacy, improving access to care, and educating a robust behavioral health workforce.

Table 5: *Leading Organizations/Associations*

VA Service Line	Public and Private Industry Leaders	Professional Societies or Organizations
GEN DOM	American Residential Treatment Association	National Association for Behavioral Healthcare National Alliance on Mental Illness
DOM PTSD	Sierra Tucson	PTSD Alliance
DOM SUD	Hazelden Betty Ford Caron American Addiction Centers Naval Medical Center Portsmouth Substance Abuse Rehabilitation Program	American Society of Addiction Medicine. National Association of Addiction Treatment Providers. National Certification Commission for Addiction Professionals National Association of Addiction Treatment Providers
DCHV	PATH Dream Center	National Health Care for the Homeless Council
CWT-TR	Fountain House	Clubhouse International

General Focus

American Residential Treatment Association (ARTA) [54]

ARTA is comprised of a 30-member organization across 15 states and offers treatment in four distinct settings in both rural and urban environments.

ARTA facilities treat a range of mental health conditions including bipolar disorder, schizophrenia, depression, personality disorders, mood disorders, anxiety disorders, PTSD, and disorders that co-occur with SUDs. ARTA facilities treat multiple diagnoses at any given time, and there is no guarantee that these facilities are positioned to treat co-occurring conditions with any regularity, nor does any facility have a focused emphasis on one mental health condition such as SUD. Additionally, ARTA facilities are largely fee-for-service.

Among the ARTA facilities, Clinical Residential Treatment programs utilize EBT, including CBT and dialectical behavior therapy and are CARF accredited—unlike the Group Residential Communities, which are facilities specifically designed as residential homes that may or may not have clinical treatment capabilities.

Treatment settings for Group Residential Communities vary among ARTA facilities. For example, the Lakewood Residential Treatment Center is located outside of Orlando, Florida. Residents there receive 24-hour care and have a minimum six month stay. By comparison, EIKOS Community Services in the urban Chestnut Hill neighborhood in Boston, Massachusetts has a main house which provides housing for up to 14 residents as well as two satellites that appear to be a step down with greater independence provided. Lakewood Residential and EIKOS both provide medication administration and counseling.

In addition to the Group Residential and Clinical Residential programs, ARTA also has several Farm/Work Based programs. Many are co-located with clinical-based capabilities.

SUD

Treatment for SUD is at the forefront in the commercial sector. As opioid addiction has soared, the number of centers across the country has increased to meet the treatment demand. [55] Among the industry leaders in SUD, identified by the MH RRTP Program Office, non-profit treatment centers such as the Hazelden Betty Ford Center and Caron took part in a three-year pilot program with eight other treatment centers to develop a uniform outcome measurement platform sponsored by the National Association of Addiction Treatment Providers. [56] The National Association of Addiction Treatment Providers provides leadership, advocacy, training, and member support services to improve the quality of addiction treatment. The result of the program concluded in the development of standardized outcomes measurement during client intake, data collection, and best practices. Recovery outcomes are guided by SAMHSA's definition

of recovery: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” [56]

Given the fragmentation of programs and inconsistent regulatory processes amongst the states, in 2017 Hazelden Betty Ford Foundation and the Caron Treatment Center co-authored criteria for a treatment center to be considered a center of excellence within the industry. Table 6 lists defining characteristics which share a common thread with SAMHSA’s standards of care: [57]

Table 6: *Characteristics of a Centers of Excellence in SUD*

Categories	Hazelden Betty Ford	Caron
Accreditation	TJC and CARF	TJC and CARF
Evidence-Based Treatment	Yes	Yes
Technology and Data Systems	MORE: My Ongoing Recovery Experience helps patients discharged in tracking their progress	Passport: Patient interface program tracks patient progress, stores treatment homework and serves as an interface with counselors
Care for Co-Occurring Disorders	Yes	Yes
Performance Measurement System	Yes	Yes
Quality and Process Improvement: Benchmarking criteria including satisfaction rates, average LOS, abstinence rates, reengagement rates	Yes Participant in National Association of Addiction Treatment Program Outcomes Study	Yes Participant in National Association of Addiction Treatment Program Outcomes Study
Full Continuum of Care: Treatment programs for both pre and post care.	Monitoring one year or longer through *My Ongoing Recovery Experience (MORE)*	Monitoring one year or longer through *Passport*
Education and Scholarship: Collaboration with local university or colleges by creating fellowships, internships, and clinical development	Graduate Degree in Addiction Counseling Addiction Research Continuing Education	Research partner with Penn State College of Medicine, Brown University, University of Pennsylvania, Rutgers, and University of Southern Mississippi
Sound and Ethical Business Practices: Marketing and advertising should be ethical and legal.	Yes	Yes

Categories	Hazelden Betty Ford	Caron
A Broad Reach: Available to all of those across a wide socioeconomic fabric, as well as practice diversity.	Yes	Yes
Staff Development	Yes	Yes
Qualified Clinicians	It is preferred that counselors have a master's level of education. Bachelor of Arts is minimum threshold	It is preferred that counselors a have master's level of education. Bachelor of Arts is minimum threshold

Hazelden Betty Ford[58]

Hazelden Betty Ford has been providing care for over 70 years and is considered one of the top drug and alcohol treatment centers in the world. Hazelden Betty Ford has 17 locations nationwide with virtual services available in eight states. Of the 17 locations, four of the centers offer both inpatient and sober living programs and two centers offer only sober living. The organization is accredited by TJC, indicating it is operating transparently and in compliance with applicable laws and regulations. The organization reports high scores on patient satisfaction based on Press Ganey scores. All inpatient and outpatient addiction treatment professionals within the rehab programs are Licensed Alcohol and Drug Counselors, Licensed Professional Counselors, Certified Addictions Counselors, or Certified Cooccurring Disorders Counselors.

According to the Butler Center for Research, Hazelden Betty Ford's internal scientific research department reported that 88.6% of residents at Hazelden Betty Ford were alcohol-free one month after rehab, 85.0% to 95.0% of residents were abstinent from all other drugs nine months after rehab, and 80.0% of residents report improved quality of life and health after rehab.

The organization gathers performance data within three categories: length of sobriety, quality of life, and aftercare compliance. During the patient admission process Hazelden Betty Ford provides patients with the opportunity to sign a release allowing staff to contact them after discharge. The organization operates a call center that reaches out to patients at one, three, six, nine, and twelve-month intervals post-discharge to see how patients are doing and collect data about the patient's recovery process and overall quality of life. Data collected includes information regarding physical and mental health, quality of relationships, level of function in school or career, and the tracking of days being abstinent from alcohol and drugs. Hazelden Betty Ford cites the collection of these metrics as being necessary to monitor the quality of their programs.

Caron[59]

Similar to Hazelden Betty Ford, Caron has been providing SUD treatment for over 60 years and is also internationally recognized. Consistent with Hazelden Betty Ford, Caron's counselors and staff are certified or licensed in CBT, dialectical behavior

therapy, and motivational interviewing, among other modalities. Results at Caron are recorded through the "My First Year of Recovery" program which is a roadmap given to residents and their families to remain accountable during their journey to recovery. Per self-reported metrics, 62.0% of alumni of this program remain abstinent and 45.6% of participants continue with treatment. Caron maintains a research partnership with Temple University, University of Pennsylvania, and Penn State Hershey.

American Addiction Centers [60]

American Addition Centers (AAC) is among the largest network of rehabilitation facilities with 20 locations nationwide. Founded in 2007, AAC was the first publicly traded addiction treatment provider in the U.S. AAC incorporates the 12 Step Program into their treatment practices and carries CARF accreditation. Unique to the AAC is the organization's "Salute to Recovery" program which is dedicated to military (and first responders) and focuses on the unique needs of Veterans, including service-related mental health challenges. In addition to treatment for drugs and/or alcohol, participants are assisted with managing co-occurring mental health conditions such as PTSD, depression, and anxiety. This program is provided exclusively at the Desert Hope facility in Las Vegas, Nevada and Recover First in Hollywood, Florida. [61] Unlike AAC, Caron or Hazelden do not have programs dedicated specifically to the treatment and care of Veterans, though Veterans are supported in other ways. In 2015, Hazelden Betty Ford launched "Vet to Vet" which is a free online peer-support platform and Caron has Veteran workshops directed to Veterans and their spouses.

Naval Medical Center Portsmouth Substance Abuse Rehabilitation Program [48]

SUD treatment services for active-duty military can be obtained through the Naval Medical Center Portsmouth's SARP. The program treats dual-diagnosis patients that have been cleared for suicidal ideation, homicidal ideation, and hallucinations.

The program offers four treatment levels based on the Diagnostic and Statistical Manual of Mental Disorders criteria for mild, moderate, or severe SUD and ASAM criteria defining levels of care: 0.5, 1, 2, and 3. Levels 0.5 to 2 are OP programs while level 3 is residential. Outpatient programs are offered at the main SARP, as well as two clinic locations.

- IMPACT (Level 0.5) is a 30 day, 20-hour outpatient educational course geared toward early intervention and prevention, generally for patients without a diagnosis.
- Level 1 is a two-week outpatient program for patients with a mild alcohol diagnosis or no diagnosis with a history of driving under influence.
- Level 2 is an outpatient abstinence-based program for patients diagnosed with mild to moderate SUD who also have an appropriately safe, sober, and supportive home environment and reliable transportation. The program is three-and-a half weeks in length but can be extended if needed.

- Level 3 is a residential abstinence-based program for patients diagnosed with mild to moderate SUD. The program is five weeks in length but can be extended if needed. The residential program is geared toward patients who do not live locally, are at risk for not sustaining abstinence during treatment, live aboard a ship, have no transportation, or do not have an appropriate home environment.

Aftercare services include continuing group meetings, Alcohol Anonymous and Narcotics Anonymous meetings, participation in the Navy My Ongoing Recovery Experience program, meetings with a Navy Drug and Alcohol Program Adviser, and referrals to other health care providers. Aftercare is suggested by the SARP but at the discretion of the service member's chain of command, which can decide to alter or end aftercare treatment.

