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Veterans Health Administration  
Washington, DC 20420

VHA HANDBOOK 1162.XX  
Transmittal Sheet  
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## HEALTH CARE FOR HOMELESS VETERANS (HCHV) PROGRAM

- 1. PURPOSE.** This Veterans Health Administration (VHA) Handbook establishes procedures for the Health Care for Homeless Veterans Program (HCHV) and sets forth national authority for the administration, monitoring, and oversight of HCHV-funded contract and community-based programs.
- 2. SUMMARY OF CHANGES.** This Handbook clarifies the duties of those assigned responsibilities under the HCHV Program including implementing and monitoring HCHV-funded programs nationally.
- 3. RELATED ISSUES.** VHA Directive 1162 (to be published).
- 4. FOLLOW-UP RESPONSIBILITY.** The Office of Mental Health Services (116E), Health Care for Homeless Veterans Program, and The Office of Patient Care Services (11), is responsible for the contents of this Handbook. Questions may be directed to the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Services, at (202) 461-7348.
- 5. RELATED PROGRAMS.** MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM (MH RRTP); GRANT AND PER DIEM HANDBOOK; HUD-VASH HANDBOOK.
- 6. RE-CERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of January 2013.



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## HEALTH CARE FOR HOMELESS VETERANS (HCHV) PROGRAM

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for the Health Care for Homeless Veterans (HCHV) Program and sets forth national authority for the administration, monitoring, and oversight of HCHV Program.

### 2. BACKGROUND

a. The HCHV Program was developed from the original Homeless Chronically Mentally Ill (HCMI) Program, a 6-month pilot project, established by Public Law (Pub. L.) 100-6, February 12, 1987. With the demonstration of VA's ability to quickly launch HCMI, funding and authorization were extended by subsequent legislation. (Pub. L. 101-237). After several years of successful operation, the need to better define the program's principles and scope became apparent. This redefining coupled with the potentially stigmatizing label of "chronically mentally ill" led to the program being renamed as the HCHV Program.

b. The HCHV Program has been successful in establishing services for homeless veterans diagnosed with a mental illness since its inception. The initial core mission of HCHV was primarily to perform outreach, typically provided by VA social workers, to identify homeless veterans who were eligible for VA healthcare and assist these veterans in accessing appropriate levels of care. During the 1990s, additional programs were developed and implemented under the auspices of HCHV. Many were expanded to include VA Supportive Housing, Compensated Work Therapy, and other programmatic components to address the gaps in services for homeless veterans. Today, many HCHV programs now serve as the hub for a myriad of services and provide VA a way to outreach and assist homeless veterans by offering them entry to VA care.

c. In addition to its initial core mission, HCHV also functions as a mechanism to contract with providers for community-based residential treatment for homeless veterans. However, with the expansion of the Grant and Per Diem Program, some HCHV programs have been reduced or have shifted priorities to provide oversight of grant recipients' transitional housing. As a result of recent funding enhancements for the HCHV Program and renewed effort to address the needs of those homeless veterans diagnosed with a mental illness, the HCHV program is renewing its focus on outreach and services to homeless veterans.

d. The HCHV Program, an essential and critical part of VHA, is vital for providing a gateway to VA and community supportive services for eligible veterans who are homeless. Additionally, the HCHV Contract Residential Treatment Program for homeless veterans diagnosed with a mental illness is a vital program focused on addressing the needs of the most vulnerable and at risk homeless veterans. Ensuring that veterans with serious mental health diagnoses can be placed in community-based

programs which provide quality housing and services that meet the needs of this special population is a particular focus of the HCHV program.

### 3. AUTHORITY

38 USCA 2031 authorizes this program.

### 4. DEFINITION

Homeless Veteran means:

- a. An individual who lacks a fixed, regular, and adequate nighttime residence;  
and
- b. An individual who has a primary night time residence that is -
  - (1) A supervised publicly or privately operated shelter designed to provide temporary living accommodations including welfare hotels, congregate shelters, and transitional housing for the mentally ill;
  - (2) An institution that provides a temporary residence for individuals intended to be institutionalized; or
  - (3) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

38 USCA 2002; 42 USCA 11302(a).

**NOTE:** For purposes of this act, the term "homeless" or "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a State law.

### 5. SCOPE

- a. The core of the HCHV program is the outreach component. The central goal of the HCHV program is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs.
- b. The HCHV Program was developed to provide health care and other required services for homeless veterans, many of them diagnosed with a mental illness. Because of social alienation and the multiplicity of health care problems, the homeless mentally ill populations require specialized treatment services. HCHV Programs provide outreach services in community locations to engage homeless veterans who have been underserved. These veterans often require mental health and substance abuse treatment services, but will not avail themselves of such help without the encouragement of outreach workers.

c. The program philosophy and principles described in this Handbook apply to all VA HCHV Programs. However, it is recognized that flexibility will be required to adapt these guidelines to each VA medical center's HCHV Program, because of variations in staff qualifications, special needs of the veteran population, and local resources.

## 6. RANGE OF SERVICES

The HCHV Program is included in the wide array of services available to homeless veterans in the continuum of care through both VA health care and community resources. HCHV is generally the entry point to those care services. The HCHV Program is a multistage program that establishes contact with homeless veterans, many with mental illness, and facilitates their access to a wide range of medical and psychiatric services and available resources. All homeless veterans who have significant contacts with the HCHV Program staff will be assessed for VA eligibility and required services. This is dependent upon the veteran's cooperation and condition. Only some veterans progress through all of the following stages of care:

a. **Outreach** to identify veterans among homeless persons encountered in shelters, soup kitchens and other community locations. Engaging the veteran in participation in the assessment and follow-up with indicated services is a vital component of outreach.

b. **Clinical Assessment** to provide a determination of the needs of each veteran seen by the team and to identify those who are most vulnerable.

c. **Education** to provide the veteran with information on alternative treatment resources such as medical and psychiatric inpatient and outpatient treatment programs, other community-based residential programs or social services, and entitlement providers with referral and linkage to indicated services. The HCHV Outreach Specialist works to maintain low barriers and easy access, for the veterans, to required services in the VA and the community.

d. **Case Management** to plan and coordinate homeless veterans care. Case management continues to be provided by the HCHV Outreach worker for veterans placed in HCHV Contract Residential Treatment Programs, but is entrusted to other VA supportive or transitional housing programs, such as Grant and Per Diem, Domiciliary Care for Homeless Veterans, HUD-VASH, or Compensated Work Therapy/Transitional Residence program staff. At a minimum, case management services will include the following:

- (1) Work towards the rapid placement of the veteran in a safe, appropriate setting. Placement will be based on assessment of needs and patient readiness for treatment.
- (2) Arrange and coordinate care and provide direct clinical services (assessment, treatment plan, reassessment, etc.) and support;
- (3) Using Recovery Model principles, actively involve the veteran in the development of an integrated interdisciplinary treatment plan with explicit goals and objectives.

