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RESCISSIONS

The following material is rescinded.

l. COMPLETE RESCISSIONS

Circulars

10-89-92 and Supplement No. 1

2. PARTIAL RESCISSION

Circulars

10-86-103, Attachment B

CHAPTER 31. LONG-TERM CARE PATIENT ASSESSMENT

31.01 PURPOSE

a. These assessments of the intermediate medicine and nursing home care bed occupants are the data source for the Austin, Texas, DPC (Data Processing Center) PAF (Patient Assessment File) which supports the RUG (Resource Utilization Group) classification system.

b. The LTC (Long-Term Care) PAI (patient assessment instrument) looks at selected characteristics of a patient, not the total patient picture. The RUG-II casemix model; developed by the New York State Case Mix Reimbursement Project, is based upon the concept that patients can be classified into groups according to the amount of resources they need by means of selected indicators. An indicator is a patient characteristic (or set of them) which reflects a larger group of characteristics, is the most important characteristic to identify resource use, and which serves as a representative characteristic because it predicts a certain level of resource use.

31.02 POLICY

a. Allocation of resources within LTC is based upon the RUG-II patient classification system. VA Form 10-0064a, Long-Term Care Patient Assessment Instrument, will be utilized to describe facility workloads and ascertain future requirements for resource distribution purposes.

b. Assessments of all long-term care intermediate and nursing home bed occupants are to be taken upon admission, transfer and on a semi-annual basis.

31.03 ADMINISTRATIVE RESPONSIBILITY

a. The Chief, Medical Administration, or an designee, e.g., Medical Records Administration, will serve as the survey coordinator for each facility. The survey coordinator will have overall administrative responsibility for the surveys including notification to bed services and nursing service of their expected participation.

b. VA Form 10-0064a will be completed by a Registered Nurse who is familiar with the patient and who is familiar in making assessments of this type.

c. The coordinator is also accountable for computerized transmission of assessment data, utilizating DHCP software, to the DPC in Austin, Texas.

31.04 SELECTION OF BED OCCUPANTS

a. Assessments are to be completed and submitted for intermediate medicine and/or nursing home care patients. Only officially designated intermediate medicine or nursing home care units are to be included in these surveys. VHA

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(Veteran Health Administration) beneficiaries in non-VHA facilities are also excluded from the surveys.

b. Semi-annual surveys are to be taken of 100 percent of the bed occupants in intermediate medicine and/or nursing home care units as of 11:59 p.m. on each survey date.

c. Any person admitted or transferred into an intermediate medicine or nursing home care bed is to be assessed as soon as possible after the admission or transfer date up to a

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maximum delay of 2 weeks. All admissions and transfers require a new patient assessment, regardless of how long the patient has been absent from the long-term care bed section or how long the patient stays in the long-term care bed section upon returning from elsewhere.

d. Only one admission/transfer assessment is to be completed for each episode of care within the intermediate medicine or nursing home care unit. An assessment is not to be completed because of a change in the condition of a patient, unless a change of bed section is involved.

31.05 PATIENT ASSESSMENT FILE SCHEDULE

a. Semi-annual assessment dates are April 1 and October 1 of each year. By April 30 and October 31 of each year, all original data should have been submitted to the DPC in Austin from the first and second halves of the fiscal year, respectively. Final closeout dates for semi-annual assessments taken April 1 and October 1 are May 31 and November 30, respectively. THERE WILL BE NO EXCEPTIONS TO FINAL CLOSEOUT DATES; THEREFORE, DATA NOT RECEIVED BY FINAL DATABASE CLOSEOUT CANNOT BE UTILIZED TO DETERMINE FACILITY CASE-MIX. The 2-month period between the semi-annual assessment dates and the final closeout dates provide time to complete original data entry and correct errors prior to final database closeout.

b. Admission/transfer assessment data can be transmitted to the DPC at Austin on a monthly basis. The DPC issues two types of monthly reports to facilities:

(1) A listing of all valid PAIs received, and

(2) An error listing showing the number of records accepted and the number rejected, if any, with a printout of the rejected records indicating where the errors occurred which caused the rejection.

