(7) Maintaining accurate records pertaining to the HBPC Program.

(8) Compiling data for statistical reporting and cost accounting.

(9) Participating and supporting the facility and program customer satisfaction activities.

8. REFERENCES

a. 38 U.S.C. "Veterans First Act" Section 231 – 234.

b. 38 CFR 17.38(a)(1)(ix), Medical Benefits Package.

c. VA Handbook 5005/36 Appendix G15, "Licensed Pharmacist Qualification Standard".

d. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook**,** http://www.va.gov/vhapublications/publications.cfm?Pub=2

e. VHA Handbook 1109.08, Nutrition Care Process Handbook, http://www.va.gov/vhapublications/publications.cfm?Pub=2

f. VHA Handbook 1141.02, Medical Foster Home Procedures, http://www.va.gov/vhapublications/publications.cfm?Pub=2

g. VHA Handbook 1108.05, Outpatient Pharmacy Services, http://www.va.gov/vhapublications/publications.cfm?Pub=2

h. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, http://www.va.gov/vhapublications/publications.cfm?Pub=2

i. VHA Directive 1043, Restructuring of VHA Clinical Program, http://www.va.gov/vhapublications/publications.cfm?Pub=1

j. VHA Handbook 1141.03, Adult Day Health Care, http://www.va.gov/vhapublications/publications.cfm?Pub=2

k. VHA Handbook 1140.6, Purchased Home Health Care Services Procedures, http://www.va.gov/vhapublications/publications.cfm?Pub=2

l. VHA Handbook 1140.3, Home Health and Hospice Care Reimbursement Handbook, http://www.va.gov/vhapublications/publications.cfm?Pub=2

m. VHA Handbook 1108.11, Clinical Pharmacy Services, http://www.va.gov/vhapublications/publications.cfm?Pub=2

n. VHA Directive 1230, Outpatient Scheduling Processes and Procedures. http://www.va.gov/vhapublications/publications.cfm?Pub=1

HBPC CASELOAD STANDARDS

Patient caseload ranges per Full-Time Employee Equivalent (1.0 FTEE) are as follows:

Rehabilitation Therapist: 85 - 115
Clinical Social Worker: 80 - 100
Registered Dietitian: 95 - 125
Registered Nurse (RN):

a. working with physician: 25-30
b. working with ARNP/PA: 25-35
c. ***NOTE:*** *Caseloads below 25 may be appropriate for RNs also doing frequent skilled care to decrease non-VA care costs*

ARNP/AP Provider: (Nurse Practitioner and/or Physician Assistant)

a. working without HBPC RNs: 30 - 35
b. working with HBPC RNs: 35 - 90
   (1) caseloads in the lower end of this range would be appropriate for ARNP/PA's working with less than 1 FTE RN
   (2) caseloads up to 50 would be appropriate for ARNP/PA working with at least 1 FTE RN
   (3) caseloads up to 75 would be appropriate for ARNP/PA working with at least 2 FTE RN
   (4) caseloads up to 90 would be appropriate for ARNP/PA working with 3.0 FTE RN *(**NOTE:** Increasing RN support to a full 3.0 FTE for one ARNP/PA provider does not appear to allow the ARNP/PA provider's caseload to increase above 90, due to reported adverse outcomes with ARNP/PA provider caseloads above 90 regardless of number of RNs)*

Physician:

a. acting as the Primary Care Provider (PCP):100 - 150
b. routinely providing direct patient care in the home when assigned as the PCP:150 - 250
c. acting as Medical Director; ARNP/PA are the PCPs; physician makes occasional but not routine home visits: 300 - 400

Caseload standards for the Mental Health provider were developed with guidance from the Office of Mental Health Services:

Mental Health Specialist (Psychologist and/or Psychiatrist): 120 - 140
NOTE: *Although caseload is expressed as Average Daily Census (ADC)/1.0 FTE, mental health providers generally do not provide in-person care to all Veterans in HBPC. Rather, they work with the team to identify Veterans and caregivers in need of mental health services and provide direct care for those Veterans and caregivers who require specialized mental health assessment and/or intervention.*
For mental health visits, a coding "QuickGuide", entitled *Mental Health Guidance on Workload Capture: Home Based Primary Care (HBPC)* is available via the Office of

Mental Health Operations or the HBPC VA Pulse Site.
https://www.vapulse.net/community/focus-areas/geriatrics-and-extended-care/home-based-primary-care

HBPC Clinical Pharmacy Specialist (CPS):* 100

a. Performing Core Program requirements including comprehensive medication and disease state management under a scope of practice in addition to program management including performing a comprehensive medication assessments of medication therapy (e.g., initial, quarterly, and when clinically indicated), participating in interdisciplinary team meetings, program management and other activities outlined in section 8.l.

NOTE: *This caseload accounted for 0.2 FTE being dedicated to comprehensive medication management and disease state management activities and 0.25 FTE dedicated to program requirements of comprehensive medication assessments (initial, quarterly, and as needed). Comprehensive medication and disease state management will be outlined in the individual scope of practice and encompass the general practice area and common conditions seen in the HBPC patient which include, but are not limited to, diabetes, hyperlipidemia, hypertension, bone health, anemia, and anticoagulation management.*

* In developing caseload standards for the CPS, the Pharmacy Benefits Management (PBM) Service utilized the following items as guidance to include a 2014 Survey Assessment of HBPC Clinical Pharmacy programs, as well as a time-in-motion study performed by the Clinical Pharmacy Practice Office (CPPO) HBPC Subject Matter Expert Workgroup. PBM developed a HBPC Clinical Pharmacy Staffing Tool to individualize caseload and appropriate FTE to further evaluate staffing needs. The HBPC Clinical Pharmacy Staffing Tool may be accessed at the following link: http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/default.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

Programs should ensure that the HBPC CPS has support for routine pharmacy functions, nursing home inspections as well as other functions which can be performed by other clinical pharmacists as described in VHA Handbook 1108.11, Clinical Pharmacy Services.

