

Bay Pines VA Healthcare System

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Community Nursing Home

The Community Nursing Home Care (CNH) program is designed to assist veterans and their families in making the transition from an episode of hospital, nursing home, or Domiciliary care to the community. The lengths of contracts vary depending on eligibility and need for continued nursing home care.

Admission Criteria

Community nursing home care at VA expense is provided to any veteran who requires nursing home level of care and meets one of the following criteria:

- has a combined service connected disability rating of 70% or more
- care is needed for a Service Connected (SC) condition
- is officially rated 60% SC and unemployable
- is officially rated 60% SC and Permanent and total disabled

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Home or Community Hospice and Palliative Care

The VA will assist any enrolled veteran to obtain outpatient hospice services through referral or purchase as appropriate. Care can be provided in the home or other approved community settings.

Admission Criteria

- The patient has an end-stage life-limiting illness as determined by the patient's attending physician.
- The estimated survival of the patient is less than 6 months.
- The patient requires treatment of pain and symptoms related to the life-limiting illness and/or be in need of emotional, spiritual, physical, or social support rather than curative measures.

Discharge

- The patient may elect to withdraw from Hospice care at any time. The Hospice team will work with community hospices to provide support in the environment of Discharge.
- The patient may be withdrawn from Hospice care if the patient's condition significantly improves so that death is no longer imminent, i.e., survival is expected to be greater than 6 months or patient is not benefiting from Hospice care.

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Respite Program

Respite care provides temporary relief to 24-hour unpaid caregivers from routine tasks and supports the caregiver in maintaining the chronically ill veteran. Care may be provided in a non-VA nursing home, adult day care, Assisted Living Facility, or in-home care. The caregiver selects the appropriate facility and verifies bed availability with the facility for a non-VA nursing home, Assisted Living Facility or Adult Day Health Care respite. Respite care may be provided overnight and/or daily. The eligible veteran may utilize the respite for up to 30 days annually. Alternate sources of care providing longer lengths of stay should be pursued if the caregiver is unable to provide care during personal emergencies or illness.

Admission Criteria

- Veteran is enrolled in the VA and has a Primary Care provider
- The veteran has a diagnosed chronic disabling illness or condition and needs assistance bathing, dressing, mobility or behavior management.

The need for relief by caregiver is expressed with medical documentation to support activities of daily living (bathing, dressing, mobility) deficits or behavioral management difficulties.

- The veteran lives at home and requires substantial assistance in activities of daily living in order to continue to reside safely in the home
- Veteran's medical, psychiatric and behavioral problems can be safely managed by specific respite program.

Exclusions

Veterans who do not meet the admission criteria.

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Home Based Primary Care (HBPC)

HBPC is a program that delivers primary health care in the home. Care is delivered by an interdisciplinary team composed of VA staff to homebound veterans whose medical complexity and functional impairment precludes treatment in an ambulatory care setting.

Services include: primary care, nursing care and education, rehabilitation services, nutritional counseling, social work services, and clinical pharmacy services care management.

HBPC has a Telehealth program for patients with chronic medical conditions who would otherwise require frequent home visits.

Admission Criteria

- Patient lives in Pinellas County south of State Road 580.
- Patient has an identified caregiver, or can manage their own care.
- Patient has difficulty leaving home
- Has a multi-faceted disease process necessitating care by an interdisciplinary team
- Patient and/or caregiver accept HBPC as primary care provider
- Home environment is safe for the well being of the patient, caregiver and staff

Emergency Care

Patients are instructed to call the emergency room at the VA Medical Center after 4:30 p.m. on weekdays and at anytime during weekends and holidays.

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Care Coordination Home Telehealth (CCHT)

Each day the veteran/caregiver input health related data using a home video or non-video monitor from their residence to the CCHT office. A Registered Nurse Care Coordinator from the CCHT office monitoring the data provides progressive, ongoing care to veterans and their caregivers using this technology.

Admission Criteria

- Patients with chronic conditions, including but not limited to COPD, Chronic Pain, Diabetes, CHF, hypertension
- Recent changes in medical conditions that require frequent monitoring.
- A home environment and family support system/caregiver in which daily care and medical problems can be managed in the home setting
- Access to a land (phone) line
- Patient/caregiver demonstrate competency in using and maintaining home telehealth equipment

Exclusions

- Veteran and/or caregiver are unwilling or unable to operate telehealth equipment
- Veteran is uncooperative or combative
- Residence does not have a compatible or working land (phone) line
- Veteran has a history of non-compliance or behaviors such as active substance abuse that might impact the safety of staff and/or equipment in the home

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Homemaker/Home Health Aide (H/HHA)

A program designed to provide limited homemaking services and assistance with basic home health needs for veterans who are at risk for nursing home placement. Community state licensed agencies deliver these services under a system of case management provided directly by the VA Healthcare System.

Admission Criteria

- At risk for nursing home placement
- Dependence in 2 or more Activities of Daily Living (bathing, dressing, mobility) and 2 or

more of the following conditions:

- Dependence in 3 or more Instrumental Activities of Daily Living (cooking, shopping, cleaning, banking)
- Advanced age (75 years or older)
- High use of medical services defined as 3 or more hospitalizations in the past year and/or utilization of outpatient clinics/Emergency Evaluation Units 12 or more times in the past year.
- Living alone in the community with little or no support system
- Significant cognitive impairment
- Clinical depression
- Enrolled in VA system and receiving primary care from the VA

Exclusions

- Does not meet above criteria

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Home IV Therapy

Outpatient IV Therapy is a complex, comprehensive, multidisciplinary procedure, which is an alternative to hospitalization and will be provided to those home bound patients who meet the criteria for home IV therapy.

Admission Criteria

- The patient requires long-term IV therapy but no longer requires hospitalization.
- The ward multidisciplinary health care team will determine if the patient is a candidate for home IV therapy. Other home health care services may also be required.

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Purchased Skilled Home Care

Purchased Skilled Home Health Care is designed to maintain continuity of care to veterans who need further nursing care or other related health services at home. In order to provide continuity, VA Community Health Services acts as a contact between the home health agency, interdisciplinary team, and the veteran. The goals of Community Health Services are to maintain veterans in their home environment, reduce re-hospitalization, and provide cost effective treatment.

Veterans who meet the eligibility requirements for spinal cord fee basis care may be provided fee basis bowel and bladder care when authorized by a VA physician.

Admission Criteria

- The veteran must be enrolled in the VA health care system
- The veteran must have a medical need requiring services of a skilled care provider.
- The veteran must be homebound except when care needs cannot feasibly be met in an ambulatory care setting.

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Geriatric Primary Care (GPC)

The Geriatric Primary Care Clinic provides primary care in an ambulatory setting, through an interdisciplinary approach. A comprehensive assessment is focused on patients and significant others, which address the medical, social, and psychological problems affecting the older adult.

The goal of the clinic is to maintain the quality of life, and enhance the patients' functional abilities, through comprehensive evaluation, with the emphasis on continuity and wellness in order to keep veterans at home, reduce institutionalization, and frequent hospital admissions.

Our policy is to provide geriatric primary care through coordinated, interdisciplinary provision of medical, nursing, psychosocial services, preventive health services, health education to patients and caregivers, referral for specialty, rehabilitation and other levels of care, follow-up and overall care management by primary care provider and support team.

Admission Criteria

- Advanced age (80 years and older)
- Veterans most likely to benefit from geriatric primary care will have complex health conditions in addition to one or more of the following geriatric syndromes:
 - Gait impairment
 - Self-care deficits
 - Urinary incontinence
 - Dementia
 - Delirium
 - Malnutrition
 - Polypharmacy
 - Inability to manage own medications

- Depression
- Sensory impairments
- Difficult social situations

Enrollment is limited and requires physician to physician consultation.

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Palliative Care Clinic

Admission Criteria

- The patient has a life-limiting illness (with life expectancy less than 12 months) as determined by the Palliative Care Consult Team (PCCT) clinic physician.
- The patient requires treatment of pain and symptoms related to the life-limiting illness and/or be in need of emotional, spiritual, physical, or social support rather than curative measures.

Discharge

- The patient may elect to withdraw from the PCCT clinic at any time.
- The patient may be withdrawn from the PCCT clinic if his/her condition remains stable for greater than 12 months or improves.

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Bereavement Clinic

The Bereavement Program at Bay Pines VA Healthcare System is designed to provide varying kinds of support and outreach to the families and significant others grieving the death of a loved one.

The Bereavement Program has 10 components:

- Anticipatory Grief Support Group for families
- Telephone support
- Grief Recovery Support group
- Informational mailings
- Three memorial services annually
- Referral to community resources
- Memorial Day picnic
- Holiday Tree Gathering
- 24 hour emergency number
- 1:1 Bereavement support

Admission Criteria

Family members of those who die at Bay Pines and families of veterans who die in the community are eligible for bereavement care. Veterans and employees who experience losses are also eligible.

The bereavement clinic provides anticipatory grief support and bereavement follow-up for each patient and their significant other. Bereavement care will be provided to families of those who die in hospice for at least one year after the death. Bereavement intervention/treatment varies from person to person.

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