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Riverside County, California

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1141.01
Transmittal Sheet
January 31, 2007

HOME-BASED PRIMARY CARE PROGRAM

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook addresses the establishment, operation, and standards of VA Home-Based Primary Care (HBPC) programs.

2. SUMMARY OF MAJOR CHANGES. This is a new Handbook that incorporates the application process for new HBPC programs, revised standards, target populations, workload capture, data management, and web-based resources.

3. RELATED PUBLICATIONS. VHA Directive 1141 (to be published).

4. FOLLOW-UP RESPONSIBILITY. The Chief Consultant for Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Handbook. Questions may be addressed to 202-273-8543.

5. RECISSIONS. VHA Manual M-5, Part V, Hospital-Based Home Care, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for re-certification on or before the last working day of February 2012.

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Acting Under Secretary for Health

DISTRIBUTION: CO: E-mailed 2/2/2007
                FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 2/2/2007

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HOME-BASED PRIMARY CARE (HBPC) PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines standards and procedures for establishing and operating Home-Based Primary Care (HBPC) programs. It provides guidance for: identifying appropriate target populations, providing continuity across care settings, integrating HBPC with non-Department of Veterans Affairs (VA) home care, incorporating home care into medical education, improving quality of care, and meeting care needs through the end of life.

2. AUTHORITY

VHA is authorized to provide home care including HBPC to all eligible veterans under Title 38 United States Code (U.S.C.) 1717. Home care is a covered benefit for all eligible veterans, on par with all other medical services included in the Medical Benefits Package under Title 38 Code of Federal Regulations (CFR) 17.38 (a) (1) (ix).

3. BACKGROUND

a. HBPC began as a pilot project at six facilities in 1970 and became an established program in 1972. It was designed to serve the chronically ill through the months and years before death, providing needed long-term care services in the home. HBPC is a unique model of home care that is very different in target population, process, and outcomes from home care that is available under Federal and State programs such as Medicare and Medicaid. The HBPC model targets persons with complex chronic diseases that worsen over time and provides interdisciplinary care that is longitudinal and comprehensive rather than episodic and focused. HBPC provides cost effective primary care services in the home and includes palliative care, rehabilitation, disease management, and coordination of care.

b. The HBPC mission is to provide comprehensive, interdisciplinary, primary care in the homes of veterans with complex medical, social, and behavioral conditions for whom routine clinic-based care is not effective. The primary focus of HBPC is longitudinal care for complex chronic disabling disease.

c. HBPC targets frail, chronically ill veterans who require interdisciplinary health care teams, continuity, coordination of care, and the integration of diverse services to cover their complex medical, social, rehabilitative, and behavioral care needs. These veterans need comprehensive, longitudinal home care services, as they age, to maximize function, minimize institutionalization, and maintain quality of life.

d. HBPC was implemented first in VHA's largest teaching facilities. The program has successfully expanded to over 100 sites both rural and urban, and serves as a major training site for health profession students. HBPC is a unique model of non-institutional long-term care and an important part of VHA's array of services designed to meet the care needs of the increasing number of veterans with complex chronic disease who require attentive management throughout

the remainder of life. HBPC provides the needed care and management in harmony with VHA's acute care services thus avoiding duplication and reducing total health care expenditures.

4. DEFINITIONS

a. **HBPC.** HBPC is comprehensive, longitudinal primary care provided by a physician-supervised interdisciplinary team of VA staff in the homes of veterans with complex, chronic, disabling disease for whom routine clinic-based care is not effective.

b. **Longitudinal Care.** Longitudinal care is routine care and the continuous provision of services that involve ongoing monitoring, routine comprehensive assessment, coordination of care, prevention or early detection of worsening condition, and timely interventions delivered throughout the protracted course of chronic disease. This is in contrast to episodic care that is provided only at intervals of disease presentation or exacerbation.

c. **Veterans for Whom Routine Clinic-based Care is not Effective.** Veterans for whom routine clinic-based care is not effective may include those with:

(1) Impaired mobility due to disability or functional limitation making it difficult to leave home without the assistance of a device or another person.

(2) Inability to cope with clinic environment due to cognitive, physical, or psychiatric impairment.

(3) Need for frequent coordinated interventions from multiple disciplines.

(4) Recurrent hospitalizations or urgent care episodes.

d. **Home.** Home is defined as the place where a veteran resides, excluding a nursing home.

e. **Caregiver.** Caregiver is defined as a person related to or associated with the veteran, who routinely performs or assists in the care of the veteran in the veteran's home.

5. SCOPE

a. HBPC is a home care program designed to meet the longitudinal, primary care needs of an aging veteran population with complex, chronic, disabling disease. In contrast to the episodic, time-limited and focused skilled care services reimbursed by other funding mechanisms such as Medicare, HBPC provides comprehensive longitudinal care of the patient often for the remainder of their life.

b. HBPC is patient centered. The unit of care is the patient and the caregiver, if present. Their needs and preferences guide the goals of the care and treatment plan.

c. HBPC targets primarily the following three types of patients in need of home care:

(1) Longitudinal care patients with chronic complex medical, social, and behavioral conditions, particularly those at high risk of hospital, nursing home, or recurrent emergency care.

(2) Longitudinal care patients who require palliative care for an advanced disease that is life limiting and refractory to disease-modifying treatment.

(3) Patients whose home care needs are expected to be of short duration or for a focused problem, when such services best help the facility meet the needs of this population.

6. GOALS

The goals of care for HBPC patients include:

a. Promoting the veteran's maximum level of health and independence by providing comprehensive care and optimizing physical, cognitive, and psychosocial function.

b. Reducing the need for, and providing an acceptable alternative to, hospitalization, nursing home care, emergency department and outpatient clinic visits, through longitudinal care that provides close monitoring, early intervention, and a therapeutic safe home environment.

c. Assisting in the transition from a health care facility to the home by providing patient and caregiver education, guiding rehabilitation and use of adaptive equipment in the home, adapting the home as needed for a safe and therapeutic environment, and arranging and coordinating supportive services including home Telehealth, as appropriate.

d. Supporting the caregiver in the care of the veteran.

e. Meeting the changing needs and preferences of the veteran and family throughout the course of chronic disease, often through the end of life.

f. Enhancing the veteran's quality of life through symptom management and other comfort measures.

g. Allowing the veteran the option of dying at home rather than in an institution.

h. Helping the veteran and family cope with all elements of chronic disease.

i. Promoting an enduring network of skilled home care professionals by providing an academic and clinical setting for health care trainees to experience interdisciplinary delivery of primary care in the home.