(4) Refer and provide linkage to VA medical facilities, VA Regional Offices, and/or community-based agencies for a variety of services that may include health care, entitlements, vocational assistance, education, recreation, and any other needed assistance.

(5) Provide for the provision of mental health and substance abuse counseling, either through linkage to available resources, or directly if necessary.

(6) Provide crisis management services. Monitor psychiatric status and stability.

(7) Arrange or provide for transportation to necessary clinical and social services.

(8) Intervene, when necessary, and advocate on behalf of the veteran to fill gaps in the delivery of services. Typically, this assistance includes referrals for credit problems and legal issues stemming from child support, fines, and warrants.

e. **Residential Treatment** to address the causes and effects of homelessness in a community-based setting that provides direct services in a safe, sober environment, which supports recovery and meets the needs of homeless veterans. Examples of possible residential treatment specifically developed to address the needs of homeless veterans are indicated above in Case Management.

f. **Follow-up Case Management** to assist the veteran in community re-entry and assist in prevention of future homeless episodes.

*Note: The HCHV Range of Services is not limited to these functions. For example, the HCHV program might want to include a regular class or group or have a clinic for a service provider, such as the IRS or entitlement officer, to meet with veterans.*

## 7. RESPONSIBILITIES OF THE OFFICE OF MENTAL HEALTH SERVICES

The Office of Mental Health Services (116E), HCHV Programs, VA Central Office is responsible for ensuring that:

a. Funds for HCHV programs and their subsequent contracts are distributed to the medical centers expeditiously and in a manner consistent with VA regulations.

b. Guidance, based on relevant laws, rules, regulations, directives, and analysis of collected data, is provided to Veterans Integrated Service Networks (VISNs) and VA medical centers. This ensures that HCHV programs are maintained and that the programs provide quality services which are in compliance with existing VA regulation as well as operating in accordance with the VA Mental Health Strategic Plan.

## 8. RESPONSIBILITIES OF THE VISN DIRECTOR

Each VISN Director is responsible for ensuring that:



- a. The VISN Homeless Coordinator, or designee, will review the initial and yearly re-inspections of contracted residential treatment programs funded under the HCHV Program, in coordination with the VA medical center inspection team; and
- b. The VISN Homeless Coordinator establishes methods and procedures to ensure that HCHV oversight is conducted in accordance with this Handbook.

## 9. RESPONSIBILITIES OF THE VA MEDICAL CENTER DIRECTOR

Each medical center Director is responsible for:

- a. Providing and maintaining oversight of HCHV Programs to ensure the programs offer quality services that are in compliance with existing laws and regulations.
- b. Providing and maintaining oversight of HCHV contract community providers to ensure they are operating the program in accordance with the negotiated contract (see Attachment – Contract, Section xx).
- c. Reviewing yearly inspections of HCHV contract community-based programs and making a determination for approval of continued contract payments based on the program meeting requirements and standards as set forth in this Handbook and contracts.
- d. Establishing a plan of correction for deficiencies noted in inspection reports, establishing reasonable timeframes for programs to address deficiencies, and tracking that progress to ensure that deficiencies are corrected.
- e. Ensuring that VA medical center personnel conduct an initial and an annual inspection of each HCHV contract residential treatment program. Inspections must include a team review of the HCHV contract program's general operation including, but not limited to life/safety, clinical care, nutrition, security, staffing, operations, data collection, payment and billing, and system of records.

**NOTE:** *HCHV contract funds are specifically designated for the HCHV Contract Residential Treatment Programs. Thus, they must only be used for this purpose. This program is completely separate from Grant and Per Diem, HUD-VASH and other transitional or supportive housing programs. Funding for the HCHV Contract Residential Treatment Program must not be used for any other program.*

## 10. RESPONSIBILITIES OF THE NETWORK HOMELESS COORDINATOR

Each Network Homeless Coordinator has VISN-level responsibility for oversight and monitoring of the HCHV programs in their VISN. Each Network Homeless Coordinator is responsible for:

- a. Reviewing initial and annual inspections of HCHV contract programs using this Handbook and VA directives as guidelines.

- b. Reviewing the medical centers' plans of correction that have been developed as a result of inspection deficiencies noted in HCHV contract programs and tracking follow-up activities associated with deficiencies.
- c. Reviewing Northeast Program Evaluation Center (NEPEC) results and other evaluation data and working with VA medical centers and HCHV coordinators to develop thresholds, clinical indicators and program monitors, and to develop corrective actions.
- d. Working with HCHV and medical center Quality and Performance Management staff to develop risk management and reporting systems for HCHV Programs.
- e. Reviewing the HCHV Program critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the medical center.
- f. Providing support, guidance, and advice to HCHV staff through regular communications, including site visits.

## **11. RESPONSIBILITIES OF THE HCHV COORDINATOR**

Each VA HCHV Coordinator is responsible for:

- a. Providing services to, and oversight of, the HCHV Program as outlined in this Handbook and appropriate VA regulations, including any homeless programs at the VA medical facility placed under the HCHV umbrella (such as Grant and Per Diem, HUD- VASH, CWT, etc.)
- b. Developing processes for verifying the veteran status and eligibility of program participants.
- c. Collecting and submitting HCHV program participant data, as outlined by NEPEC evaluation procedures.
- d. Providing oversight of outreach and case management activities.
- e. Facilitating outreach by disseminating information on VA Homeless Services to area shelters, food pantries and other agencies that typically serve homeless persons.
- f. Establishing a process for referrals, screenings, admissions and discharges to all residential treatment programs HCHV provides oversight for, particularly the Contract Residential Program.
- g. Developing processes for verifying admission and discharge dates for billing purposes within the Contract Residential Program.
- h. Providing oversight of HCHV Contract Residential Programs by monitoring and assessing the compliance of the contractor and, when necessary, intervening to facilitate compliance in terms of veteran care.

- i. Ensuring that budget, payment, and resource allocations meet all VA standards.
- j. Ensuring that the HCHV Program obtains and maintains a third party accreditation in accordance with VHA Handbook 1170.01, Accreditation for Veterans Health Administration Rehabilitation Programs.

