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

1. SUMMARY OF MAJOR CHANGES: This directive:

a. Removes the requirement for the Home-Based Primary Care (HBPC) Program Director to create HBPC Standard Operating Procedures (SOP) or a manual. ***NOTE:*** *HBPC Program documentation is still required; however, the requirement that documentation be formatted as an SOP or manual has been removed to allow for flexibility in implementation.*

b. Adds responsibilities in paragraph 2 for the Executive Director, Geriatrics and Extended Care; HBPC Patient Aligned Care Team (PACT) Physician; HBPC PACT Care Manager; Veterans Integrated Services Network (VISN) Director; and VISN Rehabilitation and Extended Care Integrated Clinical Community Leader.

c. Updates responsibilities in paragraph 2 for the Department of Veterans Affairs (VA) medical facility Director, HBPC Program Director, HBPC Program Assistant Director, HBPC Medical Director, HBPC Team Physician, HBPC PACT Advanced Practice Provider, HBPC PACT Clinical Social Worker, HBPC PACT Registered Dietitian Nutritionist, HBPC PACT Mental Health Professional, HBPC PACT Rehabilitation Therapist and HBPC PACT Clinical Pharmacist Practitioner.

d. Removes monitoring of Advanced Practice Provider practice from VA medical facility HBPC PACT Physician responsibilities in paragraph 2.

e. Designates required HBPC PACT members and outlines interdisciplinary team duties in paragraph 3.

f. Defines Rural-Focus HBPC Programs, outlines staffing allowances and states additional requirements for Rural-Focus HBPC Programs to obtain VA HBPC Program recognition in paragraph 4.

g. Updates Appendices A-D; removes the appendix regarding research, surveys and HBPC data management which is now available on the HBPC Program SharePoint website at: https://dvagov.sharepoint.com/sites/vhafocus-areas/HBPC. ***NOTE:*** *This is an internal VA website that is not available to the public.*

2. RELATED ISSUES: VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022; VHA Directive 1140.04, Geriatric Evaluation, dated October 25, 2022; VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated March 23, 2021; VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017; VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 09, 2020; VHA Directive 1160.01, Uniform Mental Health

Services in VHA Medical Points of Service, dated April 27, 2023; VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 05, 2014; and VHA Handbook 1140.6, Purchased Home Health Care Services Procedures, dated July 21, 2006.

3. POLICY OWNER: The Office of Geriatrics and Extended Care (GEC) (12GEC) is responsible for the content of this directive. Questions may be addressed to VHA GEC HCBPC at VHAGECHCBPC@va.gov.

4. RESCISSIONS: VHA Directive 1411(1), Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017, is rescinded.

5. RECERTIFICATION: This Veterans Health Administration (VHA) directive is scheduled for recertification on or before the last working day of December 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. LOCAL DOCUMENT REQUIREMENT: There are no local document creation requirements in this directive.

7. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

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

/s/ M. Christopher Saslo
DNS, ARNP-BC, FAANP
Assistant Under Secretary for Health
for Patient Care Services/CNO

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

DISTRIBUTION: Emailed to the VHA Publications Distribution List on December 29, 2023.

CONTENTS

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

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

1. POLICY

It is Veterans Health Administration (VHA) policy that Home-Based Primary Care (HBPC) Special Population Patient Aligned Care Teams (PACTs) serve eligible Veterans by identifying appropriate target populations, providing continuity and quality of care across settings, integrating HBPC with community care, expanding access to HBPC Programs in rural communities, integrating telehealth into HBPC Program services, meeting care needs of the Veteran through the end of life, incorporating home care into medical and clinical education and following and participating in evidence-based research. **AUTHORITY:** 38 U.S.C. §§ 1703, 1717, 1720C and 1720G; 38 C.F.R § 17.38(a)(1)(ix). ***NOTE:*** *For the purposes of this directive, the term caregiver includes individuals other than family caregivers, but does not imply that the individual is eligible for the Caregiver Support Program authorized by 38 U.S.C. § 1720G and in 38 C.F.R. part 71. Caregiver services authorized by that program are outside the scope of this directive.*

2. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for supporting the Office of Geriatrics and Extended Care (GEC) with implementation and oversight of this directive.

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

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

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all Department of Veterans Affairs (VA) medical facilities within that VISN.

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

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

(1) Ensuring VISN and VA medical facility compliance with this directive through appropriate monitoring activities and ensuring that corrective action is taken when non-compliance is identified.

(2) Overseeing continuous quality assessment of VA medical facility HBPC Programs including program structure, care processes and Veteran outcomes.

(3) Tracking access to HBPC Programs using available VHA data, including but not limited to clinical consults, to ensure fair and equitable access to GEC programs and services.

(4) Allocating dedicated resources for HBPC Program enterprise-wide analytics, quality improvement and research initiatives.

(5) Coordinating with VHA Support Service Center and other data reporting programs and dashboards utilized by VHA to obtain HBPC Program reports and disseminating these reports to the VISN Rehabilitation and Extended Care Integrated Clinical Community (REC ICC) Leader for dissemination within the VISN. ***NOTE:*** *HBPC Program reports include, but are not limited to, patient complexity, the number of Veterans receiving care from each HBPC Program, quality and outcomes, cost and Veteran experience and satisfaction.*

(6) Reviewing VA medical facility HBPC Program applications for formal recognition and providing a recognition letter to the VA medical facility Director when a HBPC Program is approved for formal recognition. For further details regarding the recognition process, see Appendix B.

(7) Requesting and reviewing HBPC Program action plans from VA medical facility HBPC Program Directors or VA medical facility HBPC Medical Directors when HBPC Program deficiencies are identified and notifying Austin Information Technology Center when a HBPC Program has VA HBPC Program recognition revoked. See Appendix B for additional information.

(8) Administering the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) to Veterans who received care in HBPC. Additional information on HHCAHPS is available at: https://homehealthcahps.org.

(9) Reviewing and approving HBPC PACT Program waivers submitted by the VA medical facility Director in alignment with VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023. See paragraph 8 in Appendix C for additional information on HBPC Program waiver requests.

e. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

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

(2) Communicating national HBPC Program policies, guidance and other HBPC-related information to VA medical facilities within the VISN, as shared by the Assistant Under Secretary for Health for Operations. ***NOTE:*** *The following VHA policies contain information pertaining to HBPC Programs: VHA Directive 1108.07, General Pharmacy*

Service Requirements, dated November 28, 2022; VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017; VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated March 23, 2021; VHA Directive 1140.04, Geriatric Evaluation, dated October 25, 2022; VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 9, 2020; VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023; VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014; and VHA Handbook 1140.6, Purchased Home Health Care Services Procedures, dated July 21, 2006.

(3) Ensuring that all VA medical facilities within the VISN comply with Managerial Cost Accounting Office (MCAO) HBPC guidance on labor mapping requirements, available at: http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

f. **Veterans Integrated Services Network Rehabilitation and Extended Care Integrated Clinical Community Leader.** The VISN REC ICC Leader is responsible for:

(1) Collaborating with VISN and VA medical facility ICC leadership to spread HBPC Program best practices, facilitate quality improvement and support internal and external research and educational activities.

(2) Ensuring that leaders and points of contact for HBPC Programs within the VISN are informed of, or participate in, national, VISN and VA medical facility geriatric program activities, including those that are functionally located in non-GEC reporting structures.

(3) Disseminating HBPC Program reports received from the Executive Director, GEC, as appropriate, to VA medical facilities within their VISN. HBPC Program reports include, but are not limited to, patient complexity, the number of Veterans receiving care from each HBPC Program, quality and outcomes, cost and Veteran experience and satisfaction.

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

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(2) Submitting applications for HBPC Program recognition to the GEC program office and notifying the current accrediting organization of newly recognized HBPC Programs within the VA medical facility as required by accreditation standards. See Appendix B for additional information on the application and recognition process for HBPC Programs.

(3) Ensuring the VA medical facility HBPC Program Director and HBPC Medical Director develop procedures for implementing the HBPC Program and that the HBPC Program is integrated into VA medical facility procedures when appropriate. For details regarding local procedures, see paragraph 1 in Appendix C.

(4) Ensuring the HBPC program has infrastructure supports, including adequate space, supplies, access to government vehicles, communication and information technology.

(5) Tracking and monitoring HBPC Program workload, staffing and productivity based on information provided by the HBPC Program Director.

(6) Ensuring that in-home oversight visits conducted for HBPC Program staff are completed as required by accreditation standards and that the HBPC Program Director communicates accreditation standards to clinical supervisors completing the in-home oversight visit. ***NOTE:*** *In-home oversight visits must be conducted by the relevant clinical supervisor, in accordance with accreditation standards. For additional information on in-home oversight visits, see Appendix B. Results from in-home oversight visits must be communicated to the HBPC Program Director.*

(7) Initiating waiver requests on behalf of the VA medical facility HBPC Program Director and acting as the waiver sponsor or requestor. The VA medical facility Director must submit waiver requests to the Executive Director, GEC, in alignment with VHA Notice 2023-02. See Appendix C for additional information on HBPC Program waivers.

h. **VA Medical Facility Associate Chief of Staff for Geriatrics and Extended Care.** ***NOTE:*** *GEC recommends that VA medical facility HBPC Programs be aligned under the Associate Chief of Staff for GEC (ACOS/GEC) or Chief, GEC for optimal program management. If such alignment does not exist at the VA medical facility, the HBPC Program can function under any service or product line under the VA medical facility leadership team (e.g., Quadrad, Pentad)*. The VA medical facility ACOS/GEC or Chief, GEC, or equivalent, is responsible for:

(1) Overseeing the HBPC Program at the VA medical facility.

(2) Ensuring collaboration between centralized, discipline-specific VA medical facility Service Chiefs, HBPC Program Director and HBPC Medical Director to provide clinical oversight and competency of HBPC PACT members within the service line.

(3) Overseeing and approving service agreements between the HBPC Program and VA medical facility service lines, when necessary. See Appendix C for additional information on service agreements.

(4) Collaborating with VA medical facility service and product line leadership to include but not limited to credentialing, privileging, scope and competencies.

i. **VA Medical Facility Home-Based Primary Care Program Director.** ***NOTE:*** *The VA medical facility HBPC Program Director is a title 38 or title 38 hybrid clinician represented in the HBPC PACT who is designated by the VA medical facility Director and reports directly to the VA medical facility ACOS/GEC or equivalent; see paragraph 1 in Appendix C for details regarding HBPC Program organization*. *This role may also*

be locally titled as the HBPC Program Coordinator or Program Manager. The VA medical facility HBPC Program Director is responsible for:

(1) Managing the HBPC Program across all assigned sites of care. Management functions include, but are not limited to planning, budgeting and, evaluating and tracking the HBPC Program to ensure program standards are met and developing VA and community relationships*. **NOTE:** The HBPC Program Director must communicate HBPC Program standards to HBPC Program staff as appropriate. For specific HBPC Program standards, see Appendix B*.