PTSD

Sierra Tucson

PTSD programs often co-exist in facilities treating other disorders such as chronic pain or SUD. Sierra Tucson, a member of the Acadia Healthcare international network, is one of these facilities, existing for 36 years with programs specifically designed to treat behavioral health issues, including chronic pain, SUD, and PTSD. The practitioners use evidenced-based care in their treatment methodology. Specific to PTSD, Sierra Tucson's Trauma Recovery Program is designed to care for those with PTSD related to traumatic events stemming from sexual abuse or abuse in general. Residents of the program experience an integrative treatment approach combining medication management, group therapy sessions as well as holistic offerings. [62]

Additionally, Sierra Tucson has the Red, White, and Blue Program dedicated specifically to the treatment and care of Veterans, active-duty military, reservists, and first responders and the unique needs of this population. This program offers personalized and comprehensive care to address physical, behavioral, and mental health needs. Specifically, the PTSD program offers services including, but not limited to, EBT, medication management, individual and group therapy, and therapeutic and recreational activities. [63]

Homelessness

Project for Assistance and Transition from Homelessness

Similar to other residential treatment specialties, homeless programs are equally as fragmented, but they share a common theme of dual diagnosis. To aid in the homeless epidemic, SAMSHA's Projects for Assistance in Transition from Homelessness, which funds services for individuals with SMI experiencing homelessness, awards grants to the 50 states, Washington D.C., Puerto Rico, and four US Territories for the sole purpose of: [64]

- Outreach
- Screening and diagnostic treatment
- Habilitation and rehabilitation
- Community mental health
- Substance use treatment
- Case management services
- Referrals for primary health care, job training, educational services, and housing

A review by Human Research Services Institute found that Projects for Assistance in Transition from Homelessness "grantees were clearly targeting the intended population: 90.1% of enrolled consumers had a mental illness diagnosis; approximately 50% had co-occurring mental health and substance use disorders; and over 50.0% met the definition of literal homelessness." [65] Organizations may apply for these funds within their state which is administrated by each state's Department of Health Services. Stable housing can, depending on the type of housing provided, influence reducing substance use, symptoms of mental disorder and the need for psychiatric emergency services and psychiatric hospitalizations.

Dream Center [66]

The Dream Center in Los Angeles, California is a well-known homeless network spawning 84 Dream Centers across the county. Serving as a hub for the Dream Center is the former Queen of Angels Hospital, a 14-story tower which provides housing to the homeless population in the Los Angeles community. In addition to offering programs focused on building a healthy road to recovery, housing, or employment, the Dream Center also has a Veterans program: "The Dream Center Veterans Program is a one-year residential program designed to help equip male and female military veterans with the spiritual, practical, and foundational skills needed to transition back into civilian life. In collaboration with local organizations, volunteers, and the Dream Center community, and by providing individualized assistance, the program enables Veterans to develop positive social skills, build life skills, find employment resources, continue in education, learn to utilize veterans' benefits, and grow in a like-minded environment."

Vocational Rehabilitation and Supportive Employment

Fountain House [67]

The Fountain House in New York City has been modeled throughout the world for their mental health programs serving over 500 members a year in varied levels of supported housing including Fountain House residences, independent apartments or with family and friends. Members of the Fountain House community, with the assistance of staff, operate employment, education, housing, and wellness programs. In 2011, Fountain House was nationally recognized by the National Registry of Evidence-based Programs and Practices, specifically for their International Center for Clubhouse Development model.

There are seven areas that members work collaboratively in at the Fountain House, including communications, culinary, education, horticulture, reception and membership, research, and wellness. Each area is integral to the operations of the organization. The cornerstone of Fountain House is their Employment Program which was originally designed in the 1950s with a focus on providing individuals with mental health conditions the tools to obtain "soft skills" such as how to interact with a manager, setting a work schedule and getting along with co-workers. Fountain House provides two employment programs:

- Transitional Employment: This program combines the work that members do at the Fountain House with part time employment at companies and stores within New York City. The program continues to focus on skill development and adds to their overall work experience.
- Supportive Employment: A more rigorous program that places a member in direct competition for job placement at New York City employers with other candidates from outside the organization. Fountain House often has relationships with these employers and members and are provided ongoing support of the organization throughout the job application process.

As a result of the employment programs at Fountain House, 42.0% of their members have achieved a level of employment.

In addition to these programs, Fountain House also has social enterprise programs that have been created to cultivate an entrepreneurial drive within members.

International

Prevention and Recovery Care [68]

The Prevention and Recovery Care model in Australia is a residential model offering seven to 28-day subacute treatment. The program is designed for those with SMI to avoid a "step-up" to a psychiatric hospital or to allow transition into the community. In the continuum of care, this program lies between IP hospitalization and living independently. The objectives of the Prevention and Recovery Care model are to:

- Provide mental health services when treatment is better performed isolated to an intensive short-term setting in a residential atmosphere;
- Provide a mix of clinical and psychological support building on the success of IP treatment programs; and
- Supplement crisis intervention through the reduction of unneeded readmission.

Residential units within this system are co-located with existing community residential support units, within a facility or hospital location, or in a cluster of similar housing units.

Social Firms or Work Integration Social Enterprises

Found primarily in Europe, Social Firms and Work Integration Social Enterprises are businesses with a dual purpose to employ individuals with disabilities while providing a service or product to the community. Created to reduce social exclusion of disadvantaged groups, these organizations provide contracted transitional work programs with the goal of training and providing work experience. [69] Many of these programs specifically target those with mental illness, homelessness, and SUD. [70] And although the existence of Social Housing programs in many European countries targets the same population there is no true integrated effort between the two programs. [71]

There are four means of integration through Work Integration Social Enterprise programs: [69]

1) Transitional occupation: Focused on providing experience and training with the goal of integrating this population into the workforce.
2) Creation of permanent self-financed jobs: Job integration funded through subsidies until job training is complete at which time the subsidies begin to taper off.
3) Professional integration with permanent subsidies: Created for the most disabled of work groups. These enterprises are often in sheltered settings.
4) Socialization through a productive activity: This is not a formal integration into the labor market but rather the opportunity to re-introduce these individuals into a structured lifestyle.

Technology Assisted Care

Major strides have increased the use of telehealth as a medium for both treatment and support. The use of messaging with a video interface has the potential to reach more patients and provide support within their own home environment synchronously or asynchronously. Technology assisted care may serve to bridge a gap in care for communities that lack the accessibility to counseling services or reach individuals who are not interested in traditional service models. [72]

Both Hazelden Betty Ford and Caron incorporate technology platforms into their care model as a continuum of clinical support through counselors and/or peers within their rehabilitation community. *My Ongoing Recovery Experience* (Hazelden Betty Ford) and *Passport* (Caron) programs utilize technology following a patient's discharge to track recovery process and interface with recovery coaches. [73]

Sierra Tucson's PTSD program provides connectivity following discharge through the Connect 365 program which allows former residents access to a recovery coach through a mobile application. This level of communication is thought to provide ongoing encouragement long after discharge from the program. [62]

Similarly, VA has created a range of mobile mental health applications. One example is the PTSD Coach application, which allows users to manage their symptoms associated with PTSD. Available to all Veterans, the PTSD Coach application provides a symptom tracker, accessible tools and information and direct links for support. [4]

4. Service Planning Framework

4.1 Program Priorities

The mission of MH RRTPs is to "provide timely, state-of-the-art, high quality residential and treatment services for Veterans with mental health and substance use disorders that are often complex and co-occur with medical conditions and psychosocial needs such as low income, unemployment and homelessness." [1]

The key program priorities that have guided the development of planning guidelines include increasing access, aligning capacity with projected demand, and ensuring quality and performance across programs. These are discussed in more detail below. Other important program priorities include:

- Adhering to Federal regulations and VA policies and procedures including staffing requirements;
- Providing programs to meet the unique needs of special populations including ensuring sufficient capacity to meet the needs of women Veterans; and
- Ensuring that each Veteran makes a seamless transition from MH RRTP to outpatient continuing care individualized to meet their needs.

1. **Increasing Access** [4]

   The main priority of the MH RRTP is to increase access for Veterans who require mental health treatment in a structured, residential setting. Providing access means reducing wait times and travel distances so Veterans are not generally required to travel outside their VISN for care unless the location is closer for the Veteran. Program leadership has asserted that it is not desirable for Veterans to have to travel across the country to receive services when those services can be provided in a more local setting. To meet these criteria, a full continuum of core MH RRTP services should be available in each VISN.

   Specific consideration needs to be given to the unique needs of women Veterans when aligning capacity with projected demand and ensuring access to residential treatment for women Veterans. There is no universal model for the provision of residential treatment for women Veterans; rather, the preferences of the individual Veteran must be considered. This requires consideration for units that support separate and secured living space for women Veterans while providing a mix of gender specific and mixed gender services as well as access to women Veteran only residential programs when requested.

2. **Aligning Capacity with Projected Demand** [1]

   Matching demand projections with VISN and market-level capacity also supports the main priority of increased access. This may entail increasing, decreasing, or

rebalancing capacity in different VISNs as there is currently a mismatch of capacity and demand in some geographies.

3. **Ensuring Quality and Performance** [4]

   The residential treatment industry is challenged by a lack of standardized quality and performance measures and treatment protocols. VA, and the MH RRTP Program Office specifically, has prioritized the widespread and continued adoption of evidence-based treatment as described in detail in Section 2.2. In addition, the MH RRTP has championed the adoption of measurement-based care to standardize the tracking of symptom management and overall patient outcomes and provide data that could be used to benchmark best practices in the future. Maintaining adequate staffing levels is a related aspect of quality that is also a key priority.

4.2 Geographic Service Area

The MH RRTP is a VISN-level service with specific program types including GEN DOMs, DOM SUD programs, DOM PTSD programs, DCHV programs, and CWT-TR programs, which are distributed in combination or as stand-alone programs throughout VISNs and markets. Planning guidelines suggest there should be a minimum of one of each program type per VISN with potential to add additional programs if demand and drive time criteria are met. Often, for some program types, there will be more than one of each per VISN.

Though not explicitly categorized as regional or national programs, there are a small number of specialized MH RRTPs with focus areas—such as PTSD programs for Veterans who have experienced a traumatic brain injury or MST—that do draw Veterans from throughout the country and operate effectively. Historically, there were also large “mega-DOMs,” often with several hundred beds, which provided longer term residential services on a regional and national level. These facilities have been partially downsized in recent years, but several continue to draw workload from outside the VISN.

