RECOVERY-ORIENTED ACUTE INPATIENT SCALE v.1.0
Template version "RAIN Scoring Procedures 1.0 19-01-31"

A note on scoring: For scoring in general, consideration should be given to both the quality of the care provided, in general, and the consistency with which the highest level of care is given. Each item provides guidance regarding the elements that may lead to high quality care. Regarding consistency, raters should make note of the degree to which quality varies systematically (e.g., based on presenting condition, degree that a patient can engage in care, etc.) or failures to establish infrastructure to support consistency (e.g., formal processes and procedures, written decision aids, etc.).

Recovery Planning

Recovery-oriented inpatient care is driven by recovery-oriented planning for both treatment on the inpatient unit and coordination of subsequent outpatient care. Both processes begin with a recovery assessment and goal setting, reflected in a written treatment plan, followed by shared decision-making, and processes to ensure Veterans are seamlessly linked with appropriate care.

1) Recovery Goal-Setting

The treatment team elicits each Veteran's recovery goals and these goals guide care.

Elements:

Recovery-oriented assessment develops an understanding of the Veteran as a person and how the current hospitalization fits within the Veteran's journey toward recovery.

Recovery goals are derived from the assessment. Simply asking the Veteran her goals may start the process, but should be followed by a conversation to better understand the stated goal, what motivates the Veteran, and arrive at desired end-states that the Veteran finds personally meaningful (e.g., consistent with whom they believe they are or wish to become).

Iterative and on-going: The recovery plan is modified based on a constantly updated understanding of the Veteran, her goals, and progress. For full credit, recovery goals should be referenced at multiple points in the course of treatment (e.g., treatment planning and discharge planning).

Scoring Notes:

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no goal setting

2) Written Treatment Plan

Veterans' recovery goals are recorded in one, integrated treatment plan that coordinates care while on the unit.

Elements:

Goals are derived from goal setting (see #1) and stated in the Veteran's words, include non-symptom goals, and are individualized (not from a standardized set used across the unit). Should include rehabilitation goals related to living, learning, working, socializing or other interpersonal goals, or hobbies.

Objectives operationalize what will be accomplished while the Veteran is on the unit in specific terms.

Interventions, including specification of who is going to do what in order to accomplish the Veteran's objectives and goals.

Updates should be made to the treatment plan regularly. This includes revising the plan based on Veterans' participation in and reaction to treatment options and ongoing recovery assessment. Updates should evidence progress (e.g., "resolved" goals and objectives). Veterans with short lengths of stay may not require an update.

Integrated plan: If various portions of the treatment plan exist in various documents (e.g., each discipline maintains separate treatment plans) partial credit may be given. Consideration should be given to the ease of accessing pertinent information. Ideally, one plan includes goals, objectives, and interventions derived from all disciplines. If such a singular plan does not exist, partial credit may be given, with more credit given if separate plans are easily identifiable (e.g., distinct note titles such as "social work plan of care").

Scoring Notes:

Quality is rated as consistency with all the elements.

Consistency is the percentage of Veterans who have a written treatment plan regardless of quality.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no treatment planning

3) Shared-Decision-Making for Medication Management

Providers (e.g., physicians, nurse practitioners, pharmacists) work with Veterans to identify preferences regarding medications and to make decisions regarding medications using an informed consent process that supports recovery goals.

Elements:

Positive indicators include discussion of the Veteran's needs and preferences, risks and benefits of medication, why medication is being prescribed, and potential alternative treatment options (including non-medical options).

For highest score, the conversation begins with the Veteran's interests and circles back to those interests in the end (i.e., asking what they want at the beginning or end without their input in the overall decision is not sufficient).

Decisional aids facilitate Veteran understanding; however, passive decisional aids are not sufficient.

Use of "teach-back" technique is a positive indicator.

Veterans also have the option to decline medication treatment.

Scoring Notes:

Regularly beginning the medication discussion by first suggesting a medication with some review of pros/cons along with Veteran option to decline would be a regular deficit in quality (i.e., score = 1.0). Generally suggesting a medication with alternatives accepted only after the Veteran proactively raises objection would be regular deficits in quality and consistency (i.e., score = 0.5).