7. APPLICATION PROCESS FOR SANCTIONED VA HBPC PROGRAMS

a. Proposals for sanctioned VA HBPC programs are to be submitted to the Director of Home and Community-based Care in VA Central Office (114), who makes the determination of standards and sanctioned status of VA HBPC programs.

b. Critical elements in the proposal include:

(1) A description of the proposed program, with attention to the program elements that are in paragraph 8.

(2) A depiction of the interdisciplinary team as described in this Handbook, and a description of the responsibilities of each team member. The specified responsibilities of the clinical members include home visits and attendance at interdisciplinary team meetings.

(3) A listing of each HBPC position and the respective Full-time Equivalent (FTE) staff devoted to HBPC. VA standards call for at least three FTE direct-care nursing staff, the minimum needed for adequate coverage in starting a small program. The HBPC program staff must include administrative and clerical support.

(4) Confirmation of 24-hour telephone coverage for HBPC, specifying daytime coverage by the HBPC clerical position and the plan for coverage during off-duty hours.

(5) Stipulation for interdisciplinary team meetings held at least weekly.

(6) Evidence of facility support including information technology, vehicles, and space.

8. HBPC PROGRAM STANDARDS

a. Principle requirements of VA HBPC programs include:

(1) An interdisciplinary team consisting of specified staff, each with sufficient dedicated time for HBPC as part of their position description or functional statement. The interdisciplinary team includes a physician medical director, a program director, and staff from nursing, social work, rehabilitation (Physical Therapy, Occupational Therapy or Kinesiotherapy), dietetics, and pharmacy. Other services frequently needed include pastoral care and mental health. A minimum of three FTE direct-care nursing staff is required for a program of any size.

(2) Caseload is to be determined locally as it is dependent on many factors, including geography, driving times, coverage area, patient complexity, patient and staff turnover rate, staff experience, team composition, pharmacy support, medical record sophistication, and HBPC program support including vehicles, computers, and a staff support assistant.

(3) Experience and a detailed analysis indicate that appropriate maximal caseloads per FTE are in the range of 20 to 30 patients for a nurse (Registered Nurse (RN) or licensed practical nurse (LPN)), 80-105 for a social worker, 85 to 115 for a rehabilitation therapist, and 95 to 125 for a dietitian. Nurse practitioners may be able to effectively manage a caseload of up to 34 patients per FTE, and a range of 70 to 90 if assisted by two RNs or LPNs covering the same patients. *NOTE: These recommended caseload ranges are guidelines for upper limits. Programs have experienced negative consequences with provider caseloads below the highest number in each range. A range is provided because the limits of caseload are dependent upon the caseload determinants described in subparagraph 8a(2).*

(4) Targeting of patients with complex, chronic disabling disease is encouraged, thereby discouraging a caseload higher than the preceding guidelines.

(5) The members of the interdisciplinary team meet at least weekly as a team to discuss specific patients, direct their care, and formulate care plans.

(6) Comprehensive primary care provided directly by VA HBPC team staff.

(7) VA Physician oversight with participation in care planning and interdisciplinary team meetings.

(8) Support staff in place for administrative as well as clinical demands. This must include dedicated clerical support for the HBPC Program.

(9) Resources designated for the support of the HBPC Program. This must include space, medical and information technology equipment, and vehicles for the daily use of HBPC team members.

(10) Meets home care accreditation standards. All HBPC programs are required to meet VHA standards, the home care standards of an accreditation organization that has deemed status for Medicare home care, and the home care standards necessary for hospital accreditation of the parent facility.

(11) Local policy documents are in place covering the following items:

(a) Local HBPC Policy Memorandum. A facility or health care system Policy Memorandum which outlines the requirements, policies and procedures necessary for the operation of the HBPC Program is to be issued by the facility or health care system Director. Among the elements to be covered in this memorandum are: the delegation of authority to the HBPC Program Director, organizational placement of the program, lines of authority, scope of program services, and referral, admission and discharge procedures.

(b) Local HBPC Policy and Procedure Manual. A policy and procedure manual is developed by the HBPC team to define and govern the clinical and administrative aspects of the program at the facility. This manual is a dynamic document that reflects local team practices. It is to be reviewed and revised by the team as needed, but no less frequently than every 3 years. This manual is to be reviewed and approved by the HBPC Program and Medical Directors and the facility Director or designee. Some of the required policy elements include: patient and staff safety, environmental safety, emergency preparedness, medication management, infection control in the home, death in the home, awareness of do not resuscitate (DNR) regulations in the local community, confidentiality, and information security.

(c) HBPC Patient Rights and Responsibilities. Patients in the HBPC Program have the same rights and responsibilities as other patients in the VHA system (see IB-190). Every effort is to be made to ensure that the patients understand and exercise their rights and responsibilities in relation to their own care. In the event that the patient lacks decision-making capacity, a surrogate decision maker must be identified consistent with 38 CFR 17.32.

(12) A facility HBPC patient information handbook provided to each patient upon admission to the HBPC Program. This handbook is to contain at a minimum:

(a) Names of HBPC team members and office telephone numbers.

(b) An explanation of the HBPC Program, its capabilities and limitations.

(c) HBPC patients' rights and responsibilities, including the complaint process.

(d) Specific instructions for accessing care during and after the regular hours of operation of the HBPC Program.

(e) Procedures to follow in the event of a disaster or medical emergency.

(f) Any co-payments, if applicable.

b. The HBPC Program provides primary care services that are accessible, comprehensive, coordinated, longitudinal, accountable, and acceptable:

(1) **Accessible.** The HBPC patient, and caregiver if present, has access to the HBPC providers and explicit provisions have been made for emergencies during the night, weekends, and holidays.

(2) **Comprehensive.** The HBPC team provides health care in a holistic manner and is able to treat and manage the majority of health problems that arise in the HBPC population.

