MAHSO

MARKET AREA HEALTH SYSTEMS OPTIMIZATION

National Planning Strategy

Inpatient Mental Health

March 2021

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Executive Summary

The Department of Veterans Affairs (VA) Market Area Health Systems Optimization (MAHSO) effort completed draft market assessments of 18 VA Veteran Integrated Service Networks (VISNs) and 96 markets 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.

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.

The Inpatient Mental Health National Planning Strategy establishes a consistent set of guidelines which will help to develop the opportunities that are specific to Inpatient Mental Health services. Using comprehensive VA data, the guidelines can facilitate improved alignment of Inpatient Mental Health capacity and capabilities with the evolving needs of Veterans.

The VHA Chief Strategy Office (CSO) is committed to working with offices across the organization to create strategies that best serve Veterans. The Inpatient Mental Health National Planning Strategy was developed in consultation with the Office of Mental Health and Suicide Prevention (OMHSP).

Inpatient Mental Health Program Overview

Veterans face many unique challenges that can contribute to mental illness, and VA has developed a broad range of mental health services to address complex clinical problems. VA inpatient mental health led by OMHSP, offers a variety of Veteran-centric services that focus on optimizing the health, recovery, and well-being of Veterans. VA is the primary provider of inpatient mental health services for enrolled Veterans with some care provided by the Community Care Network (CCN).

Common inpatient mental health planning challenges include balancing capacity with current and future demand; managing admission rates and wait times; optimizing inpatient length of stay against quality of care; and maximizing bed utilization. Solving these planning challenges can help VA further deliver on its strengths, namely, a full continuum of mental health services, an interdisciplinary treatment approach that meets the specialized needs of Veterans, and an industry leading progressive suicide prevention program. Understanding the strengths and challenges for VA inpatient

mental health services provides an opportunity to ensure access to high quality care for current and future Veterans.

- Inpatient Mental Health Program Purpose: VA inpatient mental health services provide a safe and therapeutic environment to stabilize patients experiencing an acute mental health crisis. The goals of inpatient mental health include provision of evidence-based and recovery-oriented treatment to improve a Veteran's functional status while in a secure setting. After stabilization, patients are transitioned to the next level of care in the integrated continuum of services with the goal of having the Veteran return to the community whenever possible.
- Programmatic Overview: Inpatient mental health remains an essential level of care that requires a planning strategy that reflects a commitment to meet the needs of the population and provide timely access to services. In fiscal year (FY) 2019, 84 of the 96 VA markets, which include both rural and urban markets, had inpatient mental health beds. From FY 2016-19, inpatient mental health utilization by bed days of care (BDOC) decreased by 10.0%. [1] Furthermore, inpatient mental health BDOC are projected to decrease by 16.1% by FY 2027. [2] The median occupancy rate in FY 2019 was 67.3% across all VA Medical Centers (VAMCs).
- Inpatient mental health is a critical service for Veterans with acute mental health diagnoses. Planning efforts can be challenging due to the lack of standardization, special population considerations, and limited insight to local level concerns. The inpatient mental health national planning strategy aims to ensure care continuity, reduce gaps in access, and match supply with projected demand.

Resulting Planning Guidelines

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

As a result, the planning priorities for inpatient mental health are to align capacity with demand, increase access in underserved areas, provide coordination of care, and ensure high quality care in a safe and therapeutic environment. Planning guidelines for inpatient mental health are collectively designed to support immediate access for this inpatient level of care at a market level within a 60-minute drive time of the Veteran. The guidance provided in this report intends to support strategic planning efforts.

The Inpatient Mental Health National Planning Strategy provides quantitative and qualitative planning guidelines across demand, supply, access, quality, and other applicable domains for each service type.

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

Inpatient Mental Health Planning Guidelines

Service	Primary Planning Guideline

Inpatient Mental Health	• **Market Guidelines:**
	  ○ Minimum of 1 per market if minimum service area demand criteria is met and/or there is a lack of high-quality community beds
	  ○ Target occupancy rate is 80% with an acceptable range of 75% to 90%
	• **Open**:
	  ○ Urban: 10-year projected market ADC ≥ 12.0
	  ○ Rural: 10-year projected market ADC ≥ 9.6
	• **Maintain**:
	  ○ Urban: 10-year projected market ADC ≥ 9.6
	  ○ Rural: 10-year projected market ADC ≥ 8.0
	• **Partner**:
	  ○ Projected Market ADC does not meet minimum service area requirements for open or maintain planning moves
	  ○ Community Centers for Medicare and Medicaid Services (CMS) Star Quality Rating is 3 stars or above
	  ○ Community capacity can absorb projected ADC without exceeding 80% occupancy
	  ○ VA must provide partner with guidance and education on military cultural competency, Veteran-specific challenges, care needs, and the transition of Veterans back to VA outpatient mental health service post-discharge

Future Program Planning

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

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

The planning guidelines and thresholds from the Inpatient Mental Health National Planning Strategy 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

Inpatient mental health care, an integral part of treating the whole health of the Veteran, is delivered by VA at most VAMCs as well as purchased through the CCN. OMHSP is tasked with monitoring and managing inpatient mental health quality and outcomes across these programs. Inpatient mental health program planning, development, and operations are the domain of local and regional executive leadership, sometimes in concert with academic affiliates This national planning strategy for inpatient mental health aims to produce an objective and data-driven strategy for planning inpatient mental health capacity and capability for the high performing integrated delivery network that VA envisions.

Veterans have unique mental health needs, and it is essential for VA's mental health continuum of services to provide access to high quality, Veteran-centric acute inpatient care that will provide support during acute mental health challenges. Though most VAMCs across the nation are equipped to provide acute inpatient mental health care, systemwide bed supply and utilization have decreased in the past years. Policy shifts in mental health treatment (or services) require that patients receive care in the least restrictive setting that also meets their clinical needs. The decreasing acute inpatient utilization may be related to Veterans receiving outpatient mental health services earlier in less restrictive settings. Demand for acute inpatient mental health care provided in VA hospitals is projected to decrease further in the years ahead while demand for alternatives for serving Veterans with cognitive or complex needs related to aging remains not fully known or understood. Future inpatient mental health planning must also address difficulties with access, environmental safety, staffing shortages, and lack of standardization of care. Although VA acute inpatient mental health services may face some challenges, VA is likely best equipped to understand and treat the needs of the Veteran population.

Mental Health Continuum of Care

Figure 1: *VA Mental Health Continuum of Care* [3]

The Mental Health Continuum of Care is comprised of integrated treatment options that provide Veterans with access to the appropriate level of care to facilitate recovery. The least restrictive settings are outpatient care including primary care integrated with mental health, peer support, individual and group therapy, self-directed care, and other alternative care models. Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) and Community Living Centers (CLCs) provide residential care for Veterans with challenges such as Posttraumatic Stress Disorder (PTSD), Serious Mental Illness

(SMI), Substance Use Disorder (SUD), housing, and vocational needs. The most restrictive setting is acute inpatient mental health as illustrated in Figure 1. [4]

1.1 Program Mission

The purpose of the VA inpatient mental health service is to provide a safe and secure therapeutic environment to stabilize patients experiencing acute distress and improve their functional status, so they no longer require acute hospitalization. This level of care is typically provided in a locked inpatient setting to ensure safety and provide the type and intensity of clinical intervention necessary. Post-discharge, care management and integration within the full continuum of services are essential components of meeting the mental health needs of Veterans. [5]

Veterans are uniquely vulnerable to mental health and substance use disorder (SUD) challenges related to military service, combat experience, and history of childhood trauma. [6, 7, 8] In fiscal year (FY) 2019, 36.2% of the total VA service users had a mental health diagnosis and approximately 57,000 Veterans received inpatient mental health services through VA. [9] Veterans disproportionately experience PTSD, SUD, depression, and anxiety. In addition, Veterans made up 7.9% of the US population but accounted for 13.5% of total deaths by suicide in 2017. [10] Based on these risks, VA must provide a broad spectrum of inpatient and outpatient services to meet the treatment needs of Veterans with a mental health diagnosis, particularly those in crisis and requiring stabilization. Within the mental health continuum, inpatient mental health provides a foundational set of services designed to support Veterans who are experiencing acute mental health crises while serving as a bridge to other recovery-oriented VA mental health services.

Due to the importance of acute inpatient mental health care, there are several challenges in the planning, delivery, and standardization of services that require close attention. VA hospitals follow standard accreditation processes and procedures and although they are Federal entities, these hospitals must follow local state mental health codes regarding non-voluntary hospitalization. VA hospitals also must follow national standards for admission and continued stay criteria, developed by McKesson. [11] As a result, national VA guidance must be interpreted and operationalized at the local level, leading to natural variation in the care delivered to Veterans. [11] The major challenge for OMHSP leadership is the lack of visibility and resources available to track the specific care provided on inpatient units, conduct national strategic planning, or ensure the consistent provision of services based on enterprise policy. In addition, there currently are inadequate resources to support conducting annual site visits or detailed surveys of clinical services for inpatient mental health units. [11] Annual site visits or surveys would create the opportunity to understand the provision of inpatient mental health, gather data about best practices and evidence-based care utilization, improve the consistency of services, and ensure care is being provided in the most appropriate settings.

In alignment with its projected demand, comprehensive care models, and an engaged program office, a national planning strategy must be developed to better standardize services provided, minimize variance in resourcing and performance and ultimately drive a higher standard of care. This study will review VA inpatient mental health services and define inpatient mental health planning guidelines designed to adopt industry leading practices, maximize performance outcomes, address access, safety, and quality at the best value.

1.2 Opportunity Statement

VA must develop a national, integrated, data-driven care delivery approach to planning inpatient mental health services. Inpatient mental health is part of a larger continuum of mental health care that supports a diverse Veteran population with complex and evolving health care needs. This national planning strategy is designed to ensure care continuity, reduce gaps in access, deliver high quality care, and continue the VA focus on stabilization and recovery. It will be important to provide staff and facilities with the resources necessary to treat Veterans that require acute inpatient mental health care. There are also Veterans who do not have acute care needs but have complex psychosocial challenges that exceed care provided in less restrictive settings and thus are placed on these units as the best current alternative for their care. However, this may result in reduced access for the appropriately targeted inpatient population.

2. Current State Overview

VA is the largest integrated health care delivery system in the United States. VA's mission is to provide high quality, accessible, and Veteran-centered health services, including inpatient mental health. Acute inpatient mental health care is an integral VA service with the primary aim of stabilizing patients with psychiatric and behavioral issues and safely transitioning them to the next appropriate level of care.

According to OMHSP, the inpatient mental health Veteran patient population often has unique needs and multiple psychological and medical comorbidities. As of FY 2019, approximately two-thirds (115 of 170) of VAMCs reported having inpatient mental health beds to support Veteran needs. However, as VA has focused on the expansion and utilization of prevention and recovery-oriented treatment options, both inpatient mental health supply and demand have decreased. In addition, the 2017 Enrollee Health Care Projection Model (EHCPM) projects inpatient mental health demand will continue to decrease by 16.1% from FY 2017 through FY 2027, while the general enrollee population is projected to remain stable, increasing by 1.6%. [2] Conversely, commercial inpatient mental health utilization by the general population is projected to increase with limited increases in capacity, which may also present access challenges for Veterans seeking care in the community.

2.1 Demographic and Programmatic Distribution Analysis

Programmatic Overview

The primary goal of a VA acute inpatient mental health unit is to stabilize Veterans experiencing a mental health crisis. Inpatient mental health units are typically planned at the local market level. Veterans experiencing an exacerbation of severe mental illness (SMI), suicidal ideation, or severe depression/anxiety should have immediate access to inpatient mental health services, targeted to be within a drive time of 60 minutes or less. [12]

It is important that inpatient mental health units are not only accessible, but also appropriately staffed. Staffing of inpatient mental health units with a range of interdisciplinary staff is critical to serve the needs of Veterans in crisis. These units typically include a range of psychiatrists, social workers, psychologists, and other mental health clinical support staff. The nursing staff may include licensed practical

Guiding Principles for Acute Inpatient Mental Health Services

Handbook 1160.06 Inpatient Mental Health Services (2013) [5]:
- Patient centered, collaborative care
- Recovery oriented clinical care
- Safe and healing environment

Additional guiding principles to be incorporated in the updated directive*:
- Comprehensive mental health care provided by an interdisciplinary team
- Evidence based treatment
- Inclusivity and cultural sensitivity

*As indicated by OMHSP

nurses, registered nurses, or nurse practitioners focused on the acute needs of patients. Some units may also provide peer support. Each unit has access to mental health specialists to treat the individual needs of the Veteran with a focus on recovery-oriented care. VA requires all staff who work on the units, even sporadically, to participate in inpatient mental health unit-specific training to ensure ongoing competencies to support Veterans are in place. [5]

To aid in recovery, VA requires active participation of the Veteran in developing their treatment plan, safety plan, and discharge plan. Development of these plans must begin at admission and include the Veteran's support system, treatment team, and clear aftercare or transfer instructions. Treatment provided during hospitalization includes comprehensive mental health services that target a Veteran's treatment plan goals, psychoeducation regarding medication and symptom management, and any necessary medical consultation and care. Staff are available 24/7 to address the Veteran's mental health issues and maintain a safe and therapeutic milieu. VA staff schedule Veterans for outpatient visits prior to their discharge from inpatient care; this facilitates engagement in their post-discharge care and can reduce future readmission. VA monitors post discharge engagement by assessing if the Veteran has three to four outpatient visits within 30 days of discharge from an inpatient mental health unit. [11]

To ensure Veterans are able to access the care they need following inpatient mental health hospitalization, a care network that includes primary care mental health integration (PCMHI), general and specialized outpatient mental health services, Mental Health RRTP, support groups, Vet Centers, programs for homeless Veterans, and community social agencies is available. Effective discharge planning allows subsequent mental health treatment to be delivered in the least restrictive care setting. [11]