## 12. HCHV STAFF TRAINING AND DUTIES

### a. Composition of HCHV Program Teams:

(1) The composition of HCHV Program teams will vary from site to site. Typically HCHV Program coordinators hold Master's Degrees in social work, nursing, or psychology, and may or may not be part of the outreach team; outreach workers usually are Master's prepared staff, however, outreach can be conducted with BA level staff or paraprofessionals. Many programs utilize a part-time clerk to assist with data collection forms and administration.

(2) It is important that professionals working in the HCHV Program have the freedom and flexibility to move beyond traditional modes of treatment in order to develop innovative approaches to reach out and assist homeless veterans. These non-traditional approaches may include casual dress, irregular tours of duty, the use of office space donated by community agencies, and coordination activities with community agencies. HCHV Program staff must be self-motivated and must be given the autonomy and flexibility to develop innovative programs that identify and engage those homeless veterans who are truly underserved.

***NOTE:** It is beneficial to include a Veterans Benefits Administration (VBA) representative as an associate member of the team. Because of VBA outreach efforts, a number of referrals to HCHV Programs originate from the VBA outreach worker. VBA staff may be available to address the benefit eligibility issues for homeless veterans in the HCHV Programs.*

(3) HCHV staff must develop partnerships with the veteran and VA-community-based services. The success of individual programs depends greatly on the rapport and collaborative efforts established between the HCHV staff and the community providers. HCHV staff must have the skills required to provide this function.

(4) The staff selected to work in HCHV Programs must have experience working with community-based providers and be qualified to provide oversight of Contract Residential Treatment Programs and case management for program participants.

**b. HCHV Staff Duties:** The following HCHV staff duties, which are deemed necessary to carry out those responsibilities and ensure program oversight, are not to be viewed as inclusive or limited. Since staff are under the direction of the medical center Director, the following expectations may be expanded, or limited, based on medical center policies, protocols, standards, position descriptions, staffing levels, etc. They include:

- (1) Performing outreach activities as directed by HCHV Coordinator.
- (2) Verifying veterans' eligibility for VA medical care.

(a) HCHV Programs have initiated procedures enabling the clinician to complete eligibility applications. Clinicians may find it helpful to assist the veteran in completing other eligibility procedures, such as: discharge upgrades, statements in support of benefits claims, etc. This type of practical assistance will help the worker establish rapport and develop trust so that the veteran will accept the indicated treatment.

(b) Many clinicians assist the veteran in completing VA Form 10-10, Application for Medical Benefits, and VA Form 10-10f, Financial Worksheet, for those veterans not seen at the medical center.

(c) Clinicians with wireless laptops may also be authorized access to check eligibility status.

(d) Because homeless individuals' needs will be urgent, HCHV Program clinicians often try to expedite verification of veterans' eligibility status through close working relationships with the Medical Center Administration Eligibility Section and VBA Regional Office staff.

(e) In cases where eligibility is not yet determined and the veteran is at risk, the clinician needs to make every attempt to arrange for provision of care through VA or community resources.

(3) Providing case management for veterans in both the community and Contract Residential Treatment Programs.

(4) Documenting, using VA standards, the clinical progress of the veteran.

(5) Educating veterans about available resources with referral and linkage for services homeless veterans will require or want.

(6) Instilling hope that the homeless veteran can end homelessness and have a greatly improved quality of life.

(7) Utilizing, when necessary, a focus on low-demand services and the use of motivational techniques for those veterans in the "contemplative" stage of treatment readiness.

(8) Developing, maintaining and expanding relationships with service providers in the VA medical facility and community to keep barriers to services low and access to care timely and expand the continuum of care available to the veteran.

(9) Participating in the HCHV Program evaluation activities.

(10) Performing site visits of HCHV Contract Residential Treatment Programs and other residential programs under the oversight of HCHV such as GPD, HUD-VASH or CWT-TR to ensure compliance with statements of work, clinical standards, and to facilitate proper billing and payment.

c. **NEPEC Training.** Additional training from NEPEC is required for HCHV clinical staff. The HCHV Coordinator must contact NEPEC upon the hiring of a new clinician to schedule an appointment for this training.

d. **Workloads**

(1) Staff are expected to carry a representative workload.

(2) Staff workloads will vary based on a number of factors. Due to the diversity of tasks HCHV Program clinicians encounter, they may not meet usual office based mental health clinic workloads. Extenuating factors, such as site- specific situations (urban vs. rural) will impact workloads. For example, time spent traveling to outreach sites and residential treatment facilities reduces the time available for clinical care; and travel distances between community outreach locations may be particularly large in rural settings.

(3) HCHV Program staff are involved in advocacy, networking, and collaboration with community-based organizations. Functioning on community boards, contacting community agencies, developing resources, and participating in community meetings account for much of what is done in the HCHV Program and will account for variations in workload.

(4) HCHV Program clinic visits are entered into the 529 stop code. These clinic visits will be retrieved for management purposes at the local medical center. They are routinely reported in conference call minutes and reports to Congress concerning the HCHV Program (see par 11, RESPONSIBILITIES OF HCHV COORDINATOR).

(5) Telephone contacts made by HCHV Program clinicians to or from homeless veterans with mental health and/or substance abuse disorders or members of homeless veterans' families are entered into the 528 stop code.

### 13. VETERANS SERVED

a. **Eligibility Status.** Veterans who receive services from the program must be eligible for VA medical care.

***NOTE:** Each site must follow the recommendations of the local Medical Administration Service (MAS ) or Health Administration Service (HAS) to ensure that the veteran's visit is registered as a clinic visit.*

b. **Homeless Veteran:**

(1) The HCHV program works with homeless veterans suffering from serious mental illness by helping them access a broad range of care, treatment and rehabilitation services. The HCHV Program targets those veterans diagnosed with a serious or chronic mental illness or substance abuse problem and defined as homeless (see par. 4, DEFINITIONS), or at imminent risk of homelessness.

(2) Homeless veterans will likely be experiencing various bio-psychosocial effects of homelessness which must to be taken into account in determining the veteran's overall individual service needs.

#### **14. TREATMENT OBJECTIVES**

**Treatment objectives are obtained primarily utilizing** case management in the HCHV Program to ensure continuity of care. HCHV Program clinicians are responsible for the overall management of a veteran within the HCHV Program from intake to discharge utilizing the continuum of care available to the homeless veteran. Engagement, assessment, health care, advocacy, education about resources, referral, and supportive counseling are the essential skills of the HCHV Program clinician. Individual HCHV Programs must select treatment modalities and models which serve the individual needs of the veteran, the treatment setting (residential or community), staff attitudes and skills, and available community resources. Treatment will be provided by the HCHV Outreach Program team, community providers, or VA outpatient clinics and may include the HCHV Contract Residential Treatment Program. The HCHV Outpatient team may also seek placement in other VA residential treatment programs (DCHV, GPD, HUD-VASH, CWT/ TR) as a part of the continuum of care and as indicated by the veteran's individual needs.

