VHA HANDBOOK 1141.02 Transmittal Sheet November 10, 2009

MEDICAL FOSTER HOME PROCEDURES

- **1. REASON FOR ISSUE**. This Veterans Health Administration (VHA) Handbook addresses the establishment, operation, procedures, and standards of Medical Foster Home (MFH).
- **2. SUMMARY OF MAJOR CHANGES.** This is the first Handbook for the new MFH service under which the Department of Veterans Affairs (VA) provides interdisciplinary home care to Veterans placed in homes in accordance with the Community Residential Care (CRC) authority of Title 38 United States Code (U.S.C.) Section 1730.
- **3. RELATED PUBLICATIONS.** VHA Handbook 1140.01, VHA Handbook 1141.01, and VHA Handbook 1176.1.
- **4. RESPONSIBLE OFFICE.** The Office of Patient Care Services, Geriatrics and Extended Care Services (114), is responsible for the contents of this Handbook. Questions may be addressed to (202) 461-6750.
- 5. RESCISSIONS. None.
- **6. RECERTIFICATION**. This VHA Handbook is scheduled for recertification on or before the last working day of November 2014.

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MEDICAL FOSTER HOME PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides specific guidance for establishing and operating a Medical Foster Home (MFH) service under the authority and standards of the Department of Veterans Affairs (VA) Community Residential Care (CRC) program as described in the VHA Handbook 1140.01, and in conjunction with a VA interdisciplinary home care team.

2. BACKGROUND

- a. Many Veterans with a disability due to complex chronic disease or traumatic injury may not be able to safely live independently, or may have care needs that exceed the capabilities of their families. Traditionally this situation was resolved by nursing home placement. However, many Veterans prefer to live in a home-like setting rather than a nursing home. Moreover, with the proper support, many Veterans who previously would have been placed in nursing homes can continue to live in a home and delay, or totally avoid, the need for nursing home care.
- b. Since 1951, the VA's CRC Program has provided health care supervision to eligible Veterans not in need of hospital care or nursing home care, but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. The CRC Program is an important component in VA's continuum of long-term care services.
- c. MFH is one end of the spectrum of CRC for Veterans who are more medically complex and disabled, and who will benefit from receiving interdisciplinary primary care in the home. MFH combines Veteran placement in a small CRC home with Home Based Primary Care (HBPC) or Spinal Cord Injury (SCI) Home Care (HC). MFH offers a safe alternative to nursing home care by placement into a private home in the community that may be a more acceptable care environment to Veterans and those responsible for their care.
- d. MFH was developed based on state models of adult foster care. As of 2008, eighteen states participated in Medicaid waiver programs to delay or prevent nursing home placement for individuals who could be adequately cared for in the adult foster care setting. Evaluations of the longest running state program in Oregon, as well as a VA analysis, show that adult foster care is a safe, cost-effective, and a favorable extended care option for individuals with functional impairments who may otherwise reside in nursing homes if adult foster care were not available. VA MFH was successfully piloted at the Little Rock VA Medical Center in 1999. In 2004, two additional sites implemented MFH programs in Tampa, FL, and San Juan, PR. With this demonstrated success at three locations, MFH is deemed ready for expansion and implementation at other sites.

3. AUTHORITY AND ELIGIBILITY

a. VHA is authorized to provide a comprehensive array of medically necessary in-home services, including HBPC, to all enrolled Veterans (see Title 38, Code of Federal Regulations (CFR) Section 17.38 (a) (1)(ix)).

b. The CRC Program is operated under the authority of Title 38, United States Code (U.S.C.) Section 1730. Any Veteran who lives in an approved CRC residence in the community is under the oversight of the CRC Program.

4. **DEFINITIONS**

- a. <u>Adult Foster Home.</u> An Adult Foster Home is a family home in which supportive care for compensation is provided in a home-like environment to adults who are frail or physically disabled.
- b. Community Residential Care (CRC). CRC is a form of enriched housing that provides health care supervision to eligible Veterans not in need of hospital or nursing home care, but who, because of medical, psychiatric, functional, or psychosocial limitations, are not able to live independently and have no suitable family or significant other to provide needed supervision and supportive care. Examples of CRC's enriched housing may include, but are not limited to: MFHs, Assisted Living Homes, Group Living Homes, Family Care Homes, and Psychiatric CRC Homes. Care must consist of room, board, assistance with Activities of Daily Living (ADL), and supervision as determined on an individual basis. The cost of residential care is financed by the Veteran's own resources. Placement is offered in residential settings, after inspection and approval by the appropriate VA medical center, and the choice is made by the Veteran (see VHA Handbook 1140.01).

c. Medical Foster Home (MFH)

- (1) MFH is an adult foster home combined with a VA interdisciplinary home care team, such as VA HBPC or SCI-HC, to provide non-institutional long-term care for Veterans who are unable to live independently and prefer a family setting.
- (2) MFH is a form of CRC for the more medically complex and disabled Veterans, and is generally distinguished from other CRC homes by the following:
 - (a) The home is owned or rented by the MFH caregiver;
 - (b) The MFH caregiver lives in the MFH and provides personal care and supervision;
- (c) There are not more than three residents receiving care in the MFH, including both Veterans and non-Veterans; and
 - (d) Veteran MFH residents are enrolled in a VA HBPC or SCI-HC Program.
- d. <u>MFH Caregiver</u>. The MFH caregiver is the person who provides care in the person's home to medically complex Veterans as delegated and supervised by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Physician Assistant (PA). This caregiver, with assistance from relief caregivers, provides room and board, appropriate levels of supervision, and assists Veterans in performing ADL, in a safe environment. *NOTE:* This person is known as a sponsor or facility operator in the CRC Program (see VHA Handbook 1140.01).
- e. **Family.** Family consists of person(s) considered by the Veteran to be the Veterans primary source of support, who may or may not be related by blood or marriage.