(2) Ensuring that the HBPC Program is provided administrative support by a medical support assistant, program support assistant, administrative officer, secretary or other administrative personnel, appropriate to the needs of the HBPC Program.

(3) Acquiring and managing HBPC Program resources by identifying required resources and effective resource management to support HBPC Program goals and objectives. This includes, but is not limited to:

(a) Accurate determination of the HBPC Program's limits of capacity, such as monitoring of staffing, referrals, admissions, discharges, caseloads and accurate workload reporting.

(b) Coordination and utilization of VA and community care services in HBPC.

(c) Accurate monitoring of Veteran outcome measures, including utilization of health resources (e.g., emergency care, outpatient care and hospitalizations).

(d) Ensuring all HBPC PACT members have accurate mapping of time devoted to clinical, administrative, educational and research activities to meet MCAO guidance on labor mapping requirements. Additional guidance on labor mapping is available at: 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) Evaluating and communicating infrastructure support needs, including but not limited to adequate space, supplies, access to government vehicles, communication and information technology to the VA medical facility Director.

(4) Directing the clinical services offered by the HBPC Program to ensure compliance with local and national VHA standards and policies related to HBPC and relevant accreditation standards for home care organizations. ***NOTE:*** *For additional information pertaining to HBPC Program application and accreditation processes see paragraph 1 in Appendix B. For a list of relevant VHA policies, see paragraph 2.e.(2).*

(5) Collaborating with other HBPC Program Directors, VISN leadership and national home- and community-based care leaders (e.g., the National HBPC Program Manager, the National HBPC Quality Program Manager) on HBPC Program development, operation and innovative expansion and when available, a PACT High-Risk Committee. ***NOTE:*** *The PACT High-Risk Roadmap can be accessed at:*

https://vaww.va.gov/PRIMARYCARE/components/Welcome_to_the_PACT_Roadmap.asp. This is an internal VA website that is not available to the public. *When opportunities for HBPC Program innovative expansion arise, the HBPC Program Director must adhere to the waiver request process outlined in VHA Notice 2023-02 and work with the VA medical facility Director to request a waiver as outlined in paragraph 2.g. See paragraph 8 in Appendix C for additional information on HBPC Program waivers.*

(6) Communicating VHA policies and HBPC Program guidance to the HBPC PACT staff, VA medical facility leaders and staff, and community care entities. ***NOTE:*** *For a list of related VHA policies, see note under paragraph 2.e.(2).*

(7) Collaborating with the VA medical facility HBPC Medical Director to:

(a) Develop a performance improvement process in conjunction with the VA medical facility's overall performance improvement plan initiatives and sharing results from performance activities with the VA medical facility through established reporting communication lines. This includes completing an annual review as required by the accrediting agency and participating in continuous performance improvement activities. ***NOTE:*** *Results obtained from HHCAHPS must be incorporated into HBPC Program performance improvement plans. For additional guidance on evaluation methods and performance improvement activities, see Appendix D.*

(b) Develop a HBPC Program-specific incident reporting process in conjunction with the VA medical facility's overall incident and near-miss reporting requirements.

(c) Write and submit HBPC Program action plans to the Executive Director, GEC, as requested. ***NOTE:*** *Action plans must include target dates and deadlines to address HBPC Program deficiencies identified by the Executive Director, GEC during HBPC Program reviews*.

(d) Ensure the VA medical facility Medical Foster Home (MFH) Coordinator is included as an active HBPC PACT member and is included in all HBPC PACT meetings. ***NOTE:*** *The MFH Coordinator is not a required member of the HBPC PACT, however, this collaboration is necessary to ensure that Veterans with the most significant need are being admitted to the program best equipped to meet the needs of the Veteran.*

(e) Manage human resources for the HBPC Program. This includes but is not limited to selecting qualified clinical and administrative staff, orienting and mentoring HBPC Program staff, evaluating staff performance, coordinating training and educational programs for the HBPC PACT to promote professional growth and ensure competency and developing and maintaining a staffing plan for temporary shortages (e.g., extended leave, position turnover). ***NOTE:*** *See paragraph 3 for required HBPC PACT members. For HBPC Program caseload recommendations and staffing guidance, see Appendix A.*

(f) Provide clinical oversight and ensure competency of HBPC PACT members in conjunction with the centralized, discipline-specific Service Chiefs or HBPC PACT members within the service line at the VA medical facility.

(g) Develop, approve and implement local HBPC Program procedures to operationalize this directive and hospital procedures, with input as indicated from interdisciplinary service line managers or Service Chiefs. ***NOTE:*** *For additional information on local HBPC Program procedures, see paragraph 1 in Appendix C.*

(h) Determine the need for, and establish, satellite HBPC Programs as an extension of the primary HBPC Program, as necessary. ***NOTE:*** *HBPC Programs providing satellite services must remain under the oversight of, report to and adhere to the procedures of the primary HBPC Program. See paragraph 7.d. for additional information on expanded HBPC Programs.*

(i) Advocate for HBPC with VA medical facility leadership and the medical community.

(8) Processing, assigning for review and monitoring Veteran consults to the HBPC Program to ensure efficient access and care coordination. ***NOTE:*** *For additional information on HBPC Program consult management, see paragraph 3 in Appendix C.*

(9) Collaborating with data and technology departments to ensure accurate HBPC Program clinical, administrative and workload data. ***NOTE:*** *The HBPC Program Director must communicate staffing and workload data to the VA medical facility Director for appropriate tracking and monitoring.*

(10) Assuring all HBPC Program PACT members are appropriately assigned in the Primary Care Management Module.

(11) Writing and submitting proposals for VA HBPC Program formal recognition through VA medical facility and VISN leadership to the Executive Director, GEC and maintaining compliance with VA HBPC Program recognition standards. ***NOTE:*** *For guidance on the HBPC Program formal recognition process and ongoing program standards, see Appendix B.*

(12) Collaborating with the Chief, VA medical facility Financial Service to create and provide accurate program cost data reports.

(13) Comparing HBPC Program data to national data to determine whether caseloads below the identified range are necessary to maintain excellent patient and staff outcomes. Factors that must be considered during this data comparison are in Appendix A.

j. **VA Medical Facility Home-Based Primary Care Assistant Director.** ***NOTE:*** *The VA medical facility HBPC Assistant Director is a title 38 or title 38 hybrid clinician represented in the HBPC PACT roles stated in paragraph 3 of this directive. The HBPC Program Assistant Director reports to the HBPC Program Director and is required for HBPC Programs operating at multiple VA outpatient clinic locations in addition to the main VA medical facility, or those that have an average daily census exceeding 300 Veterans. For additional information regarding staffing recommendations, see Appendix A.* The VA medical facility HBPC Program Assistant Director is responsible for

assisting the HBPC Program Director in any of their assigned responsibilities and supervising HBPC Program staff, as necessary.

k. **VA Medical Facility Home-Based Primary Care Medical Director.** ***NOTE:*** *The VA medical facility HBPC Medical Director is an appropriately credentialed and privileged physician who is responsible for the overall care delivered by the HBPC PACT and reports directly to the ACOS/GEC or equivalent as outlined in paragraph 2.i. In VA medical facilities with academic affiliations, the HBPC Medical Director is encouraged to have a faculty appointment and be involved in academic activities. When sites have not been successful in recruiting a physician to act as HBPC Medical Director due to circumstances such as rural location, a Certified Nurse Practitioner or Physician Assistant may be authorized by waiver after review with GEC program office, as outlined in VHA Notice 2023-02.* The VA medical facility HBPC Medical Director is responsible for:

(1) Collaborating with the VA medical facility HBPC Program Director on HBPC Program management responsibilities outlined in paragraph 2.i.(7).

(2) Planning and directing the educational and clinical experience of health professions trainees (HPTs) assigned to the HBPC Program; See VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019; VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015; VHA Handbook 1400.07, Education of Advanced Fellows, dated February 26, 2016; VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016; and VHA Directive 1400.09(1) Education of Physicians and Dentists, dated September 9, 2016, for additional information.

(3) Being readily accessible and promptly responsive to calls from HBPC PACT members with urgent need for consultation, physician orders or as requested by the Veteran.

(4) Overseeing care planning for all Veterans enrolled in the HBPC Program by either actively participating in HBPC Program team meetings or delegating an HBPC PACT Physician to participate at team meetings.

(5) Communicating medical care advances and practice standards to the HBPC PACT.

(6) Arranging physician coverage as needed and communicating the plan of coverage to the HBPC PACT. ***NOTE:*** *The VA medical facility HBPC Medical Director must be available to act as back-up for HBPC PACT primary care providers and make home visits when needed or when the designated HBPC PACT primary care providers are unavailable.*

(7) Collaborating with other HBPC Medical Directors, VISN leadership and VHA Central Office staff members on program development issues.

l. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Physician/Deputy Medical Director.** The HBPC PACT Physician is a required position for HBPC Programs operating at multiple VA outpatient clinic locations in addition to the main VA medical facility with an average daily census exceeding 300 Veterans. The HBPC PACT Physician may also serve as the HBPC PACT Deputy Medical Director. For additional information regarding staffing recommendations, see Appendix A. In addition to the HBPC PACT team responsibilities outlined in paragraph 3, the VA medical facility HBPC PACT Physician is responsible for:

(1) Assuming overall medical responsibility for their assigned panel of HBPC Program Veterans.

(2) Supporting the HBPC Medical Director and serving as the Primary Care Provider (PCP) or as a collaborative physician with APPs when required; see Appendix B for additional information on HBPC Program and provider care models.

m. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Care Manager.** The VA medical facility HBPC PACT Care Manager must be a registered nurse (RN). HPBC PACTs serving less than 35 Veterans are not required to have a HBPC PACT Care Manager position in addition to a HBPC PACT PCP. The VA medical facility HBPC PACT Care Manager, in addition to the HBPC PACT team responsibilities outlined in paragraph 3, is responsible for:

(1) Delivering direct nursing care in the home to HBPC-enrolled Veterans.