The treatment objectives of the HCHV Program are to:

- a. Improve the veteran's safety,
- b. Assist the veteran in achieving, or returning to mainstream community housing,
- c. Improve the veteran's overall physical and mental status,
- d. Instill hope,
- e. Promote clean and sober lifestyle,
- f. Increase employability or increase income, or improve income management,
- g. Improve the veteran's overall quality of life,
- h. Improve the veteran's self- esteem, self- efficacy and independence,
- i. Assist the veteran in achieving an optimal level of psychosocial functioning.

#### **15. DISCHARGE FROM HCHV OUTREACH PROGRAM:**

a. Veterans who are admitted to the HCHV Outreach Program (i.e., who have developed a treatment plan with an HCHV Program clinician, whether or not they are placed in residential treatment) must be discharged from the HCHV Outreach Program after individual treatment goals have been attained and the veteran no longer requires HCHV Outreach Program services.

b. Although veterans may be discharged because they do not cooperate with case management or due to non-compliance with program rules, it is expected that staff will utilize a variety of modalities and approaches to maintain or build a therapeutic relationship to engage the veteran in services. Typically, motivational techniques and other low-demand services may be employed. It may be appropriate to focus on concrete needs that will address the veteran's health and safety while the veteran struggles with sobriety and the elements of their treatment plan.

c. Veterans involved with HCHV Outreach Program require services from this program because they are often not able to engage in treatment with other providers or their mental illness prevents them from participating consistently. Every effort must be made to maintain contact with the veteran in the HCHV Outreach Program until the veteran has engaged in other treatment services or reached their goals. If the veteran is discharged from the HCHV Outreach Program, the veteran's options for obtaining appropriate VA outpatient services will be impacted. Viable aftercare must be available for the veteran, including referral to non-VA programs where necessary.

## 16. ENVIRONMENT AND FACILITIES

a. **Location:** HCHV Outreach Program staff usually has office space located in the VA Medical Center. However, due to the outreach nature of the program, HCHV Outreach Staff often use space provided by community agencies that serve the general homeless population, such as, shelters, daytime drop-in centers, or community centers.

b. **Space and Environment:**

(1) Safe, private space needs to be available for HCHV Outreach team members to provide adequate privacy for clinical interviews. In addition, the HCHV Program needs to have space included for:

- (a) Clerical staff,
- (b) Secure storage of records,
- (c) A conference room for team meetings; and
- (d) An adequate waiting room for homeless veterans

(2) Some medical centers have arranged for community-based space for HCHV Program teams. These accommodations are best when they allow for safe, private interviews and the secure storage of records and sensitive materials. Access to phones is essential.

**NOTE:** *To enhance outreach activities, other innovative arrangements may be required, such as the use of vans, cellular telephones, and remote computer connections.*

c. **Safety**

(1) **Settings:** HCHV Outreach clinicians often visit community settings which may present some level of personal risk. Since security personnel are generally not available to mitigate this risk, HCHV Outreach professionals are encouraged to use common sense to maintain their safety. For example, clinicians may travel in teams, select daylight hours, and carry a minimum of gear. Due to risks involved, HCHV Outreach clinicians must consider alternatives to transporting veterans who are unknown to them.

(2) **Security Policy and Training:** Some HCHV Outreach Programs may find it advisable to develop a security policy for the protection of personnel potentially exposed to assault by the population served by the HCHV Outreach Program. Training will be provided to enable personnel to identify situations that are likely to result in violence, and approaches to use when confronted with a violent encounter. In those instances where clinical staff must go into homeless shelters or other areas outside of the medical center, consultation with community police departments for information regarding safety is advised.

(3) **Technology:** Proactive tactics utilizing technology, such as cell phones, laptop computers, and vehicles will be afforded to HCHV staff working in the community. Not only are these items necessary for the completion of work; they afford field staff additional security when working outside of the VA facility.

**17. LOCAL WRITTEN POLICY AND PROCEDURES**

a. Local program operating guides, which may include a mission statement, policies, and procedures, are in use at some HCHV Program sites. While not required, they may be useful for local program definition.

b. Other materials which may be included are:

1. Forms and instructions for collecting statistical data for program evaluation and monitoring,
2. Position descriptions and duties,
3. Staff transportation and education policies,
4. Residential care conditions of placement,
5. Regulations and procedures for psychiatric and medical emergencies,
6. Suicide Prevention policies,
7. Documentation of policies and procedures,
8. Staff schedules and outreach sites,



9. Guidelines and procedures for routine medical and psychiatric care referral,
10. End of month reports procedures,
11. Program rules and regulations,
12. Veteran grievance procedures,
13. Policy for incident reports,
14. Quality and Performance Initiative reports,
15. Fiscal worksheets, and
16. Statements of veteran rights and responsibilities.
17. Policies and procedures relating to confidentiality of patient medical records.

## **18. MEDICAL RECORDS**

- a. Medical record documentation must comply with medical center guidelines and all applicable accreditation standards.
- b. The residential care treatment contractor must provide a detailed discharge summary, which must be filed in the medical record.

## **19. CONFERENCE CALLS, MEETINGS, AND MINUTES**

- a. All staff members must attend staff meetings, which must be scheduled on a regular basis to address program planning and issues. Quality and performance initiative activities may be scheduled for these meetings. Staff must also participate in Homeless Continuum of Care meetings, if available, to ensure communication between homeless programs.

**NOTE:** *Staff are encouraged to attend medical center conferences and community conferences to further develop their clinical skills.*

- b. Interdisciplinary clinical staff conferences must be scheduled on a regular basis to discuss the veteran's treatment plan, compliance issues, progress, and discharge from the program.

- c. HCHV Programs with a day treatment component may wish to schedule weekly community meetings as a way of communicating program issues and policy within a positive and collaborative milieu.

