

## VA OPERATED ADULT DAY HEALTH CARE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive describes policy, program standards, operational procedures, target population, and benefits of the Department of Veterans Affairs (VA) operated Adult Day Health Care (ADHC) programs, including both facility-based and mobile ADHC programs.

**2. SUMMARY OF MAJOR CHANGES:** This revised VHA directive:

a. Describes the establishment, target population, operation, and benefits of VA-operated ADHC programs.

b. Updates definitions to include and define ADHC Mobile Program.

c. Clarifies the role of the ADHC Medical Director.

d. Provides additional requirements concerning the discharge process.

e. Provides additional data management requirements.

f. Clarifies the incorporation of Patient-Aligned Care Teams (PACT) with the responsibilities of the ADHC interdisciplinary team, staffing, and process of care provision.

g. Identifies consequences for not maintaining ADHC program standards.

h. Includes updated VA revocable license template.

**3. RELATED ISSUES:** None.

**4. RESPONSIBLE OFFICE:** The Office of Patient Care Services, Geriatrics and Extended Care Services (12GEC, formerly 10NC4), is responsible for the contents of this directive. Questions may be referred to 202-461-6751.

**5. RECISSIONS:** VHA Handbook 1141.03, dated September 29, 2009, is rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of November 2025. This VHA directive will continue to serve as national policy until it is recertified or rescinded.

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

November 9, 2020

VHA DIRECTIVE 1141.03

/s/ Beth Taylor, DHA  
Assistant Under Secretary for Health  
for Patient Care Services

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

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## VA OPERATED ADULT DAY HEALTH CARE

### 1. PURPOSE

This Veterans Health Administration (VHA) directive provides procedures for the implementation and management of Department of Veterans Affairs (VA) operated Adult Day Health Care (ADHC) services, including facility based and mobile ADHC programs. **AUTHORITY:** Public Law (P.L.) 106-117, 38 United States Code (U.S.C.) §§ 1710B, 1720(f), 1720B, 38 Code of Federal Regulations (C.F.R.) 17.38(a)(1)(xi)(B), 17.111.

### 2. BACKGROUND

a. VA recognizes Veterans' preferences for non-institutional care and is committed to supporting a continuum of non-institutional extended care services for Veterans at risk of institutional care who want to remain at home in their communities. The primary goal of ADHC is to provide a non-institutional care program that prevents or delays the need for institutional care for at-risk Veterans through an interdisciplinary health service in a group setting that improves or maintains overall health, functional status, and quality of life, as well as providing respite and support to the Veterans' family caregivers or in-home care providers.

b. The 1999 Veterans Millennium Health Care and Benefits Act, P.L. 106-117, requires that ADHC services be available to all enrolled Veterans who need such services, either through VA-operated onsite centers or through contracted care at community-based facilities. ADHC programs include skilled nursing care, rehabilitation, social services, nutrition, therapeutic and socialization activities, and care coordination. Services are targeted for Veterans who are at risk for nursing home placement and may have family caregivers or in-home care providers in need of respite care. VA has a goal to provide care in the least restrictive environment that is safe for the Veteran, through a continuum of services. ADHC is a key component in the continuum of long-term care, assisting Veterans to remain in their homes.

### 3. DEFINITIONS

a. **Activities of Daily Living.** Activities of daily living (ADL) are 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. Basic ADLs consist of self-care tasks, including:

- (1) Bathing, shaving, brushing teeth, combing hair;
- (2) Dressing;
- (3) Eating;
- (4) Getting in or getting out of bed;

(5) Toileting; and

(6) Walking.

b. **Adult Day Health Care.** ADHC is a non-institutional care option in which the Veteran participates in a therapeutic, aggregate community and receives coordinated, interdisciplinary interventions from a variety of team members including, but not limited to, nursing, rehabilitation, social work, and nutrition. Recreation and socialization are key components of the experience. For the family caregiver or in-home care provider, ADHC affords a defined period of respite with access to education and support.

c. **Adult Day Health Care Mobile Program.** This mobile program brings the ADHC program to Veterans' communities with an assigned team of traveling ADHC staff.

d. **Adult Day Health Social Model:** The social model generally provides a secure environment, supervision, assistance with some ADLs, and therapeutic activities aimed at helping participants to achieve optimal physical and mental functioning.

e. **Family Caregiver.** A family caregiver is any family member or friend who provides substantive assistance, i.e., assistance with ADL and/or Instrumental Activities of Daily Living (IADL) on an ongoing basis for the Veteran in the Veteran's place of residence. The assistance may involve, but is not limited to, direct personal care activities, such as bathing, dressing, and grooming, or other activities, such as laundry, shopping, and meal preparation

f. **Health Disparity.** A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based racial or ethnic group, gender, age geographic location, religion, socio-economic status, sexual orientation, mental health, military era, disability status (cognitive, sensory, and physical), and other characteristics historically linked to discrimination or exclusion.

g. **Home.** Home is defined as a private residence in which the Veteran resides. This would include medical foster home, adult foster care, and community residential care settings. This does not include inpatient health care settings such as nursing homes, skilled care facilities, and other inpatient institutional care settings.

h. **In-Home Care Provider.** An in-home care provider is any non-family member who is compensated for providing substantive assistance, i.e., assistance with ADL and/or IADL on an ongoing basis for the Veteran in the Veteran's place of residence. The assistance may involve, but is not limited to, direct personal care activities, such as bathing, dressing, and grooming, or other activities, such as laundry, shopping and meal preparation.

i. **Instrumental Activities of Daily Living.** IADL are daily self-care activities that are not necessary for fundamental functioning, but they let an individual live independently in a community. They include:

- (1) Ability to manage finances;
- (2) Ability to use the telephone;
- (3) Assistance with transportation;
- (4) Housekeeping and cleaning rooms;
- (5) Laundry;
- (6) Meal preparation;
- (7) Obtaining appointments;
- (8) Shopping- for groceries or clothing, etc.;
- (9) Taking medications; and
- (10) Writing letters or other electronic communications.

j. **Respite Care.** Respite care is an intervention that provides the family caregivers or in-home care providers with an opportunity to take a break from caregiving responsibilities while Veteran attends the ADHC program outside the home.

k. **Transitions of Care.** The movement of a patient from one setting of care to another.

#### 4. POLICY

It is VHA policy that all VA operated ADHC programs serve the needs of Veterans receiving adult day health care and that the ADHC programs will be modified as required to serve the changing needs of Veterans.

#### 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for national oversight of the ADHC program.

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

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

(2) Assisting VISN Directors resolve implementation and compliance challenges in all VA medical facilities within that VISN.

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

(4) Facilitating communication among the VA medical facility ADHC programs, the Veterans Integrated Service Networks (VISN), and the Office of Geriatrics and Extended Care (GEC).

(5) Notifying the Office of GEC of any proposed program changes that might reduce staffing or the level of extended care services.

c. **Chief Consultant, Geriatrics and Extended Care Services.** The Chief Consultant, Geriatrics and Extended Care Services (10NC4) is responsible for:

(1) Developing national policy for VA ADHC.

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

(3) Providing comparative data to VHA facilities on ADHC characteristics, populations served (including race/ethnicity, gender, military era/period of service, gender identity, mental health status) utilization, quality, and outcomes.

(4) Facilitating expansion of ADHC by promoting reliable access to non-institutional extended care services through national initiatives, when available, and by providing VA facility-specific guidance and support.

(5) Providing and disseminating educational resources to enhance the expertise of staff providing ADHC services via a monthly national teleconference.

(6) Maintaining communication and networking with ADHC program leaders through an interactive mail group and national conference calls.

(7) Promoting collaborative relationships with community ADHC programs to enhance access to services.

(8) Compiling national ADHC workload reports from VHA Support Service Center (VSSC) and Managerial Cost Accounting Office (MCAO) and disseminating the reports to the VISNs and medical facilities.

(9) Providing guidance regarding facility ADHC proposals and working with the facilities to ensure that their proposals meet all ADHC Program policy standards.

(10) Providing the final approval of proposals for program formal recognition. **NOTE:** The program is formally recognized as an approved program once the proposal is approved, all VA staffing positions are filled, local policies are written, and all the necessary support structures are in place.

d. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:



(1) Facilitating communication between facility ADHC programs and the Offices of Geriatrics and Extended Care Services.

(2) Ensuring that facilities maintain staffing and capacity in ADHC programs, in accordance with Title 38 U.S.C. 1710B(b), requiring that staffing and levels of extended care services be maintained.

e. **VA Medical Facility Director.** The medical facility Director's specific responsibilities include:

(1) Appointing the ADHC Program Director and delegating to that person the authority and responsibility for the day-to-day operations of the program.

(2) Ensuring the ADHC program is organizationally aligned under the Chief of Staff (COS) Office and within GEC Services. If GEC does not exist as a Service at the facility, the program can function under the COS, the Associate Chief of Staff for Ambulatory Care, the Chief of Medical Service, or an interdisciplinary Care Line Director.