(2) Providing intensive care management by developing and coordinating the HBPC-enrolled Veteran's care plan, including ongoing assessment and re-assessment, care planning, care coordination, monitoring and evaluating clinical outcomes. All required HBPC Program assessments must be scheduled to be completed before the initial care plan meeting, no later than 30 days from the HBPC Program admission date. ***NOTE:*** *For additional information on HBPC Program operation processes, see Appendix C.*

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

(4) Providing individualized education and support to include self-care and self-management of chronic conditions for the Veteran and caregiver to optimize clinical outcomes and support quality of life decisions.

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

(6) Coordinating resources to avoid duplication of services and streamline staff interaction and services with the Veteran.

n. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Advanced Practice Provider.** The VA medical facility HBPC PACT Advanced Practice

Provider (APP), in addition to the HBPC PACT team responsibilities outlined in paragraph 3, must partake in care management, clinical procedures and tasks as needed. Care management, clinical procedures and additional tasks required of the VA medical facility HBPC PACT APP depend on the HBPC Program care model used; see paragraph 2 in Appendix B. The VA medical facility HBPC PACT APP is also responsible for:

(1) Assuming primary medical responsibility for assigned Veterans.

(2) Delivering care in the home.

(3) Assessing care needs, values and preferences of Veterans.

(4) Identifying and diagnosing a Veteran's medical problems and defining the medical management. This includes, but is not limited to, determining the need for consultation from subspecialties.

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

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

o. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Clinical Social Worker.** The VA medical facility HBPC PACT Clinical Social Worker, in addition to the HBPC PACT team responsibilities outlined in paragraph 3, is responsible for:

(1) Performing comprehensive initial in-home clinical assessments upon Veteran admission to the HBPC Program and in-home follow-up assessments when clinically indicated, at minimum annually. The initial in-home clinical assessment includes, but is not limited to relationship health and safety, housing stability, financial stability, food security and other safety and health screens.

(2) Identifying psychosocial issues impacting the Veteran or caregiver's ability to achieve optimal outcomes, implementing interventions and providing social work case management to address psychosocial needs and support Veteran-driven goals of care.

(3) Developing a psychosocial plan of care for HBPC Program enrolled Veterans. This may include but is not limited to individual or family counseling, long-term and advance care planning, non-pharmacological pain interventions, support for mental health or substance abuse issues, stress management, caregiver respite and psycho-educational programs, grief and bereavement counseling.

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

(5) Assessing and providing necessary education and assistance to HBPC-enrolled Veterans about securing completed Advanced Directives, Medical Power of Attorney designation and alternative caregiver plans in alignment with VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, dated December 24, 2013.

(6) Keeping the HBPC PACT informed of available VHA and community resources and benefits for the Veteran and caregiver.

p. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Registered Dietitian Nutritionist.** The VA medical facility HBPC PACT Registered Dietitian Nutritionist, in addition to the HBPC PACT team responsibilities outlined in paragraph 3, is responsible for:

(1) Ensuring the overall nutritional care of the Veteran and full implementation of a nutrition care process in accordance with VHA Directive 1438(1), Clinical Nutrition Management and Therapy, dated September 19, 2019.

(2) Completing an initial comprehensive in-home nutrition assessment upon Veteran admission to the HBPC Program and in-home follow-up assessments when clinically indicated, at minimum annually. The VA medical facility HBPC PACT registered dietitian nutritionist must communicate the expected frequency of follow-up HBPC Program nutrition assessments to the Veteran and caregiver. The frequency of follow-up assessments is based upon the nutrition assessment, needs and preferences of the Veteran. ***NOTE:*** *The nutrition assessment must adhere to the nutrition care process as outlined in VHA Directive 1438(1). Additional resources for HBPC Program nutrition assessments is available at: https://dvagov.sharepoint.com/sites/vhafocus-areas/HBPC/HBPC%20Disciplines%20Dietitians/Forms/AllItems.aspx. This is an internal VA website that is not available to the public*.

(3) Educating Veterans and caregivers on their nutrition plan of care and counseling the Veteran, caregiver and HBPC Program staff in the role of nutrition in disease prevention and processes, the therapeutic benefits of specific nutrition choices and the effective ways of managing and resolving identified nutritional problems.

(4) Identifying and intervening on significant drug-nutrient interactions and drug-nutrient depletions as indicated by local procedures.

(5) Assessing Veteran and caregiver ability to prepare recommended meals or administer enteral feeding.

(6) Identifying food insecurity and supporting interdisciplinary problem-solving discussions and interventions.

q. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Mental Health Professional.** The VA medical facility HBPC PACT Mental Health Professional is a psychologist or psychiatrist; in addition to the HBPC PACT team

responsibilities outlined in paragraph 3, the HBPC PACT Mental Health Professional is responsible for:

(1) Functioning as the primary mental health care provider of the HBPC PACT providing mental health prevention, assessment, treatment, management and professional consultation services. ***NOTE:*** *The HBPC PACT must collaborate with VA medical facility mental health and behavioral health services to facilitate assessments and treatment of mental health concerns that cannot be addressed fully by the HBPC PACT.*

(2) Collaborating with other mental health treatment programs in which the HBPC-enrolled Veteran is concurrently receiving treatment to ensure seamless delivery of high-quality care.

(3) Providing in-home assessment, diagnosis and treatment of psychological conditions for HBPC-enrolled Veterans, with an emphasis on the application of time-limited, evidence-based approaches; see VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023; VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorders, dated December 8, 2022; VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021; and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019.

(4) Providing services to the caregivers of Veterans when such care is related to the Veteran's overall plan of care. ***NOTE:*** *Caregivers participating in VA's Program of Comprehensive Assistance for Family Caregivers (PFAC) are eligible to receive mental health services from VA, independent of the Veteran's plan of care and involvement in HBPC. Information on the VA Program of Comprehensive Assistance for Family Caregivers can be accessed at: https://www.va.gov/family-member-benefits/comprehensive-assistance-for-family-caregivers/.*

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

(6) Providing support to HBPC-enrolled Veterans and caregivers who are coping with feelings of grief or loss or facilitating transition to new living situations.

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

(8) Providing ad-hoc mental health consultative support and guidance to the HBPC PACT during care planning discussions to guide PACT members on management of clinician-reported mental health issues of HBPC-enrolled Veterans and facilitate the care plan and treatment process.

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

r. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Rehabilitation Therapist.** The VA medical facility HBPC PACT Rehabilitation Therapist (e.g., Occupational Therapist, Physical Therapist, Kinesiotherapist or any combination of disciplines based upon clinical need), in addition to the HBPC PACT team responsibilities outlined in paragraph 3, is responsible for:

(1) Ensuring the overall physical medicine and rehabilitation care of the Veteran in accordance with VHA Directive 1170.03(1), Physical Medicine and Rehabilitation Service, dated November 5, 2019.

(2) Performing a comprehensive in-home environmental and functional assessment upon Veteran admission to the HBPC Program and assurance of in-home follow-up assessments and treatments when clinically indicated, at minimum annually, to monitor and evaluate a Veteran's progress. ***NOTE:*** *The Veteran's home must be evaluated by the HBPC PACT Rehabilitation Therapist at least once a year or more frequently as clinically indicated, to identify the need for structural modification and adaptive equipment to improve the safety and accessibility of the home environment.*

(a) The environmental assessment must include but is not limited to the need for structural modification and adaptive equipment to improve the safety and accessibility of the home environment, home safety risks and emergency planning.

(b) The functional assessment must include but is not limited to the use of standardized tools for identifying functional deficits, fall risk and planning and implementing interventions as clinically indicated.

(3) Determining the need for durable medical equipment (DME); teaching the HBPC-enrolled Veteran and caregiver safe use and maintenance of DME devices; and reporting equipment problems and facilitating repair or replacement of DME via the Prosthetic and Sensory Aids Service.

(4) Teaching body mechanics to the HBPC-enrolled Veteran and caregiver to minimize risk of injury.

(5) Establishing a long-term therapeutic program for Veterans to maximize or maintain the Veteran's functional status and monitor the Veteran's response.

s. **VA Medical Facility Home-Based Primary Care Patient Aligned Care Team Clinical Pharmacist Practitioner.** ***NOTE:*** *The VA medical facility HBPC PACT Clinical Pharmacist Practitioner(CPP) is a clinical pharmacist with a scope of practice authorized by the medical staff as an APP defined within medical staff bylaws.* The VA

medical facility HBPC CPP, in addition to the HBPC PACT team responsibilities outlined in paragraph 3, is responsible for:

(1) Providing direct Veteran care and comprehensive medication services to HBPC-enrolled Veterans consistent with VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015, the Pharmacy Benefits Manual (PBM) Guidance Clinical Pharmacy and Standardization of Non-Clinic Based Practice Areas and the PBM Guidance Pharmacy Business Rules for Home-Based Primary Care. Both PBM guidance documents can be accessed at: https://dvagov.sharepoint.com/sites/VHAClinicalPharmacy/SitePages/Practice-Area-Resources%281%29.aspx (see Home Based Primary Care Practice Area, "Document Type: CPPO Guidance" folder). ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) Performing comprehensive medication management (CMM) as part of the Care Management Module patient care process initially, quarterly and when clinically indicated, including recommendations or actions performed under the CPP scope of practice that ensure a custom approach that supports Veteran preference and adherence.

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

(4) Performing home and telehealth visits, when clinically indicated and agreed upon within the individual plan of care, for comprehensive medication or disease state management and medication safety concerns.

(5) Providing continuous pharmacy and medication education and reference materials for the HBPC PACT.

3. HOME-BASED PRIMARY CARE PATIENT ALIGNED CARE TEAMS

a. VA medical facility HBPC PACTs provide care that is longitudinal and comprehensive to Veterans with serious medical, social, and behavioral conditions for whom routine clinic-based care is not effective. HBPC PACTs employ Age Friendly Health Systems and Health Promotion and Disease Prevention tools and concepts in providing Veteran-centered care. ***NOTE:*** *Additional information is available at: https://dvagov.sharepoint.com/sites/vhacogec/SitePages/Age-Friendly-Health-Systems.aspx?OR=Teams-HL&CT=1657224805453&params=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMjA1MDEwMTAwOSJ9 and outlined in VHA Directive 1120.02(1), Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018. This is an internal VA website that is not available to the public.*

b. The VA medical facility HBPC Program Director and VA medical facility HBPC Medical Director must collaborate to select qualified clinicians and staff for the HBPC

PACT. Each VA medical facility HBPC PACT, except for those considered a Rural-Focus HBPC PACT as outlined in paragraph 4, must include all of the following:

(1) HBPC PACT Program Director.

(2) HBPC PACT Medical Director.