Rural and Highly Rural staffing standards:

Adjusted caseload standards for Rural and Highly Rural programs:

a. Registered Nurse: 16-25

Rural programs are encouraged to develop efficient ways of managing the extensive distances they cover by hiring staff in the area of the Veterans they serve, locating vehicles near the staff, using video telehealth technologies, using laptop computers with mobile electronic documentation software, and utilizing work-from-home arrangements. Programs should consider lower provider and interdisciplinary team member caseloads adjusted for prolonged driving times.

NOTE: *Programs have experienced negative consequences at caseloads below upper limits; the highest number in the range is to be viewed as a number not to be surpassed rather than as a target capacity. Upper limit standards are based on the following determinants: Average DCG 2.5; Urban/Rural mix of >66 percent urban, Drive time under 17 minutes per patient. A range is also dependent on many other factors including geography, coverage area, patient complexity, patient attrition, staff recruitment and retention, staff experience, team composition, pharmacy support, medical record sophistication, and HBPC program support including vehicles, computers, and a staff support assistant.*

APPLICATION PROCESS FOR RECOGNITION OF VA HBPC PROGRAMS and ONGOING PROGRAM MINIMUM STANDARDS

1. Proposals for formal recognition as a VA HBPC program are to be submitted by the HBPC Program Director, through facility leadership to VA Central Office (VACO) GEC Operations. GEC Operations will review the application package and arrange subsequent calls to verify readiness of the program for full recognition. The facility is responsible for notifying the Joint Commission as required by the accreditation standards. GEC Operations takes the lead, working with VACO GEC Services to recognize VA HBPC programs, and provide a recognition letter to the medical center. Once recognized, the program is responsible for maintaining recognition standards. Periodic reviews may be conducted to assure program compliance is maintained. VA Central Office may require submission of action plans to GEC Operations, which will include target dates and deadlines to address any identified deficiencies and may result in provisional or revoked recognition until deficiencies are corrected. If recognition is revoked, Austin Information Technology Center (AITC) will be notified to remove the facility from the data systems and the facility will no longer receive workload credit until recognition is restored.

2. Critical elements in the proposal and ongoing program standards include:

a. A description of the proposed program, with attention to the program elements that are outlined in paragraph 6 of this directive.

b. A description of the interdisciplinary team as described in this directive, and of the responsibilities of each team member. The specified responsibilities of the core clinical members must include home visits and participation in interdisciplinary team conferences.

c. A listing of each HBPC position and the respective Full-time Equivalent (FTE) staff committed to HBPC. Each HBPC program will have a full time HBPC Program Director and a core interdisciplinary team. This interdisciplinary team will consist of specified staff, each with sufficient time dedicated to HBPC as part of their position description or functional statement. A core interdisciplinary HBPC team will consist of at minimum the following VA employee positions: medical director, a primary care provider, care manager, social worker, rehabilitation specialist, a registered dietitian, a clinical pharmacy specialist (CPS), program support or medical support assistant, and mental health specialist (psychologist or psychiatrist). An HBPC physician, who may not necessarily serve as the HBPC Medical Director, attends the HBPC interdisciplinary team meetings and oversees the medical care through routine collaboration with all team members. There are 3 acceptable provider and care manager models of HBPC Special Population PACT: 1) Physician is the Primary Care Provider (PCP) with a maximum of 5 Nurse Care Managers 2) Nurse Practitioner (ARNP) or Physician Assistant (PA) is the PCP with a maximum of 3 Nurse Care Managers 3) Nurse Practitioner or Physician Assistant is the PCP and also serves as the HBPC Care Manager. A facility may choose to list the Physician as the PCP on a team with the Nurse Practitioner or Physician Assistant as the associate providers; however the

visiting associate provider will be primary on encounters. FTE for each team should be based on the HBPC Special Population PACT Model of care and Caseload Maximum Capacity in Appendix A.

Physician Primary Care Provider with Care Managers	ARNP/PA Primary Care Provider with Care Manager(s)	ARNP/PA Primary Care Provider without additional Care Manager
HBPC Program or Medical Support Assistant	HBPC Program or Medical Support Assistant	HBPC Program or Medical Support Assistant
HBPC Medical Director/Physician PCP	HBPC Medical Director	HBPC Medical Director
N/A	HBPC ARNP/PA	HBPC ARNP/PA serving as PCP and Care Manager
HBPC RNCM (up to 5)	HBPC RNCM (up to 3)	N/A
HBPC Licensed Clinical Social Worker	HBPC Licensed Clinical Social Worker	HBPC Licensed Clinical Social Worker
HBPC CPS	HBPC CPS	HBPC CPS
HBPC Rehabilitation Specialist (OT, PT, KT)	HBPC Rehabilitation Specialist (OT, PT, KT)	HBPC Rehabilitation Specialist (OT, PT, KT)
HBPC Dietitian	HBPC Dietitian	HBPC Dietitian
HBPC Mental Health Specialist (Psychologist or Psychiatrist)	HBPC Mental Health Specialist (Psychologist or Psychiatrist)	HBPC Mental Health Specialist (Psychologist or Psychiatrist)

(1) In addition, the HBPC interdisciplinary team may include other services frequently needed, such as pastoral care, speech therapy, respiratory therapy, and recreational therapy. HBPC programs are encouraged to provide care for Veterans with complex, specialized needs, and include necessary interdisciplinary competency and staff beyond the designated core team members when serving these populations. An example of such interdisciplinary staff includes a Respiratory Therapist for the ventilator dependent HBPC Veteran population diagnosed with spinal cord injury (SCI) or amyotrophic lateral sclerosis (ALS).

