

MEDICAL FOSTER HOME PROGRAM PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive addresses the establishment, operation, policy, procedures, and standards of the Medical Foster Home (MFH) Program.

2. SUMMARY OF CONTENT: This is a new directive incorporating the contents of VHA Handbook 1141.02, Medical Foster Home Program Procedures. The MFH program under which the Department of Veterans Affairs (VA) provides interdisciplinary home care to Veterans placed in homes in accordance with the Community Residential Care (CRC) authority of Title 38 United States Code (U.S.C.) 1730. The content in this directive reflects major changes to the MFH program to include removing the Mental Health Intensive Case Management Program as a qualifying program. The content also reflects the most recent changes to MFH approval standards based on updates to the Community Residential Care regulation.

3. RELATED ISSUES: VHA Handbook 1140.01, VHA Handbook 1176.01, VHA Handbook 1000.01, and VHA Handbook 1101.10.

4. RESPONSIBLE OFFICE: The Office of Geriatrics and Extended Care Operations (10NC4) is responsible for the content of this directive. Questions may be referred to 202-461-6751.

5. RESCISSIONS: VHA Handbook 1141.02, dated November 10, 2009, is rescinded.

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 This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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CONTENTS

MEDICAL FOSTER HOME PROCEDURES

1. PURPOSE 1

2. BACKGROUND..... 1

3. DEFINITIONS 2

4. POLICY 5

5. MEDICAL FOSTER HOME PROGRAM GOALS 5

6. VETERAN ELEGIBILITY 5

7. MEDICAL FOSTER HOME PROGRAM CAPACITY 5

8. ESTABLISHING A RECOGNIZED MFH PROGRAM TO BE OPERATED OUT OF A VA MEDICAL FACILITY 6

9. ORGANIZATIONAL PLACEMENT OF THE MEDICAL FOSTER HOME PROGRAM 7

10. STAFFING OF THE MEDICAL FOSTER HOME PROGRAM 7

11. RESPONSIBILITIES 8

12. RECRUITMENT OF MEDICAL FOSTER HOME CAREGIVERS..... 13

13. MEDICAL FOSTER HOME CAREGIVER SELECTION AND TRAINING 15

14. MEDICAL FOSTER HOME STANDARDS 17

15. REFERRAL OF VETERANS TO MFH 17

16. PLACEMENT OF VETERANS IN MFH 18

17. QUALITY MONITORING AFTER MEDICAL FOSTER HOME PLACEMENT 20

18. RELEASE OF PATIENT-SPECIFIC HEALTH INFORMATION 23

19. DUE PROCESS AND REQUEST FOR HEARING..... 23

20. QUALITY MANAGEMENT AND EVALUATION 23

21. QUALITY ASSURANCE IN THE MEDICAL FOSTER HOME PROGRAM 24

22. RETENTION OF MFH CAREGIVERS 25

23. MEDICAL FOSTER HOME CAREGIVER SUPPORT SERVICES 25

24. FINANCIAL ARRANGEMENTS 26

25. LEGAL ISSUES..... 26

26. VA RECORDS..... 26

27. REPORTING SYSTEM 27

28. REFERENCES..... 27

MEDICAL FOSTER HOME PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) directive provides specific policy and guidance for establishing and operating a Medical Foster Home (MFH) Program under the standards of the Department of Veterans Affairs (VA) Community Residential Care (CRC) Program, of which it is a sub-component, as described in VHA Handbook 1140.01, Community Residential Care Program, dated February 10, 2014, or subsequent policy. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1730 and Title 38 Code of Federal Regulations (CFR) Section 17.61-74.

2. BACKGROUND

a. Many Veterans with a disability due to complex chronic disease or traumatic injury may not be able to safely live independently, or may have care needs that exceed the capabilities of their families. Traditionally, this situation was resolved by nursing home placement. However, many Veterans prefer to live in a home-like setting rather than a nursing home. Moreover, with the proper support, many Veterans who previously would have been placed in nursing homes can continue to live in a home and delay, or totally avoid, the need for nursing home care.

b. The MFH Program is one end of the spectrum of CRC for Veterans who are more medically complex and disabled and who will benefit from receiving interdisciplinary primary care in the home. The MFH Program combines Veteran placement in a small CRC home with a VA interdisciplinary home care team. An example is Home-Based Primary Care (HBPC), but there might be other medical home-based health care teams that would partner with the MFH program. The MFH Program offers a safe alternative to nursing home care by placement into a VA-approved private home in the community that may be a more acceptable care environment to Veterans and those responsible for their care.

c. The MFH is intended to serve Veterans who are unable to live independently due to functional, cognitive, or psychosocial impairment resulting from conditions such as complex chronic disease, psychological disorder, spinal cord injury or Polytrauma. These Veterans may have no family currently available to provide needed monitoring, supervision, and assistance with the Veteran's activities of daily living (ADL). A VA interdisciplinary home care team addresses the health conditions, while the MFH caregiver serves in the capacity of family caregiver to provide monitoring, supervision, and personal assistance.

d. The MFH Program was developed based on state models of adult foster care. VA analysis shows that adult foster care is a safe, cost-effective, and favorable extended care option for individuals with functional impairments who may otherwise reside in nursing homes if adult foster care were not available. The VA MFH Program was successfully piloted at the Little Rock VA Medical Center in 1999. In 2004, two additional sites implemented MFH programs in Tampa, FL, and San Juan, PR. With

this demonstrated success at three locations, MFH has been progressively expanding. MFH is a small community residential home, combined with a VA interdisciplinary home care team, such as VA HBPC, or Spinal Cord Injury-Home Care (SCI-HC), to provide non-institutional long-term care for Veterans who are presently unable to live independently and prefer a family setting. MFH is a form of CRC for the more medically complex and disabled Veterans, who meet nursing home level of care.

3. DEFINITIONS

a. Activities of Daily Living and Instrumental Activities of Daily Living.

Activities of Daily Living (ADL) refer to daily self-care activities. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person, particularly in regards to people with disabilities and the elderly.

(1) Basic ADLs consist of self-care tasks, including:

- (a) Bathing, shaving, brushing teeth, combing hair;
- (b) Dressing;
- (c) Eating;
- (d) Getting in or getting out of bed;
- (e) Toileting; and
- (f) Walking.