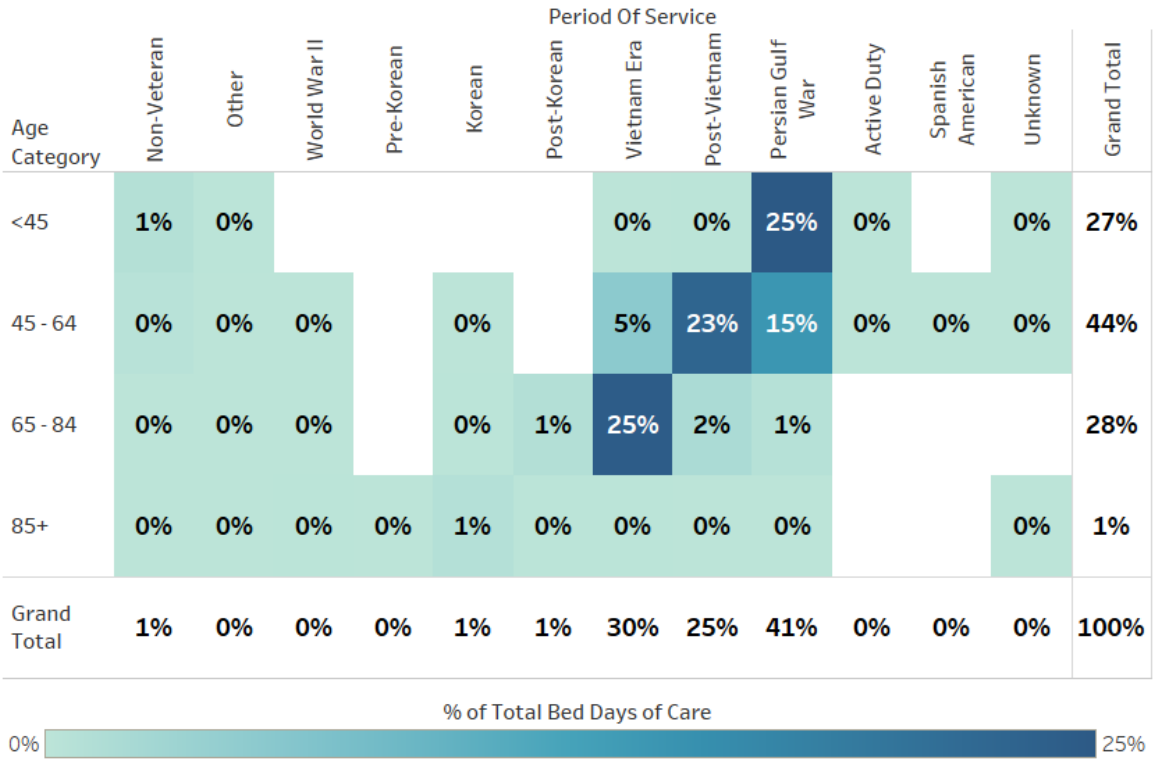
Inpatient Mental Health Demographics

Age is a key driver in VA inpatient mental health utilization trends. In FY 2019, Veterans under age 65 accounted for 81.5% of inpatient mental health uniques. [9] The 45-64 age group received the largest percentage of inpatient mental health services by BDOC as illustrated in Figures 2 and 3. Use of acute mental health and substance use services decrease as Veterans age. [13] While the data reflects a negative correlation between aging and the need for inpatient mental health treatment, the literature review conducted did not provide insights for the cause of the negative correlation.

Veteran Priority Groups also show interesting demographic trends in inpatient mental health demand. Veterans are assigned to a Priority Group between 1 and 8 when applying for VA delivered health care. Priority Group assignment is based on several factors; military service history, disability rating, income level, ability to qualify for Medicaid, and additional benefits received, such as VA pensions. [14] The higher the service-connected disability, the higher the Priority Group assigned, with Priority Group

1 being the highest and 8 being the lowest. Priority Group 1 Veterans were the highest users of VA mental health services by BDOC in FY 2019 as seen in Figure 3.

Figure 2: *FY 2019 Inpatient Mental Health Demand (% BDOC) by Period of Service and Age*



Source: VSSC Treating Specialty Cube
Note: Unknown variables were omitted.

Figure 3: *FY 2019 Inpatient Mental Health Demand (% BDOC) by Priority Group and Age*

Age Category	Priority Group: Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Non-Vet	Grand Total
<45	18%	1%	2%	0%	3%	0%	0%	1%	1%	27%
45 - 64	20%	2%	4%	5%	10%	0%	0%	1%	0%	44%
65 - 84	12%	1%	2%	5%	7%	0%	0%	1%	0%	28%
85+	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Grand Total	50%	4%	8%	11%	20%	1%	1%	3%	1%	100%

% of Total Bed Days of Care

0% 20%

Source: VSSC Treating Specialty Cube
Note: Unknown variables were omitted.

2.2 Current VA Program Review and Analysis

VA acute inpatient mental health services provide stabilization and treatment for Veterans experiencing a mental health crisis who require a secure, 24-hour setting. Veterans utilizing inpatient mental health may be experiencing an exacerbation so overwhelming that their ability to remain safe in the community is compromised. [5] Although inpatient mental health services are intended for a short stay or patient stabilization and transfer to the most appropriate, least restrictive level of care, VA will provide for a longer stay whenever it is clinically indicated.

Over the past two decades, VA has transformed its efforts to address Veteran mental health needs earlier by expanding access to lower acuity levels of care, with an emphasis on proactive, person-centered, and recovery-oriented care. The continuum includes PCMHI, general and specialized outpatient mental health services, mental health intensive case management (MHICM), and MH RRTP. This transformation has resulted in a reduction in overall acute inpatient mental health admissions and length of stay per thousand enrolled Veterans. [5] VA has also focused on consistently providing mental health services with a Veteran-centered, recovery-oriented clinical care model across the continuum of care, emphasizing empowerment, quality of life factors, and Veteran choice for goal setting.

In 2003, the Presidential Commission on Mental Health released a report that served to advance guiding principles for VA to develop a recovery-oriented model of care for mental health treatment options for Veterans. [5, 15] As part of this initiative, VA created a Local Recovery Coordinator position to "help transform local VA mental health services to a recovery-oriented model of care, to sustain those changes, and to support further systemic change as new evidence becomes available on optimal delivery of recovery-oriented mental health care." [5(p13)] Across the enterprise, Local Recovery Coordinators provide education and training regarding recovery-oriented care and are often very involved with inpatient mental health therapeutic programming.

Recovery-oriented mental health care is a holistic, person-centered approach to treatment. This evidence-based approach includes identifying the person with a mental health diagnosis as a "service user" to reduce stigmatization, increase engagement, and create a sense of control over one's diagnosis. [16] The interventions and approaches to recovery-oriented clinical care are as complex and varied as the mental health diagnoses themselves. This approach is also about focusing on the service user living the best possible life and managing symptoms within that context. [17] This commitment to an outcomes-based, recovery-oriented clinical treatment for mental health services was a shift from the medical model of treatment and improved the clinical programming provided on inpatient units. [5]

Current and Historical Supply

While the majority of VAMCs have acute inpatient mental health programs, 55 of the 170 total VAMCs did not report having any inpatient mental health beds in FY 2019. The data in Table 1 illustrates that the number of inpatient mental health operating beds systemwide decreased by 10.8% from 3,860 beds in FY 2016 to 3,444 in FY 2019. In FY 2019, 14 individual VAMCs had acute mental health beds but no medical inpatient beds, but eight of the 14 VAMCs were part of a Health Care System (HCS) with a nearby partner VAMC equipped with inpatient medical services. As a result, six VAMCs provided inpatient mental health services without easy access to VA inpatient medical care, which could present challenges for inpatient mental health patients with medical comorbidities. [18, 9]

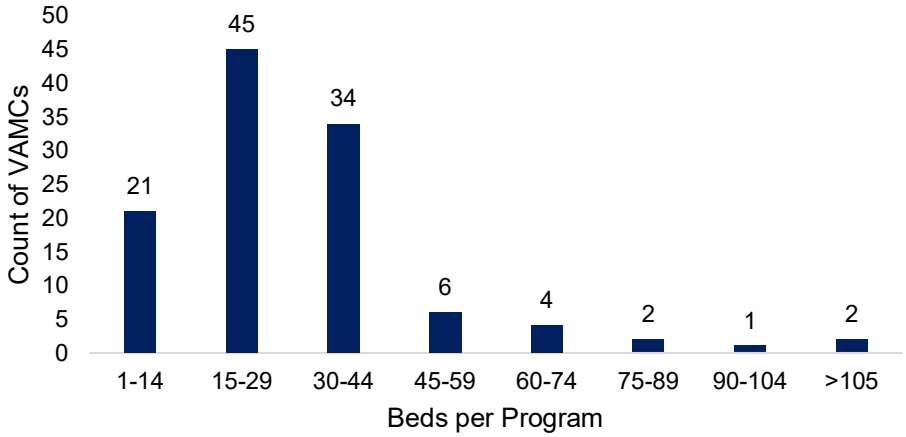
Table 1: FY 2016-19 Inpatient Mental Health Bed Counts [9]

	Bed Count*			
Fiscal Year	Operating Mental Health Beds	Operating Non-Mental Health Beds	Total Operating Beds	Mental Health as a Percent of All Beds
2019	3,444	11,733	15,177	22.7%
2018	3,565	12,006	15,571	22.9%
2017	3,656	12,098	15,754	23.2%
2016	3,860	12,148	16,008	24.1%

*The source for the bed count data is the VSSC Bed Control Pyramid. The bed section codes that were used were 72, 73, 74, 79, 89, 91, 92, and 93.

In FY 2019, VA inpatient mental health units range from 6 beds at the Sioux Fall VAMC to 126 beds at the Brockton VAMC, part of the VA Boston Healthcare System. There is an average of 31 beds among VAMCs and HSCs with inpatient mental health beds. [9] At the individual VAMC level, most facilities have between 15 and 29 beds. Figure 4 illustrates the inpatient mental health total program size distribution among all VAMCs with inpatient mental health beds in FY 2019. [18]

Figure 4: *Inpatient Mental Health Program Size Distribution FY 2019*



Bed sections used to calculate these measures are 72, 73, 74, 79, 89, 91, 92, 93, and 94
Source: VSSC Beds Using PTF Cube

Another component of supply is the availability of staff. National staffing shortages in key inpatient mental health roles such as psychiatrists, psychologists, and nurses are a challenge across all VA and non-VA health care settings. [19] VA also struggles to retain social workers and nurse managers in inpatient mental health units. The Federal position qualification and job grading, or general schedule (GS) level, for many positions on VA inpatient mental health programs results in difficulties in the recruitment and retention of social workers and nurse managers at lower GS levels, as more experienced clinicians transfer to other parts of the system where they can obtain a job with a higher GS classification. [11] These barriers to staffing can make inpatient mental health care delivery challenging.

Location of Facilities

A key element of health care planning involves optimizing facility locations to maximize access. The Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 established drive time requirements for both VA points of care and for partner providers in the CCN. These requirements allow more Veterans to leverage CCN inpatient mental health options closer to where they live instead of traveling long distances for VA care. For inpatient care, Veterans requiring travel of 60 minutes or more are eligible to seek treatment from a community provider. [12] The access standards vary for VA, CCN third party administrators (TPA), and Medicare networks as detailed in Table 2.

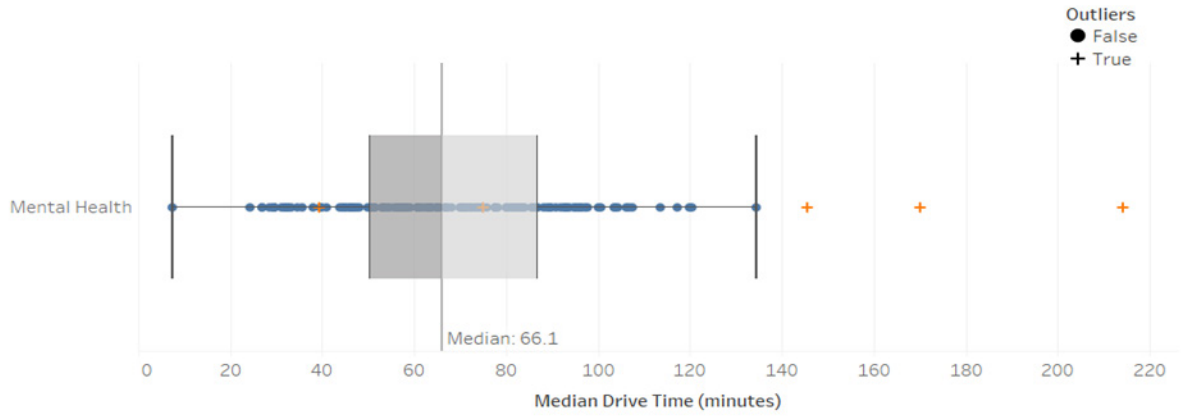
Table 2: Access Standards by Network in Minutes

	VA Access Standards			CCN Third Party Administrator			Medicare Network Adequacy		
Specialty	**Urban**	**Rural**	**Highly Rural**	**Urban**	**Rural**	**Highly Rural**	**Urban**	**Rural**	**Highly Rural**
Primary Care and Outpatient Mental Health	30	30	30	30	45	60	30	40	70
Inpatient Care	60	60	60	45	100	180	50-100	75-110	95-145

Source: MISSION Act, CARES Act, and CMS

In FY 2019, the median travel time to inpatient mental health services at a VAMC was 66.1 minutes, as demonstrated in Figure 5. [1] This suggests patients need to travel longer distances for inpatient mental health care than established access standards. A portion of inpatient admissions are also involuntary and may involve transfers from non-VA emergency departments or urgent care centers and VA is unable to meet drive time guidelines in these situations.