(3) Providing necessary resources for adequate staffing and enrollment, including appropriate medical and information technology equipment.

(4) Notifying the VISN Director, the Deputy Under Secretary for Health for Operations and Management, and VA Central Office GEC Service, in advance of any proposed changes that might reduce capacity, staffing, or services provided by the ADHC Program. Notification should be made following policy found in VHA Directive 1043, Restructuring of VHA Clinical Programs, published November 2, 2016, or subsequent policy.

f. **Chief of Staff and Associate Director Patient Care Services.** The COS and Associate Director Patient Care Services have responsibility for appointing the ADHC Medical Director, as well as the ADHC Program Director. The ADHC Program Director must be a health care professional, such as but not limited to: a physician, nurse, social worker, or rehabilitation therapist.

g. **Adult Day Health Care Program Director.** The ADHC Program Director is responsible for:

(1) Planning and developing the program, projecting for program resources.

(2) Monitoring program quality and improvement activities and sharing results with facility and VISN leadership.

(3) Ensuring the treatments and services delivered by the ADHC team and consultants are of high quality.

(4) Implementing and overseeing ADHC staff orientation and education.

(5) Ensuring there is a written and published facility ADHC Policy and Procedural Manual outlining policies and procedures necessary for the successful operation of the ADHC Program. It is to be updated and re-issued as indicated. Elements in this policy must include processes for addressing sentinel adverse events, infection control, falls, emergency management, delegation of authority to the ADHC Program Director, organizational placement of the program, lines of authority, scope of program services and resources, referral procedures and eligibility, and admission and discharge procedures.

(6) Collaborating and coordinating with the Clinical Service leadership who are part of the ADHC interdisciplinary team to:

(a) Develop team role expectations for the ADHC interdisciplinary team that are consistent with the unique characteristics of the program.

(b) Develop team functioning and in-service training for staff to ensure understanding of goals, objectives, and procedures of the ADHC program.

(7) Work with medical facility administration to help ensure appropriate staffing levels.

(8) Participating in the selection of ADHC staff.

(9) Completing and/or collaborating with direct clinical supervisors on staff annual performance and competency evaluations.

(10) Directing the clinical services to ensure that the program is in compliance with VA and VHA policies.

(11) Working with engineering and facility management with the goal of ensuring that the physical design and environment of the ADHC Program meet the current Federal Life Safety Code. See paragraph 22.c. of this directive, Space Allocation.

(12) Participating in national adult day care organizations and other relevant community organizations/forums.

(13) Maintaining communication with the VISN, Office of GEC Services and participating in these offices' conference calls, conferences, etc., as appropriate.

(14) Ensuring that workload is accurately captured in the national database, and that mapping in the Decision Support System (DSS) is appropriate and correct.

(15) Establishing strategies to effectively liaise with community agencies and service organizations to identify Veterans eligible for ADHC and to establish outreach and marketing plans to enroll Veterans in target populations. For additional information see paragraph 10 of this directive, Outreach and Marketing.

h. **Facility ADHC Medical Director.** The facility ADHC program has an identified Medical Director acting as a clinical champion. The person acting as the facility ADHC Medical Director might be an Associate Chief of Staff, physician, GEC Geriatric fellow, physician assistant (PA), or a nurse practitioner (NP), with full practice authority, seeing patients on site. The ADHC Medical Director is responsible for collaborating with the ADHC Program Director to:

- (1) Provide leadership to the ADHC Program.
- (2) Plan and direct the educational and clinical experience of medical students, residents, fellows, and other allied health professionals assigned to the ADHC Program.
- (3) Participate in the development and implementation of ADHC's on-going performance improvement plan development and review.
- (4) Participate in selecting ADHC team members.
- (5) Provide consultation for patient treatment plan as indicated and available.
- (6) Collaborate with the ADHC team members when medical or other problems arise.
- (7) Review and sign treatment plans.
- (8) Works with the Program Director to apprise the ADHC team of medical care advances and practice standards.
- (9) Represent and advocate for ADHC with VISN, VHA, and the medical community, through the appropriate chain of command.

i. **Service Line Chiefs.** The Service Line Chiefs are responsible for appointing appropriate staff to this ADHC Interdisciplinary Team.

j. **ADHC Interdisciplinary Team.** The ADHC Interdisciplinary Team is responsible for providing the following services to the facility ADHC patients and program:

- (1) Providing the diverse array of professional services required to effectively treat and manage the multiple interactive health, psychosocial, and functional impairments of Veterans.
- (2) Collaborating in planning, problem solving, decision making, implementing, and evaluating team-related tasks.
- (3) Reporting clinical issues concerning facility ADHC patients in a timely manner to the facility's ADHC Program Director and/or facility's ADHC Medical Director.
- (4) Developing an interdisciplinary treatment plan for each Veteran, based on clinical assessment and patients/family caregiver/in-home care provider preference.

(5) Working collaboratively with the Veteran's primary care provider, other members of the Veteran's Patient Aligned Care Team (PACT), and mental health provider, if patient is engaged in VA Mental Health services.

(6) Developing a facility-specific ADHC program policy and procedure guide (refer to paragraph 10. of this directive, Outreach and Marketing, for elements that must be included). This guide operationalizes the existing medical facility policies into the facility ADHC program. It defines and governs the clinical and administrative aspects of the program. This guide must be reviewed and revised at least every 3 years.

(7) Developing a local written Veteran participant brochure to give to the Veteran, family caregiver, and in-home care provider when the Veteran is admitted to the facility ADHC Program. This information must comply with all facility policies and at a minimum must include, but is not restricted to:

(a) Names and office telephone numbers of ADHC team members.

(b) An explanation of the mission and goals of ADHC.

(c) Specific instructions on how to obtain care for the Veteran after regular operation hours of ADHC.

(d) ADHC Veterans' rights and responsibilities, including following the facility's clinical grievance process.

(e) Procedures to follow in the event of a Veteran or family caregiver or in-home care provider emergency.

(f) An explanation that some Veterans may be subject to a copayment for ADHC services. A Veteran who is not known to be exempt from copayment is advised to complete the VA Form 10-10EC, (OMB Control Number 2900-0629) Application for Extended Care Services, to determine extended care copayment exemption or non-exemption.

(8) Determining Veterans' preferences for future treatment in accordance with the requirements of VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, published December 24, 2013, or subsequent policy, and VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017, or subsequent policy.

## **6. GOALS**

a. VA-operated ADHC programs include key elements that address health needs, physical and cognitive function, the need for socialization, and caregiver support. Veterans receiving ADHC are most often the frail elderly and functionally impaired. An individualized plan of care is delivered by an interdisciplinary team of health professionals and support staff, with an emphasis on helping participants and their

family caregivers or in-home care provider develop the knowledge and skills necessary to be successful at home and in the community.

b. ADHC targets Veterans with complex medical, functional, behavioral, or cognitive impairment, and provides evaluation and therapy in a setting outside the home. ADHC interdisciplinary team also provides referral as needed for identified problems outside the scope of ADHC program.

c. The ADHC program is centered on the Veteran and family caregiver/in-home care provider. Services are provided by an interdisciplinary team. Staff flexibility and collaboration within the program and across programs and services are essential to respond to the needs of these Veterans. Medical care may be provided on-site by ADHC staff or in collaboration with outpatient clinic staff (see paragraph 11 in this directive, Staffing, for specific guidance about medical care provided).

d. ADHC creates and employs the therapeutic environment as a tool to engage Veterans and enhance the quality of their lives. Throughout the day, all activities and interventions are designed to improve and maintain the Veteran's physical and mental well-being.

e. The unique blend of ADHC as a mode of service delivery in the continuum of non-institutional care includes:

(1) A Veteran-Centered approach which provides an individualized plan of care based on comprehensive interdisciplinary assessments of the Veteran's needs.

(2) Emphasis on the family caregiver or in-home care provider and their needs related to support, education, and respite services in order to successfully maintain the Veteran in the home.

f. The therapeutic milieu for promoting well-being among Veterans at risk for isolation and/or depression related to illness and/or functional deficits.

g. Assisting Veterans to remain in their homes.

h. Identifying interdisciplinary interventions, services, and adaptive equipment that may enable frail or functionally impaired Veterans to remain in supportive home environments.

i. Participating in transitions of care to reduce the risk of re-hospitalization or institutional placement.

j. Improving the quality of the Veteran's life by maximizing the Veteran's physical, cognitive, and psychosocial function.

k. Providing support, education, and respite for the family caregiver, in-home care provider, and other primary care providers.

