

**ADMISSION CRITERIA, SERVICE CODES, AND DISCHARGE CRITERIA FOR
DEPARTMENT OF VETERANS AFFAIRS COMMUNITY LIVING CENTERS**

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook provides Department of Veterans Affairs (VA) policy and procedures regarding VA Community Living Center (CLC) admission criteria, service codes, and discharge criteria. *AUTHORITY: Title 38 United States Code §§ 101(28), 1710, 1710A, and 1710B.*
- 2. SUMMARY OF MAJOR CHANGES:** This is a new VHA Handbook.
- 3. RELATED DIRECTIVE:** VHA Directive 1142 (to be published).
- 4. RESPONSIBLE OFFICE:** The Office of Geriatrics and Extended Care (10P4G) in the Office of Patient Care Services (10P4) is responsible for the contents of this Handbook. Questions may be referred to Director, VHA Community Living Centers, at 202-461-6779.
- 5. RESCISSIONS:** VHA Directive 2006-014, VHA Manual M-2, Part I, Chapter 16, and VHA Manual M-5, Part II, Chapters 1, 2, and 3 are rescinded.
- 6. RECERTIFICATIONS:** This VHA Handbook is scheduled for recertification on or before the last working day of September 2017.

Robert A. Petzel, M.D.
Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 9/6/2012

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ADMISSION CRITERIA, SERVICE CODES, AND DISCHARGE CRITERIA FOR DEPARTMENT OF VETERANS AFFAIRS COMMUNITY LIVING CENTERS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides Department of Veterans Affairs (VA) procedures regarding VA Community Living Center (CLC) admission criteria, service codes, and discharge criteria. **AUTHORITY:** *Title 38 United States Code (U.S.C.) Sections 101(28), 1710, 1710A, and 1710B.*

2. BACKGROUND

The ultimate goal of CLC programs and services is to assist Veterans to achieve the highest practicable level of well-being and function. VA CLCs must designate services provided into identifiable services that are defined by treating specialty codes. The delineation of services by treating specialty codes facilitates ease in the identification of services provided and Veterans served by Resource Utilization Group (RUG) and case mix.

a. RUGs and case mix are generated from the Resident Assessment Instrument (RAI) Minimum Data Set (MDS). RUGs identify CLC residents' treatment needs and the resources required to provide that care. Case mix is a weighted average of RUGs on a unit or in the CLC.

b. The RAI MDS is a standardized assessment and treatment planning instrument established by the Centers for Medicare and Medicaid Services (CMS) to comply with certain nursing home related reforms required by the Omnibus Budget Reconciliation Act of 1987, Public Law (Pub. L.) No. 100-203, title IV, subtitle C, 101 Stat 1330 (1987). These requirements apply to all nursing homes in the United States (U.S.) that are certified by CMS. They require nursing homes to identify and act on risk factors to prevent functional decline in residents and to plan care that would delay any decline in residents' function. The RAI MDS was implemented in all U.S. private sector nursing homes in 1990 and is updated periodically. As a matter of policy, VA uses the same CMS standardized assessment and treatment instrument for its CLC program as a means of ensuring consistency with national nursing home standards, meeting accreditation standards of The Joint Commission, and facilitating comparisons between VA CLCs and nursing homes in the community or private sector.

NOTE: *CLCs are subject to the laws and policies governing nursing home care in VA nursing homes (see 38 U.S.C. Sections 101(28), 1710, 1710A, and 1710B). State Veterans Homes, which are governed by the State, are not governed by this VHA Handbook (See title 38 Code of Federal Regulations (CFR) parts 51 through 53 for the regulations governing State Veterans Homes).*

3. SCOPE

This VHA Handbook defines the services CLCs provide and describes the procedures for the admission and discharge process. This Handbook identifies uniform nomenclature for services offered in VA CLCs. Terms such as "subacute care, intermediate care, and transitional care" are not considered official nomenclature for services in VA CLCs.

4. DEFINITIONS

- a. **Short-stay.** Short-stay services are those where, on admission, the Veteran's expected length of stay in the CLC is 90 days or less.
- b. **Long-stay.** Long-stay services are those where, on admission, the Veteran's expected length of stay is greater than 90 days.

