

COMMUNITY RESIDENTIAL CARE PROGRAM

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) directive provides the policy regarding the Department of Veteran Affairs (VA) Community Residential Care (CRC) Program.

2. SUMMARY OF MAJOR CHANGES.

a. Amendment dated September 24, 2021 updates the screening and evaluation process for suicide risk utilizing VA's Suicide Risk Identification process in paragraphs 15.a.(4), 15.b.(5)(c) and 15.d.(3). The amendment adds potential clinical situations as the responsibility of the VA health care team in paragraph 15.c.(1) and the utilization of The Columbia Suicide Severity Rating Scale in these situations in paragraph 15.c.(2). Additionally, the amendment updates the website for Suicide Risk Identification and Management strategies appropriate for non-providers in paragraph 22.a.(3).

b. This revised directive, published April 1, 2020:

(1) Describes a new requirement for Ensuring a Safe Environment for Community Residential Care Residents, title 38 Code of Federal Regulations (CFR) 17 Regulation Identification Number (RIN) 2900-APO6. See Appendix A.

(2) Describes changes in reporting revocations to appropriate state agencies. See paragraph 13.f.

(3) Describes changes in CRC Sponsor education program requirements. See paragraph 16.c.

(4) Describes new approval criteria for rates charged for CRC. See paragraph 14.b.

(5) Removed court reporter requirements for Notice and Conduct of hearing.

3. RELATED ISSUES. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016; VHA Directive 1141.02(1), Medical Foster Home Procedures, dated August 9, 2017; VHA Directive 1108.07, Pharmacy General Requirements, dated March 10, 2017; and VHA Handbook 1108.05, Outpatient Pharmacy Services, dated June 16, 2016.

4. RESPONSIBLE OFFICE. The Office of Geriatrics and Extended Care (12GEC), is responsible for the contents of this directive. Questions may be directed to 202-461-6751.

April 1, 2020

VHA DIRECTIVE 1140.01(1)

5. RESCISSIONS. VHA Handbook 1140.01, Community Residential Care Program, dated February 10, 2014; and VHA Notice 2018-06, state Reporting Requirements for Revocation of Approval Medical Foster Homes, dated February 5, 2018, are rescinded.

6. RECERTIFICATION. This VHA directive is scheduled for recertification on or before the last working day of April 2025.

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

/s/ Renee Oshinski
Deputy Secretary for Health for
Operations and Management

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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COMMUNITY RESIDENTIAL CARE STANDARDS THAT MUST BE INSPECTEDA-1

COMMUNITY RESIDENTIAL CARE PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive provides the policy regarding the Community Residential Care (CRC) Program. Any Veteran who lives in a Department of Veterans Affairs (VA) approved CRC facility in the community is under the oversight of the respective CRC. **AUTHORITY:** Title 5 United States Code (U.S.C.) 552, 552a; 38 U.S.C. 1730, 5701, 5705, 7301(b), 7332; Title 38 Code of Federal Regulations (CFR) 17.61-17.72; 45 CFR 164.501 and 164.502.

2. BACKGROUND

Since 1951, VA's CRC Program, a form of enriched housing, has provided health care supervision to eligible Veterans not in need of acute hospital care, but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. When published in 1989, VA's regulations were the first Federal regulations addressing the health and safety of residents in this level of care. The CRC Program is an important component in VA's continuum of care. Enriched housing is referred to by different names in various states and settings such as medical foster homes, assisted living, personal care homes, family care homes, and psychiatric CRC homes.

3. DEFINITIONS

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

(1) Activities of Daily Living (ADL) are daily self-care activities. Health providers 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:

- (a) Bathing, shaving, brushing teeth, combing hair;
- (b) Dressing;
- (c) Eating;
- (d) Getting in or getting out of bed;
- (e) Toileting;
- (f) Transferring; and
- (g) 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 cleaning room;
- (e) Laundry;
- (f) Meal preparation;
- (g) Obtaining appointments;
- (h) Shopping for groceries or clothing;
- (i) Taking medications; and
- (j) Writing letters or other electronic communications.

b. **Approving Official.** An Approving Official is the Director or, if designated by the Director, the Associate Director or Chief of Staff, or Associate Director for Patient Care Services of a VA medical facility or Outpatient Clinic which has jurisdiction to approve a CRC facility.

c. **Community Residential Care Facility.** A CRC facility is a privately or publicly owned residence or group living facility situated in the community. It provides room, board, supervision, and assistance in ADLs and IADLs in a home-like environment. CRC facilities focus on providing opportunities for residents to regain their level of functioning to the greatest extent possible in a supportive, supervised setting.

d. **Community Residential Care Sponsor.** A CRC Sponsor is the owner of the home or CRC facility. The sponsor may or may not be the caregiver but is responsible for the management of the CRC facility. ***NOTE: Historically, the CRC sponsor has been called the Facility Sponsor.***

e. **Fiduciary.** A fiduciary is:

(1) A guardian, curator, conservator, committee, or person legally vested with the responsibility or care of a claimant (or a claimant's estate) or of a beneficiary (or a beneficiary's estate).

(2) Any other person having been appointed in a representative capacity to receive money paid under any of the laws administered by the Secretary for the use and benefit of a minor, someone who has been adjudicated as incompetent to handle their financial affairs, or other beneficiary.

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 facility or Outpatient Clinic which has jurisdiction to approve a CRC facility.

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

h. **Medical Foster Home.** As defined in VHA Directive 1141.02(1), Medical Foster Home Procedures, dated August 9, 2017, a Medical Foster Home (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 or partners may share a room if in need of MFH. **NOTE:** Please see VHA Directive 1141.02(1) for details.

i. **Oral Hearing.** An Oral Hearing is the in-person testimony of representatives of a CRC facility and VA before the Hearing Official and the review of the written evidence of record by that official. **NOTE:** See 38 CFR 17.62(d) for additional information.

j. **Paper Hearing.** A Paper Hearing is a review of the written evidence of record by the Hearing Official. **NOTE:** See 38 CFR 17.62(c) for additional information.

4. POLICY

It is VHA policy that every CRC program will be developed, implemented, and sustained within VHA so Veterans can successfully utilize the program to live at their highest level of functioning in the least restrictive community setting that is safe, best meets their needs, and provides a positive quality of life.

5. 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 for Health for Operations and Management is responsible for:

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

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

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

(4) Reviewing and approving the implementation of any proposed program restructuring submitted by the VISN Director that could significantly increase or reduce staffing or capacity of the CRC programs, in accordance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

c. **Executive Director, Office of Geriatrics and Extended Care.** The Executive Director, Geriatrics and Extended Care (GEC) is responsible for:

(1) Developing national policy for VA CRC program.

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

(3) Providing comparative data quarterly to VA medical facilities on CRC characteristics, populations served, demographic information including race/ethnicity, gender, military era/period of service, gender identity, mental health status, utilization, quality and outcomes. CRC facilities can use the information to track trends over time or compare themselves to like facilities as part of quality management.

(4) Maintaining communications and networking with CRC program leaders through an interactive mail group and national monthly conference calls.

(5) Collaborating with involved services and program offices to develop ongoing guidance as indicated.

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

(1) Facilitating communication between VA medical facility CRC programs and GEC.

(2) Ensuring that VA medical facilities maintain staffing and capacity in CRC programs in accordance with 38 U.S.C. 1710 B(b).

(3) Ensuring compliance with the policies in this directive by all VA medical facilities under their jurisdiction.

(4) Notifying and requesting approval from 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 increase or reduce staffing or capacity of the CRC programs, in accordance with VHA Directive 1043.

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

(1) Overseeing the management of the local CRC Program, including when a participating CRC facility could pose excessive risk to Veterans or VHA.

(2) Designating an interdisciplinary inspection team.

(3) Ensuring that VA medical facility staff comply with VHA policy and this directive.

(4) Ensuring that sufficient resources and transportation are available to the interdisciplinary inspection team for evaluation and follow-up.

(5) Acting as final Approving Official of prospective facilities for participation in the CRC Program.