**7. NEW PROGRAM APPLICATION** Proposals for formal recognition for VA medical facility based ADHC programs are to be submitted to VA Central Office (VACO), Office of GEC and approved by the GEC Chief Consultant. See Appendix A for application and approval process for ADHC Mobile programs.

b. The proposal must include a description of the proposed program, to include:

(1) A written statement of the proposed ADHC interdisciplinary team. The team shall consist of specified staff as described below, each with sufficient dedicated time for ADHC as part of their position description (i.e., not as a collateral duty). Additional team members may be identified based on patient care needs. To maintain continuity of patient care, it is imperative to have consistency in team members when possible. This team should consist of, but is not limited to:

(a) An ADHC Medical Director with a recommended background in Internal Medicine, Family Practice, or Rehabilitation Medicine, and training or experience in geriatrics and care of the disabled;

(b) A Program Director, or Coordinator, who has demonstrated health care and administrative experience, with training or experience in care of those who are elderly, disabled, or with cognitive and behavioral challenges;

(c) A Social Worker with Community Living Center (CLC) or long-term care experience;

(d) A Registered Nurse (RN) with expertise in geriatrics and extended care;

(e) A rehabilitation therapist (Occupational Therapist (OT), Physical Therapist (PT), or Kinesiotherapist (KT)) or certified therapy assistant (with professional supervision from the OT, PT, or KT);

(f) A Dietitian, or Dietetic Technician (with professional supervision from the Dietitian); and

(g) A Recreation Therapist.

(h) In addition, the proposal may include team members from other services as needed, for example, pastoral care, mental health care, and clinical pharmacy specialist.

(1) Readily available consultative care.

(2) Support staff in place for administrative, as well as clinical demands. This must include dedicated clerical support for the ADHC Program.

(3) The proposal must include a sample of planned daily programs scheduled for therapeutic and social activities. These may include, but are not limited to: games, exercises, current events, crafts, music, excursions, and other recreational therapy. A

monthly calendar of activities and events must be prepared and posted for Veterans and family caregivers/in-home care providers.

c. Resources designated for the support of the ADHC program proposals must include:

(1) Space adequate for daily use by ADHC Veterans, team members, meals, evaluations, and a quiet room. Include an estimate of needed space, and space to be provided. For program space specifications, see paragraph 22, Space Allocation.

(2) A population analysis that identifies the target geographic range, target population characteristics, projected number of Veterans likely to utilize ADHC services, and estimated target average daily census.

(3) Full time equivalent (FTE) interdisciplinary members of the team, i.e., number of staff and proportion of their time to provide needed program support and care to program's Veterans. Responsibilities of the interdisciplinary team members are detailed in paragraph 5, Responsibilities.

(4) Maintaining Staffing ratio. The staff-to-Veteran ratio may vary, depending on the complexity and care needs of the Veterans; however, adequate staffing levels must be maintained to provide appropriate program support and patient care. A minimum of one staff to six Veterans and one staff to four Veterans with dementia is recommended. Administrative and clerical support staff must be adequate to meet the program's needs (See paragraph 11 in this directive, Staffing, for more information).

(5) A proposed schedule for interdisciplinary team meetings and a plan for communicating the meeting schedule to staff.

(6) A Quality Improvement program monitoring and evaluating activities described in paragraph 26 in this directive, Research and Surveys.

(7) A process for screening Veterans (mental health, medical conditions, communicable diseases, and functional disabilities) and for ensuring subsequent evaluation for identified medical conditions and depression/suicide risk.

(8) Evidence of adequate facility information technology and transportation resource support for the program.

## **8. TARGET POPULATION**

The target population for all ADHC programs includes:

a. Veterans at risk for institutionalization due to physical and/or cognitive functional impairment, dementias/memory deficits, advanced age, frailty, and/or behavioral disturbances, including those associated with traumatic brain injury (TBI) or acquired brain injury.

b. Veterans for whom clinical follow-up has not been adequate to maintain medical stability/optimal clinical outcomes, such as Veterans requiring frequent clinic visits, emergency department visits, or hospitalizations.

c. Veterans in need of transitional care from institutional settings to home care (i.e., those Veterans being discharged from hospital care, rehabilitation units, and nursing homes who are not fully independent.)

d. Veterans who present with depression/anxiety and/or who are socially isolated and who could benefit from a structured, therapeutic environment.

e. Veterans at risk for health and health care disparities.

## 9. CLINICAL ELIGIBILITY

a. Veterans meet clinical eligibility for the ADHC program on the basis of an interdisciplinary assessment which identifies one or more of the following conditions:

(1) Three or more ADL dependencies,

(2) Significant cognitive impairment, or

(3) Two ADL dependencies and two or more of the following conditions:

(a) Recent discharge from a nursing home or planned nursing home discharge that is contingent on receipt of home and community-based care services,

(b) Seventy-five years old or older,

(c) High use of medical services defined as three or more hospitalizations in the past year or 12 or more visits to outpatient clinics and emergency evaluation units, combined, in the past year,

(d) Clinical depression and/or anxiety and

(e) Living alone in the community.

b. It is recognized that every contingency cannot be foreseen. When a Veteran who does not strictly meet the preceding criteria nevertheless is determined by the clinical care team to need ADHC services, the services may be ordered. The reason for the variance from these standards must be documented in the Veteran's electronic health record by the team member completing the assessment.

c. The Veteran must give oral informed consent to participate in ADHC as provided in VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

## 10. OUTREACH AND MARKETING



a. Each ADHC program is expected to establish strategies to effectively liaise with community agencies and service organizations in order to identify Veterans who are eligible for ADHC and to establish outreach and marketing plans to enroll Veterans in target populations. See paragraph 8 in this directive, Target Population.

b. ADHC staff members are encouraged to develop presentations for target referral sources, such as clinic staff, medical residents, social workers, discharge planners, and community agencies.

c. Development of an ADHC brochure is advised and can be very helpful for providers, nurses, social workers, and other health professionals in identifying and referring appropriate Veterans.

d. Interaction and networking with community agencies is encouraged, especially through established Veteran Community Partnerships that serve similar needs population to encourage cross referral.

e. ADHC program staff should work with the medical facility Public Affairs Officer to develop social media communication, open houses, slide presentations, flyers, and other public and/or media strategies that are helpful in marketing the ADHC Program.

f. The use of the ADHC program as a training site for health care professionals serves to promote awareness, referral, and career opportunities.

**11. STAFFING**A variety of health care professionals are needed to meet the clinical needs of the Veteran population. All ADHC team members are expected to be culturally competent per their annual competency assessment. In addition, all ADHC team members are responsible for complying with their discipline's continuing education requirement for licensure and/or certification and complying with all mandatory VA education requirements.

b. The following services and staff must be available at each ADHC site:

(1) Nursing Service. At least one RN with geriatric experience must be on duty in ADHC whenever Veterans are present, for assessment, for participation in treatment planning, and for supervision of other nursing staff. Additional nursing staff may include a licensed practical nurse, nursing assistant, or health technician who provides assistance in daily program activities.

(2) Medical Service. Medical care may be provided at the ADHC site by the ADHC Medical Director or another VA physician, NP, or PA. The medical care provider works closely with the ADHC nursing staff. Medical center clinics are to be used by ADHC Veterans for same-day specialty consultations and services. ADHC staff will work closely with members of the Veteran's PACT.

(3) Social Work Services. A social worker must be available daily for psychosocial assessment, participation in treatment planning, consultation, providing intervention and appropriate care coordination, counseling, and caregiver support.

(4) Rehabilitation Services. Rehabilitation services must be available daily for assessment, treatment planning, therapy, consultation, and education; this includes physical therapy or kinesiotherapy and occupational therapy. A qualified therapy assistant, or aide, (e.g., certified occupational therapy assistant, physical therapy assistant or restorative nursing assistant) may be assigned to the ADHC program with regular consultation by a licensed professional. Consultation with speech therapy is to be requested as needed. Speech pathology, blind rehabilitation, and low vision services are to be provided on a consultation basis.

(5) Recreation Services. Recreation therapy must be provided daily. This therapy should focus on helping Veterans to achieve optimum levels of independence and the greatest possible quality of life. A recreation therapist or recreation therapy assistant must be available to facilitate assessment, planning, and delivery of activities with outcomes that are based on “real life” (e.g., attending a sports event, social outing with family, etc.) functions within the community for ADHC patients.

(6) Nutrition Services. Nutrition services must be provided daily, including regular meals, snacks, and attention to special diets. At a minimum, a registered dietitian must be available by consultation for assessment and education. If available, a clinical dietetic technician may assist in treatment planning, participate in team meetings, and provide group instruction such as cooking lessons.

(7) Clerical Staff. Clerical support must be provided daily to assist with record keeping, office operations, appointment management, workload capture, telephone reception, and participating in and supporting the facility’s specific customer satisfaction activities.

(8) Clinical Pharmacy Services. A clinical pharmacy specialist (CPS) must be available on a consultative basis to provide medication management services and education to Veterans, family caregivers and in-home providers when a need is identified. The CPS should perform a comprehensive assessment of each patient’s medication regime upon admission and when clinically indicated. The CPS should be present during interdisciplinary team meetings when medication-related treatment planning is discussed. The CPS should provide education to staff concerning those Veterans who have special needs (i.e., blindness, need for medicine dispensed in weekly trays, etc.).

