

## HOSPITAL IN HOME PROGRAM

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes policy and procedures for implementing Hospital in Home (HIH) programs.

**2. SUMMARY OF CONTENT:**

a. Amendment dated June 4, 2025, changes “gender” to “sex” to comply with EO 14168.

b. As published January 19, 2021, this directive defined a new policy and provided procedures for implementing, managing and overseeing HIH programs.

**3. RELATED ISSUES:** VHA Directive 1411, Home Based Primary Care, dated June 5, 2017 and VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016.

**5. RESPONSIBLE OFFICE:** The Office of Geriatrics and Extended Care (12GEC) is responsible for the contents of this directive. Questions may be addressed to 202-461-6750.

**6. RESCISSIONS:** None.

**7. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of January 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF  
THE UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA, RN  
Assistant Under Secretary for Health  
for Patient Care Services (Chief Nursing  
Officer)

**NOTE:** All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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## HOSPITAL IN HOME PROGRAM

### 1. PURPOSE

This Veterans Health Administration (VHA) directive provides procedures for the implementation and management of the Hospital in Home (HIH) programs.

**AUTHORITY:** Title 38 United States Code (U.S.C.) § 1717, 38 Code of Federal Regulations (C.F.R.) § 17.38 (a)(1)(ix).

### 2. BACKGROUND

a. The Department of Veterans Affairs (VA) *Blueprint for Excellence* provides strategies and themes for transforming VA health services from being provider-centric to being Veteran-centric. The HIH model is a patient-centric model of care with shared decision making between the Veteran, their family and health care providers that enhances access to and coordination of Veteran care.

b. The VHA Office of Geriatrics and Extended Care offers a unique continuum of home and community-based services that includes Home Based Primary Care (HBPC), HIH, Medical Foster Home (MFH), Community Residential Care (CRC), Purchased Homemaker/Home Health Aide (H/HHA), Purchased Skilled Care, Veteran Directed Care (VDC), Purchased Home Hospice, Adult Day Health Care (both VA and Purchased) and respite.

c. HIH was implemented at several VA medical centers as part of the New Models of Care, Non-Institutional Long-Term Care initiative. Broader dissemination of the program has continued through mentoring partnerships between established HIH program sites and new sites. HIH offers Veterans increased choice in how their care is provided. At VHA facilities with a HIH program, Veterans who are evaluated by at least one approved HIH clinical provider, and are determined to be eligible for treatment by HIH care, may be offered an opportunity to choose to be cared for in their home as an alternative to hospitalization.

### 3. DEFINITIONS

a. **Caregiver.** For the purpose of this directive, a caregiver provides substantive assistance in the Veteran's place of residence, i.e., assistance with Activities of Daily Living (ADL) /or with Instrumental Activities of Daily Living (IADL) on an ongoing basis for the Veteran or supervision, protection or assistance as a result of the Veterans' cognitive or mental health impairment. The assistance includes, but is not limited to, direct personal care activities, such as bathing, dressing, grooming, laundry, shopping, meal preparation, protection from safety risks and supporting self-regulation, memory, and everyday planning and decision-making. The caregiver may be a family member, friend, Medical Foster Home or Community Residential Care operator, or neighbor who lives with or lives separately from the Veteran.

b. **Concurrent Care.** Concurrent care occurs when more than one agency or program provides services during a period of time. Concurrent care involving multiple

agency services and supplementation of services is permissible when service plans are both explicit and discrete and do not create a duplication of service.

c. **Health Care Setting.** For this directive, health care setting is defined as a community nursing home, community living center, or hospital.

d. **Home.** Home is defined as the private residence in which the Veteran resides. This would include the Veteran's residence, Medical Foster Home, adult foster care, and community residential care settings. This does not include inpatient health care settings such as nursing homes, skilled care facilities, domiciliary and other inpatient institutional care settings.

e. **Home Based Primary Care.** Home Based Primary Care (HBPC) is synonymous with HBPC Special Population Patient Aligned Care Team (PACT) and means comprehensive, longitudinal, in-home primary care provided by a VA- interdisciplinary team with physician oversight in the homes of Veterans with a complex, chronic and disabling disease for whom routine clinic-based care is not effective.

f. **Home Based Transitional Care.** Home Based Transitional Care (HBTC) services are in-home clinical interventions designed to ensure the coordination and continuity of health care while a Veteran relocates among different healthcare settings and the home.

g. **Hospital in Home.** HIH offers intensive time limited home-care to Veterans with specified acute and/or complex medical conditions such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Community Acquired Pneumonia (CAP), cellulitis or other specified conditions amenable to safe and effective management in the home setting, with the goal of reducing hospital admissions, decreasing hospital length of stay by allowing patients to be discharged earlier from the hospital, reducing the likelihood of readmissions, decreasing the risk of adverse events and improving outcomes. The HIH Model shifts the focus from problem-based disease care, to patient-centered health care by delivering medical care to the patients in their homes through recurring RN visits and physician communication by telephone or through the use of telehealth equipment. This enables patients to maintain their independence and decreases the risks of re-hospitalization.