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no shared decision-making

4) Shared Decision Making for Inpatient Treatment

Providers (e.g., physicians, nurse practitioners, pharmacists) work with Veterans to identify preferences regarding interventions aside from medications and to make decisions using an informed consent process that supports recovery goals.

Elements:

Educate: Staff members *educate Veterans* regarding treatment offerings available while hospitalized (e.g., specific groups, individual therapy, etc.).

Discuss: Staff discuss these options in the context of the Veteran's recovery goals, needs, and preferences.

Plan: Staff and the Veteran form a plan based on this conversation.

Scoring Notes:

For highest score, the conversation begins with the Veteran's interests and circles back to those interests in the end (i.e., asking what they want at the beginning or end without their input in the overall decision is not sufficient).

For the highest score, conversations should focus on specific groups relevant to recovery goals rather than groups, in general. Passive means (e.g., posters, manuals, and worksheets outlining treatments) are helpful but not sufficient and must be paired with a conversation with staff members regarding potential helpfulness relative to Veteran goals.

Use of "teach-back" technique is a positive indicator.

Veterans also have the option to decline treatment.

Veterans should be included in decisions about length of stay or discharge date.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no shared decision-making

5) Shared Decision Making for Outpatient Treatment

Staff members *educate Veterans* regarding treatment offerings available following hospitalization (e.g., clinics and associated services, discharge placements, etc.); *discuss these options* in the context of the Veterans' recovery goals, needs, and preferences; and form a *plan* with the Veteran based on this conversation.

Elements:

Educate: Staff members *educate Veterans* regarding treatment offerings available post-discharge.

Discuss: Staff discuss these options in the context of the Veteran's recovery goals, needs, and preferences

Plan: Staff and the Veteran form a plan based on this conversation.

Scoring Notes:

For highest score, the conversation begins with the Veteran's interests and circles back to those interests in the end (i.e., asking what they want at the beginning or end without their input in the overall decision is not sufficient) to develop a plan to participate in the interventions that best meet the Veteran's needs and preferences.

Passive means (e.g., posters, manuals, and worksheets) are helpful but not sufficient, and must be paired with a conversation with staff.

In-reach (see #8) from outpatient providers is considered to be a positive indicator of high-quality care but not required for full credit.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no shared decision-making

6) Outpatient Care Coordination

Staff utilize a process that maximizes the likelihood that Veterans engage in planned outpatient treatment.

Elements:

Formal screening and enrollment in outpatient specialty services. Veteran should also be made aware of the outcome of the evaluation as soon as possible (e.g., a Veteran is determined ineligible for MHICM due to not meeting criteria) to have the opportunity to make alternative plans if ineligible.

Warm hand-off between inpatient and outpatient staff. This may include either direct communication between inpatient and outpatient provider or an administrative handoff where records are sent/consults are made via EMR. This can be evidenced by consults being made to programs such as MHICM, CWT, HCHV as determined by chart reviews, observation of team meetings (via calls or instant messages directly to providers or those who screen for eligibility).

Scheduling outpatient appointments.

Review of outpatient care, appointments, etc., with the Veteran (and her significant others, as appropriate). Details of future outpatient appointments (i.e., date, time, provider name, address of clinic, type of appointment) should be clearly communicated to the Veteran prior to, at discharge, or both. Highest quality reviews include written materials and checking for agreement and understanding (e.g., teach-backs).

Trouble-shooting potential barriers. In-reach (see #8), while not necessary, may facilitate much of this process.

Scoring notes:

Raters should ask themselves for each Veteran "is it highly likely that this Veteran will attend their initial outpatient appointments as planned?" While the shared decision-making item focuses on Veteran motivation and buy-in, this item focuses on the ***logistics*** necessary to ensure a seamless transition from inpatient to planned outpatient care.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no outpatient care coordination

7) Least Restrictive Discharge

Discharge planning is focused on placement that integrates Veterans into the community as much as is possible.

Elements:

Because all sorts of factors can drive the actual discharge placement that are out of the control of the staff, the scoring of this item is mainly driven by program philosophy. In highest scoring units the philosophy is to avoid residential and/or skilled nursing facilities unless the Veteran cannot be reasonably supported by extant community support services in independent living. While living situation prior to hospitalization may provide data, highest scoring units look for opportunities to support previously institutionalized Veterans in community settings with appropriate supports.