(6) Acting as Hearing Official for appeals filed by CRC Sponsors as provided in 38 CFR 17.66 – 17.71.

(7) Notifying the VISN Director and VA Central Office GEC in advance of any proposed changes or restructuring that could significantly increase or reduce staffing or capacity of CRC services, in accordance with VHA Directive 1043.

(8) Ensuring that the VA medical facility Service Chief or Associate Service Chief integrates the CRC Program into the VA medical facility's Quality Management Program.

f. **VA Medical Facility Service Chief or Associate Service Chief.** The VA medical facility Service Chief, who may be the Associate Chief of Staff for GEC or Associate Chief Nurse of GEC, the Chief of Staff or Associate Chief Nurse of Ambulatory Care, the Chief of Mental Health, or an interdisciplinary care line Director, is responsible for:

(1) Managing the CRC program.

(2) Providing clinical oversight and ensuring competency of the employees within their disciplines.

(3) Acting as Hearing Official for appeals filed by CRC Sponsors as provided in 38 CFR 17.66 – 17.71, when delegated by the VA medical facility Director.

(4) Integrating the CRC program into the VA medical facility's Quality Management Program.

NOTE: *Some facilities may employ a supervisor that oversees the VA CRC Coordinator and they should report to the VA Medical Facility Service Chief or Associate Service Chief and be responsible for oversight of the CRC Coordinator.*

g. **Interdisciplinary Inspection Team.** The Interdisciplinary Inspection Team is responsible for conducting inspections of CRC facilities and recommending approval or disapproval of these facilities as a condition of their participation in the CRC Program. At a minimum, the team must consist of a social worker, nurse, dietitian, and a fire and safety specialist. Adjunct team members, including a physician, clinical pharmacy specialist, rehabilitation medicine staff member, mental health provider, infection prevention and control staff professional, and the Women Veteran Program Manager, must participate in team meetings and be available to assist the interdisciplinary inspection team upon consultation with the CRC Program Coordinator.

h. **Veterans Benefits Administration Field and Fiduciary Supervisors.** The Veterans Benefits Administration (VBA) field and fiduciary supervisors have agreed to:

(1) Meet at least annually with the CRC Program Coordinator to discuss the placement and ongoing needs of Veterans in the CRC Program who have been determined incompetent to handle their financial affairs.

(2) Take appropriate action as needed based on the annual meetings.

i. **Community Residential Care Program Coordinator.** The CRC Program Coordinator is responsible for overall program development, management, operations, and evaluation of the CRC Program, and reports directly to the designated chief of service or designee, in which the program is aligned. This includes:

(1) Recruiting and screening CRC facilities;

(2) Developing the application that the CRC Sponsor must complete when applying to participate in the CRC program;

(3) Overseeing Veteran referral and monitoring placement into CRC facilities;

(4) Directing VA CRC Program staff duties;

(5) Coordinating and retaining record of VA inspections of CRC facilities;

(6) Planning and developing of CRC sponsor educational programming;

(7) Record keeping in compliance with Federal regulations, state licensing requirements, and local regulations;

(8) Coordinating of VA inspections of CRCs;

(9) Monitoring and reporting quality of the CRC and evaluating status of the Veterans residing in VA approved CRC homes;

(10) Ensuring that all deficiencies are corrected, establishing timelines or deadlines for correcting of any deficiency;

(11) Directing VA CRC staff duties;

(12) Planning and developing of CRC Sponsor educational programming, as described in paragraph 16 of this directive; and

(13) Visiting each CRC facility monthly for oversight and compliance with standards.

NOTE: *Some facilities may employ a supervisor that oversees the VA CRC Coordinator, as such they will be responsible for making sure the CRC coordinator carries out their responsibilities outlined above in adherence with this policy.*

j. **Community Residential Care Case Manager.** The VA CRC Case Manager is responsible for:

(1) Overseeing the direct case management of Veterans residing in approved CRCs.

(2) Visiting each Veteran resident and provider at least monthly in the home or CRC facility; residents who have special needs must be seen more frequently.

NOTE: *In the absence of a CRC Case Manager, these responsibilities fall to the CRC Program Coordinator.*

k. **Community Residential Care Program Staff.** In CRC programs that have staff supervised by the CRC Program Coordinator, the CRC program staff is responsible for:

(1) Maintaining records and information regarding residents in the CRC facilities, as described in Appendix A.

(2) If applicable, assisting Veterans in accessing sufficient funds to pay the cost of residential care (see paragraph 14 for information regarding the cost of the residential care program).

6. GOALS

The goals of the CRC Program are to:

a. Provide the appropriate level of care and an improved quality of life for Veterans who do not require hospital or a skilled nursing facility, but who are not capable of independent living;

b. Facilitate the most appropriate use of VA and community resources;

c. Maintain or improve the Veteran's health and social functioning in a supportive environment;

d. Support the highest level of functioning of the Veteran including discharge to independent living, when possible; and

e. Provide a home environment where the Veteran may remain in comfort, retain dignity, and have the needed support through the end of life, guided by Veteran preference and feasibility.

7. ELIGIBILITY

Veterans may be self-referred to the CRC Program or referred by member of the VA health care team if they meet the following criteria at the time of referral:

a. The Veteran is receiving VA medical services on an outpatient basis, or is a patient at a VA medical facility, domiciliary, MFH, Community Living Center, or contract

nursing home; or such care or services were furnished to the Veteran within the preceding 12 months.

b. The Veteran does not need hospital or nursing home care but is unable to live independently, as determined by family, social workers, or appropriate state agency, because of medical (including psychiatric) conditions and has no suitable significant others to provide needed monitoring, supervision, and necessary assistance in ADLs or IADLs.

c. The Veteran has been screened by primary care, or attending physician, for any active communicable disease.

d. The Veteran must have the financial resources, as determined by referral source, to pay for room and board.

e. The Veteran agrees to ongoing treatment from VA primary care team.

NOTE: *The specific methods of referral vary by VA medical facility. See paragraph 15, Selection, Enrollment, and Follow-Up of Residents.*

NOTE: *This program is distinct from the Veterans Community Care Program (VCCP), and VCCP eligibility requirements are not applicable to eligibility for placement in a Community Residential Care program.*

8. ORGANIZATIONAL PLACEMENT OF THE COMMUNITY RESIDENTIAL CARE PROGRAM

GEC recommends that the CRC Program be aligned under the Associate Chief of Staff for GEC for optimal program management. If such a position does not yet exist at the VA medical facility, CRC can function under the Chief of Staff for Ambulatory Care, the Chief of Mental Health, or an interdisciplinary Care Line Director. If the VA medical facility has centralized discipline-specific services (e.g., social work, nursing), the respective Service Chief may have responsibility for clinical oversight and competency of the employees within that discipline. CRC will serve Veterans from all VA programs and referral sources.

9. COMMUNITY RESIDENTIAL CARE SPONSOR PARTICIPATION

a. CRC Sponsors who apply for participation in the CRC Program must accept the VA conditions of participation, as outlined in VA Form 10-2407, Residential Care Home Program Sponsor Application (https://www.va.gov/vaforms/form_detail.asp?FormNo=2407). VA inspects CRC facilities with the permission of the CRC Sponsor and, if deficiencies are found during the inspection, the CRC Sponsor decides whether to correct the deficiencies in order to become or remain a part of the CRC Program. **NOTE:** *Approved CRC facilities receive referrals from VA and payment directly from Veterans residing in the CRC facility. VA employees are strongly encouraged to obtain advice from the appropriate government ethics official before deciding to apply for approval as a CRC Sponsor. Any concerns*

that involve criminal conflict of interest law or Standards of Conduct are matters for the Designated Agency Ethics Official (DAEO). The DAEO, the Assistant General Counsel for Professional Staff Group III, addresses issues involving the application of criminal conflict of interest laws (18 U.S.C. 11) and the Standards of Conduct for Executive Branch Employees (5 CFR 2635). The DAEO, the Alternate DAEO and the Deputy Ethics Officials in the Regional Counsel offices and in Professional Staff Group III are the only source of authoritative advice on criminal conflicts of interest and the legal questions relating to Standards of Conduct. These Deputy Ethics Officials can be contacted at governmentethics@va.gov. Following the good faith advice of such ethics officials provides the employee with meaningful protection from criminal or administrative sanctions. The imposition of criminal sanctions ultimately rests with the Department of Justice after receiving the matter from the Inspector General.

b. To ensure a safe environment for Veterans residing in the CRC, the VA-approved CRC sponsor must meet regulatory requirements. **NOTE:** See Appendix A.