5. RESPONSIBILITIES OF THE MEDICAL FACILITY DIRECTOR

The Medical Facility Director is responsible for:

- a. Ensuring all admissions to VA CLCs are properly assessed for medical and psychiatric stability and appropriateness of admission by a CLC-based admission coordinator or team.
- b. Ensuring all CLC admissions are categorized into short-stay services or long-stay services, and coded as the appropriate treating specialty in the Veterans Health Information Systems and Technology Architecture (VistA) according to the admission categories most closely reflective of the service needs (see App. A for service categories and treating specialty codes).
- c. Ensuring all CLC admissions have documentation of an anticipated discharge date and anticipated discharge destination.
- d. Ensuring designated CLC beds are not used for observation care, hoptel, or other services not specifically designated as CLC beds without prior approval of the VHA Central Office Program Office and submission of an appropriate bed request.

6. SERVICES

NOTE: The following services may be offered in VA CLCs. The service descriptions provide VA CLC admission coordinators, teams or designees with a framework for admission decisions based on services offered.

- a. **Short-stay Rehabilitation.** Short-stay rehabilitation is time-limited, goal-directed care for the purpose of returning the Veteran to functioning as independently as possible.

(1) Care and services are provided in a home environment that enhances preparation for discharge and readies the Veteran to function in a non-institutional setting. The program may be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF).

(2) The primary resources for care are physical therapy, occupational therapy, recreation therapy (RT), speech and language pathology, or a combination of all four. Therapy minutes must be clearly documented and the Veteran's MDS assessment needs to generate one of the subgroups in the Rehabilitation RUG. Outcomes are measured by Functional Independence Measure scores. Levels of care are ultra high, very high, high, medium, or low intensity inpatient care, depending on the Veteran's needs and goals for rehabilitation. Mental health

providers (psychology and psychiatry), required to be fully integrated into the CLC pursuant to VHA Handbook 1160.01, must be available to support rehabilitative care goals. The goals of care are restoration of the highest practicable level of well-being and functional independence.

b. **Short-stay Skilled Nursing Care.** Short-stay skilled nursing care is time-limited, goal-directed care for specific conditions or interventions that require the involvement of a Registered Nurse (RN) or a licensed nurse (Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN)) on a daily basis. Care and services are provided in a home environment that enhances preparation for discharge and readies the Veteran to function in a non-institutional setting. Mental health providers (psychology and psychiatry), required to be fully integrated into the CLC pursuant to VHA Handbook 1160.01, must be available as needed.

(1) Examples of short-stay skilled nursing services include, but are not limited to: intravenous therapy, care of stages 3 and 4 pressure ulcers, complex wound care, ventilator care, suctioning, tracheotomy care, tube feeding, and other interventions where the complexity of Veteran needs requires direct intervention by a licensed nurse. The goal of care is to prepare the Veteran for discharge to a home and community-based setting and facilitate the achievement of the highest practicable level of well-being and function.

(2) Short-stay skilled nursing care for Veterans with Spinal Cord Injury or Disorders (SCI/D) is identified under skilled nursing. Veterans with a primary diagnosis of SCI/D are often admitted to a CLC for time-limited, goal-directed care to achieve and maintain the highest level of function and well-being.

(a) Primary resources to achieve this level of care include, but are not limited to: skilled nursing, respiratory therapy (RT), physical therapy (PT), occupational therapy (OT), kinesiotherapy (KT), and therapeutic recreation. Staff competencies are essential for the unique conditions and problems that Veterans with SCI/D may develop related to the underlying SCI/D. These include, but are not limited to: autonomic dysreflexia (AD), neurogenic bowel and the need for a scheduled bowel program, neurogenic bladder and the difference between colonized urine and a urinary tract infection, respiratory complications due to impaired cough and difficulty in mobilizing secretions, spasticity and the need for daily range of motion, and pressure ulcers secondary to neurogenic skin.

