Department of Veterans Affairs **VHA HANDBOOK 1162.03**
Veterans Health Administration
Washington, DC 20420 **October 19, 2006**

PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)

1. PURPOSE. This Veterans Health Administration (VHA) Handbook provides the procedures and reporting requirements for the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) bed level of care.

2. SUMMARY OF CHANGES. This is a new VHA Handbook defining the procedures relating to PRRTP.

3. RELATED ISSUES. VHA Directive 1162 (to be published).

4. RESPONSIBLE OFFICE. The Office of Mental Health Services (116) in the Office of Patient Care Services is responsible for the contents of this Handbook. Questions may be addressed to the PRRTP Program Manager at (757) 722-9961, extension 1123.

5. RESCISSIONS. VHA Directives 2001-010 and 2001-011 are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of October 2011.

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PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedures and reporting requirements for the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) bed level of care.

2. BACKGROUND

The Department of Veterans Affairs (VA) established the PRRTP bed level of care in 1995. This distinct level of inpatient mental health care is appropriate for veterans with mental illnesses and addictive disorders who require additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment. It recognizes the need for psychiatric and psychotherapeutic treatment and symptom reduction of mental and addictive disorders, and provides opportunities to improve functional status, while also providing psychosocial rehabilitation, which focuses on a patient's strengths. This rehabilitative approach recognizes that persons with mental illness and addictive disorders can achieve their goals for healthy and productive lives. PRRTPs are designed to provide comprehensive treatment and rehabilitative services that are to improve quality of life and diminish reliance upon more resource-intensive forms of treatment.

3. AUTHORITY

Title 38, United States Code (U.S.C.), Section 1710 authorizes VA to provide inpatient care including PRRTPs. Title 38 U.S.C., Section 2032 authorizes the Compensated Work Therapy (CWT)-Traditional Residence (TR) Program. ***NOTE:*** *This Handbook does not replace those source documents. It is essential that source documents be read and understood to ensure uniform and appropriate application.*

4. DEFINITIONS

The following definitions are applicable to PRRTP. The term PRRTP is the bed category and includes the models listed below.

a. **General Psychosocial Residential Rehabilitation Treatment Programs (PRRTP).** A General PRRTP is developed to provide a residential level of care for a general patient population. General PRRTPs provide a 24-hour-per-day, 7 days-per-week, (24/7) structured and supportive residential environment as a part of the rehabilitative treatment regime.

b. **Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program (PRRP).** A PRRP is developed to provide a residential level of care to veterans with Post-Traumatic Stress Disorder (PTSD). PRRP provides a 24/7 structured and supportive residential environment as a part of the PTSD rehabilitative treatment regime.

c. **Substance Abuse Residential Rehabilitation Treatment Program (SARRTP).** An SARRTP is developed to provide a residential level of care to veterans with Substance Use Disorders (SUD). SARRTP provides a 24-hour-per-day, 7 days-per-week, (24/7) structured and supportive residential environment as a part of the SUD rehabilitative treatment regime.

d. **Homeless Chronically Mentally Ill (HCMI) CWT-TR.** An HCMI CWT-TR is developed to provide transitional residence services to homeless veterans. HCMI CWT-TR offers therapeutic work-based residential rehabilitation services designed to facilitate successful community reintegration.

e. **Substance Abuse (SA) CWT-TR.** A SA CWT-TR is developed to provide transitional residence services to veterans with substance use disorders. SA CWT-TR offers therapeutic work-based residential rehabilitation services designed to facilitate successful community reintegration.

f. **Post-Traumatic Stress Disorder (PTSD) CWT-TR.** A PTSD CWT-TR is developed to provide transitional residence services to veterans with PTSD. PTSD CWT-TR offers therapeutic work-based residential rehabilitation services designed to facilitate successful community reintegration.

g. **General Compensated Work Therapy (CWT) Transitional Residence (TR).** A General CWT-TR is not targeted exclusively for any particular mental health population and is developed to provide transitional residence services. General CWT-TR offers therapeutic work-based residential rehabilitation services designed to facilitate successful community reintegration.

5. SCOPE

a. VHA policy establishes a PRRTP residential level of bed care, distinct from medium and high-intensity inpatient psychiatry beds, which provide a 24-hour therapeutic setting for veterans with multiple and severe psychosocial deficits to identify and address goals of health maintenance, improved quality of life, and community integration in addition to specific treatment of mental illnesses and addictive disorders.

b. PRRTP residential settings utilize a milieu of peer and professional support, with a strong emphasis on psychosocial rehabilitation services that increase personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living. Given their distinct mission to serve veterans with multiple and severe psychosocial deficits, PRRTPs must not be used as a simple substitute for community housing or as VA lodging or Hoptel facilities. ***NOTE:*** *Additionally, VA lodging or Hoptel facilities do not provide the necessary structure, programming, and support, and are not an appropriate alternative or replacement for veterans assessed as needing a residential rehabilitation level of care.*

c. PRRTP beds are distinct from a sub-acute or intermediate psychiatry beds that are co-located or integrated with an acute unit and provide short-term discharge planning.

6. VA CENTRAL OFFICE RESPONSIBILITIES

The VA Central Office, Office of Mental Health Services, Homeless and Residential Rehabilitation and Treatment Programs is responsible for:

a. Developing national policy and procedures for PRRTPs based on relevant laws and regulations and VHA's mission, goals, and objectives.

b. Providing consultation and guidance to Veterans Integrated Service Networks (VISNs) and VA medical centers for the development and operation of PRRTPs (see App. A).

c. Leading the Mental Health Residential Rehabilitation and Treatment Program (MHRRTP) Field Advisory Board (FAB).

d. Reviewing all medical center MHRRTP bed and program change proposals and providing comments to the Deputy Under Secretary for Health for Operations and Management.

7. RESPONSIBILITIES OF THE VISN DIRECTOR

Each VISN Director is responsible for ensuring that PRRTPs are operated in compliance with relevant Public Laws, regulations, and VHA policy and procedures.

8. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each facility Director is responsible for:

a. Providing and maintaining program oversight to ensure quality services and compliance with VHA policy and procedures. Special attention must be given to addressing the unique needs of special populations including women veterans.

b. Ensuring the timely completion of all mandated reporting (see App. B), monitoring, and accreditation requirements.

c. Providing a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances the recovery efforts of the veteran. Attention must be given to the unique environmental and safety needs of women veterans.

d. Ensuring the financial management and fiscal stability of the PRRTP, including those utilizing veteran program fees to fund housing-related expenses.

e. Appointing a program manager for each PRRTP, who is responsible for the safe, efficient, and effective operation of all aspects of the program.

f. Ensuring consultation with the Office of Mental Health Services prior to bed or program changes as outlined in VHA bed control policy and VHA Mental Health program change policy.

g. Providing appropriate support and resources to ensure the PRRTP is able to accomplish its stated mission, goals, and objectives.

h. Requiring specific training and competencies for managers and clinicians to address the mental health needs specific to treatment population and gender-based needs.

i. Ensuring that mental health services are provided to women veterans at a level on par with male veterans at each facility.

j. Ensuring that a PRRTP operated in partnership with a community organization provides safe, efficient and effective services comparable to an on-station program and in compliance with the procedures in this handbook.

9. RESPONSIBILITIES OF THE PRRTP MANAGER

The PRRTP Manager is responsible for:

a. Managing all clinical and administrative operations to ensure the safe, efficient, and effective provision of rehabilitation and treatment services.

b. Ensuring the PRRTP is operated in compliance with all the VHA policies and procedures.

c. Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to the PRRTP.

10. PROGRAM ELEMENTS

The following program elements are applicable to all PRRTP models:

a. **Eligibility.** PRRTP is considered "hospital care" for purposes of eligibility determinations; therefore, eligibility rules for hospital care would apply for PRRTP admissions. Veterans in a PRRTP have psychiatric and/or psychosocial needs which are clinically determined to benefit from a 24-hour-per-day, 7-days-per-week, (24/7) structured and supportive environment as a part of the rehabilitative treatment regime. Treatment and/or therapeutic activities must be provided at least 4 hours per day, 7 days per week. Veterans need to be clinically stable to be able to function outside of a medium or high-intensity hospital setting and must be capable of self-preservation in case of a disaster. Veterans in a PRRTP who develop an acute psychiatric or medical condition are to be moved to a medium or high-intensity psychiatric or medical unit until they are stable enough to either return to the PRRTP or make other treatment arrangements.

b. **Design.** The PRRTP model is designed for maximum flexibility of program design. Within this residential level of care, programming may range from relatively short-term care of limited focus (i.e., less than 30 days and targeted primarily towards diagnosis-specific education, counseling, and symptom management), to long-term, comprehensive rehabilitation (i.e., exceeding 1 year and including a full-range of psychosocial services, such as life-skills training, social learning, vocational rehabilitation therapy, CWT, etc.). Within various types of PRRTPs,

specific, sub-populations may be targeted, such as dually-diagnosed or geriatric populations necessitating specialized staff and rehabilitative approaches. There may also be specific PRRTP "tracks" within targeted populations, for example: a substance abuse residential program designed for veterans with dual diagnoses, and another for veterans with a substance abuse diagnosis only, or another with a strong psychosocial rehabilitation component addressing issues of work and independent living skills. For example, a PRRTP might have a shorter length of stay concentrating on psychotherapy and education for veterans targeted needs, while the same PRRTP might provide more comprehensive rehabilitative services and a longer length of stay (LOS) for veterans with more extensive needs. This model may help smaller medical centers in accommodating diverse needs within limited space and personnel resources. This flexibility in PRRTP program design suggests that a site may establish more than one of a specific type of PRRTP in order to most efficiently meet the rehabilitative needs of a diverse veteran population.

c. **Location.**

(1) PRRTPs may be established either on VA medical center grounds, or in community facilities owned, leased, or otherwise acquired by VA. Regardless of the location of PRRTP beds, they must be designated as official VA beds in accordance with VA Bed Control Policy and reported on the Gains and Losses (G&L) statement of the associated VA health care system or medical center. PRRTPs, whether on-station or located in the community, are distinct from Contract Residential Care programs where VA pays a fee to a community organization to provide housing and/or rehabilitation services. Medical centers may establish PRRTPs through a lease with a community organization. In these situations, VA may contract with the community organization for non-clinical services. The residence must be a separate and distinct unit where only veterans of the PRRTP may reside. Through contracts with VA, the community organization may provide non-professional staff to monitor the residence on evenings, nights, and weekends and provide other services such as meals, housekeeping, transportation, etc. In all other respects, a PRRTP located in the community must be operated in a similar manner to an on-station program, and be in compliance with VHA policies and procedures including adherence to all relevant VA and accrediting body environment of care standards.

(2) When operating a PRRTP in partnership with a community organization, the medical center Director must ensure:

(a) The community organization's staff that provides services to veterans has appropriate training and qualifications to provide a safe, secure, confidential, and structured residential environment that address the needs of the veteran. The non-professional staff in the community organization needs to have comparable competencies to the non-professional VA staff in an on-station PRRTP.

(b) There is a process in place to provide guidance from VA staff to the community organization to ensure the continuity of care particularly on evenings, nights, and weekends.

(c) There is a plan in place to provide for the availability of appropriate VA staff at all times.

(d) An evaluation of the performance of the partnership to develop a quality improvement plan needs to address identified deficits on at least a yearly basis. ***NOTE:*** *This Handbook can*

be used as a guide in developing an evaluation. This system must allow VA access to the community organizations records to facilitate appropriate information which needs to be integrated into the consolidated medical record.

d. **Staffing**

(1) PRRTPs may have flexible staffing patterns, since, by their residential nature, they are designed to maximize peer support and self-care, as compared to a traditional hospital bed. However, the safety and welfare of both PRRTP staff and veterans must be a primary consideration. In addition, 24/7, on-site supervision of PRRTPs is required. The type of staffing provided must be determined by the clinical needs of the veterans served by the PRRTP and by standards applied by external accrediting bodies. Professional PRRTP staff must be on call by radio, telephone, or beeper at all times. PRRTPs are generally under the clinical supervision of the Mental Health Service Line Director, who appoints the PRRTP Manager. Generally the Manager has primary responsibility for, and for concurring in, all PRRTP admissions and is responsible for program policy and procedures.