10. SELECTION OF FACILITIES

a. VA GEC Services works with the CRC Program in recruitment of VA approved homes that meet the needs of Veterans in both rural and urban areas. Therefore, facilities within the catchment area will not be limited to narrow parameters surrounding a VA medical facility. CRC Programs are meant to cover the distance necessary to provide VA-approved placement options for Veterans in their own communities. This includes outreach to rural areas. A facility's application for participation in the CRC Program must be made in writing to the CRC Coordinator of the VA medical facility of jurisdiction by the prospective CRC Sponsor. The data elements below are identified as examples of application items that may be required by state or local laws. The CRC Sponsor application will be developed by the CRC Coordinator to meet VA, state, and local requirements. The completed application must be returned to the CRC Program Coordinator by the prospective CRC Sponsor. The individual CRC Program may request additional information at the time of application as required by state or local laws or as required by VA regulations. **NOTE:** See Appendix A.

(1) A completed VA Form 10-2407, Residential Care Home Program Sponsor Application (https://www.va.gov/vaforms/form_detail.asp?FormNo=2407) is required of all applicants.

(2) Examples of additional information that may be required from the applicant include:

- (a) State facility operator's license number and renewal date;
- (b) Highest education level completed;
- (c) Employment history;
- (d) Driver's license number, state of issue and expiration date;

- (e) Proof of vehicle insurance;
- (f) U.S. Citizenship or Residence status;
- (g) Languages spoken;
- (h) Designated relief person;
- (i) Number of pets in the facility and documentation of pet vaccinations;
- (j) Number of smokers in the facility; and
- (k) Documentation of pest control.

(3) When the CRC Sponsor resides in the same facility as Veterans, the following additional information may be required:

- (a) Completed screening for any active communicable disease;
- (b) Personal references; and
- (c) Documentation of home ownership or current lease.

b. **Informal Discussions.** The prospective CRC Sponsor may informally discuss the potential for the facility's participation in the CRC Program with the CRC Program Coordinator, or designee.

c. **Initial Review of Application.** When a formal application is made it must be reviewed by the CRC Program Coordinator, who is to contact the applicant to arrange a site visit, if indicated.

(1) The CRC Program Coordinator may visit the prospective CRC Sponsor and the facility to make an initial assessment of whether the facility could meet VA standards.

(2) If the recommendation of the CRC Program Coordinator is positive after the initial assessment, a formal inspection is scheduled. In those states requiring a license to operate a residential care home, the CRC Sponsor must provide proof of licensure to the CRC Program Coordinator prior to the initial assessment or Interdisciplinary Inspection Team visit.

(3) If the recommendation of the CRC Program Coordinator, is negative, the applicant must be notified in writing within 30 days by the CRC Program Coordinator. Applicants do not have a right to a hearing.

d. **Inspection.** Following an initial review of the application, a VA inspection is scheduled and conducted by the interdisciplinary inspection team. All prospective CRC facilities must be inspected within 30 days and approved by a VA inspection team prior to referring Veterans to the facilities. Inspections must be carried out in accordance with standards delineated in Appendix A of this directive. During the inspection,

attention must be given to the CRC's emergency evacuation plan and its adherence to applicable life safety codes. All reports from the interdisciplinary inspection team must be submitted, in writing, to the CRC Program Coordinator for review. The CRC Program Coordinator must make a recommendation of approval or disapproval. **NOTE:** *The initial assessment and interdisciplinary team inspection may be combined into one step.*

e. **Notification of Community Residential Care Facility Sponsor.** Following the interdisciplinary team inspection, a letter of final acceptance or rejection must be sent to the applicant within 30 days of the completion of the inspection.

f. **Sale or Transfer of Ownership.** VA approval is not transferable or applicable to any other location or other owner. The CRC Sponsor is required to notify the VA and state licensing office, if applicable, in writing in the event of sale, transfer of ownership, or closure of the facility.

11. STANDARDS FOR FACILITIES

The approving official may approve a CRC facility, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, if that facility meets all applicable Federal regulations, state licensing requirements, and local regulations, including standards as described in 38 CFR 17.63, listed in Appendix A.

12. RE-INSPECTIONS AND DURATION OF APPROVAL

a. **Approval and Provisional Approval.** Approval may be valid for up to 12 months when VA finds that the CRC facility has complied with all standards during the current inspection, all previous VA inspections, and any interim monitoring, per 38 CFR 17.65.

(1) An approval of a facility meeting all of the standards in 38 CFR 17.63 based on the report of a VA inspection and any findings of necessary interim monitoring of the facility, shall be for a 12-month period.

(2) The approving official, based on the report of a VA inspection and on any findings of necessary interim monitoring of the CRC facility, may provide a community residential care facility with a provisional approval if that facility does not meet one or more of the standards in 38 CFR 17.63, provided that the deficiencies do not jeopardize the health or safety of the residents, and that the facility management and VA agree to a plan of correcting the deficiencies in a specified amount of time. A provisional approval shall not be for more than 12 months and shall not be for more time than VA determines is reasonable for correcting the specific deficiencies.

(3) An approval may be changed to a provisional approval or terminated under the provisions of 38 CFR 17.66 through 17.71 because of a subsequent failure to meet the standards of 38 CFR 17.63 and a provisional approval may be terminated under the provisions of 38 CFR 17.66 through 17.71 based on failure to meet the plan of correction or failure otherwise to meet the standards of 38 CFR 17.63.

b. **Annual Inspections.** Annual inspections must be carried out by an interdisciplinary inspection team. At a minimum, the team must consist of a social worker, nurse, dietitian, and a fire and safety specialist. Based upon the interdisciplinary inspection team's findings, additional disciplines must participate in the inspection process as determined by the CRC Program Coordinator. Additional disciplines include, but are not limited to, physicians, rehabilitation medicine, and infection prevention and control. The Women Veterans Program Manager is a consultant to the CRC program and this interdisciplinary inspection team.

c. **Correcting Deficiencies.** The CRC Program Coordinator is responsible for ensuring that all deficiencies are corrected, establishing timelines or deadlines for correcting of any deficiency.

(1) The VA approving official must notify the CRC Sponsor, in writing, of the identified deficiencies and must send the notice within 30 days of the completion of the inspection.

(2) The CRC Sponsor must correct all deficiencies and provide appropriate documentation to the CRC Program Coordinator within a timeframe agreed upon once the deficiency was identified and a corrective action plan initiated based on clinical judgement and on a case-by-case basis.