(3) **Coordinated.** The HBPC team coordinates the patient's care across all settings to provide continuity of care by: referring patients to the appropriate services; collaborating and communicating pertinent information with the patient's primary care providers and specialists; and explaining and teaching about the disease, treatment, and self care to the patients and caregivers.

(4) **Longitudinal.** Regular visits over time from the HBPC team and maintenance of complete medical records that are regularly reviewed and used in planning care.

(5) **Accountable.** The HBPC team implements a performance improvement program that tracks and evaluates services and outcomes. The HBPC performance improvement program fully integrates with that of the facility or health care system. Attention must be devoted to resource management and the provision of cost efficient care.

(6) **Acceptable.** The HBPC patient, and caregiver if present, agrees to receive HBPC services and to participate in the development of the goals of care and an individualized treatment plan.

9. RESPONSIBILITIES OF THE FACILITY DIRECTOR

a. The VHA facility or health care system Director and Chief of Staff designate the HBPC Program Director who must be a health care professional with demonstrated ability and competence in patient care, interpersonal relationships, communication, customer service, and program administration

b. The VHA facility Director delegates the management of the program to the HBPC Program Director. Program management encompasses all assigned settings including outreach expansions. Management functions include: planning, directing, budgeting, evaluating and tracking the program, and developing VHA and community relationships.

10. RESPONSIBILITIES OF THE HBPC PROGRAM DIRECTOR

The HBPC Program Director is responsible for:

a. Directing the clinical services offered by the program to ensure that the program is in compliance with local and national VHA standards and policies as well as accreditation standards for home care organizations.

b. The development and continued effective functioning of the interdisciplinary health care team. The skills, knowledge, and contributions of each team member are recognized and utilized.

c. Collaborating with other HBPC Program Directors, Veterans Integrated Service Network (VISN) leadership and VA Central Office staff on issues of program development.

d. Providing direction and team leadership to include:

(1) Interpreting and communicating VA policies to the HBPC team and the VHA facility, as well as non-VA national, state, and local home care policies to facilitate the interface with non-VA care providers.

(2) Assisting the team in developing and implementing local HBPC policies and procedures to include performance improvement, patient safety, utilization review, emergency preparedness, and staff safety.

(3) Evaluating the effectiveness of the HBPC Program.

(4) Managing human resources for the HBPC Program including: selecting qualified staff in collaboration with the HBPC Medical Director, orienting and mentoring the staff, and promoting staff development and professional growth to ensure competency.

(5) Coordinating student educational programs.

(6) Managing and tracking program resources.

    (7) Processing, assigning, and tracking referrals to HBPC, and ensuring timely access to HBPC.

    (8) Managing the Electronic Wait List (EWL) for HBPC referrals.

    (9) Collaborating with the Office of Information Technology to ensure accurate reporting of HBPC clinical, administrative, and workload data.

11. RESPONSIBILITIES OF THE HBPC MEDICAL DIRECTOR

    The HBPC Medical Director, appointed by the Chief of Staff, must be a physician who is responsible for the overall medical care delivered by the HBPC team. ***NOTE: In facilities with academic affiliations, the HBPC Medical Director is encouraged to have a faculty appointment and be involved in academic activities.*** The HBPC Medical Director is responsible for:

    a. Collaborating with the HBPC Program Director to:

    (1) Provide leadership to the HBPC Program.

    (2) Plan and direct the educational and clinical experience of medical students, residents, and fellows assigned to the HBPC Program.

    (3) Assume a leadership role in the development and implementation of HBPC's performance improvement plan.

    (4) Advocate for HBPC with VHA leadership and the medical community.

    (5) Jointly select HBPC team members.

    b. Providing clinical input and oversight for all patient treatment plans.

    c. Being readily available to the team members for collaboration when medical or other problems arise.

    d. Participating in HBPC team meetings.

    e. Keeping the HBPC team apprised of medical care advances and practice standards.

    f. Arranging physician coverage and communicating the plan of coverage to the HBPC team.

    g. Serving as back-up for other HBPC team physicians.

    h. Collaborating with other HBPC Medical Directors, VISN leadership, and VA Central Office staff on program development issues.

12. RESPONSIBILITIES OF THE HBPC TEAM PHYSICIAN

The HBPC team physician(s), who may or may not be the Medical Director, in collaboration with the HBPC team is responsible for:

a. Assuming primary medical responsibility for their assigned HBPC patients.

b. Identifying the patients' medical problems.

c. Defining the medical management of these problems.

d. Determining the need for consultation from medical, surgical, and/or psychiatric subspecialty clinics.

e. Determining the need for, and facilitating, admission to the hospital.

f. Visiting the HBPC patients at home, when appropriate.

g. Serving as collaborator for advanced practice nurses and physician assistants.

h. Providing medical administrative support such as signing forms requiring physician signature for the HBPC patients.

13. THE INTERDISCIPLINARY TEAM

a. Because of the diverse array of professional services required to effectively treat and manage the complex health problems of chronically or terminally ill patients, HBPC is provided directly by an interdisciplinary team. This team promotes collaboration and coordination among all team members. The HBPC team members work interdependently in assessing, planning, problem solving, decision-making, and implementing team tasks.

b. The core HBPC team is comprised of physician, nurse, social worker, rehabilitation therapist, pharmacist, and dietitian. Other disciplines are often helpful and may be included, such as a chaplain, physician assistant, psychologist, or psychiatrist. *NOTE: The staffing mix and FTE must be adequate to manage the needs of the patient population.*

c. All HBPC staff must possess certain qualifications and competencies unique to the home care setting and the population served, which include:

(1) Demonstrated clinical competencies in such areas as age-specific care, cultural assessment, and health education.

(2) An ability to effectively function autonomously, as well as a member of an interdisciplinary team.

(3) Respect for cultural and spiritual values.

(4) A commitment to discipline-specific standards of practice, including: ethical conduct, the primary care delivery model, chronic disease management, palliative care, principles of care management, a holistic framework of practice, and geriatric care skills.

d. All clinical HBPC Team members are expected to:

(1) Determine the appropriateness of patients for admission into the HBPC Program.

(2) Help develop patient treatment plans based on a comprehensive interdisciplinary assessment of the patient and the caregiver.