The restrictiveness of non-community placements used should be accounted for as well. For instance, a tendency toward placing Veterans in locked skilled nursing units would indicate a further deviation from the desired driving program philosophy compared to sites emphasizing less restrictive congregate housing with limited staffing.

Veteran preference should be accounted for; however, standards of shared decision making should be applied and when a Veteran can be supported in a less restrictive placement than the Veteran initially requests, other options should be presented for discussion. Adjustments or delays in discharge to accommodate Veteran preferences or needs for housing (waiting for a spot to open within an appropriate placement), should NOT count as a deficit for this item.

Scoring Notes:

2.0 The program actively pursues least restrictive settings for all Veterans

1.5 Philosophy mixed but leans more toward community-based independent living for Veterans at discharge

1.0 The program's driving philosophy is more about maintaining the status quo. Programs look to discharge back to the same level as care as from where Veterans were admitted

0.5 Philosophy mixed but leans more toward congregate and other residential living settings for Veterans at discharge

0.0 The program's driving philosophy strongly emphasizes congregate and other residential living settings for most Veterans

Inpatient Care

8) In-Reach

In-reach consists of systematic methods to not only make Veterans aware of outpatient services relevant to their needs but also to expose Veterans to those outpatient services and programs while on the inpatient unit.

Elements:

There should be active efforts to introduce and engage the Veteran with those outpatient services/programs/providers. Additionally, outpatient providers (including already established providers) meeting with the Veteran during their inpatient stay or consulting remotely may also count toward this.

The in-reach is *systematic*— This may be evidenced by inpatient groups reliably occurring and led by providers from outpatient programs/clinics such as substance use group led by outpatient substance use disorder clinic provider or PRRC Bridge group led by peer; consults routinely being made; existing outpatient providers routinely coming to see Veteran patients on the inpatient unit or consulting remotely.

Veterans are being *made aware* of the types of outpatient services/programs available for in-reach—Veteran is given information on programs available for in-reach contact and this is discussed (e.g., packet given upon admission re: housing, supported employment programs); also, may be evidenced by treatment team members informing Veterans of outpatient programs during meetings with Veterans.

Veterans are actually being *exposed to outpatient* services/programs/providers— This may include the a provider both describing the program during group (e.g., PRRC, Domiciliary) and giving information of how to connect; consults with Veteran (to programs like compensated work therapy) are not only scheduled but are also occurring on the inpatient unit; Veteran goes off the unit to actually tour the PRRC or the Domiciliary prior to discharge.

Services/programs must be *relevant to the Veteran's individual needs* – There needs to be evidence that the in-reach is individualized to the Veteran (e.g., consults should be made specific to Veteran's needs). Also, if many Veterans on a unit have a need for specific types of services or programming, there should be an opportunity for this to make that connection ideally via regularly occurring group (e.g., substance use disorder group led by provider from outpatient program if there is a number of Veterans at this site with substance issues).

Scoring notes:

In order to score a 2, there has to be recognition for wide variety of clinical needs. Just offering a PRRC group is ***not*** a 2; other types of services are needed. Scores will not be lowered if in-reach groups exist but attendance is low if Veterans are regularly encouraged to attend. Note that the clinical skill with which groups are offered is scored under Quality Programming.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no in-reach

9) Integrated Care for Comorbid Physical Health Needs

Evaluation/screening, direct care, referrals, and care coordination is undertaken for common comorbid health issues as appropriate to Veteran's need, interest, and eligibility.

Given high rates of medical comorbidities (e.g., diabetes, pain, heart disease, dental needs), higher mortality for those with severe mental illness, and physical health side effects from psychotropic medication, attention to common medical comorbidities is a critical aspect of inpatient psychiatric care. Also, links between physical and mental health wellness should be emphasized, including Veteran education on the importance of healthy self-management practices such as getting physical activity and proper sleep in mental health recovery and coping with medication side effects.

Elements:

Screening/evaluation: A Designated person/person on the unit evaluates Veterans for comorbid physical health needs. The designated can be the psychiatrist or other professional; however, the person must systematically screen and evaluate physical health issues.