(2) The HBPC program staff will include sufficient dedicated administrative and clerical support.

d. HBPC is an important care option for Veterans with significant health care needs living in rural areas and who have limited access to regular care. A rural focus HBPC program is designated rural by the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, and qualifies for the designated rural staffing allowances as long as the HBPC program average daily census remains under 40 Veterans. Programs qualifying as a rural focus HBPC program must provide the full complement of HBPC PACT interdisciplinary care services and have, at minimum, a VA staffed program director, program or medical support assistant, medical director, primary provider, care manager, CPS and social worker.

e. Ideally all HBPC clinicians should be VA employees. However, to address barriers with staff recruitment and retention and to optimize delivery of care, HBPC programs operating in rural and highly rural areas are encouraged to use video telehealth options and will be allowed to establish contractual arrangements with Medicare certified home care agencies for certain disciplines such as rehabilitation, mental health, and nutrition. When contracting with non-VA staff, continuity of patient care must be maintained by having consistent contract staff and full participation in the HBPC interdisciplinary conferences and care planning in person or via teleconference or video. All clinical documentation must be timely and available in the patient's VA electronic record. Staffing for each team should be based on the HBPC Special Population PACT Model of Care and caseload maximum capacity in Appendix A, using local adjustments for rural caseload determinants described there.

f. Evidence of facility support including information technology, vehicles, and space.

g. Innovative HBPC practices with strong evidence of meeting standards at or above national expectations for safety, quality, outcomes, and customer satisfaction may be submitted to VACO GEC Operations for consideration of ongoing recognition for HBPC programs.

PROGRAM OPERATION PROCESSES

1. ORGANIZATION OF HBPC: Geriatric and Extended Care Services (GEC) recommends that the HBPC Program be aligned under the Associate Chief of Staff for Geriatrics and Extended Care for optimal program management, based on considerable experience and evaluation. If such a position does not yet exist at the facility, HBPC can temporarily function under the Chief of Staff, the Associate Chief of Staff for Ambulatory Care, the Chief of Medical Service, or an interdisciplinary Care Line Director. If the facility has centralized discipline-specific services (e.g., social work, nursing, nutrition and food services), the respective Service Chief may have responsibility for clinical oversight and competency of members of the HBPC team within that discipline. This separation of program management from clinical practice oversight is an important distinction that allows the HBPC Program Director and HBPC Medical Director to lead the program together reporting to the same supervisor for program management, while the Service Chiefs of the respective clinical disciplines provide oversight of clinical practice and competencies, thereby strengthening the effectiveness of the interdisciplinary team. A service agreement that delineates the respective responsibilities for ensuring clinical competency, communication for performance and peer reviews, quality improvement, and adherence to home care standards of care is recommended.

2. ORIENTATION AND EDUCATION OF HBPC TEAM MEMBERS: New HBPC team members will be oriented by the HBPC Program Director and appropriate clinical team members to ensure understanding of the goals, objectives and procedures utilized by the HBPC Program. This directive, the VA medical facility HBPC policy, and program SOP serve as the basic orientation guides that reflect local and related national policies. Both the orientation and ongoing education of HBPC team members should include, but are not limited to, geriatric specific education (e.g., end of life issues, goals of care, and dementia), information security, current National Patient Safety Goals, staff safety, continuous quality improvement, new technology, and program/practice updates.

3. REFERRAL: HBPC teams are to work with PACTS to: 1) identify appropriate referrals, 2) develop and maintain open communication, 3) build relationships for smooth transitions of care, 4) foster interdisciplinary learning and education.

4. Veterans who may benefit from the services of HBPC may be referred from any site of care. An electronic consult is to be utilized for accountability and tracking. The referral process to HBPC is as follows:

a. Assure referral is appropriate for HBPC:

(1) Veterans for whom routine clinic-based care is not effective may include those with:

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

(3) Inability to cope with clinic environment due to cognitive, physical, or mental health impairment.

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

(5) Recurrent hospitalizations or urgent care episodes.

b. The acceptance or rejection of the referrals or consults to HBPC are due no later than 7 days from the date of the request.

c. If there is no caseload availability of appropriate staff, the patient will be immediately placed on an electronic waiting list.

d. If referral is appropriate, the response will include scheduling an initial home visit. The HBPC Program Director or designee will assign the appropriate staff for the initial visit. If the referral is deemed inappropriate for HBPC, the response will include rationale for rejection and recommendations, as appropriate. When the referral is rejected, discussion with the referral source is strongly encouraged to offer education in regard to HBPC services and to recommend appropriate support services.

e. Veterans referred for Medical Foster Home (MFH) with HBPC will be evaluated through a collaborative local process, with admission prioritized based on clinical necessity. HBPC admission should be concurrent with the move to the medical foster home.

f. Once a consult/referral is accepted, delays in scheduling the home visit due to Veteran unavailability or preference may occur and should be documented. In cases where the Veteran has requested a delay without specifying a date to be seen, the consult may be closed and the Veteran or their family will be given the contact information of HBPC staff to contact once the Veteran wishes to schedule the initial admission evaluation home visit.

g. Referral to HBPC and scheduling of an initial admission evaluation home visit is not confirmation of admission or enrollment to the program. Careful coordination with the patient's current provider or team to ensure continuity during the HBPC intake and assessment process is critical.

