

December 7, 2005

VA NURSING HOME CARE UNIT (NHCU) ADMISSION CRITERIA, SERVICE CODES, AND DISCHARGE CRITERIA

1. PURPOSE: The Veterans Health Administration (VHA) Directive provides policy regarding Department of Veterans Affairs (VA) Nursing Home Care Unit (NHCU) admissions, service codes, and discharge criteria.

2. BACKGROUND

a. Nursing home care delivery has undergone significant change in service structure over the past 10 years, both in VHA and in the private sector. The delineation of services has become clearer and the population served more readily identifiable by resource utilization group (RUG) and case mix. VA NHCUs need to designate services already provided under NHCU into identifiable units that are defined by new codes. The following definitions are the types of services offered in VA nursing homes; they provide VA NHCU admission committees with a framework for admission decisions based on services offered rather than demand alone.

d. **Definitions**

(1) **Short Stay.** Short stay services are those where, on admission, the veteran's expected length of stay in the NHCU is 90 days or less.

(2) **Long Stay.** Long stay services are those where, on admission, the veteran's expected length of stay is beyond 90 days.

(3) **Short-stay Rehabilitation.** Time-limited, goal-directed care for the purpose of returning the veteran to functioning as independently as possible. Services are rendered and goals achieved by an interdisciplinary effort to improve function. The primary resources for care are physical therapy (PT), occupational therapy (OT), kinesiotherapy (KT), speech and language pathology (SLP), or a combination of all four. Therapy minutes are clearly documented and the resident's Minimum Data Set (MDS) assessment generates one of the subgroups in the Rehabilitation Resource Utilization Groups (RUG). Outcomes are measured by Functional Independence Measure (FIM) scores. Levels of care are: high-, medium-, or low-intensity inpatient care, depending on the veteran's needs and goals for rehabilitation.

(4) **Short-stay Skilled Nursing Care.** Time-limited, goal-directed care for specific conditions and/or interventions that require the involvement of a Registered Nurse (RN) and/or licensed nurse (Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN)) on a daily basis. Examples of short-term skilled services include: intravenous therapy; stages 3 and 4 pressure sores; complex wound care; ventilator, respirator, suctioning, or tracheotomy care; tube feeding; and other interventions where the complexity of resident needs requires direct intervention by a licensed nurse. This population may also benefit from episodic or supportive

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rehabilitation, as indicated with at least one therapy intervention such as PT, OT, KT, or SLP, based on identified changes in functional status as documented in the MDS and/or progress notes by the nursing staff.

(5) **Short-stay Restorative Care.** Time-limited care with the purpose of providing short-term restorative interventions, such as bowel and bladder training and toileting; restorative dining; ambulation; etc. The purpose of the admission is to provide a transition from the hospital through short-term restorative care prior to discharge. The primary resources for care include: restorative aides, nurses, KT, and recreation therapy. This population may also benefit from supportive or low-intensity rehabilitation as indicated, with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(6) **Short-stay Maintenance Care.** Time-limited care for those awaiting alternative placement, such as to a community nursing home or state veterans home. The primary resources for care include social work, nursing, and therapeutic recreation or KT. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(7) **Short-stay Psychiatric or Chronically Mentally Ill Care.** Time-limited care with purpose of providing evaluation and management, such as medication adjustment and behavioral interventions for veterans with exacerbation of medical and or behavioral symptoms. These veterans are expected to return to their previous living arrangements upon discharge. The primary resources for care include: recreation therapy, social work, nursing, and psychology and/or psychiatry. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(8) **Short-stay Dementia Care.** Time-limited, goal-directed care with the purpose of stabilizing symptoms and developing a plan of care to meet ongoing needs within the secure environment of an existing dementia program. Staff competencies are evident; dementia-specific care centers on behaviors, functional and cognitive deficits, patient and caregiver education and support. Return to the home or discharge to the community is expected. The primary resources for care include activities and recreation therapy, social work, nursing, and psychology or psychiatry. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(9) **Long-stay Dementia Care.** Although dementia specific care may be delivered in any nursing home environment where the safety of the resident is protected, the environment is appropriately stimulating, and staff competencies are evident, dementia specific units and care consider the functional deficits associated with long-term, chronic cognitive deficits. The primary resources for care include recreation therapy, KT, social work, and nursing. This population may also benefit from supportive or episodic rehabilitation as indicated with at least