Referral/consult: Direct care is provided or arranged while on the unit. Care is coordinated with medical professionals (caring for physical health needs) both while on the unit and post-discharge.

Education: Staff provide information about important links between physical and mental wellness, common comorbidities, and healthy lifestyle choices that support recovery.

Scoring Notes:

If a physical exam is done elsewhere in the hospital just prior to admission (e.g., in the emergency department), the unit does not need to duplicate the assessment, but should be fully aware of and act upon any findings to receive credit for screening.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no attention to comorbidities

10) Individual Evidence-Based Psychotherapies are Available

In addition to ongoing availability of supportive and therapeutically valuable interactions between Veterans and staff, individual, evidence-based psychotherapy (e.g., cognitive behavioral therapy, acceptance and commitment therapy, interpersonal therapy, motivational enhancement therapy) is offered and available.

Elements:

Individual therapy is systematically available and considered for the majority of Veterans based on clinical presentation, need, etc. Need for therapy could be evaluated/staffed in team meeting or rounds (amongst providers); therapy does not need to be provided to each veteran to meet this criterion. There should also be evidence that individual therapy is reasonably integrated within inpatient programming—staff should be aware that individual therapy is available and acknowledge it as a part of programming.

Veterans are systematically made aware that therapy is available. This process may occur upon admission—intake, admission booklet, community meeting, during team meeting, etc. Veteran interviews and onsite observations are used as data sources for this element.

Providers reach out to Veterans to setup individual therapy sessions. Veterans can reach out seeking therapy, but providers generally do so, rather than wait for Veterans to request.

Individual therapy must be evidence-based and/or of good quality. Individual therapies offered should be based on the best available evidence. Particularly in the case of "quality", the judgement is somewhat subjective and may be inferred from direct observation and discussion with therapist to gauge whether therapy is provided in a skilled way by competent staff.

Therapy is provided by licensed independent practitioners, including inpatient psychologist/master's level therapist/ designated outpatient staff similarly qualified.

Scoring notes:

Administrative data indicating percentage of encounters coding for individual therapy can be used to triangulate, as well as other data sources.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no individual therapy

11) Suicide Prevention

Inpatient units have systematic procedures for conducting high quality suicide risk assessment and safety planning.

Elements:

Risk assessment includes both screening and, for those who screen positive, in-depth suicide risk assessment. Safety planning is informed by this assessment and includes planning for safety both on the unit and after discharge. When warranted, the suicide prevention coordinator is informed of the status of the Veteran in order to apply the appropriate flags in the chart and assist in informing a well-conceived safety plan for discharge.

Scoring Notes:

Indicators of a 2 may include significant others in the community and outpatient providers should be involved in safety planning to maximize the success of the plan after the Veteran is discharged.

This should be an active process, not just having the Veteran fill out their safety plan on their own.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no systematic suicide prevention services

12) Sufficient Volume of Group Programming

Veterans are provided 30 or more hours of therapeutic programming each week (e.g., exceeding 4 hours each day, including weekends).

Elements:

Facilitated: Professional staff or qualified volunteers lead the group.

Therapeutic intent: The intent of group programming considered in this item should be to help the Veterans.

Scoring Notes:

What counts as a group: In order to count toward sufficient group volume, groups should be led by a facilitator with a therapeutic intent. Conversely, milieu-based activities without a therapeutic facilitator would NOT count toward group programming volume. In general, the quality of the therapeutic programming would not need to be confirmed in order to count the group time for the volume item, but therapeutic programming should be the intention of the group in order to count. For example, a poorly run "goals" group that actually does attempt to cover Veteran goals could still be counted toward volume. A recreation therapy group with a facilitator who does very little facilitation would count. Morning or evening "check-in" groups should be observed to see if any therapeutic content is intended to be provided. For example, a morning check-in that simply provides an orientation to unit rules, or a group consisting entirely of watching a video with no staff facilitation or interaction is NOT therapeutic programming. A timeslot for journaling or quiet activity with no facilitation also would NOT count.