(2) At a minimum, the following staff functions are required to operate the PRRTP's residential component: Program Coordinator; Case Manager; Medical Doctor (MD); Physician Assistant (PA); or Nurse Practitioner (NP); evening, night, and weekend staff, and the program or ward clerk. The level of these direct residential rehabilitation staffing is dependent on a number of factors, including number and distribution of beds, location and type of residential facility, veteran demographics, rehabilitation service offerings, and functioning of the peer supported residential milieu. Additional professional staff provides the treatment services to PRRTP veterans either on the unit or in outpatient programs. These professional staff may include psychologists, social workers, rehabilitation counselors, addiction therapists, vocational specialists, chaplains, occupational therapists, dieticians, etc. While the level and make-up of professional staff is variable, the level must meet the VA clinical practice standards and accreditation body standards based on the PRRT's mission and services provided.

(3) In most cases (except CWT-TR programs), the evening and/or weekend coverage must consist of paid VA staff, ranging from Nursing Assistants and/or Rehabilitation Technicians to professional Nursing staff. The type of staff required for evening and/or weekend coverage is to vary depending on:

(a) The clinical needs of residents (use of the American Society of Addictive Medicine (ASAM) criteria to assess various domains is encouraged).

(b) The intensity of programmatic structure (i.e., scheduled activities, individual rehabilitation plan expectations, peer support expectations, assigned residential responsibilities, etc.).

(c) The maturity of the residential culture (the extent to which residents actually do support each other, strength of resident councils, etc.).

(d) Accreditation requirements.

(4) PRRTPs require an interdisciplinary team for comprehensive assessment and rehabilitation and/or discharge planning. This team may often consist of staff from the Outpatient program(s), such as Outpatient Substance Abuse, PTSD Clinical Team (PCT), Day Treatment, CWT, etc., where the PRRTP veterans may receive most of their clinical care. The team must also generally include the Program Manager and staff who are assigned to facilitate the rehabilitation services in the residence and provide evening and/or weekend coverage on the unit itself.

(5) In some cases, such as the CWT-TRs, a current or "graduate" resident may supervise the residence in lieu of staff. These "House Managers" must have a stable, responsible, caring demeanor, and have leadership qualities such as effective communication skills, ability to motivate, etc. At a minimum, House Managers and non-professional staff are to be trained to observe resident behaviors, facilitate a healthy therapeutic environment, (i.e., encourage socialization and participation, coordinate residential activities, etc.), ensure safety, and initiate the call for professional staff intervention. Professional staff must be available on an emergency and/or callback basis. A graduate of CWT-TR acting as a House Manager must be established as a without compensation (WOC) employee through Human Resource Management Service.

e. **Program Structure.** PRRTPs may provide the treatment program within the PRRTP residential program itself, or veterans in PRRTPs may participate in an intensive regimen of outpatient services, such as outpatient substance abuse, PTSD, day treatment, and vocational rehabilitation, which are then augmented by the PRRTP residential component of care. In all cases, the residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. Treatment intensity, environmental structures, milieu, and type of supervision vary based on population served, and needs to be relevant to the diversity of the population, i.e., age, ethnicity, culture, etc. There are two basic structures for residential rehabilitation programming.

(1) **All Inclusive Residential Model.** The structure of the all-inclusive residential model is similar to a traditional inpatient program, where staff dedicated to the PRRTP unit provides virtually all treatment and rehabilitative services, and do so exclusively for the patients in those beds. ***NOTE:*** *This model may provide advantages for programming which is tailored specifically for group treatment approaches. It may also be used more often for programs that are targeting a higher acuity of illness and are, therefore, providing higher intensity of care.*

(2) **Supportive Residential Model.** This program structure provides a supportive residential component to augment intensive treatment provided through the Ambulatory Care System, such as the Intensive Outpatient Substance Abuse Program, Day Treatment Program, CWT, etc. It is designed to minimize risk and maximize benefit of the ambulatory care services provided to veterans whose health and/or lifestyle necessitate a supervised, structured environment while receiving care, or those requiring comprehensive rehabilitation to learn and practice new behaviors. In addition to meeting a key agency objective of increasing outpatient services, this model may provide advantages such as:

(a) The unit does not require staffing during the period of the day when all veterans are off the unit receiving rehabilitation and treatment services or working.

(b) Residents of the unit are exposed to other veterans in the Outpatient Treatment environments who are higher functioning (i.e., not in need of supportive 24-hour residential programming), and participate in treatment more as 'community citizens' than 'hospital patients.'

(c) Residents of the unit gain familiarity and establish therapeutic relationships with Outpatient Treatment staff that can be maintained beyond the residential stay.

(d) Outpatients experiencing need for more comprehensive care (i.e., 24-hour residential services) may be more likely to accept such care, knowing that they do not have to establish all new therapeutic relationships by so doing.

NOTE: *In some cases, this model has facilitated the development of previously non-existent Aftercare Services due to increased efficiency in staff utilization) treatment staff is not assigned strictly to operate an 'all inclusive inpatient' unit, and are therefore available to provide outpatient services as well).*

f. **Resident Selection and Admission.** The following veterans need to be screened for their need for psychosocial residential treatment services. Each PRRTP is to develop local policies, procedures, guidelines and selection criteria that minimize access barriers to the program.

(1) Veterans requiring 24-hour supervised care who do not meet criteria for Acute psychiatry or medical admission,

(2) Veterans receiving outpatient mental health services who lack a stable lifestyle or living arrangement that is conducive to recovery.

g. **Medications.** Veterans in PRRTPs are able to learn and practice self-management of their medication regimens in order to achieve independent medication administration. Each veteran needs to be assessed as semi-independent or independent for the Self-Medication Program (SMP) as outlined in VHA Handbook 1108.3. Medications are kept in a locked cabinet or locker accessible only to that veteran and designated staff personnel. In cases where a veteran is assessed as semi-independent, it is necessary for appropriately licensed staff to be available to administer and/or monitor medications for veterans in the PRRTP.

h. **Meals.** In most cases, the cost of and preparation of meals is the responsibility of the medical center. In many PRRTPs, especially those on medical center grounds, veterans eat in the medical center dining room or in dining rooms on the unit. Where appropriate, (for example, in CWT-TR) preparation of meals in PRRTPs may be done by the veterans themselves, or by personnel associated with the residence. When veterans assigned to the PRRTP are responsible for their meals, sufficient staff supervision needs to be provided to assure patients engage in appropriate meal planning, food preparation, sanitation, and safety.