one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(10) **Long-stay Skilled Nursing Care.** Skilled-nursing care that is time-limited, goal-directed and/or for specific conditions and/or interventions that require the involvement of an RN and/or an LPN or LVN on a daily basis, but exceeds the 90 day requirement for short stay skilled nursing care. Examples of long stay skilled services include prolonged wound care; persistent Total Parenteral Nutrition (TPN), ventilator, respirator, suctioning, or tracheotomy care; tube feeding; and other interventions where the complexity of resident needs requires direct intervention by licensed nurses over a time frame greater than 90 days. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(11) **Long-stay Maintenance Care.** Emphasis of care is on maintaining function and/or preventing further decline in nursing home residents with multiple functional deficits who require supervision and oversight by an RN, but who do not require licensed nurse interventions daily. For example, veterans with long-standing chronic functional disabilities for whom active rehabilitation is no longer an option, or the deployment of an RN, LPN, or LVN, is not necessary. Primary resources for care include recreation therapy, nursing, and social work. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(12) **Long-stay Psychiatric or Chronically Mentally Ill.** Differentiated from acute long-term psychiatric care and dementia care, veterans admitted have chronic stable mental illness coupled with geriatric syndromes that render them less able to function in non-institutional settings. The homelike environment and milieu on a unit, or in a program specifically-designed for caring for this population, minimizes aberrant behavior and utilizes therapeutic recreation and socialization to enhance quality of life and prevent psychiatric exacerbations. Primary resources for care include recreation therapy, social work, psychology, and psychiatry. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.

(13) **Long-stay Spinal Cord Injury and Disorders (SCI&D).** Emphasis of care is on veterans who have a primary diagnosis of SCI&D and require nursing home care for extended periods of time or for life. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes. Primary resources for care include: skilled nursing, PT, OT, KT, as well as lifetime care for patients that are unable to be managed in non institutional settings due to level of assistance required and functional impairment.

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(14) **Palliative Care.** In admitting veterans for palliative care, it is important to note that hospice care currently has a designated treating specialty code, 96, while palliative care has not been assigned a code. Palliative care is a broader term that includes hospice care as well as other care that emphasizes symptom control, but does not necessarily require presence of an imminently terminal condition, a time-limited prognosis, or exclusion of all aggressive or curative therapies. Palliative care may include a balance of comfort measures and curative interventions that vary across a wide spectrum.

(a) Therefore, a veteran who has been designated as palliative care in the physician orders, in the admission note, or in a progress note, needs to be admitted to the particular service that is offered in the nursing home and not necessarily to a palliative care unit, unless the veteran is admitted for hospice services which will then be coded as hospice. In this situation, the admitting diagnosis reflects the resident needs for a particular service. Palliative care is entered as the secondary diagnosis designating special attention to the fact that this veteran has a condition that is life limiting, but not imminent.

(b) For example, a veteran with advanced dementia may be receiving outpatient palliative care consistent with the expressed goal of comfort and then develop a hip fracture from a fall. Surgical repair of the hip fracture may be appropriate, with the goals of reducing pain and promoting maximal mobility. The veteran may be admitted to the nursing home for short-term rehabilitation services. The primary diagnosis must reflect the need for rehabilitation; the admissions orders or the admission note must indicate palliative care as a secondary code.

3. POLICY: It is VHA policy that VA NHCUs admissions must be categorized into short-stay services or long-stay services, and coded and placed in the appropriate treating specialty.

4. ACTION: Medical facility Directors are responsible for ensuring that effective January 31, 2006, all new admissions to VA NHCUs are placed in the appropriate treating specialty, and coded into the Veterans Health Information Systems and Technology Architecture (VistA) according to the admission categories most closely reflective of the service needs. These service categories and codes are:

(1) **Short Stay**

(a) Rehabilitation (64)

(b) Skilled Nursing (95)

(c) Restorative care (66)

(d) Maintenance care for those awaiting alternative placement (67)

(e) Psychiatric Care (68)

(f) Dementia Care (69)

- (g) Geriatric Evaluation and Management (GEM) (81)
- (h) Hospice (may exceed 90 days) (96)
- (i) Respite Care (47)
- (2) **Long Stay**
- (a) Dementia care (42)
- (b) Skilled Nursing Care (43)
- (c) Maintenance Care (44)
- (d) Psychiatric Care or Chronically Mentally Ill Care (45)
- (e) Spinal Cord Injury and Disorders (46)

NOTE: The treating specialty code for NHCU 80 will be discontinued on April 1, 2006.

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The Office of Geriatrics and Extended Care (114) is responsible for the contents of this Directive. Questions may be referred to Chief, Nursing Home Care, at 202-273-8544.