(3) A copy of the deficiencies, a proposed plan of corrective action, and a copy of the confirmation letter that the deficiencies have been corrected must be maintained by the CRC Program Coordinator and made available to the VA medical facility Director, as requested. ***NOTE: If an annual inspection identifies substandard medication management activities at an individual CRC facility, the CRC facility must provide VA evidence of closer monitoring of the identified deficiency within 30 days. The appropriate inspection team member(s) must conduct a follow-up site review to confirm compliance within 30 days. The follow-up site review team may include a pharmacist manager to assist with verifying compliance with medication use standards.***

13. DUE PROCESS: NON-COMPLIANCE WITH VA STANDARDS AND REQUEST FOR HEARING

a. **Notice of Non-Compliance with VA Standards.** If the Hearing Official determines that an approved CRC facility does not comply with standards set forth in Appendix A, or if the CRC Sponsor refuses to make necessary corrections as a result of the annual inspection, the CRC Program Coordinator must notify the CRC facility in writing identifying:

(1) Which standards have not been met;

(2) The date by which the standards must be met to avoid revocation of VA approval;

(3) That the CRC Sponsor has an opportunity to request an oral or paper hearing before VA approval is revoked; and

(4) The date by which the Hearing Official (VA medical facility Director or designee) must receive the CRC Sponsor's request for a hearing. **NOTE:** *The date by which the Hearing Official must receive the request for a hearing must not be less than 10 calendar days and not more than 20 calendar days after the date of VA notice of non-compliance, unless the Hearing Official determines that non-compliance with the standards threatens the lives of residents, in which case the hearing official must receive the CRC Sponsor's request for an oral or paper hearing within 36 hours of receipt of the VA notice. Nothing in this directive prevents VA officials from assisting a Veteran who resides in a CRC facility in finding temporary lodging or an alternative placement, with permission from the Veteran or the authorized representative of the Veteran. NOTE: See 38 CFR 17.66(d) for more information about dates listed above.*

b. **Request for Hearing.** The CRC Sponsor may request a hearing per 38 CFR 17.67.

c. **Notice and Conduct of Hearing.**

(1) Upon receipt of a request for an oral hearing, the Hearing Official must notify the CRC Sponsor:

(a) In writing, of the date, time, and location of the hearing; and

(b) That written statements and other evidence for the record may be submitted to the Hearing Official before the date of the hearing. Oral hearings are to be informal and rules of evidence are not followed. Witnesses must testify under oath or affirmation. A recording or transcript of every hearing must be made at the expense of the jurisdictional VA medical facility. The Hearing Official may exclude irrelevant, immaterial, or unduly repetitious testimony.

(2) Upon receipt of a request for a paper hearing, the Hearing Official must notify the CRC Sponsor that written statements and other evidence must be submitted to the Hearing Official by a specified date to be considered as part of the record.

(3) In all hearings, the CRC Sponsor and VA may be represented by counsel.

NOTE: *See 38 CFR 17.68 for additional information.*

d. **Waiver of Opportunity for Hearing.** If representatives of a CRC Sponsor which were issued a notice of non-compliance fail to appear at an oral hearing of which they have been notified, or fail to submit written statements for a paper hearing (unless their failure to appear was due to circumstances beyond their control as determined by the Hearing Official), the Hearing Official must:

(1) Consider the representatives of the CRC Sponsor to have waived their opportunity for a hearing; and

(2) Revoke VA approval of the CRC facility and notify the CRC Sponsor of this revocation.

NOTE: See 38 CFR 17.69 for additional information.

e. **Written Decision Following a Hearing.**

(1) The Hearing Official must issue a written decision within 20 days of the completion of the hearing. An oral hearing is considered completed when the hearing ceases to receive in-person testimony. A paper hearing is considered complete on the day by which written statements must be submitted to the Hearing Official to be considered as part of the record.

(2) The Hearing Official's determination of a CRC facility's noncompliance with VA standards must be based on the preponderance of the evidence.

(3) The written decision must include:

(a) A statement of the facts; and

(b) A determination whether the CRC facility complies with the standards in the regulations found in 38 CFR 17.63.

(4) The written decision must include a determination of the time period the CRC facility has to remedy any noncompliance with VA standards before revocation of VA approval occurs.

(5) The Hearing Official's determination of any time period must consider the safety and health of the residents of the CRC facility and the length of time since the CRC facility received notice of the noncompliance.

NOTE: See 38 CFR 17.70 for additional information.

f. **Revocation of VA Approval.**

(1) If the Hearing Official determines that the CRC facility does not comply with the standards and that the CRC facility does not have further time to remedy the noncompliance, the Hearing Official must revoke approval of the CRC facility and notify the CRC facility of this revocation within 20 days of the completion of the hearing.

(2) Upon revocation of approval, VA health care personnel must:

(a) Cease referring Veterans to the CRC facility;

(b) In states that require licensing of the CRC, report revocations to the agency that grants and monitors the license by the next business day;

(c) For non-licensing states, report revocations to the appropriate state agency on aging, long term care, adult protective services, or mental health services by the next business day; and

(d) Notify any Veteran residing in the CRC facility of the facility's disapproval and request permission to assist in the Veteran's removal from the facility. **NOTE:** *If a Veteran has a person or entity authorized by law to give permission on behalf of the Veteran, VA health care personnel shall notify that person or entity of the CRC facility's disapproval and request permission to assist in removing the Veteran from the CRC facility.*

(3) If the Hearing Official determines that the CRC Sponsor is to be given additional time with which to remedy the noncompliance, the Hearing Official must establish a new date for review. If at the end of the time period, the CRC Sponsor still does not comply with these or any other standards, the Hearing Official must repeat the procedures in paragraph 13.f.(1) of this directive.

NOTE: *See 38 CFR 17.71 for additional information.*

14. FINANCIAL ARRANGEMENTS

a. Cost of Community Residential Care.

(1) CRC must provide the resident, at a minimum, a base level of care including:

(a) Room and board;

(b) Nutrition consisting of three meals per day and two snacks, or as required to meet special dietary needs;

(c) Laundry services;

(d) Transportation, either provided or arranged, for routine health care;

(e) 24-hour supervision, if indicated; and accompanying the resident to appointments if needed; and

(f) Care, and supervision and assistance with Activities of Daily Learning (ADL) and Instrumental Activities of Daily Learning (IADL). In those cases where the resident requires more than the base level of care, the medically appropriate level of care must be provided.

(2) Payment of the charges of a CRC facility for any care or service provided to a Veteran referred to that CRC facility under this paragraph is not the responsibility of the U.S. Government or VA, per 38 CFR 17.63.

(3) The cost of CRC must reflect the cost of providing the base level of care as defined above.

(4) The resident, or an authorized personal representative, and a representative of the CRC Sponsor must agree upon the charge and payment procedures for care. Any agreement between the resident or an authorized personal representative and the CRC

facility must be approved by the Approving Official. The agreement must be in writing and signed by both parties and a copy of the agreement must be provided to each party.

b. **Rates for Community Residential Care.** The CRC Program Coordinator must determine that the rates charged for CRC, as agreed to by the resident (or an authorized personal representative) and the CRC Sponsor, are reasonable and that increases in those rates comply with 38 CFR 17.63.

(1) The charges for care in the CRC facility must be reviewed annually, or as indicated, due to changes in care needs. This must be documented in the Veteran's medical record by the CRC Program Coordinator or CRC Case Manager.

(2) The charges for CRC must be reasonable and comparable to the current average rate for residential care in the state or region for the same level of care provided to the resident. Notwithstanding, any year-to-year increase in the charge for care in a CRC facility for the same level of care, the charges may not exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year. In establishing an individual resident rate, consideration must be given to the level of care required and the individual needs of the resident. The approving official may approve a rate:

(a) Lower than the current average rate for residential care in the state or region for the same level of care if the CRC facility and the resident or authorized personal representative agreed to such rate, provided such lower rate does not result in a lower level of care than the resident requires.

(b) Higher than the current average rate for residential care in the state or region for the same level of care if the CRC facility and the resident, or authorized personal representative, agreed to such rate, and the higher rate is related to the individual needs of the resident which exceed the base level of care as defined above. Examples of services which exceed the base level of care may include handling disbursement of funds solely at the request of the resident, fulfilling special dietary requests by the resident or family member, and bowel and bladder care.

(3) The approving official may approve a deviation from the requirements, if the resident chooses to pay more for care at a CRC facility which exceeds the base level of care as defined above notwithstanding the resident's needs.

(4) The CRC facility must provide a 30-day written notice to the Veteran if there is a change in the rate.

15. SELECTION, ENROLLMENT, AND FOLLOW-UP OF RESIDENTS

a. Selection of Potential Residents.

(1) Potential residents for CRC placement must meet the criteria found in paragraph 7.

(2) The CRC Program Coordinator will determine appropriateness of Veteran enrollment in the CRC Program. The CRC Program Coordinator will review the referral and Veteran assessment and decide for enrollment in the Program. Enrollment authority resides with the CRC Program.