- f. <u>Home-based Primary Care (HBPC)</u>. 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.
- (1) HBPC targets Veterans who are generally too sick to go to clinic, and routine clinic-based care is not effective for reasons such as:
- (a) Impaired mobility due to disability or functional limitation, making it difficult to leave home without the assistance of a device or another person;
- (b) Inability to cope with clinic environment due to cognitive, physical, or psychiatric impairment;
 - (c) Need for frequent coordinated interventions from multiple disciplines; or
 - (d) Recurrent hospitalizations or urgent care episodes.
 - (2) The longitudinal care incorporates primary care and palliative care.
- (3) A VHA interdisciplinary team composed of a geriatrician, nurse, social worker, pharmacist, dietitian, psychologist, and rehabilitation therapist provides care (see VHA Handbook 1141.01).
- g. Spinal Cord Injury Home Care (<u>SCI-HC</u>). SCI-HC supports the transition and medical needs of Spinal Cord Injury and Disorder (SCI&D) patients to the home setting. The SCI-HC Program identifies and supports access to important medical, rehabilitation, and preventive services determined necessary to sustain the Veteran with SCI in the community.
- (1) SCI-HC consists of interdisciplinary services as an integral part of the SCI outpatient services under the clinical and administrative responsibility of the Chief, SCI Service. Interdisciplinary teams are composed of a physician, social worker, advanced registered nurse practitioner (ARNP), physical therapist, dietitian, occupational therapist, vocational rehabilitation specialist, chaplain, and other individuals based on Veteran and family needs.
- (2) These services are provided by HBPC with SCI Primary Care Team or an SCI Center consultation when distance prohibits follow-up by SCI-HC (see VHA Handbook 1176.1).
- h. <u>VA Interdisciplinary Home Care Team Program Director</u>. The Program Director of the HBPC, SCI-HC, or other VA interdisciplinary home care team, has the administrative responsibilities over the home care staff providing longitudinal health care in the home. This individual is the MFH Coordinator's point of contact for administrative issues related to the home care Veterans receive in MFH.

5. SCOPE

a. MFH combines selected CRC homes and a VA interdisciplinary home care team, such as HBPC or SCI-HC, to provide a non-institutional alternative for nursing home care.

- b. MFH operates under CRC regulatory authority for oversight, recruitment, and inspection of family-style homes in which to place Veterans.
- c. MFH is intended to serve Veterans who are unable to live independently due to functional, cognitive, or psychosocial impairment resulting from conditions, such as: complex chronic disease, psychological disorder, spinal cord injury or polytrauma, and have no suitable family resources to provide needed monitoring, supervision, and assistance in the Veteran's ADL.
- d. The VA interdisciplinary home care team addresses the health conditions; the MFH caregiver serves in the capacity of family caregiver to provide monitoring, supervision and personal assistance.

6. MEDICAL FOSTER HOME (MFH) GOALS

The goals of the MFH are to:

- a. Provide an alternative to institutionalization for dependent Veterans with advanced, chronic, or terminal disease, through care in a therapeutic personal home setting.
- b. Improve the quality of life for dependent Veterans when they lack the ability to remain safely in their own homes.
- c. Provide longitudinal health care in a home setting to include preventive and end-of-life care.
- d. Facilitate the most prudent use of VA and community resources, by reducing health care expenditures for a high-cost population.
- e. Provide a non-institutional option for VA to meet increasing Veteran demand for long-term care services.
- f. Provide a home setting during rehabilitative care until the Veteran can return to the Veteran's own home.

7. TARGET POPULATION

- a. MFH targets Veterans who meet the following eligibility criteria for CRC, which includes:
- (1) At the time of referral to MFH, the Veteran is receiving VA medical services on an outpatient basis; in a VA medical center, domiciliary, or nursing home care; or has received such care or services within the preceding 12 months.
- (2) The Veteran meets the nursing home level of care and prefers a non-institutional setting for long-term care, but does not need nursing home or hospital care if a MFH is available.
- (3) The Veteran is unable to safely live independently due to functional, cognitive, or psychosocial impairment.

- (4) The Veteran's family is not able to provide needed monitoring, supervision, and personal assistance.
 - b. Additional target population criteria for MFH includes the Veteran:
- (1) Having complex medical conditions requiring care from a VA interdisciplinary home care team and accept care from this home care team.
- (2) Having care needs that can be met by the MFH and the VA interdisciplinary home care team.
- (3) Not being effectively managed solely by routine clinic-based care, as evidenced by one or more factors:
 - (a) Impaired mobility due to disability or functional limitations.
- (b) Inability to cope with clinic environment due to cognitive, physical, or psychosocial impairment.
 - (c) Need for frequent coordinated interventions from multiple disciplines.
 - (d) Recurrent hospitalizations or urgent care episodes.

8. MFH SERVICE CAPACITY

The capacity of the MFH Service depends on many factors including:

- a. Staffing of MFH and VA interdisciplinary home care team.
- b. Turnover rate of residents.
- c. Access to VA and non-VA home care services.
- d. Severity and complexity of residents' medical, psychiatric, or psychosocial needs.
- e. Geographic distance and travel time from the VA facility to the MFH.
- f. Number of Veterans per MFH caregiver.
- g. Number of individual MFHs under supervision.

9. ESTABLISHING A SANCTIONED MFH SERVICE TO BE OPERATED OUT OF A VA FACILITY

a. <u>Team Training</u>. Due to the vulnerable nature of the Veterans placed in MFH care, and the complexity of elements critical to the development of MFH, VA facilities are strongly encouraged to have a team participate in MFH Team Training prior to establishing a MFH at the VA facility. *NOTE:* Contact Geriatrics and Extended Care Services for more information.

- b. <u>Proposals</u>. Proposals to establish a VA MFH service are to be submitted to the Director of Home and Community-based Care in Geriatrics and Extended Care Services, VA Central Office. This office reviews and provides guidance on proposals, and makes the determination of standards and sanctioned status of a VA MFH service. Critical elements in the proposal include:
- (1) An established VA interdisciplinary home care team, such as the HBPC or SCI-HC program, that provides medical home care to Veterans in MFHs. A VA interdisciplinary home care team is an integral component of the care and oversight required by MFH residents. A VA medical center must have the support of a functioning HBPC or SCI-HC program meeting VHA standards before establishing a MFH program.
- (2) A description of the proposed MFH service, with attention to the program elements that are included in this Handbook, as well as VHA Handbook 1140.01 or the most recent guidance regarding Spinal Cord Injury and System of Care Procedures. The program description needs to outline any state licensure requirements under which the MFH program operates.
- (3) An explanation of the staffing as described in paragraph 11. This is to include the responsibilities and full-time equivalent (FTE) employee of the MFH Coordinator and MFH Program Support Assistant (PSA), and the positions and respective FTE of the interdisciplinary home care team.

(4) Confirmation of:

- (a) Twenty-four hour telephone coverage for MFH, specifying coverage by the PSA during routine office hours, and
- (b) The process by which Veterans and caregivers are able to reach appropriate facility staff during off-duty hours.
- (5) Evidence of VA facility support including: adequate space, information technology, General Services Administration (GSA) vehicles, support of the VA interdisciplinary home care team, and equipment (e.g., computers, cell phones, pagers).
- (6) A statement that local program policies and procedures are developed based on national VA policy and regulation, as well as applicable state regulations. These local policies and procedures include a caregiver guide, guidelines for recruitment of MFHs, caregiver application process, MFH quality oversight process, policies for referral and placement of MFH Veterans, and Veteran discharge policies.
- (7) A description of VA stakeholders and a statement that these stakeholders have been informed of the intent to implement MFH. MFH programs are encouraged to secure Statements of Cooperation (SOC) or Memoranda of Understanding (MOU) with various stakeholders and service lines involved in the care of MFH residents. These stakeholders may include: Geriatrics and Extended Care, HBPC, CRC, SCI, Social Work, Mental Health, Rehabilitation Services, Primary Care, Food and Nutrition Service, Fire and Safety, and the Community Health Nurse Coordinator.