(b) The CLC must contact the closest SCI/D Center for consultation in the care of all Veterans with SCI/D and review the SCI/D Services Intranet site at <http://vaww.sci.va.gov> for care of the unique needs of these Veterans. **NOTE:** *This is an internal Web site and is not available to the public.*

(3) Short-stay skilled nursing care is available for Veterans admitted to the Geriatrics Evaluation and Management (GEM) program where a Veteran is assessed by a multidisciplinary team. The multidisciplinary team provides comprehensive evaluation of the Veteran's health status, management of chronic stable conditions including, but not limited to: a thorough assessment of function, medication management, and support services. The program recommends interventions and prepares the Veteran to be able to continue to live in the community. The goal of care is to enhance the ability of the Veteran to achieve the highest practicable level of well-being and to remain in the community.

c. **Short-stay Restorative Care.** Short-stay restorative care is time-limited care with the purpose of providing short-term restorative interventions, such as bowel and bladder training and toileting, restorative dining, and ambulation.

(1) The goal of care is to facilitate Veteran's achievement of the highest practicable level of independence, well-being, and function.

(2) The purpose of the admission is to provide a transition from the hospital through short-term restorative care prior to discharge to a non-institutional setting that is the least restrictive yet most appropriate setting for the Veteran.

(3) The primary resources for care include a home environment and restorative nursing, nurses, KT, and RT. Veterans receiving this level of care may benefit from episodic or supportive low-intensity rehabilitation as indicated, with at least one therapy intervention such as PT, OT, KT, and Speech and Language Pathology (SLP) based on identified needs. Mental health providers (psychology and psychiatry), required to be fully integrated into the CLC pursuant to VHA Handbook 1160.01, must also be available as needed.

d. **Short-stay Continuing Care.** Short-stay continuing care is time-limited care for Veterans awaiting alternative placement (for instance, to a community nursing home, State Veterans Home, or any other community-based setting), and time-limited care for Veterans admitted to the CLC for Respite services.

(1) The goal of care is to achieve the highest practicable level of well-being, function, and prevention of premature decline.

(2) The primary resources for care include social work, nursing, and therapeutic recreation or KT. Veterans receiving this level of care may benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified needs. Mental health providers (psychology and psychiatry), required to be fully integrated into the CLC pursuant to VHA Handbook 1160.01, must also be available as needed.

e. **Short-stay Mental Health Recovery.** Short-stay mental health recovery is time-limited recovery centered care with the purpose of providing evaluation and management, such as medication adjustment, evidence-based psychosocial behavioral interventions for Veterans with exacerbation of medical and/or behavioral symptoms that can be managed in a non-psychiatric inpatient setting.

(1) Veterans receiving this level of care are expected to return to their previous living arrangements upon discharge. In this recovery-oriented therapeutic setting, active, evidence-based psychological and psychopharmacological treatment services needs to be the focus of care. The Veteran and family members or significant other must be given opportunities to learn how to manage care and challenging behaviors. Education for the Veteran and the family must include how to identify factors that prevent behavioral exacerbations, behavioral management techniques, and assistance in identifying relevant VA and community based resources.

(2) The primary resources for care include RT, social work, nursing, and psychology and psychiatry. VHA Handbook 1160.01 requires that all CLCs have fully integrated mental health providers who serve as integral members of the interdisciplinary care team. The care setting reflects home and provides opportunities for Veterans and their care givers to engage in activities that prepare the Veteran for discharge to a non-institutional setting. Veterans receiving this level of care 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 needs. The focus of care and therapy must include activities that enhance physical strength and mobility and psychological recovery to maintain the highest practicable level of well-being and overall function.

f. **Short-stay Dementia Care.** Short-stay dementia care is 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.

(1) Veterans receiving this level of care are expected to return to their previous living arrangements upon discharge. Therefore, the household environment provides cues for resident behavior management and functional improvements. The family, or significant other, need to be involved in learning about safe and effective care practices in the home, resources for continued support, access to home telehealth, and other services that support the Veteran and assist the family, or significant other, to continue to care for the Veteran at home. This program may offer family, or significant other, behavior management skills and opportunities to practice skills while the Veteran is in the CLC.