5. ELECTRONIC WAIT LIST: The mandatory EWL is implemented when the HBPC program encounters staffing limitations and is unable to accommodate routine admissions to the program. Given the nature of the HBPC program and the population served, the Veteran is placed immediately on the EWL if a caseload is full. If caseload capacity allows for HBPC admissions, the patient should be seen as soon as possible, by the timeframe requested by the ordering provider, or based on the Veteran or caregiver preference. For referrals generated during inpatient stays, including the Community Living Centers, the visit should be scheduled as close to the time of discharge to home, as specified by the ordering provider or based on the Veteran or caregiver preference.

a. HBPC programs will activate and implement the EWL system, as delineated in the implementation of VHA Directive 1230 Outpatient Scheduling Processes and Procedures, Appendix J.

b. HBPC is a program that is minimally available in private sector health care and therefore cannot be consistently provided through community purchased care programs. This fact emphasizes VA's responsibility to expand the program services to all areas of each VA's catchment. Examples of methods of identifying the magnitude of unmet need and the priority for resource allocation and care options to meet that need include consistent use of EWL, working with local VA Public Affairs Office and Veterans Service Organizations (VSOs) to market in areas underserved by VA, using available data from the local VA medical center Health Planner to project unmet demand. VACO GEC Clinical Operations can also provide facility-specific market demand estimates.

c. HBPC programs should anticipate resource needs and collaborate closely with local and VISN management to strategize options to support and expand HBPC services. Any proposed change in an HBPC program that may result in a significant restructuring of the program, reduction in staffing, services, or number of Veterans served, or closure of the program must go through a VACO notification process as described in VHA Directive 1043, Restructuring Clinical Programs.

6. DETERMINATION OF PATIENT APPROPRIATENESS FOR HOME CARE: Before the Veteran is admitted to HBPC, at least one initial admission evaluation home visit by an HBPC clinician is completed. This clinician will recommend appropriateness for admission, with concurrence by the interdisciplinary team. If not appropriate for admission, the HBPC team makes and communicates recommendations regarding an alternate plan for managing the Veteran's needs. The following considerations are to be used in determining whether the Veteran is appropriate for admission to the HBPC Program:

a. The Veteran is enrolled in the VA health care system.

b. The Veteran lives within HBPC's service area designated by each VA medical facility to represent a safe and efficient service delivery area. (often designated by driving time)

c. The Veteran has advanced age or serious chronic, disabling conditions that would be amenable to HBPC interdisciplinary intervention.

d. The Veteran and caregiver voluntarily accept HBPC to provide or support coordinated interdisciplinary primary care.

e. The Veteran's care needs can be met by the HBPC program.

f. The Veteran has an identified caregiver, if the HBPC team determines the need for one.

g. The Veteran's home environment is adequately safe and determined to be an appropriate venue for care as determined by the HBPC team.

h. The Veteran is included in one of the populations targeted by HBPC that include:

(1) Patients identified as high risk through PACT, which could include, high utilization 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 or missed appointments).

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

(3) Veterans at high risk of recurrent hospitalization and emergency care or nursing home placement.

7. ADMISSION: If the HBPC interdisciplinary team determines that the Veteran meets HBPC admission criteria, the Veteran is scheduled for the comprehensive, interdisciplinary team assessments. Once admitted to HBPC, the Veteran is assigned in Primary Care Management Module (PCMM) to an HBPC Special Population PACT Team. Hand-off communication is required when transferring primary care teams and should include the opportunity for discussion between the giver and receiver of patient information. All required HBPC assessments are scheduled to be completed no later than 30 days from the HBPC admission date. The medical record is to contain a note with an "admission" title or a clear statement of "admission" to the HBPC program within a progress note. This will serve as the admission date to HBPC.

8. PROGRAM ORIENTATION FOR PATIENT AND CAREGIVER: The eligible Veteran and caregiver will be oriented by the assigned care manager or PCP to the HBPC program and will voluntarily consent to be enrolled. A full discussion of program objectives, capabilities, limitations, and alternatives as well as the rights and responsibilities of all parties, including potential out-of-pocket expenses, is conducted in the home and is provided in writing to the Veteran and the caregiver. This informational counseling and the Veteran or caregiver's acceptance to participate in the HBPC program constitute informed consent of the Veteran to participate in the HBPC Program and will be documented in the Veteran's medical record.

9. ASSESSMENT OF PATIENTS: Once admitted, all patients undergo a comprehensive, interdisciplinary assessment. This assessment will address, but is not limited to, health history, physical and cognitive functioning, nutritional assessment, skin integrity issues, patient safety issues, an environmental safety assessment, home oxygen safety, medication management, pain management, mental health needs including suicide risk assessment, substance abuse, psychosocial functioning, informal and formal supports, cultural, spiritual and lifestyle considerations impacting care, as well as living will and advance directives planning.

10. PLAN OF CARE: Once the assessment is completed on the patient, the plan of care will be developed by the HBPC team using the assessment information within a month after admission. Plans of care should be reviewed on a quarterly basis on all HBPC patients. Utilizing screening and assessment results and taking patient and caregiver input and preferences into consideration, the HBPC team develops an interdisciplinary plan of care during a regularly scheduled team conference. The plan of care for each patient is customized to include problems identified by the members of the team, patient and caregiver goals and preferences, a current medication profile and goals of care with specific interventions, timeframes, and assigned team member responsibility. The HBPC interdisciplinary team members acknowledge and concur with the plan of care in the medical record, which is signed by the medical Director, or designee. As the health condition of the patient changes, the plan will be updated as needed. It is recommended that team conferences be scheduled on a weekly basis to ensure timeliness of care planning for new and established patients.