Figure 5: *Inpatient Mental Health Median Patient Drive Time by Facility*



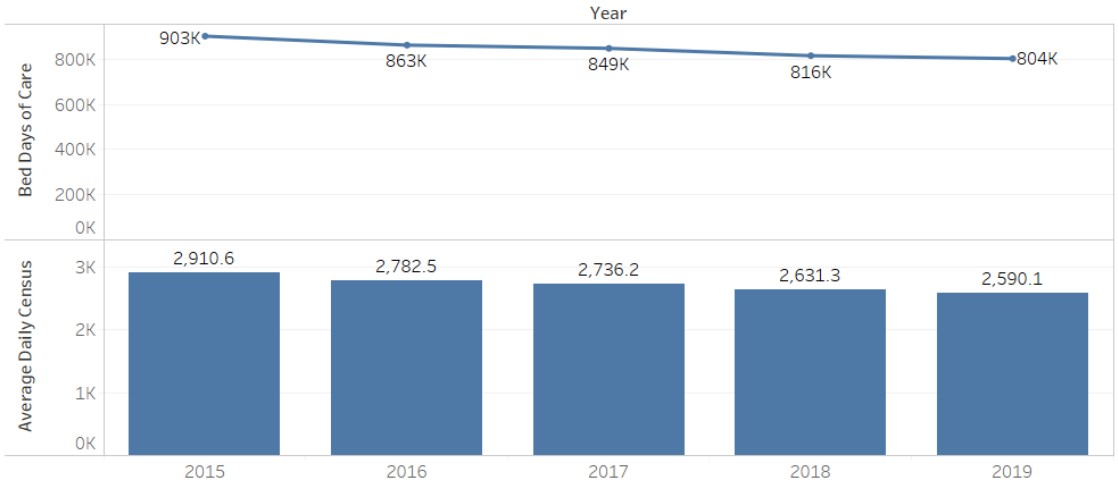
Source: VSSC Treating Specialty Cube

Current and Historical Demand

Total VA inpatient mental health BDOC and inpatient mental health beds decreased from FY 2015-19. More specifically, total VA inpatient mental health BDOC decreased by 10.0% nationally, representing a decrease of about 320 patients per day, referred to as Average Daily Census (ADC). Accordingly, VA inpatient mental health ADC declined from 21.1 in FY 2015 to 19.0 in FY 2019 per VAMC. Figure 6 illustrates the inpatient mental health BDOC and ADC trend. The FY 2019 median occupancy rate was 67.3% across all VAMCs. [1] While utilization decreased systemwide, there were regional differences. For example, an analysis of VISN utilization found that inpatient mental health BDOC from FY 2015 to FY 2019 remained relatively stable across VAMCs in

VISN 16 in the South, increasing by 1.2%. The VAMCs in VISN 23, in the Midwest, experienced a 6.9% growth during the same timeframe. [1] The aging population and the focus in shifting care to the least restrictive setting has been a major driver of the decline both in VA inpatient mental health supply and demand. However, there is still a complex patient population that relies on acute inpatient mental health services.

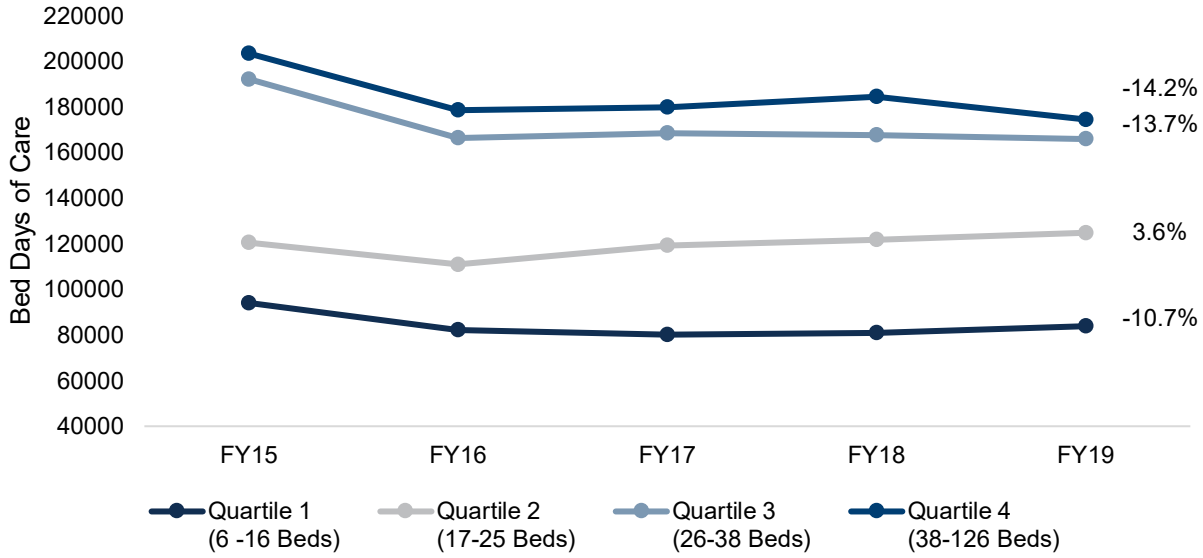
Figure 6: *Inpatient Mental Health Demand*



Bed sections used to calculate these measures are 72, 73, 74, 79, 89, 91, 92, 93, and 94
Source: VSSC Treating Specialty Cube

The number of beds within a facility also yielded differences in utilization. When programs were distributed by size into their respective quartiles, trends indicated that facilities with 17 to 25 inpatient mental health beds experienced increases in demand as measured by BDOC. Meanwhile, the smallest programs and the largest programs had reductions in inpatient mental health utilization. [1 18] Multiple factors influence utilization data, including environment of care challenges, renovations, staffing shortages, and the inconsistent submission of bed change requests. [11] Figure 7 displays the trends in detail.

Figure 7: *Inpatient Mental Health Utilization by Bed Quartiles, FY 2015-19*

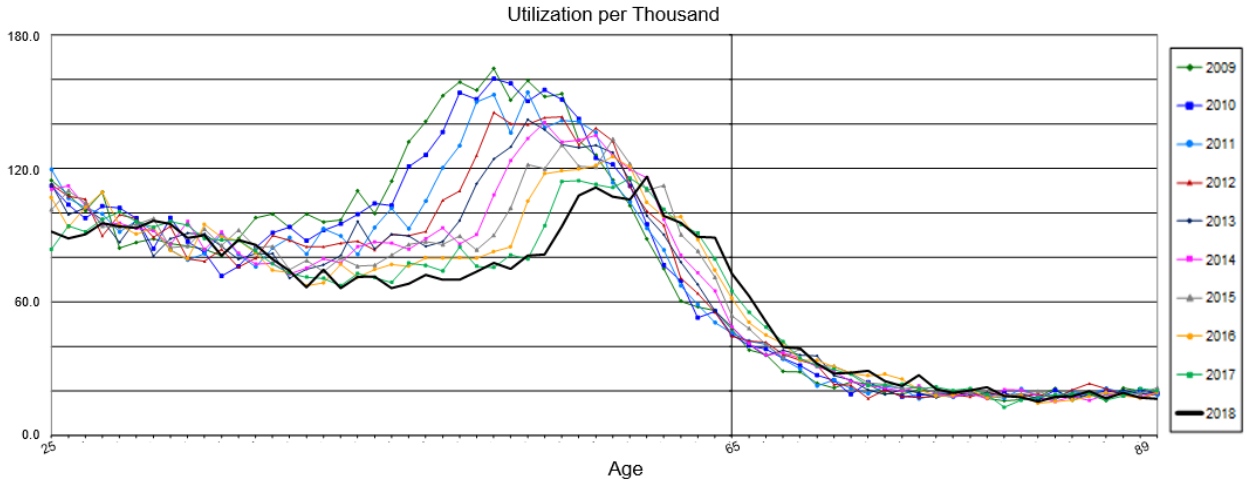


Bed sections used to calculate these measures are 72, 73, 74, 79, 89, 91, 92, 93, and 94. Diagnosis-Related Group codes used to calculate these measures are 880, 881, 882, 883, 884, 885, 996, 887, 894, 895, 896, and 897.
Source: VSSC Treating Specialty Cube; VSSC Beds Using PTF Cube

Key Drivers of Inpatient Mental Health Demand

Demand decreases by age are generally consistent across all psychiatric and substance use disorder services and illustrated in Figure 8. [13] While the data reflects a decrease in utilization related to aging, growth of enrollees in service-connected Priority Groups 1 to 3 illustrates an increased reliance on VA health care services. [13] Although some increase in demand may be driven by service-connected Priority Group growth, the declines due to aging have a greater influence on the overall inpatient mental health VA market reliance. Therefore, the data suggests aging appears to be a major negative driver of inpatient mental health utilization, and the growing, aging Veteran population may contribute to declines in projected total inpatient mental health demand in FY 2027.[2]

Figure 8: *VA Inpatient Mental Health Utilization Trends by Veteran Age* [13]



Urban and Rural Differences in Inpatient Mental Health Demand

Planning guidelines must be informed by the influence of rurality on demand and must also consider the differences between urban and rural volumes. To study this, each market was classified as either urban or rural. Rural markets have greater than 50% of their enrollees living in rural areas, while urban markets have 50% or less of their enrollees in rural areas. VAMCs were assigned the same rurality classification as their VA market. The rurality classification was kept at the market level as opposed to a more local level to mitigate the fact that most VAMCs – even in highly rural parts of the country – are located in population-dense areas and would therefore be classified as urban. All VAMCs with any reported inpatient mental health volume between FY 2017 and FY 2019 were then assessed.

As illustrated in Table 3, rural inpatient mental health programs average fewer patients per day than their urban counterparts. Rural inpatient mental health units had a three-year (FY 2017-19) blended median average daily census (ADC) of 8.9 and urban inpatient mental health units had a blended median ADC of 15.9. [1]

Table 3: *Inpatient Mental Health Median ADC (FY 2017-19)*

Median ADC	Rural	Urban	Total
FY 2017 Median	9.2	16.0	14.0
FY 2018 Median	8.6	15.8	13.3
FY 2019 Median	8.9	15.8	13.4
3-Yr Blended Median	8.9	15.9	13.6

Source: VSSC Treating Specialty Cube

Inpatient Mental Health Length of Stay

Although stabilizing patients in crisis is the primary target, average length of stay (ALOS) within VA inpatient mental health settings is an important metric to assess. Between FY 2016 and FY 2019, the inpatient mental health ALOS decreased overall, and total ALOS with and without a 365-day cut off decreased 17.9% and 10.0%, respectively. In addition, discharges with long ALOS, greater than 180 days, were only 0.24% of total discharges in 2019. [9] Table 4 details inpatient mental health LOS trends. Additional contributing factors for declining ALOS in inpatient mental health services include the implementation of comprehensive recovery-oriented care, improved medication and medical management during acute mental health hospitalization, and improved post-discharge engagement. [11] The declining ALOS likely also reflects the significant progress VA has made toward providing earlier interventions in lower levels of care.

Table 4: *Inpatient Mental Health Length of Stay (FY 2016-19)*

	Length of Stay						
Fiscal Year	Total Average Length of Stay (w/out cut off)	Total Average Length of Stay (with 365 day cut off)	Total Discharges	Number of Discharges with LOS >180 days	Percentage of Discharges with LOS >180 days	Number of Discharges with LOS>365 days	Percentage of Discharges with LOS >365
2019	10.8	10.1	85,096	206	0.2%	80	0.1%
2018	11.6	10.3	84,776	241	0.3%	92	0.1%
2017	12.3	10.7	88,462	274	0.3%	106	0.1%
2016	13.2	11.2	85,472	304	0.4%	136	0.2%

Source: National Hospital Mental Health Program Performance Monitoring System: FY 2019 Annual Report.

Non-Acute Needs Being Met in Acute Settings

Patients who have extended stays are a Veteran population receiving mental health care in inpatient settings who might be better served in another level of care. Extended inpatient mental health stays are defined as a length of stay 30 days or longer. [13] Protracted stays sometimes begin with Veterans admitted who do not meet acute care criteria but who require a secure setting for safety reasons. These stays may also occur due to a lack of access to transitional care settings, increased care needs beyond stabilization, or complex psychosocial issues that prevent transfer to a lower level of care. There may also be a lack of available care options in less restrictive environments, whether in VA or the community. According to OMHSP leadership, factors contributing to extended stays may include challenging behaviors, lack of family support, history of forensic involvement, and other psychosocial factors that make discharge to a lower level of care challenging. [11]

In FY 2019, extended stays made up 25.3% of inpatient mental health total BDOC. From FY 2017 to FY 2019, total inpatient mental health extended stays BDOC

increased 3.5% from 269,404 to 278,934. This increase was primarily driven by services received through community care. VA facility in-house extended stay BDOC decreased 11.6% (from 238,438 to 210,893) while community care extended stay BDOC grew 119.7% (30,966 to 68,041). [20] Robust discharge protocols and transition of care planning may reduce the number of Veterans in inappropriate acute extended stays. [11] Given the notable difference in the increase of extended care BDOC in the community, VA should consider a review of the care currently provided in the community for these Veterans to assess the appropriateness of these lengths of stay and issues that may exist with appropriate discharges to other care settings.

Inpatient Mental Health Market Reliance

Veterans may be beneficiaries of additional insurance coverage such as Medicare or private insurance. Market reliance measures the portion of an enrollee's total health care need that the Veteran is expected to receive in VA facilities and community care paid for by VA rather than through other health care sources. [13] While enrollee reliance is increasing over time as illustrated in Table 5, acute inpatient mental health demand, measured in BDOC, is declining over time due to other factors, including the changing demographic mix of the enrollee population over time.

Table 5: *Acute Inpatient Mental Health Market Reliance (FY 2015-27)*

Acute Inpatient Mental Health	FY 2015	FY 2016	FY 2017	FY 2018	FY 2027
Total Reliance	43.6%	43.6%	44.0%	44.3%	56.1%
VA Facility Reliance	35.2%	33.8%	34.5%	34.5%	40.2%
Community Care Reliance	8.5%	9.9%	9.5%	9.9%	15.9%

Source: BY 2017 EHCPM

Projected Future Demand

Across the VA system, acute inpatient mental health demand, measured in BDOC, is projected to decrease by 16.1% from FY 2017 to FY 2027, not including extended stays.[11] During the same period, total enrollee population is projected to remain relatively stable, increasing by 1.6%. Figure 9 and Table 6 illustrate consistent decreases in acute inpatient mental health BDOC among all VISNs, though decreases vary in magnitude. The projected declines in acute inpatient mental health BDOC are decreasing at a greater rate than the projected changes in Veteran enrollee population for every VISN between FY 2017 and FY 2027.[11] In addition, inpatient mental health extended stays are also projected to decrease 9.8% across VA, both in-house and through community care, from FY 2017 to FY 2027. While the majority of VISNs are projected to experience decreases in extended stays, VISNs 5, 17, 19, and 20 are projected to have slight increases of less than 4%. [2]

OMHSP is working with facilities to convert inpatient mental health beds with historically longer lengths of stay to RRTP or CLC programs, which contributes to the projected decrease in inpatient mental health BDOC. Currently, there are five RRTP and one CLC

conversion planned. [11,f] This should be considered when assessing the FY 2027 projections for future demand.