(2) Staff competencies are essential and must be documented in the staff member's record and must be evident when care delivery is observed. Dementia-specific care focuses on the respectful management of challenging behaviors, functional and cognitive improvement, meaningful use of time, and Veteran and caregiver education and support.

(3) The primary resources for care include activities and RT, social work, nursing, and psychology or psychiatry. Veterans receiving this level of care may benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified needs. Mental health providers (psychology and psychiatry) must also be available and part of the overall interdisciplinary care team to help address challenging dementia-related behaviors and other mental health issues that may arise in Veterans cared for in this setting. The focus of care and therapy needs to include activities that enhance physical strength and mobility and promote maximal psychological functioning to allow the Veteran to maintain the highest practicable level of well-being and overall function.

g. **Hospice and 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.

(1) Palliative care may include a balance of comfort measures and curative interventions that vary across a wide spectrum. Palliative care may also include psychosocial, as well as spiritual care to help address psychological and existential issues.

(2) A Veteran who has been determined as requiring palliative care in the physician orders, in the admission note, or in a progress note and is not yet receiving hospice care, is to be admitted to the particular treating specialty that is offered in the CLC.

(a) If the Veteran is admitted for hospice services, the admission must be coded as hospice care. In the situation of palliative care, the admitting diagnosis reflects the Veteran's need for a particular service designated by treating specialty code.

(b) 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 is not imminently terminal. For example, a Veteran with advanced dementia may be receiving outpatient palliative care consistent with the expressed goal of comfort and then may 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 CLC for short-term rehabilitation services as the treating specialty. The primary diagnosis must reflect the need for rehabilitation; the admission orders or the admission note must indicate palliative care as a secondary diagnosis.

(3) Veterans who are receiving hospice care in the community may be admitted directly or through the Emergency Department (ED) to the CLC only under the following conditions:

(a) The Veteran is known to the CLC providers or Hospice and Palliative Care Team or was examined in the ED by the CLC or Hospice and Palliative Care Team and deemed appropriate for admission to the CLC, and the CLC is able to provide care for the Veteran.

(b) The CLC admission coordinator or team or a CLC RN leader (who may be a charge RN) is notified of the potential admission and agrees that the CLC can provide the appropriate care.

(c) The CLC staff is able to provide the appropriate care and treatment for the Veteran. For example, if a Veteran on hospice is using a ventilator and the CLC does not provide ventilator care, the Veteran may not be admitted to the CLC.

h. **Long-stay Dementia Care.** Dementia-specific care may be delivered in any CLC environment where the safety of the Veteran is protected or in a dementia-specific household.

(1) A dementia-specific household is a model of care where the care unit looks and feels like a home.

(a) This type of environment provides the resident with cues for daily living and functioning at the highest level possible. Dementia-specific households need to consider the functional deficits associated with long-term chronic cognitive deficits.

(b) The care environment must be appropriately stimulating and minimize challenging behaviors.

(c) The home environment and ambience in a household or in a program specifically designed for caring for this population must utilize therapeutic recreation, have a structured and creative approach to daily routines, provide meaningful use of time, and create opportunities for socialization to enhance quality of life.

(2) Staff competencies are essential and must be documented in the staff member's record and must be evident when care delivery is observed. Dementia-specific care focuses on the respectful management of challenging behaviors, functional and cognitive improvement, meaningful use of time, and Veteran and caregiver education and support.

(3) The primary resources for care include RT, KT, social work, and nursing with consultation from mental health professionals. Veterans receiving this level of care may benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified needs. Mental health providers (psychology and psychiatry) must also be available and part of the overall interdisciplinary care team to help address challenging dementia-related behaviors and other mental health issues that may arise in Veterans cared for in this setting. The focus of care and therapy needs to include activities that enhance physical strength and mobility and promote maximal psychological functioning to allow the Veteran to maintain the highest practicable level of well-being and overall function.

i. **Long-stay Continuing Care.** Veterans receiving continuing care are expected to remain in the CLC for 91 days or more. Care is provided in a home environment. The goal of care is maintaining the highest practicable level of well-being and function and prevention of further decline.