(2) Instrumental Activities of Daily Living (IADL) are not necessary for fundamental functioning, but they let an individual live independently in a community. They include:

- (a) Ability to manage finances;
- (b) Ability to use the telephone;
- (c) Assistance with transportation;
- (d) Housekeeping and room cleaning;
- (e) Laundry;
- (f) Meal preparation;
- (g) Obtaining scheduled appointments;
- (h) Shopping for groceries or clothing, etc.;
- (i) Taking medications; and

(j) Writing letters.

b. **Adult Foster Home.** An adult foster home is a private family home in which supportive care for compensation is provided in a home-like environment to adults who are frail or physically disabled.

c. **Approving official.** Approving official means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

d. **Community Residential Care.** Community Residential Care (CRC) is a form of enriched housing that provides health care supervision to eligible Veterans not in need of hospital or nursing home care, but who, because of medical, psychiatric, functional, or psychosocial limitations, are presently not able to live independently and have no suitable family or significant other to provide needed supervision and supportive care. Examples of CRC's enriched housing may include, but are not limited to: Assisted living homes, group living homes, family care homes, and psychiatric CRC homes. Care must consist of room, board, assistance with ADLs, and supervision. The cost of residential care is financed by the Veteran's own resources. Placement is offered in residential settings, after inspection and approval by the VA medical center of jurisdiction, and the choice is made by the Veteran (see VHA Handbook 1140.01, or subsequent policy). A Medical Foster Home is a subtype of a CRC.

e. **Family.** A family consists of person(s) considered by the Veteran to be the Veteran's primary source of support, who may or may not be related by blood or marriage.

f. **Hearing Official.** A hearing official is the Director or, if designated by the Director, the Associate Director or Chief of Staff of a VA medical center or outpatient clinic with jurisdiction to approve an MFH.

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

(4) A core interdisciplinary HBPC PACT team will be set up according the VHA Handbook 1101.10, Patient Aligned Care Team (PACT), dated February 5, 2014, or subsequent policy.

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

h. **Medical Foster Home.** A MFH is a private home in which an MFH caregiver provides care to a Veteran resident and the MFH caregiver lives in the MFH. No more than three residents may receive care in the MFH, including both Veteran and non-Veteran residents, and there is a recommendation of no more than one Veteran per bedroom. Spouses / partners may share a room if in need of MFH.

NOTE: *Veteran MFH residents also must be enrolled in a VA HBPC, SCI-HC, or a similar VA interdisciplinary program designed to assist medically complex Veterans living in the home. Additionally, MFH caregivers are not necessarily caregivers or family caregivers as defined in 38 CFR part 71. Please refer to these regulations for further information on the caregiver benefits program.*

i. **Medical Foster Home Caregiver.** The MFH caregiver, with assistance from relief caregivers, provides substantive assistance (i.e., assistance with ADLs and/or IADLs) on an ongoing basis for the Veteran in the Veteran's residence, the MFH. The assistance may include, but is not limited to: direct personal care activities, such as bathing, dressing, grooming, or other activities such as laundry, shopping, and meal preparation. As this is an ongoing commitment to the Veterans residing in the home, the MFH caregiver should carefully consider whether he/she can make the required investment of his/her time and energy in caring for the Veterans. The involvement of the MFH caregiver in other activities that may require significant diversion of his/her time or attention besides caring for the Veterans is discouraged. ***NOTE:*** *The MFH caregiver is known as a sponsor or facility operator in the CRC Program (see VHA Handbook 1140.01, or subsequent policy).*

j. **Spinal Cord Injury Home Care.** Spinal Cord Injury Home Care (SCI-HC) supports the transition and medical needs of Spinal Cord Injury and Disorder (SCI&D) patients in the home setting. The SCI-HC Program identifies and supports access to important medical, rehabilitation, and preventive services determined necessary to sustain the Veteran with SCI in the community.

(1) SCI-HC consists of interdisciplinary services as an integral part of SCI outpatient services under the clinical and administrative responsibility of the Chief, SCI Service. Interdisciplinary teams are composed of a physician, social worker, advanced practice registered nurse (APRN), physical therapist, dietitian, occupational therapist, vocational rehabilitation specialist, chaplain, and other individuals based on Veteran and family needs.

(2) These services can be provided collaboratively with HBPC and SCI Primary Care Team, or SCI Center, as appropriate and when needed or in consultation. (See VHA

Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care, dated February 8, 2011, or subsequent policy).

k. **VA Interdisciplinary Home Care Team Program Director and Coordinators.**

The VA Interdisciplinary Home Care Team Program Director for HBPC, SCI-HC, and MFH Coordinators have administrative and clinical responsibilities over the VA home care staff providing longitudinal health care in the home. The MFH Coordinator is the point of contact for administrative issues related to the home care Veterans receive in MFH.

4. POLICY

It is VHA policy that every MFH Program will be developed, implemented, and sustained within VHA in conformance with the standards and practices established in this directive.

5. MEDICAL FOSTER HOME PROGRAM GOALS

The goals of the MFH Program are to:

- a. Honor a Veteran's preference to reside and obtain primary health care in a home residence as an alternative to facility-based institutional long-term care.
- b. Provide longitudinal primary health care in a home setting for Veterans with personal care dependence needs and advanced, chronic medical conditions, including persistent mental illness and terminal illness, through care in a therapeutic personal home setting.
- c. Improve the quality of life for Veterans with personal care dependence needs and advanced, chronic medical conditions, including persistent mental illness and terminal illness when they lack the ability to remain safely in their own homes.
- d. Provide the full continuum of longitudinal care including preventive care through end-of-life care. Provide (non-monetary) assistance to Veterans to optimize the use of their personal funds to procure services and residence in a MFH setting to meet their needs for long term care.

6. VETERAN ELEGIBILITY

At the time of referral to the MFH Program, the Veteran must meet the eligibility criteria in 38 CFR 17.61 and the MFH must meet the requirements of 38 CFR 17.73.

7. MEDICAL FOSTER HOME PROGRAM CAPACITY

The capacity of the MFH Program depends on multiple factors, including:

- a. Staffing of MFH and VA interdisciplinary home care team;

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

8. ESTABLISHING A RECOGNIZED MFH PROGRAM TO BE OPERATED OUT OF A VA MEDICAL FACILITY

a. **Team Training.** All MFH Coordinators, Program (or Medical) Support Assistants (MSA or PSA), and other staff as applicable will actively participate in the national training and mentor program.

b. **Proposals.** Proposals to establish a VA MFH service are to be submitted to the Executive Director, Geriatrics & Extended Care Office of Clinical Operations, VA Central Office. This Office reviews and provides guidance on proposals and makes the determination of standards and recognized status of a VA MFH service. Critical elements in the proposal include:

(1) An established VA interdisciplinary home care team, such as the HBPC, or SCI-HC program, provides medical home care to Veterans in MFHs. A VA interdisciplinary home care team is an integral component of the care and oversight required by MFH residents. A VA medical center must have the support of a functioning HBPC, or SCI-HC program meeting VHA standards before establishing an MFH program.

(2) A description of the proposed MFH service, with attention to the program elements that are included in this directive, as well as VHA Handbook 1140.01 and VHA Handbook 1176.01, or subsequent policies. The program description needs to outline any state licensure requirements under which the MFH program operates.

(3) An explanation of the staffing as described in paragraph 10. This is to include the responsibilities of the full-time equivalent (FTE) employee of the MFH Coordinator without collateral duties and of the MFH PSA, and the positions and respective FTE of the interdisciplinary home care team.

