

HOME-BASED PRIMARY CARE SPECIAL POPULATION PATIENT ALIGNED CARE TEAM PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive addresses the establishment, operation, and standards of Department of Veterans Affairs (VA) Home-Based Primary Care (HBPC), Special Population Patient Aligned Care Team (PACT) program.

2. SUMMARY OF MAJOR CHANGES: This revised policy:

a. Adopts HBPC Special Population PACT model of care requiring all HBPC programs to provide in-home primary care and enrollment in the Primary Care Management Model (PCMM) HBPC Special Population PACT teams.

b. Revises standards, workload capture, data management, and web-based resources.

c. Includes revised national staffing standards for HBPC clinical roles.

d. Incorporates rural HBPC Special Population PACT programs.

e. Eliminates Veteran enrollment in the HBPC program for non-primary care home care services. Facilities may continue these services outside of the HBPC program.

f. Identifies consequences for not maintaining HBPC Special Population PACT program standards.

g. Includes telehealth and other virtual care modalities in HBPC operational processes.

3. RELATED ISSUES: VHA Handbook 1141.02, VHA Handbook 1101.10, VHA Handbook 1109.08, VHA Handbook 1108.05, VHA Handbook 1160.01, VHA Directive 1043, VHA Handbook 1141.03, VHA Handbook 1140.6, VHA Handbook 1108.11, and VHA Handbook 1140.3.

4. RESPONSIBLE OFFICE: The Office of Patient Care Services, Geriatrics and Extended Care Services (10P11) is responsible for the content of this directive. Questions may be addressed to 202-461-6750.

5. RESCISSIONS: VHA Handbook 1141.01, dated January 31, 2007, is rescinded.

June 5, 2017

VHA DIRECTIVE 1411

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Acting Under Secretary for Health

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HOME-BASED PRIMARY CARE SPECIAL POPULATION PATIENT ALIGNED CARE TEAM PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive defines standards and procedures for establishing and operating the Department of Veterans Affairs (VA) Geriatrics and Extended Care (GEC) Home-Based Primary Care (HBPC) Special Population Patient Aligned Care Team (PACT) program. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1717, 1720C, and 1720G; Title 38 Code of Federal Regulations (CFR) 17.38(a)(1)(ix).

2. BACKGROUND

PACTs care for many Veterans with multiple chronic illness who are at high risk for poor outcomes such as death and frequent hospital admissions. HBPC is well suited to partner with PACT to help identify these Veterans and accept many in referral for transfer and further management (refer to PACT High risk Roadmap: <http://vaww.infoshare.va.gov/sites/primarycare/Resource%20Documents/PC%20Intranet%20Documents%20Storage/Roadmaps/High%20Risk%20Roadmap%20-%20Final.docx>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

a. HBPC is a unique model of home health care that is different in target population, process, and outcomes from home care that is available under Federal and state programs such as Medicare and Medicaid. The HBPC model targets persons with complex chronic diseases that worsen over time and provides interdisciplinary care that is longitudinal and comprehensive rather than episodic and single-problem focused. HBPC provides cost effective primary care services in the home and includes palliative care, rehabilitation, disease management, caregiver assistance and support, and coordination of care.

b. HBPC Special Population PACT is a VA home care program that provides comprehensive, interdisciplinary, primary care in the homes of Veterans with serious medical, social, and behavioral conditions for whom routine clinic-based care is not effective or may not be possible. HBPC Special Population PACT furnishes in-home interdisciplinary primary care services to a Veteran where the Veteran is residing. Providing VA HBPC services does not relieve any other person or entity of a contractual obligation to furnish services to the Veteran.

c. In contrast to other systems such as Medicare home care that target patients with short-term remediable needs and provide episodic, time-limited and focused skilled services, HBPC Special Population PACT serves Veterans as they face the challenges of disability, aging, and chronic disease by providing comprehensive longitudinal home care. HBPC Special Population PACT is designed to serve Veterans through the months and years before death, providing primary care, palliative care, rehabilitation, disease management and coordination of care services.

d. HBPC is a GEC Special Population PACT and, as such, provides personalized, proactive, patient-driven care. The unit of care is the patient and the caregiver, if present. Their needs and preferences guide both the goals and plan of care. HBPC targets primarily the following patients in need of home care:

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

(2) Longitudinal care patients who require palliative care for a serious disease that is life limiting or refractory to disease modifying treatment.

(3) Patients whose complex chronic disease is not managed effectively by routine clinic-based care.

e. The HBPC program is featured in over 430 VA Medical Centers, Health Care Centers, and Community Based Outpatient Centers, in both rural and urban settings, and serves as a major training site for health profession students. HBPC is a unique model of non-institutional long-term care and an important part of VHA's array of services designed to meet the care needs of the increasing number of Veterans with complex chronic disease who require attentive management through all episodes of care.