(9) Mental Health Services. A psychologist or other mental health provider must be available on a routine or consultative basis for the Veterans and to help family members and staff effectively manage Veterans with problematic behaviors and to provide individual or group counseling on issues relating to adaptation to community living. They provide guidance to staff to manage difficult behaviors at the ADHC site and to the family to manage the difficult behaviors at home.

(a) Given the diverse needs of the ADHC population, psychological and cognitive assessments, as well as psychotherapy and other psychosocial interventions, may be provided.

(b) The availability of psychiatric services to respond to psycho-pharmacotherapy needs is important, including the availability of gero-psychiatry services to help address the often complex psychopharmacological issues with older Veterans.

c. In addition to appropriate professional credentials and competencies, all ADHC staff must possess certain qualifications unique to the practice setting and the population served. These include, but are not limited to:

(1) Discipline-specific and age-competency standards of practice.

(2) An ability to effectively function both autonomously and as a member of an interdisciplinary team.

(3) A clinical background which includes demonstrated competency in assessment, problem solving, group leadership skills, home and community-based care, and teaching.

d. All ADHC staff members will have their time that is devoted to clinical, administration, education, and research activities accurately labor mapped according to Decision Support System (DSS) guidelines:

[http://vaww.dss.med.va.gov/programdocs/pd\\_ProAud.asp](http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp) **NOTE:** This is an internal VA website that is not available to the public.

e. It is necessary to have a staff-to-Veteran ratio that provides the needed services specific to the program's Veteran population with optimal resource utilization. The ratio may vary depending on number of Veterans in the program, their complexity, and care needs; however, a minimum of one staff to six Veterans and one staff to four Veterans with dementia is recommended. The Life Safety Code National Fire Protection Association (NFPA) 101 "Life Safety Code for Self-Preservation for Day-Care Occupancy" recommends a ratio of two staff to 12 participants, but only three of the 12 participants can be incapable of self-preservation.

**NOTE:** The staff-to-Veteran ratio includes only those staff members who spend at least 70% of their time in direct Veteran care service.

## 12. CAREGIVER SUPPORT

a. ADHC considers the Veteran and the family caregiver/in-home care provider as the unit of care and recognizes that stress may create social, psychological, physical, and economic burdens for the family caregiver/in-home care provider.

b. The ADHC program assesses family caregiver/in-home care provider stress at the time the Veteran is enrolled using a standardized tool, such as the Zarit burden interview, short/screening version, to identify opportunities and services to address caregiver burden.

c. Interventions for addressing family caregiver/in-home care provider stress are to be incorporated into the ADHC plan of care and reviewed quarterly. Family caregiver/in-home care provider reassessment is to be conducted at least annually.

d. A variety of VA and community educational, informational, support, and referral services are available to family caregivers and in-home care providers of all Veterans. The local Caregiver Support Coordinator can provide additional consultation and local options. **NOTE:** For further information, see VHA Notice 2020-31, Caregiver Support Program, dated October 1, 2020.

### 13. PROVIDING CARE

a. **Referral.** Veterans must have a VA primary care provider and preferably be enrolled in a PACT, Spinal Cord Injury) PACT, GeriPACT, or Home Based Primary Care PACT (see VHA Handbook 1101.10(1), PACT Handbook, dated February 5, 2015). Veterans may be referred to ADHC from any setting including inpatient, outpatient, residential, and local community sources.

(1) Designated ADHC staff will receive the consult and determine eligibility. Consults will be reviewed and scheduled (or first contact attempt made and recorded) within 2 business days of the consult creation.

(2) If the Veteran is not eligible for ADHC enrollment, ADHC will close the consult and make recommendations regarding alternate services.

(3) If the Veteran is eligible, staff will schedule an ADHC screening interview with the Veteran and family caregiver/in home care provider.

(4) If ADHC does not have the capacity to enroll the Veteran on the referral date or the desired date, the Veteran will be placed on the Electronic Wait List (EWL), and recommendations for alternate services should be made, including Community Adult Day Health Care.

(5) The EWL is monitored weekly by the ADHC program. Veterans are enrolled into ADHC as service becomes available based on guidance for priority removal from EWL. The EWL is not utilized for requests from Veterans to increase their ADHC services.

b. **Orientation to the Program.** The Veteran and the family caregiver/in-home care provider must receive an orientation to ADHC program from the assigned ADHC staff member. The orientation must include a full explanation of program objectives, capabilities, and limitations; a review of services; and how interventions are determined and coordinated. The orientation and acceptance by the Veteran or their representatives or caregivers to participate in the ADHC program will be documented in the Veteran's medical record.

c. **Assessment.** Within 30 calendar days of the Veteran's enrollment, ADHC team members must conduct discipline-specific assessments and screenings to identify the individual Veteran's strengths, limitations, and potential. The goal of these assessments

is to support the Veteran's ability to achieve and maintain their highest level of functioning in order to live safely in the least restrictive environment.

(1) The Veteran's caregiver, if one is identified, is also assessed as specified in paragraph 12 in this directive, Caregiver Support.

(2) The ADHC program must have a written procedure in place, following local policy, to address patient and caregiver concerns and/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 ADHC Program Director and access to the Patient Advocate.

d. **Treatment Planning.** Based on the interdisciplinary assessment, a comprehensive treatment plan must be developed no later than 30 calendar days from the date of ADHC admission.

(1) The treatment plan must include:

(a) Veteran's bio-psychosocial needs based on assessment;

(b) Care preferences of the Veteran, family caregiver, and in-home care provider

(c) Appropriate health care discipline on the interdisciplinary treatment team and frequency of treatment for each identified need;

(d) Expected outcome against which progress will be measured;

(e) Target dates for completion of each component;

(f) Interventions identified for caregiver support/education;

(g) End-of-life planning needs and preferences; and

(h) Anticipated discharge plan with identified community resources.

(2) The Veteran, family caregiver /in-home care provider must be involved in developing and implementing the treatment plan.

(3) The medical provider must be involved in developing and implementing the treatment plan.

(4) The treatment plan must include orders from the medical provider. The orders are reviewed by the ADHC staff and integrated into the treatment plan (both initially and prior to each ADHC visit) as appropriate.

(5) The ADHC treatment plan should demonstrate integration, collaboration, and communication with current VA primary and specialty providers and clinicians.

(6) Treatment plans are reviewed or revised by the ADHC team at least every 3 months, or sooner if there is a significant change in the Veteran's condition. Progress in achieving treatment goals is reviewed with the Veteran and family caregiver/in-home care provider. The team must document these reviews in the Veteran's medical record.

e. **Discharge.** ADHC treatment planning anticipates the Veteran's changing needs and addresses appropriate conditions for discharge with the Veteran and the family caregiver/in-home care provider. Whenever possible, a discharge from ADHC is a planned, coordinated transition with appropriate recommendations for continuity of care.

(1) A Veteran is discharged from ADHC when any of the following occurs:

(a) The Veteran requests discharge;

(b) The Veteran becomes ineligible for VA care based on administrative criteria;

(c) The Veteran relocates from the ADHC program's geographical service area;

(d) The Veteran develops needs beyond the capability of the program, as determined by the interdisciplinary treatment team in collaboration with the Veteran;

(e) The Veteran demonstrates an inability to tolerate and be managed in a group setting, such that the safety of the Veteran, staff, or other enrollees might be jeopardized; or

(f) The Veteran dies.

**NOTE:** *Non-compliance with treatment plan alone is not a criterion for discharge. Veterans with problematic non-compliance are to be assessed for insufficiently addressed concurrent conditions such as depression, dementia, delirium, and effects of substance use.*

(2) Veterans may be considered for discharge if it is anticipated that they will be absent from program for two weeks or more, as the result of acute hospitalization or nursing home care, depending on the Veteran's specific circumstances and the program waiting list.

(3) Veterans may be considered for discharge if they are absent from the program for 30 days or more for non-medical reasons, depending on the Veteran's specific circumstances and the program waiting list.

(4) A discharge note summarizing the course of treatment and options for discharge planning must be entered in the patient's medical record.

## 14. PROGRAMMING

**NOTE:** *When ADHC is not located at a VA medical facility, but instead located at a different building on the same campus or in the mobile program, procedures must be*

*developed to accommodate the need for diagnostics, pharmaceuticals, medical records, support services, and access to care in the event of medical emergency.*

a. Once the proposal is approved and the program is recognized, the ADHC program is responsible for maintaining standards as outlined in the proposal. Periodic reviews may be conducted to assure program compliance is maintained. VACO may require submission of action plans to GEC that will include target dates and deadlines to address any identified deficiencies which may result in provisional or revoked recognition until deficiencies are corrected. If recognition is revoked, Austin Information Technology Center will be notified to remove the facility from the data systems and the facility will no longer be approved to use the ADHC stop codes, until deficiencies are corrected.

b. ADHC offers a comprehensive and structured treatment and activity program utilizing the interdisciplinary team process. The program is tailored to each Veteran's individual physical and psychosocial treatment needs and preferences. ADHC is required to offer a stimulating program to maintain or restore the functional status of each Veteran with provisions made for each individual to participate at their own optimal level of functioning and to progress according to their own pace.