(8) A determination by VA Regional Counsel that the care provided by the MFH caregiver, under the supervision of the VA interdisciplinary home care team, does not violate the applicable state Nurse Practice Act.

10. ORGANIZATIONAL PLACEMENT OF MFH

Nationally, MFH 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 at the VA facility level. If such a position does not exist at the VA facility, MFH can function effectively under the Chief of Staff, the Associate Chief of Staff for Ambulatory Care, the Chief of Medical Services, the Chief of Spinal Cord Injury and Disorders, or a Care Line Director. MFH will serve Veterans from all VA programs and referral sources.

11. STAFFING OF THE MFH PROGRAM

- a. <u>MFH Coordinator.</u> The MFH Coordinator position requires one FTE employee. *NOTE:* An experienced senior level social worker is recommended due to the complex nature of this position. CRC standards require an additional social work FTE for programs exceeding 30 to 50 residents, but given the higher level of care needs and vulnerability of the MFH population, 40 residents is the maximum recommended caseload per MFH Coordinator FTE.
- b. <u>Care Manager</u>. Care management for MFH residents is to be provided by the interdisciplinary home care team's social worker or nurse care manager, and not the MFH Coordinator. These duties need to be assigned consistent with standards set by individual programs (e.g., geographic distribution).
- c. <u>MFH Program Support Assistant (PSA)</u>. The PSA position is recommended at one FTE employee. The PSA supports the MFH Coordinator and is responsible for clerical functions, phone coverage, assistance with reports, coordination of MFH resident visits, program workload, and quality measure tabulation.
- d. <u>VA Interdisciplinary Home Care Team.</u> The Interdisciplinary Home Care Team members consist of a dietitian, RN, social worker, rehabilitation therapist, pharmacist, mental health provider, and physician. Based upon resident characteristics and needs, this interdisciplinary team may be expanded to include others, such as a chaplain, or psychiatrist. *NOTE:* VA HBPC or VA SCI-HC programs meet this requirement.
- e. <u>Recreation Therapist.</u> Each MFH site must incorporate recreation therapy into its program. The recreation therapist works with MFH Veterans and caregivers to develop treatment plans to improve overall physical, mental, and emotional well-being, as well as facilitating access to community resources to improve quality of life. The recreation therapist may be a member of the VA interdisciplinary home care team or aligned under another service.

f. VA Inspection Team

(1) The VA inspection team includes, but is not limited to, a nurse, social worker, dietitian, and a safety officer. *NOTE: MFH* sites are advised to consider including a rehabilitation therapist on the inspection team, particularly when homes may need structural alterations to meet the safety needs of MFH residents.

- (2) The inspection team requests visits by other disciplines based upon its findings.
- (3) All CRC programs utilize an inspection team; this inspection team may serve multiple care settings and programs for the VA facility. The VA inspection team makes initial and annual inspections of the MFHs to ensure compliance with applicable fire and safety requirements, dietary and medical treatment plans, and to make recommendations as needed.

12. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

The VISN Director is responsible for:

- a. Facilitating communications between the MFH Coordinators and the Office of Patient Care Services, Geriatrics and Extended Care Services (114).
- b. Ensuring that VA facilities maintain staffing and capacity of the interdisciplinary home care programs that serve Veterans in MFHs, in accordance with 38 U.S.C. 1710B(b) requiring that staffing and levels of extended care services be maintained.
- c. Notifying the Deputy Under Secretary for Health for Operations and Management (10N) by Outlook e-mail at least 10-days prior to implementation of any proposed program restructuring that could reduce staffing or the capacity of MFH services or the home care programs that provide care to Veterans in MFH, in accordance with VHA Handbook 1000.1.

13. RESPONSIBILITIES OF THE VA FACILITY DIRECTOR

The VA Facility Director, or designee, has the overall responsibility for MFH and appoints and delegates the authority and responsibility for the day-to-day operations to the MFH Coordinator. In addition, the Facility Director is responsible for:

- a. Acting as the Hearing Official if a hearing is requested by a MFH caregiver, or delegates this duty to the facility Associate Director or Chief of Staff.
- b. Maintaining the staffing and capacity of the MFH service and the interdisciplinary home care programs that serve Veterans in MFHs.
- c. Notifying the VISN Director the Deputy Under Secretary for Health for Operations and Management (10N), and VA Central Office Geriatrics and Extended Care Services in advance of any proposed changes or restructuring that could reduce staffing, capacity of MFH services or the home care programs that provide care to Veterans in MFHs.

14. RESPONSIBILITIES OF THE CHIEF CONSULTANT, GERIATRICS AND EXTENDED CARE

The Chief Consultant, Geriatrics and Extended Care, is responsible for:

a. Developing national policy for MFH.

- b. Promoting MFH development in the field through guidance, support, email groups, conference calls and educational programs.
- c. Providing comparative feedback to VA facilities on MFH characteristics, population served, utilization, quality and outcomes.
- d. Facilitating expansion of MFH to promote reliable access to non-institutional extended care services, through national initiatives and VA facility-specific guidance and support.

15. MHF COORDINATOR

The VA facility Director delegates the day-to-day operations of the MFH service to the MFH Coordinator. The MFH Coordinator is responsible for program development, operations, and evaluation. The responsibilities of the MFH Coordinator include:

- a. Marketing MFH to VA staff, Veterans and families, Veterans Service Organizations, and the community.
- b. Establishing working relationships with all involved non-VA parties: agencies, communities, Veterans, families, and caregivers.
- c. Maintaining appropriate working relationships with all levels of VA staff including the Veteran's VA care manager and interdisciplinary home care team.
- d. Recruiting, and recommending approval of new homes that could provide care to Veterans in need of MFH care.
- e. Assessing potential MFH environments for needed structural alterations; facilitating Home Improvement Structural Alterations (HISA) grant, if needed.
- f. Implementing a process for referral and placement of Veterans into MFHs (see subpar. 21b).
 - g. Ensuring adherence to criteria for an approved MFH service (see par. 9).
 - h. Quality monitoring of MFHs after placement of each Veteran.
- i. Ensuring adherence to processes for addressing MFH non-compliance with VA's CRC standards.
- j. Meeting at least quarterly with HBPC Director or the SCI Home Care Director, or designees, to discuss program coordination and to review the status of each MFH resident.
- k. Ensuring initial and annual home inspections are done by the interdisciplinary VA inspection team.
- 1. Ensuring that the MFH caregivers are furnished with, and understand, the inspection team's recommendations.