(3) Potential residents for CRC placement must have or be eligible for sufficient resources to meet the cost of care and other incidental needs. **NOTE:** *VA Staff may assist the Veteran in accessing sufficient funds to pay the cost of residential care, e.g., utilizing the expedited pension claims process as it is available.*

(4) All potential residents must be medically and psychiatrically stable. They must not be a danger to themselves or others and need to demonstrate behavior that is acceptable for community living. The CRC Program Coordinator, or designee, determine a Veteran's stability for placement. Screening and evaluation of suicide risk must take place upon admission and must align with VA's Suicide Risk Identification process (VA Risk ID). This entails screening and appropriate clinical follow up after positive screening results. See

<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>.

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

NOTE: *If Veterans with complex medical conditions require more than basic residential care and can be managed in a VA approved CRC facility, the additional care may be provided through other VA and community programs, i.e., Home-Based Primary Care (HBPC), Spinal Cord Injury (SCI), or Mental Health Intensive Case Management (MHICM).*

b. Placement of Residents.

(1) The CRC Program Coordinator, or designee, in collaboration with the treatment team, assists the Veteran in the final selection of a CRC facility and assists in arranging for the placement.

(2) Pertinent health information must be shared with the CRC Sponsor, as a CRC Sponsor is considered an important component in the continuum of care services.

(3) The placement must be documented in the Veteran's medical record.

(4) Placements made from one VA medical facility into another VA medical facility's CRC Program must be accomplished by submission of the referral to the receiving VA medical facility's CRC Program Coordinator for evaluation and placement. The receiving CRC Program Coordinator must approve the referral prior to placement. If a Veteran is not accepted, the reasons must be communicated to the referring VA medical facility and clearly documented in the patients' medical record by the receiving CRC Coordinator. If a Veteran is placed but the placement is ultimately not suitable, and no alternate CRC placement is available, the referring VA medical facility must either re-admit the Veteran if medically indicated or assist the Veteran in finding an alternative placement. The receiving VA medical facility's CRC Program Coordinator

must be provided with the ability to screen and review the records of Veterans for potential placement in the CRC Program through Remote Data View or VistA web.

(5) Placement in VA-approved CRC facilities is designed to provide a safe and stable residence in the least restrictive home-like environment capable of meeting the Veteran's physical and psychological care needs. The VA medical facility of jurisdiction must help the Veteran with a readmission if medically indicated, specifically when a Veteran:

(a) Becomes ill or unstable or exhibits behavior unacceptable for community living;

(b) Makes direct or indirect threats to the CRC Sponsor, caregiver, or other residents in the CRC facility; or

(c) Becomes unable to maintain their safety independently. Screening and evaluation of suicide risk must align with VA's Risk ID process.

(6) All Veterans in the CRC Program who require hospitalization must be readmitted to the VA medical facility of jurisdiction, or the most appropriate alternative facility.

(7) VA CRC programs are encouraged to respond to special initiatives and Veterans with special needs. Examples include Veterans with traumatic brain injury (TBI), SCI, or other cognitive impairments. The need for specialized CRC facilities to address the ever increasing TBI population is especially important and supports CRC goals to provide care in the least restrictive environment possible while supporting a Veteran's move to independent living. Veterans with serious mental illnesses may benefit from CRC placement if they need a short-term residential placement designed to improve social skills. VA CRC programs are encouraged to expand the recovery-oriented residential options available for short and long term stays to meet the community living needs of a broad range of Veterans with special needs.

c. Follow-up.

(1) The CRC Program Coordinator or CRC Case Manager must ensure that each resident and CRC facility is visited at least monthly by a member of the VA health care team. Duties of the VA health care team member include: acting as a liaison between the Veteran, the CRC Sponsor, family or personal representative, and VHA; addressing psychosocial needs; monitoring CRC environment; providing care; and ensuring safety and continuity of care. There may be additional clinical situations, such as when a Veteran presents with a new behavioral health concern, where screening and evaluation of suicide risk are indicated. See

<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>.

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

(2) The Columbia Suicide Severity Rating Scale (C-SSRS) must be used to screen individuals in such cases. Those who screen positive on the C-SSRS receive the VA Comprehensive Suicide Risk Evaluation. Residents who have been assessed and have medical or psychiatric needs must be seen more frequently, as clinically indicated, or as

their care needs change. Other team members may visit the residents or CRC facilities as needed.

(3) Veterans in the CRC Program must be seen at least annually by a Primary Care Provider and be screened for any active communicable disease.

(4) All Veterans in the CRC Program who require hospitalization must be admitted to the VA medical facility of jurisdiction, or the most appropriate alternative facility.

(5) All follow-up visits to the Veteran in the CRC Program require documentation of visit and data entry into the Veteran's VA medical record by a member of the VA health care team, in accordance with local facility documentation requirements.

(6) CRC Sponsors must be provided instructions by a VA health care team member for Veteran care needs following a CRC Veteran's hospitalization or significant changes in treatment plan following a clinic visit. These discussions between VA health care team members and the CRC Sponsors are to be documented by a VA health care team member in the Veteran's medical record.

(7) The CRC Program Coordinator must meet at least annually with VBA Field and Fiduciary supervisors to discuss the placement and ongoing needs of Veterans in the CRC Program who have been determined to be incompetent to handle their financial affairs. These discussions must be documented by CRC Program Coordinator in accordance with local facility documentation requirements, and appropriate action taken. **NOTE:** *This is a joint requirement, as indicated by VBA Fiduciary Program Manual M21-1MR, XI.1.B.9.c, which states, each fiduciary activity supervisor should meet with the appropriate personnel from each VA medical facility in their jurisdiction at least once a year to discuss services to incompetent Veterans. These meetings may be conducted by meeting with the appropriate individuals separately or as a group.*

d. Discharge from the CRC Program.

(1) Veterans will be discharged from the CRC Program under the following conditions:

(a) Transfer to another level of care or independent living arrangement;

(b) Voluntary discharge which occurs when the Veteran no longer desires follow-up monitoring services by VA staff, or when the Veteran decides to move to a non-VA approved facility;

(c) Failure to comply with CRC rules, disruptive behavior or activities, or request by CRC Sponsor; or

(d) Death.

(2) The CRC Program Coordinator or CRC Case Manager must record in the Veteran's VA medical record the type of discharge and relevant information in accordance with local facility documentation requirements.

(3) Screening and evaluation of suicide risk must take place upon discharge and must align with VA's Risk ID process. This entails screening and appropriate clinical follow up after positive screening results. See

<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>

NOTE: This is an internal VA Web site that is not available to the public.

(4) A Veteran or guardian, referred to the CRC Program, may choose to remain in a non-VA approved CRC facility upon that facility's revocation from the CRC program. This choice must be documented in the Veteran's medical record by the CRC Program Coordinator or CRC Case Manager. A sample documentation template for a placement waiver is available on the National CRC SharePoint:

<http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/CRC>. **NOTE:** This is an internal VA

Web site that is not available to the public. Access is restricted to relevant employees.

Coordinators may wish to access this template for VA medical facility use.

16. COMMUNITY RESIDENTIAL CARE SPONSOR KNOWLEDGE, SKILL, AND EDUCATION

a. **Staffing Levels.** CRC Sponsors must ensure that sufficient, qualified staff are on duty and available to care for residents and provide for the health and safety of each resident at the CRC facility. A staff member who has completed courses in First Aid and cardiopulmonary resuscitation (CPR) and holds a currently valid card documenting completion of such courses must be in the CRC facility at all times.

b. **Community Residential Care Sponsor's Guide.** A CRC Sponsor's Guide must be developed by the CRC Program Coordinator and must be distributed to each CRC Sponsor. This Guide must be reviewed annually, updated as needed and reviewed with the CRC Sponsor annually. CRC staff must sign a statement and place it in VA's records that this review occurred. The CRC Sponsor's Guide must 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 CRC Sponsor's rights.

NOTE: The CRC Sponsor's Guide is available on the National CRC SharePoint: <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/CRC>. **NOTE:** This is an internal VA

Web site that is not available to the public. Access is restricted to relevant VA employees.

c. **Education for CRC Sponsors.** CRC Sponsors are required to attend CRC trainings at least twice annually in order to:

(1) Maintain the quality of skills acquired by the CRC Sponsor, and

(2) Provide updated information on local, Federal, and state CRC care and management. **NOTE:** *Additional training topics are provided in paragraph 22. Trainings may be held at the VA medical facility or in the community.*

d. **Consultations.** Consultative education by VA staff must be made available to CRC Sponsors, when necessary to educate on the specific clinical needs of a Veteran.