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) and/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 is the provision of services by more than one agency or program during a period of time. Concurrent care involving multiple agency services and supplementation of services is permissible when service plans are both explicit and discreet and do not create a duplication of service. The most common examples include HBPC concurrent care with Spinal Cord Injury (SCI), Home Hospice, purchased or Medicare skilled home care, Mental Health Intensive Case Management (MHICM), and Caregiver Support.

c. **Duplication of Services.** Duplication of services means the act of two "agencies" providing identical service plans.

d. **Home.** Home is defined as the private residence in which the Veteran resides. This would include medical foster home (MFH), 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 (HBPC).** For purposes of this directive, HBPC is synonymous with HBPC Special Population 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 Primary Care PACT Team.** The HBPC PACT team consists of: Medical Director, Primary Care Provider (MD, NP, or PA), Nurse, Social Worker, Rehabilitation Therapist, Dietitian, Pharmacist and Mental Health Professional (Psychologist and/or Psychiatrist). Some team members may have multiple HBPC PACT team assignments.

g. **Medical Foster Home (MFH).** Medical Foster Home means a private home in which a medical foster home caregiver provides care to a Veteran resident and: (i) The medical foster home caregiver lives in the medical foster home; (ii) The medical foster home caregiver owns or rents the medical foster home; and (iii) There are not more than three residents receiving care (including Veteran and non-Veteran residents).

h. **Registered Nurse Care Manager.** The Registered Nurse Care Manager (RNCM) is a PACT team member who provides comprehensive and coordinated nursing care to an assigned panel of patients. The RNCM collaborates with both VA services and community services, as appropriate, to effectively meet the health promotion or disease prevention, acute, chronic, and long-term needs, based on the Veteran's goals and plan of care with a focus on self-management.

i. **Standard Operating Procedure Manual.** A standard operating procedure (SOP) manual is a dynamic document that reflects local team practices. It is to be reviewed and revised by the team as needed, but no less frequently than required by local SOP. This manual is to be reviewed and approved by the HBPC Program and Medical Directors. Some of the SOP elements should include, but are not limited to: patient and staff safety, environmental safety, emergency preparedness, medication management, including the handling of high risk medications in the home, infection control in home care, management of patients 'Do Not Resuscitate (DNR) / Do not intubate (DNI) / Medical Orders for Life Sustaining Treatment (MOLST), confidentiality, information security, and addressing patient/caregiver concerns/complaints.

4. POLICY

It is VHA policy to adopt the PACT model of primary care by: Identifying appropriate target populations, providing continuity of care across settings, integrating HBPC with non-VA home care, expanding rural access, integrating telehealth, improving quality of

care, meeting care needs through the end of life, and incorporating home care into medical/clinical education and research.

5. GOALS

The goals of the HBPC program are to:

a. Provide HBPC targeted to frail, chronically ill, or disabled Veterans who require interdisciplinary health care teams for continuity and coordination of care, as well as integration of diverse services to address complex medical, psychosocial, rehabilitative, behavioral or palliative care needs. These Veterans require comprehensive, longitudinal, interdisciplinary home care services, to maximize or maintain function, minimize institutionalization, and maintain quality of life.

b. Reduce the need for, and provide an acceptable alternative to, hospitalization, nursing home care, emergency and outpatient visits. This is achieved through longitudinal care that provides close monitoring, early intervention, and promotion of a safe, therapeutic home environment through coordinated home and community based services.

c. Recognize the important role of the caregiver and provide support to the Veteran and caregiver in coping with all aspects of chronic disease, including assessment and intervention that addresses caregiver burden.

d. Enhance the Veteran's quality of life through the end of life by respecting the needs and preferences of the Veteran and caregiver, addressing symptom management, supporting the option of dying with palliative care at home if that is the Veteran's wish. In addition, HBPC Team may provide initial bereavement care to the caregiver with community referral for formal or longer term bereavement support and counseling if needed.

e. Promote an enduring network of qualified home care professionals by providing an academic and clinical setting that allows for research and training in interdisciplinary delivery of primary care in the home.

6. HBPC PROGRAM STANDARDS

VA HBPC programs must meet all of the following requirements:

a. The members of the interdisciplinary team convene at least weekly to discuss and plan patient care.

b. Caseloads are not to exceed maximum caseload standards provided in Appendix A. Caseloads below maximum standards may be determined locally, based on factors such as geography, driving times, service area, patient complexity, patient and staff turnover rate, staff experience, team composition, and logistical resources such as vehicles, computers, and program support assistance.

c. Comprehensive primary care is provided directly by VA HBPC team staff members except as provided in appendix B, paragraph 2.d. for rural focus HBPC programs.

d. A VA physician provides oversight with participation in care planning and interdisciplinary team meetings and is accessible and responsive when time sensitive situations arise.

e. Adequate program staff is available to support clerical, administrative, and clinical demands.

f. All HBPC programs must meet and maintain VHA standards including, the home care standards necessary for accreditation of the parent VA medical facility.

g. Each patient in the HBPC Program is provided primary care services that are interdisciplinary, accessible, comprehensive, coordinated, longitudinal, accountable and acceptable as detailed below:

(1) **Interdisciplinary.** A core interdisciplinary HBPC team is established and members participate in regular HBPC interdisciplinary team conferences, collaborate with Veterans and caregivers in care planning and conduct home visits as appropriate.