- m. Ensuring a safe, suitable, and therapeutic environment for Veterans residing in MFH.
- n. Identifying concerns of the Veteran, the inspection team, or any member of the care team, and discussing concerns and resolutions with the MFH caregiver.
 - o. Documenting and overseeing correction of any MFH violations.
 - p. Developing and annual update of local MFH policies, procedures, and caregiver guide.
- q. Arranging the semi-annual training sessions for the MFH caregivers, as required by the most current CRC standards.
- r. Ensuring that MFH caregivers are provided with, and understand, the local caregiver guide.

16. MEDICAL FOSTER HOME PROGRAM SUPPORT ASSISTANT (PSA)

The PSA, position vital to the overall operation of the program, assists the MFH Coordinator in all facets of the program and oversees the program office in the absence of the MFH Coordinator. PSA responsibilities include:

- a. Clerical functions including, but not limited to: answering telephone inquiries, contacting the MFH Coordinator in the field when appropriate, maintaining files and record keeping systems, assisting with preparation of reports and marketing materials, and facilitating communication with the VA interdisciplinary home care team.
- b. The intake of a resident and MFH caregiver referrals to include gathering preliminary applicant information, answering applicant questions, and referring applicants to the MFH Coordinator.
 - c. Assisting in coordinating placement of Veterans.
- d. Retrieving patient information from VHA electronic records and relevant non-VA medical records.
 - e. Setting up and maintaining a file for each MFH to include:
 - (1) MFH caregiver's application,
 - (2) Initial evaluation by MFH Coordinator,
 - (3) Inspection reports,
 - (4) All correspondence related to the MFH, and
 - (5) All material relating to any hearing and decision.
- f. Collecting and maintaining electronic data for each resident and each MFH, which is used for program monitoring and evaluation.

- g. Scheduling periodic requirements, such as annual inspections to ensure CRC standards are met by MFHs and caregiver training.
- h. Tracking subject matter of training provided to MFH caregivers to facilitate curricula development of future trainings.

17. INTERDISCIPLINARY HOME CARE TEAM

The HBPC or SCI-HC interdisciplinary team is required to provide home health care, perform assessments, and monitor care provided by the MFH caregiver. The team must:

- a. Provide home health care services to Veterans in MFH in accordance with current national program policy for HBPC or SCI-HC.
- b. Educate the MFH caregiver and relief caregivers in specialized resident care needs as noted in the plan of care. This includes promptly communicating any significant changes in the resident's normal appearance, behavior, or state of health, to the HBPC or SCI-HC team.
- c. Evaluate need for adaptive medical equipment and for appropriate home improvements to facilitate access and resident care activities. A rehabilitation therapist assists eligible Veterans in applying for HISA grants when indicated, and makes initial and periodic home visits.
- d. Identify the need for community resources and coordinate purchase of community home care services.
- e. Support the MFH caregiver and residents through timely communication and problem solving.
- f. With the Veteran's consent, update the Veteran's family or surrogate regarding changes in the Veteran's medical condition in accordance with VA privacy policy and procedures.
- g. Assist the MFH Coordinator in monitoring the MFH environment with special emphasis on safety, potential for abuse and neglect, signs of caregiver stress or burnout, and any other issues and concerns that may arise.
 - h. Report any medical, psychiatric, or psychosocial concerns to the MFH Coordinator.
- i. Collaborate with, and assist, the MFH Coordinator and PSA in scheduling respites to alleviate caregiver stress and fatigue.
- j. Follow SCI patients enrolled in the MFH program, using HBPC or SCI staff to provide their primary care.

18. RECRUITMENT OF MEDICAL FOSTER HOME CAREGIVERS

- a. The recruitment of MFHs and MFH caregivers is the responsibility of the MFH Coordinator. The MFH Coordinator ensures that the process for selection of homes and caregivers complies with the regulations pertaining to the CRC program (38 CFR 17.61-17.72) as outlined in this document.
- b. The MFH Coordinator actively recruits individuals in the community with nurturing dispositions and suitable, or potentially suitable, living environments to serve as MFH caregivers for Veterans. Individuals wishing to become MFH caregivers may contact the VA medical center either by telephone, in writing, or in person. Referrals may come from the individuals themselves, or from other VA and non-VA personnel. *NOTE:* VA employees who wish to be a MFH caregiver need to consider whether doing so would violate the "Standards of Ethical Conduct for Employees of the Executive Branch" if the MFH takes VA referrals or is seeking VA referrals.
- c. Prospective caregivers must submit an application in writing to the MFH Coordinator. VA Form 10-2407, Residential Care Home Program Sponsor Application, may be used. When formal application is made, it must be reviewed by the MFH Coordinator, or designee, who is to contact the applicant to arrange a site visit. The MFH Coordinator is advised to informally discuss the application process, caregiver selection criteria, and financial aspects of MFH with each applicant.
 - d. The MFH Coordinator must inform the applicant of program expectations, including:
- (1) The primary intent of MFH, which is the permanent placement of the Veteran, often through the end of life. A secondary purpose of MFH may include a safe, community living option for Veterans receiving long-term rehabilitative care.
- (2) The Veteran's condition is likely to worsen over time, and the caregiver's workload may increase. In some situations, the Veteran may be rehabilitated and return home.
- e. The applicant must meet with the MFH Coordinator for evaluation of key physical and interpersonal skills, and to complete an initial home assessment.
- f. In addition to the written application and meeting with the MFH Coordinator, the following information may be considered in the evaluation of the applicant. The MFH Coordinator must convey that this information is not a required portion of the application, but it facilitates the process of matching Veterans with appropriate MFHs; ones that can meet their needs and preferences for care. This includes:
 - (1) Information from State and Federal background checks.
- (2) A financial statement indicating financial stability, which may include other sources of income, a history of bankruptcies, and level of debt and financial liabilities.
 - (3) Personal references.

- g. In states requiring licensure for adult foster homes with three or fewer residents, the applicant must provide proof of licensure.
- h. If the MFH Coordinator does not recommend proceeding with inspection or placement, the applicant must be notified in writing, including deficiencies related to CRC standards and guidance for correction, if these are applicable.
- i. Provided the applicant passes the initial screening process, the VA Interdisciplinary Inspection Team conducts a formal inspection as required under CRC policy.
- j. Following the team inspection of the home, a letter of final acceptance or rejection from the Director or designee, is sent to the applicant, preferably within 30 days of the inspection date.