Cancelled and shortened groups: This item is scored based the actual groups provided during the site visit and extrapolating to the rest of the week's schedule based on cancelled or shortened groups directly observed, as well as Veteran and staff reports on frequency of cancellations and shortened groups. For instance, if a group is cancelled and Veterans and staff report a group is cancelled about twice each week, raters should prorate the group volume accordingly. If a one-hour group on the schedule concludes in 30 minutes and staff and/or Veterans report this as typical, then volume counted is 30 minutes. Groups less than 30 minutes get no credit (not a standard therapeutic group duration); groups that are 30-60 minutes can be prorated. Similarly, groups that are more than 60 mins (e.g., 90 min whole health group) be counted as 90 minutes of group time volume.

2.0 30 or more hours weekly

1.5 21-29 hours of group programming weekly

1.0 11-20 hours of group programming weekly

0.5 1-10 hours of group programming weekly

0.0 no groups of standard duration (30 mins or more)

13) Sufficient Group Variety

Group programming covers a range of domains to meet the diverse needs of Veterans, and to facilitate a holistic approach to mental health services and recovery.

Elements:

Sufficient variety is indicated by presence/absence of group programming in each of several topical domains.

Required Domains:

1. *Mood and trauma* (Depression, PTSD, Anxiety. Skills group focusing on managing emotions fall in this category.)
2. *Substance abuse groups*
3. *Safety/ Suicide Prevention*
4. *Self-care/ Self-Management groups* (coping skills, medication education/pharmacy, VA whole health)

Optional Domains:

5. *Healthy Life Style* (physical activity, nutrition, sleep, spirituality) and *Physical health* (classes related to general health, e.g. pain, TBI, diabetes, etc.)
6. Severe Mental Illness (SMI) ***groups*** (e.g., IMR, PRRC Bridge group, dual diagnoses groups, psychosis, etc.)
7. *Social relations/Community groups* (groups related to work, housing, community living/integration or independent living, e.g., vocational rehabilitation groups, managing financing, job search, etc.)
8. *Interpersonal skills* (e.g., social skills training, effective communication, personal development, goal setting)
9. *Creative groups* (e.g., art, occupational, music, recreational, or pet therapy)

Scoring Notes:

The required domains represent group activities that meet the presenting needs of most Veterans in inpatient units.

If more than two-thirds of the Veteran population on site has a presenting concern, (e.g. substance misuse), the site needs to offer more than 1 substance use/abuse group per week or 1 substance use/abuse group plus a Twelve Step meeting to receive full credit for that domain. A Twelve Step group is not considered therapeutic on its own.

A non-required item may become required if the site has a substantial percentage of a population with presenting concern related to that domain. For example, while a group for SMI is not a required domain (see above), it may become required if two-thirds of the unit's population has a SMI diagnosis or present to the unit for SMI related concerns.

2.0 Site offers 7 out of 9 domains, AND must include all 4 required domains

1.5 Sites offers 5-6 out of 10 domains, AND must include all 4 required domains

1.0 Site offers 4 out of 9 domains, AND must include all 4 required domains

0.5 Site offers less than 4 out of 9 domains, AND a minimum of 2 required domains

0.0 Site offers 0 or 1 required domains

14) Support for Programming

Members of the treatment team are actively involved in encouraging Veterans to participate in unit programming by being verbally supportive of group participation, reminding and encouraging Veterans to attend groups, and creating an environment that minimizes distractions and interruptions.

Elements:

Staff in the milieu should encourage participation by ensuring Veterans are aware when and where groups are taking place, decreasing distractions in the milieu such as television, and ensuring group spaces are quiet and free from distractions (e.g., people walking through, Veterans being pulled from group, etc.). While general announcements such as posting of group schedules and overhead announcements may help encourage participation, in-person reminders and conversations about participation are optimal. Therapeutic programs should not be interrupted for routine services that could occur outside of the treatment time (e.g., for regular blood pressure checks, general medication delivery). Not every team member need be directly involved in supporting participation (e.g., one nurse might be designated to facilitate group attendance); however, no staff members should be discouraging or non-supportive of group participation.

Scoring notes:

Major violations of support for programming such as frequent non-essential interruptions of group limit scoring to **≤ 1.0.**

To justify a score of 2.0, almost all Veterans must receive active encouragement to attend programming from multiple disciplines and attempts are made to encourage participation in all or almost all groups.