#### **4. POLICY**

It is VHA policy that VA medical facilities offering HIH programs establish procedures for the implementation and management of HIH programs to meet the needs of Veterans requiring this service in order to enable patients to maintain their independence and reduce the adverse consequences of re-hospitalization. These programs accomplish this by providing an avenue for patients still requiring acute care services to be discharged home early and by breaking the cycle of admissions from the Emergency Department (ED) that are significant sources of admissions (inside and outside VA).

## 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for supporting the program office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Veterans Integrated Services Network (VISN) Director.** The Veterans Integrated Services Network (VISN) Director is responsible for:

(1) Ensuring that adequate resources are provided to fully implement HIH in each of the VA medical facilities within the VISN that establishes HIH.

(2) Supporting all components and services in HIH care as described in this directive and its appendices.

(3) Providing and facilitating necessary communication, resources and quality improvement efforts to maintain expertise and quality services.

(4) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

e. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that adequate resources are provided to fully implement, manage and sustain HIH.

(2) Providing resources and policies for the provision of HIH services as described in this directive and its appendices.

(3) Ensuring that local policy and procedures, consistent with this directive are developed and implemented.

***NOTE:*** *Hospital in Home at the local level may be included in other local policy (e.g., Infection Control, Emergency Management) and does not need to be a stand alone local policy.*

(4) Ensuring that the HIH Program implements a performance improvement process in conjunction with the VA medical facility's overall Performance Improvement Plan, that is consistent with the standards set forth by VHA and the contracted accrediting organization.

(5) Issuing A VA Policy Memorandum that outlines the requirements, policies and procedures necessary for the operation of HIH at the VA medical facility.

f. **Hospital In Home (HIH) Medical Director.** The HIH medical director must be a physician who is responsible for the overall medical care delivered by the HIH team. The HIH medical director is responsible for:

(1) Ensuring appropriate physician oversight in care of all HIH Veterans.

(2) Providing leadership to the HIH program.

(3) Planning and directing the educational and clinical experience of medical students, residents, fellows and nurse practitioner trainees assigned to the HIH program.

(4) Assuming a leadership role in the development and implementation of the HIH's performance improvement plan.

(5) Assuring the relevant home care standards set forth by VHA and the contracted accrediting organization are met.

(6) Jointly selecting HIH team in collaboration with the services who are part of the program.

(7) Providing clinical input and oversight for all patient treatment plans.

(8) Is readily available to the team members for collaboration when medical or other problems arise.

(9) Participates in HIH team meetings.

## 6. GOALS

The HIH program is developed to reduce the adverse consequences of hospital admissions. It does this by providing an avenue for patients still requiring acute care services to be discharged home early and by breaking the cycle of hospital admissions from the Emergency Department (ED) that are significant sources of admissions (inside and outside VA). By diverting cases from the ED, Veterans are spared exposure to pathogens, disorientation, deconditioning, fall risk, etc. in the hospital setting that can lead to higher costs, deteriorating patient health and elevated risk for readmission following discharge. Close monitoring of patients in their home setting allows for some types of early intensive medical intervention that can prevent hospital readmission. The goals of VHA HIH programs include, but are not limited to:

- a. Providing clinically appropriate acute hospital level care in a home setting.
- b. Reducing needless hospital admissions and readmissions.
- c. Fostering early discharge from the hospital.
- d. Supporting Veterans in restoring or improving their health status and maintaining their independence.
- e. Assuring a patient-centered, interdisciplinary mode of care-delivery, following established standards of clinical care.
- f. Supporting paid and unpaid caregivers in the care of the Veteran. Unpaid family, neighbors and friends may be directed to the caregiver support services, such as the Caregiver Support Program.

## 7. ESTABLISHING HIH

National expansion of the HIH model within VHA is compatible with the goals of the *Blueprint for Excellence* and GEC's strategic plan. VA Central Office, Office of Geriatrics and Extended Care (GEC) has established a two-year mentoring program to assist facilities in developing and implementing HIH. Sites interested in establishing HIH through an approved GEC Mentoring Partnership should contact the VACO GEC office (12GEC). Sites proposing to establish a HIH program without an approved GEC Mentoring Partnership will submit a Clinical Restructuring proposal through VA Central Office as per VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

## 8. NEW PROGRAM APPROVAL

The VA Central Office, Office of Geriatrics and Extended Care manages applications for mentoring partnership agreements.

a. **Applications.** Applications for formal recognition of new HIH programs must be submitted with letters of commitment from the VA medical facility and VISN Directors, to VA Central Office, Office of Geriatrics and Extended Care (GEC).

b. **Required HIH application elements.**

(1) **A description of the proposed program:**

(a) Goals;

(b) Criteria for patient inclusion;

(c) Quality Improvement/Performance Improvement Plan, including health equity impact assessment;

(d) Agreement to meet the relevant standards of Joint Commission, American Nurses Credentialing Center (ANCC), and Pathways to Excellence (PTE); and

(e) Policies, Procedures and Standard Operating Procedures (SOPs).