- d. When appropriate, staff from community agencies and VA programs will be invited to present information concerning their programs to both veterans and staff. **NOTE:** *It may be beneficial to have a VBA staff member available to address the benefit eligibility issues for homeless veterans in the HCHV Program.*

e. Staff are often asked to;

- (1) Present the HCHV Program to community agencies, and
- (2) Provide in-service education to medical center staff and to participants attending VA-sponsored educational programs.

f. HCHV Program staff at each medical center are to attend the monthly 1-hour conference call. Program policy, trends, and resources, as well as, site specific issues and problems are addressed in this open forum and are documented in the minutes of the call, which are mailed to each site. Periodically, HCHV Program sites present information on new program ideas or on interesting cases or problem cases during this call.

g. HCHV staff may be asked to serve as the CHALENG point-of-contact (POC). Even if not designated as the POC, HCHV staff are expected to take an active role in the CHALENG survey process by soliciting consumer and community participation.

## 20. CONFLICTS OF INTEREST

In networking with not-for-profit agencies or other community providers, HCHV Program staff must be aware of the possibility of situations which could lead to conflict of interest. Staff must periodically review VA's "Standards of Ethical Conduct" provisions; any questions are to be directed to the Regional Counsel.

## 21. RELATIONSHIP WITH VA MEDICAL FACILITIES AND COMMUNITY

a. **Sources of Referrals.** The primary source of HCHV Program referrals is the community.

(1) When the HCHV Program was established, the idea of reaching out to veterans in community settings was identified as a key concept. Outreach is important because many of the homeless feel alienated from large, impersonal organizations such as hospitals.

(2) Homeless veterans have high rates of mental illness and substance abuse which may impede their access to established services. HCHV Program outreach specialists are encouraged to make initial contact with homeless veterans at places in the community where they congregate. (i.e. shelters, soup kitchens, and day programs)

(3) Community networking by HCHV Program staff encourages and facilitates referrals by other homeless providers who will be in contact with underserved homeless veterans. It is not possible for HCHV staff to offer direct outreach services to all homeless veterans in their catchment area; therefore, education of community agencies and providers is an essential tool in reaching out to homeless veterans.

b. **Working in the Community and at the VA Medical Center.** It is important that the HCHV Program be viewed as an integral part of the VA medical care system, as well as the community's network of service providers.

(1) The essence of the HCHV Program staff's role in the community is to promote change through interacting with others, sharing information and ideas, and modeling a genuine caring and concern for the veterans served.

(2) One of the many roles of HCHV Program staff is that of a facilitator. The goal is to identify the needs of homeless veterans and bring about change by forming partnerships with community organizations, State and local governments, and other VA programs. These changes may differ from site to site. For instance some HCHV Programs staff must:

- (a) Enlighten the community and other VA staff about the myths of homelessness,
- (b) Educate veterans and the community about the services VA provides and the quality of VA services,
- (c) Address issues concerning veterans' eligibility for community services just as other citizens are entitled, and
- (d) Work with the community to develop therapeutic programs for homeless citizens.

c. **Networking with Other Homeless Providers.** To provide the fullest possible range of services, HCHV Program staff actively network with VA and community programs and organizations.

(1) Membership and active participation in local community groups, such as Homeless Coalitions, Mental Health Councils, and other homeless service providers are useful. These linkages provide additional sources for referrals and will offer alternative resources that assist VA staff in meeting the needs of the homeless. These organizations will be helpful in identifying local needs and developing solutions.

***NOTE:*** *Involvement with relevant State agencies and familiarity with national homeless groups will prove beneficial.*

(2) The process of assessing the needs of the homeless population in specific communities and working toward solutions is ongoing. New linkages are constantly being established with the goal of implementing constructive changes. Through the collaborative efforts of VA and community agencies, creative solutions to difficult problems are continually developed and implemented.

(3) HCHV participation in the local HUD Continuum of Care (CoC) is an essential part of HCHV networking activity. CoCs are charged with prioritizing funding and coordinating local services to homeless persons. One of its mandates is to assess the needs of the area's homeless veteran population and develop plans based upon that assessment. HCHV is in a unique position to contribute to this planning effort.

**NOTE:** *HCHV Program staff will serve as clinical advisors in the development and implementation of new and innovative programs associated with housing developments that often will benefit homeless veterans.*

d. **Networking with Other VA Programs**

(1) The HCHV Program is a part of the continuum of care for homeless veterans. Developing strong relationships with other VA programs and staff expands the scope of services the HCHV Program can provide to homeless veterans. Programs, such as the Incarcerated Veterans Program, Homeless Dental Initiative, Women's Program, Homeless Domiciliary Program, Grant and Per Diem Program, HUD/VASH, CWT/TR and the CHALENG process are part of the continuum of care and ensure seamless integration of services. HCHV staff should play an active role in organizing local Stand Downs. This requires coordinating the involvement of VA staff and their roles in supporting Stand Down.

(2) VA medical centers will have inpatient and outpatient programs that can be utilized by homeless veterans. The development of strong relationships with other VA programs will ease a veteran's entry into indicated treatment. With the assistance of HCHV Program staff and these liaisons, many homeless veterans are able to maneuver through the system more easily.

(3) In addition to formal programs, other VA staff members have been very helpful in meeting the needs of the homeless. At some sites they routinely donate food, clothing, and usable household items. For example, at one site when there is a need for refrigerators, couches, beds, or other household furnishings, a notice is published in the daily hospital newsletter. Employees call the program with the information about the items they are interested in donating. Using the help of several homeless veterans in the program, HCHV Program staff coordinates the collection and distribution of these donations.

(4) Many HCHV Programs have developed strong links with Veterans Benefits Counselors and the Vet Centers. Veterans Benefits Counselors may accompany HCHV Program staff into the community and help homeless veterans apply for indicated benefits. Vet Center staff provides needed and/or additional services.

(5) There are many different avenues for programs to establish local, regional, and national linkages with other HCHV Programs and VA medical centers. It is recommended that all programs develop and maintain such linkages.

(a) Electronic Mail is one mode that provides linkage.

(b) Regionally, many HCHV Program sites have established monthly conference calls or meet quarterly to share information and program concerns.

(c) The monthly nationwide HCHV Program conference call is another avenue for creating linkages, sharing information, and developing new program ideas. These conference calls serve to inform HCHV Program sites about new program directions, congressional actions, data gathering information and requirements, and administrative actions by VHA Central Office, such as changes in funding.

## 22. PROGRAM EVALUATION

### a. North East Program Evaluation Center (NEPEC):

1. **Goals.** Since its inception, the HCHV Program has been monitored by VA's Northeast Program Evaluation Center (NEPEC) at the West Haven VA Medical Center. The evaluation program goals are to:

- (a) Describe the status and needs of homeless veterans,
- (b) Monitor services delivered to veterans in the program,
- (c) Ensure program accountability, and
- (d) Identify ways of refining the clinical program.