4.3 Planning Guidelines and Thresholds

Planning guidelines and thresholds seek to inform the market assessment process. The rationale for establishing VA planning guidelines and thresholds is rooted in the belief that where a VA service falls below the identified measure, quality, patient safety, or operational efficiency may be compromised. Therefore, a service must be carefully examined to ensure that Veteran needs are appropriately met. Planning guidelines and thresholds focus on a broad range of access, demand, staffing, quality, and facilities/ environment of care considerations and are meant to help identify areas where the teams should carefully consider measurable performance indicators. The guidelines and thresholds developed are not meant as standalone decision criteria to be used to make specific recommendations.

When conducting the market assessments, the opportunities developed were standardized across a range of move (or strategic task) types. Those developed included major moves as well as opportunities defined to be addressed during the ordinary course of business. Major moves represent the platform which will be vetted with senior VA leadership, with the VHA Under Secretary of Health, the Secretary of VA, the Asset and Infrastructure Review (AIR) Commission, and ultimately with Congress.

Planning guidelines derived from these efforts have been designed to assist in the standardization of major market moves and include the following:*

- **Open** – Establish a new site or program in an area with no current MH RRTP services
- **Maintain:**
    - **Maintain** – no major move is recommended
    - **Resize** – maintain services at the current site and size appropriately to accommodate projected demand
    - **Relocate Program –** maintain services within the same geographic service area but relocate the program to another VA site
    - **Relocate Facility** – maintain services and relocate the site within the same county to better place services closer to where Veterans live or to a site that can better fit services
    - **Modernize Facility** – update environment of care by improving or adding new building systems without changing the function of the existing space
    - **Replace Facility move** – applicable for standalone programs – maintain services within the same area in a new facility due to the current facility's inability to modernize efficiently
- **Partner** – Create a partnership where VA providers deliver care in coordination with a partner or where VA transitions care to a partner
    - **Partner (VA Delivered)** – a partnership in which VA providers deliver care to Veterans in coordination with a partner, such as through a VA hospital within a hospital on a partner hospital campus, credentialing VA providers within a partner facility, or establishing a VA point of care within a partner space
    - **Partner (CCN/AA/Federal)** – transition care from a VA site and from VA providers to the Community Care Network, an Academic Affiliate, or to Federal providers and facilities; VA provides care coordination but does not deliver clinical care

* All National Planning Strategy service planning guidelines may not include all major market move types.

Planning Guidelines Table

For Planning Guidelines Table terminology and detailed descriptions, see Appendix C.

MAHSO Planning Guidelines and Thresholds	
Service	GEN DOM, DOM SUD, DOM PTSD, and DCHV
Geography	Minimum of one of each program type per VISN. Additional programs may be added based on 120-minute drive time and/or demand criteria listed below.
Prerequisites	All MH RRTPs are required to be accredited under TJC Behavioral Health Standards Manual and attain and maintain accreditation under CARF Behavior Health Standards Manual – Residential Treatment standards. All new programs are required attain accreditation within 18 months of opening.

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• Minimum projected 10-year BDOC of 6,205 (17.0 ADC) based on the 3D Model	Demand criteria are based on: • Analysis and comparison of the projections from the 3D Model and EHCPM (See Appendix D) • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Supply	• Lack of VAMC with relevant MH RRTP services within a 120-minute drive time • Lack of community providers • Minimum size of 20 beds (minimum of 10 beds if co-located with another program) • Ability to sustain an 85.0% occupancy rate • Ability to meet minimum staffing requirements based on the number of beds being opened	Supply criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice site (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Access	• A new site ideally should be located within a 120-minute drive time of a HRR center/Metropolitan Statistical Area (MSA) that meets demand criteria • For GEN DOMs, DOM SUD programs, and DOM PTSD programs, a new site should be located within a major urban/ suburban population center and HRR center/MSA • For DCHV programs a new site should be located within an urban population center with affordable housing and entry-level job availability • New sites should be located on or within a half hour of a VAMC campus for optimal access to other VA services	Access criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E)
Quality	Quality metrics are not used to determine the opening of a new site	
Other	• Must comply with National Directive (VHA Directive 1162.02) and Design Guide ○ New site should be built with a home-like environment with access to exterior space ○ New sites should have adequate group rooms and both private and semi-private rooms to facilitate communication and socialization ○ Units should be designed with audio and visual monitoring capabilities ○ Units should be secured with a single point of access	Other criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of current VA Design Guide and VHA Directive 1162.02

Source: Department of Veterans Affairs Mental Health Residential Rehab Treatment Program Diagnosis and Demographic-Based Demand (MH RRTP 3D) Model Validation BY 2018

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	**No Change, Resize, Modernize, or Replace** • Minimum projected 10-year BDOC of 4,964 (13.6 ADC) based on the 3D Model **Relocate Program** • Projected 10-year BDOC is less than 4,964 (13.6 ADC) based on the 3D Model in current location	Demand criteria are based on: • Analysis and comparison of the projections from the 3D Model and EHCPM (See Appendix D) • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Supply	• Minimum size of 16 beds (minimum of 10 beds if co-located with another program) • Ability to sustain an 85.0% occupancy rate • Ability to meet staffing requirements based on the number of beds in use	Supply criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Access	• The existing site should be within a 120-minute drive time of a HRR center/MSA that meets demand criteria • The existing site has an average wait time goal of seven days or less for admission* • For GEN DOMs, DOM SUD programs, and DOM PTSD programs, a site should be located within a major urban/suburban population center and HRR center/MSA • For DCHV programs a site should be located within an urban population center with affordable housing and entry-level job availability • New sites should be located on or within a half hour of a VAMC campus	Access criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of current VA Design Guide

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**
Quality	• Admits per User value within 10.0% above or below VA national mean • ALOS within 10.0% above or below VA national mean	Quality criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Based on an analysis of the program specific national means for ALOS and Admits per User values from the BY 2018 3D Model (ranges are located in the Detailed Planning Guide Rationale)

Other	**No Change**
	• Sized appropriately to sustain 85.0% occupancy rate based on 10-year demand projections Planning guidelines are met or exceeded
	Resize (increase capacity)
	• Demand exceeds capacity
	Resize (decease capacity)
	• Demand is below capacity
	Relocate Program
	• Relocate MH RRTP services to a HRR center/MSA that meets demand criteria
	Modernize or Replace
	• Should comply with National Directive (VHA Directive 1162.02) and Design Guide
	  ○ The existing site lacks a therapeutically enriching environment that is home-like and promotes healing, autonomy, respect, and privacy
	  ○ The Facilities Condition Assessment (FCA) indicates the cost to replace facilities housing MH RRTP services is less than the cost to repair or maintain
		No Change
		• Current resources can meet projected demand
		Resize (increase capacity)
		• The current number of MH RRTP beds is unable to accommodate projected demand
		Resize (decrease capacity)
		• The current number of MH RRTP beds is greater than the projected demand
		Relocate Program
		• The current number of MH RRTP beds is unable to accommodate projected demand
		Modernize
		• The infrastructure does not adhere to current VA Design Guide and VHA Directive 1162.02 requirements
		Replace
		• The infrastructure does not adhere to current VA Design Guide and VHA Directive 1162.02 requirements and it is unable/more costly to modernize than replace

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**

Source: Department of Veterans Affairs Mental Health Residential Rehab Treatment Program Diagnosis and Demographic-Based Demand (MH RRTP 3D) Model Validation BY 2018

* Longer wait times may indicate a need for additional capacity, operational inefficiencies, lack of admissions staff, or lack of capacity and require further investigation

Partner VA Delivered
There are no current examples of VA delivered care with community partners and no viable community partners were identified.

Partner AA / Federal / CCN (Buy)		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• Projected 10-year BDOC at the existing VA site is less than 4,964 (13.6 ADC) based on the 3D Model	Demand criteria are based on: • Analysis and comparison of the projections from the 3D Model and EHCPM (See Appendix D) • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Supply	• No VAMC with relevant MH RRTP services within a 120-minute drive time of a HRR center/MSA that meets demand criteria • The community provides services that are comparable to VA MH RRTP services • The community has enough beds to absorb projected demand from the existing VA site	Supply criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Access	• For relevant residential treatment programs, such as those for SUD and PTSD, a CCN partner should be located within a HRR center/MSA • For homeless programs, a CCN partner should be located within an urban population center with affordable housing and entry-level job availability	Access criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E)

Partner AA / Federal / CCN (Buy)		
Planning Domain	**Planning Guideline**	**Rationale**
Quality	• The CCN partner is TJC and CARF accredited	Quality criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E)
Other	• The CCN partner has services within a home-like environment with access to exterior space • The CCN partner has adequate group rooms and both private and semi-private rooms to facilitate communication and socialization • The CCN partner has units equipped with audio and visual monitoring capabilities • Units should be secured with a single point of access The CCN partner has units secured with a single point of access	Other criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of current VA Design Guide

Source: Department of Veterans Affairs Mental Health Residential Rehab Treatment Program Diagnosis and Demographic-Based Demand (MH RRTP 3D) Model Validation BY 2018

MAHSO Planning Guidelines and Thresholds	
Service	CWT-TR
Geography	Minimum of one program per VISN. Additional programs may be added based on a 120-minute drive time and demand criteria listed below.
Prerequisites	All MH RRTPs are required to be accredited under TJC Behavioral Health Standards Manual and attain and maintain accreditation under CARF Behavior Health Standards Manual – Residential Treatment standards. Additionally, all CWT-TR programs are required to be accredited under CARF Behavioral Standards-Community Housing: Psychosocial Rehabilitation standards. All new programs are required attain accreditation within 18 months of opening.