**(2) Processes:**

(a) Consult/referral;

(b) Provider acceptance;

(c) Admission;

(d) Plan of care; and

(e) Discharge.

**(3) Documentation:**

(a) Clinics/stop code;

(b) Encounters; and

(c) Notes.

**(4) Diagnosis and Treatment Modalities.**

**(5) Organizational chart.**

**(6) Business Plan:**

(a) Fund Control Point (FCP);

(b) Facility will provide a business plan that shall include:

1. Executive summary of the program

2. Resource Requirements (such as FTE, equipment, supplies, vehicles)

3. Team positions

4. Program overview

5. VERA Analysis-projected VERA revenue

6. Budget and Spend Plan

7. Cost Benefit analysis

8. Conclusion

**(7) Pharmacy:**

- (a) Staff to include Clinical Pharmacy Specialist (CPS) team support;
- (b) Supplies;
- (c) Delivery; and
- (d) Contracts/Memorandums of Understandings (MOUs) are in place when Community Services are required.

**(8) Patient Supplies:**

- (a) Pharmacy
- (b) Sterile Processing Department (SPD); and
- (c) Prosthetics, including patient mobility devices as medically appropriate.

**(9) Physical space.**

**(10) Government vehicles.**

**(11) Equipment** (Information Technology (IT), nursing supplies).

**(12) Staffing.** The HIH Staffing and FTE, including: Medical Doctor (MD/DO)/Nurse Practitioner (NP)/Physician Assistant (PA)/Registered Nurse (RN)/Social Worker (SW)/Physical Therapist (PT)/Clinical Pharmacist Specialist (CPS)/Dietitian (RD):

- (a) Staffing methodology based on best practice and evidence based literature.
- (b) Recruitment, hire, orientation, training, competency, simulation of skills.

**(13) Laboratory:** Any laboratory testing is required to meet the federal laboratory requirements (Title 42 C.F.R. § 493), VA requirements as outlined in VHA Handbook 1106.01, Pathology and Laboratory Medicine Serviced Procedures, dated January 29, 2016 and accreditation requirements. Non-waived laboratory testing requires accreditation under a deemed status accrediting organization. The laboratory and HIH program are to work together to implement testing and ensure accreditation requirements are met.

- (a) Options, Point of Care testing devices (e.g.; iSTAT).
- (b) Staff to provide laboratory Ancillary Testing oversight.
- (c) Clinical Laboratory Amendments (CLIA) certificate.
- (d) Laboratory instrument selection and validation.

- (e) Laboratory testing training and competency assessment.
- (f) Laboratory testing accreditation.
- (g) Laboratory proficiency testing.
- (h) Resources for increased testing volumes (specimens delivered to the main laboratory for testing).

## 9. VETERAN ADMISSION TO THE HIH PROGRAM

Veterans who require the services of HIH may be referred from any setting through the appropriate referral process. Before a Veteran can be admitted into the HIH program, the Veteran must be evaluated by at least one approved HIH clinical provider and meet the admission requirements. For a detailed list of the admission criteria, to include but not limited to the referral process, determination of patient appropriateness for home care, informed consent, admission to HIH, delivery of care, etc. please refer to Appendix B, Program Operation Processes.

## 10. REFERENCES

- a. 42 C.F.R. § 493, Laboratory Requirements.
- b. Public Law 106-117. Veterans Millennium Health Care and Benefits Act. Washington, DC: US Government Printing Office, 1999.  
<https://www.govinfo.gov/content/pkg/PLAW-106publ117/pdf/PLAW-106publ117.pdf>.
- c. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- d. VHA Directive 1068, Recall of Defective Medical Devices and Medical Products, Including Food and Food Products, dated July 22, 2014.
- e. VHA Directive 1069, National Pharmacy Benefits Management (PBM) Drug Safety Alert Distribution, dated November 24, 2014.
- f. VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016.
- g. VHA Directive 1200, Research & Development Program, dated May 13, 2016.
- h. VHA Directive 1411, Home Based Primary Care, dated June 5, 2017.
- i. VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals, and Preferences, dated January 11, 2017.
- j. VHA Handbook 1106.01 Pathology and Laboratory Medicine Service Procedures, dated January 29, 2016.

k. VHA Handbook 1108.11, Clinical Pharmacy Services, dated July 1, 2015, amended June 29, 2017.

l. VHA National Patient Safety Improvement Handbook, 1050.01, dated March 4, 2011.

m. Home Care Accreditation Requirements: Joint Commission accreditation requirements fall into two major categories: Standards and National Patient Safety Goals,  
[https://www.jointcommission.org/accreditation/home\\_care\\_accreditation\\_requirements.aspx](https://www.jointcommission.org/accreditation/home_care_accreditation_requirements.aspx).

n. National Home Infusion Association, <https://www.nhia.org>.