(2) **Accessible.** The HBPC patient and caregiver have access to the HBPC team with explicit provisions for concerns during non-working hours.

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

(4) **Coordinated.** The HBPC team coordinates transitioning patient care across all settings by referring patients to the appropriate services and collaborating and communicating pertinent information with patient and providers within and outside VA.

(5) **Longitudinal Care.** The HBPC team provides routine care and continuous services that involve ongoing monitoring, comprehensive assessment, coordination of care, prevention or early detection of worsening conditions, and timely interventions delivered throughout the protracted course of chronic disease. Longitudinal care is in contrast to episodic care that is provided only during periods of disease presentation or exacerbation. See paragraph 3, Definitions.

(6) **Accountable.** The HBPC team implements a continuous process for performance improvement that utilizes data to track and evaluate services and outcomes. The HBPC performance improvement process fully integrates with that of the VA medical facility or health care system. The patient's feedback on care provided is a part of the performance improvement activities.

(7) **Acceptable.** The HBPC patient and caregiver voluntarily agree to receive HBPC services in their home from the interdisciplinary team. The HBPC patient and caregiver

participate in the development of an individualized plan of care that recognizes and incorporates patient/caregiver preferences to the extent possible.

h. Each HBPC Program must have a local patient information handbook. Veterans in the HBPC Program have the same rights and responsibilities as other patients in the VA health care system. The rights of each Veteran will be outlined in that patient information Handbook, and will reflect those of The Joint Commission Accreditation Manual for Home Care, "current edition." Every effort will be made to ensure that the patients understand and exercise their rights and responsibilities in relation to their own care. In the event that the patient lacks decision-making capacity, every effort will be made to identify a surrogate decision maker consistent with 38 CFR 17.32.

7. RESPONSIBILITIES

a. **Geriatrics & Extended Care Services and Geriatrics & Extended Care Operations.** Nationally, HBPC is organizationally aligned under the Office of Geriatrics and Extended Care Operations (10NC4) and Geriatrics and Extended Care Services (10P4G). Geriatrics and Extended Care (GEC) Services (10P4G) and Geriatrics and Extended Care (GEC) Operations (10NC4) are responsible for the HBPC Program policy development and operations at the national level. GEC has the responsibility to collaborate with involved services to develop ongoing guidance as indicated.

b. **VISN GEC Leader.** The VISN GEC designated leader is responsible for HBPC program oversight and support. The VISN GEC leader collaborates with the responsible facility leaders to share practices of excellence and address individual facility issues as necessary.

c. **VA Medical Facility Director.** The VA medical facility Director and Chief of Staff designate the HBPC Program Director who will be a health care professional with demonstrated ability and competence in patient care, interpersonal relationships, communication, customer service, and program administration.

(1) The VA medical facility Director delegates the management of the program to the HBPC Program Director.

(2) The VA medical facility Director is responsible for issuing and updating the facility's HBPC Policy Memorandum, which outlines the requirements, policies and procedures necessary for the operation of the HBPC Program. In addition, the facility director is responsible for assuring the integration of HBPC into facility policies when appropriate. Among the elements to be covered in this memorandum are: the delegation of authority to the HBPC Program Director, organizational placement of the program, lines of authority, scope of program services, and referral, admission and discharge procedures.

d. **HBPC Program Director.** The HBPC Program Director is a clinician, dedicated to the responsibilities of program management. Program management encompasses all assigned sites of care, including VA medical facilities and outreach/satellite expansions. The Program Director is to report directly to ACOS/GEC or equivalent. Management

functions include, but are not limited to: planning, staffing, directing, budgeting, evaluating and tracking the program, and developing VA and community relationships. Resource management responsibilities include assuring appropriate resources are designated for the support of the HBPC Program and safety of the HBPC staff. These include appropriate space, time, medical and information technology and communications equipment, as well as vehicles for the daily use of HBPC staff. This role may also be titled as the HBPC Program Coordinator or Program Manager. The HBPC Program Director is also responsible for:

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

(2) The development and continued effective functioning of the interdisciplinary health care team. The Program Director recognizes and effectively utilizes the skills, knowledge, and contributions of each team member.

(3) Collaborating with other HBPC Program Directors, VISN leadership, and VA Central Office staff on issues of program development and operation.