17. MONITORING COMPLIANCE WITH CONDITIONS OF PARTICIPATION IN PROGRAM

a. **Responsibility.** The VA medical facility must integrate the CRC Program into its Quality Management Program. Generally, this integration is the responsibility of the clinical area (service line or care line) leader with program oversight.

b. **Quality Management.** CRC Program monitoring must include:

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

(2) Veteran safety data such as:

(a) **Adverse Events.** Adverse events are untoward incidents, therapeutic accidents, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a VA medical facility, outpatient clinic, or other VA entities. Adverse events may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic interventions, adverse reactions or negative outcomes of treatment). Other examples include patient falls, adverse drug events, procedural errors or complications, completed suicides, self-injurious behaviors, and missing patient events.

(b) **Sentinel Events.** A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

c. **Reporting.**

(1) The CRC Program Coordinator of the VA medical facility of jurisdiction is required to report the following to GEC and copy the designated VISN liaison and VA medical facility Director, or designee, within 24 hours after being notified by the CRC facility of:

(a) All sentinel events;

(b) Adverse events which include: elopements for more than 24 hours; substantiated allegations of mistreatment, neglect, abuse, or misappropriation of resident property; fires; and loss of licensure;

(c) Any information regarding a CRC facility that appears in local or national media including television, newspapers or radio; and

(d) Closure or removal of Veterans from CRC facilities.

(2) The CRC Program Coordinator of the VA medical facility of jurisdiction must use the Adverse and Sentinel Event Reporting Form available on the National CRC SharePoint: <https://vaww.infoshare.va.gov/sites/geriatrics/HCBC/CRC/default.aspx>.

NOTE: *This is an internal VA Web site that is not available to the public. Access is restricted to relevant VA employees.* No individual identifiers, such as Veteran's name and Social Security Number, are to be used.

(3) **Results.** Results of monitoring activities must be used by local VA staff in suggesting program improvements and changes, and in making decisions regarding the continued approval of any CRC facility, including:

(a) Results from any Veteran or family satisfaction reports; and

(b) Any CRC-specific monitoring findings that may be established by the VA facility.

18. VA STAFFING GUIDANCE

The VA CRC Programs will be staffed in accordance with this directive. This guidance is mandatory and designed to foster awareness of the multiple variables inherent in effective management of CRC Programs and the level of staffing required to operate safely and successfully. Appropriate staffing levels prevent unnecessary sentinel and adverse events.

a. **Community Residential Care Program Coordinator.** In establishing appropriate full-time equivalent (FTE) employees for VA CRC Program operations, it is important to recognize that the CRC Program Coordinator and CRC Case Managers are separate positions with specific duties and therefore constitute separate FTE and must not be combined. The CRC Program Coordinator position requires full-time administrative effort, and must not be a collateral duty, nor will the CRC Program Coordinator manage other programs.

b. **Ratio of Residents: Case Manager.** In addition to the full time CRC Program Coordinator, the ratio of CRC residents to one VA FTE direct case manager who provides Veteran follow-up, will range from 20 to 50 depending on the factors listed below:

- (1) Turnover rate of residents;
- (2) Severity and complexity of residents' problems;
- (3) Geographic distance from the CRC to the VA medical facility of jurisdiction;
- (4) Number of Veterans per CRC facility;
- (5) Number of individual CRC facilities under supervision;
- (6) Number of referrals to the VA CRC Program;
- (7) Access to VA and non-VA services; and
- (8) Any special requirements of the VA CRC Program(s) providing follow up care to Veterans.

c. **Workload Assessment.** FTE positions will be based on the VA CRC Program needs, number of referrals, requirements, and potential growth rather than encounter equivalents which are not capable of capturing CRC staff workload. Considerations for workload demand include the CRC Program Coordinator's responsibility for CRC facility recruitment and oversight, initial and annual home inspections, community and CRC sponsor needs for education, and the distance traveled from the VA medical facility to CRC facilities. Use of an encounter workload design is insufficient to measure Veteran safety and program effectiveness; therefore, should not be the basis for staffing needs.

19. RELEASE OF PATIENT-SPECIFIC HEALTH INFORMATION

a. **Regulations.** CRC Program officials, CRC staff, and CRC Sponsors may release patient-specific health information in compliance with the following laws and regulations:

- (1) 5 U.S.C. 552, the Freedom of Information Act (FOIA).
- (2) 5 U.S.C. 552a, the Privacy Act.
- (3) 38 U.S.C. 1730, Community Residential Care.
- (4) 38 U.S.C. 5701, the VA Claims Confidentiality Statute.
- (5) 38 U.S.C. 7332, Confidentiality of Drug Abuse, Alcoholism and Alcohol Abuse, Human Immunodeficiency Virus (HIV) Infection, and Sickle Cell Anemia Medical Records.

(6) 38 U.S.C. 5705, Confidentiality of Healthcare Quality Assurance Review Records Privacy Rule, 45 CFR 160, 164, Health Information Portability and Accountability Act (HIPAA).

b. **VA Community Residential Care Staff.** VA CRC staff must consult with the VA medical facility's Privacy Officer and Release of Information Office when questions arise regarding how and what patient-specific health information may be released to CRC Sponsors. CRC Sponsors must be provided instructions for Veteran care needs by VA CRC staff.

c. **Business Associate Agreement.** CRC 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 CFR 164.502(e) (ii) (A).

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

20. DATA MANAGEMENT

CRC programs must ensure the integrity of data related to program staffing, workload, and cost. Several electronic information systems support CRC 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. 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 - Current Edition and Current Procedural Terminology Coding.** CRC staff must use current International Classification of Diseases (ICD) diagnostic codes for CRC patient diagnoses.

b. **Electronic Health Care Record Management System.** The Electronic Health Care Record Management System (EHRM), enables CRC team members to enter, review, and continuously update patient clinical information.

c. **Community Residential Care Workload Capture.** CRC clinics are developed to capture workload. Program workload is entered into a designated CRC clinic via encounters and reports Veteran visits in the same manner as outpatient clinics. Each CRC clinic will include a DSS identifier code of 121 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, 121/125 would identify CRC social work workload and 121/117 would represent nursing.

(1) Stop Code Number: 121.

(2) Secondary or Pair: Leave field empty.

(3) Primary, Secondary or Either: E.

(4) Stop Code Name: Community Residential Care.

(5) Definition: Records visit by VA professional/clinical staff [usually Registered Nurse (RN), Social Worker (SW), Case Manager (CM)] for assessment of a Veteran receiving Long Term Services and Supports (LTSS) residing in a VA approved Community Residential Care (CRC) home (includes Medical Foster Homes (MFH), Assisted Living, Personal Care Homes, Family Care Homes, and psychiatric CRC Homes). VA CRC staff makes referrals to the facilities in which the Veterans reside, but the Veteran pays for her/his own care. Use Stop Code 121 in the primary position unless combined with a telephone code (e.g. 326, Telephone Geriatrics).

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

e. **Decision Support System.** 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 Information Technology (IT) systems to provide reliable information relating costs to outputs and activities. At the local level, the MCA unit advises CRC program concerning identification of departments and products, labor mapping, and the interpretation of dashboard reports. The National MCA Office SharePoint Web site is: <http://vaww.dss.med.va.gov/index.asp>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

f. **VHA Support Service Center.** The VHA Support Service Center (VSSC) contains CRC 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 Web site that is not available to the public.*

g. **Labor Mapping.** Labor mapping is a collaborative process between local managers and DSS teams to ensure CRC staff positions are mapped to the appropriate DSS department. Labor mapping must be reviewed at minimum quarterly to ensure that it accurately reflects CRC staffing and the percentage of time each position is dedicated to the program. The DSS Account Level Budget Cost Center (ALBCC) and corresponding Intermediate Product Department (IPD) for CRC are 207TK*/5TK*, CRC and MFH where * represents a single character indicating the hospital division. See http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp for MCA Labor Mapping guidance. **NOTE:** *This is an internal VA Web site that is not available to the public.*

21. REPORTING SYSTEM

By the 25th calendar day of each new fiscal quarter (October, January, April and July), the CRC Program Coordinator must electronically submit the required CRC Quarterly Report. <http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/CRC>. **NOTE:**

This is an internal VA Web site that is not available to the public. The report is to be submitted to Geriatrics and Extended Care with a copy provided to the designated VISN liaison and VA medical facility Director or designee.