i. **Evening and Weekend Programming.** PRRTP policy requires a minimum of 4 hours per day of treatment and/or therapeutic activities, 7 days per week. Programs must ensure appropriate activities in the evening and on weekends. While the use of passes by veterans to accomplish their treatment and rehabilitation goals is encouraged, programs may not place all

residents on pass for the weekend as a means of meeting the programming goal or due to staffing availability. Evening and weekend activities must have a direct relationship to assisting the veterans in meeting treatment and rehabilitation goals.

j. **Health Records Requirements.** The PRRTP record must be integrated into the Computerized Patient Record System (CPRS) as outlined in VHA Handbook 1907.01, Health Information Management and Health Records. Each period of care in a PRRTP is considered the equivalent of a period of care in any other VA bed (hospital, domiciliary, nursing home care unit). ***NOTE:*** *The health records requirements for patients in PRRTP beds must be equivalent to the requirements for VA Extended Care Patient Records found in VHA Handbook 1907.01 and consistent with facility by-laws and current Joint Commission and Accreditation Healthcare Organization (JCAHO) accreditation standards.* The PRRTP records must include, but are not limited to, the following:

(1) **Admission Note.** The Admission Note needs to include the veteran's strengths, abilities, needs, and preferences, in addition to standard admission note content.

(2) **History and Physical Exam (H&P).** An Interval H&P, reflecting any changes since the last exam, may be sufficient when deemed appropriate by professional judgment and in conformance with accrediting entities such as JCAHO. Timeframes for completion of H&Ps need to be established based on current accreditation standards. A veteran remaining on PRRTP status for 1 year or longer must be given an annual examination, to include mental status.

(3) **Comprehensive Biopsychosocial Assessment.** A comprehensive assessment must be documented to include an interpretive summary that is based on the assessment data.

(4) **Rehabilitation and/or Treatment Plan.** An individualized rehabilitation and/or treatment plan must include specific, measurable goals, targeted dates for completion, and a designated responsible individual for addressing each goal. Discharge planning must be contained in the rehabilitation or treatment plan.

(5) **Rehabilitation Progress Notes.** The frequency of recording progress notes must be established by the medical center on program policies, and be appropriate for both the veteran populations served and the program objectives.

(6) **Doctor's Orders.** Doctor's orders include, but are not limited to, the admission order, discharge order, medication order, referral or consultation order, etc.

(7) **Informed Consent.** The provisions of VHA Handbook 1004.1 on informed consent apply to all PRRTPs.

(8) **Discharge Summary.** The discharge summary, signed by a physician or appropriately credentialed health care provider, must be consistent with VHA health records policy (see VHA HK 1907.01) and the external accreditation standards facility by-laws.

(9) **Accreditation.** All PRRTPs must be accredited under the JCAHO standards for Behavioral Health Care (24-hour settings). PRRPs, SARRTPs, and general PRRTPs that want to

be recognized for state-of-the-art rehabilitative approaches may also choose to be accredited under the Residential Treatment Standards of Commission for Accreditation of Rehabilitation Facilities (CARF). All types of CWT TRs must be accredited under CARF Standards for Community Housing.

k. **Residential Costs.** Veterans in PRRTP programs may not be charged residential costs, such as lease expenses, utilities, maintenance, meals, etc., except within CWT-TR programs.

l. **Monitoring.** The Northeast Program Evaluation Center (NEPEC) located at the VA Connecticut Healthcare System at West Haven, monitors initial implementation of PRRTPs by conducting an annual survey of facilities reporting PRRTP workload. Outcomes monitoring, to include measures of efficiency, effectiveness, and veteran satisfaction are to be developed at each local program as part of quality improvement initiatives, and are to be periodically reviewed for opportunities to improve veteran outcomes and PRRTP performance. In addition to the annual survey, CWT-TR is required to fully participate in the NEPEC admission, discharge and follow-up data collection, and outcome monitoring activities.

m. **Changes in Structure, Mission, Number of Beds, or Capacity.** Changes in PRRTP structure, mission, number of beds, or capacity must follow VHA bed control policy along with the VHA policy on mental health program change. The planning for changes to PRRTPs must include a VISN level review to ensure that access and coordination of mental health and SUD services are maintained. Medical centers must consult with the Office of Mental Health Services prior to the submission of the program or bed change request.

11. SARRTP

a. **Description.** SARRTPs are designed to provide a stable drug and alcohol-free supervised environment for the treatment and rehabilitation of those substance abusing veterans who need such a setting because of the severity of their illness, the serious relapse potential they demonstrate and the effects of significant internal psychological issues, and compromising external environmental issues (e.g., lack of safe and sober living setting) which impinge on their community functioning and treatment, and negate the possibility of ambulatory treatment.

b. **Structure and Level of Care.** SARRTP operation and procedures are guided by the residential levels of care, admission criteria, staffing models, assessments, and treatment review guidelines and therapeutic interventions based on Patient Placement Criteria (PPC) of the ASAM.

c. **Referrals.** Referral for substance abuse residential treatment needs to be made to the facility's specialized substance abuse treatment program (SATP) and SARRTP, if separate units. Decisions about admission need to be made jointly by SATP and SARRTP staff. Recognizing that some SARRTPs are "all inclusive" and others are "supportive residential" models, decisions about the appropriateness of an individual setting for a given patient needs to be made during this assessment process.

d. **Assessment and Treatment.** All veterans referred for residential treatment need to have a full assessment, including history, mental status exam, and medical evaluation. All veterans

admitted to SARRTP need to have a treatment plan that includes input from the veteran, their family, SARRTP staff, and SATP staff. Treatment goals need to be individualized and based on the veteran's strengths, needs, preferences, and desired outcome. In most cases, participation in treatment of staff from the SATP, as well as the SARRTP, is to be indicated in order to provide as flexible and comprehensive a treatment program, as is needed. SARRTPs may have a general focus, treating a wide range of veterans with SUDs, or may have a specialized focus (e.g., dual diagnosis). In the case of specialized SARRTP units, or in which veterans with certain presenting issues (e.g. serious mental illness) are excluded from admission, provisions must be made for the care of individuals who require residential SUD treatment but do not meet the SARRTP admission criteria. While Residential Treatment programs are designed to provide more than a minimal LOS in order to facilitate the veteran's treatment and reintegration, no specific general LOS needs to be mandated. Rather, the LOS needs to be individualized and based on the presenting condition and the time to meet the goals identified in the treatment plan. Case reviews and utilization reviews need to be performed as needed, but no less frequently than once a month. Treatment activities (groups, counseling, community meetings, etc.) need to be available 7 days a week.