**NOTE:** *Specific program activities within ADHC vary according to its staff and case mix.*

(1) Designated ADHC staff will have access to an appropriate fund control point for the purchase of needed expendable supplies and to support a therapeutic activity program.

(2) The program must provide a balance of purposeful activities to meet Veterans' needs and interests (i.e., social, intellectual, cultural, economic, emotional, physical, and spiritual). All activity programming must provide opportunities for a variety of levels of involvement in individualized, small, and large group settings. If possible, Veteran and family caregiver/in-home care provider should be participating in planning activities. Program activities may include, but are not limited to:

- (a) Discipline specific therapies offered by team members;
- (b) Individualized training in ADL and personal care activities;
- (c) Health and nutrition education;
- (d) Reminiscence groups, discussion groups, and other cognitive stimulation activities;
- (e) Specific individual and group activities for cognitively impaired Veterans;
- (f) Activities to develop creative capacities, e.g., arts and crafts, hobbies, poetry groups, living history programs, gardening, and cooking classes;
- (g) Intergenerational experiences;

- (h) Involvement in community activities and events;
- (i) Outdoor activities, as appropriate;
- (j) Vocational rehabilitation, employment, and independent living skills; and
- (k) Caregiver training in ADL support, behavior management, and coping strategies for the family caregiver/in home care provider.

**15. DOCUMENTATION.**

DHC documentation must include:

- a. Initial assessments,
- b. Treatment plan,
- c. Medical provider orders,
- d. Quarterly interdisciplinary plan of care reviews,
- e. Significant changes in the Veteran's status or condition,
- f. Progress notes,
- g. Discharge plan, and
- h. Discharge note.

**16. HOURS OF OPERATION**

Each ADHC program must establish hours of operation that are flexible and responsive to Veteran and family caregiver/in-home care provider needs. Consideration may be given to varied staff work schedules that would facilitate Veteran care and expanded hours of operation.

**17. COOPERATION, COLLABORATION AND CONSULTATION WITH OTHER SERVICES**

a. Since the ADHC team collaborates with other services to obtain needed care for ADHC Veterans, it is able to provide continuity in therapeutic interventions for Veterans discharged to the community from other medical facility services. It also serves as a discharge resource for Veterans from the Geriatric Evaluation and Management (GEM) Program, Community Living Centers (CLCs), Contract Nursing Home (CNH), and inpatient units, and works collaboratively with staff from other Extended Care programs to exchange Veteran information and promote sharing of needed services.

b. ADHC may be provided in conjunction with other home and community-based care including home-based primary care.



c. Respite care, a distinct benefit of ADHC, is provided in addition to the routinely scheduled ADHC. For example, if a Veteran routinely receives ADHC once a week, and the family caregiver's/in-home provider's status changes such that additional respite care is needed on a temporary basis, additional ADHC visits may be provided for a specific number of days outside the number of routinely scheduled visits. These days would be counted as respite care under 38 U.S.C. § 1720B since these ADHC visits are temporary additions to the routine services the Veteran already receives.

d. When ADHC Veterans are hospitalized, ADHC staff must work closely with the inpatient team regarding discharge planning. This includes determining whether the Veteran will return to ADHC or be recommended for other more appropriate services.

## 18. STAFF ORIENTATION

The ADHC Program Director oversees ADHC staff orientation, which may include students, residents, and medical students. The orientation training is provided by VA facility staff. Completion of the orientation training will be documented and saved in the personnel files. The following topics are required to be part of the orientation training (additional topics can also be covered):

- a. The ADHC program goals, objectives, and procedures;
- b. Infection control;
- c. Safety in transfer and ambulation assistance;
- d. Emergency preparedness, including Cardiopulmonary Resuscitation (CPR), fire and safety, and missing Veteran procedure;
- e. Veteran's rights and responsibilities in the ADHC Program;
- f. Dementia, dementia care, and behavioral management;
- g. Health Insurance Portability and Accountability Act (HIPAA); and
- h. Administrative program requirements, including workload capture, documentation guidelines, etc.

**NOTE:** *This directive and the local facility ADHC guidance serve as the basic orientation guides.*

## 19. TEACHING PROGRAM

a. The ADHC Program provides a unique educational experience for students as well as interns in various health professions.

b. Medical, nursing, social work, nutrition, psychology, recreation therapy, and rehabilitation therapy trainees and interns are taught:

- (1) Interdisciplinary assessment and team dynamics,
- (2) Treatment plan development,
- (3) Community-based primary care of a chronically ill patient population.

c. The ADHC Program provides trainees with the opportunity to:

- (1) Observe and participate in an interdisciplinary team, and
- (2) Experience, first-hand, the major care issues of an aging population.

## **20. VOLUNTEERS**

a. Since volunteers can be of tremendous value to ADHC, every effort is made to identify dedicated and committed volunteers interested in serving older, disabled Veterans; however, the volunteer's aptitude for the job, perception of the program, and motivation must be assessed with care and sensitivity. ADHC volunteers are screened and trained by the VA Voluntary Services.

b. Volunteers cannot replace professional staff; the role of the volunteer must be clearly defined, with a salaried staff member to supervise.

c. Opportunities for ADHC volunteers are varied and may include, but are not limited to:

- (1) Assisting staff in limited ways that will relieve the professional of certain non-clinical tasks;
- (2) Assisting with arts and crafts, clerical duties, escort, and recreation activities;
- (3) After proper orientation and supervision, help in feeding a Veteran; and
- (4) Providing Veterans needed individualized attention.

## **21. SAFETY GOALS**

The principles of the VA Patient Safety Program and risk management apply to ADHC programs. An effective VA Patient Safety Program emphasizes learning from incidents and near misses and identifying opportunities to improve the quality of care, environment, or equipment. The ADHC program must be in compliance with the Medical Center's Patient Safety Program. Each ADHC program must address the following safety issues:

a. Identify Veterans at risk for injury from smoking, falls, wandering, and limited in-home support, and implement an appropriate safety plan.

b. Develop a system of documenting, evaluating, and reporting accidents, injuries, and safety hazards in accordance with applicable regulatory authority and VA policies and procedures.

c. Ensure home safety; a home visit may be needed.

(1) Potential hazards must be identified, and

(2) Veteran and family caregiver/in home care provider education regarding safety in the home must be provided.

d. Ensure compliance with the medical facility's fire and safety standards.

e. **Infection Prevention, Surveillance, and Control.** ADHC programs must be in compliance with the VA medical facility policies and procedures, educate Veterans and family caregivers and in-home care providers on infection control, and develop a system of reporting infections in the program.

f. **Medication Management.** Each ADHC program must:

(1) Educate the Veteran, the Veteran's family, and the Veteran's family caregiver/in-home care provider about medication management.

(2) Establish procedures and protocols to guide the interdisciplinary team in the administration, instruction, storage, and monitoring of drugs as appropriate. The management of controlled substance medications must be in compliance with all Federal laws and VHA policy.

(3) Have a crash cart and/or Basic Life Support services available.

## 22. SPACE ALLOCATION

a. A well-planned environment of the ADHC area is an important therapeutic tool because it can enhance the Veteran's ability to function independently and engage in program activities. The environment plays an even more significant role as an individual's level of impairment increases. **NOTE:** *Consultation from a professional interior designer or architect with expertise in health care environments is encouraged in developing or remodeling ADHC settings.*

b. Optimal space requirements for participants in ADHC are 128.5 square feet per Veteran. A minimum of 100 square feet per Veteran is required. This variation takes into consideration the Veteran mix and the need for wheelchairs, walking aids, etc.

c. The physical environment must meet the Centers for Medicare and Medicaid Service standards for compliance as described in the latest Life Safety Code; these standards are available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandCompliance/LSC.html>. In addition, the physical environment

must be clean, attractive, well lit, and comfortable, and the noise level in the environment needs to be kept to a minimum.

d. Each program needs to design and partition its space to meet its own needs in accordance with applicable Federal statutory and regulatory authority, but a minimal number of functional areas must be available. Space must meet current VA standards on safety, privacy, and security standards. Key features to consider in the design of an ADHC center include:

(1) Multi-purpose space for group activities, including dining.

(2) Rehabilitation areas for individual and group treatment.

(3) A kitchen area for refrigerated food storage, the preparation of meals, and training Veterans in ADL.

(4) An examination room for use by an appropriate health care provider or other professional staff.

(5) A quiet room for rest, observation, or privacy.

(6) Adequate and accessible toilet and bathing areas. The bathing facilities must facilitate assistance with bathing. The toilet facility and bathrooms must be easily accessible to people with mobility problems, including Veterans in wheelchairs, and they must provide adequate privacy for women Veterans. **NOTE:** *A washer and dryer are advisable.*

(7) Adequate storage space for items such as arts and crafts materials, personal clothing and belongings, wheelchairs, chairs, individual handiwork, and general supplies. Medical records and personal belongings must be stored in a secure area.