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• Minimum projected 10-year BDOC of 3,103 (8.5 ADC) based on the EHCPM	Demand criteria are based on: • Analysis of the EHCPM • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Supply	• Lack of VAMC with relevant CWT-TR services within a 120-minute drive time of a HRR center/MSA that meets demand criteria • Lack of community providers • Minimum size of 10 beds which may be spread across multiple homes • Ability to sustain an 85.0% occupancy rate • Ability to meet minimum staffing requirements based on the number of beds being opened	Supply criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Access	• A new site ideally should be located within a 120-minute drive time of a HRR center/ MSA that meets demand criteria • A new site should be located within an urban population center with affordable housing and entry level job availability • New sites should be in a community location within a 30-minute drive time from a VAMC	Access criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E)
Quality	Quality metrics are not used to determine the opening of a new site	

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Other	• New site should operate in a home-like environment with access to exterior space • New sites should have private or semi-private rooms • New sites should be on a community property that was purchased, leased, or otherwise acquired by VHA, or in space on VA medical facility grounds.	Other criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Review of VHA Directive 1162.02

Source: 2019 Enrollee Health Care Projection Model; MH RRTP FY 2018 Annual Program Review National Data Report Northeast Program Evaluation Center (NEPEC)

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	**No Change** • Sized appropriately to sustain 85.0% occupancy rate based on 10-year demand projections **Maintain, Resize, Modernize, or Replace** • Minimum projected 10-year BDOC of 3,103 (8.5 ADC) based on the EHCPM **Relocate Program** • Projected 10-year BDOC is less than 3,103 (8.5 ADC) based on the EHCPM	Demand criteria are based on: • Analysis of the EHCPM • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)
Supply	• Minimum size of 10 beds which may be spread across multiple homes • Sustaining an 85.0% occupancy rate • Ability to meet staffing requirements based on the number of beds in use	Supply criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E) • Analysis of staffing guidelines from VHA Directives (See Appendix B)

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**
Access	• The existing site should be within a 120-minute drive time of the a HRR center/MSA that meets demand criteria • The existing site has an average wait time goal of seven days or less for admission • Located within an urban population center with affordable housing and entry level job availability • Sites should be in a community location within half an hour from a VAMC	Access criteria are based on: • Interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites (See Appendix E)
Quality	Quality metrics are not applicable	
Other	**No Change** • Sized appropriately to sustain 85.0% occupancy rate based on 10-year demand projections **Resize (increase capacity)** • Demand exceeds capacity **Resize (decrease capacity)** • Demand is below capacity **Relocate** • Relocate CWT-TR services to a more appropriate Veteran population center **Modernize or Replace** • The existing site lacks a home-like environment with access to exterior space to place CWT-TR services within • The FCA indicates the cost to replace CWT-TR program housing is less than the cost to repair or maintain • Lack of private or semi-private rooms	**No Change** • Current resources can meet projected demand **Resize (increase capacity)** • The current number of MH RRTP beds is unable to accommodate projected demand **Resize (decrease capacity)** • The current number of MH RRTP beds is greater than the projected demand **Relocate** • The current MH RRTP site is not within an urban population center with affordable housing and entry level job availability **Modernize or Replace** • The current structures are more costly to modernize than replace

Maintain No Change, Resize, Relocate, Modernize, Replace		
Planning Domain	**Planning Guideline**	**Rationale**

Source: 2019 Enrollee Health Care Projection Model; MH RRTP FY 2018 Annual Program Review National Data Report Northeast Program Evaluation Center (NEPEC)

Partner VA Delivered
There are no current examples of VA delivered care with community partners and no viable community partners were identified that offer comparable residential services.

Partner AA / Federal / CCN (Buy)
No viable community partners were identified that offer comparable residential services.

Additional Planning Guidelines

Partnering

As stated within section 2.2, current and projected VA reliance for GEN DOM, DOM PTSD, DOM SUD, DCHV, and CWT-TR is over 99.0% based on the BY 2018 VA Reliance Dashboard. [23] The guidelines do not include Partner-VA Delivered as there are few programs with comparable offerings and a lack of standardized quality and access measures. In the future, partnering may prove a more viable option if the industry as whole moves toward greater standardization of treatment modalities as well as quality and access metrics.

Women Veterans

There are additional planning considerations for women Veterans. New MH RRTPs and renovations to an existing space must be able to support a 20.0% minimum utilization rate for women Veterans. [5] Facilities with 40 or more MH RRTP beds must establish a separate secure unit or wing for women Veterans. Facilities that have fewer than 40 beds must have a separate and secured area for women Veterans. [5] If this is not possible, then rooms designated for women Veterans should be located in close proximity to staff. Additionally, when creating a women Veteran-only program there should be a minimum of 10 beds to ensure operational efficiency. [4]

Detailed Planning Guidelines Rationale

The planning guidelines were developed in collaboration with the MH RRTP Program Office and were driven by 1) National, VISN, and market-level data analysis including projections from the 3D Model and EHCPM; 2) Current VHA Guidelines and Directives; 3) Analysis of industry best practices and research; and 4) Interviews with identified VHA best practices program leadership across all program types.

- Geographic distribution criteria were based on the analysis of current program locations, types, and capacity, as well as the percent of MH RRTP workload received from outside of the VISNs. The resulting geographic distribution criteria ensure the full continuum of care in every VISN and optimize travel time for Veterans.
- Minimum BDOC demand criteria were based on an analysis and comparison of projections from the 3D Model and EHCPM, coupled with 1) interviews with the MH RRTP Program Office and 14 MH RRTPs identified as best practice sites for insights into minimum size for operational effectiveness; and 2) staffing guidelines. The resulting BDOC demand criteria ensure sustainable, operationally efficient programs.
- Several related planning criteria were also developed, as they can influence current and future demand projections. These include ALOS and Admits per User. These criteria were determined as key inputs into the 3D Model with targets based on an analysis of national means by program type. Quality criteria applied include ALOS and Admits per User values from FY 2018 used in the BY 2018 3D Model. These values are updated annually.
    - Ranges for Admits per User within FY 2018 were: [3]
        - GEN DOM (0.94-1.14)
        - DOM SUD (0.92-1.12)
        - DOM PTSD (0.90-1.10)
        - DCHV (0.90-1.10)
    - Ranges for ALOS within FY 2018 were: [3]
        - GEN DOM (46-56 days)
        - DOM SUD (29-35 days)
        - DOM PTSD (43-53 days)
        - DCHV (76-92 days)
- Occupancy rate targets were based on the MH RRTP Program Office's national policy goal as well as an analysis of rates achieved by identified best practice sites.
- Wait time criteria were determined as guidelines based on MH RRTP Program Office priorities and industry best practices.
- Staffing criteria were based on an analysis of staffing guidelines as well as interviews with best practice sites and the MH RRTP Program Office. The resulting criteria ensures optimal staffing levels are sustainable, resulting in improved quality of care.
- Program and facility location and attributed guidelines were based on best practices interviews, current design guides, and consultation with architects with extensive VA experience. The resulting guidelines ensure safe, effective treatment in a therapeutic environment, provide efficient adjacencies, and aim to place points of care in communities that support MH RRTP goals.

5. Future Program Planning

5.1 Applying the MH RRTP National Planning Strategy to VA Market Assessments

The VA MAHSO effort completed an initial assessment of VA markets, facilities, and service lines to produce recommendations for the design of high-performing integrated delivery networks. VA Leadership identified select service lines, studied during the market assessments, for development of a standard national strategy and approach to planning and maintaining programs. MH RRTP was identified as a service line requiring a set of national planning guidelines and thresholds that would be applicable for use in current (MAHSO) and future planning efforts.

This document, the MH RRTP National Planning Strategy, establishes the definitive, consistent, planning guidelines to be used for all VA MH RRTP planning efforts moving forward.

The national planning guidelines will be used to ensure that the final market assessments apply standardized programmatic criteria across the nation, but with full consideration of the range of care archetypes that exist within VA. The planning guidelines will be useful to VA planners to inform future quadrennial market assessments and other planning exercises.

How will MAHSO apply the MH RRTP National Planning Strategy?

The four-step process for revisiting MAHSO draft opportunities describes how the MH RRTP-specific opportunities will be reviewed and updated, if necessary.

1) Review Phase 1-3 Market Assessment Data and MH RRTP Opportunities

The scope of review will include revisiting Phase 1-3 markets, re-assessing all market opportunities using new thresholds and data (as applicable), and potentially developing new opportunities.

2) Apply MH RRTP Planning Guidelines

For each market and applicable draft MH RRTP opportunity, the planner will review market assessment data and apply MH RRTP planning guidelines. The reassessment will include any new data sources in the updated methods described previously. Next, planning guidelines developed here (demand, supply, access, quality, and mission, and other applicable MISSION Act § 203 criteria) will be applied to existing opportunities.

3) Update/Create MH RRTP Opportunities

As needed, existing market optimization or capital opportunities will be revised. In addition, after application of the planning guidelines and thresholds, new MH RRTP opportunities may also be created.

4) Review and Finalize with VA Leadership

Once draft opportunities are revised or developed and are ready for VA Leadership approval, a review with the Chief Strategy Office (CSO), VHA Leadership, and VISN Directors will move the opportunities towards finalization.

Conclusion

Common health care system challenges include balancing capacity with current and future demand; managing admission rates and wait times; optimizing inpatient LOS against quality of care; and maximizing bed utilization. VA is uniquely tasked with also distributing Veteran-centric MH RRTP services across the country and matching program demand throughout the many markets and VISNs within VA. Additionally, VA must plan, fund, construct, and activate new programs across the various sites of care.

The MH RRTP National Planning Strategy, created in conjunction with the MH RRTP Program Office, is a framework for designing consistent service delivery planning for MH RRTP services. Based on program priorities, the MH RRTP National Planning Strategy provides guidance on how MH RRTPs can respond to varied market demands and trends while optimizing VA resources in a Veteran-centric framework. These guidelines and thresholds will be used to ensure that capital planning is matched to Veteran demand and a consistent set of recommendations is established to inform and support the development of the National Realignment Strategy.

5.2 Planning Steps

Planning predominantly will happen at the market level but planners may want to look at broader VISN needs. Appendix G includes a step by step method of how planners may apply these guidelines.