e. **Discharge Planning And Continuity Of Care.** Discharge planning needs to include participation of SARRTP staff, SATP staff, the veteran, and relevant family members or significant others. This planning needs to begin at admission. Crucial to discharge planning is decision making relevant to ongoing treatment following the residential care (setting, location, frequency, etc.). Staff are responsible for ensuring that access barriers to continuing outpatient care (e.g., distance, transportation, scheduling) are reduced or eliminated.

f. **Staffing.** Staffing size and expertise is dependent on the bed capacity of the SARRTP and the specialized needs of the veteran being served. For example, veterans who have recently detoxified, who have poor or underdeveloped community living skills, or who have a history of significant maladaptive social behavior require a 24-hour structured setting by VA staff capable of providing appropriate care and guidance. Alternatively, veterans who are in the final stages of a long-term community reentry focused residential treatment setting may require less direct staff supervision and structure. In all cases, staffing levels must ensure the safety and security of the veteran and staff, and meet appropriate accreditation standards. In an "all inclusive" program, the staff needs to include a minimum of at least two full-time equivalent (FTE) professional staff (e.g., MSW social worker, PhD psychologist) with credentialing and privileging in substance abuse treatment. In a "supportive residential" program, such licensed professional staff members generally provide services to SARRTP veterans as part of the SATP. In all cases, professional staff must be available to the SARRTP veterans at all times on a scheduled and on-call basis. Non-licensed staff members who have direct clinical or administrative veteran supervision duties within the SARRTP, must be trained to provide appropriate management of the therapeutic milieu, make and document accurate observations of the veteran's behavior, and provide appropriate prompting and guidance to veterans in the completion of the therapeutic assignments or in the use of skills being taught as part of the SUD treatment or residential rehabilitation.

g. **Quality of Care.** In order to maintain quality of care, SARRTPs must meet all national performance measures that apply to SARRTPs in particular and PRRTPs in general. SARRTPs must also contribute actively to the medical center's and VISN's meeting of the national

performance measures for SUD treatment and capacity. In addition, all SARRTPs need to maintain accreditation by JCAHO, but may also seek CARF accreditation.

12. PRRP

a. **Description.** The PRRP goal is to provide a safe, supportive, and structured residential rehabilitation environment for veterans with PTSD. Veterans may require residential rehabilitation based on the severity of their illness, the serious relapse potential they demonstrate and the effects of significant internal psychological issues, and compromising external environmental issues (e.g., lack of safe and sober living setting) which impinge on their community functioning, treatment, and negate the possibility of ambulatory treatment. Services need to include continuing PTSD treatment, SUD treatment, residential rehabilitation, and psychosocial rehabilitation including employment, community supports, and housing. ***NOTE:*** *The unique environmental and treatment needs of women veterans must be addressed.*

b. **Target Population.** Veterans must meet the diagnostic criteria for PTSD or have a significant trauma-related readjustment problem for admission to the PRRP. If a veteran has a co-morbid mental health diagnosis (e.g., SUD), both disorders are sufficiently under control to allow effective participation in both the treatment and residential rehabilitation services. Veterans must be able to refrain from harm to self and others, self-preserve in case of an emergency, and abstain, if possible, from substance abuse. Veterans must be capable of self-care including, where appropriate, self-medication. Veterans must demonstrate motivation for treatment and rehabilitation including, when appropriate, vocational and employment services.

c. **Treatment Modalities.** Treatment may occur within the PRRP or through participation in outpatient clinics. Treatments for PTSD need to include traditional evidence-based practices described in the Joint VA-Department of Defense (DOD) PTSD Clinical Practice Guidelines. While group treatment is the most common care delivery format, services need to include individualized services. Treatment for co-morbid disorders needs to occur on a concurrent basis, whenever possible or appropriate, either through staff embedded in the PRRP or through care from a specialized substance abuse program. A recovery orientation in rehabilitation is integral to the PRRP. Programs need to include engaging the veteran in peer support within the program and encouraging this peer support extended to outpatient care after discharge. Emphasis is placed on full partnerships between the staff and veterans in developing plans of care with the overall goal of having the veterans eventually drive their own plan of care.

13. CWT-TR

a. **Description.** The CWT-TR programs are designed for veterans whose rehabilitative focus is based on CWT and transitioning to successful independent community living. Ongoing support is provided for diagnoses-specific conditions. CWT-TRs are designed for specific populations (Homeless, PTSD, etc.) for purposes of tracking services and funds expended for special veteran populations. They need to be staffed with professionals possessing specialized expertise related to the populations served. The needs of women veterans have to be addressed, with expansion of the number of available services and beds available to women veterans.

b. **Target Population.** The CWT-TR Program was originally implemented and funded with two target populations in mind, the veteran with severe substance abuse who frequently relies on institutional care, and the homeless mentally ill veteran who under-utilizes VA services. During the initial Demonstration Phase of CWT-TR, this psychosocial rehabilitation model generally limited the targeted veteran in these populations to veterans for whom full competitive employment was an expected outcome. VA leadership has since expanded the CWT-TR target population to also include veterans diagnosed with PTSD and veterans with serious psychiatric disorders and concomitant vocational deficits. The growing population of homeless women veterans must be considered a high need population that bears special focus. Additionally, this expanded authority encourages use of the model for program design and development that is to maximize the functional status of veterans whose level of disability may preclude full employment. The primary objectives for these veterans are greater independence, improved social status, reduced hospitalization, and community work based on their needs, abilities, strengths, and desires.

c. **Financial Management Elements**

(1) The CWT-TR legislation authorizes VA to charge veterans a "Program Fee" to cover the cost of room and board, food, utilities, and housing maintenance. Money for program fees is derived from veteran's earnings obtained by working in VA's CWT Program or community employment positions. Program fees are charged primarily to foster increased responsibility of veterans for their recovery, and only secondarily, to defray the cost of maintaining the houses. Each resident, other than the house manager(s), is required to pay a "TR program fee" during resident's period of occupancy, to cover costs associated with operational expenses. These funds must be deposited in a sub-account of the local General Post Fund (GPF) and used only to support the expenses associated with the management and operations of the TR residences. If revenues (program fees) of a residence do not meet the expenses, resulting in an inability to pay actual operating expenses, the medical center of jurisdiction needs to provide the funds necessary to return the program to fiscal solvency.