**HOSPITAL IN HOME PROGRAM STANDARDS**

Principal program requirements for the VA Hospital in Home (HIH) program include the following:

a. **Interdisciplinary team.** Core staff must be composed of an interdisciplinary team, including physician or advanced practice professional(s) (APP), nursing and clinical pharmacy specialist(s), each with sufficient dedicated time for HIH as part of their position description or functional statement. The interdisciplinary team may also include other services, as indicated, including staff from social work, rehabilitation (Physical Therapy, Occupational Therapy, Kinesiotherapy, Blind Rehabilitation, Recreation Therapy and Respiratory Therapy), nutrition, patient safety and mental health. Nursing members of the team must have minimal competencies in intravenous (IV) drug administration, central line and other intravascular access devices care and management, discontinuation of peripherally inserted central catheter (PICC) lines and midline catheters, peripheral IV insertion skills and point of care testing.

b. **Pre-admission evaluations.** Prior to admission to HIH, each Veteran undergoes an evaluation by at least one approved HIH clinical provider, and meets the admission requirements for suitability of Hospital in Home care. This should also include evaluation of proposed caregiver's capability to provide care-where applicable, and the effect the provision of care in the home may have on other family or household members. In addition, the evaluation must also include the environment of care to determine suitability.

c. **Plan for patient care.** The Veteran will be evaluated clinically by a provider prior to being admitted to Hospital in Home. The Veteran will then be seen daily for his/her acute care needs until the interdisciplinary team with close physician and/or APP, determines he/she is clinically stable. The interdisciplinary team members must meet either virtually or face-to-face on a daily basis Monday through Friday to discuss specific HIH patients, direct their care, and formulate care plans.

d. **Caseload.** Caseload is to be determined locally as it is dependent on many factors, including geography, driving times, coverage area, patient complexity, patient and staff turnover rate, staff experience, team composition, pharmacy support, medical record sophistication, and program support including vehicles, computers, and a staff support assistant. It is recommended that each program determine a mileage radius from the central facility that, taking into account the factors listed above, allows each HIH nurse to complete the required number of home visits each day.

e. **Resource availability.** To meet the needs of the Veteran, the HIH interdisciplinary team will determine the acute care needs of the patient and ensure that the appropriate number of HIH nurses are available to complete the required visits based on the factors listed in item d above.

f. **Support staff.** It is recommended that one advanced medical support assistant (AMSA) be in place to facilitate the administrative demands for every 6 RN staff on the interdisciplinary team.

g. **Resources.** The HIH interdisciplinary team should have work space available to accommodate at a minimum the HIH physician, nurse practitioners and registered nurses on the team along with the team administrative support assistant. Other members of the team can work from space within their departments. All team members should have VA computer access (those members doing recurring home visits should have laptops with remote access) and cellphones. Team members doing routine/daily home visits will have assigned government vehicles through facility fleet management. The vehicle will only be utilized for official business; it will not be used for home to work transportation without appropriate authorization.

h. **Home care accreditation standards.** All HIH programs must meet and maintain VHA standards, the home care standards set forth by VHA and the contracted accrediting organization.

i. **Service Attributes.** The HIH program provides services that are accessible, comprehensive, coordinated, accountable, and acceptable:

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

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

(3) **Coordinated.** The HIH team facilitates the coordination of the Veteran's care across all settings in which HIH is provided by: referring Veterans to the appropriate services; collaborating and communicating pertinent information with the Veteran's primary care providers and specialists; and explaining and teaching about the disease, treatment, and self-care to the Veterans and caregivers.

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

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

j. **Local policy documents.** The following local policy documents must be in place:

(1) **Local HIH Medical Center Policy.** A medical center policy (MCP) that outlines the requirements, policies and procedures necessary for the operation of the HIH

Program is to be issued by the VA medical facility Director. Among the elements to be covered in this MCP are: the delegation of authority to the HIH medical director, organizational placement of the program, lines of authority, scope of program services, and referral, admission and discharge procedures.