(1) Continuing care may require the involvement of an RN for oversight, including assessment and treatment planning, guiding, directing, and observing care, but may not require daily licensed nurse interventions. Examples of long-stay continuing care may include, but is not limited to, care for Veterans:

(a) With long-standing chronic functional disabilities for whom active rehabilitation is no longer an option;

(b) Who require assistance with basic activities of daily living, medication administration, and general supervision and who do not require direct skilled nursing services; or

(c) Who continue to require skilled nursing interventions that extend beyond the short-stay limit of 90 days. For instance, Veterans who continue to require skilled nursing interventions, such as complex wound care or ventilator care, will convert from a short-stay treating specialty to long-stay continuing care until the skilled nursing services are no longer needed. The skilled nature of the interventions must be documented in the Veteran's MDS generated RUGs.

(2) Primary resources for care need to include RT, nursing, and social work. This Veteran population may benefit from supportive physical activities and preventative exercise under the

direction of a KT or episodic time-limited goal-directed rehabilitation as indicated with at least one therapy intervention, such as PT, OT, RT, KT, and SLP based on identified needs. Mental health providers (psychology and psychiatry) must also be available as needed. The focus of care and therapy needs to include activities that enhance physical strength and mobility to maintain the highest practicable level of well-being and functioning.

j. **Long-stay Mental Health Recovery.** Differentiated from acute long-term psychiatric care and dementia care, Veterans admitted under long-stay mental health recovery treating specialty have chronic stable mental illness coupled with geriatric or other syndromes that render them less able to function in non-institutional settings. The goal of care is maintaining the highest practicable level of well-being and function and prevention of further decline.

(1) The home environment and ambience in a program specifically designed for caring for this population must:

(a) Utilize active, recovery-oriented, evidence-based psychological and psychopharmacological treatment service approaches, and therapeutic recreation;

(b) Have a structured and creative approach to daily routines;

(c) Provide meaningful use of time; and

(d) Create opportunities for socialization to enhance psychosocial functioning, promote quality of life, and prevent behavioral exacerbations or psychological emergencies.

(2) Primary resources for care need to include RT, social work, psychology, and psychiatry. VHA Handbook 1160.01 requires that all CLCs have fully integrated mental health providers. This population may 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 based on identified needs. The focus of care and therapy needs to include activities that enhance physical strength, mobility, and psychological recovery to maintain the highest practicable level of well-being and overall function.

k. **Long-stay Spinal Cord Injury and Disorders (SCI/D).** Veterans admitted under long-stay SCI/D treating specialty have a primary diagnosis of SCI/D and require CLC care for extended periods of time due to the level of assistance required and functional impairments that do not allow for independent living in the community.

(1) A home environment and recovery setting provides the Veteran with resources to achieve the highest level of well-being and function at the highest level. The CLC needs to contact the closest SCI/D Center for consultation in the care of Veterans with SCI/D. These Veterans must also be offered annual evaluations in a Spinal Cord Injury Center each year.

(2) Primary resources for care include, but are not limited to: skilled nursing, respiratory therapy, PT, OT, KT, and therapeutic recreation. Mental health providers (psychology and psychiatry) must also be available as needed. This population may benefit from supportive and episodic rehabilitation as indicated, with at least one therapy intervention such as PT, OT, KT,

RT, and SLP based on identified needs. The focus of care and therapy needs to include activities that enhance physical strength and mobility, functional activities, safety (e.g., fall prevention), stretching to avoid contractures, frequent pressure relief, and meticulous skin care to avoid pressure ulcers in order for the Veteran to achieve the highest practical level of well-being, independence and function.

(3) Staff competencies are essential for the unique conditions and problems that Veterans with SCI/D may develop related to the underlying SCI/D. These include but are not limited to: AD, neurogenic bowel and the need for a scheduled bowel program, neurogenic bladder and the difference between colonized urine and a urinary tract infection, respiratory complications due to impaired cough and difficulty in mobilizing secretions, spasticity, and the need for daily range of motion, and pressure ulcers secondary to neurogenic skin.