(4) Providing direction and team leadership to include:

(a) Communicating VA policies to the HBPC team, VA medical facility staff, PACTs and non-VA entities.

(b) Developing and implementing the local HBPC Standard Operating Procedures (SOP), in order to operationalize the hospital policies, with input as indicated from interdisciplinary service line managers or chiefs.

(c) Managing program SOP and activities to include, but not limited to, performance improvement, patient safety, utilization review, emergency preparedness, and staff safety.

(d) Evaluating the effectiveness of the HBPC Program (e.g., program outcomes, performance improvement). See Appendix D.

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

(f) Coordinating training and educational programs.

(g) Acquiring, managing, and remaining accountable for program resources and resource utilization.

(h) Processing, assigning, and monitoring referrals to HBPC to ensure timely access and care coordination.

(i) Managing the Electronic Wait List (EWL) for HBPC referrals, as necessary.

(j) Collaborating with appropriate data and technology departments to ensure accurate HBPC clinical, administrative, and workload data.

e. **Assistant HBPC Program Director or HBPC Nurse Manager.** The Assistant HBPC Program Director or HBPC Nurse Manager is an optional position that is recommended for programs operating at multiple VA outpatient clinic locations in addition to the main VA medical center, or those that have an average daily census exceeding 150 Veterans. The Assistant HBPC Program Director or Nurse Manager is responsible for assisting the HBPC Program Director in any of the assigned responsibilities for the program director and may also have employee supervision responsibilities.

f. **HBPC Medical Director.** The HBPC Medical Director must be a physician who is responsible for the overall medical care delivered by the HBPC team. The Medical Director is to report directly to the ACOS/GEC or equivalent. **NOTE:** *In VA medical facilities with academic affiliations, the HBPC Medical Director is encouraged to have a faculty appointment and be involved in academic activities.*

(1) The HBPC Medical Director is responsible for collaborating with the HBPC Program Director to:

(a) Provide leadership to the HBPC Program, including, but not limited to, clinical activities and approval of local HBPC SOP.

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

(c) Assume a leadership role in the development and implementation of HBPC's process for continuous performance improvement.

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

(e) Develop partnerships and coordination with PACTs and the PACT High Risk Committee.

(f) Participate in selecting HBPC team members.

(2) Provide clinical input and oversight for all patient treatment plans unless delegated to an HBPC team physician.

(3) Be readily accessible and promptly responsive to calls from team members currently in a Veteran's home with urgent need for consultation or physician orders.

(4) Ensure Physician Medical Care Plan oversight at HBPC team meetings by either actively participating in HBPC team meetings or delegating an HBPC Team Physician to participate at team meetings.

- (5) Keep the HBPC team apprised of medical care advances and practice standards.
- (6) Arrange physician coverage and communicate the plan of coverage to the HBPC team.
- (7) Serve as back-up for other HBPC primary care providers.
- (8) Make occasional but not routine home visits.
- (9) Collaborate with other HBPC Medical Directors, VISN leadership, and VA Central Office staff members on program development issues.

g. **HBPC Interdisciplinary Team.** The HBPC team members work interdependently in assessing, planning, problem solving, decision-making, and implementing team tasks. **NOTE:** *The staffing mix and FTE must be adequate to manage the needs of the patient population.* All clinical HBPC team members are expected to:

(1) Participate in the development of a local manual of SOP's that define and govern the clinical and administrative aspects of the program at the VA medical facility. This manual is a dynamic document that reflects local team practices. It is to be reviewed and revised by the team including the HBPC Program and Medical Directors as needed, but no less frequently than required by local SOP. Some of the SOP elements should include, but are not limited to: patient and staff safety, environmental safety, emergency preparedness, medication management, including the handling of high risk medications in the home, infection control in home care, management of patients 'Do Not Resuscitate (DNR) / Do not intubate (DNI) / Medical Orders for Life Sustaining Treatment (MOLST), confidentiality, information security, and addressing patient/caregiver concerns/complaints.

(2) When indicated, participate in the determination of the appropriateness of patients for admission to or discharge from the HBPC Program.

(3) Conduct appropriate clinical reviews or conduct assessments in the home to develop treatment goals and plans based on comprehensive interdisciplinary assessment of the patient and the caregiver. Formal consults are not required among the core clinical team members, although consults may be useful for specific workload capture or tracking purposes. Disciplines that require provider orders will operate under orders.

(4) Initiate an individualized plan of care through the initial team care planning process.

(5) Implement the plan of care through home visits or Telehealth, as indicated.

(6) Review the progress toward goals at regular intervals, as a team, on a quarterly basis, or more frequently when there is a change in the patient's condition.