(4) Confirmation of:

(a) Twenty-four hour telephone coverage for MFH, specifying coverage by the PSA during routine office hours; and

(b) The process by which Veterans and caregivers are able to reach appropriate VA medical facility staff during off-duty hours.

(5) Evidence of VA medical facility support, including: adequate space, information technology, General Services Administration (GSA) vehicles, support of the VA interdisciplinary home care team, and equipment (e.g., computers, cell phones, pagers).

(6) Evidence that local program policies and procedures are developed based on national VA policy and regulation, as well as applicable state regulations. Documents include a caregiver guide, guidelines for recruitment of MFHs, caregiver application process, MFH quality oversight process, policies for referral and placement of MFH Veterans, and Veteran discharge policies.

(7) Evidence that there has been introductory contact with the VA Regional Counsel for general guidance.

9. ORGANIZATIONAL PLACEMENT OF THE MEDICAL FOSTER HOME PROGRAM

Nationally, the MFH Program is under the oversight of the Offices of Geriatrics and Extended Care Services and Geriatrics and Extended Care Operations. These are two different VA Central Office program offices involved in HBPC Program policy development, oversight, and operations at the national level. At the VA medical facility level, the MFH program should be under the direction of the Associate Chief of Staff for Geriatrics and Extended Care. If such a position does not exist at the VA medical facility, an MFH program can function effectively under the Chief of Staff or designated Associate Chief of Staff or Chief of Spinal Cord Injury and Disorders. MFH will serve Veterans from all VA programs and referral sources.

10. STAFFING OF THE MEDICAL FOSTER HOME PROGRAM

a. **Medical Foster Home Coordinator.** The MFH Coordinator position requires one FTE employee without collateral duties. **NOTE:** *An experienced senior level social worker is recommended due to the complex nature of this position. For this reason, a senior member of the Social Work Service should be a part of the hiring panel for the position.* Given the higher level of care needs and vulnerability of the MFH population, 30 residents is the maximum recommended caseload per MFH Coordinator FTE. In situations in which the caseload exceeds this, a second MFH program with a separate 1.0 FTE MFH Coordinator is indicated.

b. **Medical Foster Home Program Support Assistant.** The MFH PSA position is recommended at one FTE employee. The PSA supports the MFH Coordinator and is responsible for clerical functions, phone coverage, assistance with reports, and coordination of MFH resident visits, program workload, and quality measure tabulation.

c. **VA Interdisciplinary Home Care Team.** The Interdisciplinary Home Care Team members consist of a provider (physician, APRN, physician assistant (PA), licensed dietitian, registered nurse (RN), social worker, rehabilitation therapist, pharmacist, and psychologist. Based upon resident characteristics and needs, this interdisciplinary team may be expanded to include others, such as a chaplain or Women's Veterans Program Manager. **NOTE:** *VA HBPC, or VA SCI-HC programs meet this requirement.*

d. **Recreation Therapist.** Each MFH site must incorporate recreation therapy into its program. The required time allocation of this position is at least 0.25 FTE to the program, increasing proportionately as the MFH census grows. The recreation therapist works with MFH Veterans and caregivers to develop treatment plans to improve overall physical, mental, and emotional well-being, as well as facilitating access to community resources to improve quality of life. The recreation therapist may be a member of the VA interdisciplinary home care team or aligned under another service.

e. **VA Inspection Team.** The MFH program utilizes an inspection team. This inspection team may serve multiple care settings and programs for the VA medical facility. The VA inspection team makes initial and annual inspections of the MFHs to ensure compliance with applicable fire and safety requirements, dietary and medical treatment plans, and to make recommendations as needed. Annual inspections must be carried out by an interdisciplinary team. At a minimum, the team must consist of a social worker, nurse, dietitian, and a fire and safety specialist. A rehabilitation therapist is a highly-recommended addition to the inspection team. Based upon the inspection team's findings, additional disciplines must participate in the inspection process as determined by the MFH Program Coordinator. Additional disciplines include, but are not limited to, a physician and infection control. The Women Veterans Program Manager is a consultant to the MFH program and this interdisciplinary team.

NOTE: Any exceptions to the staffing levels must be approved by the National MFH Program Coordinator.

11. RESPONSIBILITIES

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

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management, or designee, is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN);

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all of the VA health facilities within that VISN; and

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Chief Consultant, Geriatrics and Extended Care Services.** The Chief Consultant, Geriatrics and Extended Care Services, is responsible for:

(1) Developing policy, monitoring program activity, and ensuring compliance to this directive.

(2) Promoting MFH program development in the field through guidance, support, email groups, conference calls, and educational programs.

d. **Executive Director, Geriatrics and Extended Care Operations.** The Executive Director, Geriatrics and Extended Care Operations, is responsible for:

(1) Providing comparative feedback to VA medical facilities on MFH characteristics, populations served utilization, quality, and outcomes.

(2) Facilitating expansion of the MFH Program to promote reliable access to non-institutional extended care services, through national initiatives and VA medical facility-specific guidance and support.

(3) Providing operational guidance to the field on the situations that occur in the daily management of the MFH programs.

e. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for:

(1) Facilitating communications between the MFH Coordinators and the Offices of Geriatrics and Extended Care for Operations and Policy.

(2) Ensuring that VA medical facilities maintain staffing and capacity of the interdisciplinary home care programs that serve Veterans in MFHs, in accordance with 38 U.S.C. 1710B(b).

(3) Notifying the Deputy Under Secretary for Health for Operations and Management by email at least 10-calendar days prior to implementation of any proposed program restructuring that could reduce staffing or the capacity of MFH services or the home care programs that provide care to Veterans in MFH, in accordance with VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010, or subsequent policy.

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

(1) Serving as the hearing official, or may designate the Associate Director, or Chief of Staff of a VA medical center or outpatient clinic, that has jurisdiction to approve a MFH;

(2) Providing needed resources to maintain the staffing and capacity of the MFH Program and the interdisciplinary home care programs that serve Veterans in MFHs; and

(3) Notifying the Deputy Under Secretary for Health for Operations and Management and VA Central Office Geriatrics and Extended Care Operations in advance of any

proposed changes or restructuring that could reduce staffing, capacity of MFH services, or the home care programs that provide care to Veterans in MFHs, in accordance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016, or subsequent policy.

g. **Medical Foster Home Coordinator.** The MFH Coordinator is responsible for:

- (1) Marketing MFHs to VA staff members, Veterans and families, Veterans Service Organizations, and the community;
- (2) Establishing working relationships with all internal and external stakeholders;
- (3) Maintaining appropriate working relationships with all levels of VA staff including the Veteran's VA interdisciplinary home care team. This should include active outreach, education and case finding with all VA interdisciplinary teams;
- (4) Recruiting MFHs and MFH caregivers;
- (5) Screening MFH environments for needed structural alterations and supporting and providing guidance to Veterans who chose to apply for Home Improvement Structural Alterations (HISA) grants, if needed;
- (6) Facilitating the process of transitioning (not physically moving) Veterans into MFHs;
- (7) Ensuring adherence to the criteria for an approved MFH program to include staffing standards;
- (8) Monitoring the quality of MFHs after placement of each Veteran by the MFH Coordinator with collaboration of the interdisciplinary home care team;
- (9) Ensuring adherence to the standards described in this VHA directive;
- (10) Meeting at least quarterly with the HBPC Director, or SCI Home Care Director, or designees, to discuss program coordination and to review the status of each MFH resident;
- (11) Ensuring initial and annual home inspections are done by the interdisciplinary VA inspection team;
- (12) Ensuring that the MFH caregivers are furnished with, and understand, the inspection team's recommendations;
- (13) Ensuring a safe, suitable, and therapeutic environment for Veterans residing in MFH;
- (14) Identifying concerns of the Veteran, the inspection team, or any member of the care team, and discussing those concerns and resolutions with the MFH caregiver;

(15) Documenting and overseeing corrections of any MFH violations;

(16) Developing the initial MFH policies and procedures;

(17) Arranging at least semi-annual training sessions for the MFH caregivers, as required by the most current MFH standards;

(18) Developing a MFH Caregivers Guide for distribution to each caregiver. This Guide must be reviewed annually, updated as needed by the MFH Coordinator and reviewed with the caregiver annually. Ensuring that MFH caregivers are provided with, and understand, the local caregiver guide; and

(19) Assisting the Veteran in identifying eligibility for obtaining, and maximizing any additional VA benefits.

(20) Ensuring that an individual assessment of the MFH caregiver's suitability is performed by VA in those cases in which the MFH caregiver fails to meet the requirements of 38 CFR 17.63(j)(4), and obtaining review and final determination from the approving official regarding the individual assessment.

h. **Medical Foster Home Program Support Assistant.** The Medical Foster Home Program Support Assistant (PSA) position is vital to the overall operation of the program, assists the MFH Coordinator in all facets of the program and oversees the program office in the absence of the MFH Coordinator. PSA responsibilities include:

(1) Clerical functions including, but not limited to: answering telephone inquiries, contacting the MFH Coordinator in the field when appropriate, maintaining files and record keeping systems, assisting with preparation of reports and marketing materials, and facilitating communication with the VA interdisciplinary home care team.

(2) The intake of a resident and MFH caregiver referrals to include gathering preliminary applicant information, answering applicant questions, and referring applicants to the MFH Coordinator.

(3) Assisting in coordinating the placement of Veterans.

(4) Obtaining patient information from VHA electronic records and relevant non-VA medical records.

(5) Setting up and maintaining a file for each MFH to include:

(a) MFH caregiver's application, the agreement between the MFH caregiver and Veteran or the Veteran's representative, and other required documents;

(b) Initial evaluation by the MFH Coordinator;

(c) Inspection reports;

- (d) All correspondence related to the MFH and caregiver;
- (e) Required documentation for relief caregivers; and
- (f) All material relating to any hearing and decision.

(6) Collecting and maintaining for each resident electronic data which is used for program monitoring and evaluation.

(7) Scheduling program requirements, such as annual inspections to ensure MFH standards are met by MFHs, and caregiver training.

(8) Tracking the subject matter of the training provided to MFH caregivers to facilitate curricula development for future trainings.

i. **Interdisciplinary Home Care Team.** The HBPC, SCI-HC, or other interdisciplinary team is required to screen potential MFH patients to ensure that they meet program criteria. The primary interdisciplinary team will assist the MFH Coordinator with the admission process to provide home health care, perform assessments, and monitor care provided by the MFH caregiver. The interdisciplinary home care team must:

(1) Provide home health care services to Veterans in MFH in accordance with current national program policy for the given programs.

(2) Educate the MFH caregiver and relief caregivers in specialized resident care needs as noted in the plan of care. This includes promptly communicating any significant changes in the resident's normal appearance, behavior, or state of health, to the HBPC, or SCI-HC team.

(3) Evaluate the need for adaptive medical equipment and for appropriate home improvements to facilitate access and resident care activities. A rehabilitation therapist assists eligible Veterans in applying for HISA grants when indicated, and makes initial and periodic home visits.

(4) Identify the need for community resources and coordinate purchase of community home care services.

(5) Support the MFH caregiver and residents through timely communication and problem solving.

(6) Update the Veteran's family or surrogate, with the Veteran's consent, regarding changes in the Veteran's medical condition in accordance with VHA Directive 1605.1, Privacy and Release of Information, dated August 31, 2016, or subsequent policy.

(7) Assist the MFH Coordinator in monitoring the MFH environment with special emphasis on safety, potential for abuse and neglect, signs of caregiver stress or burnout, and any other issues and concerns that may arise.

(8) Report any medical, psychiatric, or psychosocial concerns to the MFH Coordinator.

(9) Consult with the MFH Coordinator when scheduling periods of respite.

12. RECRUITMENT OF MEDICAL FOSTER HOME CAREGIVERS

a. Recruitment of MFHs and MFH caregivers is the responsibility of the MFH Coordinator. The MFH Coordinator ensures that the process for selection of homes and caregivers complies with the regulations pertaining to the MFH program (38 CFR 17.61-17.74).

b. The MFH Coordinator actively recruits individuals in the community with nurturing dispositions and suitable, or potentially suitable, living environments to serve as MFH caregivers for Veterans. Individuals wishing to become MFH caregivers may contact the VA medical center either by telephone, in writing, or in person. Referrals may come from the individuals themselves, or from other VA or non-VA personnel. **NOTE:** *MFH Coordinators need to be aware that VA employees (or close family members of VA employees such as spouses) who request to be a MFH caregiver may jeopardize their employment status. Employees need to consider whether their employment would conflict with the responsibilities of the MFH caregiver, and be in violation of the "Standards of Ethical Conduct for Employees of the Executive Branch" (5 CFR part 2635) due to the MFH taking VA referrals or is seeking VA referrals.*

c. The MFH Coordinator conducts an initial on-site visit prescreens of prospective caregivers to ensure the environment, facility, and caregiver meet basic requirements. Additional visits may be necessary to continue the prescreen assessment process.

d. Once a prescreen visit has been completed and the MFH Coordinator has decided to move forward with further evaluation of the potential home, the prospective caregiver in the home must submit an application in writing to the MFH Coordinator. When formal application is made, it must be reviewed by the MFH Coordinator, or designee, who contacts the applicant to arrange a formal inspection. The MFH Coordinator should discuss the application process, caregiver selection criteria, and financial aspects of MFH with each applicant.

e. The MFH Coordinator must inform the applicant of program expectations, including:

(1) The primary intent of MFH, which is the permanent placement of the Veteran (at the Veteran's preference), often through the end of life. A secondary purpose of MFH may include providing a safe community living option for Veterans receiving long-term rehabilitative care.