(2) **Local HIH Governing Documents.** This catalog of documents (often referred to as a manual) encompasses the local policies, procedures, and standard operating procedures (SOPs) that the VA medical facility uses to run the program locally. This collection of documents is developed by the HIH team to define and govern the clinical and administrative aspects of the program at the VA medical facility. It is to be reviewed and revised by the team as needed, but no less frequently than every 3 years. These governing documents are to be reviewed and approved by the HIH medical director and the VA medical facility director as indicated. The required policy elements include but are not limited to: referral process, patient and staff safety, environmental safety, emergency preparedness, medication management, infection prevention and control practices, death in the home, awareness of do not resuscitate (DNR) regulations in the local community, DNR/Do not intubate (DNI)/Medical Orders for Life Sustaining Treatment (MOLST) confidentiality, information security and addressing patient/caregiver concerns/complaints. **NOTE:** *VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals, and Preferences, dated January 11, 2017*, establishes standardized procedures for eliciting, documenting, and honoring patients' values, goals, and preferences regarding the initiation, limitation or discontinuation of life-sustaining treatments. **NOTE:** *The Hospital in Home program may be incorporated into local VA medical facility policy and does not need to be a stand alone policy but must be a part of the local HIH governing documents.*

(3) **HIH Patient Rights and Responsibilities.** Veterans in the HIH Program have the same rights and responsibilities as other patients in the VHA system. Every effort is to be made to ensure that the Veterans understand and exercise their rights and responsibilities in relation to their own care. If the patient lacks decision-making capacity, a surrogate decision maker must be identified consistent with 38 C.F.R. § 17.32.

k. **Patient Handbook.** A facility HIH patient information handbook is provided to each Veteran and unpaid family caregiver upon admission to the HIH Program. This handbook is to contain at a minimum:

- (1) Names of HIH team members and office telephone numbers.
- (2) An explanation of the HIH Program, its capabilities and limitations.
- (3) HIH patients' rights and responsibilities, including the complaint process.

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

- (5) Procedures to follow in the event of a disaster or medical emergency.
- (6) Any co-payments, if applicable.

## PROGRAM OPERATION PROCESSES

a. **Organization of Hospital in Home.** Hospital in Home (HIH) is an interdisciplinary home health care program. Nationally, HIH is managed under the Office of Geriatrics and Extended Care. Locally it is recommended to be under the direction of the Associate Chief of Staff for Geriatrics and Extended Care or equivalent. If such a position does not exist at the facility, HIH can report to the Chief of Staff, the Associate Chief of Staff for Ambulatory Care, the Chief of Medical Service, or a Care Line Director.

b. **Case Finding & Marketing.** Case finding and marketing are important components of the HIH program. HIH team members are to be assigned specifically to these roles as part of the start-up of the program. Activities may include:

- (1) Creating a plan outline and timeline order of process steps.
- (2) Identifying top diagnosis to target and points of care.
- (3) Utilize reports, statistics and data specific to the VA medical facility and diagnosis that are targeted.
- (4) HIH team member(s) attend discharge meetings.
- (5) Develop handouts, brochures, etc. to make it easy for others to contact members of the HIH team. Consider both paper and electronic versions.
- (6) Arrange to meet with shareholders and potential referral sources at their convenience. (e.g., staff meetings, etc.) Examples of successful partnerships by programs include, implementing a Congestive Heart Failure focused HIH program in conjunction with cardiology clinic and implementing a COPD focused HIH program in collaboration with pulmonary service.
- (7) Follow-up with each service to address any questions, suggestions, etc.
- (8) Poster presentations at Hospital-Wide Quality & Safety Events/Fairs.
- (9) Develop quick guide sheets outlining process from consult to admission to HIH program.
- (10) Include VHA community partnerships (e.g., Hospital at Home programs) in marketing efforts in accordance with the terms and conditions established in VHA community partnership agreements.

c. **Orientation and Continuing Education of HIH Team Members.** New HIH team members must be oriented to ensure understanding of the goals, objectives and procedures utilized by the HIH Program.

(1) The facility HIH policy and procedure manual serves as the basic orientation guide.

(2) The orientation, competency and continuing education program of HIH team members must regularly address infection prevention and control practices, basic home safety, emergency preparedness, HIH patients' rights and responsibilities, information security, confidentiality, and pain management.

(3) All HIH team members are responsible for maintaining their discipline's competency, continuing education requirements for licensure or certification and any mandatory VHA education requirements.

d. **Referral.** Veterans who require the services of HIH may be referred from any setting. Veterans are evaluated for possible HIH treatment by at least one approved HIH clinical provider. Referrals for HIH must be submitted through the appropriate referral process. Consults are reviewed daily. A contact attempt to schedule (or first contact attempt made and recorded) must be completed within 2 business days of the consult creation. The acceptance or rejection of the referrals or consults to HIH are due no later than 5 days from the date of request. ***NOTE: Please consult local policy guidance.***

e. **Admission Criteria.** Examples of diagnoses referred to the program include: Ambulatory Care Sensitive-Conditions (ACSC) including but not limited to, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, and diagnoses such as cellulitis, osteomyelitis, urinary tract infection (UTI), wound care and others as deemed appropriate by the HIH physician. Programs may also include those conditions found to be responsible for increased re-admission rates. If the diagnosis and living environment is determined to be appropriate, the Veteran is offered the option of HIH care in lieu of an inpatient stay.