(2) Each CWT-TR program is required to justify the amount of the program fee charged to veterans. On an annual basis, the CWT-TR program manager must develop a projected operating budget. On a semi-annual basis, the CWT-TR program manager is required to compare the actual program revenues and expenses with the projected budget. If revenues or expenses are over or under projections by more that 5 percent, the program manager must take the steps necessary to ensure financial stability. In order to meet this requirement, the medical center's Chief Financial Officer must provide a quarterly CWT-TR Budget Report which contains a beginning balance, total revenues, expenses by cost center, and the ending balance.

d. **Length of Stay (LOS).** A resident's length of stay in transitional housing does not usually need to exceed 12 months. Veterans with exceptionally complex psychosocial needs or deficits may require a longer length of stay to successfully transition to the community. The LOS needs to be based on the measurable goals and objectives listed in the rehabilitation plan. The CWT-TR program may not be used as a substitute for housing.

e. **Drug and Alcohol Screening.** Residents are prohibited from using or possessing alcohol or illegal drugs while residing in the CWT-TR Program. Residents must agree to regular, random alcohol and drug screenings to ensure a substance-free environment.

f. **Eligibility**

(1) Only veterans enrolled in VHA priority Groups 1-6 participating in the CWT Program and a House Manager may reside in the CWT-TR houses.

(2) Veterans must be enrolled and working in the CWT Transitional Work Experience or Supported Employment program to be admitted to the CWT-TR Program. As veterans are successful in obtaining community employment or a work opportunity that meets their needs, abilities, strengths, and desires, the veteran may remain in the CWT-TR house for a period of time necessary to accomplish the goals and objectives listed on the rehabilitation plan and agreed to by the veteran, program staff, and treatment team.

g. **Staffing and House Managers.** The CWT-TR may be minimally staffed, since by their nature, they are designed to maximize peer support and self-care. However, the safety and welfare of both CWT-TR staff and residents must be the primary consideration. When a veteran is present in the house, on-site supervision of a CWT-TR house is required. A live-in house manager generally provides this on-site supervision. Documented training of the House managers is required. The House Manager's duties must be outlined in a position description and VA staff must regularly assess their performance and competencies. The type of professional staffing provided must be determined by the clinical needs of the veterans served and by standards applied by external accrediting bodies. Professional staffing must be available by radio, pager, or telephone at all times. A graduate of CWT-TR acting as a house manager must be established as a Without Compensation (WOC) employee through Human Resources Management Service.

h. **Approval, Acquisition, Code Requirements, and Maintenance**

(1) The CWT-TR program may operate in a community property that was purchased, leased, or otherwise acquired, in space on the medical center grounds, or in the community. Approval to establish a new CWT-TR or expand an existing program requires VA Central Office approval through an announced request for proposals (RFP) or by following VHA Directives for Bed Change Requests and Mental Health Program Changes.

(2) As prescribed by 38, U.S.C., Section 2032, in the establishment and operation of a CWT-TR residences, medical centers need to consult with appropriate representatives of the community in which the housing is established and comply with zoning requirements, building permit requirements, and other similar requirements applicable to other real property used for similar purposes in the community. The residence or facility needs to meet community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located, but fire and safety requirements applicable to buildings of the Federal Government do not need to apply to such property. ***NOTE:*** *While Federal fire and safety requirements do not apply to CWT-TR properties, medical centers may*

choose to follow fire and safety standards from the National Fire Protection Association's Life Safety Code.

(3) With appropriate support and assistance from Engineering, Contracting, and Fiscal Services, needed house repairs, maintenance and household goods, and furniture replacement need to be prioritized and completed with projected costs integrated into the annual CWT-TR projected budget. Veterans residing in the houses need to accomplish appropriate minor repairs and maintenance. On-station CWT-TR residences are usually maintained by engineering staff, while community properties may be maintained by engineering staff or community contractors. Medical center management must develop procedures for annual home inspections and budget reviews to ensure plans and funds are in place to appropriately maintain these VA housing resources.

14. REFFERENCES

a. VHA Directive 1000.1.

b. VHA Manual M-1, Part I, Chapter l.

c. VHA Handbook 1907.1.

GUIDANCE ON THE ESTABLISHMENT AND ADMINISTRATIVE MANAGEMENT OF A PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)

1. STEPS FOR VA MEDICAL CENTER

a. Prior to formal submission of a Psychosocial Residential Rehabilitation Treatment Program (PRRTP) proposal, it is suggested that contact be made with the Department of Veterans Affairs (VA) Central Office PRRTP Manager, Office of Mental Health Services, at (757) 722-9961, extension 1123. This initial contact allows an opportunity for a brief consultation of the PRRTP plans to permit expeditious approval of formal proposal.

b. The following is to be submitted to the associated Veterans Integrated Service Network (VISN) Director:

(1) A proposal or plan addressing PRRTP activation.

(2) A formal Bed Change Request.

(3) A letter to VA Central Office Director Information Management Service (045A4), through the Deputy Under Secretary for Health for Operations and Management (10N), requesting VA medical center assignment of "PA" suffix, to establish the PRRTP as a separate division of the associated VA medical center.

2. STEPS FOR VETERANS INTEGRATED SERVICE NETWORK (VISN)

a. Forward the VISN-approved proposal to the Deputy Under Secretary for Health for Operations and Management (10N), who must formally request comment from the Deputy Chief Patient Care Services Officer for Mental Health and/or other Patient Care Services program offices as appropriate.

b. Forward the VISN-approved request for PA Suffix letter to: VA Central Office, Director, Information Management Service (045A4), through the Deputy Chief Patient Care Services Officer for Mental Health and/or other Patient Care Services program offices as appropriate.

c. Upon approval of proposal by the Under Secretary for Health, process Bed Change designation in Bed Control System.