- (7) Assess and support the caregiver's capability to continue to provide care.
 - (8) Educate the patient and the caregiver.
 - (9) Coordinate the process of care with the other team members to maximize efficiency and improve clinical outcomes.
 - (10) Assess the patient's continuing need for HBPC care and plan for HBPC discharge when indicated.
 - (11) Document all patient care activities in a timely manner, defined by local policies.
 - (12) Identify areas for continuing education and participate in training activities.
 - (13) Participate in developing and implementing the process for continuous performance improvement.
 - (14) Instruct students of various disciplines in providing successful home care and addressing the challenges encountered in delivering health care in the home setting.
 - (15) Serve as a role model in the effective operation of an interdisciplinary team.
 - (16) Use VHA and community resources as appropriate.
 - (17) Participate in interdisciplinary care meetings and the development of the individual plan of care for assigned panel of patients.
 - (18) HBPC team members are responsible for maintaining their discipline's continuing education requirements for licensure and/or certification in addition to mandatory VHA education requirements.
- h. **HBPC Team Physician.** The HBPC team physician, who may or may not be the HBPC Medical Director, in collaboration with the HBPC team, is responsible for:
- (1) Assuming overall medical responsibility for assigned HBPC patients.
 - (2) Serving, when indicated, as the primary care provider and collaborative physician for advanced practice nurses and physician assistants and serve as back-up for other HBPC primary care providers.
 - (3) Identifying a patient's medical problems.
 - (4) Defining the medical management of a patient's medical problems.
 - (5) Determining the need for consultation from medical, surgical, or psychiatric or other subspecialty clinics.

(6) Determining the need for, and facilitating admission to the hospital and other transitions of care.

(7) Visiting the HBPC patients at home for medical evaluation and treatment when clinically indicated.

(8) Providing medical administrative support such as completing physician required orders and forms for the HBPC patients.

(9) Planning and directing the educational and clinical experience of medical students, residents, and fellows assigned to the HBPC Program, when indicated.

(10) Assuming a leadership role in the development and implementation of HBPC's process for continuous performance improvement.

(11) Being readily available to the team members for collaboration when clinical or program issues arise.

(12) Participating in the development of the individual plan of care at interdisciplinary care meetings for primary care provider assigned panel of patients.

i. **HBPC Registered Nurse.** The HBPC registered nurse, in addition to being a core member of the HBPC interdisciplinary team, functions in the PACT team role as a care manager and is responsible for:

(1) Delivering direct nursing care in the home setting.

(2) Developing and coordinating the patient's plan of care to include ongoing assessment and re-assessment, care planning, care coordination, monitoring, and evaluating clinical outcomes.

(3) Interacting, coordinating and advocating for the patient/caregiver with other relevant parties across a continuum of care, beyond a single episode of care, ensuring seamless transitions.

(4) Providing individualized education and support to the patient and caregiver to optimize clinical outcomes and support quality of life decisions.

(5) Delegating and supervising the care given to the patient by licensed practical nurses (LPNs) or vocational nurses, and home health technicians, as applicable.

(6) Providing intensive care management.

(7) Linking Veterans with resources.

(8) Coordinating resources for comprehensive care to avoid duplication of services and streamline staff interaction and services with the Veteran.

(9) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

j. **HBPC Provider (Advanced Practice Nurse or Physician Assistant)**. In addition to being a core member of the HBPC interdisciplinary team, the HBPC provider may also perform nurse functions, to include care management. The provider collaborates with an HBPC physician and is responsible for:

(1) Assuming primary medical responsibility for assigned patients.

(2) Delivering care in the home.

(3) Assessing care needs of patients and caregivers.

(4) Identifying a patient's medical problems and defining the medical management.

(5) Prescribing medications and treatment in accordance with their individual scope of practice or delineation of privileges.

(6) Determining the need for consultation from subspecialties.

(7) Determining the need for, and facilitating admission to, the VA medical facility and other transitions of care.

(8) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

(9) Participating in the development and implementation of HBPC's process for continuous performance improvement.

(1) **HBPC Clinical Social Worker**. The HBPC clinical social worker, in addition to being a core member of the HBPC interdisciplinary team, is responsible for:

(2) Performing comprehensive initial clinical assessments and follow-up assessments when clinically indicated or at minimum annually, in-home assessments of the psychosocial needs and functioning of the patient, caregiver and their support systems.

(3) Identifying psychosocial issues impacting the patient/caregiver's ability to achieve optimal outcomes and implementing interventions and provide social work case management to address psychosocial needs and support patient driven goals of care.

(4) Developing a psychosocial plan of care which may include individual/family counseling, long-term and advance care planning, non-pharmacological pain interventions, stress management, caregiver respite, psycho-educational programs, as well as grief and bereavement counseling.

(5) Facilitating access to and maximizing VA and community resources and services, such as concrete support services involving housing, in-home assistance and financial support.

(6) Interacting, coordinating and advocating for the patient/caregiver with other relevant parties across a continuum of care, beyond a single episode of care.