22. TRAINING

It is expected and required that CRC Sponsors will be provided appropriate education and training by the local VA medical facility to carry out the full range of their responsibilities, as described below.

a. **Knowledge and Skills.** To meet the needs of Veteran residents, CRC Sponsors must be trained in caring for the Veterans and attend two CRC Program Coordinator-led trainings per year. Training may include the following:

(1) Provision of personal care specific to ADL and IADL;

(2) Medication management;

(3) Suicide Risk Identification and Management strategies appropriate for non-providers. Located here:

<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>.

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

(4) Crisis management and re-hospitalization procedures;

(5) Provision of supportive and emotional care, including the concepts of recovery;

(6) Nutrition and proper food preparation, distribution, and storage;

(7) Activity and program planning;

(8) Fall Prevention;

(9) Applicable local VA medical facility standard operating procedures (SOPs);

(10) Protecting the resident's privacy and confidentiality;

(11) Local and state laws and ordinances; and

(12) Fire and safety procedures.

b. **Continuing Education.** The CRC Program Coordinator must provide ongoing training including diversity and ethics, training on personal boundaries, and conflict of interest for CRC Sponsors and staff. CRC Program Coordinator must document the training in the CRC facility file kept at the VA medical facility.

23. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

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

b. **Workload and Data Capture.** Workload and data capture must be completed for each encounter, in accordance with national and local facility documentation requirements.

c. **Record Keeping.** The CRC Program Coordinator must maintain a file on each CRC facility. The file must contain:

(1) VA Form 10-2407, Residential Care Home Program Sponsor Application (https://www.va.gov/vaforms/form_detail.asp?FormNo=2407). The individual VA CRC Program may request additional information at the time of application.

(2) Inspection reports in accordance with local facility documentation requirements.

(3) All correspondence relating to the facility.

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

(5) CRC Facility Records. See Appendix A.

24. REFERENCES

a. 5 U.S.C. 552.

b. 18 U.S.C. 11.

c. 38 U.S.C. 1730.

d. 38 U.S.C. 5701.

e. 38 U.S.C. 5705.

f. 38 U.S.C. 1710 B(b).

g. 38 U.S.C. 7301(b).

h. 38 U.S.C. 7332.

i. 5 CFR 2635.

j. 38 CFR 17 Regulation Identification Number (RIN) 2900-APO6.

- k. 38 CFR 17.61-17.74.
- l. 38 CFR 51.90(b)
- m. 45 CFR 160, 164.
- n. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- o. VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016.
- p. VHA Directive 1141.02(1) Medical Foster Home Program Procedures, dated August 9, 2017.
- q. VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated November 28, 2017.
- r. VHA Directive 1233, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census, dated June 14, 2017.
- s. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.
- t. VHA Handbook 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018.
- u. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT), dated February 5, 2014.
- v. VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care, dated February 8, 2011.
- w. VBA Fiduciary Program Manual M21-1MR, XI.1.B.9.c.
- x. DSS Program Documents Processing and Auditing Web site:
http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- y. National CRC SharePoint Web site:
<http://vaww.infoshare.va.gov/sites/geriatrics/HCBC/CRC>. **NOTE:** *This is an internal VA Web site that is not available to the public. Access is restricted to relevant VA employees.*
- z. National MCA Office SharePoint Web site: <http://vaww.dss.med.va.gov/index.asp>.
NOTE: *This is an internal VA Web site that is not available to the public.*
- aa. VA Form 10-2407, Residential Care Home Program, Sponsor Application:
https://www.va.gov/vaforms/form_detail.asp?FormNo=2407.

bb. VSSC Non-Institutionalized Care Web site:

<https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fNVA%2fNVARpts%2fUniques +NICReport&rs:command=Render>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

cc. National Fire Protection Association (NFPA) Code and Standards Web site:

<https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/List-of-Codes-and-Standards>. **NOTE:** *This Web Site is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

COMMUNITY RESIDENTIAL CARE STANDARDS THAT MUST BE INSPECTED

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

(1) Meet all Federal, state, and local requirements including construction, maintenance, and sanitation regulations and the requirements in applicable National Fire Protection Association (NFPA) 101 and NFPA 101A and the other publications referenced in those provisions. The Community Residential Care (CRC) facility must provide sufficient staff to assist patients in the event of fire or other emergency. Any equivalences or variances to the Department of Veterans Affairs (VA) requirements must be approved by the appropriate Veterans Health Administration (VHA) Veterans Integrated Service Network (VISN) Director.

(2) Have safe and functioning systems for: heating and cooling as needed (a heating or cooling system is required if VA determines that, in the county, parish or similar jurisdiction where the facility is located, a majority of CRC facilities or extended care facilities have one), hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation.

(3) The CRC facility meets the following additional requirements if the provisions for “One- or Two-Family Dwellings,” as defined in NFPA 101, are applicable to the facility:

(a) Portable fire extinguishers must be installed, inspected, and maintained in accordance with NFPA 10.

(b) The facility must meet the requirements in section 33.7 of NFPA 101.

b. **Interior Plan.** The CRC facility must:

(1) Have comfortable dining areas, adequate in size for the number of residents;

(2) Have comfortable living room areas, adequate in size to accommodate a reasonable proportion of residents;

(3) Promote a therapeutic, recovery-oriented environment and interior design, with ease of mobility and noise control; and

(4) Maintain at least one functional toilet and lavatory, and bathing or shower facility for every six people living in the facility. New facilities or existing facilities that are expanding services must maintain at least one functional toilet and lavatory, and bathing or shower facility for every four people living at the facility. The bathrooms should have appropriate locks for privacy and safety.

c. **Laundry Service.** The CRC facility must provide or arrange for laundry service.

d. **Resident Bedrooms.**

(1) Facilities approved before August 24, 2017 may not establish any new resident bedrooms with more than two beds per room.

(2) Facilities approved after August 24, 2017 may not provide resident bedrooms containing more than two beds per room.

(3) Bedrooms must measure, exclusive of closet space, at least 100 square feet for a single-resident room and 80 square feet for each resident in a multi-resident room.

NOTE: *The complex nature of certain Veterans' condition or status may dictate the need for single occupancy in a bedroom.*

(4) Bedrooms must contain, at a minimum, a suitable bed and furnishings.

e. **Nutrition.** The CRC facility must:

(1) Provide a safe and sanitary food service that meets individual nutritional requirements and residents' preferences; and

(2) Plan menus to meet currently recommended dietary allowances for residents.

f. **Activities.** The facility must plan and facilitate appropriate recreational and leisure activities to meet individual needs.

g. **Health Services.** The CRC facility is strongly advised to assist residents in obtaining health services in accordance with instructions given by the health care provider. Veterans residing in CRC facilities may receive follow-up services through VA medical facility programs, such as Primary Care, Geriatrics, Mental Health Intensive Case Management (MHICM), Mental Health Services, Home-Based Primary Care (HBPC) for Veterans requiring in-home care, and other clinics as indicated.

h. **Dental Services.** The CRC facility is advised to assist residents in obtaining routine and emergency dental care to meet the needs of the resident according to VHA dental eligibility policy.

i. **Resident Rights.** The CRC Sponsor must have written policies and procedures that ensure and inform each resident of the following rights:

(1) **General.** All residents have the right to:

(a) Be treated with respect, dignity, and consideration;

(b) The confidentiality and non-disclosure of records and information on the residents obtained or kept by the CRC facility's staff, except in accordance with the requirements of applicable law;

(c) Review the resident's own records kept by the CRC facility as well as CRC policies;

(d) Exercise rights as a citizen; and

(e) Voice grievances and make recommendations concerning policies and procedures of the CRC facility.