(8) Adequate office space offering privacy for interviewing, telephoning, and counseling.

(9) A reception area.

(10) Secured outside areas, such as gardens or recreational areas, are strongly encouraged in the design and development of ADHC programs.

## 23. EQUIPMENT AND FURNISHINGS

a. ADHC facility equipment and furnishings used by staff and participants must be selected for patient comfort and safety and be appropriate for use by adults with physical disabilities, visual and mobility limitations, and cognitive impairment.

b. Adequate equipment is necessary to meet the needs of each ADHC discipline.

c. Special equipment (in addition to the equipment needed for each discipline) needs to include:

- (1) Aids for mobility, such as: wheelchairs, walkers, lifting devices, and special chairs that meet the needs of geriatric and disabled Veterans;
- (2) Appropriate equipment and assistive devices for training Veterans in ADL;
- (3) Equipment to be used in Therapeutic Recreation Program; and
- (4) Suitable furniture for activity areas, dining area, and treatment rooms.

## 24. TRANSPORTATION

a. The success of ADHC Programs is largely dependent on their ability to secure safe and adequate transportation for Veterans.

b. ADHC's primary role is in facilitating Veterans' maximum use of community transportation systems, identifying systems, and aid in the application process, etc. Such systems may include:

- (1) Area "Agency on Aging" supported transportation;
- (2) Family Caregivers;
- (3) In-Home Care Providers;
- (4) Regional transit;
- (5) Local handicapped transportation resources;
- (6) Veteran Service Organization vehicles; and
- (7) Volunteer transportation systems, etc.

c. When there is a lack of adequate community transportation systems, coordination of local Disabled American Veteran (DAV) transportation services may be sought.

d. Escorts are provided, as needed, to assist Veterans to and from the vehicle at the ADHC site or other VA facility, as clinically indicated. In facilitating transportation, consideration must be given to safety, specific needs of each Veteran, and limiting the amount of time that the Veteran is in transit. Transit should not exceed 1 hour, except for rare instances. **NOTE:** *Special attention such as the use of escorts should be given for safe travel for Veterans with dementia.*

e. The VA Beneficiary Travel program is generally administered by the facility Business Office. This program provides certain eligible Veterans with mileage reimbursement or special mode transportation (ambulance, wheelchair van, etc.) based on medical needs. Outside of VA specific Beneficiary Travel program authority, facilities

may consider options such as Voluntary Services who may assist in the coordination of local DAV transportation services or referral to the local site's Social Work Services for community transportation assistance.

## 25. QUALITY MANAGEMENT

### Quality Improvement Activities.

a. A Quality Improvement (QI) program is required in all ADHC programs. The program will assess and improve important aspects of care and is designed to help the ADHC program appropriately utilize its resources and manage the quality of care it provides. The monitoring and evaluating of the program are to be:

- (1) On-going, planned, systematic, and comprehensive;
- (2) Designed so that data collection and evaluation are adequate to identify opportunities for improvement;
- (3) Measured through patient outcomes. Such health care data should be analyzed in order to make informed process improvements that can positively impact patient care; and
- (4) Led and coordinated by the ADHC Program Director with involvement of the interdisciplinary ADHC team and collaboration as appropriate with the facility QI program. Quality improvement activities need to incorporate the principles of Systems Redesign where appropriate.

b. Each ADHC program must develop and implement an annual QI Plan. An annual evaluation of the effectiveness of the QI program must be reported by the ADHC Program Director to the facility Chief of Quality Improvement to ensure successful program implementation. These findings must also be shared with facility and VISN leadership. This plan is to be a part of the medical facility's overall QI program and must be consistent with all national and local policies relating to that program. **NOTE:** *It is strongly encouraged that the QI plan in ADHC be interdisciplinary in focus involving evaluation of all services provided in the program.* Examples of areas that could be tracked are: Patient, family caregiver, and in-home provider satisfaction, caregiver burden assessments, ER visits, falls, depression, discharges, hospitalizations, and weight loss.

## 26. RESEARCH AND SURVEYS

ADHC is a setting which offers unique opportunities to study and evaluate health care and the delivery of services to geriatric and chronically ill Veterans. ADHC patient surveys must comply with VA policies, including any requisite approval of the OMB. Additionally, surveys that are part of a research process must be approved through appropriate Research and Development Service channels, in accordance with VHA Directive 1200, Research and Development Program, published May 13, 2016, or subsequent policy.

**27. DATA MANAGEMENT**

ADHC programs must ensure the integrity of important data related to program staffing, workload, and cost. A number of electronic information systems support ADHC with data vital to the delivery of care to Veterans in the program. Data collected is subject to workload closeout based on VHA Directive 1233, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census, dated June 14, 2017, or subsequent policy. Data and resources may be subject to changes; it is important to regularly check the provided resource Web sites. These systems include but are not limited to:

a. **International Classification of Diseases (ICD) - Current Edition and Current Procedural Terminology (CPT) Coding.** ADHC staff must use current ICD diagnostic codes for ADHC patient diagnoses.

b. **Electronic Health Record.** The electronic health record enables ADHC team members to enter, review, and continuously update patient clinical information.

c. **ADHC Workload Capture.** ADHC clinics are developed to capture workload. Program workload is entered into a designated ADHC clinic via encounters and reports Veteran visits in the same manner as outpatient clinics. Each ADHC clinic will include a DSS identifier code of 190 in either a primary or secondary position. A secondary code is used to reflect a specific type of service or a specific discipline’s work. For example, 190/125 would identify ADHC social work workload and 190/117 would represent nursing.

Stop Code Number	Secondary or Pair	Primary, Secondary, or either	Stop Code Name	Definition
190		E	Adult Day Health Care (ADHC)  (VA-based ADHC)	Records a visit of a patient to an approved VA-based ADHC program. Purpose of visit is to provide care and/or treatment during day hours only, patient returns home each evening. Use in primary position unless combined with a telephone Stop Code (e.g., Stop Code 326, “Telephone Geriatrics”)

d. **Managerial Cost Accounting.** The local Managerial Cost Accounting (MCA) units provide assistance with data management.

e. **Decision Support System.** DSS is the designated MCA System of VA. DSS is the VA system that provides clinical and financial data at the patient level. DSS combines data from 26 autonomous VA IT systems to provide reliable information

relating costs to outputs and activities. At the local level, the MCA unit advises ADHC 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 website that is not available to the public.*

f. **Veterans Equitable Resources Allocation.** Veterans Equitable Resources Allocation (VERA), is the methodology for the annual patient classification and funding to the VISNs. ADHC services documented in clinic stop 190 will qualify for the new class within Price Group 4, “Basic Care with Home and Community Services.” Class #41: Complex Care class: Multiple Problem with Home and Community Services. This class will include patients in Price Group 5 with ten or more Non-Institutional Care visits. This class will be funded in Price Group 7, “Multiple Problem with Home and Community Services.” Qualifying workload will include daily visits documented in VHA clinic stop 190: Adult Day Health Care. The ADHC patient class is for patients who receive long-term home care in lieu of institutional care and meet VERA ADHC criteria. See Web site: <http://vaww.arc.med.va.gov> for current VERA reports and classifications. **NOTE:** *This is an internal VA website that is not available to the public.* Qualification into the ADHC 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.

g. **VHA Support Service Center.** The VSSC contains ADHC patient data and reports that can be drilled down to the service level. The former census measures have been replaced with Unduplicated Unique measures (<https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fNVA%2fNVARpts%2fUniques +NICReport&rs:command=Render>). **NOTE:** *This is an internal VA website and that is not available to the public.*

h. **Labor Mapping.** Labor mapping is a collaborative process between local managers and DSS teams. ADHC staff positions are mapped to the appropriate DSS department. Labor mapping should be reviewed regularly to ensure that it accurately reflects ADHC staffing and the percentage of time each position is dedicated to the program ([http://vaww.dss.med.va.gov/programdocs/pd\\_ProAud.asp](http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp)). **NOTE:** *This is an internal VA website that is not available to the public.*

## 28. REFERENCES

- a. P. L. 106-117, Veterans Millennium Health Care and Benefits Act of 1999.
- b. 38 U.S.C. §§ 1710B, 1720(f), 1720B.
- c. 38 C.F.R. §§ 17.38(a)(1)(xi)(B), 17.111.
- d. VHA Directive 1043, Restructuring of VHA Clinical Program, dated November 2, 2016.



e. VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics. dated October 11, 2016.

f. VHA Directive 1200, Research and Development Program, dated May 13, 2016.

g. VHA Directive 1233, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census, dated June 14, 2017.

h. VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

i. VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, dated December 24, 2013.

j. VHA Handbook 1004.03(1), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

k. VHA Handbook 1101.10(1), PACT Handbook, dated February 5, 2015.

l. VHA Handbook 1140.02, Respite Care, dated November 10, 2008.

m. VHA Handbook 1140.07, Geriatric Patient-Aligned Care Team (GeriPACT).

n. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

o. VHA Notice 2020-31, Caregiver Support Program, dated October 1, 2020.

p. DSS guidelines: [http://vaww.dss.med.va.gov/programdocs/pd\\_ProAud.asp](http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp) **NOTE:** *This is an internal VA website that is not available to the public.*

q. Life Safety Code; these standards are available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandCompliance/LSC.html>.