Figure 9: *FY 2017-27 VISN Acute Inpatient Mental Health Demand (BDOC) Projections* [2]

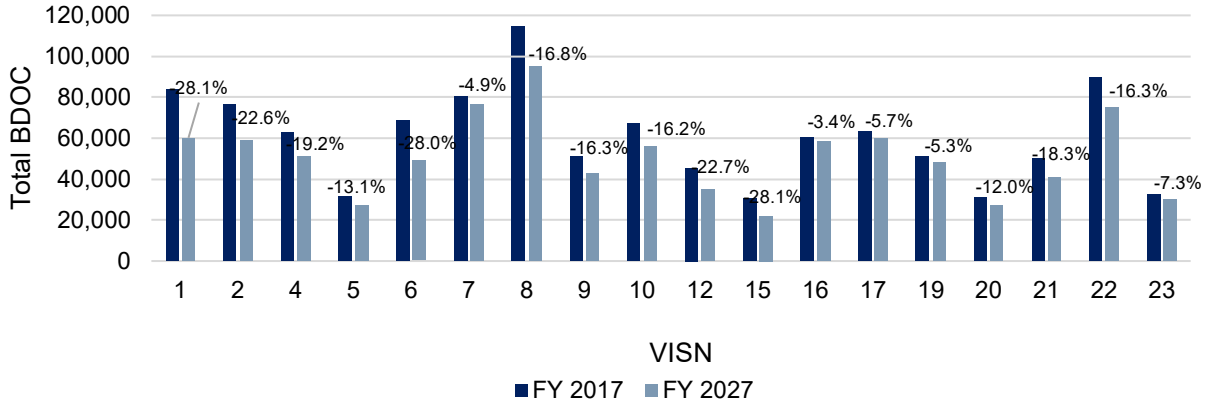


Table 6: *FY 2017-27 Acute Inpatient Mental Health Demand (BDOC) and Total Enrollee Projections by VISN*

VISN	FY 2017 IP MH BDOC	FY 2027 Proj. IP MH BDOC	10 Year % Change	FY 2017 Total Enrollees	FY 2027 Proj. Enrollees	10 Year % Change
1	83,702	60,196	-28.1%	1,032,150	949,747	-8.0%
2	76,406	59,172	-22.6%	1,358,805	1,129,163	-16.9%
4	62,990	50,893	-19.2%	1,227,729	1,137,131	-7.4%
5	31,353	27,253	-13.1%	941,961	963,709	2.3%
6	68,246	49,138	-28.0%	1,576,731	1,802,391	14.3%
7	80,145	76,222	-4.9%	1,839,435	2,092,597	13.8%
8	114,296	95,148	-16.8%	2,201,955	2,135,303	-3.0%
9	51,117	42,783	-16.3%	1,105,434	1,174,156	6.2%
10	66,845	55,989	-16.2%	2,005,512	1,987,968	-0.9%
12	45,659	35,314	-22.7%	1,123,710	1,033,354	-8.0%
15	30,385	21,861	-28.1%	988,758	968,084	-2.1%
16	60,522	58,473	-3.4%	1,272,372	1,302,084	2.3%
17	63,408	59,797	-5.7%	2,153,406	2,466,633	14.5%
19	51,019	48,291	-5.3%	1,310,265	1,409,252	7.6%
20	30,778	27,091	-12.0%	1,313,907	1,405,388	7.0%

[ϕ] OMHSP reports that the following facilities are currently planning to convert their inpatient MH mental health programs: Central Massachusetts HCS (Specialized inpatient PTSD unit and STAR unit projected to convert to residential); Northern Indiana VAMC (inpatient mental health program projected to convert to residential); Battle Creek VAMC (inpatient mental health program projected to convert to CLC); Eastern Kansas HCS (Two inpatient mental health programs projected to convert to residential); Alexandria HCS (inpatient mental health program projected to convert to residential).

VISN	FY 2017 IP MH BDOC	FY 2027 Proj. IP MH BDOC	10 Year % Change	FY 2017 Total Enrollees	FY 2027 Proj. Enrollees	10 Year % Change
21	49,959	40,795	-18.3%	1,357,626	1,328,933	-2.1%
22	89,497	74,865	-16.3%	2,181,531	2,183,335	0.1%
23	32,181	29,831	-7.3%	1,269,825	1,219,942	-3.9%
Total	1,088,508	913,112	-16.1%	26,261,112	26,689,172	1.6%

Source: BY 2017 EHCPM

Program Quality and Value

The complexity and variability of inpatient mental health care makes the assessment of quality and measurement of value difficult for all health care providers. Overall Veteran satisfaction for VA mental health services is high, but satisfaction is not measured at the inpatient level. [10] Similar to the broader health care industry, VA has not developed national quality metrics for inpatient mental health services. This section does not evaluate the quality of VA inpatient mental health services but seeks to understand what data exists to develop quality standards that can be used to improve inpatient mental health care. Consistent standards must be developed to assess the degree to which community providers meet VA inpatient mental health quality and value of both VA and CCN inpatient mental health. As a result, the quality analysis includes performance metrics from VA's Northeast Program Evaluation Center (NEPEC), which performs national program evaluation of mental health services within VA, and related academic research.

Although readmission rates are often used as an indicator of care quality, inpatient mental health readmissions result from factors of which clinical care or discharge planning have limited control and may not be an accurate representation of inpatient mental health quality. [21] Studies have found that inpatient mental health patients are most susceptible to readmission within 30 days after discharge. [22] Table 7 shows that between FY 2016 and FY 2019, VA inpatient mental health readmission rates within 14, 30, and 180 days of discharge remained fairly stable at approximately 10%, 15%, and 35%, respectively. [9] Although data can be provided on the metrics in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, these CMS quality metrics are for a Pay-for-Performance program which is not fully applicable to VA. [23] A U.S. Department of Health and Human Services (HHS) review of quality metrics found several measures that are collected by VA, but these indicators include four admission screenings and one outpatient measure, and have limited relevance to inpatient mental health. [24] Overall, there are few universally agreed upon quality metrics both within and outside VA, and development of these metrics is an area for continued improvement.

Although the focus of inpatient care is stabilization, coordination of care transitions and post-discharge treatment are necessary for high quality care and ensure continued recovery. In FY 2016, 72.8% of inpatient mental health patients received outpatient mental health care within seven days post-discharge. By FY 2019, this percentage

dropped to 65.8%. [9] However, in 2019, VA added to the SAIL quality measurement system the Post Discharge Engagement (PDE1) protocols to evaluate the percentage of Veterans receiving outpatient mental health engagement within 30 days of discharge from inpatient mental health care and RRTP care. PDE1 is a composite metric that looks at Veterans with high risk flags during discharge planning. For inpatient mental health patients, the PDE1 requires three outpatient mental health visits for high-risk patients and four outpatient mental health visits for Veterans screening positive for suicide risk. In FY 2019, the VA mental health information system's Measurement Components Summary reflects that 73.2% of inpatient and RRTP mental health discharges received the required outpatient mental health care within 30 days post-discharge. [25] Although the percentage receiving engagement within the first seven days post-discharge may have decreased slightly, almost three-quarters of Veterans are still receiving more post-discharge clinical follow up than in the community (where the standard is often only one required visit in the 30 days after discharge). [9] However, 27% of Veterans are not yet receiving VA's required level of follow up care after discharge. In addition, the average per capita outpatient mental health stops within 30 days of discharge and within 180 days of discharge have remained stable as illustrated in Table 7.

Table 7: *Inpatient Mental Health Care Transitions and Readmissions* [9]

	Care Transitions			Readmission		
Fiscal Year	Percent with Outpatient Mental Health Care within 7 Days of Discharge from Hospital Care*	Average Per Capita Outpatient Mental Health Stops within 30 Days of Discharge from Hospital Care	Average Per Capita Outpatient Mental Health Stops Within 180 Days of Discharge from Hospital Care*,**	Percent Readmitted to Mental Health Hospital Care Within 14 Days of Discharge	Percent Readmitted to Mental Health Hospital Care Within 30 Days of Discharge	Percent Readmitted to Mental Health Hospital Care Within 180 Days of Discharge
2019	65.8%	11.1	39.7	10.0%	15.8%	35.6%
2018	68.4%	11.4	39.6	9.9%	15.5%	35.7%
2017	72.0%	10.9	38.9	9.8%	15.4%	35.4%
2016	72.8%	11.1	38.8	9.4%	14.9%	35.1%

*This NEPEC constructed measure utilized home station location rather than discharge location (that is, where the individual received the most services). Thus, referrals count.
**This measure only includes Veterans with at least one outpatient stop.

VA Inpatient Mental Health Cost

Between FY 2015 and FY 2018, total VA in-house acute inpatient mental health costs increased 6.5% from $1.27 billion to $1.35 billion. [26] According to VA's Allocation Resource Center data, the cost per BDOC of VA-provided inpatient mental health care increased 23.8% from $1,463.16 in FY 2016 to $1,812.00 in FY 2019. [9]

An independent third-party evaluation of quality and cost of VA inpatient mental health care during the first- and second-years post-discharge from acute care found that "utilization and costs for all mental health and primary care services *increased significantly* from pre-admission to one-year post-discharge for Veterans admitted to acute inpatient mental health services. However, the analyses also show that, by two years post-discharge from acute inpatient mental health services, both utilization and costs are *significantly lower* than pre-admission levels." [10(p167)] This suggests that mental health costs decrease and utilization improve over time. [10]

Inpatient Mental Health and VA's Fourth Mission

The Department of Veterans Affairs (VA) 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. That 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." [27] 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 (PPE) to other health care organizations. It is less likely that it would be necessary for VA to provide inpatient mental health during a national crisis, as inpatient mental health demand does not usually fluctuate dramatically, although local or regional support could be available for more circumscribed disasters or events.

2.3 Commercial and Federal Trends

Beginning in 1963, new pharmaceutical treatments for mental illness and new public policy initiatives combined to provide an opportunity to shift care from institutions to the community. Over the next four decades, shifts in philosophy and policy created opportunities to develop and expand community-based treatment options for people with disabilities or long-term care needs in the least restrictive settings. An unintended consequence of this shift was the closing of many state and private hospitals that served people with SMI, disabilities, and elders with dementia, thus resulting in 500,000 fewer inpatient mental health beds today. [28] This decrease in available beds in commercial and Federal settings has driven significant wait times to receive inpatient mental health care in many communities. Patients experiencing a mental health crisis often face lengthy waits in emergency rooms, which in turn increases wait times for people facing a medical crisis in emergency rooms. [29] It is important to note that it can be challenging to make comparisons between commercial and VA inpatient mental health services due to the unique inpatient mental health needs of Veterans.

Inpatient Mental Health Practices in Federal Agencies

Inpatient mental health trends in the Federal space focus on improving evidence-based care best practices, suicide prevention, and data collection. The absence of standardized data collection and metrics specific to inpatient mental health creates challenges for program evaluation and quality assessment. To address this, VA and other Federal programs including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the DoD Psychological Health Center of Excellence (PHCoE) are identifying best practices, providing evidence-based tool kits, and making recommendations to improve data collection for mental health, including inpatient care. Their goal is to guide more consistent interventions and treatment and to support the evaluation of the efficacy of all aspects of mental health care. This has resulted in both SAMHSA and PHCoE starting efforts to create research opportunities, policies to address disparities, and develop robust data collection systems and tools. For example, SAMHSA created a four-year strategy for FY 2019 to FY 2023 to focus efforts on addressing SMI and comorbidities, enhancing substance use disorder services, improving program and policy evaluation, and strengthening health care practitioner training. [30] Additionally, PHCoE policies and programs are mirroring those of VA and SAMHSA to address gaps for how mental health services are delivered. [8]

Another inpatient mental health trend is to more comprehensively address suicidal behavior and ideation, which often results in the need for an acute inpatient hospitalization. SAMHSA is addressing this issue through the enhancement of Federal coordination and expansion of outreach initiatives. Some examples include conducting expert panel meetings on co-occurring disorders and inpatient care, expanding professional development by increasing the quality of workforce through partnerships, and leveraging resources to improve integration between mental illness and substance use disorders.[30] In 2012, the Obama administration also implemented an interagency task force with DoD, VA, and HHS to improve suicide prevention efforts, better coordinate research for mental health interventions, and implement evidence-based practices for mental health treatment. [30] Through this effort, VA and DoD developed consistent messaging and increased communication for both active-duty service members and Veterans and increased clinical mental health and peer support staff. [8] This DoD and VA collaboration also resulted in the development of metrics and dashboards to evaluate the efficacy of evidence-based practices and initiate national suicide prevention programs with the goal of reducing suicide across both populations. [31] VA also has comprehensive suicide prevention efforts in preventing hospitalization and during hospitalization outlined in Section 3, informed by the National Strategy for Preventing Veteran Suicide and the VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide (2019). [31]

Inpatient mental health trends for improving mental health data collection and dissemination are driven by SAMHSA and the agency's prioritization of the collection of insights from its grant recipients regarding grant performance and outcomes. This focus has resulted in efforts by SAMHSA to execute these activities through robust data collection and program evaluation. Examples of these efforts include implementing

surveys as a surveillance system to provide information on substance use-involved emergency department (ED) visits and modernizing reporting systems to capture real-time data and measure the effectiveness of grant programs. [30] These efforts should result in a deeper understanding of community mental health needs, identification of access issues, and more effective treatment modalities.

Community Inpatient Mental Health Costs and Reimbursement

Health care spending in the United States continues to increase at an unsustainable rate. [32] The primary drivers for this growth are the increased cost of care and the increased utilization of services as the population ages. Slowing the growth curve for health care costs is challenging due to the fragmentation of the medical and mental health care delivery system. The Mental Health Parity and Addiction Equity Act of 2009 requires large insurance companies and Affordable Care Act plans to provide the general equivalence in how benefits are reimbursed for mental health, substance use disorder treatment, and medical treatment. [33] In FY 2018, VA spent $131 million on Non-VA Community Care inpatient mental health services. [34]

Commercial and Federal Inpatient Mental Health Staffing Trends

The number of practicing psychiatrists has decreased nationwide, which presents inpatient mental health care supply challenges for both VA and commercial organizations. From 2003 to 2013, the number of practicing psychiatrists per 100,000 residents decreased 10.2%. [35] VA reported additional challenges recruiting and retaining psychologists and social workers (interviews). The shortage is particularly challenging in rural regions, select urban neighborhoods, and community mental health centers that often treat the most severe mental illnesses. [36] This shortage is driven by multiple factors including demand outpacing supply, lower reimbursement for mental health providers compared to physical health providers, and the aging psychiatrist population. Over 60% of practicing psychiatrists are age 55 or older as of 2015. [36]

The nationwide staffing shortage presents barriers to care in inpatient mental health and throughout the mental health care continuum. In response to these staffing challenges, SAMHSA, the Military Health System, and VA are supporting efforts to improve workforce training to enhance clinical skills and improve retention of mental health staff. These efforts are accomplished by developing workforce training and education tools, collaborating with Health Resources and Services Administration (HRSA), CMS, and other partners to improve recruitment and retention opportunities, and utilizing credentialed peer providers as a method of addressing the staffing shortage. [8, 30] VA also encourages the use of advanced practice registered nurses, clinical pharmacists, and telemental health care to address staffing shortages. [11]

Commercial and Federal Inpatient Mental Health Utilization

Demand for inpatient mental health services in the Military Health System (MHS) has decreased, similar to the trend in VA. Between 2012 and 2017, annual inpatient SUD hospitalizations in MHS decreased from approximately 1,000 to 500 and hospitalizations for acute PTSD decreased from 1,100 to 800 . [37] Similar early

interventions and outreach to identify and assess the clinical needs of patients and treat mental health illness before an acute crisis occurs are likely drivers of the reductions in both health care systems. [8]

In contrast, total inpatient mental health demand for the commercial sector is projected to increase for the general population by 11.0% from 2020 to 2030. Capacity constraints and staffing shortages in the commercial sector may also contribute to the limited availability in beds. [29, 36] The increase in demand and shortage of supply could make access to inpatient mental health non-VA care in the community challenging.