19. MFH CAREGIVER SELECTION AND TRAINING

MFH Caregivers are selected based on requirements in VHA Handbook 1140.01 and VA regulations. These requirements are:

a. Selection Standards or Guidelines for a MFH Caregiver

- (1) Sufficient, qualified caregivers must be on duty and available to ensure the health, safety, and care of each resident. MFH caregivers may have a relief caregiver who can fulfill responsibilities including: the supervision of the MFH, needed personal assistance to the Veterans, and having the discretion to call for emergency assistance if needed. There needs to be a written backup plan that could be activated if the MFH caregiver becomes temporarily incapacitated.
- (2) The MFH caregiver and relief caregivers must have adequate education, training, and experience to maintain the MFH. This includes the experience and physical ability to provide the needed care.
- (3) The MFH caregiver must agree to assist residents in obtaining their plan of care as developed by the VA interdisciplinary home care team. The MFH caregiver generally needs to accept, participate in, and follow that plan.

b. MFH Caregiver Education and Training

- (1) VA trains MFH caregivers, or encourages MFH caregivers to obtain the knowledge and skills, in the care of frail populations in accordance with the VHA Handbook 1140.01. These include:
 - (a) Provision of personal care, specific to ADL.
 - (b) Medication management.
 - (b) Crisis management and re-hospitalization procedures.
 - (d) Provision of supportive and emotional care.

- (e) Nutrition and proper food preparation, distribution, and storage.
- (f) Activity and program planning.
- (g) Applicable VA policies.
- (h) Protect the resident's privacy and confidentiality.
- (i) Local and State laws and ordinances.
- (j) Fire and safety procedures.
- (2) VA staff continues to provide training semi-annually, and on an as needed basis determined by the MFH Coordinator.

20. MFH STANDARDS

As part of the CRC Program, a MFH must meet the standards for that program which are set forth the CRC regulations and handbook.

a. **Health and Safety Standards.** The MFH must:

- (1) Meet all applicable State and local licensure requirements and regulations including construction, fire, maintenance, and sanitation regulations.
- (2) Have safe and functioning systems for: heating, hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation.
- b. <u>Health Services.</u> The MFH must agree to assist residents in obtaining the statement of needed care developed by VA.
 - c. **Home Interior Plan.** The MFH must:
 - (1) Have comfortable dining areas, adequate in size for the number of residents.
- (2) Have comfortable living room areas, adequate in size to accommodate a reasonable proportion of residents.
- (3) Maintain at least one functional toilet and lavatory, and bathing or shower facility for every six people living in the MFH, including MFH caregiver and all residents.
 - d. Laundry Service. The MFH must provide or arrange for laundry service.

e. Residents' Bedrooms

(1) Resident bedrooms must contain no more than four beds. *NOTE:* It is strongly recommended Veterans have their own living space. The complex nature of certain medical needs may dictate the need for single occupancy in a bedroom.

- (2) Bedrooms must measure, exclusive of closet space, at least 100 square feet for a single resident room and 80 square feet for each resident in a multi-resident room.
- (3) Bedrooms must contain, at a minimum, a suitable bed and appropriate furniture and furnishings.

f. **Nutrition.** The MFH must:

- (1) Provide a safe and sanitary food service that meets individual nutritional requirements and residents' preferences;
 - (2) Plan menus to meet currently recommended dietary allowances.
- g. <u>Activities.</u> The MFH must plan and facilitate appropriate recreational and leisure activities to meet individual needs specified in the plan of care.

h. MFH Records

- (1) The MFH must maintain resident records in a secure place.
- (2) The MFH records must include the following information:
- (a) A copy of the Veteran's plan of care,
- (b) Emergency notification procedures,
- (c) A copy of all signed agreements with the resident or the resident's fiduciary.
- (3) The MFH must maintain records in compliance with applicable State and local laws and may only disclose them with the resident's permission, or when required by law.

21. REFERRAL OF VETERANS TO MFH

Veterans who require the services of MFH may be referred if they are receiving medical services in a VA hospital or outpatient facility, or are receiving VA nursing home or domiciliary care or have received such care or services within the preceding 12 months. Referrals need to be with a concurrence from the Veteran's primary care provider. *NOTE:* Referrals for MFH must be submitted through the appropriate referral process to the MFH Coordinator. Upon referral, the MFH Coordinator is responsible for:

- a. Ensuring the Veteran is accepted by a VA interdisciplinary home care team.
- b. Determining if the Veteran has the financial resources or eligibility for enhanced VA benefits sufficient to fund placement in a MFH.
- c. Identifying if someone other than the Veteran has the authority to make financial and health care decisions. If not, the MFH Coordinator educates the prospective MFH resident on the importance of having a surrogate and works with the Veteran to identify an individual who

can manage funds and make health care decisions should the Veteran become incapacitated in the future.

- d. Reviewing the Veteran's medical records with input from the treating team to assess physical and psychosocial functioning.
- e. Collaborating with the referral source, VA staff, the Veteran or surrogate, and if appropriate the Veteran's family, to establish an accurate profile of the Veteran and expected care needs.
 - f. Identifying whether the Veteran has been diagnosed with an active communicable disease.
- g. Ensuring that Veterans who are being followed by a mental health provider continue to receive mental health care. For Veterans with a major psychiatric diagnosis, requests certification from a psychiatrist that the Veteran can safely live in the MFH.
 - h. Determining that the Veteran is not a danger to self or others.
 - i. Explaining MFH to Veteran and family members.
- j. Promoting optimal match of Veteran and MFH by ensuring MFH caregiver skills and home standards meet specific care and safety needs of the Veteran, as well as through compatibility of interests, temperament, and lifestyle of the Veteran and MFH caregiver.
 - k. Securing appropriate consent to a release of the Veteran's information.
- 1. Providing the MFH caregiver with a health summary that includes psychosocial, functional, behavioral, nutritional, and medical information, including communicable diseases.
- m. Encouraging the Veteran, family, or surrogate to visit available MFHs before a decision is made.
- n. Ensuring that upon matching a Veteran with a MFH caregiver, the Veteran or an authorized personal representative and the MFH caregiver, or authorized representative, must agree upon the charge and payment procedures for care. This agreement must be in writing and signed by both parties, and a copy of the agreement must be provided to each party and to the MFH Coordinator for inclusion in the Veteran's VA medical record.