Appendix A: References

1. "Pre-Decisional Deliberative Document"- Department of Veterans Affairs Office of Mental Health and Suicide Prevention. *Mental Health Residential Rehabilitation Treatment Program (MH RRTP) Program Overview and National Access Plan*: U.S. Department of Veterans Affairs; 2020.
2. Department of Veterans Affairs, Northeast Program Evaluation Center. *MH RRTP FY2020 Annual Program Review Program & VISN Level Data Report Northeast Program Evaluation Center (NEPEC)*.
3. Department of Veterans Affairs, Chief Strategy Office. *Mental Health Residential Rehab Morbidity 3D Model Summary of Users and Utilization by Residence and Treatment Location* April 13, 2020.
4. MH RRTP Program Office. *National Planning Strategy Meeting Notes*: Office of Mental Health and Suicide Prevention, Department of Veterans Affairs; August 2020-March 2021.
5. Department of Veteran Affairs. *VHA Directive 1162.02: Mental Health Residential Rehabilitation Treatment Program (MH RRTP)* 2019.
6. Cornell Law School. 38 U.S. Code § 1710 - Eligibility for Hospital, Nursing Home, and Domiciliary Care. *LII / Legal Information Institute*. Available at: https://www.law.cornell.edu/uscode/text/38/1710. Accessed March 2021.
7. Cornell Law School. 38 CFR § 17.46 - Eligibility for Hospital, Domiciliary or Nursing Home Care of Persons Discharged or Released from Active Military, Naval, or Air Service. *LII / Legal Information Institute*. Available at: https://www.law.cornell.edu/cfr/text/38/17.46. Accessed March 2021.
8. Cornell Law School. 38 U.S. Code § 2043 - Domiciliary Care Programs. *LII / Legal Information Institute*. Available at: https://www.law.cornell.edu/uscode/text/38/2043. Accessed March 2021.
9. Department of Veterans Affairs. Definitions of MH RRTPs. https://www.va.gov/HOMELESS/docs/DCHV_Definitions_of_MHRRTPs.pdf. Accessed March 2021.
10. American Public Health Association. *Removing Barriers to Mental Health Services for Veterans. Policy Number: 201411* 2014.
11. Substance Abuse and Mental Health Services Administration. *2019 National Survey on Drug Use and Health: Veteran Adults*: U.S. Department of Health and Human Services; September 2020.
12. Office of Disease Prevention and Health Promotion. Mental Health. *HealthyPeople.gov*. October 8, 2020. Available at:

https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health/determinants.

13. National Veterans Foundation. Troubling Veteran Mental Health Facts and Statistics that Need to be Addressed. March 25, 2016. Available at: https://nvf.org/veteran-mental-health-facts-statistics/.

14. Department of Veterans Affairs. How Common is PTSD in Veterans? *PTSD: National Center for PTSD*. September 24, 2018. Available at: https://www.ptsd.va.gov/understand/common/common_veterans.asp#:~:text=Operations%20Iraqi%20Freedom%20(OIF)%20and,PTSD%20in%20a%20given%20year.&text=It%20is%20estimated%20that%20about,had%20PTSD%20in%20their%20lifetime.

15. Department of Veterans Affairs. Military Sexual Trauma. Available at: https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

16. Department of Veteran Affairs. Women Veterans Health Care: Facts and Statistics about Women Veterans. n.d.. Available at: https://www.womenshealth.va.gov/womenshealth/latestinformation/facts.asp.

17. American Psychological Association. Government Relations Office. *The Mental Health Needs of Veterans, Service Members and Their Families* n.d.

18. Eckerlin M, Kovalesky , Jakupcak. Military Sexual Trama in Male Service Members. *The American Journal of Nursing*. September 2016;116(9).

19. U.S Interagency Council on Homelessness. *Homeless in America: Focus on Veterans* June 2018.

20. Substance Abuse and Mental Health Services Administration. *National Survey Of Substance Abuse Treatment Services (N-SSATS): 2019, Data On Substance Abuse Treatment Facilities* August 20, 2020.

21. Department of Veterans Affairs, National Center for PTSD. For Veterans and Families: Understanding PTSD and Substance Use. *Advancing Science and Promoting Understanding of Traumatic Stress*. https://www.ptsd.va.gov/publications/print/sudptsdflyer.pdf. Accessed February 15, 2021.

22. Department of Veterans Affairs. Spotlight on Substance Use Disorder. *Health Services Research & Development*. April 2019. Available at: https://www.hsrd.research.va.gov/news/feature/sud2019.cfm.

23. Department of Veterans Affairs, Northeast Program Evaluation Center. *Northeast Program Evaluation Center (NEPEC) FY19 'Closeout' Summary Workbook* February 21, 2020.

24. Department of Veterans Affairs. *VHA Directive 1170.01- Accreditation of Veterans Health Administration Rehabilitation Programs* 2017.

25. Department of Veterans Affairs. VA/DoD Clinical Practice Guidelines. n.d. Available at: https://www.healthquality.va.gov/.

26. Department of Veterans Affairs, Northeast Program Evaluation Center. *Northeast Program Evaluation Center (NEPEC) National Workbook_FY20_FINAL*.

27. Stewart MT, O'Brien PL, Shields MC, White MC, Mulvaney-Day N. *State Residential Treatment For Behavioral Health Conditions:Regulation And Policy Environmental Scan*. Washington D.C.: U.S. Department of Health and Human Services; 2019.

28. Department of Veterans Affairs. *Clay Hunt Suicide Prevention for American Veterans (SAV) Act, 2019 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation*. Washington D.C.: Department of Veterans Affairs ; 2019.

29. Department of Veterans Affairs. *About VA*. January 5, 2021. Available at: https://www.va.gov/about_va/.

30. Substance Abuse and Mental Health Services Administration. *National Mental Health Services Survey (N-MHSS): 2017--Data on Mental Health Treatment Facilities* 2017.

31. McGovern MP, Lambert-Harris C, Gotham HJ, Claus RE, Xie H. Dual Diagnosis Capability in Mental Health and Addiction Treatment Services: An Assessment of Programs Across Multiple State Systems. *Administration and Policy in Mentahl Health and Mental Health Services Research*. 2014(41):205-214.

32. Ireys H, Achman L, Takyi A. *State Regulation of Residential Facilities for Adults with Mental Illness*. Rockville, MD: Department of Health and Human Services ; 2006. DHHS Pub. No. (SMA) 06-4166.

33. Arizona Department of Health Services. Behavior Health Residential Facilities, Arizona Administrative Rules, Title 9, Chapter 10, Article 7. 2012. https://azdhs.gov/documents/licensing/trainings-exercises-collaboratives/rules/residential-facilities-new-rules-training-presentation.pdf.

34. Department of Health Care Services. California Code of Regulations, Title 9, Division 4, Chapter 5, Subchapter 1, Article 2. October 23, 2019. Available at: https://www.dhcs.ca.gov/provgovpart/Pages/Reg1_10501.aspx.

35. Texas Register. Texas Administrative Code, Title 25, Part 1, Chapter 404, Subchapter E. October 1, 1996. Available at: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=404&rl=153.

36. Leavitt M. Medscape's Response to the Institute of Medicine Report: Crossing the Quality Chasm: A New Health System for the 21st Century. *Medscape General Medicine*. 2001;3(2).

37. Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions. *National Academies Press*. 2006.

38. Kilbourne AM, Beck , Spaeth-Rublee B, et al. Measuring and Improving the Quality of Mental Health Care: A Global Perspective. *World Psychiatry*. February 2018;17(1):30-38.

39. Lewis C, Puspitasari A, Boyd MR. Implementing Measurement Based Care in Community Mental Health: A Description Tailored and Standardized Methods. *BMC Research Notes*. January 2018;11(76).

40. World Health Organization. *World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2* 2005.

41. Wammes J, Stadhouders N, Westert G. International Healthcare System Profiles, Netherlands. *The Commonwealth Fund*. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands.

42. Burgess P, Coombs T, Clarke A, Dickson R, Pirkis J. Achievements in Mental Health Outcome Measurement in Australia: Reflections on Progress Made by the Australian Mental Health Outcomes and Classification Network (AMHOCN). *International Journal of Mental Health Systems*. 2012;6(1):4.

43. National Health System Benchmarking Network. The in-house benchmarking service of the NHS. n.d.. Available at: https://www.nhsbenchmarking.nhs.uk/.

44. de Andrade D, Elphinston RA, Quinn C, Allan J, Hides L. The Effectiveness of Residential Treatment Services for Individuals with Substance Use Disorders: A Systematic Review. *Drug and Alcohol Dependence*. 2019(201):227-235.

45. CARF International. Accreditation Benefits. Available at: http://www.carf.org/Accreditation/ValueOfAccreditation/Benefits/.

46. American Society of Addiction Medicine. ASAM and CARF Launch Transformative Residential Addiction Treatment Certification Nationwide [Press release]. June 1, 2021. Available at: https://www.asam.org/docs/default-source/quality-science/asam-level-of-care-certification-launch-press-release-2020-final.pdf?sfvrsn=414d54c2_2.

47. Medicaid Innovation Accelerator Program. Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms. April 2017. Available at: https://www.medicaid.gov/state-

resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf.

48. Naval Medical Center Portsmouth. Available at: https://eisenhower.amedd.army.mil/HealthcareServices/BehavioralHealth/RTF/.
49. Eisenhower Army Medical Center. Available at: https://eisenhower.amedd.army.mil/HealthcareServices/BehavioralHealth/RTF/.
50. Grace-Simons K. Living in Recovery: A look into Madigan's Residential Treatment Facility. *U.S. Army*. May 30, 2019. Available at: https://www.army.mil/article/222588/living_in_recovery_a_look_into_madigans_residential_treatment_facility.
51. Naval Medical Center San Diego. Available at: https://www.med.navy.mil/sites/nmcsd/Pages/Services/Substance-Abuse-Rehabilitation-Program-(SARP).aspx.
52. Fort Belvoir Community Hospital. Residential Treatment Center. Available at: https://belvoirhospital.tricare.mil/Health-Services/Mental-Health-Substance-Abuse/Residential-Treatment-Facility.
53. Department of Defense, Department of Veterans Affairs, Department of Health and Human Services. *Interagency Task Force on Military and Veterans Mental Health, 2017 Annual Report* 2017.
54. American Residential Treatment Association. American Residential Treatment Association. n.d.. Available at: https://artausa.org/.
55. National Institutes of Health NIoDA. Opioid Overdose Crisis. May 27, 2020. Available at: https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis.
56. Hirsh H, Wheeler N, Gelman K, Swan J. *Outcomes Measurement Toolkit and Pilot Program Final Report*. Denver 2019.
57. Caron Treatment Centers and Hazelden Betty Ford Foundation. Defining a Center of Excellence: An Addiction Treatment Model. February 2016.
58. Hazelden Betty Ford Foundation. Why Choose Hazelden Betty Ford. n.d.. Available at: https://www.hazeldenbettyford.org/about-us/why-choose.
59. Caron. Treatment Programs. Available at: https://www.caron.org/treatment-programs.
60. Close L. The Components of the Best Residential Drug Treatment Programs. *American Addiction Centers*. June 1, 2020. Available at: https://americanaddictioncenters.org/rehab-guide/residential.