2.4 Current Program Summary

Inpatient mental health is a key component in the VA mental health continuum, an established network of services designed to meet the spectrum of Veteran mental health needs. The majority of VA markets (84 out of 96) provided in-house inpatient mental health care in FY 2019, but inpatient mental health demand and supply have both declined from FY 2016 to FY 2019. While VA inpatient mental health demand is projected to continue to decrease, the commercial sector also expects to experience continued capacity constraints and psychiatrist and other clinician shortages. Additionally, there is a lack of agreement on quality standards across the commercial market, which further emphasizes the importance of ensuring quality inpatient mental health options to Veterans moving forward. In order to do so, OMHSP will need to address the lack of standardization and limited insight at the local level, but inadequate resources present barriers. Despite these challenges, VA inpatient mental health strives to provide Veteran-centric, recovery-oriented care utilizing an interdisciplinary care team that may include specialty mental health care, treatment for medical comorbidities, and SUD treatment.

3. Leading Practices

Health care organizations and Federal providers are increasingly focused on identifying leading practices, developing quality metrics, and evolving inpatient mental health services to meet the changing needs of a progressively complex population requiring acute mental health services.

Focus on prioritizing patient safety through suicide prevention, creating a safe physical environment that promotes healing, and implementing recovery oriented clinical care to prevent readmission.

Within the mental health continuum of care, the primary goal of inpatient mental health is to stabilize patients in crisis using comprehensive assessments, treatments, and planning for follow up care after discharge. Leading inpatient mental health services prioritize patient safety through suicide prevention, creating a safe physical environment that promotes healing, and implementation of recovery-oriented clinical care to continue treatment post-discharge and prevent readmission of Veterans. [38] Specialized inpatient mental health units in areas such as geriatric mental health and integrated medical and mental health care aim to treat specific populations. The scarcity of these resources in VA and in commercial organizations, as well as lack of consistency in treatment models, creates both challenges and opportunities. Due to its integrated structure and unique patient population, VA has the opportunity to provide innovative, Veteran-centric care that is not found in the commercial sector. VA and commercial organizations are engaging in leading practices that a national planning strategy should adopt and expand.

3.1 Leading Practice Analysis

Although it is difficult to identify industry leaders in inpatient mental health, there are specific areas that all organizations, including VA, prioritize. Suicide prevention and environmental design are key components to an effective inpatient mental health unit. The leading practices described in this section are meant to provide illustrative examples of inpatient mental health innovations or potential best practices and are not meant to suggest comparisons of organizational practices or efficacy. Examples from both VA and commercial organizations can inform leading practices in these focus areas.

Suicide Prevention

Suicide prevention is a national priority in the United States and is VA's top clinical priority. VA has been a leader in the field of suicide prevention for many years, with comprehensive clinical interventions across the continuum of care, and innovative public health approaches to reach Veterans in the community. [10, 21, 39] Multi-pronged efforts have addressed increased risk for suicide either during the acute inpatient mental health stay or in the time following discharge. For example, after reviewing a decade of root cause analyses of suicides occurring during the inpatient mental health stay, VA developed new standards for the physical environment on inpatient units and

instituted the VA Mental Health Environment of Care Checklist (MH EoCC) 2007. [40] Use of this checklist substantially lowered the rate of suicide on inpatient mental health units in VA. [41] VA has also used a data driven assessment to determine that over a period of several years, 43.6% of suicides were a result of hanging, with doors serving as the most frequent anchor points and sheets or bedding as the most likely lanyards. [42] The installation of door top alarms are required for all swinging corridor doors of inpatient mental health patient rooms and have proven to be excellent notification to staff of suicide attempts. [43] VA implemented a MH EoCC review and appeal process to ensure that facilities mitigate any identified hazards in a timely manner. Data consistently demonstrates that VA leads the country in addressing suicide prevention during inpatient mental health hospitalization. [44, 45, 46]

VA also places significant emphasis on transition points, such as the time after discharge from an inpatient hospitalization, given the increased risk of suicide in the 30 days after an inpatient mental health discharge. [39] Thus, VA has implemented a variety of proactive interventions and outreach. VA mental health clinicians engage Veterans in evidence-based suicide prevention strategies while providing treatment at all touchpoints including post-discharge. Through the Risk Identification Process (Risk ID), clinicians initiate the Columbia-Suicide Severity Rating Scale (C-SSRS) as a screening tool within 24 hours of admission and again within 24 hours of discharge. If the Veteran screens positive for suicide risk, the inpatient mental health team conducts a VA Comprehensive Suicide Risk Evaluation (CSRE) within 24 hours. [47] The information collected during CSRE is utilized to develop the comprehensive treatment plan and in collaboration with the Veterans, post-discharge safety plan. Risk ID emphasizes communication between mental health sites of care and the Veteran. The screening tools may be conducted electronically, improving compliance and timeliness for documentation. [47]

Essential safety planning is described in the Inpatient Mental Health Services Handbook, and there is currently a national focus on standardizing safety planning. VA is evaluating a safety planning tool that is designed to empower vulnerable Veterans and reduce risk of suicide. VA Emergency department and mental health staff receive training regarding the key elements of this evidence-based intervention, and the plan includes data collected in the CSRE, information about warning signs, coping strategies and skills developed during the inpatient mental health hospitalization. [48]

Building on this concern about patient risk of suicide following inpatient discharge, there is a growing body of evidence supporting the positive outcomes of “caring contacts” following certain episodes of care related to suicidality. [49] Caring contacts is a simple intervention that involves sending patients who are suicidal brief, non-demanding expressions of care and concern over a year or more. [50] Caring contacts are promising for preventing suicide attempts and ideation and may also facilitate engagement in follow-up care. It is a relatively low-intensity, easily accessible, low-cost intervention that is feasible to implement across a large health care system. Initially pioneered across nine psychiatric inpatient commercial facilities in San Francisco, caring contact letters

have now been tested across multiple military treatment facilities and VAMCs. A similar method that adds additional intervention related to reducing suicide risk, the Attempted Suicide Short Intervention Program has been tested with patients admitted to the Bern University General Hospital in Switzerland for recently attempted suicide. [51]

The Henry Ford Health System is another hospital leader in the prevention of suicide. After implementation of the Perfect Depression Care Initiative, the suicide rate for patients receiving mental health care in the Henry Ford Health System decreased by more than 75%, which earned the Henry Ford Health System the 2011 Malcolm Baldrige National Quality Award. [52] This initiative included performance improvement activities in four domains: partnership with patients, clinical care (planned care model), access, and information flow. This effort has been further developed into the Zero Suicide Framework, which has now been implemented across more than 200 Federal and community-based health care systems. The framework includes seven components:

1) Lead system-wide culture change committed to reducing suicides;
2) Train a competent, confident, and caring workforce;
3) Identify individuals with suicide risk via comprehensive screening and assessment;
4) Engage all individuals at-risk of suicide using a suicide care management plan;
5) Treat suicidal thoughts and behaviors directly using evidence-based treatments;
6) Transition individuals through care with warm hand-offs and supportive contacts; and
7) Improve policies and procedures through continuous quality improvement.

Although there are operational differences in the ways that community and VA hospitals process admissions, discharges, and data collection that preclude direct comparison on numbers, the principles of the Zero Suicide framework are similar to the multiple strategies and approaches utilized in VA care.

Environmental Design

According to Karlin and Zeiss, “high-quality care and positive clinical outcomes in inpatient psychiatric treatment necessitate a broad conceptualization of forces that lead to therapeutic changes that include attention to environmental design.” [53(p1378)] Environmental design factors should be part of the planning and design of inpatient psychiatric unit construction or renovation. [53] While safety of the inpatient psychiatric unit is the top priority, the interior and exterior design features are important to reduce the sterile appearance and create an environment that promotes healing.

Important design features include private rooms with bathrooms, interior lighting, access to nature and the outdoors, natural light brought in through low positioned windows, the use of a soft pastel color palette, quiet and calming rooms with changing colors and music that can be controlled by the patient, community space for group activities and therapies that take into account social density to not promote a crowded feel, and having secure staff space that is "off stage." [54] To reduce institutionalized features in the environment, a mobile staff team station in a public area of the unit is suggested instead of dedicated "staff station." This element changes the power dynamic for patients while keeping secured private staff space out of the main area, so that staff may have a quiet, dedicated space for documentation and administrative tasks. [55]

The University of Texas Health Science Center at Houston and the Texas Health and Human Services Commission have a joint project to create a public mental health facility. The design will incorporate uncrowded spaces, natural light, and patient access to the outdoors, all of which can contribute to better outcomes. Natural lighting and darkness will be used to minimize disruption to circadian rhythms. Noise levels will be minimized to decrease stress levels (Lake, 2019; DiNardo, 2019).

A national planning strategy must support full incorporation of environmental design elements. The VA Design Guide for Inpatient Mental Health and Residential Rehabilitation Treatment Program Facilities, updated in January 2021 by an interdisciplinary team of VA leadership and subject matter experts, provides comprehensive guidance, design detail and descriptions, and technical considerations when planning a new inpatient mental health unit or renovating an existing inpatient mental health unit. With a focus on creating a therapeutic environment, the design guide details every feature including self-harm protective elements, interior design, outdoor spaces, and infrastructure planning. The design guide recommends that inpatient mental health programs undergoing planned construction or renovations form an advisory committee that includes staff who will be working in the programs, Veterans, and other stakeholders as the construction or renovations progresses. [43]

The 2021 Guide foreword states that "all participants in the project development process must embrace VA Planning, Design, and Construction Standards as fundamental in providing optimum environments for Veteran's care and service, in fulfilling VA's mission," [43(p1-4)] There are challenges with the inconsistency in the implementation of the design guide features and a lack of resources to oversee the design or renovation of dozens of inpatient mental health units that may not yet meet these standards. [11]

Innovative Approaches in Inpatient Mental Health Subspecialties

Two subspecialties particularly relevant to the Veteran population are geriatric inpatient mental health care and integrated inpatient medical and mental health care. The development of specialized units to address the unique needs of the most vulnerable patients is an important innovation in inpatient mental health treatment.

Geriatric Inpatient Mental Health Care

Older Veterans are resilient, but less likely to participate in a mental health intervention even though they benefit from treatment as much as younger Veterans. [56] In addition, older adults have unique, age-related needs that often require additional support. This suggests a need for specialized mental health services to support older Veterans. The VA Inpatient Mental Health Handbook (2013) suggests the following regarding the treatment of older adults in inpatient mental health facilities:

> Units must provide a safe and clinically appropriate setting for geriatric patients. Frail, elderly, or patients with disruptive behavior secondary to dementia must be kept safe from patients demonstrating agitated behavior to prevent inadvertent injury. Larger facilities may establish a separate wing or unit for geriatric patients with treatment programs designed to meet their needs. [5(p14)]

There is a growing body of research that suggests that older adults, defined as people over the age of 65 years, benefit from receiving care from clinical staff trained to appreciate their unique needs. [57] The risk of a serious fall, agitation related to cognitive decline, and unsafe wandering are other factors to consider in any mental health setting with older adults. [58] Older adults often require assistance with activities of daily living such as bathing, toileting, and dressing. Additionally, older patients can be diagnosed with dementia, delirium, and other age-related neurological or psychological symptoms that create a treatment challenge in acute units in which older and younger patients mix. [59] Understanding of the age-related physical and emotional changes, psychosocial factors, and social determinants of health in elders is an important clinical subspecialty. As a result, commercial health organizations are increasing the availability of inpatient geriatric mental health units. There is also compelling evidence that patients in inpatient geriatric mental health units receive more appropriate clinical care resulting in a shorter length of stay. [57, 60]

The McLean hospital in Massachusetts, which has a Cognitive Neuropsychiatry program specializing in the care of people 50 years old and older with degenerative, progressive neurological disorders of aging, is an example of innovative inpatient programming. This program provides all the components of a typical geriatric mental health inpatient unit but also works with the patient to diagnosis specific illnesses, manage symptoms and expectations for disease progression, and provide psychoeducational support for family caregivers. While many geriatric mental health units also provide diagnostic and treatment options for people with cognitive decline, this unit only provides care for people diagnosed with Alzheimer's disease and related disorders. [61]

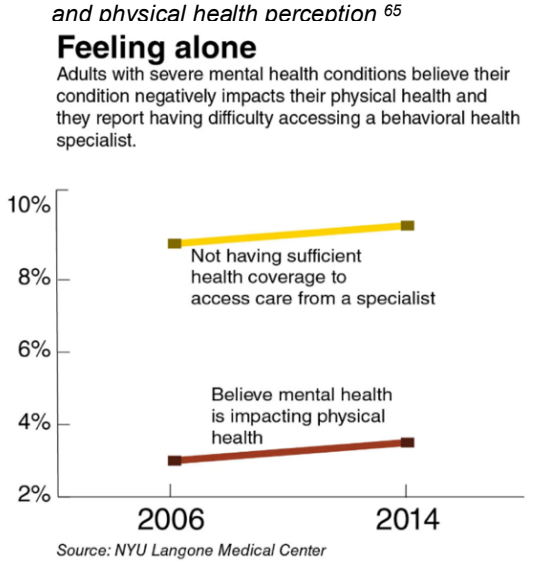
Despite the increasing demand for geriatric inpatient care, there is a growing workforce shortage for geriatric mental health clinicians. In 2019, the American Psychological Association's Center for Workforce Studies surveyed psychologists across the country and found only 1.2% of participants described geropsychology as their specialty area, although 37.2% reported seeing older adults frequently. [62] Therefore, training in foundational geropsychology competencies including cognitive, affective, and behavior management, end-of-life care, understanding of complex of chronic illness in older adults, hospital patient safety, ambulatory care, and transitions of care is critical for mental health clinicians. [62] In locations with limited access to mental health clinicians, utilization of telepsychiatry or telemental health may be an effective way to increase access to mental health care across the continuum.