(3) Implement the patient's treatment plan through home visits, as needed.

(4) Review the patient's progress as a team at regular intervals, at least every 90 days, or when there is a change in the patient's condition.

(5) Assess and support the caregiver's capability to continue to provide care.

(6) Educate the patient and the caregiver.

(7) Coordinate the process of care with the other team members to maximize efficiency.

(8) Assess the patient's continuing need for HBPC care, and plan for HBPC discharge when indicated.

(9) Document all patient care activities in a timely manner.

(10) Identify areas for continuing education and participate in in-service training.

(11) Participate in developing and implementing the performance improvement plan.

(12l) Instruct students of various disciplines in the challenges encountered in delivering health care in the home setting.

(13) Serve as a role model in the effective operation of an interdisciplinary team.

(14) Participate in the development and periodic review of the local HBPC Policy and Procedure Manual.

(15) Utilize VHA and community resources as appropriate.

(16) Participate in HBPC team meetings

14. RESPONSIBILITIES OF THE HBPC REGISTERED NURSE (RN)

The RN functions as a care manager for the HBPC assigned veterans, and is responsible for:

a. Assessing and continually reassessing the needs of veterans and caregivers.

b. Delivering nursing care in the home.

c. Delegating and supervising the care by LPNs or vocational nurses, and home health technicians, if applicable.

15. RESPONSIBILITIES OF THE HBPC ADVANCED PRACTICE NURSE (APN)

The APN performs all of the functions of the RN and, in addition, collaborates with the HBPC team physician. The APN is responsible for:

a. Assuming primary medical responsibility for their assigned patients.

b. Identifying the patients' medical problems and defining the medical management.

c. Prescribing medications and treatment in accordance with their individual scope of practice.

d. Determining the need for consultation from subspecialty clinics.

e. Determining the need for and facilitating admission to the hospital.

16. RESPONSIBILITIES OF THE HBPC PHYSICIAN ASSISTANT (PA)

The HBPC PA must be under the supervision of the HBPC physician; the PA:

a. Functions as a care manager with primary medical responsibility for their assigned patients.

b. Delivers care in the home.

c. Assesses care needs of patients and caregivers.

d. Identifies and defines the medical management of patients' medical problems.

e. Determines the need for consultation from subspecialty clinics.

f. Determines the need for, and facilitates admission to the hospital.

17. RESPONSIBILITIES OF THE HBPC SOCIAL WORKER

The HBPC Social Worker is responsible for:

a. Performing initial and on-going assessment of the interpersonal resources and psychosocial functioning of the veteran, the caregiver, and their support system.

b. Identifying psychosocial problems.

c. Providing psychosocial treatment, which may include individual and family counseling, long-term care and advance care planning, non-pharmacological pain interventions, and grief and bereavement counseling.

d. Coordinating discharge planning for HBPC patients.

e. Collaborating with other health professionals on behalf of the veteran and caregiver.

f. Supervising the social work students assigned to the HBPC Program.

g. Maximizing the VHA and non-VHA resources available to veteran and caregiver.

h. Keeping the HBPC team informed of available VHA and community resources.

18. RESPONSIBILITIES OF THE HBPC DIETITIAN

The HBPC Dietitian is responsible for:

a. Performing the initial and ongoing assessments of the patient's nutritional status.

b. Recommending to the veteran special diets and dietary modifications and educating the veterans regarding the same.

c. Monitoring for food and drug interactions.

d. Assessing the adequacy of the caregiver's capacity to prepare recommended meals.

e. Contributing to optimal disease management by educating the veteran, caregiver, and staff in:

(1) The role of nutrition in the veteran's diseases,

(2) The therapeutic benefits of specific dietary choices, and

(3) Effective ways of managing identified nutritional problems.

f. Supervising the dietetic students and interns assigned to the HBPC Program.

19. RESPONSIBILITIES OF THE HBPC REHABILITATION THERAPIST

The HBPC rehabilitation therapist is responsible for:

a. Performing the initial and ongoing assessments of the veteran's functional status.

b. Evaluating the veteran's home for the structural modifications needed to make the home environment safe and accessible, and performing the initial and ongoing assessments of safety in the home environment.

c. Determining the need for home medical equipment (HME).

d. Teaching and monitoring the safe use of HME devices.

e. Reporting equipment problems to the Prosthetic and Sensory Aids Service.

f. Teaching body mechanics to the caregiver to minimize risk of injury.

g. Establishing a therapeutic program for the veteran and caregiver to maximize or maintain the veteran 's functional status, and monitoring the response.

h. Supervising rehabilitation therapy students assigned to the HBPC Program.

i. Collaborating with the team physician on patient needs for consultation with other rehabilitation services.

20. RESPONSIBILITIES OF THE HBPC CLINICAL PHARMACIST

The HBPC clinical pharmacist is responsible for:

a. Performing initial and periodic assessment of medication therapy, with monitoring as needed.

b. Identifying patient-specific medication issues, including drug interactions, adverse effects, efficacy, appropriateness, and compliance problems.

c. In collaboration with other HBPC staff, educating the veterans and caregivers regarding the proper use of medications.

d. Participating in HBPC patient care conferences and making recommendations for medication regimen changes.

e. Recommending medication education materials for HBPC use.

f. Providing medication information to other HBPC team members.

g. Supervising pharmacy trainees assigned to the program.

21. RESPONSIBILITIES OF THE HBPC PROGRAM SUPPORT ASSISTANT

The HBPC Program Support Assistant is responsible for:

a. Managing the daily operation of the HBPC office

b. Serving as an administrative assistant to the HBPC Program Director

c. Answering and triaging incoming calls from HBPC veterans, families, and medical staff.

d. Being aware of daily staff schedules, and contacting staff, as indicated, to respond to patient care calls.

e. Scheduling appointments and travel for veterans needing care at the VA facility.

f. Maintaining all records pertaining to the HBPC Program

g. Compiling data for statistical reports and cost accounting.