(2) The Veteran's condition is likely to worsen over time, and the caregiver's workload may increase. In other situations, the Veteran may be rehabilitated and return home.

f. The applicant must meet with the MFH Coordinator for evaluation of key physical and interpersonal skills, and to complete an initial home assessment.

g. In addition to the written application and meeting with the MFH Coordinator, the following information shall be considered in the evaluation of the applicant to best facilitate the process of matching Veterans with appropriate MFHs; that can meet their needs and preferences for care. This includes:

(1) To ensure a safe environment for Veterans residing in the MFH, the VA-approved MFH caregiver must meet regulatory requirements. A MFH is prohibited from employing an individual who has been convicted in a court of law of certain listed crimes within 7 years of conviction, or has had a finding within 6 months entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of property. This prohibition applies likewise to the MFH caregiver/operator. The MFH is required to conduct an individual assessment of suitability for employment for any conviction or finding outside either the 7 year or 6 month parameters. The MFH is also required to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The MFH must report and investigate any allegations of abuse or mistreatment. The MFH must also screen individuals who are not CRC residents, but have direct access to a veteran living in a CRC. See 38 CFR 17.63(j).

(2) A financial statement indicating financial stability, which may include other sources of income, a history of bankruptcies, and level of debt and financial liabilities.

(3) HIPAA Use and Disclosure Form; health certificate or physical; copy of home owners and automobile insurance certificates; copy of first aid certificate card; copy of CPR certificate card; copy of state driver's license; copy of pet vaccination and license; and copy of pest control.

(4) Personal and professional references.

h. In states requiring licensure for adult foster homes with three or fewer residents, the applicant must provide proof of licensure.

i. If the potential caregiver is renting, the homeowner needs to be aware and agree to the home being used as a MFH. This needs to be demonstrated in writing by the homeowner.

j. Provided the applicant passes the initial screening process, the VA interdisciplinary inspection team conducts a formal inspection as required according to this directive.

k. Following the team inspection of the home, a letter of final acceptance or rejection from the VA medical facility Director, or designee, is sent to the applicant, preferably within 30 calendar days of the inspection date.

13. MEDICAL FOSTER HOME CAREGIVER SELECTION AND TRAINING

MFH caregivers are selected based on requirements in VHA Handbook 1140.01, or subsequent policy and VA regulations at 38 CFR 17.61-17.74. Requirements for MFH caregivers are:

a. Selection Standards or Guidelines for a Medical Foster Home Caregiver.

(1) Sufficient, qualified caregivers, recognized as such by Geriatrics and Extended Care Operations, or designee, must be at home and available to ensure the health, safety, and care of each resident. MFH caregivers are required to have a relief caregiver who can fulfill responsibilities including: the supervision of the MFH, needed personal assistance to the Veterans, and having the discretion to call for emergency assistance if needed. There needs to be a written backup plan that could be activated if the MFH caregiver becomes temporarily incapacitated.

(2) The MFH caregiver and relief caregivers must have formal or informal caregiver experience working with chronic medically complex patients who may also have mental health and cognitive impairments, adequate education, training, and experience to maintain the MFH. This includes the experience and physical ability to provide the needed care.

(3) The MFH caregiver must agree to assist residents in obtaining their plan of care as developed by the VA interdisciplinary home care team. The MFH caregiver generally needs to accept, participate in, and follow that plan.

b. Medical Foster Home Caregiver Education and Training.

(1) The MFH Coordinator trains, or encourages MFH caregivers to obtain, knowledge and skills, in the care of frail populations in accordance with the VHA Handbook 1140.01, or subsequent policy. Training materials are located <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/MFH/>. **NOTE:** *This is an internal VA Web site that is not available to the public.* The following topics must be covered annually, and the MFH Coordinator is responsible for validating this occurs:

- (a) Provision of personal care, specific to ADL;
- (b) Medication management;
- (c) Crisis management and re-hospitalization procedures;
- (d) Provision of supportive and emotional care;
- (e) Nutrition and proper food preparation, distribution, and storage;
- (f) Activity and program planning;
- (g) Applicable VA policies;

- (h) Protecting the resident's privacy and confidentiality;
- (i) Local and state laws and ordinances;
- (j) Fire and safety procedures;
- (k) End-of-life issues;
- (l) Reviewing the Caregiver Guide; and

(m) Reviewing annually: the Memorandum of Understanding (MOU), standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements, resident rights, caregiver rights, and the caregiver/Veteran agreement.

(2) VA staff members will provide the MFH caregivers training semi-annually, and on an as-needed basis determined and coordinated by the MFH Coordinator.

c. **Caregiver CPR and First Aid Requirement.** The MFH Coordinator must ensure that sufficient, qualified caregivers are at home and available to care for residents and provide for the health and safety of each resident. A caregiver who has completed courses in First Aid and Cardiopulmonary Resuscitation (CPR) and holds a current valid card documenting completion of such courses must be in the MFH at all times. Documentation of attendance at First Aid and CPR course offered by an accredited college, university or vocational school, a licensed hospital, the American Red Cross, American Heart Association, National Safety Council, or a provider approved by the Department of Health satisfies this requirement.

d. **Ongoing Training.** Ongoing training must be provided, including diversity and ethics training on personal boundaries and conflict of interest for caregivers. Documentation of the training must be maintained in the VA medical facility record. For training materials visit <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/MFH/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

e. **Medical Foster Home Caregiver Guide.** A MFH Caregiver Guide developed by the MFH Coordinator, based on the national template, will be distributed to caregivers upon formal approval into the program, and reviewed annually. The national template can be found at <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/MFH/>. **NOTE:** *This is an internal VA Web site that is not available to the public.* MFH staff members must sign a statement and place it in VAMC MFH records at the medical center that this review occurred annually. The Caregiver Guide will include, but is not limited to:

- (1) Standards for operation of the home;
- (2) Resident's rights and responsibilities;
- (3) Protocol for emergencies;
- (4) Points of contact; and

- (5) The MFH caregiver rights.

14. MEDICAL FOSTER HOME STANDARDS

- a. The VAMC Medical Director, as the approving official or designee, may approve a MFH based on the report of a VA inspection team and on any findings of necessary interim monitoring of the home, if the home meets all applicable Federal regulations (including the standards described in 38 CFR 17.61-17.74, state licensing requirements, and local regulations.