7. RESCISSIONS: None. This VHA Directive expires December 31, 2010.

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ATTACHMENT A

VA NURSING HOME CARE UNIT (NHCU) ADMISSION, SERVICE DELIVERY, AND DISCHARGE CRITERIA

1. ADMISSION CRITERIA

- a. The veteran must be medically and psychiatrically stable,
- b. The primary type of service needed must be documented according to paragraph 3 of the Directive,
- c. The anticipated length of stay is documented,
- d. The anticipated discharge disposition from the Nursing Home care Unit (NHCU) is documented, and
- e. Priority for the NHCU is established and documented. *NOTE: Special Populations for whom community placement is difficult will receive special consideration.*

2. APPROVING VETERANS FOR ADMISSION

- a. Decisions regarding approval of admissions to the NHCU for services and designation of treating specialty must be made by an established interdisciplinary NHCU screening and/or admissions committee and/or a designated NHCU admission coordinator or leader. The treating specialty codes must be entered into the Veterans Health Information Systems and Technology Architecture (VistA) by the designated unit clerk or person authorized to enter treating specialty codes into VistA.
- b. If there is a dispute about an admission decision, the final decision is the purview of the NHCU medical director and must be based on the veteran's need for care, the services defined and available in the nursing home, and the competencies of the NHCU staff to provide the service.

3. SERVICE DELIVERY

- a. **Staff Competencies.** Services may be provided on designated units or areas in the NHCU, or may be provided without specific designation. Regardless of where NHCU services are provided, staff must demonstrate age-specific competencies and competencies in regard to specific service the resident needs to receive. For example, if a NHCU admits residents for short-term skilled nursing services for intravenous (IV) therapy, staff must have documented competencies in this skill set; or if the NHCU admits residents for dementia care, the facility must ensure that the resident is safe, restraint free, and that the staff is competent to provide care to this dementia population.

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b. **Minimum Data Set (MDS)-type Completion.** When a resident is admitted for a short-stay service, the Medicare Prospective Payment Assessment of Function (MPAF) schedule must be followed. When a resident is admitted for a long-stay service, the 14 day MDS schedule must be followed.

4. CHANGES IN SERVICE NEEDS AFTER ADMISSION

a. If the resident is in need of multiple services, the resident needs to be admitted to the service that meets the resident's highest level and/or primary needs. For example, if the resident needs skilled care and rehabilitation, the resident needs to be admitted to rehabilitation. Once the resident has reached the rehabilitation goals, the resident needs to have the service changed to skilled nursing. If there is a significant change in condition, at the same time the service need changes, a change in condition MDS is to be completed and a new treating specialty ordered.

b. If a veteran is initially admitted for long-term maintenance care and develops a need for rehabilitation services or short-term skilled nursing, a change in condition MDS needs to be completed and the appropriate therapies ordered. The Resource Utilization Groups (RUGs) reflect the new status, but the code for long-term maintenance care needs to remain the same. The rehabilitation services are captured in the RUGs. Facilities need to contact Pharmacy Automated Data Processing Application Coordinators to check "ORDER ACTIONS ON PATIENT TRANSFER," and need to contact Clinical Applications Coordinators to review the Computerized Patient Record System (CPRS) Auto-DC events and/or rules to ensure that orders are not discontinued when residents are transferred to the NHCU treating specialties.

c. An order to change the treating specialty must be written by the medical provider accompanied by additions or discontinuation of previous orders to accompany the change. A new set of orders need not be written.

5. AVAILABILITY OF PARTICULAR SERVICES

It is important that the Department of Veterans Affairs (VA) NHCU Program is able to provide a broad-range of services needed by veterans. If the NHCU is unable to provide a particular service, it is advisable that the facility arrange for the service to be provided elsewhere. Every VA NHCU may not be able to provide the entire spectrum of NHCU services.

NOTE: Specific facility-based admission and discharge criteria for each service needs to be clearly defined by each facility taking into consideration staff competencies, staffing capability, and staff availability.

6. DISCHARGE CRITERIA

- a. The resident has met the treatment goals.
- b. The facility can no longer accommodate the resident due to change in care needs.

c. The resident evidences flagrant disregard for policies of the medical center (i.e., illegal activities) after being appropriately advised of such.

d. Long-stay residents who meet the criteria under Public Law 106-117 for long stay:

(1) May not be discharged to another facility or setting if they continue to require nursing home care, unless they agree to such a transfer.

(2) May be discharged, if they no longer require nursing home care, to another facility or setting if they continue to require nursing home care, such as when they have met their goals for admission and/or their condition has improved to the extent that they no longer require nursing home care.