22. PROGRAM OPERATION PROCESSES

a. **Organization of HBPC.** HBPC is an interdisciplinary home health care program. Nationally, HBPC is managed under the Office of Geriatrics and Extended Care, and is recommended to be under the direction of the Associate Chief of Staff for Geriatrics and Extended Care. If such a position does not exist at the facility, HBPC can function effectively under the Chief of Staff, the Associate Chief of Staff for Ambulatory Care, the Chief of Medical Service, or a Care Line Director.

b. **Orientation and Continuing Education of HBPC Team Members.** New HBPC team members must be oriented to ensure understanding of the goals, objectives, and procedures utilized by the HBPC Program. The facility HBPC Policy and Procedure Manual serves as the basic orientation guide. Both the orientation and continuing education program of HBPC team members must regularly address infection control in the home, basic home safety, emergency preparedness, HBPC patients' rights and responsibilities, information security, confidentiality, and pain management. In addition, all HBPC team members are responsible for maintaining their discipline's continuing education requirements for licensure and/or certification and any mandatory VHA education requirements. *NOTE: Orientation materials are available on the Home and Community-Based Care Website http://vaww.va.gov/hcbc.*

c. **Referral.** Veterans who require the services of HBPC may be referred from any setting, including hospital, outpatient, or nursing home, providing the veteran's primary care provider concurs. Referrals for HBPC must be submitted through the appropriate referral process using the VA Form 10-0415, VA Geriatrics and Extended Care (GEC) Referral.

d. **Determination of Patient Appropriateness for Home Care.** Before the veteran is admitted to HBPC, the veteran must be evaluated by at least one HBPC team member. If the veteran and the home situation are found to meet HBPC admission criteria and are deemed appropriate, the veteran is accepted in the HBPC Program. If not, the HBPC team makes recommendations regarding an alternate plan for managing the veteran's care needs.

e. **Informed Consent.** The accepted veteran and caregiver must be oriented to HBPC. A full explanation of the program, its objectives, capabilities, and limitations are provided to the

veteran and the caregiver verbally and in the facility handbook. This counseling and the veteran and/or caregiver's acceptance constitute informed consent of the veteran to participate in the HBPC Program and must be documented in the veteran's medical record.

    f. **Assessment of Patients.** After deemed appropriate for admission to the program, all veterans undergo a comprehensive assessment (health history, physical, psychosocial, financial, cultural, spiritual, nutritional, functional, home environment, pain, etc.). The longitudinal patients, who comprise the majority of HBPC patients, require an interdisciplinary assessment by at least three disciplines in the veteran's home.

    g. **Treatment Planning.** Following the initial assessment of new patients by the different disciplines, the HBPC team develops the patient's interdisciplinary treatment plan during a formal team meeting. At these weekly team meetings, the team works collaboratively and interdependently under the direction of the HBPC Program and Medical Directors. The treatment plan for each veteran includes all problems identified by the members of the team, medication profile, and measurable objectives with specific methods including the responsible team member. All team members responsible for the veteran, including the HBPC physician, sign the treatment plan. The veteran's treatment plan is individualized, based upon the veteran's and the caregiver's goals, and constitutes the physician's orders for care. *NOTE: Participation of the veteran and the caregiver in the development of the treatment plan is essential.*

    h. **Delivery of Care.** HBPC staff provides direct care in the veteran's home, based upon the treatment plan, and promotes a therapeutic home environment. Duration of care and frequency of home visits are determined by veteran needs and clinical judgment.

    i. **Patient Education.** HBPC teams must educate the veteran and the caregiver on the treatment plan. The team must delineate the roles and responsibilities of the team, the veteran, and the caregiver in the implementation of the plan.   The veteran and the caregiver are responsible for the routine daily care of the veteran. In the event that the veteran and/or the caregiver cannot provide all of the needed care for the veteran, the HBPC team assists in mobilizing community and/or VHA resources.

    j. **Treatment Plan Review.** The treatment plan is reviewed and modified by the team as the health condition of the veteran changes, but no less frequently than every 90 days. Team meetings are conducted on a weekly basis to write treatment plans for new patients and review treatment plans for established patients.

    k. **Integration with non-VA Home Care Services.** When the home care needs of an HBPC patient exceed the ability of the HBPC team and the veteran chooses to remain in the home, other home care services may be provided concurrently, provided that there is no duplication of services.   For example, if the veteran needs home hospice care, home health aide, or an intensity of skilled care services that the HBPC Program cannot provide, options for additional VA-purchased and non-VA services are offered to the veteran. The veteran has the right to choose the payer. If Medicare skilled home care or Medicare-Medicaid home hospice services are provided concurrently with HBPC, the role of HBPC will be medical management, or other services that are not covered by the agency providing non-VA home care.

l. **Admission to HBPC.** Each of the following factors must be considered in determining whether the veteran is appropriate for admission to the HBPC Program:

(1) Veteran is enrolled for VHA care.

(2) Veteran lives within HBPC's service area designated by each health care facility.

(3) Veteran has complex chronic disabling disease that necessitates care by an interdisciplinary team

(4) Veteran and/or caregiver accept HBPC as the primary care provider

(5) Veteran's care needs can be met by HBPC Program.

(6) Veteran has an identified caregiver, if the need for one is determined by the HBPC team.

(7) The veteran's home is the most appropriate venue for care as determined by the HBPC team.

(8) The veteran 's home environment is safe for the well-being of the veteran, the caregiver, and the HBPC team members.

(9) Veteran is included in one of the populations targeted by HBPC as:

(a) Veterans who have complex chronic disease not managed effectively by routine clinic-based care.

(b) Palliative care patients with advanced disease.

(c) Veterans whose home care needs are expected to be of short duration or for a focused problem, when such services best help the facility meet the needs of this population.

(10) Veteran is at high risk of recurrent hospitalization and emergency care or nursing home placement. These patients are high utilizers of health care resources (e.g., two or more hospital admissions or emergency department visits in the last 6 months, or multiple unscheduled clinic visits) <u>and</u> have one or more of the following diagnoses:

(a) Congestive Heart Failure;

(b) Chronic Obstructive Pulmonary Disease;

(c) Neurological disease (Parkinson's, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, stroke, dementia, etc.);

(d) Diabetes Mellitus;

(e) Coronary Artery Disease;

(f) Cancer;

(g) Acquired Immunodeficiency Syndrome (AIDS); and/or

(h) End-stage liver disease.

m. **Discharge from HBPC**. The decision to discharge a veteran is made by the team. The date of discharge, the name of the provider from whom the veteran will receive future care, and the overall status of the veteran at discharge must be documented in the medical record. The veteran and the caregiver participate in the discharge planning process. The HBPC team furnishes information about the status of the veteran and collaborates with the staff of the VHA medical center or non-VHA providers to ensure a smooth transition. Circumstances under which veterans are discharged from HBPC include:

(1) Veteran death.