- b. In order to provide a safe environment for all residents and caregivers, residents are expected to respect other residents and caregivers and to follow the MFH rules. Caregivers may establish reasonable rules and guidelines for residents as a condition for continued residency in a MFH. The purpose of these rules and guidelines is to ensure a safe and inviting environment for both residents and caregivers. MFH rules and guidelines may include, but are not limited to, establishing reasonable visitation hours, providing for separate smoking and non-smoking areas, and restricting consumption and storage of food to certain areas. Methods must be implemented to maintain and adjust care environments to support Veterans dignity, privacy, and security. Other elements within the environment that are of special concern to women Veterans may require the Women Veteran Program Manager (WVPM).

15. REFERRAL OF VETERANS TO MFH

Veterans can be referred by VA staff members, community agencies, family members, the Veteran or other agency. Upon referral, the MFH Coordinator, or designee, is responsible for reviewing the referral and Veteran assessment and making a determination for placement in the program. Placements must be approved by the MFH Coordinator before a Veteran can be placed into a VA MFH. Placement authority resides with the MFH Coordinator. Other referral duties of the MFH Coordinator include:

- a. If necessary, the MFH Coordinator will assist Veterans with enrolling in the VA health care system and with obtaining a primary care provider.
- b. Ensuring the Veteran is accepted by a VA interdisciplinary home care team.
- c. Determining if the Veteran has the financial resources or eligibility for enhanced VA benefits sufficient to fund placement in a MFH. The MFH Coordinator is responsible for assisting the Veteran with identifying eligibility for, obtaining, and maximizing any additional VA benefits. Identifying if someone other than the Veteran has the authority to make financial and health care decisions. If not, the MFH Coordinator must educate the prospective MFH resident on the importance of having a surrogate and work with the Veteran to identify an individual who can manage funds and make health care decisions should the Veteran become incapacitated in the future.
- d. Reviewing the Veteran's medical records with input from the treating team to assess physical and psychosocial functioning.

e. Collaborating with the referral source, VA staff, the Veteran or surrogate, and if appropriate the Veteran's family, to establish an accurate profile of the Veteran and expected care needs.

f. Responsible for assuring screening is completed for any active communicable disease.

g. Ensuring that Veterans who are being followed by a mental health provider continue to receive mental health care. For Veterans with a major psychiatric diagnosis, the MFH Coordinator must request certification from a psychiatrist that the Veteran can safely live in the MFH and does not pose a danger to self or others.

h. Explaining the MFH Program to the Veteran and family members.

i. Promoting the optimal match of the Veteran and a MFH by ensuring MFH caregiver skills and home standards meet the specific care and safety needs of the Veteran, as well as through compatibility of interests, temperament, and lifestyle of the Veteran and MFH caregiver.

j. Securing appropriate consent to release the Veteran's information.

k. Provide appropriate health information to the MFH caregiver with a health summary that includes psychosocial, functional, behavioral, nutritional, and medical information, including communicable diseases.

l. Encouraging the Veteran, family, or surrogate to tour available MFHs before making a decision.

m. Ensuring that, upon matching a Veteran with a MFH caregiver, the Veteran or the Veteran's authorized personal representative and the MFH caregiver, or the MFH caregiver's authorized representative, must agree upon the charge and payment procedures for care. This agreement must be in writing and signed by both parties, and a copy of the agreement must be provided to each party and to the MFH Coordinator for inclusion in the MFH Coordinator's administrative file.

16. PLACEMENT OF VETERANS IN MFH

a. Acceptance.

(1) Whenever possible, it is highly recommended that the Veteran and MFH caregiver should meet prior to placement.

(2) The MFH Coordinator recommends the MFH caregiver and Veteran establish a written agreement that has been approved by the MFH Coordinator concerning the terms of the room, board, and personal care assistance provided by the MFH caregiver to the Veteran. **NOTE:** *The MFH Coordinator will provide an example agreement to the MFH caregiver and Veteran.*

(3) The MFH Coordinator needs to recommend that a written agreement include:

(a) A list that specifies the services and accommodations to be provided by the MFH;

(b) The cost of care rates and charges, based on the Veteran's level of care, following established guidelines;

(c) A statement that the MFH caregiver must provide at least 30 calendar days' notice before implementing a rate increase, unless there is a sudden change in the necessary level of care;

(d) A bed-hold policy for Veterans who request the caregiver reserve a bed during the Veteran's admission(s) to a hospital;

(e) The MFH discharge policy. The MFH Coordinator must require the MFH caregiver not discharge a Veteran without 30 calendar days written notice that states the reason(s) for the requested move or transfer, except when the situation requires immediate removal.

(f) A refund policy when a Veteran is discharged or dies.

b. Procedure for Placement of Veteran in a Medical Foster Home.

(1) All requests and placements in MFH must go through the MFH Coordinator.

(2) The discharge date from an inpatient facility must be coordinated with the HBPC, SCI-HC, or other care manager. **NOTE:** *Generally, the Veteran is not discharged to a MFH until 24 hours after making significant treatment changes (e.g., discontinue catheters, feeding tubes, oxygen) that may result in acute problems in the MFH, and lead to emergency room visits or hospital re-admission within hours of discharge.*

(3) The specific home equipment needs of the Veteran must be assessed prior to admission to a MFH.

(4) For SCI-HC patients, specialized home assessment and SCI training must be provided to the MFH caregiver and patient by a registered nurse, including bowel and bladder care, wound care, and pain management.

(5) The MFH Coordinator contacts the MFH caregiver to verify readiness to receive the Veteran and explore any remaining needs or concerns.

(6) The MFH Coordinator educates the MFH caregiver regarding responsibility for the Veteran's current and anticipated personal and health care needs, including the necessary level of supervision.

(7) The MFH Coordinator ensures all appropriate adaptive medical equipment (hospital bed, bedside commode, wheelchair, oxygen concentrator, feeding pump, etc.),

medications, treatments, and supplies are ordered and delivered to the MFH prior to the arrival of the Veteran and that all appropriate training is provided.

(8) The MFH Coordinator ensures transportation is arranged for the Veteran to the MFH. Responsibility for discharge transportation is not to be delegated to the MFH caregiver.

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

c. Upon Placement in a Medical Foster Home.

(1) The MFH Coordinator informs the pension center or VBA that the Veteran has been physically placed in a MFH to maximize benefits (Aid and Attendance (A&A)/Special Service-connected compensation).

(2) The MFH Coordinator establishes a mechanism to monitor and encourage timely payment to the MFH caregiver by the Veteran.

(3) The MFH Coordinator and the MFH caregiver must: verify the medications and supplies ordered and received; review the Veteran's physical condition on arrival; and review any other medical issues, such as special diets, the Veteran's mobility, and any adaptive medical equipment.

(4) On the day the Veteran moves into the MFH, the MFH Coordinator assures a VA interdisciplinary home care team member makes contact with the MFH either by a home visit or by telephone to respond to any questions or issues that may arise.

(5) The MFH Coordinator assists the Veteran with providing the MFH caregiver with pertinent information, such as: family contact information, Medicare Supplemental Insurance, advance directive or living will (if available), designated funeral home preference, and whatever additional information may be needed for making decisions in a timely manner when the Veteran cannot communicate.