***NOTE:** NEPEC issues an annual progress report to Congress, which details the HCHV Program on a national basis and the work of each HCHV Program site. NEPEC reports are available on-line: <http://vaww.nepec.mentalhealth.va.gov/PHV/description.htm>*

2. **Evaluation Components.** The monitoring component of the HCHV Program evaluation provides on-going information about program operation. This monitoring effort includes:

- (a) Collection of information about staffing and staff vacancies,
- (b) Measurement of the workload of HCHV Program clinicians (i.e., number of veterans served and number of contacts with each veteran),
- (c) Analysis of information concerning the veterans served in the program, and
- (d) Fiscal monitoring.

***NOTE:** Two other evaluation components, the implementation component and the follow-up component, were conducted during the first and third year of program operation, respectively. These were time-limited studies. Other studies concerning particular topics of interest to VHA Central Office or Congress, as well as evaluation of the effectiveness of new initiatives, are undertaken periodically.*

### 3. Evaluation Forms

(a) HCHV Program sites are required to complete evaluation forms developed by NEPEC. These forms must be mailed monthly to NEPEC (VA Connecticut HCS; 950 Campbell Avenue; West Haven, Connecticut; 06516) for receipt by the fifth day of the month. HCHV Program sites must retain copies of all evaluation materials submitted.

**NOTE:** *These copies are useful if forms are not received at NEPEC, as well as for other clinical or administrative purposes.*

(b) Although these forms are periodically revised, they generally include an intake form, which is completed at the time of assessment, as well as admission and discharge forms, which are completed for veterans placed in contract residential treatment or certain supported housing initiatives.

(1) Intake forms include demographic items and questions pertaining to homelessness, psychiatric and substance abuse disorders, work and income, and past treatment.

(2) Discharge forms summarize expenditures for episodes of treatment and record information concerning clinical problems and progress in treatment.

(3) Sites will be furnished with master copies of each form used for reproduction.

(c) The HCHV Program Coordinator, or designee, is responsible for completing all forms which may include: statistics, annual reports, clinic visit notations, case openings and closings, program related expenses, and monthly fiscal reports.

**NOTE:** *Questions about how to obtain or complete these, or other required evaluation forms, must be directed to NEPEC (203) 937-3850.*

#### 4. **Critical Monitors**

(a) Various indicators, called critical monitors, are used to ensure that each program site conforms to the goals of the overall program. Some of the more important indicators are volume of intakes, degree of homelessness of veterans served, the presence of psychiatric and substance abuse problems among veterans seen, and the way contact was initiated with veterans.

(b) Performance of the HCHV Program at each medical center is assessed through comparison with other sites, especially with respect to critical monitors. Those sites which differ significantly from the others on any particular indicator are identified as outliers. The identification of a site as an outlier will help the coordinator to align the site more closely with the national program. However, sometimes there are reasons for the difference which are related to situations peculiar to a site, and which do not warrant correction. HCHV Program coordinators discuss the local program environment and the possible need for changes in the operation with NEPEC.

5. **Feedback to Local HCHV Programs.** In addition to progress reports which are issued annually, NEPEC gives sites information about their performance through the national conference call minutes. Preliminary tables for the progress report are posted on VHA Intranet. Program coordinators are to correct faulty data and to submit any additional information as requested.

6. **Use of Evaluation Data at Local HCHV Program.** Although evaluation forms are developed and analyzed by NEPEC, local HCHV Programs often find the information captured

through these forms to be useful for clinical and administrative purposes. Many sites use the intake forms as a psychosocial assessment tool. Evaluation data are sometimes used in support of quality assurance efforts, student education, and public relations within and outside of the medical center.

***NOTE:*** *Information contained in the intake forms is useful for local program development; however, local programs will not publish evaluation form data without the approval of NEPEC.*

**b. Quality and Performance Processes:** Quality assurance and improvement processes are to be carried out in conjunction with, and according to, medical center Quality and Performance Initiatives Policy.

**c. Accreditation:** Many HCHV Programs are required to be Commission for the Accreditation of Rehabilitation Facilities (CARF) accredited. This independent third-party review is crucial to the quality of VA programs and their perception in both the medical care industry and the community (see VHA Handbook 1170.01).

## 23. REPORTING REQUIREMENTS

a. Administrative reports for Homeless and Residential Rehabilitation and Treatment Services in VHA Central Office must follow established VA guidelines and policies. The HCHV report will be in an acceptable VA business format. Specific HCHV Contract Residential Program reporting items will include:

- (1) The reporting period, to include the Fiscal Year (FY) and Quarter.
- (2) The VISN and station information, to include:
  - (a) VISN number,
  - (b) VISN Homeless Coordinator name and phone,
  - (c) The station number and station name, and
  - (d) The station Point of Contact and telephone number.
- (3) Funding, to include:
  - (a) Total funding sent to the station,
  - (b) Total funding expended in the Quarter, and
  - (c) Total accumulated funding expended in the FY.
- (4) Participant information for the current Quarter reported is to include:

- (a) Total number of veterans admitted for the current Quarter,
- (b) Total number of veterans discharged for the current Quarter,
- (c) Total bed days of care for the current Quarter, and
- (d) Total number of veterans housed at the end of the current Quarter.
- (5) Provider information, to include:
  - (a) Community program name,
  - (b) Number of beds available under the HCHV contract,
  - (c) Date the program began as a HCHV provider, and
  - (d) Date the program terminated as a HCHV provider, if applicable.

b. The HCHV Program Coordinator, or designee, is responsible for completing all reporting requirements under this section and submitting the reports through the Network Homeless Coordinator (NHC).

## 24. CRITERIA FOR ADMISSION TO CONTRACT RESIDENTIAL TREATMENT

(1) **Eligibility:**

- (a) Are homeless, as per definition in Section 4;
- (b) Are diagnosed with a serious mental illness or substance use disorder; and
- (c) Are eligible for VA medical care.

(2) **Further clinical considerations:**

(a) Mental health is stable: Suicidal or homicidal ideations or behaviors must be addressed and stabilized prior to consideration for admission.

(b) Physical health is stable: Medical concerns requiring hospitalization must be addressed prior to consideration for admission.

(c) Substance Use Disorder is clinically managed.

*Note: If space in the program is limited, veterans with service-connected (SC) disabilities who are at equal risk with other veterans have priority.*

(4) **Referral Sources.** Although veterans encountered through Outreach efforts are given priority in the HCHV Contract Residential Treatment Program, some veterans are referred to the



HCHV Program from various VA and community programs. Equal consideration must be given to those veterans referred from community agencies which primarily serve the homeless population, such as: shelters, homeless day centers, and soup kitchens. Other referral sources will include mental health centers, detoxification units, Veterans Service Organizations (VSOs), VA-community-based veterans programs, such as Vet Centers, as well as State or county VA offices. Clinical judgment must be utilized to determine suitability and appropriateness for the Contract Residential Treatment Program based on a veteran's history of homelessness and diagnosis of mental illness.