These monthly reports are not cumulative. Therefore, if a facility does not transmit data during a given month, the error listing will simply show 0 accepted and 0 rejected. THE SURVEY COORDINATOR WILL MONITOR THESE REPORTS CLOSELY TO ENSURE THAT ALL PAIs HAVE BEEN ENTERED AND CORRECTIONS MADE WITHIN THE CORRECTION CYCLE AND BEFORE THE FINAL CLOSEOUT OF THE DATABASE.

31.06 ASSESSMENT FORM

a. VA Form 10-0064a, Long-Term Care Patient Assessment Instruction, dated September 1989, will be utilized by the survey coordinator, or designee, to record the assessment data.

b. All questions must be answered using the letter or numeric codes provided. No questions are to be left blank (excluding spaces marked "reserved"). The data sources for completing the assessment form will be obtained from medical and administrative records and professional knowledge of the patient.

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c. Instructions for completing VA Form 10-0064a are in appendix 31A.

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INSTRUCTIONS FOR COMPLETING ASSESSMENT VA FORM 10-0064a

1. Administrative Data Section

a. 1. Patient Social Security Number - Record the bed occupants nine-digit actual or pseudo social security number.

b. 2. Sex - self explanatory.

c. 3. Year of Birth - Enter the four digit year (e.g., 1905, 1920). Enter "0000" if unknown.

d. 4. Assessment Date - Enter the month, day and year the assessment is completed. For example, the October 1, 1991, semi-annual assessment would be coded "100191."

e. 5. Assessment Purpose - Enter "1" if the assessment is being completed within approximately 1 week after admission/transfer into the Intermediate Medicine or Nursing Home Care unit. Enter "2" if the assessment is completed on patients in bed as of a semi-annual survey date. If semi-annual assessment date coincides with the day on which an admission/transfer assessment would have been done, record "2" as the purpose.

f. 6. Date of Admission/Transfer (in): Record the month, day, and year (e.g. "10-20-90" for October 20, 1990) of the most recent admission to the intermediate medicine or nursing home care bed unit in which the patient is located as of the admission date. Transfers from outside the facility or from other bed sections are new admissions for the purposes of this section. Date of admission data is used for descriptive purposes only and does not affect case-mix workload measurements or funding levels.

g. 7. Medical Center Number - Self explanatory.

h. 8. Bed Section - Self explanatory.

2. Medical Treatments Section

a. General. Treatment must have been given during the past 4 weeks and is still required. If the treatment has been provided for less than 4 weeks due to new admission/transfer, a physician order must state that this treatment is anticipated to continue for at least 4 weeks. Physician order specifying that treatment should be given must also include frequency of ordered treatment.

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b. 9. Tracheostomy Care. Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help. Frequency = daily.

c. 10. Suctioning. Nasal or oral techniques for clearing away fluid or secretions; excluding any tracheostomy suctioning. Frequency = daily.

d. 11. Oxygen Therapy. Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone or oxygen tent for conditions resulting from oxygen deficiency (for example, cardiopulmonary condition); excluding inhalators, oxygen in room, but not in use. Frequency = daily.

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e. 12. Respiratory Care. Care for any portion of the respiratory tract, especially the lungs (for example, COPD, pneumonia.) This care may include one or more of the following: percussion or cupping, postural draining, positive pressure machine, possibly oxygen to administer drugs, etc; excluding suctioning. Frequency = daily.

f. 13. Tube Feeding. Primary food intake is via tube to the stomach or intestines by whatever route; no exclusions, gastrostomy not applicable. Frequency = none specified.

g. 14. Parental Feeding. Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (for example, comatose, damaged stomach); no exclusions, gastrostomy not applicable. Frequency = none specified.

h. 15. Wound care. Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers; excluding decubiti, stasis ulcers, skin tears, feeding tubes. Frequency = care must be required for at least three consecutive weeks.

i. 16. Chemotherapy. Treatment of carcinoma through intravenous and/or oral chemical agents, as ordered by a physician; no exclusions. Frequency = none specified.

j. 17. Transfusions. Introduction of whole blood or blood components directly into the blood system; no exclusions. Frequency = none specified.

k. 18. Dialysis. The process of removing impurities from the blood of persons who have renal disease. Included within this definition are patients receiving any of the processes used to separate blood components in order to remove known or suspected pathogenic elements; no exclusions. Frequency = none specified.

l. 19. Radiation Therapy. Treatment of carcinoma by means of ionizing radiation; no exclusions. Frequency = none specified.

m. 20. Tube Feeding Route. Respond with appropriate code in the following list; no exclusions. Frequency = none specified.