f. **Determination of Patient Appropriateness for Home Care.** Before the Veteran is admitted to HIH, the Veteran must be evaluated by an approved HIH clinical provider. If the Veteran and the home situation are found to meet HIH admission criteria and are deemed appropriate, the Veteran is accepted in the HIH Program. If not, the HIH team makes recommendations regarding measures that may remediate the deficiencies or an alternate plan for managing the Veteran's care needs.

g. **Informed Consent.** The eligible Veteran and caregiver will be oriented by a designated HIH program provider and will voluntarily consent to receive HIH care. 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 and is provided in writing to the Veteran and the caregiver. This informational counseling and the Veteran and caregiver's acceptance to participate in the HIH program constitute informed consent and will be documented in the Veteran's medical record.

h. **Admission to HIH.** Each of the following factors must be considered in determining whether a Veteran is appropriate for admission to the HIH Program:

(1) Veteran is enrolled for VHA care.

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

(3) Veteran has one or more identified diagnoses appropriate for admission to HIH, which are amenable to management in the home setting by the HIH program.

(4) When applicable, Veteran and caregiver are educated on co-pays.

(5) Veteran and caregiver(s) (paid and unpaid) consent to the HIH Program.

(6) The Veteran's home (personal residence, medical foster home or community residential care facility) is the most appropriate venue for care as determined by the HIH team.

(7) The Veteran's home environment (personal residence, medical foster home or community residential facility) is safe for the well-being of the Veteran, the caregiver(s) (paid and unpaid) and the HIH team members.

i. **Clinical Assessment of Patients.** After deemed appropriate for admission to the program, all Veterans undergo a comprehensive assessment. The mentoring program will assist the new HIH program in developing a process to determine admission criteria, for example, working with local subspecialty practices such as: Cardiology, Pulmonary and Infectious Disease.

j. **Plan of Care.** Once the assessment of the Veteran has been completed, the plan of care should be developed by the HIH team. The plan of care and updates need to be communicated to the Veteran's PACT team. Plans of care are reviewed in a time frame as specified by local policy. The plan of care for each Veteran is customized to include problems identified by the members of the team. It also includes the Veteran and caregiver(s) (paid and unpaid) goals and preferences and constitutes the provider's orders for care. As the health condition of the Veteran changes, the plan is updated as needed. Team conferences are to be held on a regular basis as outlined by local policy.

k. **Delivery of Care.** HIH staff provides direct care in the Veteran's home, based on the treatment plan. This should include the promotion of a therapeutic home environment. Duration of care and frequency of home visits are determined by Veteran needs and clinical judgement.

l. **Patient Education.** Information and education are to be provided to the patient and caregiver(s) on self-management and the plan of care 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 regarding potential undesirable outcomes of their treatment decisions. The HIH team must document this education as well as the patient and caregivers understanding and address their capacity to make decisions as necessary.

m. **Integration with VA and non-VA Home Care Services.** As dictated by the plan of care, other home care services may be provided concurrently, if there is no direct duplication of services and that clinical responsibility and tasks are delineated for the care or services rendered.

n. **Discharge from HIH.** The decision to discharge a Veteran should be proposed by the HIH team and mutually agreed upon in full partnership with, the Veteran and caregiver(s). Veterans may elect to be discharged from HIH at any time.

(1) A formal discharge note should be entered into the medical record and at a minimum, include the date of admission, the date of discharge treatments received during HIH, a list of medications to be continued after discharge and the overall status of the Veteran at the time discharge.

(2) Communication of patient information is vital to the continuity of care across levels of care. It is the intent of the HIH program to appropriately convey significant information to and from other providers of care within and outside the VA health care system for Veterans enrolled to the HIH service.

(3) Hand-off communication is required when discharging HIH Veterans back to their primary care teams. This communication between the HIH team and the primary care team (PACT) should include the information contained in the formal discharge note as well as any additional pertinent information important to the Veteran's continuity of care.

(4) The HIH 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.

(5) Circumstances under which Veterans may be discharged from HIH include:

(a) Veteran death.

(b) Veteran and caregiver (paid and unpaid) request discharge from the HIH Program.

(c) Veteran relocates out of the HIH service area.

(d) Veteran has reached maximum benefits from the HIH program and can be transitioned to VA or community outpatient care or VA Home Based Primary Care.

(e) Veteran and caregiver(s) (paid and unpaid) repeatedly 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 and interventions 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 HIH team members.