(2) Veteran is an inpatient in a hospital or nursing home for 16 or more consecutive days. This is independent of VA or non-VA setting and of reason for admission. On inpatient day 16, the veteran is to be discharged from HBPC unless discharged from inpatient care to home that day.

(3) Veteran has reached maximum benefits from the program and can be effectively managed through routine clinic-based care.

(4) Veteran's care needs exceed the capability of the HBPC Program.

(5) Veteran and/or caregiver request discharge from the HBPC Program.

(6) Veteran and/or caregiver are not participating in a significant portion of the treatment plan. This on-going lack of participation must be documented in the patient's medical record. *NOTE: Prior to discharge, staff must consider evaluation for dementia, depression, and substance abuse.*

(7) Veteran's home environment is unsafe for the veteran, or for the HBPC team members.

(8) Continuation of home care is deemed by the HBPC team to be unsafe for the veteran or caregiver, relative to other available options.

(9) Veteran moves out of the HBPC service area.

n. **After Office Hours Coverage.** Each HBPC Program must have a policy providing for the care of patients at other than the regular hours of program operation. HBPC patients and their caregivers must be given, verbally and in the facility's handbook, specific instructions regarding how to access care at all times (during and outside regular hours of program operation). Some HBPC programs have established 24-hour coverage, others refer patients to

specific units at the medical center, and some advise patients to report to the medical center's emergency department or ambulatory care clinic if problems arise after office hours.

    o. **Waiting Lists**

    (1) Every effort is to be made to provide needed HBPC in a timely manner; home care is a covered benefit for all enrolled veterans, delays in care often lead to more costly emergency and hospital care.

    (2) When enrollment into HBPC must be delayed, veterans are to be entered into the EWL using Decision Support System (DSS) codes. Waiting lists are to be routinely monitored by the HBPC Program Director and HBPC Medical Director, and reported at least quarterly to the facility Director.

    (3) VA facilities must utilize EWL to capture veterans in need of and seeking HBPC services.

    (4) All HBPC programs must activate and implement the EWL system, as delineated in current VHA EWL policies (see the EWL manuals located on http://www.va.gov/vdl for complete instructions on software setup and usage).

    (a) Appointment Management EWL software must be in HBPC package at each facility

    (b) IRM is to activate "Report option" for 170-177 series DSS identifiers and assign necessary Security Key(s), so that HBPC staff can use EWL.

    (c) Any HBPC provider may enter into EWL; facilities may determine which HBPC providers will do EWL entry and management.

    (5) All referrals and consults to HBPC must be acted on within 7 business days of the request, through one of the following three options:

    (a) Complete consult or referral documentation within 7 business days. This is achieved by either admitting the veteran into HBPC, or deeming the veteran inappropriate for HBPC with this response written in a consult.

    (b) Schedule a home visit to occur within 30 calendar days of request, if the veteran cannot be seen within 7 business days (examples are: staffing limitations, or veteran in hospital at time of referral).

    (c) Place the veteran on the EWL if a home visit is not scheduled to occur within 30 calendar days of request, or if the consult is still pending review after 7 business days from the date of the consult. The veteran must be placed on the EWL and the consult is to be marked "Received/Active." *NOTE: If the veteran is an inpatient and not near hospital discharge at the time of consult, the consult may be completed by requesting repeat consult when hospital discharge is anticipated within 7 days.*

(6) Veterans must be scheduled for HBPC visits based on the priorities and guidelines delineated in EWL policies.

(7)   All HBPC programs must enter patients into the EWL and manage the EWL under the following guidelines:

(a) Any veteran referred to HBPC who cannot be scheduled for HBPC visit within 30 days of referral, or whose consult is not acted upon within 7 business days of request is to be placed on EWL.

(b) Any veteran already enrolled in HBPC who cannot be scheduled for home visit within 30 days of desired date, or the date set by clinician in conjunction with the veteran, based on clinical need and urgency, is to be placed on EWL.

(c) All veterans must be notified in writing when placed on the EWL. ***NOTE: Guidance and template are in EWL policies.***

(d) Veterans on HBPC EWL are to be removed from EWL as delineated in EWL policies.

(8) Mechanisms must be in place at each facility to monitor the following:

(a) Review and management of EWL in order to disposition patients in a timely manner. It is recommended that the list is reviewed at least once a week.

(b) Time in queue for HBPC patients awaiting first appointment.

(c) Number of HBPC patients on the wait list.

(d) Number of service connected veterans appropriate for HBPC, but receiving VA-purchased care due to HBPC appointment unavailability.

(e) HBPC patients remaining on the EWL until they have been seen, at which point they will be removed from EWL.

p. **Absent Sick in Hospital (ASIH) Status**

(1) When HBPC patients are admitted to a hospital or nursing home with anticipated stay of 15 days or less, they are placed in ASIH status. On the 16th day patients are to be discharged from HBPC, unless discharged from inpatient care to home that day. Information about the treatment plan and course of care in the home are to be furnished to the inpatient and/or nursing home staff. While hospitalized, the HBPC team is to provide follow-up contacts with the veteran and the caregiver, as feasible.

(2) If the veteran is discharged from and later readmitted to HBPC, the interdisciplinary assessment is repeated and the process of care begins anew.

q. **Cooperation, Collaboration, and Consultation with Other Services**

(1) The HBPC team routinely cooperates and collaborates with ancillary services to obtain needed services and procedures for HBPC patients.

(2) Health problems of the HBPC patient population often include mental health components. A liaison with Mental Health and Behavioral Science Service is to be sought to facilitate assessment and treatment of these problems. An ongoing consultative relationship is to include continuing education for the team members, consultation regarding assessment and treatment of individual patients, or family members, and indications and procedures for obtaining direct mental health treatment.