(6) The MFH caregiver is required to complete an inventory of the Veteran's personal possessions and has the Veteran, or surrogate, sign the list to prevent future claims of missing property.

(7) The Veteran will be provided a copy of the house rules, resident agreement, resident's rights, grievance policy, and the phone number to the local ombudsman.

17. QUALITY MONITORING AFTER MEDICAL FOSTER HOME PLACEMENT

a. **Within 24 Hours (or Next Business Day) of Placement.** The MFH Coordinator or PSA contacts the MFH to check on the Veteran and the MFH caregiver. The MFH

caregiver is asked if the instructions regarding the Veteran's medical condition and the Veteran's care needs were adequate.

b. **Within 2 Weeks of Placement.** The MFH Coordinator makes a home visit to evaluate the adjustment of the MFH caregiver and the Veteran.

c. **Monthly.** Unannounced visits by MFH Coordinator, or designated health care professionals, are conducted monthly to do all of the following:

(1) Observe for abuse or neglect. Suspected abuse or neglect needs to be reported in accordance with VHA Directive 1605.1, Privacy and Release of Information, dated August 31, 2016, or subsequent policy, and VHA Directive 1199, Reporting Cases of Abuse and Neglect, or subsequent policy.

(2) Assure the resident has the required caregiver supervision. Determine if the MFH caregiver leaves the resident without adequate supervision.

(3) Observe for caregiver stress. The MFH Coordinator may encourage respite or suggest that the MFH caregiver hire assistance for relief.

(4) Observe for conflicts between, or among, any of the involved parties: residents, MFH caregiver, family members (resident's or the caregiver's), surrogate, friends, and VA staff members.

(5) Encourage the MFH caregiver, the resident, family, or surrogate to seek help from the MFH Coordinator in resolving conflicts and addressing problems that arise in the home.

(6) Monitor for financial issues, e.g., protection of the Veterans' personal funds, inadequate, late, or non-payments, complaints about rate amounts or changes, concerns relating to vacancies, and decreased income.

(7) Discuss potential violations of the written agreement between the Veteran and the MFH caregiver and assist in dispute resolution.

(8) Reeducate the Veteran and the MFH caregiver, as needed, about each other's rights and responsibilities in the MFH.

(9) Explore the Veteran's ongoing adjustment to the MFH environment and to the MFH caregiver, including resident satisfaction with the MFH Program.

(10) Ensure all communication of instructions or pertinent information is provided verbally or in writing to the resident, MFH caregivers, families, and surrogate, as appropriate.

(11) Ensure compliance with all MFH regulations.

(12) Ensuring processes for reporting MFH revocations are in place to ensure current and future resident safety.

(13) Reporting all safety concerns and issues to local, VISN and national VA Leadership.

(14) In cases of suspected abuse and/or financial exploitation, report these concerns in accordance with Directive 1199, Reporting Cases of Abuse and Neglect, which includes reference to local and state authorities.

(15) Submitting an Issue Brief within 24 hours of notification or discovery of the issue.

(16) Maintaining open communication with the Office of Regional Counsel for advice on legal issues pertaining to the MFH Program.

(17) Ensuring documentation of caregiver non-compliance with program standards, which includes efforts made to provide education and training to caregivers when appropriate.

d. **Justification for Suspending Placement.** Removal of a MFH from VA's referral list must follow the procedures set forth in 38 CFR 17.65-17.72; however, pursuant to 38 CFR 17.73, a medical foster home must meet all of VA's regulatory criteria for approval or VA will not refer Veterans to the home and will not provide services to Veterans in the home. Therefore, any of the following serve as justification for immediately suspending placements in a MFH and offering alternative placements to Veterans in that home (see paragraph 14) while the regulatory procedures are being followed:

(1) Abuse or neglect of any resident;

(2) Documented instances that put the safety or well-being of resident at ongoing risk;

(3) Inability of the MFH caregiver to provide adequate care for resident(s);

(4) Documented non-compliance with a resident's treatment plan of care; and/or

(5) Documented non-compliance with program standards, including fire and safety inspection recommendations or participation in required training sessions.

(6) In states that require licensing of the MFH, report revocations to the agency that grants and monitors the license.

(7) For non-licensing states, report revocations to the appropriate state agency on aging, long term care, adult protective services and/or mental health services.

e. **Adjudicated Incompetent Residents Placed in MFH.** The MFH Coordinator must:

(1) Meet on an annual basis with VA Regional Office Guardianship staff members to discuss financial arrangements of the adjudicated incompetent residents placed in MFH.

(2) Provide VA Regional Office Guardianship staff members timely notification of change in cost of care or in the location of these residents.

18. RELEASE OF PATIENT-SPECIFIC HEALTH INFORMATION

a. **Authority.** MFH Program officials and MFH caregivers may release patient-specific health information in compliance with the following statutes and their implementing regulations: 5 U.S.C. 552 and 552a; 38 U.S.C. 1730, 5701, 5705, and 7332; and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

b. **VA Medical Foster Home Staff.** VA MFH staff members must consult with the VA medical center's Privacy Officer and Release of Information Office when questions arise regarding how and what patient-specific health information may be released to MFH caregivers.

c. **Business Associate Agreement.** MFH Services are considered a continuation of treatment as defined by the HIPAA Privacy Rule, 45 CFR 164.501. Because the disclosure is by a health care provider (VHA) to another health care provider (CRC), a Business Associate Agreement (BAA) is not required (45 C.F.R. 164.502(e)(1)(ii)).

d. **Availability of Information.** VA standards must be made available to Federal, state, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting the MFH.

19. DUE PROCESS AND REQUEST FOR HEARING

The provisions of 38 CFR 17.66-17.71 must be followed when making determinations regarding compliance with statutory or regulatory requirements.

20. QUALITY MANAGEMENT AND EVALUATION

a. **Performance Improvement Plan.** The performance improvement activities of MFH support the mission and goals of VA and the individual health care facility. All performance improvement activities must be consistent with the standards set forth by VA and the home care accrediting organization.

(1) Performance improvement information is confidential and disclosure may only be as permitted by law and VA Policy.

(2) The MFH Coordinator must conduct an annual risk assessment and, based on

the assessment, establish and operate a Performance Improvement Plan to be conducted by the MFH Coordinator and the VA interdisciplinary home care team. This risk assessment and plan must, at a minimum, address at least two or more of the following quality monitors with a quarterly or annual evaluation:

(a) Quality of life (e.g., depression, nutrition);

(b) Medication safety, including proper handling, management, storage, and prevention of misuse;

(c) Resident satisfaction and perception of care;

(d) Caregiver Stress; and

(e) Data for quality improvement and evaluation as outlined in paragraph 21.

b. **Workload and Productivity Standards**. The emphasis on workload and staff productivity for MFH considers the number and the mix of providers, the patient case mix and complexity, geography, program support, and other determinants unique to the health care facility. Workload capture must be specific to clearly delineate Geriatrics and Extended Care MFH Coordinator workload from the Interdisciplinary team.