(3) HBPC PACT Care Manager. ***NOTE:*** *HBPC PACTs serving less than 35 Veterans are not required to have a HBPC PACT Care Manager.*

(4) HBPC PACT PCP (APP or Physician).

(5) HBPC PACT Clinical Social Worker.

(6) HBPC PACT Rehabilitation Therapist (e.g., Occupational Therapist, Physical Therapist, Kinesiotherapist or any combination of rehabilitative disciplines based on clinical need).

(7) HBPC PACT Registered Dietitian Nutritionist.

(8) HBPC PACT CPP.

(9) HBPC PACT Mental Health Professional (Psychologist or Psychiatrist).

(10) HBPC PACT Administrative Support.

c. HBPC PACT members have clinical responsibilities specific to their area of practice as outlined in paragraph 2. HBPC PACT members must work interdependently in assessing, planning, problem solving, decision-making and implementing team tasks. Additionally, HBPC PACT members have the following duties:

(1) Participating in the development and revisions of local HBPC Program procedures established by the HBPC Program and Medical Directors.

(2) Reviewing consults for appropriateness of Veterans for admission to the HBPC Program using criteria described in Appendix C. New consult requests must be processed in accordance with the Consult Business Rules and Use of the Consult Package Standard Operating Procedure (SOP) as outlined in VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.

(3) Collaborating with clinic-based primary care and using the electronic consult process outlined in VHA Directive 1232(5) to identify and track appropriate Veterans for HBPC Program consults, maintain smooth transitions of care and foster interdisciplinary learning and education. See Appendix C.

(4) Conducting appropriate clinical reviews or assessments in the home to develop treatment goals and plans based on a comprehensive geriatric assessment. Effective use of telehealth services in combination with in-home visits can support clinical care

and goals when used appropriately and with Veteran or Caregiver agreement. ***NOTE:*** *For further details regarding geriatric evaluations, see VHA Directive 1140.04. Formal consults are not required among the core clinical HBPC PACT members. Disciplines that require health care provider orders operate under orders in the HBPC Program initial consult and ongoing plan of care.*

(5) Participating in HBPC PACT care meetings to initiate and develop an individualized plan of care for HBPC Program Veterans and implementing it through home visits or telehealth as clinically indicated. See Appendix C for additional detail.

(6) Reviewing and communicating any significant changes in status and the progress toward Veteran goals as a team on a quarterly basis, or more frequently when there is a change in the Veteran's condition.

(7) Coordinating the process of care with team members to maximize efficiency and improve clinical outcomes. Team members must actively collaborate when scopes of practice between disciplines overlap to ensure seamless delivery of care and alignment of patient-centered goals.

(8) Assessing the Veteran's continuing need for HBPC Program care and plan for HBPC Program discharge when indicated. See Appendix C for additional guidance on HBPC Program discharge processes.

(9) Documenting all patient care activities in alignment with VHA Directive 1232(5) and local HBPC Program procedures. ***NOTE:*** *Once a consult is accepted, delays in scheduling the home visit due to Veteran unavailability or preference may occur and must be documented by the HBPC PACT member assigned to conduct the initial home visit in accordance with VHA Directive 1232(5). Guidance on cancelling must be followed as outlined in the Consult Business Rules and Use of the Consult Package SOP available at: https://dvagov.sharepoint.com/sites/vhaovac/cpm/SitePages/AccessPolicyResources.aspx#standard-operating-procedures-%28sop%29-and-guidebooks-on-vha-policies. This is an internal VA website that is not available to the public*

(10) Identifying areas for continuing education for HBPC PACT clinicians and participating in training activities. See Appendix C for additional information on HBPC PACT continuing education and training.

(11) Participating in developing and implementing the process for continuous performance improvement of HBPC Programs. ***NOTE:*** *For further information on quality management and evaluation, see Appendix D*.

(12) Instructing HPTs of various disciplines in providing successful home care and addressing the challenges encountered in delivering health care in the home setting. See Appendix C; additional information is available in VHA Directive 1400.01, VHA Handbook 1400.04.

(13) Providing medical and other care management coordination services as

necessary in instances where concurrent care is being provided to the Veteran by community care services.

(14) Overseeing volunteers, including, at a minimum, annual observation of the interaction between the volunteer and the Veteran in the home. Additional information regarding HBPC Program volunteers is in Appendix C.

d. All HBPC PACT clinical staff are mobile workers (e.g., work characterized by routine and regular travel to conduct work in the home of the Veteran or other worksites as opposed to a single authorized worksite) and are expected to make home visits in the community. Although telework agreements are not required for mobile workers, supervisor approval is necessary for staff to work from home, and such work must meet organizational needs. ***NOTE****: If a satellite HBPC Program is established, HBPC PACT members may also work from a Community-Based Outpatient Clinic (CBOC) or virtually in the CBOC service area.*

e. For HBPC Programs to provide comprehensive geriatric assessments and management to frail, chronically ill or disabled Veterans, VA medical facility HBPC PACTs must:

(1) Convene at least once per week to discuss and plan Veteran care.

(2) Provide comprehensive primary care to Veterans receiving HBPC Program care.

(3) Support Veteran and caregiver self-management as an additional strategy to support and empower engagement in self-care and self-management throughout the duration of Veteran enrollment in a HBPC Program. This includes but is not limited to:

(a) Providing a local patient information handbook to all HBPC-enrolled Veterans and caregivers. The rights of each Veteran must be outlined in the patient information handbook and must reflect current accreditation standards for home care. The HBPC PACT must obtain documentation that the Veteran has received the patient information handbook, the Veteran has been educated on the information in the handbook and the Veteran has accepted the terms of HBPC Program care. Every effort must be made to ensure that Veterans understand and exercise their rights and responsibilities in relation to their own care. If the Veteran lacks decision-making capacity, every effort must be made to identify a surrogate decision maker consistent with 38 C.F.R. § 17.32 and in alignment with VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

(b) Assessing the caregiver's capability to provide care, educating the Veteran and caregiver based on the Veteran's care plan and respecting the needs and preferences of the Veteran and caregiver by addressing symptom management and supporting the option of dying with palliative care at home if that is the Veteran's wish. See paragraph 6 in Appendix C for additional guidance on Veteran and caregiver involvement and support. ***NOTE:*** *The HBPC PACT may provide initial bereavement care to the caregiver*

with community referral for formal or longer-term bereavement support and counseling if needed.

(c) Recognizing the important role of the caregiver and providing support to the Veteran and caregiver in coping with all aspects of chronic disease, including assessment and intervention that address caregiver burden.

(4) Promote an enduring network of qualified home care professionals by providing an academic and clinical setting that allows for research and training in interdisciplinary delivery of primary care in the home. See Appendix C for HBPC Program ongoing education and training.

(5) Collaborate with VA medical facility palliative care services, including continuing education for the HBPC PACT and access to palliative care consultation and maintain a collaborative relationship with community hospice agencies. See paragraph 8 in Appendix C for additional information regarding community care resources for HBPC Programs.

b. Primary care services provided by HBPC PACTs must be interdisciplinary, accessible, comprehensive, coordinated, longitudinal, accountable and patient-centered as detailed below:

(1) **Interdisciplinary.** HBPC PACT members participate in regular HBPC PACT conferences and team meetings, collaborate with HBPC-enrolled Veterans and caregivers in care planning and conduct home visits as appropriate.

(2) **Accessible.** The HBPC Program Veteran and caregiver have access to the HBPC PACT with explicit provisions for concerns during non-working hours. See Appendix C for guidance on HBPC PACT after office hours coverage and availability.

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

(4) **Coordinated.** HBPC PACT coordinates patient care across all settings by referring Veterans to the appropriate services and collaborating and with the Veteran, VA health care providers and community care. Coordination of care encompasses the integration of diverse services to address complex medical, psychosocial, rehabilitative, behavioral and mental health or palliative care needs. ***NOTE:*** *For additional guidance on HBPC Program integration with community care home-care services and consultation services supporting community care, see Appendix C*.

(5) **Longitudinal.** HBPC PACT provides care and services that involve ongoing monitoring, comprehensive assessment, coordination of care, prevention or early detection of worsening conditions and timely interventions delivered throughout the protracted course of chronic disease. Longitudinal care reduces the need for, and provides an acceptable alternative to, hospitalization, nursing home care, emergency and outpatient visits, and provides close monitoring, early intervention and promotion

of a safe, therapeutic home environment through coordinated home and community-based services. Longitudinal care contrasts with episodic care that is provided only during periods of disease presentation or exacerbation.

(6) **Accountable.** HBPC PACT implements a continuous process for high reliability and performance improvement that utilizes data to track and evaluate services and outcomes. The HBPC Program performance improvement process described in Appendix D fully integrates with that of the VA medical facility. The Veteran's feedback on care provided is a required component of HBPC Program performance improvement activities.

(7) **Patient-Centered.** HBPC Program Veterans and caregivers must agree to receive HBPC Program services in their home from the HBPC PACT; this agreement must be documented by HBPC PACT members. HBPC Program Veterans and caregivers, to the extent possible and preferred by the HBPC-enrolled Veteran, participate in the development of an individualized plan of care that recognizes and incorporates Veteran and caregiver preferences to the extent possible.

f. HBPC Programs must anticipate resource needs and collaborate closely with local and VISN management to strategize options to support and expand HBPC Program services. Any proposed change in an HBPC Program that may result in a significant restructuring of the program, reduction in staffing, services, number of Veterans served or closure of the program must go through a VHA Central Office notification process as described in VHA Directive 1043, Restructuring Clinical Programs, dated November 2, 2016.

4. RURAL-FOCUS HOME BASED PRIMARY CARE PROGRAMS

HBPC Programs serving rural populations with less than 40 enrolled Veterans are designated as Rural-Focus HBPC Programs and qualify for the designated rural staffing allowances, permitting Rural-Focus HBPC Programs flexibility in the structure of HBPC PACTs. Rural-Focus HBPC Programs must meet the requirements for VA HBPC Program recognition; see Appendix B for additional information on HBPC Program recognition.

c. **Rural-Focus HBPC PACT Organization.**

(1) Staffing for Rural-Focus HBPC PACTs must be based on the HBPC PACT care models and caseload maximum capacity in Appendix A, using local adjustments for rural caseload determinants described in that appendix.

(2) Rural-Focus HBPC PACTs must provide the full complement of HBPC PACT services as outlined above. Rural-Focus HBPC Programs must have, at a minimum, VA-staffed individuals in the following HBPC PACT roles:

(a) HBPC PACT Program Director.

(b) HBPC PACT Medical Director.

(c) HBPC PACT APP or Physician.