61. Miller L. How to Pay for Rehab with the MISSION Act Community Care Program. *American Addiction Centers*. May 5, 2020. Available at: https://americanaddictioncenters.org/veterans/mission-act-community-care.

62. Sierra Tucson. Best PTSD & Trauma Treatment Center & Rehab. n.d.. Available at: https://www.sierratucson.com/ptsd/.

63. Sierra Tucson. The Red, White, and Blue Program. Available at: https://www.sierratucson.com/programs/military/.

64. Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for People Who Are Homeless, A Review of the Literature, TIP 55*: U.S. Department of Health and Human Services ; 2015.

65. Human Services Research Institute. Evaluating SAMHSA's PATH Program. Available at: https://www.hsri.org/project/evaluating-samhsas-path-program. Accessed January 2021.

66. Dream Center. Residential Programs. Available at: https://www.dreamcenter.org/residential/.

67. Fountain House. Social Enterprise. Available at: https://www.fountainhouse.org/what/model/employment/social-enterprise#:~:text=Social%20enterprise%20achieves%20a%20double,and%20obtain%20invaluable%20job%20skills.

68. Department of Health. *Adult Prevention and Recovery Care (PARC) Services Framework and Operational Guidelines*. Melbourne: A Victorian Government Initiative ; 2010.

69. Davister C, Deforuny J, Gregoire O. *WORK INTEGRATION SOCIAL ENTERPRISES IN THE EUROPEAN UNION: AN OVERVIEW OF EXISTING MODELS*: EMES European Research Network; n.d. WP 4/04.

70. Spear R, Bidet E. Social enterprise for work integration in 12 european countries: a descriptive analysis. *Annals of Public and Cooperative Economics*. June 2005;76(2):195-231.

71. Czischke , Gruis V, Mullins D. Conceptualising Social Enterprise in Housing Organisations. *Housing Studies*. 2021;27(4):418-437.

72. Substance Abuse and Mental Health Services Administration. *Using Technology-Based Therapeutic Tools in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 60*. Rockville, MD 2015.

73. Hazeldon Betty Ford Foundation. Ongoing Addiction Recovery Support. n.d.. Available at: https://www.hazeldenbettyford.org/recovery/preventing-relapse/my-ongoing-recovery-experience.

74. Darmouth Atlas Project. General FAQ. Available at: https://www.dartmouthatlas.org/faq/.

75. United States Census Bureau. Core-Based Statistical Areas. December 7, 2016. Available at: https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html#:~:text=Metropolitan%20statistical%20areas%20have%20at,as%20measured%20by%20commuting%20ties.

Appendix B: Staffing

Table B1: Minimum MH RRTP FTE by Number of Beds [5]											
Staffing Positions	**< 20 Beds**	**21-30 Beds**	**31-40 Beds**	**41-50 Beds**	**51-60 Beds**	**61-80 Beds**	**81-99 Beds**	**100-125 Beds**	**125-150 Beds**	**150-175 Beds**	**176-200 Beds**
Chief or Manager	0.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant Chief or Clinical Manager	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0
MD/DO, PA or NP	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.6	1.9	2.2	2.5
Psychiatrist (MD/DO), Psychiatric Nurse Practitioner	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Psychologist	0.5	0.8	1.0	1.0	1.4	1.8	2.0	2.6	3.0	3.6	4.0
Admissions/ Transitions Coordinator	0.5	0.5	0.5	1.0	1.0	1.0	1.0	1.5	1.5	2.0	2.0
Social Worker	1.0	1.2	1.6	2.0	2.4	3.2	4.0	5.0	6.0	7.0	8.0
Employment and Vocational Services Staff	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Peer Tech	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Recreation Therapist	0.5	0.5	0.5	0.5	0.5	0.6	0.8	1.0	1.2	1.4	1.6
Dietician	0.2	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.2	1.4	1.6
Clinical Pharmacist/ Clinical Pharmacy Specialist	0.3	0.3	0.5	0.5	0.6	0.8	1.0	1.0	1.2	1.4	1.6
Medical or Program Assistant	0.5	0.8	1.0	1.3	1.5	2.0	2.5	3.1	3.8	4.4	5.0
Total FTEs	4.9	6.1	8.1	9.8	11.5	14.4	17.4	22.7	26.3	30.8	34.3

Note: 24/7 Nursing staff are determined by the Nurse Staffing Methodology

Table B2: Minimum FTE Requirements for Specialty Bed Sections [5]						
Position per Number of Beds	**<20**	**21-30**	**31-40**	**41-50**	**51-60**	**61-80**
SUD RRTP Specialty Staff (bed section)	2.0	3.5	5.0	6.0	7.0	8.0
Seriously Mentally Ill (SMI) Specialty Staffing	2.0	3.5	5.0	6.0	7.0	8.0
Psychosocial Specialty Staffing (Homeless and/or Vocational)	1.0	2.0	2.5	3.0	3.5	4.0

Note: 24/7 Nursing staff are determined by the Nurse Staffing Methodology

Table 5B3: CW TR Minimum Staffing Based on Number of Beds [5]								
Position per Number of Beds	Less than 10 Beds	11-15 Beds	16-20 Beds	21-25 Beds	25-30 Beds	31-35 Beds	35-40 Beds	40-45 Beds
Program Manager	0.2	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Care Manager	0.5	0.8	1.0	1.3	1.5	1.8	2.0	2.3
Program Clerk	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
MD/DO, PA, or Psychiatric MH NP or NP	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Program Evaluator	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
Other Clinical	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Total	1.3	1.8	2.5	3.3	4.0	4.6	5.3	6.1

Note: 24/7 Nursing staff are determined by the Nurse Staffing Methodology

Appendix C: Planning Guidelines Table Terminology and Detailed Descriptions

Program guidelines and thresholds that trigger the open move of new MH RRTPs are based on discrete criteria described below:

- **Geographic Area:** Whether a MH RRTP already exists within the VISN of a market where a MH RRTP is being planned.
    - It is recommended, at a minimum, to have a at least one of each type of MH RRTP including GEN DOMs, DOM SUD programs, DOM PTSD programs, DCHVs, and CWT-TRs within a VISN's boundaries provided that the minimum service area demand within the next 10 years justifies investment.
    - Additional programs may be added if the location of potential site exceeds 120-minute drive time from nearest MH RRTP and/or service area demand meets criteria.
- **Minimum Service Area Demand for New Sites:** The minimum projected ADC required to justify building a new MH RRTP.
    - For GEN DOMs, DOM SUD programs, DOM PTSD programs, and DCHV programs, this threshold is a 10-year projected ADC of 17.0, or 6,205 annual BDOC, as determined by the 3D Model. For CWT-TR programs, this is a 10-year projected ADC of 8.5, or 3,103 BDOC, as determined by the EHCPM.
- **Minimum Size for New Sites:** The smallest numbers of beds an individual MH RRTP can have for an efficient use of resources.
    - At a minimum, a new GEN DOM, DOM SUD program, DOM PTSD program, or DCHV program should be able to staff 20 beds. At a minimum, a new CWT-TR program should be able to staff a minimum 10 beds.
    - CWT-TR beds can be spread across multiple homes.
- **Co-located Bed Sections:** Beds that provide a specific service such as GEN DOM, DOM SUD, DOM PTSD, or DCHV that exist within a program that is a different bed section. For example, a DOM SUD bed section can exist within a GEN DOM program, meaning that some of the beds assigned to the GEN DOM program provide DOM SUD services. CWT-TR program lack co-located bed sections.
    - At a minimum, a co-located bed section should be able to staff 10 beds.
- **Ideal Program Location:** New MH RRTPs should be located within areas that can support the sustainment of the MH RRTPs to ensure the longevity of the program.
    - New sites should be located on or within a half hour of a VAMC campus for optimal access to other VA services. The physical location for GEN

DOMs, DOM SUD programs, and DOM PTSD programs, are within a HRR center/MSA. For new DCHV programs and CWT-TRs, the ideal location is within an urban population center that has affordable housing and entry level job availability to support Veterans when they are discharged from these programs.

- HRRs are defined by the Dartmouth Atlas as regional commercial health care markets for tertiary medical care defined by having at least one hospital that performs major cardiovascular procedures and neurosurgery, indicating a high concentration of medical resources. [74]
- MSAs are defined by the United States Census Bureau as consisting of one or more counties that contain a city of 50,000 or more inhabitants or contain a Census Bureau-defined urbanized area and have a total population of at least 100,000 (75,000 in New England). [75]

The maintain resize, relocate, modernize, replace, and partner moves for MH RRTPs at a site is determined by discrete program criteria described below:

- **Minimum Service Area Demand for Existing Sites:** The minimum projected ADC required to sustain an MH RRTP.
  - For GEN DOMs, DOM SUD programs, DOM PTSD programs, and DCHV programs, this threshold is a 10-year projected ADC of 13.6 or 4,964 annual BDOC as determined by the 3D Model. For CWT-TRs, this is a 10-year projected ADC of 8.5 or 3,103 BDOC as determined by the EHCPM.
- **Co-located Bed Sections:** Beds that provide a specific service such as GEN DOM, DOM SUD, DOM PTSD or DCHV that are co-located at the same facility often sharing space with centralized policies, procedures, and staffing. CWT-TR program lack co-located bed sections.
  - At a minimum, a co-located bed section should be able to staff 10 beds.
- **ALOS:** The average duration a patient stays within an MH RRTP.
  - This criterion is relevant for all programs except CWT-TRs. To sustain a MH RRTP, the program must have an ALOS that is within a range of 10.0% above or below the national mean for the relevant program. For example, the national mean for GEN DOMs was 51 days during FY 2018, so GEN DOMs that should be sustained would have an ALOS as low as 46 days and as high as 56 days. A longer ALOS requires further investigation at the site level as it can indicate justifiable differences in treatment protocols or operational inefficiencies that artificially inflate ADC and bed need.
- **Admits per User:** The number of MH RRTP admissions per unique per MH RRTP per year.