2.0 Programming is fully supported

1.5 Programming is generally supported

1.0 Programming is evenly supported and not supported

0.5 Programming is generally NOT supported

0.0 Programming is NOT supported at all

15) High-Quality Programming

Group programming is designed and provided in a way that maximizes Veteran recovery through learning information pertinent to recovery, experiencing support from staff and fellow Veterans, processing their own recovery, and planning future directions. Programming meeting these goals can be varied in form and function (e.g., psychoeducational; skills-based; process; and occupation, recreational, or physical therapy groups).

Elements:

Indicators of high quality include:
- recovery-relevant topics/information
- group conducted at an appropriate level for the Veterans present
- material presented in multiple formats
- facilitation of interactive engagement
- materials/techniques that personalize information
- connection of information to on-going recovery activities

While little research exists testing specific group models in acute inpatient settings, adapting extant evidence-based practices (e.g., social skills training, illness management and recovery, wellness action recovery planning, etc.) for brief, inpatient stays may facilitate high quality programming.

Incorporation of elements of evidence-based models of psychotherapy (e.g., cognitive-behavioral, interpersonal, acceptance and commitment, etc.) may improve quality.

Ultimately, groups should be judged based on their anticipated impact on Veterans' recovery.

Scoring Notes:

Rate the quality of what is offered, even if it is low quantity.

2.0 Uniformly high quality (exceptions or deficits rare)

1.5 Generally high quality

1.0 Mixed quality

0.5 Generally poor quality

0.0 Uniformly poor quality

Milieu

16) Warm and Inviting Unit

Recovery-oriented care occurs in a health-promoting, safe, and comfortable physical environment. As noted in the mental health design guide, while safety is "always the most important criteria in a mental health care environment," [VHA Handbook 1160.06]. Veterans benefit from aesthetically pleasing environments.

Elements:

A safe and secure environment includes minimizing potential physical hazards, ensuring staff visibility and engagement with Veterans, using abuse-resistant materials, furnishings, and fixtures, and incorporating technologies that promote safety (e.g., pressure-sensitive door alarms).

A therapeutically enriching environment includes "home-like elements such as comfortable furniture, use of color, windows that provide natural light and access to nature or 'green' space, and artwork that highlights local scenery and activities."

The environment should also respect diversity of Veteran needs, for example, with appropriate accommodations for specific Veteran groups, including specific attention to safety, privacy, and dignity for female Veterans.

Environments should also attempt to reduce sensory stimulation (e.g., noise reduction, minimal overhead announcements, lighting modifications, a sensory modulation room).

Scoring Notes:

2.0 Very warm and inviting

1.5 Generally warm and inviting

1.0 Moderately warm and inviting

0.5 Somewhat warm and inviting

0.0 No sense of warm and inviting atmosphere

17) Autonomy-Promoting Milieu

The milieu should respect the dignity and autonomy of Veterans; behavior is restricted only to the extent that it is necessary for safety.

Elements:

Staff should encourage activity that is consistent with self-determination, where Veterans can choose bedtime and clothing. Because traditional norms emphasize wearing pajamas in hospital settings, Veterans may need encouragement to wear regular personal clothing and help overcoming barriers (e.g., access to laundry, verbal reminders, access to donated clothing).

Veterans should have access to snacks, resources and entertainment (e.g., books, games, TV), and fresh air, while respecting the safety and comfort of others on the unit.

An indicator of excellence may be that any behavior allowable outside the unit is also allowable for Veterans inside the unit unless there is an overriding concern for safety or counter-productivity for recovery.

Consideration should also be given to equitable application of restrictions, with exceptions given on a case-by-case basis (to ensure fairness, yet flexibility).

Positive indicators may include active efforts to provide liberties requested by Veterans (e.g., access to outside space, cell phones, etc.) while managing safety concerns.

Scoring Notes:

2.0 Veteran autonomy actively encouraged in all cases

1.5 Veteran autonomy is the norm, with minimal notable exceptions

1.0 An equal mix of autonomy and paternalism

0.5 Mostly paternalistic environment (minor tokens of individual freedom)

0.0 Fully paternalistic environment

18) Respectful and Therapeutic Interactions

Staff members have frequent and high-quality informal interactions with Veterans that encourage recovery.