(d) HBPC PACT Care Manager.

(e) HBPC PACT CPP.

(f) HBPC PACT Clinical Social Worker.

(g) HBPC Program Administrative support.

d. To address barriers with staff recruitment and retention and to optimize delivery of care, Rural-Focus HBPC PACTs are allowed to establish contractual arrangements with community care providers for the HBPC PACT Registered Dietitian Nutritionist, HBPC PACT Mental Health Professional and HBPC PACT Rehabilitation Therapist. When a Rural-Focus HBPC Program contracts with community care providers to address barriers to staffing, Veteran care must be maintained by having consistent and full contract staff participation in HBPC PACT conferences and care planning, whether in-person or virtual. All clinical documentation must be entered in the Veteran's electronic health record.

5. TRAINING

There are no formal training requirements associated with this directive. General PACT-related training requirements for Primary Care clinical staff are outlined in VHA Directive 1120.04, Veterans Health Education and Information Core Program Requirements, dated September 4, 2020.

6. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by 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.

7. BACKGROUND

a. PACTs often care for Veterans with multiple chronic illness who are at high risk for poor outcomes such as death and frequent hospital admissions. HBPC Programs are well suited to partner with PACTs to help identify these Veterans and accept many through consults for primary care transfer and further management. ***NOTE:*** *See the PACT High-Risk Roadmap for further information, available at*: *https://vaww.va.gov/PRIMARYCARE/components/Welcome_to_the_PACT_Roadmap.asp. This is an internal VA website that is not available to the public.*

b. HBPC is a unique model of home health care that is different in target population, process and outcomes from home care that is available under Federal and State programs such as Medicare and Medicaid. The HBPC Program model primarily targets

Veterans with complex chronic diseases that worsen over time and provides interdisciplinary care that is longitudinal and comprehensive rather than episodic and single problem focused.

c. Within VA, the HBPC Program is a GEC Special Population PACT that provides cost effective, comprehensive and interdisciplinary primary care services in the homes of Veterans and includes palliative care, rehabilitation, disease management, caregiver support and coordination of care. HBPC Programs target the following Veterans in need of home care:

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

(2) Veterans with serious and chronic medical, social, behavioral and mental health conditions (e.g., impaired mobility due to disability or functional limitation making it difficult to leave home without the assistance of a device or another person or inability to cope with a clinical environment due to cognitive, physical or mental health impairment) for which the HBPC PACT can safely provide care, particularly those at high risk of hospitalization, nursing home admission or recurrent emergency care.

(3) Veterans who require palliative care for a serious disease that is life-limiting or refractory to disease-modifying treatment.

(4) Veterans whose complex chronic disease is not managed effectively by routine clinic-based care and requires frequent, coordinated interventions from multiple disciplines.

d. The HBPC Program is approved and centrally organized at each VA medical facility or VA health care system to provide care to Veterans throughout VA's service area. The primary (parent) HBPC site is the sanctioned HBPC Program site where the leadership and organizational structure of the HBPC Program is managed. There are 140 formally recognized HBPC Program sites, each of which may support several teams and locations throughout their VA medical facility catchment areas, sometimes referred to as satellite programs or teams. HBPC satellite programs may be established in communities with sufficient numbers of eligible Veterans.

8. DEFINITIONS

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

Residential Care operator or neighbor who lives with or separately from the Veteran. ***NOTE:*** *As used in this directive, the term "caregiver" does not imply that the individual is eligible for the Program for Comprehensive Support for Caregivers authorized by 38 U.S.C. § 1720G and 38 C.F.R. part 71. Caregiver services authorized by that program are outside the scope of this directive. Health care decisions for HBPC-enrolled Veterans lacking decision-making capacity must be made by the Veteran's surrogate decision maker as outlined in VHA Handbook 1004.01(5).*

b. **Concurrent Care.** Concurrent care is the provision of services by more than one agency or program during a period of time. Concurrent care involving multiple agency services and supplementation of services is permissible when service plans are both explicit, DISCRETE and do not create a duplication of service. Common examples include HBPC Program concurrent care with VA and community care services or programs such as Spinal Cord Injury and Disorders System of Care, Home Hospice, purchased or Medicare skilled home care, Mental Health Intensive Case Management and Caregiver Support Program.

c. **Duplication of Services.** Duplication of services is when two home-health agencies or programs are providing identical service plans to a Veteran within the same timeframe.

d. **Home.** Home is the private residence in which the Veteran resides. This includes MFH, adult foster care and community residential care settings. This does not include inpatient health care settings such as nursing homes, skilled care facilities, domiciliary or other inpatient institutional care settings.

e. **Home-Based Primary Care.** For the purposes of this directive, HBPC is synonymous with HBPC PACT and refers to comprehensive, longitudinal primary care provided by a VA HBPC PACT team with physician oversight in the homes of Veterans with complex, chronic or disabling diseases for whom routine clinic-based care is not effective.

f. **Medical Foster Home.** MFH is a private home in which a caregiver living in the MFH provides care to a Veteran resident; see VHA Directive 1141.02(1) for additional information.

9. REFERENCES

a. 38 U.S.C. §§ 1703, 1717, 1720C, 1720G.

b. 38 C.F.R. §§ 17.32, 17.38.

c. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 02, 2016.

d. VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022.

e. VHA Directive 1120.02(1), Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018.

f. VHA Directive 1120.04, Veterans Health Education and Information Core Program Requirements, dated September 4, 2020.

g. VHA Directive 1140.04, Geriatric Evaluation, dated October 25, 2022.

h. VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated March 23, 2021.

i. VHA Directive 1140.12, Dementia System of Care, dated October 18, 2019

j. VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017.

k. VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 9, 2020.

l. VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023.

m. VHA Directive 1160.04, VHA Programs for Veterans with Substance Use Disorders, dated December 8, 2022.

n. VHA Directive 1160.05, Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions, dated June 2, 2021.

o. VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019.

p. VHA Directive 1170.03(1), Physical Medicine and Rehabilitation Service, dated November 5, 2019.

q. VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.

r. VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.

s. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

t. VHA Directive 1400.03, Educational Relationships, dated February 23, 2022.

u. VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016.

v. VHA Directive 1438(1), Clinical Nutrition Management and Therapy, dated September 19, 2019.

w. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

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

y. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

z. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

aa. VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 01, 2015.

bb. VHA Handbook 1101.11(4), Coordinated Care For Traveling Veterans, dated April 22, 2015.

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

dd. VHA Handbook 1140.6, Purchased Home Health Care Services Procedures, dated July 21, 2006.

ee. VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016.

ff. VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

gg. HBPC High-Risk Indicator Reports: https://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/Reports.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public. Access must be requested through the VHA Support Service Center.*

hh. HBPC SharePoint Page and related content (Service Agreements and MOUs, HBPC Program nutrition assessments): https://dvagov.sharepoint.com/sites/vhafocus-areas/HBPC/Memorandums/Forms/AllItems.aspx?RootFolder=%2Fsites%2Fvhafocus%2Dareas%2FHBPC%2FMemorandums. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ii. Home Health Care Consumer Assessment of Health Care Providers and Systems Survey: https://homehealthcahps.org.

jj. Managerial Cost Accounting Office, Labor Mapping Guidance: http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

kk. VA Caregiver Support Program: https://www.caregiver.va.gov/index.asp.

ll. VA Program of Comprehensive Assistance for Family Caregivers:

https://www.va.gov/family-member-benefits/comprehensive-assistance-for-family-caregivers/.

mm. VHA Consult Business Rules and Use of the Consult Package SOP and Unable to Schedule Process SOP. https://dvagov.sharepoint.com/sites/vhaovac/cpm/SitePages/AccessPolicyResources.aspx#standard-operating-procedures-%28sop%29-and-guidebooks-on-vha-policies. ***NOTE:*** *This is an internal VA website that is not available to the public.*

nn. VHA Guide to Issue Briefs (see "Guidance" Folder in the "Documents" tab): https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/HOC/workspaces/VPO/?cid=5a76925b-a645-4752-ab61-7ed73eb55726. ***NOTE:*** *This is an internal VA website that is not available to the public.*

oo. VHA Office of Geriatrics and Extended Care. Age-Friendly Health Systems SharePoint: https://dvagov.sharepoint.com/sites/vhacogec/SitePages/Age-Friendly-Health-Systems.aspx?OR=Teams-HL&CT=1657224805453&params=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMjA1MDEwMTAwOSJ9. ***NOTE:*** *This is an internal VA website that is not available to the public*

pp. VHA Office of Primary Care. Patient Aligned Care Teams Roadmap for High-Risk Veterans (PACT High-Risk Roadmap): https://vaww.va.gov/PRIMARYCARE/components/Welcome_to_the_PACT_Roadmap.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

qq. VHA PBM Guidance Clinical Pharmacy and Standardization of Non-Clinic Based Practice Areas and VHA PBM Guidance Pharmacy Business Rules for Home-Based Primary Care: https://dvagov.sharepoint.com/sites/VHAClinicalPharmacy/SitePages/Practice-Area-Resources%281%29.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public..*

HOME-BASED PRIMARY CARE PATIENT CASELOAD STANDARDS

1. EVIDENCE-BASED PATIENT CASELOAD STANDARDS

a. Home-Based Primary Care (HBPC) Program caseloads standards are expressed as maximum capacity for a particular program; they may be reached at numbers below the maximum, depending upon the program's specific determinants of maximum capacity.

b. The below maximum patient capacities are evidence-based and developed in partnership with the Office of Productivity, Efficiency & Staffing, Office of Mental Health Services and Pharmacy Benefits Management Services. ***NOTE:*** *The maximum capacity below is to be used for planning, not as a measurement of program efficiency; sustained caseloads higher than the above maximum capacity result in poor Veteran and staff outcomes and ultimately, long-term program failure. The maximum caseload capacity must not be surpassed.*

Discipline	**Maximum Capacity Patient Caseload**
Physician Medical Director (home visits not expected)	400
Physician (Non-Primary Care Provider (PCP) with home visit expectations)	250
Physician PCP	150
Advanced Practice Provider (APP)	35, 50, 75, 90
Care Manager (RN) with APP	35
Care Manager (RN) with Physician	30
Rehabilitation Therapist	115
Clinical Social Worker	100
Registered Dietitian	125
Mental Health Professional (Psychologist, Psychiatrist)	140
Clinical Pharmacist Practitioner (CPP)	100
Administrative Support (Medical Support Assistant, Program Support Assistant, Administrative Officer)	150

c. Caseloads are based on factors such as geography, driving time or percentage, service area, patient complexity, patient and staff turnover rate, staff experience, team composition and logistical resources such as vehicles, computers and program support assistance. Maximum caseload capacity standards are based on a moderate-to-high average patient medical complexity; urban/rural mix of >66% urban and drive time under 17 minutes per patient (16% of an average work day). ***NOTE:*** *For some HBPC Programs, maximum capacity patient caseloads may be reached at lower caseload thresholds due to the caseload factors listed above. HBPC PACT mental health professionals work with the HBPC PACT to identify Veterans and caregivers in need of*

mental health services and provide direct care for those Veterans and caregivers who require specialized mental health assessment or intervention. Caseload for HBPC PACT mental health professionals is based on 1:140 ratio of Veterans enrolled in HBPC.

d. The Department of Veterans Affairs (VA) medical facility HBPC Program Directors and HBPC Medical Directors must use the following factors to compare their program to national data to determine whether caseloads below the identified range are necessary to maintain excellent Veteran and staff outcomes:

(1) **Patient Complexity.** Care Assessment Need Score, Nosos risk score, Jenn Frailty Index, Ambulatory Care Sensitive Conditions and number of Veterans identified as High-Need High-Risk. ***NOTE:*** *Additional information on patient complexity scores is available in the HBPC High-Risk Indicator Reports at: https://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/Reports.aspx. This is an internal VA website that is not available to the public. Access must be requested through the Veterans Health Administration Support Service Center.*

(2) **Rural/Urban Mix.** The team's urban-to-rural patient ratio significantly differs from that of the average national team (66:34).