## VA MOBILE ADHC PROGRAM

The VA Mobile Adult Day Health Care (ADHC) program, also known as the ADHC Mobile Veteran Program is a therapeutically oriented outpatient program that serves to enhance Veterans' quality of life and alleviate isolation and depression by maximizing their physical, mental and social abilities, and well-being. The program provides support and respite care for family caregivers and in-home care providers of Veterans who are functionally impaired and/or socially isolated, enabling the Veteran to maintain their residence in a supportive home environment. Through the development of community partnerships, urban, suburban, and rural Veterans are served by a team of traveling VA staff who provide an array of activities and supportive services, with the goal of maintaining Veterans in the community and alleviating caregiver burden.

The VA Mobile ADHC program is offered during specified days, as agreed upon with the community partner, in various community settings. These community partners are usually Veteran Service Organizations such as Veterans of Foreign Wars or American Legion Posts that donate the use of their site.

All enrolled VA Mobile ADHC program Veterans must have a designated VA primary health care provider who provides orders while the Veteran is enrolled in the program. VA Mobile ADHC program treatment team recommendations will be communicated to the primary health care provider based on the Veteran's individual need.

### 1. STAFFING

The VA Mobile ADHC program will be consistent with an adult day program social model of care. The VA Mobile ADHC program team consists of a Program Director, or Coordinator, who has demonstrated health care and administrative experience, with training or experience in care of those who are elderly or functionally impaired. The ADHC program is Veteran-centered and since the needs of the Veterans are complex and inter-related, staff flexibility, cooperation, and collaboration are essential to respond to those needs. Additional staffing will be determined by each VA site based upon the needs of enrolled Veterans, the recommendations by the Program Director or Coordinator, and VA site leadership approval. Staff may include, but not be limited to, a Registered Nurse, Certified Therapeutic Recreation Specialist, Certified Nursing Assistant, and a Licensed Practical Nurse. The staff-to-Veteran ratio may vary depending on the complexity and care needs of Veterans; however, adequate staffing levels must be maintained to provide appropriate program support and patient care. A minimum of one staff to 6 Veterans and one staff to 4 Veterans with dementia is recommended.

### 2. ADMISSION GUIDELINES

Veterans must meet the current VA eligibility requirements for outpatient services and should live within the primary service area. Participating Veterans must meet the following criteria:

- a. Veteran is socially isolated and would benefit from a structured therapeutic environment.
- b. Veteran is at risk for nursing home placement and may have a family caregiver/in-home care provider in need of respite care.
- c. Veteran is not a wander risk or with assaultive/aggressive behaviors or other significant safety concerns.
- d. Veteran would not require medication administration or medical treatment during program hours but may self-medicate.
- e. Veteran requires no more than a one person assist for transfer.
- f. Veteran is able to participate in a light exercise program.
- g. Veteran is able to tolerate a group setting with appropriate intervention, as needed.

### 3. PROGRAMMING

The care provided will be consistent with a social model of an adult day program. The program has five primary purposes, which are to: enable frail, elderly, and functionally impaired Veterans to remain in supportive home environments; facilitate hospital discharge planning; reduce risk of readmission or institutional placement; improve the quality of life by maximizing the Veteran's physical, cognitive, and psycho-social function; provide support, education, and respite for the Veteran's family caregiver/in-home care provider. The team will provide assistance with some activities of daily living (ADL) and offer therapeutic services designed to help participants with physical, social, and mental functioning.

### 4. SPACE

- a. As space for the VA Mobile ADHC program is in the community, the physical environment must meet the Centers for Medicare and Medicaid Service standards for compliance with the latest NFPA codes. Inspection of the community space is completed by the VA inspection team for final approval.
- b. Each program must have a Revocable License for VA to Occupy Non-Federal Space (see template Appendix C of this directive) completed and on file for each Non-Federal property where the VA Mobile ADHC program is operating. A revocable license grants VA permission to enter upon and conduct a specific act or series of acts upon the land of the licensor without possession or acquiring any estate. This license may be revoked by the Medical Center Director or the licensor at any time with or without cause. Each license is subject to review by District Contract Law National Practice Group. The link below will provide a point of contact for the applicable state.  
<https://vaww.ogc.vaco.portal.va.gov/offices/DCPG/SitePages/Home.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

## 5. SAFETY GOALS

The principles of the VA Patient Safety Program and risk management apply to the VA Mobile ADHC program. Each VA Mobile ADHC program must address the following safety competencies at each site:

a. Staff will observe for and identify Veterans at risk for injury from things such as smoking, falls, wandering, driving, emergency preparedness, and limited in-home support.

b. Staff will implement appropriate safety plans for individual Veterans as needed.

c. Staff will develop a system of documenting, evaluating, and reporting accidents, injuries, and safety hazards in accordance with applicable regulatory authority and VA policies and procedures.

d. Staff will identify potential hazards and provide Veteran and family caregiver/in-home care provider education regarding safety and make referrals for home and other safety evaluations as needed.

e. All staff and volunteers must know the location of all fire extinguishers in program areas.

f. Staff must be knowledgeable of fire alarm procedures: how to notify, how to alarm, location of exits and meeting place.

g. Staff must be aware of the nearest entrances/exits and handicap accessible entrances/exits to be used by the program in case of an emergency evacuation.

h. Upon an evacuation of the program, staff will initiate face checks at the designated meeting place and inform emergency personnel immediately of any missing persons.

i. Staff will be aware and understand the local VA medical center's missing patient policy and procedures.

j. Staff will be instructed to call 911 for any medical or mental health emergency issues.

k. Staff will be aware of the nearest telephone in the program area as well as the phone number for the Mobile ADHC program director or coordinator.

l. Staff will be aware of handrail safety and understands to report loose/unsecure handrails (bathrooms/entrances/exits) to Post Commander or designee, lead staff member on site and the Mobile ADHC Program Director or Coordinator.

## **6. EQUIPMENT AND FURNISHINGS**

VA Mobile ADHC program equipment and furnishing used by staff and participants must be appropriate for use by adults with physical disabilities, visual and mobility limitations, and cognitive impairment.

## **7. TRANSPORTATION**

Veteran must have appropriate transportation arranged between the Veteran's home and the program site. This transportation is not arranged by VA.

**INSTRUCTIONS TO COMPLETE TEMPLATE FOR REVOCABLE LICENSE  
AGREEMENT FOR USE OF PROPERTY**

The Office of Geriatrics and Extended Care, Office of General Counsel, Real Property Law Group, and Office of Real Property Construction & Facilities Management (OO3C1E) have determined that completion of a Revocable License Agreement for Use of Property is required for Mobile Adult Day Programs.

1. The template, found in Appendix C of this directive, is to be completed for all Mobile Adult Day Programs. Per ORP policy, this template is to be used when VA is seeking to occupy and use non-Federal space or land. To obtain more information on how to use the license template, contact ORP. In this form, VA is the licensee and the licensor is the non-federal entity.

2. In paragraph 1. Use of the template, when specifying number of days per week and the hours, wording must reflect if changes occur with the days and hours, the license is still accurate. If it is helpful, the Mobile Adult Day programs can draft a separate Memorandum of Understanding (MOU) with the licensor to address the exact hours and days. An MOU is not mandatory, but if used, it should not conflict with the terms included in the license.

3. In paragraph 2. Term.

a. Per ORP Policy on Revocable Licenses for VA Use of Non-Federal Space or Land. License terms shall not exceed five (5) years, including option years, regardless of execution authority. Contact VA's ORP, in consultation with Office of General Counsel (OGC), if guidance is needed regarding whether a license or lease is an appropriate vehicle for a particular space or real property need.

b. Execution Authorities: The positions listed below are approving authorities for the type of license listed. The approving authorities listed below may re-delegate this authority at their discretion to the extent necessary to ensure efficient application of the licensing program.

(1) For Licenses without fees or consideration:

(a) Veterans Health Administration (VHA): VISN Directors or Deputy Directors or VAMC Directors or Associate Directors or the equivalent.

4. Costs and Fees: License Fees: VA may not enter into a revocable license containing a requirement for VA to expend appropriated funds for the use of space or have in-kind consideration or pay or reimburse the licensor for any costs including but not limited to, services, taxes or utilities. Contact ORP to obtain more information on in-kind consideration. Licenses must be at no-cost when VA is Licensee. A no-cost license does not constitute a donation of real property that must be formally accepted by an Under Secretary or SECVA, since no real property interests are transferred with

licenses. If licensed space is offered to VA at no cost, a license agreement must still be completed and executed.