11. DELIVERY OF CARE: HBPC staff provides direct care in the Veteran's home as well as care management and coordination and promote a safe, therapeutic home environment that supports the Veteran and caregiver to allow the Veteran to remain in the community and avoid or delay institutional care. Duration of care and frequency of home visits are determined by clinical judgment in a process of continuous reassessment or monitoring of clinical needs. Standards for caseload size are included in appendix A of this directive. Assessments and interventions, provided by the HBPC team members, do not require formal consultations unless otherwise required by discipline-specific, license, scope of practice, or reimbursement guidelines.

12. PATIENT AND CAREGIVER PARTICIPATION AND EDUCATION: HBPC represents a partnership with the patient and caregiver. HBPC team members will collaborate with the patient and caregiver to ensure an understanding of preferences, quality lifestyle considerations and self-directed goals. Information and education are to be provided on the plan of care to the patient and caregiver with emphasis on available options and expected outcomes as well as the actions and commitment required of the patient and caregiver to achieve desired outcomes. Patients and caregivers are also to be informed and educated in regard to potential undesirable outcomes of their treatment decisions. The HBPC team must document this education as well as the patient and caregivers understanding and address their capacity to make decisions as necessary. The patient and the caregiver are responsible for meeting daily, routine care needs. For meeting care needs, the HBPC team assists in mobilizing community and/or VHA resources.

13. INTEGRATION WITH NON-VA HOME CARE SERVICES: When it is in the best interest of the patient, other home care services may be provided concurrently, provided that there is no direct duplication of services and that clinical responsibility and tasks are delineated for the care or service rendered. For example, if the patient requires home hospice care, a home health aide, or an intensity of skilled care services that the HBPC Program cannot or does not provide, then options for additional VA-purchased and non-VA funded services can be arranged. If concurrent home care is being provided by

non-VA paid services, the role of HBPC will be medical management, or other care coordination services that are not directly provided by the non-VA agency.

14. DISCHARGE FROM HBPC: As clinically appropriate, discharges from HBPC should be mutually planned by the HBPC team in conjunction with, and in full partnership with, the patient and caregiver. Patients may elect to be discharged from HBPC at any time. A formal discharge note should be entered into the medical record and minimally include the date of admission and discharge to HBPC, plan for continuity of care, summary of the course of HBPC care, current medications and treatments and the overall status of the patient at discharge. Hand-off communication is required when transferring primary care teams and should include the opportunity for discussion between the giver and receiver of patient information. The HBPC team furnishes information and collaborates with the staff of the VA medical facility or non-VA providers to ensure a seamless transition and coordinated continuity of care. Circumstances under which Veterans are discharged from HBPC include:

a. Veteran death.

b. Veteran and caregiver request discharge from the HBPC Program.

c. Veteran relocates out of the HBPC service area.

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

e. Veteran and caregiver continue to demonstrate a lack of partnering or lack of participation in a significant portion of the plan of care that negatively impacts clinical outcomes. This ongoing lack of participation, and its effect on care, will be documented in the patient's medical record. Prior to discharge, staff will consider appropriate evaluations to address, contributing factors such as the presence of dementia, depression, and substance abuse.

f. Veteran's home environment is no longer safe for the Veteran, or for the HBPC team members.

g. The Veteran's needs exceed the capability of the HBPC program and other combined home care services, making home care no longer an appropriate venue for the Veteran's care.

15. ADDRESSING STATUS OF PATIENT RECEIVING TEMPORARY CARE OUTSIDE OF HBPC: When HBPC patients temporarily travel, relocate or are institutionalized in a hospital or nursing home with anticipated stay of 15 days or more on the 16th day patients are to be discharged from the VISTA HBPC information systems active census, unless returning home that day. However, the Veteran will remain on the HBPC PACT team in PCMM until a reason for HBPC discharge is determined as stated above in the discharge section of this appendix (paragraph 14). Hand-off communication regarding the plan of care and course of care in the home

are to be furnished to the receiving staff at the temporary location whenever possible and as directed by local policies. The HBPC team conducts follow-up contacts with the patient, caregiver and treatment team, as needed, to maintain continuity of care. An in-home reassessment/readmission process must begin within 2 business days of the HBPC team being informed the Veteran has returned home. At the start of the readmission process, the Veteran should be readmitted to HBPC in the VISTA HBPC Information Systems Package by an HBPC team member, starting a new episode of active home care. The plan of care should be reviewed and updated at a scheduled team meeting within 30 days of the readmission date. Local policy outlines the specific reassessments, timeframes and disciplines designated to perform the reassessment required for the returning Veteran.

16. AFTER OFFICE HOURS COVERAGE: HBPC Programs will have a policy that delineates the provision of care to the patients 24 hours a day, 7 days a week (24/7). HBPC patients and caregivers will be given written information that includes instructions for contacting HBPC during and outside regular operation hours. Some HBPC programs have established formal 24/7 coverage by HBPC staff; others refer patients to specific units at the VA medical facility or to a VA after hour's telephone care support system. The HBPC programs have successfully established the 24/7 coverage by HBPC staff found this to be highly advantageous (lower utilization of ER, higher patient and staff satisfaction) for Veterans, as well as of notable benefit to the HBPC staff providing and maintaining care management.