(3) **Coverage Area.** Unique coverage areas may result in increased average drive time (the national average is 17 minutes per patient) and other inefficiencies unique to the coverage area (e.g., traffic patterns, parking, use of community care or Veteran socioeconomic status).

(4) **Skilled Care.** Frequent skilled care performed by registered nurses (RNs) and rehabilitation therapists to reduce community care costs may warrant a reduced caseload for these health care providers.

(5) **Additional Considerations.** Geography, Veteran attrition, staff recruitment and retention, staff experience, team composition, pharmacy service support, electronic health record (EHR) record sophistication, mobile electronic documentation software, geo-mapping, hiring staff who live in the area of the Veterans they will serve, access to equipment and supplies (e.g., number and location of fleet vehicles), administrative support, work-from-home arrangements and usage of video technology.

e. Physician PCP caseloads approaching 150 patients are rare and are reserved for teams which are stable, well-resourced and efficient. The average HBPC PACT Physician caseload maximum is 100.

f. For RNs with a majority rural or highly rural caseload with significant drive times, the range is reduced to 16-25 patients. ***NOTE:*** *If accommodating RN caseloads, consideration for adjustment of other discipline caseloads may be necessary.*

g. RN caseloads of 31-35 patients are reserved for RNs working with a Certified Nurse Practitioner (CNP) or Physician Assistant (PA).

h. If a HBPC PACT CPP is performing only comprehensive medication assessments, has a limited number of Veterans receiving comprehensive medication management by the CPP or has additional duties assigned outside of HBPC, the caseload and overall capacity number may be locally adjusted. ***NOTE:*** *Specific guidance is available on the PBM SharePoint at: https://dvagov.sharepoint.com/sites/VHAClinicalPharmacy/SitePages/Practice-Area-Resources%281%29.aspx. This is an internal VA website that is not available to the public.*

i. CNP or PA is responsible for a mix of both primary case management and PCP assignments with the following limitations:

(1) CNP or PA caseloads approaching 50 patients are appropriate for an APRN or PA working with one RN full-time equivalent employee (FTEE).

(2) CNP or PA caseloads approaching 75 patients are appropriate for an APRN or PA working with at least two RN FTEE.

(3) CNP or PA caseloads approaching 90 patients are reserved for an APRN or PA who is working with a full three RN FTEE.

APPLICATION PROCESS FOR RECOGNITION OF VA HOME-BASED PRIMARY CARE PROGRAMS AND ONGOING PROGRAM MINIMUM STANDARDS

1. HOME-BASED PRIMARY CARE PROGRAM ACCREDITATION AND RECOGNITION

a. **Home-Based Primary Care Program Accreditation.** Home-Based Primary Care (HBPC) Programs must be reported to the relevant accrediting agency once the program has an average daily census of five or more patients and has seen more than 10 patients.

b. **VA Home-Based Primary Care Program Formal Recognition.**

(1) Department of Veterans Affairs (VA) HBPC Program formal recognition is provided by the Executive Director, Geriatrics and Extended Care (GEC).

(2) Proposals for formal recognition as a VA HBPC must be submitted by the VA medical facility HBPC Program Director as outlined in paragraph 2.i. in the body of this directive. The following elements must be addressed in the HBPC Program formal recognition application package:

(a) A description of the proposed program, with attention to the program elements that are outlined in this appendix and paragraph 3 in the body of this directive.

(b) A description of the HBPC Patient Aligned Care Team (PACT) and the responsibilities of each team member as described in this directive (see paragraph 3 in the body of this directive for more information on HBPC PACTs and paragraph 2 for the practice-specific responsibilities of required HBPC PACT clinicians). This description must include a listing of each HBPC Program position and the respective full-time equivalent employee (FTEE) staff committed to the HBPC Program. See Appendix A for staffing models. ***NOTE:*** *Special provisions for staffing recommendations are provided to Rural-Focus HBPC Programs as outlined in paragraph 4 in the body of this directive.*

(3) The GEC program office reviews the application package and verifies readiness of the HBPC Program for VA HBPC Program formal recognition. Once a HBPC Program has been approved for VA HBPC Program formal recognition, the Executive Director, GEC must provide a recognition letter to the VA medical facility as outlined in paragraph 2.d. in the body of this directive.

(4) Once recognized, the VA medical facility Director must notify the accrediting agency as required by accreditation standards related to HBPC and the VA medical facility. The HBPC Program Director is responsible for maintaining recognition standards as outlined in paragraph 2.i. in the body of this directive.

(5) Periodic reviews of VA medical facility HBPC Programs may be conducted by the GEC program office to assure program compliance is maintained. The GEC program

office may request additional action plans from the VA medical facility HBPC Program, which must be provided by the VA medical facility HBPC Program Director and VA medical facility HBPC Medical Director. ***NOTE:*** *See paragraphs 2.i. and 2.k. in the body of this directive for VA medical facility HBPC Program Director and VA medical facility HBPC Medical Director responsibilities.*

c. If a VA medical facility HBPC Program has HBPC Program formal recognition revoked, the Austin Information Technology Center must be notified to remove the VA medical facility from the data systems; the VA medical facility will no longer receive workload credit until HBPC Program formal recognition is restored.

2. HOME-BASED PRIMARY CARE PATIENT ALIGNED CARE TEAMS PROVIDER AND CARE MODELS

a. There are three acceptable provider and care manager models of HBPC PACT:

(1) Physician is the Primary Care Provider (PCP) with a maximum of five FTEE Nurse Care Managers.

(2) Certified Nurse Practitioner (CNP) or physician assistant (PA) is the PCP with a maximum of three FTEE Nurse Care Managers.

(3) CNP or PA is the PCP and also serves as the HBPC PACT Care Manager. A VA medical facility may choose to list the Physician as the PCP on a team with the CNP or PA as the associate providers; however, the visiting associate provider will be primary on encounters. FTEE for each team must be based on the HBPC PACT care model and caseload maximum capacity in Appendix A.

b. VA medical facility HBPC Programs may include other services frequently needed, such as pastoral care or Chaplain services, speech therapy, respiratory therapy, recreation therapy and creative arts therapy.

HOME-BASED PRIMARY CARE PROGRAM OPERATION STANDARDS

1. ORGANIZATION OF HOME-BASED PRIMARY CARE PROGRAMS

a. The Home-Based Primary Care (HBPC) Program Director and HBPC Medical Director must report to the same leader for HBPC Program management. The Office of Geriatrics and Extended Care (GEC) recommends that HBPC Program staff are supervised by HBPC Program leadership (i.e., HBPC Program Director, HBPC Medical Director and other applicable leadership). However, when organizational alignment of clinical staff are not directly under the HBPC Program, collaborative communication between the HBPC Program and supervisory Service Chiefs is required; see paragraphs 2.h. and 2.i. in the body of this directive for additional information.

b. The separation of program management from clinical practice oversight is an important distinction that allows for an HBPC-led program. If needed, a service agreement may be used between services to clearly define these roles locally. ***NOTE:*** *Service agreements are used to establish responsibilities of each service line involved in HBPC care when conflict arises at the Department of Veterans Affairs (VA) medical facility between service lines. Examples of previous service agreements are available in the "Service Agreements and MOUs" Folder, located in the section titled "Other" at: https://dvagov.sharepoint.com/sites/vhafocus-areas/HBPC/SitePages/Human-Resources.aspx. This is an internal VA website that is not available to the public.*

c. Local HBPC Program procedures, which may only be established as outlined in paragraphs 2.i. and 2.k. in the body of this directive, allow HBPC Programs flexibility to meet Veteran needs. Elements to be covered in local HBPC Program procedures include but are not limited to:

(1) A description of the organizational placement of the HBPC Program.

(2) Scope of HBPC Program service and referral.

(3) Admission and discharge procedures, including guidance for HBPC PACT scheduling processes. ***NOTE:*** *HBPC Program scheduling processes must be tailored to the specific software being used by the HBPC Program.*

(4) Unless specifically addressed in VA medical facility procedures, clinical procedures include, but are not limited to:

(a) Patient and staff safety.

(b) Environmental safety.

(c) Emergency preparedness.

(d) Medication management, including the handling of high-risk medications in the

home.

(e) Infection prevention and control in home care.

(f) Management of patients 'Do Not Resuscitate/Do not intubate/Medical Orders for Life Sustaining Treatment', State Authorized Portable Orders.

(g) Confidentiality and information security.

(h) Addressing Veteran and caregiver concerns or complaints.

e. **Additional Resources for Program Development and Operation.** The following offer HBPC Program staff and PACT members additional information related to HBPC Program development and operation in their VA medical facility and Veterans Integrated Services Network:

(1) **Home-Based Primary Care Electronic Resource.** The HBPC Program SharePoint contains valuable information such as: orientation videos, rights and responsibilities, coding, reporting, templates, links to resources and examples of local standard operating procedures. ***NOTE:*** *The HBPC Program SharePoint can be found at: https://dvagov.sharepoint.com/sites/vhafocus-areas/HBPC/SitePages/HBPC.aspx. This is an internal VA website that is not available to the public.*

(2) **Home-Based Primary Care Mentor Program.** The National HBPC Program Mentor Program offers a training opportunity especially for new HBPC Program staff. HBPC Program Directors and HBPC Medical Directors who either would like to have a mentor or would like to serve as a mentor are encouraged to contact the GEC program office, which oversees this program. A HBPC Program Director competency exam is available in the Talent Management System to assess knowledge of key programmatic elements.