(g) The Veteran's needs exceed the capability of the HIH program and collaborating agency(s) or other combined VA and community home care services, resulting in the home no longer being the best or appropriate setting for care.

o. **After Office Hours Coverage.** Each HIH Program must have a policy providing for the care of Veterans outside of the regular hours of program operation. HIH Veterans and their caregivers, (paid and unpaid) must be given, verbally and in writing, specific instructions regarding how to access care at all times (during and outside regular hours of program operation).

p. **Cooperation, Collaboration and Consultation with Other Services.** The HIH team routinely cooperates and collaborates with ancillary services to ensure Veterans receive the appropriate level and type of needed services.

q. **Teaching Program.** The HIH program provides unique educational experiences for fellows, residents and students of various health professions.

(1) The HIH program provides each trainee with the opportunity to observe and participate in an interdisciplinary team.

(2) The HIH medical Director and team are encouraged to seek educational affiliations with a multidisciplinary range of professional schools through the promotion of the HIH program's training opportunities.

r. **HIH Mentoring Partnership Program.** New HIH programs must have a mentoring partner/program working with them for a minimum of two years. Mentoring programs must be approved by the VA Central Office, Office of Geriatrics and Extended Care. The HIH SharePoint (access granted by invitation only): <http://vaww.infoshare.va.gov/sites/geriatrics/geriprograms/gecrfp/HIH/default.aspx> contains valuable information to assist and guide programs. **NOTE:** *This is an internal VA website that is not available to the public.*

**QUALITY MANAGEMENT AND EVALUATION**

a. **Performance Improvement.** The performance improvement activities of Hospital in Home (HIH) support the mission and goals of VA and the individual health care facility. The goal of HIH 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. **Performance Improvement requirements and elements.** Each HIH 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 accrediting organization through established reporting channels. Performance improvement information is confidential and disclosure may only be as permitted by law and VA Policy. Focus areas identified for performance improvement must include:

- (1) Trends in patient care, cluster activity and specific areas impacting patient safety.
- (2) Areas/procedures involving high risk to patients/staff.
- (3) Activities that require maintenance of competency.
- (4) New processes, new procedures, new technologies.
- (5) Identified areas for staff training/education.
- (6) Feedback from patient and caregiver experience measures and factors contributing to high customer satisfaction.
- (7) Factors contributing to staff satisfaction and retention.
- (8) Health equity impact assessment. For instance, the role of social and economic factors on the health of Veterans receiving HIH including efforts to mitigate health inequities. Additionally, the program should examine the impact and track relevant data on vulnerable Veteran groups along the lines of racial or ethnic; sex; age; geographic location; religion; socioeconomic status; military era; sexual orientation; mental health; disability status including cognitive, sensory, and physical and other characteristics historically linked to discrimination or exclusion.

c. **Utilization Management.** Review of care and the utilization of resources identified as required to support program goals and objectives are essential to the accountable and responsible management of HIH.

d. **Recall of medical devices, equipment and drugs.** Programs should be aware of the national and local policies related to recall of medical devices, equipment and drugs and follow those processes. **NOTE:** See *References* section for a list of national policy governing processes.

## RESEARCH, SURVEYS, AND HIH DATA MANAGEMENT

### 1. RESEARCH AND SURVEYS

Hospital in Home (HIH) offers unique opportunities to evaluate health care and delivery of services to a chronically ill patient population in their homes. All research studies, including surveys, must be approved through appropriate Veterans Health Administration (VHA) channels, and comply with applicable ethics laws, regulations and principles. Locally-initiated patient experience surveys must follow national policies.

### 2. HIH DATA MANAGEMENT

Several electronic information systems support HIH with data vital to the continuous improvement of care delivery to Veterans in the home. These include but are not limited to:

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

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

c. **Decision Support System.** Decision Support System (DSS) is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs (VA). 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 HIH program concerning identification of departments and products, and labor mapping. The National MCA Office SharePoint site is: <http://vaww.dss.med.va.gov/index.asp>. **NOTE:** *This is an internal VA website that is not available to the public.*

d. **International Classification of Diseases-10<sup>th</sup> Edition and Current Procedural Terminology Coding.**

(1) HIH staff must use International Classification of Diseases (ICD-10) diagnostic codes for HIH patient diagnoses pertinent to the encounter.

(2) HIH 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 specialist can use the Evaluation-Management home visit CPT codes.

e. **Managerial Cost Accounting.** DSS is the MCA system for the VA. For the VHA, we can say it is the process that accumulates cost and workload data from various agency feeder systems and produces reliable cost per product.