Elements:

Positive indicators include emphasis on Veteran autonomy (e.g., "ultimately, this is your decision, I can't make the decision for you"), empathy, warmth, genuineness, and hope.

Staff have frequent interactions with Veterans. Staff are available for Veterans and responsiveness to Veterans' requests; however, interactions are not dependent on Veteran's initial contact (i.e., staff also initiate contact).

Staff-to-staff interactions, including both non-verbal and verbal, indicate a climate that supports all Veterans as people of agency who are autonomous adults. Staff members avoid stigmatizing and paternalistic language.

Scoring Notes:

While discussions with and in front of Veterans may be more heavily weighted, interactions during staffing, shift change, and other staff-to-staff interactions should also be considered as they are indicative of underlying climate and philosophy. For instance, "gallows humor" during shift change should negatively affect score.

If staff-Veteran interactions outside of formal clinical encounters are rare, **score ≤ 1.0.**

If there are serious violations to Veteran respect and/or highly stigmatizing language that is not adequately addressed, **score ≤ 0.5.**

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no respectful and therapeutic interactions

19) Behavior Managed Through Least Restrictive Means

Sites address problematic behaviors (e.g., aggression toward self, staff, or others) by using interventions that prioritize prevention, de-escalation, and that minimize use of seclusion and restraints of Veterans.

Elements:

Sites focus on the prevention of the use of seclusion and restraints (S/R) and have procedures to track, prevent, and reduce their use of seclusion and restraints.

Sites have specific policies directed at minimizing restraints and seclusion of Veterans. They have procedures in place to assess and address needs for seclusion/restraints.

Staff can successfully describe seclusion and restraints (prevention tools and report systematic use of these tools to prevent and reduce use of S/R. These may include: crisis plans, identification of triggers, transitional support to redirect and de-escalate problematic behaviors, comfort/quiet/sensory rooms, diversionary actions, etc.)

Sites require ongoing training and have dedicated/identified individuals to manage problematic behaviors in the unit.

Scoring notes:

Seclusion and restraints should be rare, and rates should be viewed in context of acuity of population.

Being able to directly observe behavior de-escalation supersedes other data for this item.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Least restrictive means are not used

Treatment Team

20) Multiple Disciplines Represented

The inpatient treatment team includes representatives from an adequate array of professional disciplines to address the essential elements of Veterans' recovery.

Elements:

Recovery-oriented care addresses multiple domains of a Veteran's life. In order to provide a coordinated, wholistic approach to recovery, care should be integrated across multiple disciplines (e.g., psychiatry, psychology, occupational/physical therapy, nursing, chaplain, peer support).

Objective representation: FTE dedicated to the unit.

Subjective adequacy of representation: Is the FTE dedicated to the unit commensurate with the basic fulfillment of that disciplines function on the unit?

Scoring notes:

Objective representation should include the FTE that is officially assigned AND the consistency with which that effort is given. For example, if an outpatient social worker is assigned to cover the unit .2 FTE, but rarely comes on his assigned day, the rater may deem the FTE to not count.

Subjective representation should be rated for each discipline. When the discipline is completely absent it should be rated 0. If the discipline is present, but core roles of this discipline cannot be accomplished due to lack of coverage, it should be rated a 1. For example, if nursing FTE is so low that Veteran's medication cannot be delivered in a timely fashion, nursing would receive a 1. However, if additional nursing FTE would allow for nurses to provide groups, nursing would still be rated as adequate because groups are not a core function of nurses on a unit.

Team Member Role	FTE	Subjective Adequacy 0- Absent; 1- Inadequate; 2- Adequate
*Psychiatrist/Psychiatric Prescriber		
*Nurses (RNs|Techs)		
*Psychologists/Therapists		
*Social Workers		
Pharmacist		
Peer		
Chaplain		
Physical Medicine/Rehab (OT/PT/RT/Nutrition)		

Core members are indicated by *

Scores are based on the average of all the subjective adequacy scores with hard thresholds:

If a core member is inadequate score ≤ 1.0.
If a core member is absent score ≤ 0.5.
If more than one core member is rated as inadequate score ≤ 0.5.
If more than one core member is absent score 0.0.