2. HOME-BASED PRIMARY CARE PROGRAM REQUIREMENTS

HBPC Programs, except those with designated as Rural-Focus HBPC Programs in paragraph 4 in the body of this directive, must meet the following requirements:

a. HBPC Program staffing levels must be adequate to manage the needs of the patient population and there must be adequate HBPC Program staff available to support clinical, clerical and administrative needs of the HBPC Program. See Appendix A for HBPC Program maximum caseloads and recommended staffing methodologies.

b. All HBPC Programs must meet and maintain Veterans Health Administration (VHA) standards in this directive and home care standards as required by the accrediting agency.

3. ORIENTATION AND EDUCATION OF HOME-BASED PRIMARY CARE PATIENT ALIGNED CARE TEAM MEMBERS

a. This directive and HBPC Program local procedures serve as the basic orientation guides that reflect local and related national policies.

b. Both the orientation and ongoing education of HBPC PACT members must include, but are not limited to, geriatric specific education (e.g., end of life issues, goals of care and dementia), information security, current National Patient Safety Goals, staff safety, continuous quality improvement, new technology and program and practice updates.

c. **Health Professions Training Program.**

(1) The HBPC Program provides unique educational experiences for health professions trainees (HPTs) from various health professions, including medicine, physician assistant, nursing, social work, mental health, nutrition, pharmacy and rehabilitation services.

(2) The HBPC Program provides HPTs with the opportunity to observe and participate in an interdisciplinary team and experience the major care issues of this country's aging population, such as chronic progressive disease management, palliative care and long-term care economics. See VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019; VHA Directive 1400.03, Educational Relationships, dated February 23, 2022; VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015; VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016; and VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016, for additional information. ***NOTE:*** *The HBPC Program Director and HBPC Medical Director are encouraged to seek educational affiliations with the various professional schools to promote the training opportunities that exist within the HBPC Program.*

4. HOME-BASED PRIMARY CARE CONSULT PROCESSES

a. **Clinic-Based Primary Care Consult.** An electronic process is used to identify and track new Veteran clinical consults in alignment with VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016, and as outlined in paragraph 3 in the body of this directive.

b. **Home-Based Primary Care Program Consult.**

(1) Veterans who may benefit from HBPC Program services may be referred from any site of care. Electronic consults must be utilized for accountability and tracking and the consult process for the HBPC Program must align with VHA Directive 1232(5). Additionally, the HBPC Program consult must determine the appropriateness for the HBPC Program. If the consult is deemed inappropriate for the HBPC Program, the

response must include rationale for cancellation and recommendations, as appropriate.

(2) When the consult is canceled, discussion with the ordering provider is strongly encouraged to offer education regarding HBPC Program services and to discuss other potential appropriate support services.

(3) Veterans referred for Medical Foster Home (MFH) with HBPC are evaluated through a collaborative local process as outlined in VHA Directive 1141.02(1), Medical Foster Homes, dated August 9, 2017. HBPC Program admission must be concurrent with the move to the MFH. The HBPC Program Director and HBPC Medical Director, as outlined in paragraphs 2.i. and 2.k. in the body of this directive, must ensure collaboration between the HBPC Program and VA medical facility MFH.

(4) Consult to the HBPC Program and scheduling of an initial evaluation visit is not confirmation of admission or enrollment to the program. The clinic-based provider remains responsible until transition to the HBPC Program is complete.

5. HOME-BASED PRIMARY CARE ADMISSION CRITERIA AND SCHEDULING PROCESSES

a. **Veteran Admission Criteria for Home-Based Primary Care.**

(1) The following considerations must be used to determine Veteran appropriateness for HBPC Program admission:

(a) The Veteran must be enrolled in the VA health care system.

(b) The Veteran must live within a HBPC Program service area designated by each VA medical facility to represent a safe and efficient service delivery area (often designated by driving time).

(c) The Veteran has advanced age or serious chronic, disabling conditions (medical, social or behavioral) that would be amenable to HBPC PACT intervention and it is determined that the Veteran's primary care needs can be met by the HBPC Program without compromising the Veteran's goals of care. ***NOTE:*** *The Veteran is not required to be home bound.*

(d) The Veteran or surrogate voluntarily permit the HBPC Program to provide or support coordinated interdisciplinary primary care.

(e) The Veteran's home environment must be determined adequately safe and an appropriate venue for care as determined by HBPC Program leadership with team collaboration. The HBPC Program must utilize the VA medical facility's appropriate disruptive behavior, ethics and risk management resources as needed.

(f) The Veteran must be included in one of the populations targeted by HBPC Programs outlined in paragraph 7 in the body of this directive.

b. **Admission.**

(1) Hand-off communication is required when transferring primary care teams and must include the opportunity for discussion between the giver and receiver of Veteran information.

(2) When the HBPC Program encounters staffing limitations and is unable to accommodate routine admissions to the program, staff must follow applicable national scheduling guidelines and standards outlined in VHA Directive 1230, Outpatient Scheduling Management and the Unable to Schedule Process SOP available at : https://dvagov.sharepoint.com/sites/vhaovac/cpm/SitePages/AccessPolicyResources.aspx. ***NOTE:*** *HBPC Program scheduling processes must be tailored to the specific software being used by the HBPC Program, which will vary across programs based on resource availability*. *This is an internal VA website that is not available to the public.*

c. **Assessment of Patients.** Once admitted, Veterans must undergo a comprehensive, interdisciplinary assessment. This assessment must address, but is not limited to, health history, physical and cognitive functioning, nutritional assessment, skin integrity issues, patient safety issues, an environmental safety assessment, home oxygen safety, medication management, pain management, mental health needs including suicide risk assessment, substance abuse, psychosocial functioning, informal and formal supports, cultural, spiritual and lifestyle considerations impacting care, living will and advance care planning (e.g., advance directives and life-sustaining treatment plans).

d. **Leave of Absence.** When HBPC Program Veterans temporarily travel, relocate or are institutionalized in a hospital or nursing home with an anticipated stay of 15 days or more, it is required to: ***NOTE:*** *For Veterans that are traveling, refer to VHA Handbook 1101.11(4), Coordinated Care for Traveling Veterans, dated April 22, 2015.*

(1) Document in the electronic health record (EHR) a hold for the active in-home plan of care. The Veteran is not clinically discharged from the HBPC Program and remains on the HBPC PACT in the Primary Care Management Module until a reason for HBPC Program discharge is determined as stated in paragraph 14 of this appendix.

(2) Transitionary communication regarding the plan of care and course of care in the home must be provided to the receiving staff at the temporary location whenever possible and as directed by local procedures. The HBPC PACT must conduct follow-up communication with the Veteran, caregiver and treatment team to maintain continuity of care. An in-home reassessment process must begin within 2 business days of the HBPC PACT being informed the Veteran has returned home.

(3) The care plan must be reviewed, resumed and updated within 30 days of the reassessment at a scheduled team meeting. Local procedures outline the specific reassessments, timeframes and disciplines designated to perform the reassessment required for the returning Veteran.

e. **After Hours Office Coverage.** HBPC Programs must support the provision of care for Veterans 24 hours a day, 7 days a week. Some HBPC Programs have established formal coverage 24 hours a day, 7 days a week by HBPC PACTs; others refer Veterans to specific units at the VA medical facility or to a VA after-hours telephone care support system.

6. HOME-BASED PRIMARY CARE VETERAN AND CAREGIVER INVOLVEMENT

a. **Home-Based Primary Care Program Orientation for Veteran and Caregiver.**

(1) The eligible Veteran and caregiver must be oriented to the HBPC Program as outlined in paragraph 3 in the body of this directive. HBPC Program orientation must include a full discussion of program objectives, capabilities, limitations and alternatives as well as the rights and responsibilities of all parties, including potential out-of-pocket expenses. Orientation is conducted in the home and the information is provided in writing to the Veteran and the caregiver.

(2) HBPC Program orientation and the Veteran or caregiver's acceptance to participate in the HBPC Program constitute consent of the Veteran to participate in the HBPC Program and to receive HBPC services in the home. Verbal consent with documentation in the EHR is required as outlined in paragraph 3 in the body of this directive. HBPC Program orientation and the Veteran or caregiver's acceptance to participate in the HBPC Program constitutes consent to receive care for HBPC services in the home. Verbal consent to receive care with documentation in the EHR is required as outlined in paragraph 3 in the body of this directive.

b. **Veteran and Caregiver Participation and Education.**

(1) The HBPC-enrolled Veteran and caregiver must receive a patient information handbook upon Veteran admission to a HBPC Program as outlined in paragraph 3.e.(3) in the body of this directive.

(2) Information and education must be provided in the plan of care to the Veteran and caregiver with emphasis on available options and expected outcomes as well as the actions and commitment required of the Veteran and caregiver to achieve desired outcomes as outlined in paragraph 3 in the body of this directive and in VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009. ***NOTE:*** *Veterans and caregivers must also be informed and educated regarding potential undesirable outcomes of their treatment decisions. The HBPC PACT must document this education as well as the Veteran and caregivers understanding and address their capacity to make decisions as necessary.*

(3) The Veteran and the caregiver are responsible for meeting daily, routine care needs. For meeting care needs, the HBPC PACT must assist in mobilizing community or VHA resources.

(4) Teams employ Age Friendly Healthcare Systems and Health Promotion and

Disease Prevention tools and concepts in providing Veteran-centered care. ***NOTE:*** *Refer to VHA Directive 1120.02(1), Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018 and https://dvagov.sharepoint.com/sites/vhacogec/SitePages/Age-Friendly-Health-Systems.aspx?OR=Teams-HL&CT=1657224805453&params=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMjA1MDEwMTAwOSJ9 for additional information. This is an internal VA website that is not available to the public.*

c. **Veteran and Caregiver Concerns or Complaints.** HBPC Programs must have a procedure in place to address Veteran and caregiver concerns or complaints that ensure issues are resolved in accordance with the VA medical facility complaint process timeframe and at the lowest level of direct care, whenever possible. The procedure provides for communication with the HBPC Program Director and access to the local Veteran advocate. See paragraph 2.i.(7) in the body of this directive.