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

g. **Veterans Equitable Resources Allocation.** Veterans Equitable Resources Allocation (VERA) is the methodology for the annual patient classification and allocation of appropriated funds to the VISNs. Current VERA reports and classifications can be found at <http://vaww.arc.med.va.gov>. **NOTE:** *This is an internal VA website that is not available to the public.*

## GUIDANCE FOR USE OF DSS 'NILC' FOUR-CHARACTER CODE (CHAR4) WITH T21 NON-INSTITUTIONAL LONG TERM CARE PROGRAMS

### 1. INTRODUCTION

Effective October 1, 2012 (FY13), the DSS CHAR4 code 'NILC' was activated as the means of uniquely identifying, in local DSS and national DSS National Data Extract (NDE) files and reports, the clinic specific workload and cost associated with the T21 Non-Institutional Long Term Care (NILTC) programs that have (at any time) received funding through T21T accounts.

a. This code is to be used for ALL T21 NILTC programs using clinics.

b. This code is to be used only for T21 NILTC programs.

c. NILTC Programs will have received funding through T21T accounts between Fiscal Year (FY)2010 and the present, and were established as 'Phase I', 'Phase II', 'Phase III' (including Phase III GRECC), and most recently (FY 2014), 'Phase IV' programs.

d. NILC workload will be included in the NIC Measures as of FY14.

### 2. ACTION FOR NILTC PROGRAM LEADS

a. All programs initiated with T21T NILTC funding that collect clinic encounter workload are required to use the NILC CHAR 4 code. **NOTE:** *The NILC code should not be removed once the T21T funding ends. If the program initiated with T21T NILTC funds expands, including expansion to additional sites, then the code should be added to all additional clinics related to the program. This is the means of tracking program progress.*

b. Determine what clinics, if any, that you have established for your T21 NILTC Phase I, Phase II, Phase III, or Phase IV program use.

c. Contact your local Decision Support System (DSS) Site Manager to assign the NILC CHAR4 code to the Feeder Key of your T21 NILTC program specific clinics. The following is the link to the DSS Site Team Phone List: [http://vaww.dss.med.va.gov/dso/dso\\_list.asp](http://vaww.dss.med.va.gov/dso/dso_list.asp). **NOTE:** *This is an internal VA website that is not available to the public.*

### 3. BACKGROUND

a. DSS, the Managerial Cost Accounting System for Veterans Health Administration (VHA), uses DSS Identifiers, also known as "Stop Codes" and "Credit Stops", to identify the type of patient care provided and the type of Provider offering this care.

b. The four-character (CHAR4) coding system is used in DSS as a means of refining unique reporting capabilities associated with program or provider workload and cost information.

c. The CHAR4 Code is an optional value added by the DSS Site Team to the DSS Clinic worksheet set-up at the site level. If no CHAR4 Code is chosen the default value of "0000" is used.

d. The code occurs in the DSS CLI Feeder Key, and may be used with the Primary Stop Code alone, or with the Primary and Secondary Stop Code (Credit Stop) together.

e. The location of the DSS CHAR4 documentation is at this link: [http://vaww.dss.med.va.gov/programdocs/pd\\_fourcc.asp](http://vaww.dss.med.va.gov/programdocs/pd_fourcc.asp). **NOTE:** *This is an internal VA website that is not available to the public.*

**4. ACTION FOR DSS SITE TEAMS**

When new VistA Clinics are established at a Department of Veterans Affairs (VA) facility, DSS site teams are responsible for reviewing and validating the Stop Code and CHAR4 assignments for accuracy, to include:

- a. Proper Stop Code(s)
- b. Proper CHAR4 Code
- c. Proper VistA Fields
- d. Proper Feeder Key
- e. Proper Action Code descriptions (from Chapter 4 of the DSS processing guide):

5	ACTION TO SEND	1: SEND STOP CODE  4: SEND BOTH AS ONE RECORD WITH <u>NATIONAL CODE</u>  5: SEND BOTH AS ONE RECORD WITHOUT NATIONAL CODE  6: DO NOT SEND
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## EXPANDING ACCESS TO HOSPITAL IN HOME

a. Satellite Hospital in Home (HIH) programs may be established as an outreach of HIH programs. HIH staff may work from a Community-based Outpatient Clinic (CBOC). A freestanding HIH satellite office may be established in communities with sufficient numbers of eligible Veterans. Satellite programs must meet the following requirements:

(1) The practices of having VA staff provide direct or oversight of care, interdisciplinary team meetings, and physician or advanced practice professional (APP) oversight.

(2) Satellite HIH programs must report to the primary HIH program and adhere to the policies and procedures of the primary HIH program. The satellite HIH Program's scope of practice, e.g., the diagnoses the satellite HIH Program treats, defined service areas, etc. remains under that of the primary HIH program.

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

c. Innovative expansion of HIH may include case finding of new patient populations with special needs and high-risk for hospitalization or re-admission. Expansion may include targeting new service locations, collaborations or partnerships with non-VA organizations, and patient populations to reduce unnecessary hospitalizations, increase efficiency in the utilization of health care and improve patient health, well-being, and satisfaction.