(4) The CLC must contact the closest SCI/D Center for consultation in the care of all Veterans with SCI/D and review the SCI/D Services Intranet site at: <http://vaww.sci.va.gov> for care of the unique needs of these Veterans. *NOTE: This is an internal Web site and is not available to the public.*

7. SERVICE DELIVERY

a. **Staff Competencies.** Services may be provided on designated specialized units or households in the CLC, or may be provided without specific designation. Regardless of where CLC services are provided; staff must demonstrate population-specific competencies and competencies in regard to a specific service the Veteran needs to receive. Examples may include but are not limited to:

(1) If a CLC admits Veterans for short-term skilled nursing services for intravenous therapy, staff must have documented competencies in this skill set.

(2) If the CLC admits Veterans for dementia care, the facility must ensure that the Veteran is safe, restraint-free, and that the staff is competent to provide care to the dementia population.

b. **Specialty Care Certifications.** Whenever possible, specialty care certifications for CLC staff are encouraged. In fact, CLC staff in a hospice and palliative care household must be encouraged to pursue a hospice and palliative care certification.

c. **Consistent Assignments.** It is expected that the same direct care staff must be consistently assigned to the same Veteran in the CLC to improve continuity of care, reduce errors, and improve Veteran outcomes.

d. **MDS Completion.** When a Veteran is admitted for a short-stay service, the Medicare Prospective Payment Assessment Form schedule must be followed. When a Veteran is admitted for a long-stay service, the 14-day MDS schedule must be followed. These schedules are located at:

<http://vaww.infoshare.va.gov/sites/geriatrics/MDS/Shared%20Documents/Forms/AllItems.aspx>

NOTE: This is an internal Web site and is not available to the public.

e. **Availability of Particular Services.** It is important that the VA CLC Program is able to provide a broad-range of services needed by Veterans. If the CLC is unable to provide a particular service, it is advisable that the facility arrange for the service to be provided elsewhere in the VA system or in the community as authorized under title 38 U.S.C. 1720. **NOTE:** *Not every VA CLC will be able to provide the entire array of CLC services.*

8. APPROVING VETERANS FOR ADMISSION

a. All Veterans admitted into the CLC must be medically and psychiatrically stable.

b. All admissions to the CLC must be properly assessed for appropriateness of admission by a CLC-based admission coordinator, team, or CLC leader. The CLC Coordinator, team, or CLC leader must have sufficient knowledge about the programs and services offered at the CLC and must be able to determine if the CLC is the most appropriate setting for a particular Veteran. The following questions must be addressed for every admission consultation:

(1) **Why (for what service) is the Veteran being admitted to the CLC?** The answer will determine the correct treating specialty code.

(2) **What is the expected length of stay?** The expected length of stay determines short-term treatment goals and facilitates discharge planning. This includes setting realistic short-term goals to ensure achievement of goals for care in preparation for discharge and setting long-term goals that describe the anticipated functional ability and state of the Veteran upon discharge. The expected length of stay in the CLC must be documented by the designated CLC admission person in the designated space in Section S of the RAI MDS at the time of admission.

(3) **To where will the Veteran be discharged?** The answer will inform the team to begin early discharge planning and prepare the Veteran for home and community-based follow up and services.

c. The primary discharge destination and type of service needed must be documented and the treating specialty codes must be determined when the admission decision is made. The designated unit clerk or authorized staff member must enter the treating specialty codes into VistA.

d. The expected length of stay and anticipated discharge destination must be documented in the transfer order by the transferring VA provider and endorsed by the designated CLC admission person or team.

e. The decision to admit a Veteran to a CLC must be based on the Veteran's need for care, the services defined, and if the services needed are available in the CLC. The ultimate decision about an admission is to be made by the VA CLC medical director in collaboration with the designated CLC nurse leader.

f. Competencies of the CLC staff to provide the service a Veteran requires must be evident by the fact that the particular service is considered common practice in the respective CLC or

training must be provided to ensure staff has the necessary competencies without compromising Veteran safety.

h. Priority for the CLC is established and documented. Special populations for whom community placement is difficult receive special consideration, provided that the CLC staff is able to provide the needed services.