'1' N/A - not tube fed

'2' Nasogastric

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'3' Nasojejunal

'4' Esophagotomy

'5' Jejunostomy

n. 21. Reserved space

3. Medical Events Section

22. Decubitus Level. Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below. For a patient to be coded as level 4, documentation by a licensed clinician (e.g., physician, podiatrist, registered nurse) must exist and describe: the patient's decubitus; the active treatment plan, circumstances or medical condition

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which led to the decubitus. (An exception to this documentation requirement can be made for newly admitted patients whose decubitus developed prior to admission and involved unknown causes and circumstances.) Levels:

'0' No reddened skin or breakdown.

'1' Reddened skin, potential breakdown.

'2' Blushed skin, dusty colored, superficial layer of broken or blistered skin.

'3' Subcutaneous skin is broken down.

'4' Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.

'5' Patient is at level 4, but the documentation qualifier has not been met.

4. Medical Conditions

a. General. For a "Yes" to be answered for any of these conditions, condition must have existed during the past 4 weeks or since admission/transfer; written support exists documenting the patient has the condition; and specific condition(s) are as defined in (d), (2) through (6).

b. 23. Comatose. Unconsciousness, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days. Example of causes; brain insult, hepatic encephalopathy, cardiovascular accident. Examples of treatments; total activities of daily living (ADL), intake and output, parenteral feeding.

c. 24. Dehydration. Excessive loss of body fluids requiring immediate medical treatment and ADL care. Examples of causes; fever, acute urinary tract infections, pneumonia, vomiting, unstable diabetes. Examples of treatments; intake and output, electrolyte laboratory tests, parenteral hydration, nasal gastric feedings.

d. 25. Internal Bleeding: Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration. Use only the causes presented in the definition; exclude external hemorrhoids and other minor blood loss which is not dangerous

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and requires only minor intervention. Examples of treatments; critical monitoring of vital signs, transfusion, use of blood pressure elevators, plasma expanders, blood likely to be needed every 60th days.

e. 26. Stasis Ulcer. Open lesion: usually in lower extremities, caused by decreased blood flow from chronic insufficiency. Examples of causes; severe edema, diabetes, PVD (Peripheral Vascular Disease). Examples of treatments; sterile dressing, compresses, whirlpool, leg elevation.

f. 27. Terminally Ill. Professional prognosis (judgment) is that patient is rapidly deteriorating and will likely die within 3 months. Examples of causes: end stages of carcinoma, renal disease, cardiac diseases. Examples of treatments: ADL care, social/emotional support.

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g. 28. Reserved space

h. 29. Reserved space

i. 30. Reserved space

5. Selected Diagnoses

a. General. For a "YES" to be answered from any of these diagnoses, written support that the patient has the disease must exist.

b. 31. Quadriplegia. Includes both complete and incomplete paralysis of all limbs. (ICD-9-CM 344.0) Does not include paraplegia or any other forms of paralysis.

c. 32. Multiple Sclerosis. (ICD-9-CM 340) does not include any other diseases of the central nervous system.

d. 33. Urinary Tract Infection. Site of infection does not have to be specified. (ICD-9-CM 599.0)

e. 34. Hemiplegia. Includes both complete and incomplete paralysis of one side of the body regardless of cause. (ICD-9-CM 342.9)

f. 35. - 38. Reserved spaces

6. Activities of Daily Living (ADL's; eating, mobility, transfer, toileting:

a. Use the following qualifiers in answering each ADL question:

(1) Time Period. Past 4 weeks or since admission/transfer.

(2) Frequency. Assess how the patient completed each ADL 60 percent or more of time it was performed (since the ADL status may fluctuate during the day or over the past 4 weeks).

(3) CHANGED CONDITION RULE. When a patient's ADL has improved or deteriorated during the past 4 weeks and this course is unlikely to change, measure the ADL according to it status during the past several days.

(4) Definitions

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(a) SUPERVISION means verbal encouragement and observation, not physical hands-on.

(b) ASSISTANCE means physical hands-on care.

(c) INTERMITTENT means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.