**NOTE:** *Veterans referred from VA medical centers are generally considered appropriate only in extraordinary circumstances where the veteran's chronic homelessness is well documented and the veteran is involved with the HCHV Outreach team. The placement of veterans must be approved by the HCHV Program treatment team based on the Contract Residential Treatment Program criteria (See para. 16).*

## **25. IDENTIFYING CONTRACT RESIDENTIAL TREATMENT PROVIDERS**

a. Identifying and contracting with residential treatment providers is an important part of developing or enhancing the HCHV Program. It is important to look for a wide range of models. Occasionally, HCHV Program sites must undertake this process after the program has been implemented in order to expand the number of beds, the types of settings available, or because it is necessary to change providers.

b. When initially visiting a potential contract site, members of the HCHV Program team must focus on an assessment of the quality of life within the residential treatment facility. If a potential contractor is identified, a pre-award survey must be conducted (see section xx).

**NOTE:** *When HCHV Program staff is on-site at an existing Contract Residential Treatment Program, it is expected that the VA clinician perform a cursory environmental review and identify any obvious hazards or other deficiencies, which must be corrected in order to obtain a contract. If a significant hazard and/or deficiency is noted, the VA clinician must notify the provider and appropriate local VA personnel for inspection and follow-up while in process to obtain contract. Any hazards or deficiencies noted must be documented in accordance with VA Medical Center policy.*

## **26. INDEPENDENT STATUS OF CONTRACT RESIDENTIAL TREATMENT PROGRAMS**

Contract Residential Treatment is a part of the HCHV Program. Admission to a contract facility occurs only through involvement and referral through the HCHV Program. Referrals to HCHV Outreach teams from both inpatient and outpatient VA programs are only appropriate when the veteran is well known to the HCHV program and meets the admission criteria listed previously.

## **27. LENGTH OF STAY IN CONTRACT RESIDENTIAL TREATMENT PROGRAMS**

HCHV Contract Residential Program contract funds are available for short and intermediate term placements in residential treatment facilities. Depending upon the needs of the veteran, or as mutually determined by the veteran and the HCHV Program treatment team, the length of stay at VA cost may be authorized for up to 6 months. In rare instances, more than 6 months of contract-supported residential treatment may be provided with the approval of the Chief of the HCHV Program's Service or Care Line at the VA Medical Care Facility.

## 28. DOCUMENTATION IN CONTRACT RESIDENTIAL TREATMENT PROGRAMS

All clinical documentation must be in compliance with local VA medical center policy and procedures.

a. **HCHV Program Documentation:** HCHV clinicians must ensure that their clinical documentation on all veterans must include the following in the clinical record:

(1) **Assessment** that includes:

- (a) History of homelessness,
- (b) Mental health history,
- (c) Physical health history,
- (d) Substance abuse history,
- (e) Social history,
- (f) Education, Vocational and Income history,
- (g) Legal history,
- (h) Strengths,
- (i) Barriers/Vulnerabilities.

(2) **Admission Note/ Initial Treatment or Service Plan:**

- (a) Reason for referral (including justification for any readmissions),
- (b) Program to which the veteran is admitted,
- (c) Pertinent past treatment history,
- (d) Veteran's engagement,
- (e) Preliminary treatment or service plan.

**(3) Treatment Plan: See Section 29**

**(4) Progress notes**, as clinically indicated and at least one per month:

- (a) Progress toward the veteran's goals,
- (b) Veteran's participation in treatment,
- (c) Progress toward Discharge goals,
- (d) Summary of service or contact,
- (e) Changes to treatment or service plan.

**(5) Discharge Note: Also see Section 30**

Veterans who have been in an HCHV Contract Residential Treatment Program must have a discharge summary upon termination from the program for each episode of care. The discharge summary must be completed by the HCHV Program clinician having primary responsibility for treatment of the veteran. All medical care and services provided, and recommendations for follow-up care, are to be documented in this discharge summary, to include:

- (a) Date of discharge,
- (b) Type of discharge,
- (c) Veteran's perception of discharge and agreement with discharge,
- (d) Status of treatment goals at time of discharge,
- (e) Aftercare plan,
- (f) Veteran's agreement with aftercare plan,
- (g) Housing status and contact information.

b. **Contract Residential Program Documentation**: An individual progress record must be securely maintained by the Contract Residential Treatment Program for each veteran placed. This progress record maintained by the Contract Residential Treatment Program must include:

- (1) Essential identifying data relevant to the veteran, including appropriate assessments and history of the veteran's homelessness;
- (2) Data relevant to the veteran's admission and anticipated length of stay;
- (3) Treatment or Service Plan (copy);

- (4) Copies of physicians orders (if applicable);
- (5) At least monthly progress reports to measure progress toward treatment goals; and
- (6) Final summaries on each veteran who leaves the contract program, which must include:
  - (a) A description of changes realized during the residential stay,
  - (b) Reasons for leaving,
  - (c) Future plans, and
  - (d) Follow-up information.

## **29. TREATMENT PLANNING AND TREATMENT PLANS IN CONTRACT RESIDENTIAL TREATMENT PROGRAMS**

*NOTE: Interdisciplinary planning must be considered, if clinically indicated and if staffing is available. HCHV Program clinicians must monitor the quality of care provided by the contract facility through regular visits to the facility. Some sites have found it advantageous to have weekly treatment groups to accomplish this goal.*

- a. Individualized treatment plans are developed through a joint effort of the veteran, contract facility staff and the HCHV Program staff. Treatment plans must be developed for each veteran based on input from HCHV Program staff assessments, other VA clinical data, and the veteran.
- b. Therapeutic and rehabilitative services must be provided by the contract facility as described in the treatment plan. In some cases, VA may complement the residential treatment facility's program with added treatment services such as participation in VA Outpatient programs (i.e., CWT, Incentive Therapy, Mental Health Clinic, Substance Abuse treatment, etc.).

## **30. DISCHARGE FROM CONTRACT RESIDENTIAL TREATMENT PROGRAM**

Discharge from a Contract Residential Treatment Program is based on individual treatment outcomes and are either planned or unplanned discharges:

- a. Planned discharges are usually accomplished with those Veterans who have achieved treatment goals, obtained employment or income, or found housing.
- b. Veterans may be discharged due to non-compliance with the Contract Residential Treatment Program or local HCHV Program rules (i.e., substance abuse, violation of treatment contract, etc.).