17. PATIENT AND CAREGIVER CONCERNS OR COMPLAINTS: HBPC Programs will have a procedure in place to address patient and caregiver concerns or complaints that ensure issues are resolved in a timely manner at the lowest level of direct care, whenever possible. The procedure provides for communication with the HBPC Program Director and access to the local patient advocate.

18. COOPERATION, COLLABORATION AND CONSULTATION SERVICES SUPPORTING NON-INSTITUTIONAL CARE: HBPC Special Population PACT program staff members are partners with PACTS and other VA programs engaged in the care of Veterans at their facility to help ensure patients receive the appropriate level and type of care utilizing PACT principles, tools, reports, and shared performance measures.

Programs often engaged by HBPC staff include, but are not limited to:

a. **Medical Foster Home.** MFH provides an alternative to institutional care by providing a home setting for a small number of Veterans residing in the home of a community caregiver with HBPC support and oversight.

b. **VA Telehealth Program.** The VA telehealth program enhances HBPC's capacity to manage complex patients, access specialty care, and extend HBPC's service area. Home Telehealth (HT) Care Coordinators are responsible for reviewing and triaging health information, including biometrics and symptom responses. This information is submitted by patients and securely transmitted via HT approved

technologies such as in-home messaging devices, Interactive Voice Response (IVR) and web-enabled technologies. Additionally, in-home Clinical Video Telehealth (CVT) enables Veterans or VA care teams in the Veteran's home to conduct live interactive telehealth services and transmission of vital signs and additional clinical information with clinicians who are not in the Veteran's home.

c. **Other Virtual Care Modalities.** Other virtual care modalities that are currently available or under development also enhance HBPC's capacity to manage and communicate with complex patients. a) VHA mobile apps have great potential to enhance HBPC's capacity to connect to home bound patients and support chronic care management. b) Expanded use of secure messaging facilitates asynchronous communication with homebound patients. Secure messaging includes pre-visit communication, completion of health questionnaires, post visit communication, and ongoing communication for routine non-urgent issues.

d. **Mental Health.** The HBPC Mental Health provider serves as liaison with Mental Health and Behavioral Health Services to facilitate assessment and treatment of mental health problems that are not able to be addressed fully by the HBPC team (e.g., specialized neuropsychological evaluation, substance use treatment, and need for inpatient mental health hospitalization). A collaborative care process will be established for Veterans who are enrolled in both HBPC and any other mental health treatment program e.g., Mental Health Intensive Care Management (MHICM).

e. **Caregiver Support Program.** This program includes VA's Program of Comprehensive Assistance for Family Caregivers: (http://www.caregiver.va.gov/pdfs/CaregiverFactSheet_Apply.pdf) as well as services available to caregivers of Veterans from all eras (i.e., The Program of General Caregiver Support Services that are specifically designed to acknowledge the caregiver's role and provide training, support and respite). Title 38 United States Code (U.S.C.) 1720G.

f. **Respite Care.** Provision of continuous care can be stressful for caregivers. A plan for providing caregivers with intermittent, short-term respite may reduce this stress, supporting continued care of the patient in the home. Respite is available as both non-institutional and institutional care and is provided in accordance with VHA Handbooks related to Non-Institutional Care (VHA Handbook 1141.03, Adult Day Health Care and VHA Handbook 1140.6, Purchased Home Health Care Services Procedures).

g. **Personal Care Services.** Personal care services for HBPC patients may be obtained from multiple VA and non-VA sources. Veteran Directed Home and Community-based Services (VD-H&CBS) and Homemaker/Home Health Aide (H/HHA) Programs are VA resources that support non-institutional care. VA Adult Day Health Care (ADHC) and Community Adult Day Health Care (CADHC) offer opportunities for caregiver respite as well as enhanced oversight and socialization for the Veteran. Non-VA resources include county based Offices on Aging and state funded long term home care and nursing home diversion programs.

h. **Program for All Inclusive Care for the Elderly.** The Program for All Inclusive Care for the Elderly (PACE) is a comprehensive long term care model for maintaining elderly in the community.

i. **Skilled Home Care.** 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 will offer to pay for or provide the needed concurrent services. A Veteran dually eligible for these services under both VA and another payer has the right to choose VA or an alternate payer. Home care services concurrent with HBPC may be provided through VA-purchased care, Medicare or other payer, during which time HBPC is to coordinate with the agency to avoid duplication of services.

j. **Palliative/Hospice Care.** Palliative/hospice care is an important aspect of HBPC. Ongoing collaboration is to occur between VA medical facility palliative care services and HBPC. This palliative care component of HBPC is to include continuing education for the HBPC team and access to palliative care consultation. Veterans in HBPC often require and are authorized to receive concurrent hospice care from a hospice agency, paid by VA, by Medicare, or by another payer. As long as Veterans are formally enrolled in HBPC, team member responsibilities continue, although the HBPC program staff may need to make adjustments to avoid duplication of services. HBPC programs are to maintain a collaborative relationship with community hospice agencies as many patients benefit from comprehensive community hospice services in conjunction with HBPC's provision of medical management and VA care coordination.

k. **Dementia Care Support.** Dementia care support is available through a number of GEC consultation services and Geriatric Evaluation and Management consultations with special emphasis on dementia and memory issues.

l. **Volunteer Services.** HBPC programs utilize volunteers through the VA Voluntary Service and other community organizations such as the Senior Companion Program. Volunteers will be trained to be competent to perform their assigned activities. HBPC staff will provide oversight of the volunteers to include, at a minimum, annual observation of the interaction with the patient in the home.

m. **VA Staffed Home Care Services.** VA Staffed Home Care Services is a growing umbrella of programs that provide VA-staffed in-home care and services for targeted goals and populations. Examples include, but are not limited to, Hospital In Home (HIH), Home Based Transitional Care (HBTC), Geriatric Resources for Assessment and Care of Elders (GRACE), Blind Rehabilitation home assessments, PACT Intensive Management, and other various forms of VA provided home care services and visits. Programs may be managed or share home care policies and procedures with the HBPC Program, however, only MFH and HBPC Special Population PACT Veterans can be entered into the HBPC information systems and census.