7. PLAN AND DELIVERY OF HOME-BASED PRIMARY CARE

a. **Plan of Care.**

(1) The plan of care for each Veteran must be customized to include problems identified by the HBPC PACT, Veteran and caregiver goals and preferences, a current medication profile and goals of care with specific interventions, timeframes and assigned team member responsibility.

(2) The HBPC PACT members acknowledge and concur with the plan of care in the EHR, which must be signed by the HBPC Medical Director, or designated HBPC PACT primary care physician.

b. **Clinical Discharge from Home-Based Primary Care Programs.**

(1) As clinically appropriate, discharges from HBPC Programs must be mutually planned by the HBPC PACT in conjunction and full partnership with the Veteran and caregiver. Veterans may elect to be discharged from the HBPC Program at any time.

(2) The following information must be included in the EHR when clinical discharge from a HBPC Program, at a minimum:

(a) The date of admission and discharge to the HBPC Program.

(b) Plan for continuity of care.

(c) Summary of the course of HBPC Program care.

(d) Current medications and treatments.

(e) The overall status of the Veteran at discharge.

(3) Hand-off communication is required between the HBPC PACT, staff of the VA medical facility or community care providers when transferring primary care teams to ensure a seamless transition of care and must include the opportunity for discussion between the giver and receiver of Veteran information.

(4) Circumstances under which Veterans are discharged from HBPC Programs include but are not limited to:

(a) Veteran death.

(b) Veteran and caregiver request discharge from the HBPC Program.

(c) Veteran relocates out of the HBPC Program service area.

(d) Veteran is receiving long-term institutional care without expectations of returning home.

(e) Veteran has reached maximum benefits from the program and can be effectively managed through routine clinic-based care.

(f) Veteran and caregiver demonstrate a consistent lack of partnering or participation in a significant portion of the plan of care that negatively impacts clinical outcomes. This ongoing lack of participation and its effect on care, must be documented in the Veteran's EHR. Prior to discharge, staff must consider appropriate evaluations and strategies to address contributing factors such as the presence of dementia, depression and substance abuse.

(g) Veteran's home is no longer a safe environment for the HBPC PACT.

(h) If the Veteran's clinical status declines but the Veteran desires to remain at home, the HBPC Program must work to honor the Veteran's choice. The HBPC PACT will facilitate transfer to a higher level of care if remaining at home places the Veteran at imminent risk of harm. The VA medical facility Ethics Committee and Risk Management may be utilized as resources.

8. HOME-BASED PRIMARY CARE AND COMMUNITY CARE RESOURCES

a. **Home-Based Primary Care Program Waivers.** HBPC Programs may submit waivers for compliance with this directive as outlined in VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023.

(1) HBPC Programs are encouraged to submit waivers for innovative expansion, which includes, but is not limited to, case finding of new Veteran populations with special needs and high risk for institutionalization; targeting new service locations and Veteran populations to reduce unnecessary health care utilization and improve Veteran health, well-being and satisfaction.

(2) In addition to the required information for waiver requests outlined in VHA Notice

2023-02, HBPC Programs who submit a waiver request must also demonstrate:

(a) Evidence of VA medical facility support, including up-to-date information technology, appropriate number of vehicles and sufficient space.

(b) Innovative practices that reflect the HBPC Program's ability to meet standards at or above national expectations for safety, quality, outcomes and patient experience. See Appendix B for more information pertaining to VA HBPC Program recognition.

b. **Integration with Community Care Home Care Services.**

(1) When it is in the best interest of the Veteran, other home care services may be provided concurrently, given there is no direct duplication of services and that clinical responsibility and tasks are delineated for the care or service rendered.

(2) If concurrent care is being provided by community care paid services, the role of HBPC PACTs must be medical management or other care coordination services that are not directly provided by the community care agency.

c. **Services Supporting Home-Based Primary Care.** Programs often engaged by HBPC PACTs include but are not limited to:

(1) **Medical Foster Home.** A Medical Foster Home (MFH) provides an alternative to institutional care by providing a home setting for a small number of Veterans residing in the home of a community caregiver with HBPC Program support and oversight. Veteran MFH residents also must be enrolled, or agrees to be enrolled in a VA HBPC Program, Spinal-Cord Injury and Disorders System of Care or a similar VA interdisciplinary program designed to assist medically complex Veterans living in the home.

(2) **VA Home Telehealth Program.** The VA home telehealth (HT) program enhances HBPC's capacity to manage complex Veterans, access specialty care and extend HBPC's service area. HT Care Coordinators are review and triage health information, including biometrics and symptom responses. This information is submitted by Veteran's and securely transmitted via HT approved technologies such as in-home messaging devices, Interactive Voice Response and web-enabled technologies.

(3) **Other Virtual Care Modalities.** Other virtual care modalities that are currently available or under development also enhance HBPC's capacity to manage and communicate with complex Veterans. Examples include, but are not limited to:

(a) VA mobile applications that can enhance HBPC's capacity to connect to homebound Veterans and support chronic care management.

(b) Expanded use of secure messaging facilitates asynchronous communication with homebound Veterans. Secure messaging includes pre-visit communication, completion of health questionnaires, post visit communication and ongoing communication for routine non-urgent issues.

(4) **Mental Health.** The HBPC PACT Mental Health Professional serves as a liaison with Mental Health and Behavioral Health Services as outlined in paragraph 2.o. in the body of this directive.

(5) **Caregiver Support Program.** The Caregiver Support Program includes VA's Program of Comprehensive Assistance for Family Caregivers as well as services available to caregivers of Veterans from all eras (i.e., the Program of General Caregiver Support Services that are specifically designed to acknowledge the caregiver's role and provide training, support and respite). See 38 U.S.C. § 1720G. ***NOTE:*** *Additional information on the VA Program of Comprehensive Assistance for Family Caregivers can be found at https://www.caregiver.va.gov/index.asp.*

(6) **Respite Care.** Respite is available as both non-institutional and institutional care and is provided in accordance with VHA Handbook 1140.02, Respite Care, dated November 10, 2008.

(7) **Personal Care Services.** Personal care services for HBPC Program Veterans can be obtained from multiple VA and community care sources. Examples include, but are not limited to: Veteran Directed Home and Community-based Services and Homemaker/Home Health Aide Programs; VA Adult Day Health Care and Community Adult Day Health Care and community resources such as county-level Offices on Aging and State-funded long-term home care and nursing home diversion programs.

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

(9) **Skilled Home Care.** Skilled home care services may be needed beyond the scope or frequency that a HBPC Program can provide. If the Veteran wants to remain at home, VA must offer to pay for or provide the needed concurrent services covered in VA's medical benefits package. A Veteran dually eligible for these services under both VA and another payer has the right to choose VA or an alternate payer. The VA medical facility HBPC Program must coordinate with the relevant payer to avoid duplication of services.

(10) **Palliative and Hospice Care.** Veterans in HBPC Programs often require and are authorized to receive concurrent hospice care from a hospice agency paid by VA, Medicare or another payer. As long as Veterans are formally enrolled in a HBPC Program, PACT member responsibilities continue and duplication of services must be avoided.

(11) **Dementia Care Support.** Dementia care support is available through a number of GEC consultation services and Geriatric Evaluation and Management consultations with special emphasis on dementia and memory issues. Dementia care is addressed in detail in VHA Directive 1140.12, Dementia System of Care, dated October 18, 2019.

(12) **Volunteer Services.** HBPC Programs utilize volunteers through the VA Center

for Development and Civic Engagement Program. HBPC Program staff provide oversight of volunteers including, at a minimum, annual observation of the interaction with the Veteran in the home.

(13) **VA Staffed Home Care Services.** VA Staffed Home Care Services are programs that provide in-home care and services for targeted goals and populations. Examples include, but are not limited to: Hospital In-Home; Home-Based Transitional Care; Geriatric Resources for Assessment and Care of Elders; Blind Rehabilitation home assessments; Home Oxygen; PACT Intensive Management and other forms of VA-provided home care services and visits.

HOME-BASED PRIMARY CARE QUALITY MANAGEMENT AND EVALUATION

1. Home-Based Primary Care (HBPC) Program performance improvement activities are used to improve overall Veteran care through planned, systematic measurement, monitoring and assessment of patient care outcomes; assessment of staff practice; and regular review of HBPC Program-related systems and processes that affect staff performance and Veteran care.

2. As required by the accrediting agency, focus areas for performance improvement include but are not limited to:

a. Trends in Veteran care, cluster activity and specific areas impacting Veteran safety.

b. Areas or procedures involving high risk to Veterans or staff.

c. Activities that require maintenance of competency.

d. New processes, procedures and technologies.

e. Identified areas for staff training or education.

f. Feedback from customer satisfaction measures and factors contributing to high customer satisfaction.

g. Factors contributing to staff satisfaction and retention.

3. The following tools are required by the accrediting agency to verify adherence to accreditation standards in the focus areas listed in paragraph 2 of this appendix and compliance with local processes:

a. **Chart Reviews and Audits.** Chart reviews and chart audits are required by the accrediting agency to monitor timeliness of assessments and care planning processes, documentation standards for timeliness and evidence of interdisciplinary collaboration in care planning process, orders, consultations as necessary, specific incident and near-miss tracking.

b. **In-Home Oversight Visits.** In-home oversight visits are required by the accrediting agency and must be included in the orientation process for new staff and incorporated into ongoing competency reviews. Compliance with home care practice accreditation standards must be verified during the in-home oversight visit and reported to the HBPC Program Director.

c. **Veteran Experience Feedback.** The nationally administered Home Health Care Consumer Assessment of Health care Providers and Systems provides customer feedback for each HBPC Program which must be incorporated into HBPC program

quality improvement initiatives. Programs must also have procedures to support customer feedback and complaints in accordance with home-health accreditation standards.

d. **Monitoring Veteran Safety.** Monitoring Veteran safety includes identifying factors and implementing processes that contribute to improving Veteran safety. The following essential elements of national patient safety goals must be evaluated as part of the HBPC Program performance improvement process:

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

(2) Sentinel events, adverse events and near misses for development of action plans leading to improved Veteran care with prevention and reduction of both risk and harm must be reported through the appropriate channels at the Department of Veterans Affairs medical facility when they occur and to the Office of Geriatrics and Extended Care via Issue Brief when necessary. Refer to the Veterans Health Administration Guide to Issue Briefs, located in the Guidance Folder in the “Documents tab at: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/HOC/workspaces/VPO/?cid=5a76925b-a645-4752-ab61-7ed73eb55726 for additional information. ***NOTE:*** *This is an internal VA website that is not available to the public.*

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