(3) Provision of 24-hour continual care is stressful to family caregivers. A plan for providing caregivers with intermittent, short-term respite may reduce this stress, facilitating the care of the patient in the home. Respite care may be provided in accordance with VHA Handbook 1140.2 and VHA respite policies.

(4) Personal care services for HBPC patients may be obtained from multiple sources. VA Homemaker-Home Health Aide (H/HHA) Program is a resource that can be arranged by the H/HHA Coordinator. Other resources include private pay, the state Medicaid Waiver program, and locally-administered aging programs.

(5) Skilled home care services may be needed beyond the scope or frequency that HBPC can provide. If the veteran wants to remain at home, VA must offer to pay for or provide the needed concurrent services. A veteran dually eligible for these services under both VA and Medicare has the right to choose VA or Medicare as payer. Home care services concurrent with HBPC may be provided through VA-purchased care, Medicare or other payer as long as they do not duplicate services provided by HBPC.

(6) Palliative care is an important aspect of HBPC. Ongoing collaboration is to occur between facility palliative care services and HBPC. This palliative care component of HBPC is to include a continuing education program for the team members and access to palliative care consultation. HBPC programs are to maintain a collaborative relationship with community hospice agencies, as many patients may choose to receive hospice care from community hospice services.

(7) Care Coordination and Home Telehealth Program integration is encouraged as appropriate to enhance HBPC's capacity to manage complex patients in the home setting and extend HBPC's service area.

(8) Other VHA medical resources are available through consultation. Developing relationships with these specialty services serves to enhance HBPC's capacity to manage complex patients in the home setting.

(9) **Volunteer Services.** HBPC programs utilize volunteers through the VA Voluntary Service, and other community organizations such as the Senior Companion Program. Volunteers must be trained and competent to perform their assigned activities. HBPC staff must provide

oversight of the volunteers and, at a minimum, biannual observation of the interaction with the patient in the home.

r. **Teaching Program**

(1) The HBPC Program provides unique educational experiences for fellows, residents, and students of various health professions including medical, nursing, social work, nutrition, pharmacy, and rehabilitation therapy trainees. The HBPC Program provides the trainee with the opportunity to observe and participate in an interdisciplinary team, as well as to experience the major care issues of this country's aging population, such as chronic progressive disease management, palliative care, and long-term care economics.

(2) The HBPC Program Director and Medical Director are encouraged to seek educational affiliations with the various professional schools through the promotion of the HBPC program's training opportunities.

(3) Curriculum guidance for home care training is available on the VA Home and Community-based Care Website at: http://vaww.va.gov/hcbc. Select "HBPC" and "Education and Training Materials."

s. **Guidance for Program Development and Operation**

(1) **Home and Community-based Care Website.** The Home and Community-based Care Website http://vaww.va.gov/hcbc contains valuable information, such as: orientation, rights and responsibilities, coding, reporting, templates, links to resources, and examples of local policies.

(2) **HBPC Mentor Program.** HBPC Program Directors and HBPC Medical Directors who either would like to have a mentor or would like to be a mentor are encouraged to contact the Office of Geriatrics and Extended Care.

23. QUALITY MANAGEMENT AND EVALUATION

a. The performance improvement activities of HBPC support the mission and goals of VA and the individual health care facility. The goal of the mandatory annual performance improvement plan is to continually improve overall patient care through planned, systematic measurement and assessment of patient care outcomes, and of those systems and processes affecting patient care. All performance improvement activities must be consistent with the standards set forth by VA and the home care accrediting organization. The HBPC performance improvement plan is a part of the health care facility total quality management program and includes feedback from patients and/or families regarding the care received. The HBPC staff, under the leadership of the HBPC Program Director and the HBPC Medical Director, participates in continuous performance improvement activities.

b. Quarterly medical record reviews ensure that the medical records reflect the care provided, the condition and progress of the veteran, and the condition of the veteran at discharge. The results of such reviews must be analyzed, documented, trended, and used to monitor practices so that the quality and efficiency of care may be improved.

c. Patient safety is an important aspect of quality management. Essential elements of a safety program are:

(1) Well-designed policies and procedures including a planned process for identifying and responding to high-risk situations.

(2) Systematic recruiting, credentialing, privileging, and training of home care staff.

(3) Training of veterans, their families, and caregivers in their home care responsibilities.

(4) Reporting and managing sentinel events, adverse events, medication errors, and other incidents.

(5) Training of staff in root cause analysis.

(6) Analysis of adverse events and refinement of educational programs based on that analysis leading to improved patient care and reduction of liability risks.

d. **Performance Improvement.** Performance improvement information is confidential and disclosure may only be as permitted by law and VA policy.

e. **Utilization Management.** Review of care and the utilization of resources is essential to the management of HBPC. Utilization review includes identifying those resources that are required and those that are available to support program goals and objectives. An integral step in utilization review is to have clearly defined program goals and objectives. Patients have initial assessments to determine home care needs, and on-going assessments to evaluate the appropriate use of resources and the need for continued care. Components of a utilization management program for HBPC include, but are not limited to:

(1) Appropriate admissions to the program.

(2) Appropriate utilization of pharmacy and prosthetic resources by the HBPC interdisciplinary team.

(3) Appropriate utilization of HBPC human resources.

(4) Appropriate utilization of non-HBPC services such as inpatient days or specialty care.

(5) Support from numerous databases including the HBPC Information System and the patient's medical record.

f. **Workload and Productivity Standards.** The emphasis on workload and staff productivity for HBPC is on the greatest number of complex medical patients that the team is able to safely manage while achieving positive outcomes, such as reduced hospitalization and high satisfaction. Workload and productivity evaluation considers the number and mix of

providers, the patient case mix and complexity, geography, program support, and other determinants unique to the health care facility.

24. RESEARCH AND SURVEYS

a. HBPC offers unique opportunities to evaluate health care and the delivery of services to a chronically ill patient population in their homes. All research studies, including surveys, must be approved through appropriate VHA channels. The process may involve seeking approval from the medical center's research committee and associated human subjects sub-committee. Input from relevant stakeholders is encouraged.

b. Locally-initiated satisfaction surveys are to follow national policies including submission to the Office of Management and Budget.