(7) Assisting with discharge planning for HBPC patients.

(8) Keeping the HBPC team informed of available VHA and community resources and benefits for the patient and caregiver.

(9) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

(10) Participating in the development and implementation of HBPC's process for continuous performance improvement.

k. **HBPC Registered Dietitian Nutritionist.** The HBPC registered dietitian nutritionist, in addition to being a core member of the HBPC interdisciplinary team, is responsible for the overall nutritional care of the patient in accordance with VHA Handbook 1109.08 Nutrition Care Process. Duties include:

(1) Performing a comprehensive in-home nutrition assessment initially and follow-up assessments when clinically indicated or at minimum annually. The HBPC registered dietitian nutritionist is responsible for ensuring full implementation of a Nutrition Care Process as outlined in VHA Handbook 1109.08, Nutrition Care Process Handbook.

(2) Indicating expected frequency of HBPC nutrition in-home or telehealth/telephone visits based upon the nutritional assessment and needs and preferences of the patient.

(3) Recommending nutrition prescriptions, including dietary and enteral feeding modifications, nutritional supplements, and enteral formulas and equipment.

(4) Educating patients and caregivers on their nutrition care plan recommendations. Contributing to optimal disease management by educating the patient, caregiver and staff in the role of nutrition in disease prevention and processes, the therapeutic benefits of specific nutrition choices and, the effective ways of managing identified nutritional problems.

(5) Monitoring for food and drug interactions.

(6) Assessing patient/caregiver capacity to prepare recommended meals or administer enteral feeding.

(7) When indicated, determining appropriate methods and criteria for nutrition screening. The specific method and process of screening is determined by local policy and is not typically completed by food and nutrition professionals.

(8) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

(9) Participating in the development and implementation of HBPC's process for continuous performance improvement.

I. **HBPC Mental Health Provider.** The HBPC mental health provider, in addition to being a core member of the HBPC interdisciplinary team, functions as the primary mental health provider of the HBPC team providing mental health prevention, assessment, treatment, management, and professional consultation services. Responsibilities of the HBPC mental health provider include:

(1) Providing in-home assessment, diagnosis and treatment of psychological conditions, with an emphasis on the application of time-limited, evidence-based approaches.

(2) Providing psychological prevention in collaboration with the team.

(3) Collaborating with the team in suicide risk assessment, management, and prevention activities, as well as assessment and management of other behavioral safety concerns including elder abuse or neglect, domestic violence, or other behaviors putting Veterans or caregivers at risk of harm.

(4) Providing services to the caregivers of patients when such care is related to the patient's overall plan of care. Caregivers participating in the Program of Comprehensive Assistance for Family Caregivers are eligible to receive mental health services from VA, independent of the patient's plan of care.

(5) Providing evaluations related to cognitive deficits and performing capacity assessments when there are questions related to a patient's ability to make medical decisions, perform other specific functions or live independently.

(6) Providing support to patients and caregivers who are coping with feelings of grief or loss and/or facilitating transition to new living situations.

(7) Providing behavioral/motivational interventions to manage pain, disability, sleep problems, facilitate weight management, promote smoking cessation and improved adherence to medical plan of care.

(8) Promoting communication/interactions and collaboration among HBPC team members, patients, and their caregivers to facilitate the plan of care and treatment process.

(9) Providing teaching and support to the HBPC interdisciplinary team so that all team members may collaborate to address behavioral and mental health concerns as part of the overall plan of care.

(10) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

(11) Participating in the development and implementation of HBPC's process for continuous performance improvement.

m. **HBPC Rehabilitation Therapist.** The HBPC rehabilitation therapist (Occupational Therapist, Physical Therapist or Kinesiotherapist), in addition to being a core member of the HBPC interdisciplinary team, is responsible for:

(1) Performing a comprehensive in-home environmental and functional assessment initially and follow-up assessments when clinically indicated or at minimum annually, that will include identifying functional deficits (Barthel Index, Katz, FIM, or other functional assessment tool), fall risk, home safety risks, assessing and planning for emergency preparedness, planning and implementing intervention using evidence-based practice guidelines, and monitoring and evaluating a patient's progress.

(2) Evaluating the patient's home, on admission and annually and as clinically indicated, to identify the need for structural modification and adaptive equipment to improve the safety and accessibility of the home environment.

(3) Determining the need for durable medical equipment (DME).

(4) Teaching and monitoring of the safe use and maintenance of DME devices.

(5) Reporting equipment problems and facilitating repair or replacement of DME via the Prosthetic and Sensory Aids Service.

(6) Teaching body mechanics to the patient and caregiver to minimize risk of injury.

(7) Establishing a therapeutic program for patients and caregivers to maximize or maintain the patient's functional status and monitoring the response.