(d) CONSTANT means one-to-one care which requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

NOTE. How these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

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b. 39. Eating. Number 3, "Requires continual help..." means that the patient requires a staff person's continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat. #5, "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified. Includes gastrostomy.

c. 40. Mobility. Number 3, "Walks with constant supervision and/or assistance..." may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is learning to ambulate.

d. 41. Transfer: Number 4, "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient requires the help of two people to transfer. Number 5, "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

e. 42. Toileting. Incontinent is defined as 60 percent or more of the time the patient loses control of bladder or bowel functions, with or without equipment.

(1) Number 1, "Continent..." Requires no or intermittent supervision.

(2) Number 2, "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with toileting equipment (for example, catheter).

(3) Number 3, "Continent...Requires constant supervision/total assistance..." refers to a patient who may not be able to balance self and transfer, has contractures, has a fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence equipment (for example, Colostomy, Ileostomy.)

(4) Number 4, "Incontinent...Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bedbound or is mentally confused to the extent that a scheduled toileting program is not beneficial.

(5) Number 5, "Incontinent...Taken to a bathroom.." refers to a patient who is on a formal toileting schedule as documented in the medical record. This

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patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

(6) A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level 4 and 5 refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

(7) Example 1: A patient requires constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PAI because the patient is receiving the type of care described in this question for bowel incontinence.

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(8) Example 2: The patient requires intermittent supervision for bowel function (level 2), and is taken to the toilet every two hours for a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

7. Behaviors Section

a. The following qualifiers must be met in responding to questions 43 - 46:

(1) Time period - past 4 weeks or since admission/transfer.

(2) Frequency - As stated in the responses to each behavioral question.

(3) Documentation. To qualify a patient as level 4 or to qualify the patient as a "yes" to "Hallucinates", patient must have an active treatment plan in current use and must have a psychiatric assessment by a recognized professional with clinical privileges to the determination that the patient exhibits a severe behavioral problem.

b. Definitions

(1) "Patient's behavior" is to be measured as displayed with the behavior modification and treatment plan in effect during the past four weeks or since admission/transfer.

(2) "Disruption" is when the patient interferes with the staff and/or other patients through verbal outbursts and/or physical actions. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.

(3) "Nondisruption" refers to the patient who may have verbal outbursts and/or physical actions but these are considered to be irritating but do not create a need for immediate action by the staff.

(4) "Unpredictable behavior" refers to when there is no evident pattern or indication of any predictable circumstance when the patient will exhibit the behavioral problem.

(5) "Predictable behavior" takes into consideration past observations and experiences staff have with the patient which allow them to plan appropriate responses in advance. For example, the behavioral problem may occur during

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bathing, specific treatments, or for a logical reason such as being criticized, bumped into, etc.

8. Specialized Services Section

Rehabilitation Medicine Therapies (RMS), 47. - 51.

a. For each therapy, three types of information will be entered on the PAI: Level, days, and number of hours and minutes per week.

b. For a patient not receiving a therapy, the "level" will always be "1" (does not receive) and the "days" will always be "0" for each therapy not being provided.

c. For a patient receiving one or more rehabilitative therapies, documentation must exist, in the patient's record, to enable the assessor to respond to the following questions:

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(1) Who ordered the therapy for the patient?

(2) Who designed and is evaluating the treatment program?

(3) How long has therapy been provided or will be provided?

(4) What is the patient's potential for recovering or improving physical or mental ability related to the practice area of the therapy being provided?

(5) What are the hours and minutes per week the patient receives therapy?

If any one of these questions cannot be answered from the patient's documentation, level "4" (non-qualifying program) should be entered.

d. To enter the hours and minutes, use a number between 0 and 5059, where the first two digits/blocks, represent hours and the second two digits/blocks, represent minutes. Do not use leading zeroes when therapy is provided; however, enter all zeroes if patient receives no rehabilitation therapy. For example: 30 minutes would be 30; 3 hours and 45 minutes would be 345; 10 hours would be 1000; and 15 and 1/2 hours would be 1530; no rehabilitation therapy received would be 0000.

e. For either level "2" (maintenance program) or level "3" (restorative program) to be entered for any therapy, a physicians order for the therapy must exist; a licensed professional therapist with a 4-year specialized therapy degree (or a more highly trained person such as an osteopath or physiarist) must have designated the program and must be evaluating the program monthly; the therapy must have been provided within the past 4 consecutive weeks.