25. HBPC DATA MANAGEMENT

A number of electronic information systems support HBPC with data vital to the delivery of care to veterans in the home. These systems integrate HBPC patient data, workload, and resources into the complete facility information system, much of which is rolled up into national VHA databases located at the Austin Automation Center (AAC).

a. **Patient Care Encounter (PCE)**. PCE provides a data repository for long-term clinical data to support many data capture methods for integrating clinical data from many environments, including HBPC. The clinical data documents "encounters" and related encounter information such as provider name, problems treated, procedures performed, immunizations, and patient education.

b. **International Classification of Diseases - 9th Edition** (**ICD-9) and Current Procedural Terminology (CPT) Coding**. HBPC staff must use ICD-9 diagnostic codes for HBPC patient diagnoses pertinent to the encounter.

(1) HBPC staff must use either CPT codes or Healthcare Common Procedure Coding System (HCPCS) ("G codes") to identify the procedures pertinent to the encounter. Only the physicians, nurse practitioners, physician assistants, and/or clinical nurse specialists are allowed to use the Evaluation-Management home visit CPT codes.

(2) Other disciplines will use the G codes for home visits, when available. If no G code for home visits is available for a specific discipline (e.g., kinesiotherapy), the team members will use the codes identified by their organization's coding specialists or consult the Home and Community-based Care website at. http://vaww.va.gov/hcbc. Select "Data and Workload Management."

c. **HBPC Information System (HBHC).** *NOTE: The system was named after the original Hospital-Based Home Care pilot and the namespace HBHC has been retained.* The HBPC Information System was designed to help HBPC sites manage their patients and resources, as well as provide VA Central Office with site-specific information for all programs. The features of the HBPC Information System include:

(1) Entry and editing of patient data on admission to, and discharge from, HBPC.

(2) Automated visit or encounter data capture from PCE.

(3) Data validation and correction at the individual facility prior to transmission to AAC.

(4) Automated data transmission to the AAC National HBPC database.

(5) The ability to generate a wide variety of local reports covering:

(a) Visit, admission, and discharge data;

(b) Length of stay;

(c) Rejections;

(d) Procedures; and

(e) Census for program, team, case manager, and/or provider.

(6) AAC produces a monthly report on active cases at each site and more detailed quarterly reports with national comparisons utilizing HBPC data.

(7) This information system is a tool that allows the HBPC Program Director to control and assess the staff workload and the organization's characteristics.

(8) The automated forms used in the HBPC Information System are VA Form 10-0014, HBHC Evaluation/Admission Form, and VA Form 10-0014a, Discharge Form. All HBPC sites and teams use the same definitions in completing the forms.

(9) Complete instructions for this system are found in the HBPC Information System User Manual at: http://www.va.gov/vdl/.   Select "Clinical."

d. **Computerized Patient Record System (CPRS).** CPRS enables HBPC team members to enter, review, and continuously update patient clinical information. HBPC teams can take advantage of CPRS features such as templates to facilitate documentation of patient care.

e. **Primary Care Management Module (PCMM).** PCMM allows HBPC to assign a HBPC team member as the patient's primary care provider. The decision is up to the facility.

f. **Monthly Program Cost Report (MPCR).** HBPC costs are reported under Account 5110 of the MPCR. The MPCR units of care for HBPC are patient days of care, which are calculated from the episode of care (HBPC admission to discharge) dates in the HBPC Information System. The HBPC Program Director and the Chief, Fiscal Service are responsible for the preparation and accuracy of the data submitted. Uniform input of data across sites is required for valid comparability. Instructions for preparation of the HBPC Account 5110 are included in the

MPCR Handbook at: http://vaww.arc.med.va.gov/ . Go to "Reports" then "MPCR and DSS."
NOTE: MPCR replaces Cost Distribution Report (CDR).

    g. **Decision Support System (DSS).** DSS is a database derived from standard VHA data sources and transmitted to a DSS database at AAC, where it is formatted and uploaded into commercial software. DSS uses clinical and financial data to provide activity-based costing and clinical productivity analyses. Each facility has a DSS Site Manager, who advises HBPC concerning identification of departments and products, labor mapping, and the interpretation of dashboard reports. *NOTE: DSS maintains a website at http://vaww.dss.med.va.gov/*

    h**. Veterans Equitable Resources Allocation (VERA).** VERA is the methodology for the annual patient classification and funding to the VISNs. HBPC is in a Complex Care Group. The HBPC patient class is for patients who receive long-term home care in lieu of institutional care and meet VERA HBPC criteria (see website: http://vaww.arc.med.va.gov for current VERA reports and classifications.

    i. **Allocation Resource Center (ARC).** The ARC is a clinically-focused health systems information and management group that assists VA policy and operations management by developing, maintaining, and using decision support patient-specific workload and expenditure databases.

    j. **KLF Menu at VISN Support Service Center (VSSC) Website.** The KLF Menu offers on-line access to reports and databases critical for managing VA health care facilities. The KLF Menu can be accessed at: http://klfmenu.med.va.gov. A description of KLF functions related to VERA is located at: http://vaww.arc.med.va.gov/references/Handbook/chap7.html

26. EXPANDING ACCESS TO HBPC

    a. Satellite HBPC programs may be established as an outreach of sanctioned HBPC programs. Satellite programs are to incorporate: the practices of having VA staff provide direct care, interdisciplinary team meetings, and physician oversight. HBPC staff may work from a Community-based Outpatient Clinic (CBOC). A freestanding HBPC satellite office may be established in communities with sufficient numbers of eligible veterans. Satellite HBPC programs must report to the primary HBPC Program and adhere to the policies and procedures of the primary HBPC Program. The satellite HBPC Program's scope of practice remains under that of the primary HBPC Program.

    b. HBPC is encouraged to utilize technology (e.g., telecommunication equipment) and technology-assisted programs such as Care Coordination and Home Telehealth to increase access, enhance patient monitoring, improve efficiency, provide patient and caregiver education, and expand support from other disciplines.

    c. Innovative expansion of HBPC may include case finding of new patient populations with special needs and high-risk for institutionalization. Expansion may include targeting new service locations and patient populations to reduce unnecessary health care utilization and improve patient health, well-being, and satisfaction. Examples include residential alternatives and mental health services.