(8) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

(9) Participating in the development and implementation of HBPC's process for continuous performance improvement.

o. **HBPC Clinical Pharmacy Specialist.** The HBPC clinical pharmacy specialist (CPS), in addition to being a core member of the HBPC interdisciplinary team, is responsible for:

(1) Performing a comprehensive medication assessment of medication therapy initially, quarterly, and when clinically indicated, to include recommendations that ensure a custom approach that supports patient preference and adherence.

(2) Providing comprehensive medication and disease state management services and prescribing medications and treatments in accordance with their individualized scope of practice, as described in VHA Handbook 1108.11, Clinical Pharmacy Services, or subsequent policy release.

(3) Reinforcing and providing education to the Veteran and caregivers on the proper use of prescribed medications, in collaboration with other HBPC team members. Education may include proper storage, administration, dosing and indication for use, side effects, disposal, and expiration dates.

(4) Providing a consultative role to facility leadership when a medication error occurs as a result of a VA system's error.

(5) Identifying patient-specific medication issues to include, but not limited to, drug interactions, adverse effects, efficacy, appropriateness (indication for medications), and adherence problems.

(6) Participating in home and telehealth visits, when clinically indicated and agreed upon, for comprehensive medication or disease state management or medication safety concerns.

(7) Providing continuous pharmacy/medication education and reference materials for the HBPC team.

(8) Performing functions consistent with their position described in Licensed Pharmacist Qualification Standard, VA Handbook 5005/36 Appendix G15.

(9) Participating in the development of the individual plan of care at interdisciplinary care meetings for assigned panel of patients.

p. **HBPC Program or Medical Support Assistant.** The HBPC program or medical support assistant works under the direction of the HBPC Program Director and is responsible for:

(1) Efficiently managing the daily office operations of the HBPC program.

(2) Serving as an administrative assistant to the HBPC Program Director.

(3) Answering and dispatching incoming telephone calls and messages for the HBPC program.

(4) Coordinating daily schedules and contacting staff, as indicated, to ensure timely response to patient needs.

(5) Scheduling appropriate patient services/appointments.

(6) Maintaining and monitoring the HBPC Electronic Wait List (EWL) as indicated.

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

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

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

8. REFERENCES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HBPC CASELOAD STANDARDS

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

Rehabilitation Therapist: 85 - 115

Clinical Social Worker: 80 - 100

Registered Dietitian: 95 - 125

Registered Nurse (RN):

a. working with physician: 25-30

b. working with ARNP/PA: 25-35

c. **NOTE:** Caseloads below 25 may be appropriate for RNs also doing frequent skilled care to decrease non-VA care costs

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

a. working without HBPC RNs: 30 - 35

b. working with HBPC RNs: 35 - 90

(1) caseloads in the lower end of this range would be appropriate for ARNP/PA's working with less than 1 FTE RN

(2) caseloads up to 50 would be appropriate for ARNP/PA working with at least 1

FTE RN

(3) caseloads up to 75 would be appropriate for ARNP/PA working with at least 2

FTE RN

(4) caseloads up to 90 would be appropriate for ARNP/PA working with 3.0 FTE

RN (**NOTE:** Increasing RN support to a full 3.0 FTE for one ARNP/PA provider does not appear to allow the ARNP/PA provider's caseload to increase above 90, due to reported adverse outcomes with ARNP/PA provider caseloads above 90 regardless of number of RNs)

Physician:

a. acting as the Primary Care Provider (PCP): 100 - 150

b. routinely providing direct patient care in the home when not assigned as the PCP: 150 - 250

c. acting as Medical Director; ARNP/PA are the PCPs; physician makes occasional but not routine home visits: 300 - 400

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

Mental Health Specialist (Psychologist and/or Psychiatrist): 120 - 140

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

Mental Health Operations or the HBPC VA Pulse Site.

<https://www.vapulse.net/community/focus-areas/geriatrics-and-extended-care/home-based-primary-care>

HBPC Clinical Pharmacy Specialist (CPS):* 100

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

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

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

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

Rural and Highly Rural staffing standards:

Adjusted caseload standards for Rural and Highly Rural programs:

- a. Registered Nurse: 16-25

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROGRAM OPERATION PROCESSES

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

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

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

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

a. Assure referral is appropriate for HBPC:

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

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

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

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

(5) Recurrent hospitalizations or urgent care episodes.

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

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

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

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

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

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

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

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

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

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

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

- a. The Veteran is enrolled in the VA health care system.
- b. The Veteran lives within HBPC's service area designated by each VA medical facility to represent a safe and efficient service delivery area. (often designated by driving time)
- c. The Veteran has advanced age or serious chronic, disabling conditions that would be amenable to HBPC interdisciplinary intervention.
- d. The Veteran and caregiver voluntarily accept HBPC to provide or support coordinated interdisciplinary primary care.
- e. The Veteran's care needs can be met by the HBPC program.
- f. The Veteran has an identified caregiver, if the HBPC team determines the need for one.