A study showed that nursing students held significant biases about older adults and people with mental health illness. The study recommended adding formal training to curricula to better prepare students to care for older adults and individuals with mental health needs (Benjenk, Buchongo, Amaize, Martinez, and Chen, 2019).

Integrated Inpatient Medical and Mental Health Care

Medical comorbidity is defined as the presence of more than one disease in the same patient at the same time. The occurrence of comorbid mental and physical disease has increased considerably over the last two decades and is projected to continue to grow. This growth is based on many factors including advances in medicine that have prolonged life expectancy without curing diseases, an aging population, unhealthy lifestyles, and environmental changes affecting the immune system. The presence of comorbidities will often worsen the prognoses of all the diseases causing the treatment to be more difficult and possibly less effective. [63] The physical diagnoses can include obesity, diabetes, hypertension, heart disease, renal disease, Human Immunodeficiency Virus (HIV), and many others. The high prevalence of common physical diagnoses among inpatients underscores the importance of adequate detection and medical treatment of physical comorbidities in inpatient mental health settings. [64]

Figure 10: *Correlation between mental health and physical health perception* [65]



OMHSP leadership stated that the interdisciplinary delivery of care and access to medical consultation and treatment while hospitalized for acute exacerbation of psychiatric distress are strengths of the VA mental health continuum of care. [11] 29% of adults with a medical condition also have some type of mental health disorder and nearly 70% of mental health patients have a medical comorbidity. [65]

Although integration of mental health and physical health treatments is more prevalent today, evidence suggests the community mental health care system is offering less access even as demand increases. "Successfully integrating mental and physical health services requires some cultural shifts; it's not just a matter of embedding a psychologist or mental health professional within a medical unit." [65] Effective inpatient medical/mental health treatment is dependent on many factors, and patients receiving integrated care report being more satisfied with their care compared with patients not receiving integrated care. [66] The Johns Hopkins Hospital system in Maryland has an 11-bed geriatric mental health unit for medically complex adults aged 60 and older who are diagnosed with severe mental illness. This unit specializes in care for treatment resistant patients who may have had unsuccessful treatment experiences in traditional inpatient and outpatient mental health treatment modalities due to their medical comorbidities. [67]

A Type IV inpatient integrated medical/psychiatric program is designed to treat patients with medical and mental health needs of medium to high acuity. [68] A study published in *Psychosomatics* compared the treatment of patients with medical/psychiatric needs in a Type IV integrated medicine and mental health inpatient unit to those patients admitted to a general medicine unit. Results showed physical symptom improvement was equal in both inpatient settings; however, psychiatric symptoms improved more in the Type IV program than on the general medicine unit. [68] Integrated care in the Type IV unit also resulted in a shorter LOS for medical patients with serious psychiatric illness than would have occurred had they been admitted to the general medicine unit. [68] Overall, the study found that "the integrated Type IV medicine and psychiatry treatment program represents an efficient and effective process improvement in the way that medical patients with comorbid medical and psychiatric illness can be treated." [68(p345)]

Leading Practices Within the Mental Health Continuum of Care

The inpatient mental health level of care is a critical component of the larger mental health continuum of care that serves a relatively small number of patients but is costly and requires extensive resources. Understanding the contributions that each level of mental health care makes in treating and preventing exacerbation of symptoms or returning functioning to baseline is essential for gaining an understanding of the interconnectedness of the care continuum. An inpatient mental health hospitalization becomes necessary when a person is experiencing a disease exacerbation and is unable to remain safely in the community. Ideally, outpatient treatment options can prevent the necessity of some acute care admissions and prevent the unnecessary stress of mental health readmission.

Shifting to Lower Acuity Care Settings

Transition from inpatient to outpatient care requires proper discharge planning. While care often has a focus on stabilization, care administered post-discharge is needed to continue treatment. Research found that 55% of post-hospitalization suicides occurred within a week of discharge. Of these, 49% of patients had not had their first follow-up appointment. [69] Transitional interventions soon after discharge aid in suicide prevention and can reduce the likelihood of acute inpatient mental health readmission. [22, 70] VA has policies in place to ensure enhanced outreach and contact in the days and weeks immediately following discharge from inpatient mental health treatment.

Transitional interventions can be administered through a variety of modalities. Phone calls, home visits, Caring Contacts letters, and cognitive behavioral therapy are among the most frequently used mechanisms. [71] SAMHSA also cites internet chat as an option for continued contact in the inpatient to outpatient transition. [72] Individuals with SMI who are enrolled in Patient-Centered Medical Homes, such as Patient Aligned Care Teams were more likely to receive timely post-discharge follow-up from a primary care provider. [73]Innovative Measures in the Emergency Department

Proper mental health care delivery at touchpoints other than in inpatient settings, such as in the emergency department (ED), are essential to providing the best care for Veterans at “the right place, at the right time.” Individuals in need of mental health care frequently present to hospital EDs, but EDs across the country are often ill-equipped to support these patients. [74] Between 2006 and 2014, the admission rate for people presenting at an ED with acute mental health and substance abuse needs grew by 31.8%. [75] Providing appropriate mental health care in the ED, as well as follow-up care, is cost-effective and essential to ensure the safety of patients and create a recovery-oriented environment. [75] A VA-developed national innovation is the Safety Planning in the Emergency Department (SPED) program. In this program, VA ED clinical staff identify Veterans expressing suicidality to develop a safety plan and schedule follow-up after discharge from the ED to facilitate outpatient mental health treatment. [76]

In 2020, the Institute for Healthcare Improvement (IHI) developed a framework to improve care for patients with mental health conditions in the ED. [74] The framework

consists of four primary drivers: (a) “process,” including standardization of ED processes; (b) “provider culture,” which calls for creation of a trauma-informed culture; (c) “patients,” achieved through engagement of patients and their families; and (d) “partnerships,” specifically with community organizations. [74] The 2013 VHA Inpatient Mental Health Handbook has guidelines to standardize mental health processes in the ED and engage and empower patients and their families in recovery-oriented clinical care. In terms of partnerships, each medical center is instructed to have liaisons with state, county, and local mental health organizations to ensure coordination between public resources which should assist with follow up care beyond the ED. Educating ED clinical staff in best practices for caring for individuals with mental health needs can empower them to best support Veterans. [5, 74]

Inpatient Mental Health Telehealth Trends

Telepsychiatry, one form of telemental health, is an innovative approach that improves access to psychiatrists in different care settings and to different patient types. More specifically, examples of telepsychiatry in the ED and telemedicine for geriatric patients have been successful. Telepsychiatry in the ED reduced wait times for patients and improved patient access to specialist emergency mental health care across rural and remote Australia through the Mental Health Emergency Care-Rural Access Program. [77] Telepsychiatry improved timeliness and access to care and reduced patients leaving without receiving care. An additional benefit of telepsychiatry for ED staff is that they report more confidence in their ability to manage the care for mental health patients experiencing a crisis without transferring patients. [77] Another study evaluating telepsychiatry in the ED found no significant difference between telemedicine and in-person interventions and patient diagnosis and disposition. [78]

A literature review of studies exploring the use of telemedicine for geriatric patients found that telemedicine can reduce the overall cost of care and improve access to specialists. The study found that telemedicine is being utilized in a variety of disciplines and settings including nursing homes, community care providers, and with integrated care models. [79] The COVID-19 pandemic accelerated the utilization of telehealth including telemental health, creating the potential for inpatient mental health to access specialty consults and/or telepsychiatry to meet future demand in areas with staffing shortages.

Challenges with Leading Practices

Measuring and assessing the value and quality of inpatient mental health services remains a significant, worldwide challenge. [80, 81] Although mental health diagnoses have increased, measurement of mental health care quality, efficacy, and innovation continues to trail that of physical health, therefore making it difficult to identify industry leaders. Additional barriers include the lack of standardized technology-based data sources, limited scientific evidence for mental health quality measures, lack of provider training and support, and cultural barriers to integrating mental health care within the larger health care delivery system. [80]

4. Market Framework

4.1 Program Priorities

Veterans served by inpatient mental health programs are experiencing an acute mental health crisis and must have timely access to care. This care is designed to be recovery-oriented, evidence-based, and Veteran-centric. The key program priorities that have guided the development of planning guidelines include increasing access and aligning capacity with projected demand, and other key priorities include ensuring quality and safety and coordinating care across programs.

Increased Access

The Inpatient Mental Health National Planning Strategy provides a planning approach to ensure access within each market to provide services close to where Veterans live, provided sufficient demand is established in a given market. As this is an acute care service, it is essential that access is available within 60-minute drive time standards and without wait for admission. Strategic placement of inpatient mental health services must balance locations in population centers with ensuring access to underserved Veteran communities.

Inpatient mental health programs should generally be located in major Veteran population centers. Due to the urgent nature of services, Veterans experiencing a mental health crisis need care that is easily and immediately accessible. [4] According to the MISSION Act access standards, inpatient mental health care should be accessible within a 60-minute drive time. [12] Veterans who live outside the 60-minute drive time may opt to receive care from a community partner. Therefore, it is essential to establish a widespread, high quality CCN in each market to ensure inpatient mental health coverage for all Veterans.

Aligning Capacity with Demand

To improve access, market-level capacity should be matched with future demand projections. Thus, recommendations for individual markets may include increasing, decreasing, or maintaining capacity, as well as establishing or closing programs.

Ensuring Quality, Safety, and Environment of Care

Inpatient mental health has limited standardized quality metrics which makes assessing quality in a consistent way a significant challenge for providers within and outside of VA. A goal for inpatient mental health is working toward the consistent implementation of recovery-oriented, evidence-based practices while reducing safety concerns. For example, the development and implementation of an environment of care safety checklist has decreased the risk of self-harm on units and is an integral component of inpatient mental health care. [40] The environment of care is of particular importance for the safety and appropriate context for treatment, and VA provides a comprehensive set

of design guidelines which should be followed. [43] VA should serve as a leader for national mental health in the development of quality of care metrics through future clinical research.

Coordination of Care

Once a Veteran is stabilized, inpatient mental health staff should continue to proactively coordinate care to the next appropriate setting in the continuum of care. Communication and collaboration between inpatient mental health and lower acuity levels of care, also known as "warm hand-offs," are critical to Veterans' successful recovery and transition back into the community.

4.2 Service Typologies

Inpatient mental health is a market-level service delivered in VAMCs that typically also provide inpatient medical and emergency service capabilities to treat medical comorbidities. As described in Section 2, the current distribution of programs and bed capacity necessitates a planning methodology that ensures access to inpatient mental health care in each market and matches capacity with future demand.

Special Population Considerations

Geriatric Inpatient Mental Health Care

VHA is serving greater numbers of older Veterans with complex medical and psychosocial needs each year. Some older Veterans may exhibit distressed behaviors (for example, physical or verbal aggression, repeated vocalizations, wandering, sexual disinhibition, psychosis, dependency/disengagement, apathy, or depression) that interfere with their quality of life, care provision, or transition to community-based care settings. [82] Individual VA medical centers have designed a variety of local programs to provide for the needs of these complex Veteran populations and some facilities in the community have developed what are known as Continuing Care Retirement Communities as a partial solution. Due to the varied needs of this complex population, no specific guidance or policy on ideal treatment models has been instituted throughout the VA system for this growing group of Veterans, and there are no agreed upon standards of care that are readily available in the community either. Thus, there are currently no guidelines that can be recommended on program size or bed capacity for inpatient geriatric mental health treatment within these planning strategies. However, all stakeholders agree that this is a high priority area on which Geriatric Extended Care (GEC) and OMHSP should continue to work together to develop such guidance in the near future, as the continuum of care for this type of complex service spans the two program offices.

Extended Stays

Another significant challenge that the VA system faces is meeting the comprehensive needs of complex Veteran patients who are currently receiving care on inpatient mental

health units through extended stays (defined by OMHSP as greater than 30 days). Many of these extended stay Veterans are technically not the acute mental health patient for whom the units are designed. These Veterans may present a number of care challenges that VA is required to address: 1) they may have initially met appropriate admission criteria to the unit but now are difficult to place elsewhere for a variety of reasons including behavioral disinhibition, lack of decisional capacity/competency, awaiting state competency determinations, sex offender status, chronic SMI; 2) they may not ever have demonstrated the high level of acuity for which an acute mental health unit is designed, but a local facility determined that the inpatient mental health level of care provided the best context of safety and stability for the care of these Veterans; and/or 3) they may routinely fluctuate between meeting inpatient acuity criteria and not meeting acuity criteria, and so it is determined that the inpatient unit provides the most stable environment of care across these fluctuating symptom levels.

OMHSP is aware of this challenge and has been exploring a number of ways of addressing the needs of these Veterans, including converting some existing inpatient units to RRTPs or CLCs (there is a current for five RRTP conversions and one CLC conversion),[1] working toward enhancing capacity for CLCs to provide care to Veterans with SMI who meet admission criteria to a CLC, and increasing the ability to work with trusted facilities in the community in new ways. Another option is to explore the possibility of developing intermediate mental health units that would focus on stabilization, enhanced interdisciplinary programming, and occupational therapy for Veterans of any age with chronic SMI or significant cognitive impairment who are not eligible or appropriate for a CLC.

As these Veterans are currently counted in the ADC for inpatient utilization, local VA medical center leaders should carefully consider their future planning for these complex patients to inform decision making on future projections vs. capacity within inpatient units. In each individual locality, the determination of whether to project needs that include these extended stay Veterans within the inpatient mental health demand will depend on whether these Veterans are likely to continue receiving care in the inpatient mental health unit of a given facility, or if this care will be transitioned to another setting or level of care. The projected local needs of these extended stay Veterans must be accounted for thoughtfully in the model in order to ensure that there are sufficient and appropriate services for their complex needs.