3. STEPS FOR VA MEDICAL CENTER FISCAL, INFORMATION RESOURCE MANAGEMENT (IRM) AND CHIEF BUSINESS OFFICE UPON BEDS BEING ESTABLISHED IN BED CONTROL SYSTEM:

a. Adjust Gains and Losses (G&L) statement to designate each PRRTP as a separate line item.

b. Acquaint Health Information Management and Coding Staff with the following Treating Specialty Codes, and ensure Decision Support System (DSS) staff establishes appropriate DSS departments as follows:

PRRTP Type	Treating Specialty Code	DSS Department			CDR
PRRTP (SMI, not otherwise specified)	25	P4A1	4A	2034A1	1711.00
PRRP (PTSD)	26	P4B1	4B	2034B1	1712.00
SARRTP (Substance Abuse)	27	P4C1	4C	2034C1	1713.00
HCMI CWT TR (Homeless)	28	P4D1	4D	2034D1	1714.00
SA CWT TR (Substance Abuse)	29	P4E1	4E	2034E1	1715.00
PTSD CWT TR	38	P4F1	4F	2034F1	1716.00
General CWT TR	39	P4G1	4G	2034G1	1717.00

4. RECURRING VA MEDICAL CENTER FISCAL, IRM, AND CHIEF BUSINESS OFFICE MANUAL PROCEDURES

a. Personnel responsible for processing of G&L need to submit a PRRTP workload Report (indicating PRRTP Bed Days of Care for previous month) to Fiscal Service by the 10th workday of each month.

b. Workload for PRRTPs must be manually inserted into VHA Work Management (VWM) segment 334 to ensure it is recorded as Psychiatry workload. Additionally, Fiscal staff must ensure that the PRRTP workload (Bed Days of Care) is credited to Cost Distribution Report (CDR) 1700.00 series account, as appropriate for type of PRRTP established.

5. STEPS FOR SERVICE LINE CHIEFS TO DISTRIBUTE COSTS

The Chief of Psychiatry, Mental Health Service Line Chief, and/or PRRTP Coordinator need to be familiar with (generally two) cost categories designed to measure the treatment cost of Residential Rehabilitation services:

(1) **Residential Inpatient Costs.** Services provided to PRRTP veterans by staff assigned to, and in support of, the PRRTP residential unit are captured as "bed days of care" and reported to the PRRTP inpatient bed category CDR account 1700 series. ***NOTE:*** *These services include, but are not limited to, PRRTP screening, admission, rehabilitation plan development, case reviews, therapeutic group, and individual counseling associated with the residential component, meals, dietetics staff, evening staff coverage, etc.*

(2) **Outpatient Costs.** Services provided to PRRTP veterans by staff providing services in established outpatient clinics (such as Outpatient Substance Abuse Clinics, Day Treatment programs, Post-traumatic Stress Disorder (PTSD) Clinical Team (PCT), Vocational Rehabilitation Therapy, Compensated Work Therapy, etc.) are captured as "outpatient visits." These costs are, therefore, reported to the appropriate Outpatient CDR Account in the 2000 series.

NOTE: *If all services provided to PRRTP residents are provided exclusively to them, in conjunction with the residential unit (as in a traditional hospital bed program), then all costs are to be captured as Residential Inpatient Costs (1700.00 series costs).*

VETERANS HEALTH INFORMATION SYSTEMS AND TECHNOLOGY ARCHITECTURE (VISTA) SET-UP INSTRUCTIONS FOR PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)
(i.e., establishing a new division under the category of Domiciliary in VistA)

NOTE: *The use of Domiciliary category for VistA setup is for domiciliary-like functionality purposes only - PRRTP beds are not otherwise to be considered Domiciliary beds, but rather PRRTP (Psychiatry) beds.*

1. TO ADD A NEW INSTITUTION

Select OPTION NAME: INSTITUTION FILE ENTER/EDIT DG INSTITUTION EDIT
Institution File Enter/Edit

Select INSTITUTION NAME: ALB-PRRTP (SUGGESTED NAME TO IDENTIFY PRRTP)
(e.g. first 3 letters of your primary division, then - PRRTP)

Are you adding 'ALB-PRRTP' as a new INSTITUTION (the 269TH)? Y (Yes)
INSTITUTION STATE: NY NEW YORK
INSTITUTION FACILITY TYPE: MC
1. MC (M&D) MEDICAL CENTER (MEDICAL AND DOMICILIARY)
2. MC (M) MEDICAL CENTER (MEDICAL LOCATION)
CHOOSE 1-2: 2
INSTITUTION STATION NUMBER: 500PA
NAME: ALB-PRRTP//
REGION:
DISTRICT:
VA TYPE CODE: MC HOSP
STATION NUMBER: 500PA//
STREET ADDR: 1: 2 3RD ST.
STREET ADDR: 2:
CITY: ALBANY
STATE: NEW YORK//
ZIP: 12180
MULTI-DIVISION FACILITY: Y YES

Select INSTITUTION NAME:

2. TO ADD A NEW DIVISION (using Medical Administrative Services (MAS) Parameter Enter/Edit)

(Screen showing divisions is not being displayed at this point)

(3) Divisions: TROY (500), ALBANY (500), MOBILE CLINIC (500MO),

TEST NUMBER (500.4), CINCINNATI (539),
ALB-PRRTP (500PA),
Select MEDICAL CENTER DIVISION NAME: ALB-PRRTP
Are you adding 'ALB-PRRTP' as
A new MEDICAL CENTER DIVISION (the 25TH)? No// Y (Yes)
MEDICAL CENTER DIVISION NUM: 541// <return>
MEDICAL CENTER DIVISION FACILITY NUMBER: 500PA
OUTPATIENT ONLY:
PRINT WRISTBANDS: Y YES
PRINT 'AA'<96' ON G&L: Y YES
PRINT 'AA' ON G&L: Y YES
NHCU/DOM/HOSP G&L: 1 SEPARATE **********
INSTITUTION FILE POINTER: ALB-PRRTP NY MC(M) 500PA
DEFAULT 1010 PRINTER:
DEFAULT DRUG PROFILE PRINTER:
DEFAULT ROUTING SLIP PRINTER:
Select MEDICAL CENTER DIVISION NAME:

NOTE: *Make sure that the primary division is the one that appears as the first entry when entering the MAS Parameter Screen (If not, the last division added with display on the top of the Bed Section Report and Treating Specialty Report).*