  - Programs with high admissions per user may indicate higher readmission rates for patients within the program. To sustain a MH RRTP, the program must have an Admits per User value that is within a range 10.0% above or below the national mean for Admits per User for a program type. For example, the Admits per User during BY 2018 for DOM SUD programs was 1.01, with an acceptable range of 0.92 to 1.12. This value is not calculated and used for CWT-TRs. Higher Admits per User rates require further investigation as they may infer greater readmission rates which in turn increases ADC.
- **Occupancy Rate Goal:** The yearly occupancy rate for a MH RRTP, which is the percentage of MH RRTP beds that have patients.
  - Across all MH RRTPs, the goal is to have an occupancy rate of 85.0%. Lower occupancies can indicate a need to better market services, staffing challenges, or in some cases excess capacity. High occupancies can indicate the need for additional beds.
- **Wait Times for Admission Goal:** The amount of time from when a patient is referred or requests MH RRTP services to the time that patient is admitted into a MH RRTP.
  - The goal across all MH RRTPs is to admit patients within seven days. Few programs are currently meeting this goal. Longer wait times may indicate a need for additional capacity, operational inefficiencies, lack of admissions staff, and require further investigation.
- **Minimum Size of Existing Sites**: The smallest number of beds an existing individual MH RRTP can have for an efficient use of resources.
  - At a minimum, GEN DOMs, DOM SUD programs, DOM PTSD programs, and DCHV programs should have 16 beds with an ADC of 13.6 to be considered sustainable. CWT-TRs should have a minimum 10 beds with an ADC of 8.5 to be considered sustainable.
  - CWT-TR beds can be spread across multiple homes.
- **Minimum Size of Co-Located Bed Sections:** The smallest size of a separate bed section that is co-located with another MH RRTP. For example, a GEN DOM can be co-located with a DOM SUD and/or DOM PTSD bed sections.
  - For these types of situations, it is recommended to have at least 10 beds for a co-located bed section. This measure is not used for CWT-TR programs.
- **Ideal Program Location:** Over time, population demographics can change and programs that were once within population rich areas may no longer be appropriately located. MH RRTPs should be located within areas that can ensure longevity of the program.
  - New sites should be located on or within a half hour of a VAMC campus for optimal access to other VA services. For GEN DOMs, DOM SUD

programs, and DOM PTSD programs, this location should be within a HRR center/MSA. For DCHV and CWT-TR programs, the ideal location is within an urban population center that has affordable housing and entry level job availability to support Veterans when they exit from these programs.

Appendix D: Comparison of Projection Models

There are two projection models for the Mental Health Residential Rehabilitation Treatment Program (MH RRTP): MH RRTP Demographic and Diagnosis-Based Demand (3D) Model and Enrollee Health Care Projection Model (EHCPM). Both models project similar utilization at the national level for MH RRTP but can differ significantly at the VISN and market levels. Based on a national comparison, the BY 2018 3D Model and EHCPM projections were within 2.0% of one another for FY 2019. The modeling methodology used in both models is intentionally built to tackle different needs in the planning process. A data driven approach to MH RRTP planning can be leveraged by understanding the capabilities of the two models and utilizing them together appropriately.

3D Model

The 3D Model's purpose is to provide an estimate of MH RRTP need among the enrollee population, independent of historical utilization patterns and any potential limitations due to supply. To develop projections, the model uses enrollees' diagnosis codes as well as their age and sex to produce a probability that the enrollee would utilize MH RRTP services. This allows the model to project how many users within a geography are projected to need VA care regardless of its availability. These projections are made separately for each MH RRTP bed section. Projected MH RRTP BDOC are then calculated by multiplying predicted users by the national ALOS, and national average admissions per user for the following MH RRTP bed sections: GEN DOM, DOM SUD, DOM PTSD, and DCHV. These bed day projections are projected forward 10 years using the utilization trends implied by the EHCPM. The estimates are developed at the submarket level and rolled up to the VISN and national levels. Predicted users and BDOC are then compared to actual VA workload data to identify differences between actual services provided and projected demand by geography. The 3D model is most credible in its projection of BDOC at the national and VISN levels. This is due to the data being less volatile and subject to less random variation. Diving into specific markets or submarkets can result in greater deviations between the actual and predicted number of BDOC. Deviations between actual and predicted BDOC may indicate the need to relocate MH RRTPs to align closer to where enrollees need the care. Discrepancies between actual and predicted BDOC may also occur when there are significant differences between local LOS and admission rates and the national averages utilized by the model. As such, it is important that planners also look at these inputs and underlying causes of any variation when assessing the totality of demand for a particular geography. Despite these limitations, the 3D Model should be utilized as the primary planning tool for determining VISN level MH RRTP resources.

EHCPM

The EHCPM is used to project enrollment and utilization of the enrolled Veteran population for 20 years into the future for approximately 140 categories of health care services including MH RRTP. First, it models the number of Veterans enrolled each year and their age, gender, priority, and geographic location. Next, the EHCPM projects the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA.

The EHCPM's projected MH RRTP BDOC are developed based on enrollees' residence. That projected workload is allocated to facilities based on historical utilization. Factors such as the presence of a program, low historical occupancy rates, long wait times, or long ALOS all impact historical utilization and, as such, impact the projections. EHCPM projections do not differentiate between utilization from Veterans residing outside of a VISN or market to receive MH RRTP care compared to Veterans who receive care in the VISN or market within which they reside. The EHCPM is intended to help understand future demand within the context of underlying constraints that impact current and future workload.

Use of the 3D Model and the EHCPM for MH RRTP Planning

Due to underlying differences in purpose between the 3D Model and the EHCPM, their use in planning for MH RRTPs is different. It is best to use the 3D Model for VISN-level planning to determine whether a VISN has enough MH RRTP beds to meet projected MH RRTP demand from within the VISN overall. The 3D Model may indicate certain populations with projected MH RRTP demand lack available MH RRTP resources near them. This can result in recommendations to develop or redistribute MH RRTPs. Additionally, due to the 3D Model providing MH RRTP bed section-based projections, the model can be used for directionally determining if a MH RRTP needs more beds of a specific MH RRTP bed section.

The EHCPM is useful for determining whether to increase or decrease the number of beds within a MH RRTP overall. Projections for CWT-TR are developed distinctly in the EHCPM, but the rest of MH RRTP bed sections are aggregated. Therefore, the EHCPM does not tell whether a specific MH RRTP bed section is projected to have more demand than another. For this reason, it can be helpful to look at the 3D Model in relation to the EHCPM to see directionally which bed sections the 3D Model predicts will increase or decrease.

Appendix E: Interviews

Office/Facility	Interviewee(s)	Title/ Position	Date(s)
MH RRTP Program Office Office of Mental Health and Suicide Prevention VACO	Jamie Ploppert	National Mental Health Director, MH RRTP (retired September 2020)	August 24, 2020
	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	
	Kimberly Coleman Prier	Deputy Director, MH RRTP	
	Noelle Smith	Project Director, MH RRTP VA Northeast Program Evaluation Center (NEPEC)	
MH RRTP Program Office Office of Mental Health and Suicide Prevention VACO	Jamie Ploppert	National Mental Health Director, MH RRTP (retired September 2020)	August 25, 2020
	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	
	Kimberly Coleman Prier	Deputy Director, MH RRTP	
	Noelle Smith	Project Director, MH RRTP VA Northeast Program Evaluation Center (NEPEC)	
MH RRTP Program Office Office of Mental Health and Suicide Prevention VACO	Jamie Ploppert	National Mental Health Director, MH RRTP (retired September 2020)	August 26, 2020
	Kimberly Coleman Prier	National Mental Health Director, MH RRTP	
MH RRTP Program Office Office of Mental Health and Suicide Prevention VACO	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	September 1, 2020
	Kimberly Coleman Prier	Deputy Director, MH RRTP	
	Noelle Smith	Project Director, MH RRTP VA Northeast Program Evaluation Center (NEPEC)	
MH RRTP Program Office	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	September 2, 2020
	Kimberly Coleman Prier	Deputy Director, MH RRTP	

	Camilla Doctor	Program Analyst, MH RRTP	
	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	September 4, 2020
	Kimberly Coleman Prier	Deputy Director, MH RRTP	
	Camilla Doctor	Program Analyst, MH RRTP	
	Dr. Jennifer Burden	National Mental Health Director, MH RRTP	September 8, 2020
	Kimberly Coleman Prier	Deputy Director, MH RRTP	
	Noelle Smith	Project Director, MH RRTP VA Northeast Program Evaluation Center (NEPEC)	
	Camilla Doctor	Program Analyst, MH RRTP	
	Dr. Octaviana Hemmy Asamasma	Clinical Psychologist, SUD Division Director	October 16, 2020
	Dr. Ryan Faulkner	Director, DCHV	
	Bobbie Sloan	Nurse Manager, Substance Dependence Services	
	Dr. David Indest	Chief of Mental Health and Homeless Operations	October 16, 2020
	Dr. Erin Anderson Fortier	Associate Chief of Staff, MH RRTP	
	Leah Poissant-Matson	Program Manager, MH RRTP	October 16, 2020
	Joseph Bonnesen	VISN 23 Homeless, Residential, and Work Therapy Coordinator	
	Dr. Ronald Braasch	Acting Chief of Staff, Mental Health and Behavior Support Specialist	October 30, 2020
	Dr. Sue Ann Garrison	Section Chief, MH RRTP	
	Todd Holliday	Program Manager, Substance Abuse Treatment Program	
	Angela Keen	VISN 4 Mental Health Lead	