[1] OMHSP reports that the following facilities are currently planning to convert their inpatient MH mental health programs: Central Massachusetts HCS (Specialized inpatient PTSD unit and STAR unit projected to convert to residential); Northern Indiana VAMC (inpatient mental health program projected to convert to residential); Battle Creek VAMC (inpatient mental health program projected to convert to CLC); Eastern Kansas HCS (Two inpatient mental health programs projected to convert to residential); Alexandria HCS (inpatient mental health program projected to convert to residential).

4.3 Planning Guidelines

Planning guidelines and thresholds seek to inform the market assessment process. The rationale for establishing VA planning guidelines 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 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 Inpatient Mental Health 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 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** – 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

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

a hospital (HwH) 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

Any inpatient mental health relocation and replacement moves for facilities should be in tandem with other inpatient acute care moves so that integrated coverage can continue to be provided. Overall, open, maintain, and partner guidelines should be leveraged to make inpatient mental health planning decisions.

Planning Guidelines Table

MAHSO Planning Guidelines	
Service	Inpatient Mental Health
Geography	Minimum of 1 per market if minimum service area demand criteria is met and/or there is a lack of high-quality community beds

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• **Urban:** Minimum market-level projected 10-year annual BDOC of 4,380 (12.0 ADC) • **Rural:** Minimum market-level projected 10-year annual BDOC of 3,504 (9.6 ADC)	• The minimum BDOC is based on an analysis of the EHCPM demand projections at the market-level, interviews with OMHSP, and industry best practice for insights into minimum demand, size, and occupancy for operational effectiveness. • There are lower guidelines for inpatient mental health in rural VA markets where geographic factors make access challenging and community supply is limited. ○ A rural market is defined as a market where more than 50% of enrollees are living in rural areas.

Open		
Planning Domain	**Planning Guideline**	**Rationale**
Supply	• **Urban:** 15 minimum total beds • **Rural:** 12 minimum total beds • Target occupancy rate of 80%	• The minimum size of 15 beds for urban programs and 12 beds for rural programs is designed to support the demand for an operationally efficient occupancy rate in accordance with industry best practices. [83] • 16 total beds for urban markets are also acceptable given the VA design guidelines suggest unit sizes of 8, 12, 16, and 20 beds. [43] • Interdisciplinary staffing guidelines are designed to meet VA and Joint Commission staffing recommendations.
Access	• Proposed location has sufficient projected market-level BDOC to meet demand guidelines. • Target a 60-minute or less drive time. • New programs must be co-located on a medical center campus with inpatient medical services. • Ideal program location is within a major Veteran population center.	• Drive time standards are aligned with MISSION Act requirements. [12] • Program location guidelines are also designed to meet MISSION Act access standards. • Colocation with inpatient medical or emergency services is designed to meet clinical needs identified by OMHSP interviews and subject matter experts. [11]
Quality	Not applicable. Although providing high quality care is an essential priority, opening sites of care will not be determined based on quality scores.	

Maintain • **No Change** • **Resize** (increase or decrease capacity) • **Relocate** • **Modernize** (facility condition, environment of care)		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• **Urban**: Minimum market-level projected 10-year annual BDOC of 3,504 (9.6 ADC) based on the EHCPM • **Rural**: Minimum market-level projected 10-year annual BDOC of 2,920 (8.0 ADC) based on the EHCPM	• The minimum BDOC is based on an analysis of the EHCPM demand projections at the market level, interviews with OMHSP and industry best practice, and VA design standards for insights into minimum demand, size, and occupancy for operational effectiveness. [83] • There are lower guidelines for inpatient mental health in rural VA markets where geographic factors make access challenging and where community supply is limited. ○ A rural market is defined as a market where more than 50% of enrollees are living in rural areas. See Section 2.2 for details on market rurality.
Supply	• 12 minimum total beds • Acceptable occupancy rate between 75% to 90% with a target occupancy rate of 80%	• Bed minimums are aligned with DHA and VA design standards. [43, 84] • Interdisciplinary staffing guidelines are designed to meet VA and Joint Commission staffing recommendations.
Access	• Location has sufficient projected market-level BDOC to meet demand guidelines. • Target a 60-minute or less drive time. • Program location is within a major Veteran population center.	• Program location guidelines are designed to support MISSION Act access standards. [12]
Quality	Not applicable. Although providing high quality care is an essential priority, maintaining sites of care will not be determined based on quality scores.	
Other	**Maintain** • Current bed supply meets projected ADC and stays within a 75% to 90% occupancy rate. [83, 85] **Relocate**	**No Change** • Inpatient mental health programs that meet the maintain guidelines do not need any change. **Relocate**

Maintain • **No Change** • **Resize** (increase or decrease capacity) • **Relocate** • **Modernize** (facility condition, environment of care)		
Planning Domain	**Planning Guideline**	**Rationale**
	• Any relocation must occur in conjunction with relocations of other inpatient medical services	• Inpatient mental health and inpatient medical services must move in tandem to ensure integrated coverage and comprehensive care management.
	Resize • Demand exceeds or is below capacity • Occupancy rate is below 75% or higher than 90%	**Resize** • The current inpatient mental health service is unable to accommodate projected demand or there is significant excess capacity on a unit compared to demand.
	Modernize • Environment of care and facility condition standards based on Design Guide for Inpatient Mental Health and Residential Rehabilitation Treatment Program Facilities. [43]	**Modernize** • Infrastructure does not adhere to current standards of safety, security, or provide a therapeutic environment.

Partner - VA		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• Market-level projected ADC does not meet minimum service area requirements for Open or Maintain planning moves. ○ **Open:** Below 12.0 ADC (Urban), below 9.6 ADC (Rural) ○ **Maintain:** Below 9.6 ADC (Urban), below 8.0 ADC (Rural)	• The guideline ensures that a potential VA-delivered partnership is prioritized if the market-level projected ADC does not meet the minimum service area demand requirements for Open or Maintain planning moves, and there are no high-quality options in the area. • There are lower guidelines for inpatient mental health in rural VA markets where geographic factors make access challenging and community supply is limited. ○ A rural market is defined as a market where more than 50% of enrollees are living in rural areas.

Partner - VA		
Planning Domain	**Planning Guideline**	**Rationale**
Supply	• Demand minimum criteria are met and there is a lack of adequate space within a VA facility. • VA facility does not provide inpatient medical footprint. • VA Partner is able to meet projected VA ADC without exceeding 80% occupancy rate	• These guidelines ensure that there are enough beds available to support projected demand without resulting in a wait time for admission. [83] • The guidelines ensure potential VA-delivered partnerships increase capacity in markets with limited supply and space constraints. • Colocation with inpatient medical or emergency services is designed to meet clinical needs as identified by OMHSP interviews and subject matter experts. [11]
Access	• Target a 60-minute or less drive time. • Ideal program location is within a major Veteran population center and on a medical campus with inpatient medical services.	• Access standards for Veterans to receive inpatient mental health care at partner facilities were developed to ensure timely access to care and establish consistent metrics across the service. • Access planning guidelines may be more lenient in underserved areas.
Quality	• Quality of community providers within 60-minutes of an enrollee-dense area is below a CMS 3 Star rating. • Preferred providers have achieved and maintained Joint Commission accreditation.	• When low quality is determined in the community, VA should consider an opportunity to leverage a VA-delivered partnership model to maintain control over the quality of the care provided with the partner. • Joint Commission Accreditation requires that an organization meet minimum standards for environment, safety, clinical standards, and many other operational standards. CMS Star ratings evaluate inpatient patient satisfaction, safety, and other factors to evaluate the quality of care. [86, 87] • While this guideline is meant to establish a quality guideline in a market with low quality providers, it is not meant to be a barrier to partnering with high quality providers. If appropriate, partnerships with high quality providers are also encouraged.

Partner – AA / Federal / CCN (Buy)		
Planning Domain	**Planning Guideline**	**Rationale**
Demand	• Market-level projected ADC does not meet minimum service area requirements for open or maintain planning moves. ○ **Open:** Below 12.0 ADC (Urban), below 9.6 ADC (Rural) ○ **Maintain:** Below 9.6 ADC (Urban), below 8.0 ADC (Rural)	• A partnership should be considered if the market-level projected ADC does not meet the minimum service area demand requirements for Open or Maintain planning moves. • There are lower guidelines for inpatient mental health in rural VA markets where geographic factors make access challenging and community supply is limited. ○ A rural market is defined as a market where more than 50% of enrollees are living in rural areas.
Supply	• The capacity of an academic affiliate, Federal provider, or community hospital can absorb VA's projected ADC without surpassing 80% occupancy. • There is an absence of VA-delivered supply that can cover projected market-level BDOC.	• This guideline ensures that there are enough beds available to support projected demand without resulting in a wait time for admission. • Partnerships with an academic affiliate or Federal partner should be prioritized, especially if the existing relationship is strong. • In markets with limited VA or community supply, academic affiliate, Federal, and community partnerships should be considered to increase capacity.
Access	• Target a 60-minute drive time or less. • Ideal program location is within a major Veteran population center and on a medical campus with inpatient medical or emergency services.	• Access standards for Veterans to receive inpatient mental health care at partner facilities were developed to ensure timely access to care and establish consistent metrics across the service. • Partnerships in underserved areas should receive special consideration.

Partner – AA / Federal / CCN (Buy)		
Planning Domain	**Planning Guideline**	**Rationale**
Quality	• Community providers and academic affiliates in the service area have a CMS 3 Star rating or above and are accredited by the Joint Commission • Federal providers should be accredited by the Joint Commission.	• Joint Commission Accreditation requires organizations to meet the minimum standards for environment, safety, clinical standards, and other operational standards. CMS Star ratings evaluate inpatient patient satisfaction, safety, and other factors to evaluate the quality of care. [86, 87] • Potential partners must meet or exceed the VA quality standards such as environment of care, safety, and recovery-oriented care guidelines for inpatient mental health.

Detailed Planning Guideline Rationale

The inpatient mental health planning guidelines were driven by data analysis, academic research, and OMHSP collaboration. Data sources used were EHCPM projections and current and past inpatient mental health data:

- Geographic distribution criteria were based on the analysis of current program locations, occupancy, and accessibility.
- Minimum BDOC demand criteria were based on an analysis of the EHCPM demand projections, past patient demand data, VA and DHA inpatient mental health design guidelines, and interviews with OMHSP for insights into minimum size for operational effectiveness. The resulting BDOC demand criteria ensures operationally efficient programs that also support a therapeutic, community environment for Veterans.
- Occupancy rate targets were based on academic research and industry standards in conjunction with feedback from the OMHSP. [83]
- Program and facility location and attribute guidelines were based on best practices interviews, current design guidelines, and collaboration with OMHSP and industry experts. [43, 11] The resulting guidelines provide efficient adjacencies and aim to place points of care in communities that support inpatient mental health program goals.

Program Sustainability Recommendations

Although each program has unique challenges and needs, there are overarching recommendations that each VA facility and market should take into consideration.

Occupancy: The goal for occupancy is 80%. [83] This is based on industry standards and best practices to ensure immediate access to inpatient mental health for Veterans

requiring acute care. Lower occupancy (below 75%) may indicate staffing challenges and excess capacity. High occupancy (above 90%) may indicate a need for additional beds in order to maintain a capacity level that supports timely admission rates.

Staffing: Inpatient mental health units must have the ability to provide the staffing necessary to deliver care appropriately. Although OMHSP does not have a national staffing plan or guideline for interdisciplinary inpatient mental health units, VA does provide staffing criteria for nursing and other staff categories by utilizing data and unit-based operations assessments. [88] Local facilities develop their own inpatient mental health staffing plans for certain positions utilizing a complex data set including patient acuity, ADC, and other criteria. [88, 89] These individual facility-based staffing requirements should be followed.

OMHSP leadership noted that all inpatient mental health units also meet Joint Commission staffing requirements. The Joint Commission provides broad guidance about clinical staff qualifications and interdisciplinary team members based on CMS regulations (§482.62 CMS). This guidance outlines specific facility requirements including engaging appropriate staff with the qualifications to assess patients, develop written individualized treatment plans, provide evidence-based interventions, and provide discharge planning and follow-up. Additional guidance is provided regarding leadership and clinical positions, however, staffing ratios or census-based staffing is not described in the regulations, allowing hospitals the flexibility to establish staffing patterns to meet the needs of the population served.

Geography: Given the importance of inpatient mental health care and the urgent nature of the services, the geographic area coverage recommended is at least one inpatient mental health program per VA market if minimum service area demand criteria are met. VA inpatient mental health services may also be appropriate if there is limited access to and availability of high-quality community inpatient mental health and outpatient services. More than one unit may be appropriate in locations with sufficient demand, for example large population centers served by a VA health care system with two VA medical centers.

Ideal Program Location: The ideal program location for an inpatient mental health unit is within a major Veteran population center. Programs in rural settings can be developed if demand planning guidelines are met and may draw from multiple communities. Facilities with inpatient mental health programs should ideally have access to a 24/7 emergency department or inpatient medical resources for the assessment and treatment of medical conditions. Additional program sustainability guidelines for specific scenarios are outlined in the following sections.

Facility Attributes and Environment of Care Design: The VA Design Guide for Inpatient Mental Health and Residential Rehabilitation Treatment Program Facilities, updated January 2021, provides comprehensive guidance, design detail and descriptions, and technical considerations when planning a new inpatient mental health

unit or renovating an existing inpatient mental health unit. The unit size proposed and recommended by VA and illustrated in the Design Guide are 8,12, 16, and 20 beds per unit, however, there may be clinical or operational considerations that effect the unit size as well. The unit size complements the clinical and therapeutic needs of patients and staff and is critical to its success. The unit size is determined by planners, designers, and facility staff. [43]

Cost Considerations: When using the planning guidelines, VA can consider comparing the costs associated with modernizing and maintaining an existing inpatient mental health program or opening a new inpatient mental health program with the cost of buying inpatient mental health services from a partner.

Major Market Moves

The planning guidelines are meant to act as recommended approaches to major market moves by leveraging data, industry leading practices, and VA standards. When deciding whether to maintain or open an inpatient mental health program, each planning scenario is unique. Recommendations of any kind should act as a guide in determining the sustainability and quality of the program while maintaining the Veteran at the forefront of all decision making. There may be instances where the guidelines are not sufficient for the needs of a particular unit such as programs susceptible to significant seasonal swings, serving large special populations like women or homeless Veterans, providing specialty care, or other considerations.