19. TRAINING PROGRAM. The HBPC Program provides unique educational experiences for fellows, residents, interns, and students from various health professions, including medicine, nursing, social work, mental health, nutrition,

pharmacy, and rehabilitation services. 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. The HBPC Program Director and Medical Director are encouraged to seek educational affiliations with the various professional schools to promote the training opportunities that exist within the HBPC program.

20. GUIDANCE FOR PROGRAM DEVELOPMENT AND OPERATION. The following offer HBPC staff information to develop and implement policies in their VA medical facility and VISN:

a. **Home and Community-Based Care Electronic Resource.** The Home and Community-based Care SharePoint (access granted to VA employees by invitation only): http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/HBPC/default.aspx or the VA HBPC Pulse site (open to all VA employees) contains valuable information, such as: orientation, rights and responsibilities, coding, reporting, templates, links to resources, and examples of local policies. ***NOTE:*** *Both the VA Pulse and VA SharePoint resources are internal VA websites that are not available to the public.*

b. **HBPC Mentor Program.** The National HBPC Mentor Program offers a training opportunity especially for new HBPC Program staff. HBPC Program Directors and HBPC Medical Directors who either would like to have a mentor or would like to serve as a mentor are encouraged to contact Geriatrics and Extended Care for Operations, which oversees this group. An HBPC Program Director competency exam is available in the Talent Management System (TMS) to assess knowledge of key programmatic elements.

QUALITY MANAGEMENT AND EVALUATION

a. The HBPC Program supports the mission and goals of VA and each VA medical facility through its continued quality improvement activities. The goal of the HBPC performance improvement activities is to improve overall patient care through planned, systematic measurement/monitoring and assessment of patient care outcomes, staff practice, and on-going review of those systems and processes that affect staff performance and patient care.

b. Each HBPC Program will develop a performance improvement process in conjunction with the VA medical facility's overall Performance Improvement Plan and Initiatives. All performance improvement activities will be consistent with the standards set forth by VA and the home care accreditation body. Results from performance improvement activities will be shared with the organization through established reporting channels. Performance improvement information is confidential and disclosure may only be as permitted by law and VA policy.

c. The HBPC interdisciplinary team, under the leadership of the HBPC Program Director and the HBPC Medical Director, participates in continuous performance improvement activities, which include, assessing for risk, ongoing monitoring, and an annual review of the process and the data collected. Focus areas for performance improvement identified must include:

(1) Trends in patient care, cluster activity, and specific areas impacting patient safety.

(2) Areas or procedures involving high risk to patients or staff.

(3) Activities that require maintenance of competency.

(4) New processes, new procedures, new technologies.

(5) Identified areas for staff training or education.

(6) Feedback from customer satisfaction measures and factors contributing to high customer satisfaction.

(7) Factors contributing to staff satisfaction and retention.

d. In addition, the annual review will analyze data and develop time-specific change strategies with an implementation process involving expected outcome measures, analysis and strategic actions based on feedback. Tools used to verify standardization and compliance with local processes include:

(1) **Chart Reviews/Audits to Monitor.** This includes timeliness of assessments and care planning processes, documentation standards for timeliness and evidence of interdisciplinary collaboration in care planning process, orders, consultations as necessary, specific incident, and near-miss tracking. Examples include, but are not

limited to: formal incident reports, patient safety issues (serious injuries, falls, fires, equipment failure, medication errors, suicide/gestures, etc.), specific infection tracking infection prevention monitors (immunizations), and skin ulcer.

(2) **In Home Oversight Visits.** Home oversight visits should be included in the orientation process for new staff, and should be a part of on-going competency reviews. During the home visit, there should be performed verification of practice compliance with home care accreditation standards. Examples include, but are not limited to: patient identification, hand sanitation and infection prevention procedures, invasive procedures, specimen handling and transport, information security procedures, medication reconciliation, patient/caregiver education, management of emergencies in the home.

(3) **Patient Satisfaction Feedback.** Obtaining feedback from patients and caregivers is an important aspect of monitoring HBPC's ability to identify and address a patient's preferences and goals for care and for partnering with patients/caregivers with a customer focus. Each HBPC program will have a procedure in place for assessing satisfaction and addressing customer complaints.

(4) **Monitoring Patient Safety.** Monitoring patient safety includes identifying factors and implementing processes that contribute to improving patient safety are essential elements of the HBPC Performance Improvement Process and include:

(a) Systematic recruiting, credentialing, privileging, and training of highly qualified home care staff.

(b) Systematic reporting and management of sentinel events, adverse events, and "near miss" situations.

(c) Using process oriented systems analysis tools such as the Root Cause Analysis (RCA) for sentinel events, adverse events and near misses for development of action plans leading to improved patient care with prevention/reduction of both risk and harm. Current VHA guidelines should be followed in reporting these events to VA GEC Operations when they occur.

(d) Providing appropriate education materials, equipment and training for Veterans and caregivers in safety techniques associated with physical and cognitive decline, especially in dementia care, the use of adaptive equipment and in making home modifications to ensure a safe, therapeutic environment.

e. **Resource Utilization Management.** HBPC utilization management includes the identification of required resources and effective resource management to support program goals and objectives. Components of a utilization management program for HBPC include, but are not limited to:

(1) Accurate determination of the program's limits of capacity, including monitoring of staffing, referrals, admissions, discharges, caseloads, and accurate workload reporting.