Office/Facility	Interviewee(s)	Title/ Position	Date(s)
Coatesville VA Medical Center	Glenn Wikel	VISN 4 Health System Specialist	October 30, 2020
	Angela McCarroll	Chief, Domiciliary	
Honolulu VA Medical Center	Dr. Michael Drexler	VISN 21 Chief Mental Health Officer	October 30, 2020
	Dr. Allison Aosved	Program Manager, PTSD Virtual-IOP Recovery Program	
Pittsburgh Heinz VA Medical Center	Tykia Andre	Program Manager, Psychosocial RRTP	October 30, 2020
	Glenn Wikel	VISN 4 Health System Specialist	
Cincinnati VA Medical Center	Kate Chard	Director, Trauma Recovery Center & Associate Chief of Staff, Research	November 13, 2020
	Nicola Caldwell	Program Manager and Associate Director, Trauma Recovery Center	
Denver VA Medical Center	Dr. Mandy Rabenhorst	Acting Domiciliary Chief for PTSD and DCHV	November 13, 2020
San Diego VA Medical Center	Dr. Carl Rimmele	Program Manager, DCHV	November 13, 2020
Oklahoma City VA Medical Center	Fawn Jones	Program Coordinator, Vocational Rehabilitation Service and Transitional Residence Program	November 13, 2020
	Tim Morrison	Vocational Rehabilitation Specialist	
Hot Springs VA Medical Center	Rodger Woeppel	CWT Supervisor	December 4, 2020
	Holly Shield	Licensed Professional Counselor	
Tampa Bay VA Medical Center	Dr. Mark Ruiz	Program Manager, DCHV	December 4, 2020
	Carri Ann Gibson	VISN 8 Chief Mental Health Officer	
	Glenn Smith	Community Programs Section Chief	
Butler VA Medical Center	Tim Morrison	Vocational Rehabilitation Specialist	December 4, 2020
	Glenn Wikel	VISN 4 Health System Specialist	

Appendix F: Abbreviation List

Abbreviation	Definition
AAC	American Addiction Centers
ACT	Assertive Community Treatment
ADC	Average Daily Census
AIR	Asset and Infrastructure Review
ARTA	American Residential Treatment Association
ALOS	Average Length of Stay
ASAM	American Society of Addiction Medicine
BDOC	Bed Days of Care
BY	Base Year
CARF	Commission on Accreditation of Rehabilitation Facilities
CBOC	Community Based Outpatient Clinic
CBT	Cognitive Behavioral Therapy
CSO	Chief Strategy Office
CWT-TR	Compensated Work Therapy-Transitional Residence
DCHV	Domiciliary Care for Homeless Veterans
DO	Doctor of Osteopathy
DOM PTSD	Domiciliary Post Traumatic Stress Disorder
DOM SUD	Domiciliary Substance Use Disorder
DoD	Department of Defense
EBC	Evidence-Based Care
EBT	Evidenced-Based Treatment
EHCPM	Enrollee Health Care Projection Model
FDA	Food and Drug Administration
FTE	Full-Time Equivalent
FY	Fiscal Year
HRR	Hospital Referral Region
LOS	Length of Stay
MAHSO	Market Area Health Systems Optimization

Abbreviation	Definition
MBC	Measurement Based Care
MD	Doctor of Medicine
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
MISSION	Maintaining Systems and Strengthening Integrated Outside Networks
MSA	Metropolitan Statistical Area
MST	Military Sexual Trauma
NEPEC	Northeast Program Evaluation Center
NP	Nurse Practitioner
PA	Physician Assistant
PARC	Prevention and Recovery Care
PATH	Project for Assistance and Transition from Homelessness
PMH-NP	Psychiatric Mental Health Nurse Practitioner
PTSD	Posttraumatic Stress Disorder
Q4	Fourth Quarter
QUERI	Quality Enhancement Research Initiative
SAMHSA	Substance Abuse and Mental Health Services Administration
SARP	Substance Abuse Rehabilitation Programs
SMI	Serious Mental Illness
SUD	Substance Use Disorder
3D Model	Demographic and Diagnosis-Based Demand Model
TJC	The Joint Commission
VA	Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Appendix G: Planning Steps

Planning predominantly will happen at market level but planners may want to look at broader VISN needs. To allow for a standardized approach toward MH RRTP planning, the following four-step process can be applied as illustrated below.

1) **Assess Current State:**
   The first step entails understanding the location, availability, type, capacity, and challenges of the existing MH RRTP supply at the VISN level.

   - Through an analysis of the latest MH RRTP data, identify the specific programs and number of beds devoted to MH RRTPs.
   - Determine whether current MH RRTPs are located within HRR centers or identified MSAs. For existing programs, review key metrics related to the programs including ALOS, Admits per User, wait times, and occupancy rates.
   - Identify other program criteria as identified in the planning guidelines including appropriateness of location, ability to staff, and any deficiencies related to the facility.
   - For markets without MH RRTPs, identify where patients within the market are receiving MH RRTP services to understand if they experience drive times exceeding 120 minutes and long wait times to receive care.

2) **Assess Demand:**
   The second step involves determining the 10-year projected demand for the VISN, markets within the VISN, and any applicable sub-markets.

   - Determine the projected demand. Utilizing the 3D Model and EHCPM, identify the need for overall MH RRTP beds within the market and VISN over the next 10 years.
   - Identify any sub-market or group of sub-markets that may have adequate demand to support a program.
   - Utilize the program level projections of the 3D Model (described in detail in Appendix D) to determine bed needs by specific program (GEN DOM, DOM SUD, DOM PTSD, and DCHV).
   - Utilize the EHCPM for CWT-TRs to determine bed need for that program as the 3D Model does not include projections for CWT-TRs.

3) Conduct Gap Analysis of Network Adequacy:
The third step involves comparing the current state to future demand in order to identify gaps and develop appropriate opportunities.

- Compare the current state beds to projected demand for each program type. Calculate projected bed need based on an 85.0% occupancy rate.
- Consider increasing or decreasing MH RRTP bed supply for scenarios where the geographic area's demand is greater or less than existing MH RRTP bed supply.
- For areas that lack an existing MH RRTP, determine if the projected demand supports a minimum of a 20-bed program for building a new GEN DOM, DOM SUD, DOM PTSD, or DCHV program. For new CWT-TR programs, determine if the projected bed need is at least 10 beds before choosing to establish a new program.
- Consider adding bed sections co-located within an existing MH RRTP if the projected demand supports a minimum of a 10-bed program.
- In addition to current state and demand criteria, evaluate any potential opportunities in the context of other listed guidelines including location, quality, ability to staff, and facility condition.

MH RRTP Detailed Planning Steps with Examples

The below bullet points provide a detailed list of steps 1-3 for developing MH RRTP plans:

1) Assess Current State
   a) Utilize VISN plans to understand the current supply of MH RRTPs and bed types within a VISN and within individual markets.
   b) Assess current locations and distribution of programs and beds.
      i) Are current programs located within HRR center/MSA or other major metropolitan areas?
         (1) *Example*: A MH RRTP is located within a rural area without a high number of community hospitals or health care resources. Based on the planning guidelines and thresholds outlined in chapter 4.3, the planner assessing the program should consider if the program is in an ideal location.
      ii) Are there significant gaps in coverage requiring over 120-minute drive time to care?
         (1) *Example:* A MH RRTP is located in an area where only 30.0% of the enrollees in the market are within 120 minutes of the facility. A planner may consider whether the program should be relocated to increase access to Veterans.
      iii) Is bed type unevenly distributed within the VISN?
         (1) *Example:* Within a VISN, DOM SUD programs are only located in a single market. A planner should look at all MH RRTP sites within the VISN and

understand why within the current state that DOM SUD programs are not better distributed across the VISN. This may identify gaps such as a lack of qualified SUD staff near certain MH RRTP sites that do not offer SUD services.

c) At the facility level, assess beds, occupancy rate, ALOS, Admits per User, and wait times for admission.
   i) *Example:* Within a MH RRTP, there are a high number of Admits per User. This may infer a high rate of Veterans being readmitted to the program. Investigate clinical, situational, and staffing challenges. Incorporate these challenges in the planning assessment.

d) At the facility level, assess the following areas:
   i) Are programs able to be staffed?
   ii) Are any programs co-located?
   iii) Are services located off the VAMC campus?
   iv) Are services housed in a dedicated building?
   v) What are the maximum beds per unit or floor?
   vi) What is the environment style of the MH RRTP space?
   vii) Does the facility's condition and design support MH RRTP delivery?
      (1) *Example:* Within a MH RRTP site, there is a lack of group rooms to facilitate communication and socialization among patients. A planner and architects must determine if the design can be corrected to meet design criteria

2) Assess VISN and Market Demand
   a) Utilize the 3D Model to determine 10-year future BDOC demand for GEN DOMs, DOM SUD programs, DOM PTSD programs, and DCHV programs at the VISN and market level. There is currently no CWT-TR 3D Model projection data, so the EHCPM discussed in Appendix D will be the source of future bed need projections for CWT-TRs.
   b) Utilize the EHCPM to determine 10-year future MH RRTP BDOC demand at the VISN and market level. The process for determining 3D Model and EHCPM demand is detailed in Appendix D.
3) Conduct Gap Analysis of Network Adequacy
   a) Aggregate the 3D Model projections to the VISN level. Compare current state to demand forecast to determine VISN-level over or undersupply of beds by program type.
      i) *Example:* Within VISN X, the total number of GEN DOM beds is 100 beds. The demand projection in the next 10 years for VISN X based on the 3D Model is 36,500 BDOC. Taking the projected BDOC and dividing by 365 days and then dividing by 0.85 to account for a recommended 85.0% bed occupancy, the future General MH RRTP bed need for VISN X is 118 beds. Based on this analysis, VISN X will need 18 additional beds within the next 10 years to meet Veteran demand within the VISN.

b) Compare demand forecast by market to existing program distribution to determine if programs and beds need to be consolidated or distributed.
   i) Consider increasing supply via new programs or additional beds in underserved markets where demand supports minimum ADC thresholds. If the market meets threshold demand, evaluate other criteria such as whether it is in a major population center and ability to staff.
      (1) *Example:* Market X currently lacks any MH RRTP beds. However, based on the total 10-year projections from the 3D Model, Market X is projected to need 6,205 SUD RRTP BDOC. By dividing 6,205 BDOC by 365 days, this would result in a future ADC of 17.0, which meets the new MH RRTP site criteria outlined within section 4.3. By identifying a HRR center/MSA and the ability to staff a new MH RRTP site of care, the justification for creating a new MH RRTP site can be met.
   ii) Consider decreasing supply.
      (1) *Example:* Market X currently has 25 GEN DOM beds. Based on projections from the 3D Model, the market is projecting 6,570 BDOC within GEN DOM within the next 10 years. By dividing 6,570 by 365 days and then dividing by 0.85 to consider bed occupancy goals, Market X requires 21 beds to meet projected GEN DOM demand. As Market X currently has 25 GEN DOM beds, a planner may conclude that four beds can be removed from market's GEN DOM.