(1) For newly admitted/transferred patients, the 4 week qualifier can be considered met if the patient has started receiving therapy and the therapist has documented in the care plan that therapy is needed for four consecutive weeks.

(2) In addition to the three basic qualifiers, for a level "2" (maintenance therapy), the patient's documentation must state that there is no potential for increased ability. In such cases, therapy is provided to maintain and/or retard deterioration of current status or ability.

(3) In addition for the three basic qualifiers for a level "3" (restorative therapy), the patient's documentation must state that there is positive potential for improved ability within a short and predictable period of time.

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The therapy plan and progress notes should support the restorative nature of the therapy, for example, evidence of improvement.

f. For "days" per week, any patient not receiving a therapy is coded as "0" in the appropriate blank(s). In entering days per week for a patient receiving therapy, count only days on which the qualifiers reflected in h., (9), (a) and (b) are met. Based on the past 4 consecutive weeks, enter the average number of days per week the patient has received therapy in sessions which meet the two qualifiers. For new admissions/transfers, enter the number of days per week the patient's therapy plan states is needed.

(1) The therapy session must be one-to-one. Exclude group therapy such as PT (Physical Therapy) or CT (Corrective Therapy) exercise or OT (Occupational Therapy) cooking sessions. Group therapy is defined as caring for two or more patients at the same time.

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(2) The therapy session must be provided by a specialized professional (4-year degree) therapist or by a therapy assistant under the supervision of a professional therapist.

g. Definition of Rehabilitation Medicine Therapies

The five therapies listed on the PAI equate to the position title and General Schedule occupational series code, as defined by the United States Office of Personnel Management, of the employee providing the one-to one therapy sessions.

(1) PT is therapy provided by a physical therapist, GS-6 33-02, or by a physical therapy assistant, GS-636-18, or therapy assistant, GS-636-07 under the supervision of a physical therapist.

(2) OT is therapy provided by an occupational therapist, GS-631-02, or by an occupational therapy assistant, GS-636-15, or therapy assistant, GS-636-07 under the supervision of an occupational therapist.

(3) Kinesiotherapy is therapy provided by a kinesiotherapist (also known as a corrective therapist) , GS-635-02, or by a kinesiotherapy assistant, GS-636-02, or therapy assistant, GS-636-07 under the supervision of a kinesiotherapist.

(4) Manual Arts Therapy is therapy provided by a manual arts therapist (also known as a vocational rehabilitation therapist), GS-636-04, or by a manual arts (or vocational rehabilitation) therapy assistant, GS-636-12, or therapy assistant, GS-636-07 under the supervision of a manual arts (vocational rehabilitation) therapist.

(5) Educational Therapy is therapy provided by an educational therapist, GS-639-04, or therapy assistant, GS-636-07 under the supervision of an educational therapist.

h. Any therapy sessions provided by a therapy aid, GS 636-06, are nonqualifying. Also excluded is therapy provided by staff holding recreational therapy positions, occupational code series GS-638.

i. Many facilities do not employ corrective, manual arts (vocational rehabilitation) and/or educational therapists. If this is the case, do not leave the responses blank for these therapies; use the appropriate codes such as "1" (does not receive) and "0" (days per week).

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November 13, 1991

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

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1. Transmitted is a new chapter to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 31, "Long-Term Care Patient Assessment."

2. Principal purposes of this chapter are:

a. Paragraph 31.01: Provides a general description of Long-Term Care Patient Assessment.

b. Paragraph 31.02: Defines the Long-Term Care Resource Allocation system which is based upon the RUG-II Patient Classification System.

c. Paragraph 31.03: Defines the administrative responsibility for completing the assessment.

d. Paragraph 31.04: Establishes the bed occupants for inclusion.

e. Paragraph 31.05: Establishes the patient assessment file schedule.

f. Paragraph 31.06: Identifies the patient assessment instrument.

g. Appendix 31A: Provides instructions for completing VA Form 10-0064a, Long-Term Care Patient Assessment Instrument.

3. Filing Instructions

After chapter 30, insert pages 31-i through 31A-8

4. RESCISSION: VHA Circular 10-89-92, dated August 28, 1991, and Supplement No. 1, and Attachment B to VHA Circular 10-86-103.

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November 13, 1991

James M. Holsinger, Jr., M.D.
Chief Medical Director

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