22. PLACEMENT OF VETERANS IN MFHs

a. Acceptance

- (1) If possible, the Veteran and MFH caregiver meet prior to placement.
- (2) The MFH Coordinator recommends the MFH caregiver and Veteran establish a written agreement concerning the terms of the room, board, and personal care assistance provided by the MFH caregiver to the Veteran. *NOTE:* The MFH Coordinator may provide an example agreement to the MFH caregiver and Veteran.

- (3) The MFH Coordinator needs to recommend that a written agreement include:
- (a) A list that specifies the services and accommodations to be provided by the MFH;
- (b) The cost of care rates and charges, based on Veteran's level of care, following established guidelines;
- (c) A statement that the MFH caregiver must provide at least 30 days notice before implementing a rate increase, unless there is a sudden change in necessary level of care;
- (d) Bed-hold policy for Veterans who request the caregiver reserve a bed during the Veteran's admissions to a hospital
- (e) The MFH discharge policy. The MFH Coordinator must recommend the MFH caregiver not discharge a Veteran without 30 days written notice that states the reasons for the requested move or transfer, except when the situation requires immediate removal.
 - (f) A refund policy when a Veteran is discharged or dies.

b. Procedure for Placement of Veteran in MFH, or for a Trial Visit.

- (1) All requests and placements in MFH must go through the MFH Coordinator.
- (2) Discharge date from inpatient facility must be coordinated with the HBPC or SCI-HC care manager. **NOTE:** Generally, the Veteran is not discharged to MFH until 24 hours after making significant treatment changes (e.g., discontinue catheters, feeding tubes, oxygen, etc.) that may result in acute problems in the MFH, and lead to Emergency Room visits or hospital readmission within hours of the discharge.
- (3) The interdisciplinary home care team members must assess the specific home equipment needs of the Veteran prior to discharge from the inpatient setting.
- (4) For SCI-HC patients, specialized home assessment and SCI training must be provided to the MFH caregiver and patient by a registered nurse, to include bowel and bladder care, wound care, and pain management.
- (5) MFH Coordinator contacts the MFH caregiver to verify readiness to receive the Veteran and explore any remaining needs or concerns.
- (6) MFH Coordinator educates the MFH caregiver regarding responsibility for the Veteran's current and anticipated personal and health care needs, including necessary level of supervision.
- (7) MFH Coordinator ensures all appropriate adaptive medical equipment (hospital bed, bedside commode, wheelchair, oxygen concentrator, feeding pump, etc.), medications, treatments, and supplies are ordered and delivered to the MFH prior to the arrival of the Veteran and that all appropriate training is provided.
- (8) The MFH Coordinator ensures transportation is arranged for the Veteran to the MFH. Responsibility for discharge transportation is not to be delegated to the MFH caregiver.

(9) If discharged from an inpatient facility, the Veteran must be reviewed by VA inpatient staff and generally discharged with at least a 30 day supply of medications and supplies. A copy of the Patient Discharge Instructions is to accompany the Veteran to the MFH.

c. Upon placement in MFH

- (1) MFH Coordinator encourages the Veteran, or surrogate, to file the Veteran's claim for a VA pension on the day of admission to MFH, or as soon as possible thereafter.
- (2) MFH Coordinator establishes a mechanism to monitor and encourage timely payment of MFH caregiver by the Veteran.
- (3) MFH Coordinator and MFH caregiver must: verify the medications and supplies ordered and received; review the Veteran's physical condition on arrival; and review any other medical issues, such as special diets, the Veteran's mobility, and any adaptive medical equipment.
- (4) On the day the Veteran moves into the MFH, the VA interdisciplinary home care team RN makes a home visit to the MFH, or is available by telephone to respond to any questions or issues that may arise.
- (5) MFH Coordinator assists the Veteran to provide the MFH caregiver with pertinent information, such as: family contact information, Medicare Supplemental Insurance, advance directives or living will (if available), designated funeral home preference, and whatever additional information may be needed for making decisions in a timely manner when the Veteran cannot communicate.
- (6) MFH Coordinator suggests that the MFH caregiver complete an inventory of the Veteran's personal possessions and have the Veteran, or surrogate, sign the list to prevent future claims of missing property.
- (7) MFH Coordinator reviews the respite schedule of current residents in the MFH, and attempts to coordinate respite care for the newly-admitted resident to match this schedule.

23. QUALITY MONITORING AFTER MFH PLACEMENT

- a. Within 24 Hours of Placement. The MFH Coordinator or PSA contacts the MFH to check on the Veteran and the MFH caregiver. The MFH caregiver is asked if the instructions regarding Veteran's medical condition and the Veteran's care needs were adequate.
- b. Within 2 Weeks of Placement. The MFH Coordinator makes a home visit to evaluate the adjustment of the MFH caregiver and Veteran.
- c. <u>Monthly.</u> Unannounced visits by MFH Coordinator, or designated health care professionals, are conducted monthly to:
- (1) Observe for abuse or neglect. Suspected abuse or neglect needs to be reported in accordance with VHA Handbook 1605.1 (see current VHA policy regarding the reporting of abuse and neglect).

- (2) Determine if the MFH caregiver leaves the resident without adequate supervision.
- (3) Observe for caregiver stress. The MFH Coordinator may encourage respite or that the MFH caregiver hire assistance for relief.
- (4) Observe for conflicts between, or among, any of the involved parties: residents, MFH caregiver, family members (resident's or the caregiver's), surrogate, friends, and VA staff members.
- (5) Encourage the MFH caregiver, the resident, family, or surrogate to seek help from the MFH Coordinator in resolving conflicts and addressing problems that arise in the home.
- (6) Monitor for financial issues; i.e., protection of the Veterans' personal funds; inadequate, late, or no payments; complaints about rate amounts or changes; concerns relating to vacancies; and decreased income, etc.
- (7) Discuss potential violations of the written agreement between the Veteran and the MFH caregiver and assist in dispute resolution.
- (8) Reeducate the Veteran and the MFH caregiver, as needed, about each other's rights and responsibilities in the MFH.
- (9) Explore the Veteran's ongoing adjustment to the MFH environment and to the MFH caregiver, including resident satisfaction with MFH.
- (10) Ensure all communication of instructions or information, is provided verbally or in writing, to the resident, MFH caregivers, families, and surrogate, as appropriate.
 - (11) Ensure compliance with all CRC regulations.
- d. <u>Justification for Suspending Placement.</u> The following serve as justification for suspending placements in a MFH and offering alternative placements to Veterans in that home (see par. 24).
 - (1) Abuse or neglect of a resident.
 - (2) Documented instances that put the safety or well-being of resident at ongoing risk.
 - (3) The MFH caregiver is incapable of providing adequate care for resident(s).
 - (4) Documented non-compliance with a resident's treatment plan of care.
- (5) Documented non-compliance with program standards, including inspection recommendations or participation in required training sessions.
 - e. Adjudicated Incompetent Residents Placed in MFH. The MFH Coordinator must:

- (1) Meet on an annual basis with VA Regional Office Guardianship staff to discuss financial arrangements of the adjudicated incompetent residents placed in MFH.
- (2) Provide VA Regional Office Guardianship staff timely notification of change in cost of care or in the location of these residents.