9. DIRECT ADMISSIONS FROM THE EMERGENCY DEPARTMENT TO THE CLC

a. Direct admissions from the ED to VA CLCs are not allowed except for Veterans who are designated as receiving or needing hospice services and who meet the criteria in subparagraph 6g (3). This limitation ensures that VA CLCs only admit Veterans whom they can safely manage. The CLC criteria for admission, requires that a CLC medical provider perform a medical and psychiatric evaluation of the Veteran to confirm that the Veteran is medically and psychiatrically stable. A designated CLC admission coordinator or team must also make a determination as to whether the needs of the Veteran can be met in the CLC (given that not all VA CLCs offer all of the services identified in this Handbook). The admission coordinator or team and the medical provider transferring the Veteran for CLC services are further required to determine the reason for admission, estimated length of stay, and estimated discharge disposition.

b. When a Veteran presents in the ED, if the acuity of the Veteran's condition for admission to the CLC is in question, the Veteran may be admitted to an observation unit for up to 23 hours and 59 minutes or to an acute inpatient unit for 24-48 hours. The CLC admission coordinator or team must be notified as soon as it is determined that a Veteran may need CLC admission. If the stability of the Veterans mental health is in question the ED provider or CLC provider must consult with the psychiatrist on call.

c. While the Veteran's medical and psychiatric stability are being assessed, the CLC admission coordinator needs to assess the availability of CLC beds, appropriateness of admission to the CLC, or the need to refer the Veteran to home-based or community-based services. The CLC admission coordinator or team must respond with a determination before the observation period ends or within the time-period determined by local policy.

10. ADMISSIONS FROM PATIENT ALIGNED CARE TEAM, COMMUNITY-BASED OUTPATIENT CLINICS, HOME-BASED PRIMARY CARE, OR NON-VA AND OTHER SETTINGS

a. VA CLCs may admit Veterans from Patient Aligned Care Teams (PACT), Community-based Outpatient Clinics (CBOC), Home-based Primary Care (HBPC), and non-VA and other settings provided that:

(1) The Veteran is already known to the CLC providers or team, or

(2) The Veteran has been previously assessed within the past 30 days and approved for admission by an authorized CLC-based admission coordinator, team or designee.

b. In instances where prior assessment or agreement regarding admission to the CLC is not possible,

(1) The Veteran must be admitted for observation in the medical facility observation program for up to 23 hours and 59 minutes in order to determine medical and psychiatric stability and appropriateness of admission to the CLC, or

(2) The Veteran must be admitted into an acute care unit in order to determine medical and psychiatric stability and appropriateness of admission to the CLC.

11. ADMISSIONS OUTSIDE NORMAL WORKING HOURS

a. A CLC with necessary resources can choose to admit Veterans outside of normal working hours on a case-by-case basis; however, the following requirements must be in place:

(1) A CLC-based admission coordinator, team, or CLC-based designee must have evaluated the Veteran for appropriateness of admission and determined that the CLC has the nursing resources and program competencies to accept the admission outside of normal working hours.

(2) The Veteran is medically and psychiatrically stable. Veterans with chronic, non-acute mental health problems, who are psychiatrically stable and otherwise eligible for CLC care must not be denied admission.

(3) There is a clearly designated and readily available medical provider.

(4) There is evidence of adequate nurse staffing.

(5) There is clearly written CLC admission orders. The CLC program must develop a CLC admission order set for these circumstances.

(6) The CLC has the nursing competencies and CLC infrastructure including pharmacy services, equipment, and other resources to serve the Veteran.

(7) Other interdisciplinary staff support must be available or on call, depending on the reason for admission and the needs of the Veteran, such as the availability of physical therapy services.

b. Transfers of a Veteran into the CLC outside of normal working hours must be made when it is least disruptive to the Veteran. For example, careful consideration needs to be given to a transfer from acute care in the middle of the night.

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.*

12. CHANGES IN SERVICE NEEDS AFTER ADMISSION

a. If the Veteran is in need of multiple services, the Veteran must be admitted to the service that meets the Veterans highest level of primary needs. For example, if the Veteran needs skilled care and rehabilitation, the Veteran is to be admitted to rehabilitation. Once the Veteran has reached the rehabilitation goals, the Veteran will 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 may need to be ordered.

b. If a Veteran is initially admitted for long-stay continuing 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 RUG is to reflect the new status, but the code for long-stay continuing care needs to remain the same. The rehabilitation or skilled nursing services for long-stay continuing care are captured in the RUGs.