3. <u>TO ADD A NEW WARD (Using Ward Definition Enter/Edit)</u>

Ward Definition Entry/Edit

Select WARD LOCATION NAME: PRRTP
Are you adding 'PRRTP' as a new WARD LOCATION (the 31ST)? Y YES
WARD LOCATION HOSPITAL LOCATION FILE POINTER: PRRTP
Are you adding 'PRRTP' as a new HOSPITAL LOCATION (the 125TH)? Y (Yes)
HOSPITAL LOCATION TYPE: W WARD
HOSPITAL LOCATION TYPE EXTENSION: WARD//
WARD LOCATION G&L ORDER: 21.5 (OR WHEREVER YOU WISH TO PRINT IT)
NAME: PRRTP//
PRINT WARD ON WRISTBAND: Y YES
DIVISION: ALB-PRRTP 500PA
INSTITUTION: ALB-PRRTP NY MC(M) 500PA
ABBREVIATION: PRRTP
BEDSECTION: PRRTP
SPECIALITY: PSYCH
1 PSYCH RESID REHAB TRMT PROG
2 PSYCHIATRIC MENTALLY INFIRM
CHOOSE 1-2: 1
SERVICE: DOM DOMICILIARY
PRIMARY LOCATION: PRRTP
Select AUTHORIZED BEDS DATE: 10 1 97 OCT 01, 1997

Are you adding 'OCT 01, 1997' as a new AUTHORIZED BEDS
DATE (the 1ST for this WARD LOCATION)? Y (Yes)
NUMBER OF AUTHORIZED BEDS: 20
SERIOUSLY ILL:
Select SYNONYM:
G&L ORDER: 21.5//
Select TOTALS: PRRTP TOTALS
Are you adding 'PRRTP TOTALS' as a new TOTALS (the 1ST for this WARD LOCATION)?
Y (Yes)
TOTALS LEVEL: 1//
PRINT IN CUMULATIVE TOTALS: Y YES
CUM TITLE: PRRTP//
Select TOTALS:

Select WARD LOCATION NAME: NCHU (OR WHATEVER YOU WANT TO PUT IT IN
FRONT OF/AFTER, ETC.) NAME: NHCU//^TOTALS
Select TOTALS: GRAND TOTALS// ?
Answer with TOTALS LEVEL
Choose from:
1 NHCU TOTALS
2 DON'T DISPLAY
3 GRAND TOTALS

MEDICAL CENTER TOTALS	40	0	0	40
PRRTP PRRTP	3	0	1	2
PRRTP TOTALS	3	0	1	2
DOMICIL DOM	1	0	0	1
DOM TOTALS	1	0	0	1
2 NHCU NHCU	1	0	0	1
NHCU NHCU	0	0	0	0
NHCU TOTALS	1	0	0	1
GRAND TOTALS	45	0	1	44

4. <u>TO PLACE WARD OUT-OF SERVICE (Using Edit Ward Out-Of-Service Dates)</u>

Select OPTION NAME: EDIT WARD OUT-OF-SERVICE DATES DGPM
WARD OOS EDIT
Edit Ward Out-of-Service Dates

Select WARD LOCATION NAME: PRRTP
Select OUT-OF-SERVICE DATE: 10 1 97 OCT 01,1997

Are you adding 'OCT 01, 1997' as a new OUT-OF-SERVICE DATE (the 1ST for this WARD LOCATION)? Y
(Yes) OUT-OF-SERVICE DATE(S): OCT 1, 1997//
REASON: OTHER
1 OTHER CONSTRUCTION
2 OTHER REASONS
CHOOSE 1-2: 2

COMMENT: PRRTP TRACKING
RETURN TO SERVICE DATE: 5 1 97 (MAY 01, 1997) (OR WHATEVER DATE YOU WISH TO ACTIVATE THIS WARD) IS ENTIRE WARD OUT OF SERVICE?: Y YES
DISPLAY OOS ON G&L: YES YES

5. <u>TO SET UP TREATING SPECIALTY REPORT FOR THE NEW WARD (PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP))</u>

Select FACILITY TREATING SPECIALTY NAME: PSYCH RESID REHAB TRMT PROG
PSYCH RESID REHAB TRMT PROG
NAME: PSYCH RESID REHAB TRMT PROG//
Select EFFECTIVE DATE: OCT 1, 1997//
EFFECTIVE DATE: OCT 1, 1997//
ACTIVE?: YES//
SPECIALTY: PSYCH RESID REHAB TRMT PROG//
SERVICE: PSYCHIATRY// DOMICILIARY
Select PROVIDERS:
ABBREVIATION:

The information for the PSYCH RESID REHAB TRMT PROG treating specialty needs to be entered by the medical center division as of midnight on Sep 30, 1997 to properly initialize the Treating Specialty Report!

Following any new entries to or revisions of this data, the Gains and Losses (G&L) MUST BE recalculated back to Oct 01, 1997.

Select MEDICAL CENTER DIVISION NAME: ALB-PRRTP 500PA
PATIENTS REMAINING: 0
PASS PATIENTS REMAINING: 0
AA PATIENTS REMAINING: 0
UA PATIENTS REMAINING: 0
ASIH PATIENTS REMAINING: 0
TSR ORDER: 200

Select MEDICAL CENTER DIVISION NAME:

Select FACILITY TREATING SPECIALTY NAME:

6. ADMIT AND/OR TRANSFER IN-PATIENTS

7. RECALCULATE GAINS AND LOSSES (G&L) CUM TOTALS BACK TO 10/1/97

8. RUN G&L, INCLUDING BSR AND TSR

9. EXPERIMENTATION WITH NEW DIVISION AND/OR DOMICILIARY WARD FOR TRACKING PRRTP

a. Create a new Institution file entry (ALB-PRRTP) -or whatever.

b. Create a new Division file entry (ALB-PRRTP) -or whatever.

c. Create a new Ward with DOMICILIARY as the SERVICE.

NOTE: *Place beds 00S from 10/1/97 and Return to Service whatever day you are going to start tracking. You must show Authorized Beds at this time.*

d. Set up the Treating Specialty Report for PRRTP as all zeroes for each of your current divisions.

e. Recalculate G&L Cum Totals back to 10/1/97.

f. Manually track any PTF records with a suffix of BU for DOM and ensure (if the facility already has a DOM), that the suffix is changed to PA.