21. QUALITY ASSURANCE IN THE MEDICAL FOSTER HOME PROGRAM

The VA medical facility must integrate the MFH Program into its facility Quality Improvement Program. Generally, this is the responsibility of the clinical area (service line or care line) with program oversight.

a. MFH data must include:

(1) Reports of surveys conducted by Federal, state, and local regulatory licensing agencies; and

(2) Veteran safety data such as:

(a) Adverse Events. Adverse events are defined in VHA Handbook 1004.08, dated October 2, 2012 or subsequent policy.

(b) Sentinel Event. A sentinel event is defined by The Joint Commission (http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/).

(c) Reporting. The MFH Program Coordinator of the VA Medical Center of Jurisdiction is required to report the following in an issue brief, within 24 hours after being notified by the MFH, to VA Central Office Geriatrics and Extended Care Operations and copy the designated VISN liaison and medical facility Director, or designee:

1. All sentinel events;

2. Adverse events;
3. Loss of licensure;
4. Any information regarding a MFH that appears in local or national media, including television, newspapers or radio; and
5. A MFH closure due to a sentinel or adverse events. (Adverse and Sentinel Event Reporting Form available on MFH SharePoint).

b. Results of quality assessment and improvement activities must be used by local VA staff members in suggesting program improvements and changes, and in making decisions regarding the continued approval of any MFH, including:

- (1) Results from any Veteran and/or family satisfaction reports; and
- (2) Any MFH-specific quality improvement findings that may be established by the VA medical facility.

22. RETENTION OF MFH CAREGIVERS

Long-term caregiving is a highly stressful responsibility. The caregiver's stress level is to be closely monitored by the MFH Coordinator and the VA home care team. Early identification of signs and symptoms of caregiver stress, with appropriate intervention, is crucial. **NOTE:** *Assessment of caregiver stress using a validated caregiver strain instrument by the MFH Coordinator or a member of the home care team is recommended at least annually.* When caregiver strain is identified by HBPC or other home care team, supportive guidance is provided by the interdisciplinary team including education on VA and non-VA caregiver support resources, setting priorities for self and for resident care, and implementing timely respite.

23. MEDICAL FOSTER HOME CAREGIVER SUPPORT SERVICES

a. In providing information and support to MFH caregivers, the MFH Coordinator and VA home care team are responsible for:

(1) Educating and training the caregivers in all aspects of resident care to meet the Veteran's individual needs, as well as to meet MFH policy. For training materials visit <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/MFH/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(2) Providing information on who to call if questions arise in between visits, including nights, weekends, and holidays.

(3) Responding to issues and concerns raised by Veterans, their families or surrogates, and the MFH caregivers.

(4) Referring Veterans to other VA and non-VA programs as appropriate. For example, Veterans may be referred to adult day care, homemaker/home health aide, nursing homes, and community home health agencies for skilled nursing, respite, rehabilitation therapy, bowel and bladder programs, or hospice services.

b. In addition, the MFH Coordinator is responsible for encouraging caregivers to establish a caregiver association or to hold meetings which offer opportunities to offer support, vent frustration, and gather ideas to improve performance of their role as caregivers.

24. FINANCIAL ARRANGEMENTS

The MFH program follows the policies in paragraph 13 of VHA Handbook 1140.01, or subsequent policy, regarding cost and fees for care. **NOTE:** *Due to high risk of conflict of interest, it is recommended the MFH caregiver not attempt to manage the resident's personal finances. See 38 CFR 13.55 and 38 CFR 13.58.*

25. LEGAL ISSUES

a. The MFH Coordinator is advised to maintain open communication with Office of Regional Counsel for advice on legal issues pertaining to the MFH Program.

b. Caregivers are prohibited from discriminating against residents in their home because of their color, race, ethnicity, age, religion, national origin, disability (whether physical or mental), gender or self-identified gender identity, in accordance with the Civil Rights Act of 1964 and its ensuing amendments, the Rehabilitation Act and the Americans with Disabilities Act.

26. VA RECORDS

a. Procedures for recording the electronic Veteran treatment record are to be consistent with VA and local VA medical facility policy and procedures.

b. Workload and data capture must be completed for each encounter on the date of the occurrence in real time.

c. Beyond the initial application to the program, the individual VA MFH Program may request additional information at the time of application.

d. The MFH Coordinator must maintain a file on each MFH. The file must contain:

(1) Preliminary MFH evaluation. The Initial Home Assessment Checklist found on the MFH Share point site may be used.

(2) Inspection reports.

(3) All correspondence relating to the facility.

(4) All material relating to any hearing and decision.

(5) MFH records.

27. REPORTING SYSTEM

By the 15th calendar day of each month, the MFH Coordinator will ensure the monthly MFH Implementation Action Report is electronically submitted through the MFH SharePoint. The report is anchored in the national standards for MFH development, and each level of reporting is aligned with the program's specific developmental responsibilities such as having an approved MFH proposal; emerging MFH workload; partnering with the interdisciplinary team and inspection personnel; and application of MFH marketing and cost-saving business tools. The SharePoint-based report is to be submitted to VA Central Office Geriatrics and Extended Care Operations, with a national MFH Dashboard and Productivity Report distributed monthly to the designated VISN liaison and medical facility Director, or designee, and the facility MFH Coordinator.

28. REFERENCES

- a. 38 U.S.C. 1710B(b).
- b. 5 CFR Part 2635.
- c. 38 CFR 13.55.
- d. 38 CFR 13.58.
- e. 38 CFR Part 71.
- f. 38 CFR 17.61-17.74.
- g. VHA Directive 1605.1, Privacy and Release of Information, dated August 31, 2016, or subsequent policy.
- h. VHA Directive 2012-022, Reporting Cases of Abuse and Neglect, dated September 4, 2012, or subsequent policy. **NOTE:** *This directive is currently being recertified and will be published as VHA Directive 1199, Reporting Cases of Abuse and Neglect. Upon publication VHA Directive 1199 will rescind VHA Directive 2012-022.*
- i. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016, or subsequent policy.
- j. VHA Handbook 1101.10, Patient Aligned Care Team (PACT), dated February 5, 2014, or subsequent policy.
- k. VHA Handbook 1140.01, Community Residential Care Program, dated February 10, 2014, or subsequent policy.

l. VHA Handbook 1176.01, Spinal Cord Injury and Disorder System of Care, dated February 8, 2011, or subsequent policy.

m. VHA Handbook 1004.08, Disclosure of Adverse Events to Patients, dated October 2, 2012, or subsequent policy.

n. Health Insurance Portability & Accountability Act (HIPAA) 1996.