*NOTE: Appropriate VA outpatient services must be arranged by the HCHV Program staff, as indicated, for aftercare regardless of discharge circumstances.*

## **REFERENCES**

38 USCA 2031  
38 USCA 2002  
42 USCA 11302(a)  
38 USCA 2022(a)  
38 CFR 17.33  
VHA Handbook 1170.01

**Attachment:**  
**XX CONTRACTS**

**1.01 METHODS OF PROCESS**

a. VA HCHV Outreach Staff develop the relationship with potential non-VA community providers that would be appropriate for meeting the parameters indicated to provide services to chronically homeless veterans with chronic mental health, including substance abuse, concerns.

b. An interdisciplinary VA team consisting of a social worker, nurse, an engineering service safety officer and, as appropriate, other designees of the VA Medical Center Director must conduct a survey of the Contract Residential Treatment Program prior to the award of a contract.

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

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

(2) VA HCHV Outreach case managers assist in the development and maintenance of clinical records established by both the VA medical facility and the Contract Residential Treatment Program.

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

e. Veterans will be provided treatment by the Contract Residential Treatment Program, once placed, with oversight by the HCHV Case Manager who also assists by providing care coordination with VA medical facility treatment and acts as the lead case manager.

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

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

(1) When two or more VA facilities place patients in the same Contract Residential Treatment Program, those VA facilities will make arrangements to ensure clinically indicated VA follow-up services are furnished without regard to which facility initially made the placement.

h. Patients who are discharged from the HCHV Program will be afforded follow-up care through the VA medical center in accordance with their ability to meet the eligibility criteria. Those veterans not eligible for VA care will be referred to community resources.

## 1.02 CONTRACTS PROCESS

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

a. VA Medical Center Directors are responsible for:

(1) Designating the appropriate individuals to:

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

(b) Develop proposed contracts.

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

(3) Issuing authorizations and processing invoices;

(4) Inspecting settings;

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

(6) Maintaining a file of all current contracts.

b. The Medical Center Contracting Officer negotiates and consummates contracts with approved community-based programs.

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

(2) Therapeutic services must be provided by the Contract Residential Treatment Program. However, those clinically indicated services not included deemed necessary for the participant should be supplied through other separate contracts, sharing agreements, and/or collaborative arrangements, or by the VA medical center.

c. Payment for residential treatment settings should be made on a monthly basis, for services rendered.

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

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

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

### 1.03 INITIAL INSPECTION

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

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

b. Preliminary to inspecting each setting and performing each survey of patient care, the team leader will:

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

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

(3) Review terms of any existing agreement.

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

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

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

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

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

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

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

(a) The addition of nutritious snacks to the requirements for board is particularly indicated for HCHV patients. Many of these patients need assistance to develop improved nutritional habits.

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

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

(8) There is documented evidence of the program's commitment to the implementation of the VA Patient's Bill of Rights (38 CFR, Section 17.33).

d. A formal report of each inspection will be prepared and forwarded to the VA Medical Center Contracting Officer. In accordance with normal contract administrative practices, the following actions can be expected to ensue:

(1) The non-VA treatment program will be advised of the findings of the inspection team.

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

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

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

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

f. In the case of multiple or scattered sites for the non-VA community health care settings, it is imperative that all components of the community healthcare and residential treatment settings be inspected by the VA team prior to approval of the contract, as is required for an integrated primary site. *Note: Each of the community settings identified in the complex as contract recipients, will be subject to the requirements for contracting, safety, and record keeping described in other parts of this document as applying to contractors.*

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

#### 1.04 SUBSEQUENT INSPECTIONS

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



**1.05 SAMPLE STATEMENT of WORK**

The following is presented as an example of the language and intent to be included in Statements of Work developed locally by the Contracting Officer in establishing contracts with local vendors providing residential treatment:

**STATEMENT OF WORK**

1. The contractor shall furnish services to the beneficiaries for whom such care is specifically authorized by the Veterans Health Administration (VHA). It is understood that the type of veterans to be cared for under this contract will require care and treatment services over and above the level of room and board.
2. The contractor shall furnish each veteran authorized care under this contract with the following basic services:
  - a. Residential Room and Board.
  - b. Laundry facilities for residents to do their own laundry.
  - c. Therapeutic, Rehabilitative, and Recovery Services determined to be needed by the individual resident in a plan developed by the contractor with consultation by the veteran and the VA case manager and/or other appropriate VA staff. Services which the contractor must be able to furnish include:
    - (1) Structured group activities as appropriate – examples include group therapy, social skills training, Alcoholics Anonymous, Narcotics Anonymous, vocational counseling, peer counseling and physical activities as appropriate.
    - (2) Collaboration with the VA program staff, which will provide supportive psychosocial services.
    - (3) Individual professional counseling, including counseling on self care skills, adaptive coping skills and, as appropriate, vocational rehabilitation counseling, in collaboration with VA program and community resources.
    - (4) Assistance to develop responsible living patterns and to achieve a more adaptive level of psychosocial functioning, upgraded social skills, and improved personal relationships.
    - (5) Support for an alcohol/drug abuse-free lifestyle.
    - (6) Assistance to gain and to apply knowledge of the illness/recovery process.
3. Unless specifically excluded in this contract, the per diem rate established will include the services listed in this document and will also include all services or supplies normally provided other patients by the facility without extra charge.

4. The contractor shall employ sufficient professional staff and other personnel to carry out the policies and procedures of the program. There will be at a minimum, an employee on duty on the premises, or residing at the program and available for emergencies, 24 hours a day, 7 days a week.
5. The contractor shall make available to the VA, documentary information deemed necessary by the VA to conduct utilization review audits for the mandated national evaluation study as required by Section 2 of Public Law 100-6; to verify quality of patient care for veterans, to assure confidentiality of patient care for veterans, to assure confidentiality of patient record information, and to determine the completeness and accuracy of financial records.
6. The contractor will collaborate with the VA program staff, who will conduct treatment and discharge planning reflecting a team assessment of health, psychosocial and vocational needs and the involvement of residents' families and appropriate community resources in resolving problems and setting goals.
7. The contractor shall comply with the VA Patient's Bill of Rights as set forth in Section 17.34a, Title 38, Code of Federal Regulations.
8. The contractor will comply with all provisions related to the program inspections as set forth in the HCHV Handbook sections, XX CONTRACTS.