24. DUE PROCESS AND REQUEST FOR HEARING

- a. <u>Notice of Non-Compliance with VA Standards.</u> If the Hearing Official (Director, or if designated by the Director, the Associate Director or Chief of Staff for a VA medical center or Outpatient Clinic) determines that an approved MFH does not comply with CRC standards, the hearing official must notify the MFH caregiver in writing:
 - (1) Which standards have not been met.
- (2) The date by which the standards must be met in order to avoid revocation of VA approval.
- (3) That the MFH caregiver has an opportunity to request an oral or paper hearing before VA approval is revoked.
- (4) The date by which the Hearing Official must receive the MFH caregiver's request for a hearing. **NOTE:** The date by which the Hearing Official must receive the request for a hearing must not be less than 10 calendar days and not more than 20 calendar days after the date of VA notice of non-compliance, unless the hearing official determines that non-compliance with the standards threatens the lives of residents, in which case the hearing official must receive the MFH caregiver's request for an oral or paper hearing within 36 hours of receipt of the VA notice. Nothing in this Handbook prevents VA officials from assisting a Veteran (with permission from the Veteran or the authorized representative of the Veteran) who resides in a MFH in finding temporary lodging.
- b. <u>Request for Hearing.</u> The MFH caregiver must specify in writing whether an oral or paper hearing is requested. The request must be sent to the Hearing Official by the date specified by the Hearing Official in order to stay the revocation of approval. The Hearing Official may accept a request for a hearing after the time limit if the MFH caregiver shows that the delay was due to circumstances beyond the MFH's control.

c. Notice and Conduct of Hearing

- (1) Upon receipt of a request for an oral hearing, the Hearing Official must notify the MFH caregiver:
 - (a) In writing, of the date, time, and location of the hearing; and
- (b) That written statements and other evidence for the record may be submitted to the Hearing Official before the date of the hearing. Oral hearings are to be informal and rules of evidence are not followed. Witnesses must testify under oath or affirmation. A recording or transcript of every hearing must be made by a certified Court Reporter at the expense of the

jurisdictional facility. The Hearing Official may exclude irrelevant, immaterial, or unduly repetitious testimony.

- (2) Upon receipt of a request for a paper hearing, the Hearing Official must notify the MFH caregiver that written statements and other evidence must be submitted to the Hearing Official by a specified date in order to be considered as part of the record.
 - (3) In all hearings, the MFH caregiver and VA may be represented by counsel.
- d. Waiver of Opportunity for Hearing. If representatives of a MFH which was issued a notice of non-compliance fail to appear at an oral hearing of which they have been notified, or fail to submit written statements for a paper hearing (unless their failure to appear was due to circumstances beyond their control as determined by the Hearing Official), the Hearing Official must:
- (1) Consider the representatives of the MFH to have waived their opportunity for a hearing; and
 - (2) Revoke VA approval of the MFH and notify the MFH caregiver of this revocation.

e. Written Decision Following a Hearing

- (1) The Hearing Official must issue a written decision within 20 days of the completion of the hearing. An oral hearing is considered completed when the hearing ceases to receive inperson testimony. A paper hearing is considered complete on the day by which written statements must be submitted to the Hearing Official in order to be considered as part of the record.
- (2) The Hearing Official's determination of a MFH caregiver's non-compliance with VA standards must be based on the preponderance of the evidence.
 - (3) The written decision must include:
 - (a) A statement of the facts; and
 - (b) A determination whether the MFH complies with the standards in this Handbook.
- (4) The written decision may include a determination of the time period the MFH has to remedy any non-compliance with VA standards before revocation of VA approval occurs.
- (5) The hearing official's determination of any time period must consider the safety and health of the residents of the MFH and the length of time since the MFH received notice of the non-compliance.

f. Revocation of VA Approval

(1) If the Hearing Official determines that the MFH does not comply with the standards and that the facility is not to be given further time to remedy the non-compliance, the Hearing Official must revoke approval of the MFH and notify the facility of this revocation.

- (2) Upon revocation of approval, VA health care personnel must:
- (a) Cease referring Veterans to the MFH;
- (b) Notify any Veteran residing in the MFH of the facility's disapproval and offer to assist with alternate placement plans. *NOTE:* If the Veteran has a legal representative, then that person must be notified and offered assistance with alternate placement planning;
- (c) In the event a Veteran chooses to remain in a MFH that has lost VA approval, the MFH Coordinator must discontinue monthly visits; however, the HBPC or SCI-HC team continues to provide home health care to the Veteran as long as clinical criteria for the program are satisfied and care needs can safely be met through these programs.
- (3) If the Hearing Official determines that the MFH is to be given additional time with which to remedy the non-compliance, the Hearing Official must establish a new date for review. If at the end of the time period, the MFH still does not comply with these or any other standards, the Hearing Official must repeat the procedures in subparagraphs 24a through 24e of this Handbook.

25. PERFORMANCE IMPROVEMENT PLAN

The MFH Coordinator must conduct an annual risk assessment and based on the assessment establish and operate a Performance Improvement Plan to be conducted by the MFH Coordinator and the VA interdisciplinary home care team. This risk assessment and plan needs, at a minimum, to address at least two or more quality monitors with a quarterly or annual evaluation; these are:

- a. Quality of life (e.g., depression, nutrition).
- b. Medication safety to include proper handling, management, storage and prevention of misuse.
 - c. Resident satisfaction and perception of care.
 - d. Cost effectiveness of MFH for VA.
 - e. Data for quality improvement as outlined in paragraph 26.

26. QUALITY ASSURANCE IN THE MFH PROGRAM

- a. <u>Responsibility.</u> The VA medical center must integrate the MFH service into its Quality Improvement Program. Generally, this is the responsibility of the clinical area (service line or care line) with program oversight.
 - b. Quality Data. MFH data must include:
- (1) **Reports of Surveys.** Reports of surveys conducted by Federal, State, and local regulatory licensing agencies, as applicable.