(2) Optimal coordination and utilization of VA and non-VA home and community support services.

(3) Ensuring infrastructure supports, including adequate space, supplies, access to government vehicles, communication, and information technology.

Accurate monitoring of patient outcome measures, including utilization of health resources (emergency care, outpatient care and hospitalizations). All HBPC staff members have their time that is devoted to clinical, administration, education, and research activities accurately labor mapped according to MCA guidance on labor mapping which can be found on the MCA Web Site at: http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp.

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 medical facility. Standards for caseload size are included in appendix A.

RESEARCH, SURVEYS, AND HBPC DATA MANAGEMENT

1. RESEARCH AND SURVEYS

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, will be approved through appropriate VHA channels. Locally initiated satisfaction surveys are to follow national policies, including submission to the Office of Management and Budget as indicated.

2. 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 Information Technology Center (AITC). Data and resources may be subject to changes; it is important to regularly check the provided links. These include but are not limited to:

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

(1) HBPC staff must use either Current Procedural Terminology (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, or clinical nurse specialists are permitted to use the Evaluation-Management home visit CPT codes.

(2) Other disciplines will use the G codes for home visits, when applicable. Alternately, Event capture or encounter codes identified by their organization's coding specialists may be used (e.g., for kinesiotherapy services, etc.). Another coding resource is located at the Home and Community-based Care SharePoint site or the HBPC VA Pulse site.

b. **HBPC Information System.** The VISTA HBPC Information System identified in VISTA as “HBHC” is to be used by HBPC sites to manage their patients and resources, and report to VA Central Office site-specific information for all programs. Complete instructions for this system are found in the HBPC Information System User Manual at: http://www.va.gov/vdl/. Select "Clinical." Monthly validation of Austin data must be conducted.

c. **Computerized Patient Record System.** The Computerized Patient Record System (CPRS) enables HBPC team members to enter, review, and continuously update patient clinical information.

d. **Mobile Electronic Documentation.** Mobile Electronic Documentation (MED) enables HBPC team members to enter, review, and continuously update patient clinical information when live connection to the VA network is not available. Data can be uploaded into MED information and resources can be obtained through these VA links: Mobile_Electronic_Documentation_Troubleshooting_Guide.pdf; MED Application Overview: History, Features, Setup; MED INSTALLATION AND SETUP; and USER INSTRUCTIONS: Mobile Electronic Documentation. ***NOTE:*** *These are internal VA Web sites that are not available to the public.*

e. **Vista Scheduling Package.** Home Based Primary Care (HBPC) will not be required to implement Vista Scheduling Package for appointment management, and is exempt from VHA Directive 2016-027, VHA Outpatient Scheduling Processes and Procedures, or subsequent policy issue, unless it directly refers to the HBPC program. HBPC is a case management model of Primary Care, referred to as HBPC Special Population PACT.

f. **Primary Care Management Module.** The PCMM allows HBPC to assign an HBPC provider (MD, PA, or ARNP) as the patient's primary care provider and HBPC team members into the PACT team. All HBPC Special Population PACT teams must contain *HBPC* in the team name.

g. **Monthly Program Cost Report.** HBPC costs are reported under Account 5110 of the Monthly Program Cost Report (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, Finance Service is responsible for the preparation and accuracy of the data submitted. Uniform input of data across sites is required for valid comparability.

h. **Decision Support System.** Decision Support System (DSS) is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs. DSS is the VA system that provides clinical and financial data at the patient level. DSS combines data from 26 autonomous VA IT systems to provide reliable information relating costs to outputs and activities. At the local level, the MCA unit advises HBPC program concerning identification of departments and products, labor mapping, and the interpretation of dashboard reports. The National MCA Office SharePoint site is: http://vaww.dss.med.va.gov/index.asp. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

i. **Veterans Equitable Resource Allocation.** Veterans Equitable Resource Allocation (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 http://vaww.arc.med.va.gov for current VERA reports and classifications). ***NOTE:*** *This is an internal VA Web site that is not available to the public.* Qualification into the HBPC complex patient class is intended to identify Veterans receiving long term chronic care. Visits beyond initial minimum qualification are expected to continue and

should be based on each Veterans individualized assessed needs and interdisciplinary plan of care.

j. **VHA Support Service Center.** The VHA Support Service Center contains HBPC patient data and reports that can provide national, network, and service level information.

k. **PACT Compass.** The PACT Team Compass brings together a series of metrics that reflects the dimensions and principles of the PACT to indicate whether a VA medical facility is on the right path. The metrics in the compass are based on patients assigned in PCMM to a primary care provider. The PACT Team Compass provides VA medical facility leadership and primary care managers and staff members access to data on HBPC panel management and inpatient utilization among other items.

l. **National Non-VA (Purchased) Medical Care Program Office.** The National Non-VA Medical Care Program Office (NNPO) is the national management organization for non-VA care programs and provides the HBPC team with data to monitor use of services by HBPC patients. NNPO site: http://nonvacare.hac.med.va.gov/policy-programs/program-information.asp. ***NOTE:*** *This is an internal VA Web site and that is not available to the public.*

EXPANDING ACCESS TO HBPC

1. Satellite HBPC programs may be established as an outreach of recognized 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) or virtually in the CBOC service area. A freestanding HBPC satellite service area may be established in communities with sufficient numbers of eligible Veterans. Satellite HBPC programs will 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.

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

3. 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.