5. The license must be reviewed by the District Contract Law National Practice Group. Using the link below, click on the state for the license and it will give you a point of contact: <https://vaww.ogc.vaco.portal.va.gov/offices/DCPG/SitePages/Home.aspx>.

**NOTE:** *This is an internal VA website that is not available to the public.*

6. Per ORP policy - Post-Execution: Upon execution of a license, forward a copy of the executed license to ORP. In addition, upload the signed license to VA's Capital Asset Inventory (CAI) database, per the CAI instructions. For questions, contact ORP.

7. In addition to providing copies of the completed license to all those involved, an additional copy should be sent to:

Office of Real Property  
Construction & Facilities Management  
425 I St., NW,  
Washington, DC 20001

**Under certain circumstances, the following clauses may be considered for inclusion when completing a revocable license for VA ADHC. As a reminder, all Revocable Licenses are subject to final review by District Contract Law National Practice Group, per paragraph 5 above.**

Operations, Maintenance, and Repair. Licensor shall provide custodial services and shall maintain and repair the interior of the structures on the Premises, including interior fixtures. Notwithstanding the foregoing, Licensee will be responsible for ongoing expenses related to removal of hazardous waste (e.g., needles/sharps, other medical waste) and other clinical and operational items as needed for Licensee's use of the Premises.

Licensor shall maintain and repair damage to the Premises and parking lot, including but not limited to, such damage caused by normal wear and tear, weather, or by persons other than Licensee's personnel. Any damage caused to the Premises by Licensee's personnel shall be subject to the Federal Tort Claims Act (28 U.S.C. §§1346(b)(1), 2671-2680).

Right of Entry. Licensor shall have the right to enter the Premises for the purposes of inspection, maintenance, construction, and repairs pursuant to the terms of this License, and upon providing prior written notice to Licensee, which for the purposes of this Agreement shall constitute not less than fifteen (15) days in non-emergency situations, and reasonable prior notice for any emergency situations, ideally twenty-four (24) hours advance notice.

Governing Law. Notwithstanding anything in this Agreement or elsewhere to the contrary, this Agreement shall at all times be subject to applicable Federal, State, and local laws, codes, ordinances, and regulations, including but not limited to, the Anti-Deficiency Act (Title 31 U.S.C. §§ 1341 and 1501), and the Federal Tort Claims Act (28 U.S.C. §§ 2671-2680).

Final Agreement. This License supersedes any and all prior understandings and agreements, whether written or oral, between the Parties with respect to the subject matter of this License. No alteration or variation of this License shall be valid unless made in writing and signed by Licensor and Licensee.

Acts of God. Licensee hereby waives any right of recovery against Licensor due to loss of or damage to the property of Licensee when such loss of or damage to property arises out of an act of God or any of the property perils included in the classification of fire or extended perils (“all risk” as such term is used in the insurance industry) whether or not such perils have been insured, self-insured, or non-insured.

Security. Licensee shall use its best efforts subject to applicable law, to comply with all security regulations in effect from time to time at Licensor’s premises and shall comply with Licensor’s security policies and procedures with respect to its computer and communications networks. Licensee shall ensure that any third-party security that the Licensee retains have adequate types and amounts of insurance, customary per industry standard. Licensee shall ensure that that Licensor is named as an additional insured on each of said policies and shall provide additional insured endorsements or certificates evidencing the same to Licensee for each year that this Agreement is in effect.

Licensee shall ensure that any third party providing additional services to the Licensee in this space has adequate types and amounts of insurance, customary per industry standard. Licensee shall further ensure that that Licensor is named as an additional insured on each of said policies and shall provide additional insured endorsements or certificates evidencing the same to Licensee for each year that this Agreement is in effect

Valid Agreement and Authorization to Enter Agreement. The Parties hereto represent and warrant that this Agreement is validly entered, and that the persons signing below are authorized to enter in this Agreement on behalf of the Party hereto represented by such person

Any questions should be directed to the Office of Geriatrics and Extended Care at 202-461-6750.



**REVOCABLE LICENSE FOR USE OF PROPERTY  
GRANTED TO  
U.S. DEPARTMENT OF VETERANS AFFAIRS  
BY**

THIS LICENSE is entered by and between \_\_\_\_\_ ("Licensor") and the U.S. DEPARTMENT OF VETERANS AFFAIRS ("Licensee") to permit Licensee to use a portion of Licensor's property located at \_\_\_\_\_ (the "Premises"), as more fully described in Paragraph 1 below. The Licensor and Licensee are collectively referred to in the License as "Parties" and severally, as a "Party."

1. Use. Licensor hereby grants to Licensee, a License to enter upon and use the Premises, and the right of ingress and egress to and from the Premises, subject to the terms and conditions herein, for the purpose of \_\_\_\_\_

\_\_\_\_\_  
The Premises shall consist of \_\_\_\_\_.  
[Licensee will use the space to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.]

Licensor agrees it is responsible for maintaining the Premises that the Licensee will use during the term of the License, as provided in Paragraph 2 below. During the term of the License, the Licensee shall not make any improvements or modifications to the Premises.

2. Term. This License shall commence on \_\_\_\_\_, 20\_\_ (the "Effective Date"), and shall expire no later than \_\_\_\_ month(s)/year(s) from such Effective Date. This License may be revoked at will at any time by the Licensor upon advance notice within \_\_\_\_\_ calendar days, pursuant to the notification terms of Paragraph 10 of this License. Licensee may end its use of the Premises under this License at any time and notify the Licensor accordingly.

3. Costs and Fees. Licensee shall pay no costs or fees for its use of the Premises.

4. Conditions Applicable to License. This License is subject to all existing covenants, conditions, reservations, contracts, leases, licenses, easements, encumbrances, restrictions, and rights of way with respect to the Premises, whether or not of record. To the best of the Licensor's knowledge, Licensor is possessed of the right to grant this License and there currently exists no condition that would adversely affect the Licensee's ability to use the Premises for the purposes described herein.

5. No Transfer or Assignment. Neither Party may assign its rights under this License to any other person or entity, except and to the extent the Parties in their

respective sole discretion may otherwise agree in writing. Any attempt to transfer or assign this License shall be grounds for immediate revocation.

6. Permits and Regulations. Licensor shall be responsible for securing any required approvals, permits, and authorizations for the Premises from any federal, state or local agencies and shall comply with all applicable laws and regulations with respect to the physical condition of the Premises.

7. No Interference. During the term of the License, neither Party shall interfere with the other Party's normal operations and activities. Both Parties shall conduct their respective activities in a manner to minimize risk of injury or inconvenience to the other Party's employees, students, agents, and invitees, or damage to the Premises.

8. No Partnership or Joint Venture. This License does not create a partnership or joint venture between Licensor and Licensee, nor shall it be construed to mean that either Party agrees to assume liability for the acts or omission of the other Party. Nothing herein shall be construed to mean that any employee of Licensee is an agent or employee of Licensor.

9. Severability. If any provision of this License shall be held to be invalid or unenforceable for any reason, (i) the remaining provisions shall continue to be valid and enforceable; or (ii) if by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed and enforced as so limited.

10. Notice. All notices and communications given under this License shall be provided as follows:

If to Licensor:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If to Licensee:

U.S. Department of Veterans Affairs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Liability. The liability, if any, of the Licensee for property damage, or personal injury or death, arising from Licensee's use of the Premises, shall be governed exclusively by the provisions of the Federal Tort Claims Act (28 U.S.C. §§ 1346(b)(1), 2671-2680).

12. Insurance. The Parties recognize and agree that the Licensee is an entity of the United States Federal Government, and is thereby a self-insured entity.

13. Valid License and Authorization to Enter into License. The Parties hereto represent and warrant that this License is validly entered, and that the persons signing below are authorized to enter in this License on behalf of the Party hereto represented by such person. No alteration or variation of this License shall be valid unless made in writing and signed by Licensor and Licensee.

14. Counterparts. This Agreement may be executed simultaneously in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument

**IN WITNESS WHEREOF**, the Parties have executed this License the day and year first above written.

**LICENSOR:**  
\_\_\_\_\_  
VETERANS AFFAIRS

**LICENSEE:**  
U.S. DEPARTMENT OF

By (Print): \_\_\_\_\_

By \_\_\_\_\_ (Print):

By (Sign): \_\_\_\_\_ By  
(Sign) \_\_\_\_\_

Its: \_\_\_\_\_ Its:  
\_\_\_\_\_

**CERTIFICATION OF AUTHORIZATION**

I, \_\_\_\_\_ (print name), certify that I am the \_\_\_\_\_ (title) of [name of organization] named as Licensor in the license and that I am duly authorized to sign for and on behalf of [name of organization] by authority of its governing body, and am acting within the scope of its corporate powers.

BY:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_