- (2) **Adverse Events.** Adverse events may result from acts of commission or omission. They include:
 - (a) Patient injuries from falls;
 - (b) Adverse drug events;
 - (c) Procedural errors and complications;
 - (d) Completed suicide;
 - (e) Para-suicidal behaviors (attempts, gestures, or threats) and missing patient events;
 - (f) Incidents of suspected neglect, abuse, or assaults on or by the MFH resident;
 - (g) Incidents that result in injury with loss of function;
 - (h) Severe psychosocial and emotional distress.
- (3) **Sentinel Events.** Sentinel events associated with Root Cause Analysis (RCA) are defined as unexpected occurrences involving death, serious physical or psychological injury, or risk thereof. They include:
 - (a) Death resulting from a medication error, or other treatment–related error.
 - (b) Suicide of a patient in a setting where the patient was receiving around-the-clock care.

NOTE: Adverse and Sentinel Events require investigation and documentation. All Adverse and Sentinel Events must be reported promptly in accordance with local VA medical center and VISN policies, and to the VHA Office of Patient Care Services, Geriatrics and Extended Care (114).

- c. <u>Results.</u> Results of quality assessment and improvement activities must be used by local VA staff in suggesting program improvements and changes, and in making decisions regarding the continued use of any MFH, including:
 - (1) Results from any Veteran or family satisfaction reports; and
- (2) Any MFH specific quality improvement findings that may be established by the VA medical center.

27. RETENTION OF MFH CAREGIVERS

a. Long-term care giving is a highly-stressful responsibility. The caregiver's stress level is to be closely monitored by the MFH Coordinator and the rest of the treating team. Early identification of signs and symptoms of caregiver stress, with appropriate intervention, is crucial. **NOTE:** Assessment of caregiver stress using a validated caregiver strain instrument is recommended at least annually.

b. When caregiver strain is identified, supportive guidance is to be provided, including education on VA and non-VA caregiver support resources, setting priorities for self and for resident care, and implementing timely respite.

28. MFH CAREGIVER SUPPORT SERVICES

- a. In providing information and support to MFH caregivers, the MFH Coordinator, HBPC, or SCI-HC team is responsible for:
- (1) Educating and training the caregivers in all aspects of resident care to meet the Veteran's individual needs, as well as to meet MFH policy.
- (2) Providing information on who to call if questions arise in between visits, including nights, weekends, and holidays.
- (3) Responding to issues and concerns raised by Veterans, their families or surrogates, and the MFH caregivers.
- (4) Referring Veterans to other VA and non-VA programs as appropriate. For example, Veterans may be referred to community home health agencies for skilled nursing, rehabilitation therapy, bowel and bladder programs, or hospice services.
 - (5) Assisting with arrangements for respite for MFH caregivers as needed.
- b. In addition, the MFH Coordinator is responsible for encouraging caregivers to establish a caregiver association or to hold meetings which offer opportunities to offer support, vent frustration, and gather ideas to improve performance of their occupation as caregivers.

29. FINANCIAL ARRANGEMENTS

- a. The MFH program follows the policies of VHA Handbook 1140.01 regarding cost and fees for care. *NOTE:* Due to high risk of conflict of interest, it is recommended the MFH caregiver not attempt to manage the resident's personal finances.
 - b. The cost of care normally covers the following services:
 - (1) Room;
 - (2) Meals, as defined in the resident's Plan of Care;
 - (3) Laundry;
 - (4) Transportation for routine health care, if appropriate;
 - (5) Twenty-four-hour supervision, if indicated; and
 - (6) Care and assistance with ADL, as defined in the care plan.

- c. Payment for MFH charges is the responsibility of the Veteran and not the responsibility of VA. *NOTE:* VA is prohibited by law from paying for this service.
- d. All financial arrangements between the MFH caregiver and the Veteran, or surrogate, must be reviewed by the MFH Coordinator to determine that the rates charged for MFH are reasonable and comply with regulation (see 38 CFR 17.63(k)).
- (1) The charges for care in the MFH must be reviewed annually, or as indicated, due to changes in care needs. This must be documented in the Veteran's medical record by the MFH Coordinator, or PSA.
- (2) For special needs or additional services, the Veteran or the Veteran's representative may agree to pay an increased rate. The MFH Coordinator may assist the MFH caregiver, the Veteran, and the Veteran's representative in establishing these rates; all of this must be documented in the Veteran's medical record by the MFH Coordinator, or PSA.

30. LEGAL ISSUES

- a. <u>Coordination with Office of Regional Counsel.</u> The MFH Coordinator is advised to maintain open communication with Office of Regional Counsel for advice on legal issues pertaining to MFH.
- b. **Residents' Rights.** The MFH caregiver must have written policies and procedures that ensure and inform residents of their following rights:
 - (1) **General.** Each MFH resident has the right to:
 - (a) Be treated with respect, dignity and consideration.
- (b) The confidentiality and non-disclosure of records and information on the resident obtained or kept by the MFH caregiver, except in accordance with the requirements of applicable law.
 - (c) A review the resident's own records kept by the MFH.
 - (d) Exercise rights as a citizen.
- (e) Voice grievances and make recommendations concerning policies and procedures of the MFH.
- (2) **Financial Affairs.** Residents must be allowed to manage their own personal financial affairs, except when restricted in this right by law. If the resident requests assistance in managing personal financial affairs, the request must be documented. The Veterans Benefits Administration (VBA) Regional Office Manager, or fiduciary, must be notified when MFH residents receiving VA benefits require assistance with managing their finances.
 - (3) **Privacy.** Residents must be allowed privacy, to include:
 - (a) Access to a phone. NOTE: Reasonable privacy must be available.

- (b) Unopened and uncensored mail. Mail must be sorted and delivered unopened and uncensored.
 - (c) Privacy of self and possessions.
- (4) **Work.** No MFH Veteran is required to perform household duties, other than personal housekeeping tasks, unless the resident receives compensation for these duties, or is told in advance they are voluntary and the Veteran agrees to do them.

(5) Freedom of Association

- (a) Veterans may receive visitors and associate freely with persons and groups of their own choosing both within and outside of the MFH, subject to any rules set forth in an agreement between the resident and the MFH caregiver. Residents may make contacts in the community and achieve the highest level of independence, autonomy, and interaction in the community of which the resident is capable.
- (b) Residents may leave and return freely to the MFH subject to any rules set forth in the agreement between the resident and the MFH caregiver.
- (c) Residents may practice the religion of their own choosing or choose to abstain from religious practice.
- (6) **Transfer or Withdraw.** A resident has the right to request a transfer to another MFH or to withdraw from the program.
- c. <u>Civil Rights Act and Americans with Disabilities Act.</u> MFH caregivers are prohibited from discriminating against residents in the MFH Program because of their color, race, age, religion, national origin, disability (whether physical or mental), or gender in accordance with the Civil Rights Act of 1964 and its ensuing amendments, the Rehabilitation Act and the Americans with Disabilities Act.