(2) **Financial Affairs.** Residents must be allowed to manage their own personal financial affairs except when restricted in this right by law. If the resident requests assistance in managing personal financial affairs, the request must be documented.

(3) **Privacy.** Residents must be allowed privacy, including:

(a) Have access, in reasonable privacy, to a telephone within the facility;

(b) Ability to send and receive unopened and uncensored mail. Mail must be sorted and delivered unopened and uncensored; and

(c) Privacy of self and possessions.

(4) **Work.** No resident is to perform household duties, other than personal housekeeping tasks, unless the resident receives compensation for these duties, or is told in advance they are voluntary, and the Veteran agrees, without coercion, to do them.

(5) **Freedom of Association.**

(a) Residents may receive visitors and associate freely with persons and groups of their own choosing both within and outside of the home subject to any rules set forth in an agreement between the resident and the CRC Sponsor. Residents may make contacts in the community and achieve the highest level of independence, autonomy, and interaction in the community of which the resident is capable.

(b) Residents may leave and return freely to the CRC facility subject to any rules set forth in an agreement between the resident and the CRC Sponsor.

(c) Residents may practice the religion of their own choosing or choose to abstain from religious practice. **NOTE:** See title 38 Code of Federal Regulation (CFR) 17.63(h)(5) for additional information.

(6) **Transfer or Withdraw.** A resident has the right to request a transfer to another CRC facility or to withdraw from the CRC Program.

(7) **CRC Facility Rules.** In order to provide a safe environment for all residents and staff, residents are expected to respect other residents and staff and to follow the facility's rules. CRC Sponsors may establish reasonable rules and guidelines for residents as a condition for continued residency in a CRC facility. The purpose of these rules and guidelines is to ensure a safe and inviting environment for both residents and staff. CRC home 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.

j. **Community Residential Care Facility Records.** CRC facility records must be made available upon request of the VA approving official and include the following:

(1) CRC facility policies;

(2) Emergency notification procedures; and

(3) CRC employees, which include:

(a) Non-VA health care providers at the CRC facility;

(b) Staff members of the CRC facility who are not a health care provider, including contractors; and

(c) Any person with direct resident access. The term “person with direct resident access” means an individual living in the facility who is not receiving services from the facility, who may have access to a resident or a resident's property, or may have one-on-one contact with a resident.

k. **Community Residential Care Resident Records.** The CRC facility's records on residents must include the following information:

(1) The agreement between the CRC and the resident;

(2) Instructions given by the VA health care team;

(3) Emergency contact information; and

(4) A copy of all signed agreements with the resident or the resident's fiduciary.

NOTE: Resident records may be disclosed only with the permission of the resident; an authorized agent, fiduciary, or personal representative if the resident is not competent; or when required by law.

l. **Community Residential Care Staff Requirements.**

(1) Sufficient, qualified staff must be on duty and available to care for the resident and ensure the health and safety of each resident. A staff member who has completed courses in First Aid and CPR and holds a currently valid card documenting completion of such courses must be in the CRC facility at all times. Documentation of attendance at First Aid or CPR course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Heart Association, or National Safety Council; or a provider approved by the state or jurisdictional department of health, will satisfy this requirement.

(2) The CRC Sponsor and staff must have the following qualifications: adequate education, training, or experience to maintain the facility.

(a) The CRC Sponsor and staff must follow state guidelines with regards to active communicable disease testing.

(b) When CRC Sponsors have positive results to communicable disease tests, CRC Sponsors must follow up with their physician.

(3) The community residential care sponsor must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(4) Except as provided in this appendix, the CRC Sponsor must not employ individuals who:

(a) Have been convicted within 7 years by a court of law of any of the following offenses or their equivalent in a state or territory:

1. Murder, attempted murder, or manslaughter;
2. Arson;
3. Assault, battery, assault and battery, assault with a dangerous weapon, mayhem or threats to do bodily harm;
4. Burglary;
5. Robbery.
6. Kidnapping;
7. Theft, fraud, forgery, extortion or blackmail;
8. Illegal use or possession of a firearm;
9. Rape, sexual assault, sexual battery, or sexual abuse;
10. Child or elder abuse, or cruelty to children or elders; or
11. Unlawful distribution or possession with intent to distribute a controlled substance.

(b) Have had a finding entered within 6 months into an applicable state registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of property.

(5) If the conviction by a court of law of a crime enumerated in paragraph k.(4)(a) of this section occurred greater than 7 years in the past, or a finding was entered into an

applicable state registry as specified in paragraph k.(11) of this section more than 6 months in the past, the community residential care provider must perform an individual assessment of the applicant or employee to determine suitability for employment. The individual assessment must include consideration of the following factors:

- (a) The nature of the job held or sought;
- (b) The nature and gravity of the offense or offenses;
- (c) The time that has passed since the conviction and/or completion of the sentence;
- (d) The facts or circumstances surrounding the offense or conduct;
- (e) The number of offenses for which the individual was convicted;
- (f) The employee or applicant's age at the time of conviction, or release from prison;
- (g) The nexus between the criminal conduct of the person and the job duties of the position;
- (h) Evidence that the individual performed the same type of work, post-conviction, with the same or a different employer, with no known incidents of criminal conduct;
- (i) The length and consistency of employment history before and after the offense or conduct; rehabilitation efforts, including education or training; and
- (j) Employment or character references and any other information regarding fitness for the particular position.

NOTE: *An individual assessment must be performed to determine suitability for employment for any conviction defined in paragraph k.(11), regardless of the age of the conviction.*

(6) The community residential care provider must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported to the approving official immediately, which means no more than 24 hours after the provider becomes aware of the alleged violation; and to other officials in accordance with state law. The report, at a minimum, must include:

- (a) The facility name, address, telephone number, and owner;
- (b) The date and time of the alleged violation;
- (c) A summary of the alleged violation;
- (d) The name of any public or private officials or VHA program offices that have been notified of the alleged violations, if any;

(e) Whether additional investigation is necessary to provide VHA with more information about the alleged violation;

(f) The name of the alleged victim;

(g) Contact information for the resident's next of kin or other designated family member, agent, personal representative, or fiduciary; and

(h) Contact information for a person who can provide additional details at the community residential care provider, including a name, position, location, and phone number.

(7) The community residential care provider must notify the resident's next of kin, caregiver, other designated family member, agent, personal representative, or fiduciary of the alleged incident concurrently with submission of the incident report to the approving official.

(8) The community residential care provider must have evidence that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are documented and thoroughly investigated, and must prevent further abuse while the investigation is in progress. The results of all investigations must be reported to the approving official within 5 working days of the incident and to other officials in accordance with all other applicable law, and appropriate corrective action must be taken if the alleged violation is verified. Any corrective action taken by the community residential care provider as a result of such investigation must be reported to the approving official, and to other officials as required under all other applicable law.

(9) The community residential care provider must remove all duties requiring direct resident contact with Veteran residents from any employee alleged to have violated this paragraph (k) during the investigation of such employee.

(10) For purposes of this paragraph (k), the term "employee" includes:

(a) Non-VA health care provider at the community residential care facility;

(b) Staff member of the community residential care facility who is not a health care provider, including a contractor; and

(c) Person with direct resident access. The term "person with direct resident access" means an individual living in the facility who is not receiving services from the facility, who may have access to a resident or a resident's property, or may have one-on-one contact with a resident.

(11) For purposes of this paragraph (k), an employee is considered "convicted" of a criminal offense:

(a) When a judgment of conviction has been entered against the individual by a Federal, state, or local court, regardless of whether there is an appeal pending.

(b) When there has been a finding of guilt against the individual by a Federal, state, or local court.

(c) When a plea of guilty or nolo contendere by the individual has been accepted by a Federal, state, or local court.

(d) When the individual has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(12) For purposes of this paragraph (k), the terms “abuse” and “neglect” have the same meaning set forth in 38 CFR 51.90(b).