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 and the reason for the change. A new set of orders does not need be written unless necessary. A facility designee needs to contact Pharmacy Automated Data Processing Application Coordinators to check "ORDER ACTIONS ON PATIENT TRANSFER," and the facility designee needs to contact Clinical Applications Coordinators to review the Computerized Patient Record System Auto-DC events and or rules to ensure that orders are not discontinued when Veterans are transferred to the CLC treating specialties.

13. DISCHARGE CRITERIA

a. A Veteran may be discharged from the CLC when:

- (1) The Veteran has met the treatment goals and no longer needs institutional care.
- (2) The facility can no longer accommodate the Veteran due to change in service needs.

(3) The Veteran shows flagrant disregard for the policies of the medical facility after being appropriately advised of such policies. For example, a Veteran may be discharged for engaging in illegal activities once appropriate internal policies and processes, including but not limited to those relating to disruptive patients, patient advocacy, and ethical considerations have been followed to address the Veterans behaviors and continuing medical needs. If the Veteran has continuing medical needs, the facility must transfer the Veteran for appropriate alternative care.

b. Consistent with the requirements of 38 U.S.C. 1710A(b)(1), Veterans described in section 1710A(a) who meet the criteria for long-stay may not, after placement in a VA CLC, be transferred to another CLC, unless the Veteran (or the Veteran's representative), agrees to such a transfer.

c Long-stay Veterans may be discharged if the Veteran no longer requires CLC or nursing home level of care. For example a Veteran no longer requires CLC care when admission goals

are met and the condition has improved to the extent that continued services can be provided in a less restrictive, non-institutional setting.

NOTE: Veterans that wish to question a discharge decision should be referred to the local channels for dispute resolution.

14. RE-ADMISSION OF A RECENTLY DISCHARGED VETERAN FROM A VA CLC

a. **Physical Examination Requirements.** When a Veteran is discharged from the CLC to a different level of care and is readmitted to the CLC within 30 days for the same or a related problem, an interval physical exam reflecting any changes may be used, provided the original exam is readily available. In either case, an interval note must be completed indicating the following:

- (1) The Medical History and Physical exam (H&P) is still accurate;
- (2) An appropriate assessment was completed on admission confirming that the necessity for CLC care is still present; and
- (3) The Veteran's condition has not changed since the H&P was originally completed, or any changes have been documented.

b. **Requirements for Interdisciplinary Team Member Assessments.** When a Veteran is discharged from the CLC to a different level of care and is readmitted to the CLC within 30 days for the same or a related problem, the required assessments by the interdisciplinary team member (for example, required Social Work, RT or Dietician assessments), must reflect any subsequent changes in the Veteran's health status. These disciplines are not required to complete a new comprehensive discipline specific admission assessment, unless there is evidence of significant change in circumstances from the original comprehensive admission assessment.

c. In accordance with current VHA policy, RAI MDS instructions must be followed for MDS completion, regardless if the readmission was expected or not.

15. REFERENCES

- a. Pub. L. No. 100-203, title IV, subtitle C, 101 Stat 1330 (1987)
- b. Title 38 CFR parts 51-53
- c. Title 38 U.S.C. §§101(28), 1710, 1710A, 1710B, and 1720
- d. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

SERVICE CATEGORIES AND TREATING SPECIALTY CODES

1. **Short-Stay**. Short-stay treating specialty codes include:

- a. Respite Care (47);
- b. Rehabilitation (64);
- c. Restorative Care (66);
- d. Continuing Care (67);
- e. Mental Health Recovery (68);
- f. Dementia Care (69);
- g. Geriatric Evaluation and Management (81);
- h. Skilled Nursing Care (95); and
- i. Hospice (may exceed 90 days) (96)

2. **Long-Stay**. Long-stay treating specialty codes include:

- a. Dementia Care (42);
- b. Continuing Care (44);
- c. Mental Health Recovery (45); and
- d. Spinal Cord Injury and Disorders (46)