2.0 Average subjective adequacy = 2

1.5 Average subjective adequacy ≥ 1.5

1.0 Average subjective adequacy ≥ 1.0

0.5 Average subjective adequacy ≥ 0.5

0.0 Average subjective adequacy = 0

21) Peer Support Specialist

Provision of ongoing availability and involvement of people with lived experience in recovery from mental health and/or substance use issues hired explicitly to support recovery through the provision of peer support.

Elements:

Peer support is a critical part of recovery. As described in the VHA Peer Support Toolkit, "Peer Specialists promote recovery by sharing their own recovery stories, providing encouragement, instilling a sense of hope, and teaching skills to Veterans."

Although Peer Support Specialists do not provide psychotherapy in the VA, they can fulfill a number of important roles as described in the toolkit, including: facilitating peer support groups, sharing their own recovery stories, advocating for Veterans, serving as a role model, providing crisis support, communicating with clinical staff and serving as a liaison with the Veteran, providing outreach, and educating staff and Veterans about peer support.

Scoring notes:

In order to receive full credit, the peer support specialist should be considered an equal member of the treatment team, whose opinions are sought and valued, and the peer must be operating at the full scope of practice.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Peer support specialists are not used

22) Interdisciplinary Treatment Team

The perspectives and contributions of all disciplines are valued (i.e., everyone has a voice) during case conceptualization, treatment planning, discharge planning processes and are utilized as appropriate. The communication and interactions across the different disciplines of the team, as well as with the Veteran, are key to this item.

Elements:

The *represented disciplines meet with the Veteran in a single session* (i.e., interdisciplinary team meeting with the Veteran). Are they systematically meeting as a team, or are the disciplines meeting individually with the Veteran (or not at all)?

All *disciplines freely contribute to the discussion during the team meeting to develop a shared understanding of the Veteran*.

That shared *understanding of the Veteran goes beyond the team meeting and has an impact on the Veteran's treatment*.

Any *differences of opinion are resolved respectfully* and ideally, the Veteran has the final say when there is a conflict between staff about care. Respectful resolution is evidenced by team members maintaining professionalism when resolving conflicts (i.e., handling disagreements civilly as opposed to chastising or passive-aggressive behavior).

Scoring notes:

Sites will not be penalized twice if a certain discipline is unrepresented (e.g., due to staffing issues) since this should be reflected in the "Multiple Disciplines Represented" score.

When scoring, consider the treatment team meeting. Do all staff members spontaneously join in the discussion of case conceptualization, treatment options, and discharge planning during team meetings? Or conversely, is one person dominating the discussion with little regard for what others have to say?

Is there evidence of action being taken on the input from the various disciplines? Are various disciplines' ideas being put into motion?

If there is no interdisciplinary treatment team meeting **score ≤ 1.0.**

To receive a **1.5**, a site must systematically discuss all or almost all of the Veterans.

To receive a **2.0**, a site must include the Veteran in the interdisciplinary treatment team meeting.

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no interdisciplinary communication

23) Family/ Significant Other Involvement

Systematic and proactive engagement of significant others (as defined by each Veteran) to assist in treatment planning, treatment while on the unit, and discharge planning.

Elements:

Family/significant others (SO) should be involved at multiple junctures (e.g., treatment planning, treatment on the unit, and discharge planning). Active involvement from family or significant others should contribute to the understanding of the Veteran as a person. The involvement is meaningful and includes bi-directional exchange between family/significant others and providers. Veterans wishes for family/SO involvement should be respected; when Veterans reject the notion of family involvement, staff may facilitate brainstorming regarding other natural supports who may be involved.

Scoring Notes:

If family/significant others involvement is only included upon request, **score ≤ 0.5.**

If family/significant others involvement is only solicited as it fulfills a team need (e.g., coordinating living arrangements for discharge or travel home; only collateral information), **score ≤ 1.0.**

2.0 Excellent quality and consistency (deviations or deficits rare)

1.5 Good quality and consistency (some deviations or minor deficits)

1.0 Regular deficits in consistency *OR* quality

0.5 Regular deficits in consistency *AND* quality

0.0 Little or no family/significant others involvement