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

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

(1) Patients identified as high risk through PACT, which could include, high utilization of health care resources (e.g., two or more hospital admissions or emergency department visits in the last 6 months, or multiple unscheduled clinic visits or missed appointments).

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

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

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

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

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

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

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

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

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

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

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

- a. Veteran death.
- b. Veteran and caregiver request discharge from the HBPC Program.
- c. Veteran relocates out of the HBPC service area.
- d. Veteran has reached maximum benefits from the program and can be effectively managed through routine clinic-based care.
- e. Veteran and caregiver continue to demonstrate a lack of partnering or lack of participation in a significant portion of the plan of care that negatively impacts clinical outcomes. This ongoing lack of participation, and its effect on care, will be documented in the patient's medical record. Prior to discharge, staff will consider appropriate evaluations to address, contributing factors such as the presence of dementia, depression, and substance abuse.
- f. Veteran's home environment is no longer safe for the Veteran, or for the HBPC team members.
- g. The Veteran's needs exceed the capability of the HBPC program and other combined home care services, making home care no longer an appropriate venue for the Veteran's care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

health, nutrition, pharmacy, and rehabilitation services. The HBPC Program provides the trainee with the opportunity to observe and participate in an interdisciplinary team, as well as to experience the major care issues of this country's aging population, such as chronic progressive disease management, palliative care, and long-term care economics. The HBPC Program Director and Medical Director are encouraged to seek educational affiliations with the various professional schools to promote the training opportunities that exist within the HBPC program.

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

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

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

QUALITY MANAGEMENT AND EVALUATION

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

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

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

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

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

(3) Activities that require maintenance of competency.

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

(5) Identified areas for staff training or education.

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

(7) Factors contributing to staff satisfaction and retention.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp.

f. **Workload and Productivity Standards.** The emphasis on workload and staff productivity for HBPC is on the greatest number of complex medical patients that the team is able to safely manage while achieving positive outcomes, such as reduced hospitalization and high satisfaction. Workload and productivity evaluation considers the number and mix of providers, the patient case mix and complexity, geography, program support, and other determinants unique to the medical facility. Standards for caseload size are included in appendix A.

RESEARCH, SURVEYS, AND HBPC DATA MANAGEMENT

1. RESEARCH AND SURVEYS

HBPC offers unique opportunities to evaluate health care and the delivery of services to a chronically ill patient population in their homes. All research studies, including surveys, will be approved through appropriate VHA channels. Locally initiated satisfaction surveys are to follow national policies, including submission to the Office of Management and Budget as indicated.

2. HBPC DATA MANAGEMENT

A number of electronic information systems support HBPC with data vital to the delivery of care to Veterans in the home. These systems integrate HBPC patient data, workload, and resources into the complete facility information system, much of which is rolled up into national VHA databases located at the Austin Information Technology Center (AITC). Data and resources may be subject to changes; it is important to regularly check the provided links. These include but are not limited to:

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

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

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

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

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

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

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

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

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

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

i. **Veterans Equitable Resource Allocation.** Veterans Equitable Resource Allocation (VERA) is the methodology for the annual patient classification and funding to the VISNs. HBPC is in a Complex Care Group. The HBPC patient class is for patients who receive long-term home care in lieu of institutional care and meet VERA HBPC criteria (see <http://vaww.arc.med.va.gov> for current VERA reports and classifications). **NOTE:** *This is an internal VA Web site that is not available to the public.* Qualification into the HBPC complex patient class is intended to identify Veterans receiving long term chronic care. Visits beyond initial minimum qualification are expected to continue and

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

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

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

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

EXPANDING ACCESS TO HBPC

1. Satellite HBPC programs may be established as an outreach of recognized HBPC programs. Satellite programs are to incorporate: the practices of having VA staff provide direct care, interdisciplinary team meetings, and physician oversight. HBPC staff may work from a Community-based Outpatient Clinic (CBOC) or virtually in the CBOC service area. A freestanding HBPC satellite service area may be established in communities with sufficient numbers of eligible Veterans. Satellite HBPC programs will report to the primary HBPC Program and adhere to the policies and procedures of the primary HBPC Program. The satellite HBPC Program's scope of practice remains under that of the primary HBPC Program.
2. HBPC is encouraged to utilize technology (e.g., telecommunication equipment) and technology-assisted programs such as Telehealth to increase access, enhance patient monitoring, improve efficiency, provide patient and caregiver education, and expand support from other disciplines.
3. Innovative expansion of HBPC may include case finding of new patient populations with special needs and high-risk for institutionalization. Expansion may include targeting new service locations and patient populations to reduce unnecessary health care utilization and improve patient health, well-being, and satisfaction. Examples include residential alternatives and mental health services.