Open New Inpatient Mental Health Program: Thoughtful analysis should be undertaken during the planning phase of deciding whether a new inpatient mental health program should be constructed. The supply and demand minimums for a new inpatient mental health unit are higher than those for existing units due to the considerable capital investment required when opening a new program. Below is a description of select criteria that should be considered when assessing the viability of a new inpatient mental health program after the determination of the initial criteria is considered:

- **Access:** Opening a new inpatient mental health program should improve access to Veterans. Veterans have the option of going to a community provider if 60-minute drive time is not met. [12] The first criteria in the decision making and planning process of whether to open a new inpatient mental health program is that the program should be located on a medical center campus that offers other inpatient medical services or has a 24/7 emergency department to be able to care for medical comorbidities. If this initial criterion is not met, a new inpatient mental health program should not be considered.
- **Minimum Service Area Demand for Opening New Sites:** Demand recommendations to open a new site are based on VA and DHA design guidelines and assessment of current programs. EHCPM projections should be leveraged to determine whether a new inpatient mental health site should be

opened. The minimum to open a new site is a10-year projected ADC of 12.0 or 4,380 annual BDOC for urban markets, and a 10-year projected ADC of 9.6 or 3,504 annual BDOC for rural markets. [43, 84]

- **Minimum Total Bed Size for Opening New Sites:** The recommended minimum total number of beds to open a new inpatient mental health program is 15 for urban programs and 12 for rural programs in order to accommodate the 10-year projected demand and operate efficiently. However, 16 total beds for urban programs would be acceptable to meet the VA unit size recommendation. [43]
- **Occupancy Rate:** The occupancy rate goal for a new inpatient mental health program should reach 80%, with an acceptable range of 75% to 90% based on industry best practices. [83]

Maintain Existing Inpatient Mental Health Services: The majority of VAMCs provide inpatient mental health services to the Veteran population. It is important that all inpatient mental health programs have enough demand and supply to be able to operate efficiently. The planning guidelines include rural and urban standards to ensure equitable access to services in every community. Below are considerations to consider when assessing the sustainability of existing units:

- **Minimum Service Area Demand for Existing Sites:** The 10-year ADC and BDOC projections from the EHCPM should be leveraged to assess the sustainability of existing programs. The minimum to sustain an inpatient mental health program is a 10-year projected ADC of 9.6 or 3,504 annual BDOC for urban programs, and a 10-year projected ADC of 8.0 or 2,920 annual BDOC for rural programs.
- **Occupancy Rate:** The target occupancy rate is 80% for an existing inpatient mental health program however, based on industry standards, an occupancy rate within the 75% to 90% range is also acceptable. [83]
- **Minimum Total Bed Size to Maintain Existing Site:** The minimum total beds to maintain a program is 12. This recommendation aligns with VA design guidelines and DHA design criteria. [43, 84]
- **Access:** MISSION Act access standards require Veterans are within a 60-minute drive time to the VA point of care for inpatient services. [12]

Resize Existing Services: Achieving and maintaining operational efficiency is another goal of the strategic planning guidelines. In addition to the criteria needed to maintain a unit, resizing a unit may also be necessary if it meets the following criteria:

- **Occupancy Rate:** An existing program should consider rightsizing its bed count if it has a projected occupancy rate below 75% but still meets the minimum service area demand criteria. An existing program should consider *increasing* its bed count if its projected occupancy rate is above 90% and meets the minimum demand criteria. [85]

Modernize Existing Services: VA inpatient mental health facilities should ensure a safe and healing environment for Veterans through modernization and renovation of existing units to meet the updated design guidelines when possible.

- **Environmental Design:** It is recommended that an existing program meet the safety and design standards to the greatest extent possible as outlined in the January 2021 Design Guide for Inpatient Mental Health and Residential Rehabilitation Treatment Program Facilities. There are challenges to renovate an existing space, and the Design Guide provides a list of priorities for such projects. [43, 84]

Partnership Considerations

If a new and or existing inpatient mental health program is unable to meet all the respective guideline criteria, a partnership should be considered to ensure Veteran access to quality services during an acute mental health crisis. Partnerships should first be prioritized to allow VA-delivered care before transitioning services to a non-VA delivered community care hospital provider. Potential partners must meet VA inpatient mental health access standards including the required drive times and low wait times (see Section 2.2 for specific drive time standards).

Community Care Provider Quality: The MISSION Act requires that community care providers hold a valid state operating license and be credentialed to be a provider through VA or a CCN Third Party Administrator (TPA). For inpatient mental health, additional qualifications should include Joint Commission Accreditation for the beds utilized to serve Veterans and a CMS 3 Star facility rating or higher. As the MISSION Act quality standards evolve, inpatient mental health community providers must meet the qualifications required by the Act. Although inpatient mental health regulations vary by state which may result in additional challenges for partnerships, VA requires contracted providers to meet the VA standards of care at a minimum. [11]

The CMS Five-Star Quality rating system utilizes several factors to allow consumers to compare facilities and evaluate the quality, safety, and compliance of facilities with the regulatory requirements. The Star ratings use patient experience data from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) standardized tool. [86, 90]

The Joint Commission is an independent, not-for-profit organization that is a recognized leader for health care accreditation. The Joint Commission Accreditation evaluates, safety, quality, patient care, environment of care, staffing, compliance with regulations, improvement efforts, and many other factors. Joint Commission Accreditation demonstrates an organization's commitment to quality improvement and patient care. [87]

Bed Availability of Potential Partner: VA must ensure that there is sufficient bed capacity before partnering with another organization to provide inpatient mental health services. The partner must demonstrate the ability to accommodate projected VA demand, to avoid the risk of Veterans not receiving needed care during an acute mental

health crisis. Therefore, the partner's inpatient mental health bed availability must be adequate to absorb the VA 10-year projected inpatient mental health ADC without exceeding an 80% occupancy rate. Through this guideline, partners will be capable of meeting future VA inpatient mental health demands.

Partnership Types

VA can leverage partnerships for providing inpatient mental health services when projected demand may not be enough to support an operationally efficient in-house program. Partnerships are advantageous to increase access and may provide considerable cost savings. VA facilities are recommended to be actively engaged in any partnership to ensure quality of care and promote continuity of care. The potential models outlined below are VA-delivered and non-VA delivered partnerships with academic affiliate, Federal/state, and community organizations, but other types of partnerships may also exist.

VA-delivered Inpatient Mental Health Partnerships: Includes the credentialing of VA providers to deliver care within a community provider space, establishing a Hospital within a Hospital, or creating another type of Veteran-centric care delivery. VA-delivered partnerships that meet the guidelines and support a new or existing educational or research mission serve a dual purpose and should be prioritized. To assess if this partnership model is suitable and sustainable, the following guidelines can potentially assist with the decision-making process:

- **Quality:** When low quality is determined in the community which is below 3 Stars based on CMS ratings, VA should consider an opportunity to leverage a VA-delivered partnership model to maintain control over the quality of the care provided in the community setting.
- **Capacity:** If VA projected ADC for inpatient mental health services will increase capacity for community providers to more than 80%, then VA should consider a VA-delivered partnership opportunity. VA-delivered partnerships that increase capacity in markets with limited supply should also be considered.
- **Access:** The desired location of a VA-delivered inpatient mental health partnership should expand access to care for Veterans. Therefore, the ideal program location is within a major population center with a considerable Veteran population within the 60-minute drive time.
- **Veteran-centric care**: VA-delivered partnerships will provide continuity of care by transitioning Veterans back to VA outpatient mental health service post-discharge.

Academic Affiliate Inpatient Mental Health Partnerships: Would allow VA to refer patients to respective facilities for inpatient mental health services and ensure that Veterans continue to receive high quality and accessible care, while potentially expanding VA's research and education mission. Academic affiliate partnerships that meet initial planning guideline requirements and support a new or existing educational or research mission serve a dual purpose and should be prioritized. To determine if this

partnership model is appropriate, the following guidelines can potentially support this decision:

- **Quality:** The quality of an academic affiliate must be 3 Stars or higher, based on CMS ratings, and achieve and maintain Joint Commission Accreditation. [86, 87]
- **Capacity:** The capacity of an academic affiliate can absorb VA's projected demand for inpatient mental health services without surpassing 80% occupancy. Academic affiliate partnerships that increase capacity in markets with limited supply should also be considered.
- **Access:** An academic affiliate partnership should be considered instead of a VA-delivered partnership if the academic affiliate is high quality, able to absorb projected demand, and within a 60-minute drive for the targeted Veteran population.
- **Veteran-centric care**: The partnering VA point of care should provide guidance to the academic affiliate partner regarding military cultural competency, Veteran-specific challenges, care needs, and the transition of Veterans back to VA outpatient mental health service post-discharge.

Federal Provider Inpatient Mental Health Partnerships: In this model, the VAMC would refer patients to Department of Defense (DoD) or Indian Health Services (IHS) facilities for inpatient mental health care. This partnership model may be leveraged to ensure that Veterans receive high quality and accessible care, while establishing and strengthening Federal relationships. Federal provider partnerships may include co-located VA and Federal facilities or a shared mission through an academic affiliation. Major advantages of this partnership opportunity can include the prevention of duplication of efforts and cost savings. However, the differences between the cohorts and missions may preclude effective treatment for Veterans in some of these settings. For example, there are differences between active-duty military hospitals designed to quickly return younger service members to duty and older Veterans who need longer periods of stabilization from chronic mental health conditions. These partnerships should be reviewed on a case-by-case basis. To determine if a Federal provider should partner with VA, the following guidelines should be considered:

- **Quality:** The Federal provider must achieve and maintain Joint Commission Accreditation. [87]
- **Capacity:** The capacity of a Federal provider can absorb VA's projected demand for inpatient mental health services without surpassing 80% occupancy. Partnerships with Federal providers that increase capacity in markets with limited community supply should also be considered.
- **Access:** Access standards for Veterans to receive care at inpatient mental health Federal facilities should mirror those access metrics for Veterans to receive care with Community Care Network providers.
- **Veteran-centric care**: The partnering VA point of care should provide guidance to the Federal partner regarding military cultural competency, Veteran-specific

challenges, care needs, and the transition of Veterans back to VA outpatient mental health service post-discharge.

Community Hospital Inpatient Mental Health Partnerships: Partnerships with community hospitals for inpatient mental health services can provide an opportunity to expand relationships with community resources, particularly where no Federal or academic affiliate providers are available. To determine if a community hospital can provide inpatient mental health care for Veterans the following should be considered:

- **Quality:** Assessing the quality of a community hospital is of particular importance as VA will have limited insight into the care being delivered. The quality of the community hospital must be 3 Stars or higher, based on CMS ratings, and must achieve and maintain Joint Commission Accreditation. [86, 87] It is critical to ensure that the Third-Party Administrator (TPA) is monitoring quality. Independent psychiatric facilities in the community may not officially adhere to CMS standards and thus may not have CMS Star ratings. In these cases, local VA mental health leadership should review the available quality metrics tracked by a given facility on a case by case basis to determine suitability for partnership.
- **Capacity:** The capacity of a community hospital can absorb VA's projected demand for inpatient mental health services without surpassing 80% occupancy. Special consideration for community hospital partnerships which increase capacity in markets with limited supply should also be considered.
- **Access:** A community hospital partnership should be considered when a potential partner can absorb projected demand and is within a 60-minute drive for the targeted Veteran population.
- **Veteran-centric care**: The partnering VA point of care should provide guidance to the community hospital partner regarding military cultural competency, Veteran-specific challenges, care needs, and the transition of Veterans back to VA outpatient mental health service post-discharge.

5. Future Program Planning

5.1 Applying the Inpatient Mental Health 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. Inpatient Mental Health was identified as a service line requiring further review to define a set of national planning guidelines that would be applicable for use in current (MAHSO) and future planning efforts.

This document, the Inpatient Mental Health National Planning Strategy, establishes the definitive, consistent, planning guidelines to be used for all VA Inpatient Mental Health 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 guidelines will be useful to VA planners to inform future quadrennial market assessments and other planning exercises.

How will MAHSO apply the Inpatient Mental Health National Planning Strategy?

The four-step process for revisiting MAHSO draft opportunities, shown below, describes how Inpatient Mental Health-specific opportunities will be reviewed and updated, if necessary.

1. Review Phase 1-3 Market Assessment Data and Inpatient Mental Health Opportunities

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

2. Apply Inpatient Mental Health Planning Guidelines

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

3. Update/Create Inpatient Mental Health Opportunities

As needed, existing market optimization or capital opportunities will be revised. In addition, after application of the planning guidelines and thresholds, new Inpatient Mental Health 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

The Inpatient Mental Health National Planning Strategy, created in conjunction with the OMHSP, is a framework for designing consistent service delivery planning for Inpatient Mental Health services. Based on OMHSP program priorities, the Inpatient Mental Health National Planning Strategy provides guidance on how Inpatient Mental Health programs 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.

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Appendix A: Acronym List

Acronym	Definition
AA	Academic Affiliate
ADC	Average Daily Census
AIR	Asset and Infrastructure Review
BDOC	Bed Days of Care
CCN	Community Care Network
CLC	Community Living Center
CMS	Centers for Medicare and Medicaid Services
CSO	Chief Strategy Office
CSRE	Comprehensive Suicide Risk Evaluation
C-SSRS	Columbia-Suicide Severity Rating Scale
DoD	Department of Defense
ED	Emergency Department
EHCPM	Enrollee Health Care Projection Model
EoCC	Environment of Care Checklist
FY	Fiscal Year
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resource and Services Administration
HwH	Hospital within a Hospital
IHI	Institute for Healthcare Improvement
IP MH	Inpatient Mental Health
IPFQR	Inpatient Psychiatric Facility Quality Reporting Program
LOS	Length of Stay
MAHSO	Market Area Health System Optimization
MHICM	Mental Health Intensive Case Management
MISSION	Maintaining Systems and Strengthening Integrated Outside Networks
NEPEC	Northeast Program Evaluation Center
OMHSP	Office of Mental Health and Suicide Prevention
PCMHI	Primary Care Mental Health Integration
PDE	Post Discharge Engagement
PHCoE	Psychological Health Center of Excellence
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RRTP	Residential Rehabilitation Treatment Program
SAIL	Strategic Analytics for Improvements and Learning

Acronym	Definition
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SPED	Safety Planning in the Emergency Department
SUD	Substance Use Disorder
TPA	Third Party Administrators
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration