Department of Veterans Affairs **VHA DIRECTIVE 2002-016**
Veterans Health Administration
Washington, DC 20420 **March 19, 2002**

RESPITE CARE

1. PURPOSE. This Veterans Health Administration (VHA) directive expands the provision of respite care beyond institutional settings, such as the Department of Veterans Affairs (VA) hospital or VA nursing home (NHCU), to include community nursing homes and non-institutional settings in the community including, but not limited to, in-home respite services. ***NOTE:*** *The expansion of respite services into the community is a direct outgrowth of the needs of the veteran population as well as the provisions of Public Law (Pub. L.) 106-117.*

2. BACKGROUND. The Department of Veterans Affairs has demonstrated commitment to providing an array of long-term care services to veterans who experience functional impairments from chronic conditions.

a. The intent is to offer the most appropriate services in the least restrictive settings ranging from inpatient nursing home care to home-based primary care. Pub. L. 106-117 expanded the array of community-based services available to veterans to include community nursing homes and non-institutional settings for respite care. Prior to the passage of Pub. L. 106-117, respite care authorization was limited to VA inpatient NHCU or hospital beds.

b. It is generally recognized that most chronically-ill persons who do not need hospital acute care services can be appropriately cared for in the home with the assistance of family or other household members. In this way, many chronically-ill veterans may be able to reside at home as long as possible. At the same time, there is recognition that such arrangements for care of a veteran at home may place severe physical and emotional burdens on the caregiver and the household.

c. The goal of respite care is to give caregivers relief from the demands of daily, home-based care for the chronically-ill veteran, thereby supporting the veteran's desire to delay, or prevent, nursing home placement. A useful characteristic of respite care is the opportunity for development of a plan for respite care in advance for acute need on the caregiver's part. In this way, respite care is a key component of, rather than incidental to the provision of, routine necessary care.

3. POLICY. It is VHA policy to expand the provision of respite care into non-institutional settings including community nursing homes, adult day care, the home ,and other community-based settings. Respite care is limited to no more than 30 days per year. ***NOTE:*** *This time limitation applies to respite care in all settings, inpatient and outpatient.*

4. ACTION: It is the responsibility of each medical facility Director, or designee, to ensure:

a. That the medical center develops policies to encompass both inpatient and non-institutional respite care, and that the policies identify how the Respite Care Program will

operate and who is responsible. When a patient is admitted for respite care, services provided must be determined by the applicable standards of care for that setting. For example, in the NHCU, services must meet the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) long-term care standards.

b. A Respite Care Coordinator is appointed, preferably one with geriatrics and extended care expertise and with knowledge of the community and patient and/or family dynamics, who has programmatic and operational responsibility.

c. That an interdisciplinary team is responsible for screening the veteran and formulating the respite treatment plan, including frequency and duration of the admission. ***NOTE:*** *The physician member of the veteran's interdisciplinary team is responsible for, or must supervise the respite care of the patient.*

d. That purpose-of-visit (POV) or respite services follow applicable guidelines as defined by the service delivery site. ***NOTE:*** *For example, respite care that is paid for by VA and provided in a non-VA setting will use a POV code 72. Additional guidance may be found by viewing http://vaww.vistau.med.va.gov/Enrollment*.

5. REFERENCES

a. Public Law 106-117 Veterans Millennium Health Care and Benefits Act, Title I, Access to Care, Subtitle A, Long-Term Care, section 101(e) (codified at Title 38 United States Code (U.S.C.) Sec. 1720B).

b. M-5, Part VII Chapter 1, dated March 3, 1995.

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant for Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Directive.

7. RESCISSIONS: None. This VHA Directive expires March 31, 2007.

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