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CHAPTER 2. POLICIES AND PROCEDURES

2.01 HBHC HOSPITAL POLICY MEMORANDUM

A Hospital Policy Memorandum which outlines the requirements, policies and procedures necessary for the operation of the HBHC program should be developed by the team, approved by the HBHC Advisory Committee and issued by the medical center Director. Delegation of authority to the HBHC Program Director, organizational placement of the program, lines of authority, scope of program services, referral procedures, admission and discharge procedures are among the elements that should be included in this memorandum.

2.02 HBHC ADVISORY COMMITTEE

An advisory committee is designated by the VA medical center Director and Chief of Staff to assist the HBHC team in the implementation, development and maintenance of the program. The functions of the HBHC Advisory Committee are outlined in a Hospital Policy Memorandum. In most medical centers, the HBHC Advisory Committee is composed of the Chiefs of the clinical services represented in the HBHC program.

2.03 THE HBHC POLICY AND PROCEDURE MANUAL

a. A policy and procedure manual is developed by the HBHC team to define and govern the clinical and administrative aspects of the program at their medical center. This manual should be a viable document that reflects current practice of the team. It should be reviewed and revised as necessary by the team but no less frequently than once a year. This manual should be reviewed and approved by the HBHC Advisory Committee and the medical center's Chief of Staff and Director.

b. JCAHO Home Care Standards for Accreditation specify the elements required in the policy and procedure manual. Some of these elements are detailed in the following paragraphs.

2.04 HBHC PATIENT INFORMATION HANDBOOK

Each HBHC team will prepare a handbook to distribute to patients upon admission to the HBHC Program. This handbook should contain, at a minimum:

- a. Names of HBHC team members and office telephone numbers.
- b. An explanation of the HBHC program, its capabilities and limitations.
- c. HBHC patients' rights and responsibilities including grievance process.

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d. Specific instructions regarding the care of the patient during and after the regular hours of operation of the HBHC program.

e. Procedures to follow in the event of an emergency.

f. Charges for services, if applicable, in accordance with the MCCR (Medical Care Cost Recovery) policies.

2.05 HBHC PATIENTS RIGHTS AND RESPONSIBILITIES

Patients in the HBHC Program have the same rights and responsibilities as other patients in the VA system. HBHC Patients Rights and Responsibilities (app. A) may be

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given to patients and/or their caregivers. Every effort is made to ensure that the patients understand and exercise their rights and responsibilities in relation to their own care. In the event that the patient lacks decision-making capacity (as determined by the team physician), a proxy decision maker will be identified.

2.06 ADMISSION GUIDELINES

Guidelines for admission of patients to the HBHC program are:

- a. Patient is eligible for VA outpatient care.
- b. Patient lives within program service area. Boundaries are designated by each medical center.
- c. Patient care needs can be met by HBHC program.
- d. Patient has an identified caregiver.
- e. Patient is homebound.
- f. Patient has a multi-faceted disease process which necessitates care by an interdisciplinary team.
- g. Patient and/or caregiver accept HBHC as the principal care provider.
- h. The patient's home environment is safe for the well-being of the patient, caregiver and the HBHC team members.

2.07 FUNCTIONS OF THE HBHC PROGRAM DIRECTOR

- a. The VA medical center Director and Chief of Staff designate the HBHC Program Director. The HBHC Program Director will be a health care professional with demonstrated ability and competence both in patient care and program administration.
- b. The VA medical center Director delegates the management of the program to the HBHC Program Director. This includes planning, directing, budgeting, monitoring and evaluating the program.
- c. The HBHC Program Director directs the clinical services offered by the program so as to ensure that the program is in compliance with the JCAHO Standards for the Accreditation of Home Care, and VA medical center and Central Office policy.
- d. The Program Director is responsible for the development and continued effective functioning of the interdisciplinary health care team. Understanding

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of the skills and knowledge of each team member and the contribution each makes to accomplish patient and program goals is of utmost importance.

e. The provision of administrative direction and team leadership includes:

(1) Interpreting national HBHC and local VA policy to the HBHC team and the medical center,

(2) Assisting the team in developing local HBHC policies and procedures and coordinating the provision of Quality Assurance, Utilization Review and Risk Management programs;

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- (2) Evaluating the effectiveness of the HBHC program;
- (4) Selecting qualified personnel to fill HBHC personnel vacancies;
- (5) Coordinating the orientation and ongoing HBHC staff and student educational programs; and
- (6) Monitoring and controlling program operation expenditures and monitoring and reporting the HBHC workload.

2.08 THE INTERDISCIPLINARY TEAM

a. Because of the diverse array of professional services required to effectively treat and manage the multiple health problems of chronic or terminally ill patients, HBHC care is best rendered by an interdisciplinary team. This team develops an identity which promotes communication and coordination among team members. The HBHC team members share common goals, collaborate and work interdependently in planning, problem solving, decision-making, implementing and evaluating team related tasks.

b. HBHC is a long-term care program; therefore, a variety of health care professionals is necessary to meet the needs of the patient population. The professional disciplines represented on the HBHC team are physician, nurse, social worker, rehabilitation therapist, pharmacist, and dietitian. A secretary is also essential to this program.

c. In addition to appropriate professional credentials, all HBHC staff should possess certain qualifications unique to the practice setting and the population served and are committed to:

- (1) Discipline-specific standards of practice;
- (2) The primary health care delivery model;
- (2) Long-term care of a community-based patient population characterized by health problems that are secondary to chronic illness, interacting medical diagnoses, aging and terminal illness; and
- (4) A holistic framework of practice.

d. An ability to effectively function both autonomously as well as a member of an interdisciplinary team.

e. A clinical background which includes demonstrated competency in assessment, problem solving, community practice and teaching.

2.09 FUNCTIONS AS A MEMBER OF THE INTERDISCIPLINARY TEAM

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Activities which demonstrate the team related functions are:

- a. Participating in the establishment and review of the goals of the local HBHC program.
- b. Determining appropriateness of patients for acceptance for HBHC care.
- c. Developing interdisciplinary team treatment plans based on comprehensive assessment of the patient and the caregiver.

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- d. Mutual follow-through with the care outlined on the patient's treatment plan through regular home visits.
- e. Reviewing the patient's progress at regular intervals or when there is a change in the patient's condition.
- f. Monitoring the caregiver's functioning.
- g. Teaching the patient and the caregiver.
- h. Collaborating formally and efficiently with the other team members throughout the process of care.
- i. Determining the patient's continuing need for HBHC care.
- j. Planning for discharge of patients from HBHC care.
- k. Documenting all patient care activities in a timely manner.
- l. Determining the need for continuing education and implementing in-service training of team members.
- m. Defining areas for continuous monitoring of the quality of care provided and participating in the evaluation process.
- n. Teaching students of various disciplines regarding the problems encountered in furnishing health care in the home setting, team functioning and the objectives of the HBHC program.
- o. Developing and revising the local HBHC Policy and Procedure Manual.

2.10 FUNCTIONS OF THE HBHC TEAM MEMBERS

a. The HBHC Medical Director is appointed by the Chief of Staff. This physician is responsible for the medical care delivered by the HBHC team. The HBHC Medical Director assumes primary medical responsibility for all the patients on the HBHC program. The physician is responsible for identifying the patients' medical problems; defining the medical management of these problems; determining the need for consultation from medical/surgical/psychiatric subspecialty clinics; and determining the need for admission to the hospital. The physician is also responsible for planning and directing the educational and clinical experience of medical students, residents and fellows assigned to the HBHC program. As the physician is usually part-time, some clinical services are performed by the physician and others are delegated to other team members so clinically privileged. The physician attends HBHC team meetings and is always available to the team members for collaboration when medical or other problems arise.

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b. The HBHC Nurse is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Nursing Service. The HBHC Nurse frequently functions as care manager linking the patient and the caregiver with the various health services offered by the HBHC team and the medical center. Patients are usually divided among HBHC nurses by geographic distribution. The nurse is responsible for: initial and continued assessment of unique nursing needs of the patient and caregiver; teaching the patient and caregiver effective and efficient ways of managing and delivering nursing care in the home; monitoring the patient's condition and the care provided in the home; supervising any

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LPNs or Home Health Technicians and/or nursing students assigned to the HBHC program. If appropriately credentialed, the HBHC Nurse frequently functions in the expanded nursing role and provides selected medical services.

c. The HBHC Social Worker is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Social Work Service. The HBHC Social Worker is responsible for the initial and continued assessment of the interpersonal resources and psychosocial functioning of the patient, the caregiver and their support system and the identification of problems. The social worker provides psychosocial treatment which may include individual and family counseling, and other specific therapies. The social worker coordinates discharge planning for HBHC patients including nursing home placement under VA contract or through other funding mechanisms and the effective use of VA and community resources. The social worker supervises the social work students assigned to the HBHC program and is responsible for teaching the impact of psychosocial problems on illness to students of other disciplines. If the program utilizes volunteers, the social worker usually trains and supervises these volunteers.

d. The HBHC Dietitian is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Dietetic Service. The HBHC Dietitian is responsible for the initial and continued assessment of the patient's nutritional status as well as the adequacy of the home caregiver's capacity to prepare recommended meals; and training the patient and the home caregiver in efficient and effective ways of managing the identified nutritional problems. The HBHC dietitian supervises the dietetic students and interns assigned to the HBHC program.

e. The HBHC RMS (Rehabilitation Medicine Service) Therapist is selected jointly by the HBHC Program Director, HBHC Medical Director, and Chief, Rehabilitation Medicine Service. The HBHC RMS Therapist is responsible for the initial and continued assessment of the patient's functional status and safety; an evaluation of the patient's home for needed structural modifications to make the home environment safe and accessible; determining the need for prosthetic equipment; teaching and monitoring the safe use of these devices; reporting equipment problems to the Prosthetic and Sensory Aids Service; teaching the caregiver body mechanics to minimize risk of injury; and establishing a therapeutic program for the patient and caregiver to maintain or enhance function or retard deterioration in the patient's functional status. The RMS therapist is also responsible for the supervision of RMS therapy students assigned to the HBHC program. Since the therapist may be an occupational therapist, physical therapist or kinesiotherapist there may be times when consultation with other RMS disciplines may be needed to solve specific patient problems.

f. The HBHC Clinical Pharmacist is selected jointly by the HBHC Program Director, HBHC Medical Director and the Chief, Pharmacy Service. The HBHC Pharmacist is responsible for the initial and continuous monitoring and

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assessment of drug therapy. The clinical pharmacist identifies patient-specific medication issues, including drug interactions, adverse affects, efficacy, appropriateness, and compliance problems. He/she educates the patient and caregivers in the home about the proper use of medications. The pharmacist participates in HBHC patient care conferences and makes recommendations for medication regimen changes. The pharmacist provides drug information to other health care professionals. The HBHC Clinical Pharmacist is responsible for the supervision of pharmacy students or residents assigned to the program.

g. The HHT (Home Health Technician) is selected jointly by the HBHC Program Director, HBHC Medical Director and Chief, Nursing Service. The HBHC HHT is

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responsible for providing services to patients in their homes such as catheterizing, suctioning, changing dressings, providing tracheostomy care and other nursing procedures which may include personal care services. The HHT provides services alone and is accompanied only occasionally to the home by the HBHC nurse. The HHT may function in an expanded role and be involved in reinforcing rehabilitation measures with the patient/caregiver; demonstrating and teaching the use of therapeutic and rehabilitative devices such as lifts and walkers; monitoring and observing the patient's nutritional, psychological and physical status; and documenting evidence of pain, edema, depression and other signs and/or symptoms.

h. The Program Secretary is selected and supervised by the HBHC Program Director. The Program Secretary is responsible for the smooth daily operation of the HBHC office and serves as an administrative assistant to the Program Director. All incoming calls from HBHC patients, families and medical center staff are received and assessed for urgency by the secretary and referred to the appropriate HBHC team member in the office or in the field. The secretary is responsible for scheduling all clinic appointments; arranging and coordinating patient travel; for facilitating issuance of prosthetic equipment and pharmaceuticals; and maintaining records of laboratory tests conducted. The secretary is accountable for all records pertaining to the program and for maintaining and controlling the clinical and administrative records of all active HBHC patients. All statistical reports and cost accounting data are compiled and prepared by the secretary for the medical center Director and also for use in QA studies and evaluations of program operation and management.

2.11 PROCESS OF CARE

a. Referral. Patients are referred to HBHC from many settings, including inpatient, outpatient, nursing homes, etc., usually by consultation. The referred patient's problems and health care needs, the home caregiver and the home environment are evaluated by the HBHC team. If the patient and the home situation are found to be appropriate, the patient is accepted in the HBHC program. If the patient is not found to be appropriate, the HBHC team makes recommendations regarding an alternate plan for managing patient's care needs.

NOTE: Generally, starting a new program involves several of the team members in patient selection and orientation but as a team matures these responsibilities may be assigned to one member at a time for more efficient staff utilization.

b. Informed Consent. The accepted patient and caregiver are oriented to HBHC. A full explanation of the program, its objectives, capabilities and limitations is provided to the patient and the caregiver. The counseling of the patient is documented in the patient's medical record as well as the patient and/or caregiver's response to the explanation. The documentation by the health

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professional of this exchange of information constitutes informed consent of the patient to participate in the HBHC program.

c. Assessment of Patients. After admission to the program, the patient receives a comprehensive and timely assessment by each member of the HBHC team. The initial visit by the nurse is primarily for the purpose of identifying any unique nursing needs of the patient and the home caregiver. The HBHC physician assesses the patient's medical status in preparation for the development of the treatment plan. The social worker visits the home to assess the patient and the home caregiver's psychosocial strengths and weaknesses as well as the adequacy of the formal and informal social support system. The RMS therapist visits the home and assesses the patient's functional status, evaluates

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safety hazards and the need for adaptive equipment and structural modifications. The dietitian also visits the home and assesses the patient's nutritional problems, and the caregiver and home's suitability for the preparation of special diets.

d. Treatment Planning. Following the initial assessment of new patients by the different disciplines, the HBHC team holds a formal team meeting to develop the patient's interdisciplinary treatment plan. At these weekly team meetings the team works collaboratively and interdependently under the direction of the HBHC Medical Director. The treatment plan for each patient consists of a problem list of all problems identified by the members of the team, medication profile, measurable objectives with specific methods including the team member responsible for achieving the objectives. All team members responsible for the patient, including the HBHC physician, sign the treatment plan.

NOTE: The patient's treatment plan is developed by the HBHC team members, is individualized to each patient/caregiver, and constitutes physician's orders for care. Participation of the patient/caregiver in the development of the treatment plan is essential.

e. Delivery of Care. Having assessed patient needs and determined individualized goals of care through the formulation of the treatment plan, the team's major effort is to promote a therapeutic environment in the home. Frequency of home visits is determined by patient needs, staff resources, and program policies.

NOTE: Since HBHC teams are responsible for providing primary care to persons with complicated health problems, considerable attention must be given to the education and training of patients and caregivers. The caregiver is responsible for the routine care administered to the patient between HBHC staff home visits. In the event that the home caregiver cannot provide all of the needed care, the HBHC team can assist in accessing community and/or VA resources. The HBHC team members monitor and document therapeutic outcomes to ensure continuity of care.

f. Treatment Plan Reviews. The interdependence of the HBHC team members is maintained through progress notes documenting visits and formal reviews of the patient's treatment plan. The plan is reviewed and modified by the team as the condition of the patient changes, but no less frequently than every 90 days. Each weekly team meeting is divided between the staffing of new patients and the review of the patients' progress in reaching treatment objectives.

g. Discharge from HBHC. The decision to discharge a patient is made by the team based on the attainment of the established treatment goals and upon the continued appropriateness of the patient for HBHC services. Reasons for patient's discharge from HBHC are documented in the discharge summary. This summary will also include date of discharge, name of care provider to which the

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patient is being referred, if applicable; the status of problems identified at admission; the overall status of the patient at discharge and a summary of care provided including length of care and services provided. The patient and the caregiver are expected to participate in the discharge planning process.

2.12 DISCHARGE GUIDELINES

a. The HBHC team will facilitate timely and orderly discharges of patients who no longer need the services of the HBHC program to other medical providers in the VA

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medical center or in the community, as appropriate. Alternative health care services appropriate to the needed level of care will be arranged prior to discharge from HBHC. Circumstances under which patients will be discharged from HBHC include:

- (1) Patient died.
- (2) Patient is admitted to a hospital for 16 days or longer.
- (2) Patient is admitted to VA Nursing Home Care Unit other than for respite.
- (4) Patient is admitted to a nursing home in the community.
- (5) Patient has reached maximum benefits from the program.
- (6) Patient's care needs exceed the capability of the HBHC program and thus necessitate a referral to another home care agency.
- (7) Patient and/or caregiver request discharge from the HBHC program.
- (8) Patient and/or caregiver are non-compliant with the treatment plan and non-compliance is documented in the patient's medical record.
- (9) Patient's home environment is no longer safe for the patient/caregiver or for the HBHC team members.

b. The HBHC team should furnish information about the medical status of the patient and work closely with the staff of the VA medical center to assure a smooth transition. The HBHC discharge summary should be written in a timely manner so that continuity of care is maintained.

c. Should the nursing home level of care become necessary for the patient who was admitted to HBHC following a period of VA hospitalization, the patient may be admitted directly to a community nursing home under VA contract. The patient is then discharged from the HBHC program on the date of nursing home admission.

2.13 AFTER OFFICE HOURS COVERAGE

Each HBHC program will have a policy providing for the care of patients at other than the regular hours of operation of the program. HBHC patients and their caregivers will be given, verbally and in writing, specific instructions about how to access care at all times (during and at other than the regular hours of operation of the program). Some HBHC programs have established 24-hour coverage, others refer patients to specific units at the medical center, and some advise patients to report to the medical center's Emergency Room if problems arise after office hours.

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2.14 ADMISSION OF HBHC PATIENTS TO VA MEDICAL FACILITIES

When admitted to HBHC, the patient and caregiver are given assurance that admission to a VA facility may be accomplished at any time it is professionally indicated. Patients who are hospitalized 15 days or less may remain enrolled in HBHC. These patients should be placed in Absent-Sick-In-Hospital status. Those HBHC patients admitted to a Nursing Home Care Unit solely for the purpose of providing respite care may be placed in Absent-Sick-in-Hospital status. Information about the course of care in the home should

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be furnished to inpatient and nursing home staff. While hospitalized, the HBHC team should provide follow-up contacts with the patient and the caregiver. Upon release from the hospital or nursing home care unit, follow-up home visits may resume without a change in HBHC status. When patients are hospitalized 16 days or more they should be discharged from the HBHC program.

2.15 COOPERATION, COLLABORATION AND CONSULTATION WITH OTHER SERVICES

a. The HBHC team regularly cooperates and collaborates with the ancillary services to obtain needed services and procedures for the HBHC patients. Laboratory Service will advise on proper handling and storage of specimens collected in the home as well as accommodate HBHC patients for procedures which cannot be done in the home. Radiology and Nuclear Medicine provide services to HBHC patients on scheduled and unscheduled bases. HBHC physician and nurses work closely with the Pharmacy over the provision of medications and supplies to HBHC patients. Collaborative arrangements at many medical centers have resulted in clinical pharmacists working closely with HBHC teams to improve prescribing habits, treatment planning and patient education. Engineering Service can enhance the HBHC team's ability to identify and advise on fire and safety problems. The Prosthetic and Sensory Aids Service may provide support to HBHC patients by assisting in the delivery and maintenance of home medical equipment, as well as the instruction of patients and/or caregivers in the proper use of home medical equipment, either directly or through contracted organizations or individuals.

b. As HBHC accepts referrals from the various units and services of the medical center collaborative relationships will develop to foster continuity of care. Furthermore, the specialty services are medical center resources available through consultation to the HBHC team when medically indicated. Such relationships and resources serve to enhance HBHC's capacity to manage complex patients in the home setting. Should the home placement begin to falter or fail, such relationships will facilitate the orderly readmission of the patient to the appropriate service for further care.

c. The health problems of the HBHC patient population often include mental health components (ref. par. 4.04). A liaison with Psychiatry and Psychology Service should be sought to facilitate the assessment and treatment of these problems. An ongoing consultive relationship should include a continuing education program for the team members, consultation regarding assessment and treatment of individual patients or family members, and indications and procedures for obtaining direct mental health treatment.

d. At the outset, the HBHC team should also develop relationships with pulmonary medicine, oncology, urology, geriatrics, neurology, orthopaedics, and other medicine and surgery subspecialties which seem appropriate. Senior clinicians from these specialties, in addition to offering opinions on specific

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patients, may be willing to assist HBHC programs in developing protocols for their specialty areas.

2.16 ORIENTATION AND CONTINUING EDUCATION OF HBHC TEAM MEMBERS

The orientation of new HBHC team members should ensure understanding of the goals, objectives, and procedures utilized by the HBHC Program. The HBHC Policy and Procedure Manual usually serves as the basic orientation guide. Both the orientation and continuing education program of HBHC team members should regularly address infection control in the home, basic home safety, emergency preparedness and HBHC patients

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rights and responsibilities. In addition, all HBHC team members are responsible for maintaining their discipline's continuing education requirements for licensure/ certification.

2.17 VOLUNTEER SERVICES

Several HBHC programs utilize volunteers through the VA Voluntary Service, the SCP (Senior Companion Program) and RSVP (Retired Senior Volunteer Program). Relationships with SCP and RSVP have been formalized through an inter-agency agreement between VA and ACTION, the federal domestic volunteer agency. HBHC volunteers are selected, trained and supervised by the HBHC team. Volunteer services provided by other than VA Voluntary Service require an inter-agency agreement.