Department of Veterans Affairs
Health Services Research & Development

RESOURCE GUIDE: VA LONG TERM CARE PROGRAMS AND SERVICES Volume 1: Program and Database Descriptions

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Executive Summary

Currently, close to 30% of all veterans are age 65 or over. By the year 2030, it is projected that 46% of the veteran population or 8.6 million veterans will be age 65 or older (Dept. of Veterans Affairs, 1990). A substantial number of these veterans have long term care needs, and the demand will grow as the elderly veteran population increases. In 1993 alone, the Department of Veterans Affairs (VA) placed 42,000 veterans in community nursing homes, cared for close to 10,000 veterans on the VA home based primary care program, discharged 2784 veterans from domiciliary care, and provided contract homemaker/home health aide services to 906 veterans[1].

The Department of Veterans Affairs health care system has one of the most comprehensive long term care programs in the country, encompassing both programs and services provided by VA, as well as, services contracted and arranged with community agencies for eligible veterans. In order to effectively manage these services and programs, it is important to maintain good data that is continuously updated and enhanced as programs and services change.

Although veterans of any age, especially those with a chronic illness may be receiving long term care (LTC), for our purposes, we focused on LTC services primarily provided to elderly veterans. Other veterans, including the chronically mentally ill, spinal cord injured, and the terminally ill may also utilize these services and programs. Our definition of long term care includes both institutional and community based programs. The following services and programs are included: VA nursing home care, community nursing home care, VA Home based primary care, community home health care services, homemaker/home health aide services, adult day health care, residential care, domiciliary care, respite, and hospice. It could be argued that additional services or programs should be included and others dropped. However, based on input from over 100 VA clinicians researchers and managers who are serving on an expert panel for this project, these programs and services were most frequently

included when asked what they considered long term care.

The first VA health services research state-of-the-art (SOTA) conference was entitled: Community-Based Long Term Care. This conference was held in September of 1992 and was attended by over 100 national experts in research, policy, and management of health and clinical care. One of the products of this conference was a set of recommendations regarding the state of VA community based long term care. Two recommendations made are directly germane to the current project. Conference participants recommended that VA:

- ❖ Establish a management information system accessible to all community-based long term care decision makers, providers and researchers;
- ❖ Design uniform patient need assessment measures that include the need for social support (MDRC, 1993; Executive Summary, p. 6).

Furthermore, the SOTA participants outlined a research agenda for health services research and dissemination that included the following areas:

- ❖ Create a national VA database to determine the needs for long term care and to frame research questions;
- ❖ Develop an integrated long term care database for all veterans regardless of program placement (e.g., hospital-based, outpatient, long term care, etc.);
- ❖ Develop and automate information systems to monitor the quality of care of existing programs (MDRC, 1993; Executive summary, p. 8).

Before the above recommendations can be addressed, it is important to assess what is currently available. Our review of computerized databases for VA long term care services and programs revealed that VA is sorely lacking good, comprehensive databases for these services and programs. Some programs do not even have a means of identifying an individual as having received a service at the national or sometimes even at the local level where more detailed information is often available (e.g., hospice, respite). Other programs

have adequate databases only at the patient (e.g., Home based primary care) or only at the program (e.g., contract nursing home care) level, making it impossible to link records across programs in order to have a clear picture of the services received by individuals. This does not make good sense in an era where VA will be increasingly pressed to tie treatment to specific outcomes.

We have compiled a three volume resource guide for use by clinicians, policy makers and researchers. *Volume I* of the guide provides an overall description of the service or program, existing databases and how they may be accessed, issues of data quality and areas in which the databases are incomplete, and a description of paper records and local VAMC efforts to compile information on a particular program or service. *Volume II* is a compendium of database file names, content statements, and value labels (when available) for all databases identified in Volume I. Also contained in *Volume II* is a table comparing the variables available in each database. You will note that there is very little comparability across databases. In part, this is attributed to the fact that some databases are at the patient level and others at the program level. Although it may be possible to identify patients within programs or services at the local level, it is impossible to identify all veterans who are receiving or have received any services at the regional or national level. *Volume III* contains a listing of relevant Health Services Research projects on VA LTC services, including abstracts and bibliographies when available.

GOALS:

Short Term Goal: Our short term goal is to ensure that every veteran receiving one of the long term care services or programs listed above can be *identified* through either the local decentralized hospital computer programs (DHCP) and/or the national patient treatment file (PTF) as having received the service or care.

Long Term Goal: To develop a core package of information that is collected on

every patient who utilizes LTC services in the VA system. This core package would contain patient demographic information, an identifier as to what service or services the veteran is receiving, and some indication of the duration of services. This goal may be accomplished by drawing from existing databases and adding to them, as necessary or by creating a new core database that would contain information necessary to make informed decisions about veterans receiving long term care services.

Other efforts have been undertaken in the Office of Geriatrics and Extended Care to capture clinical assessment data on veterans utilizing nursing home care and home health care services. Following the model of the Health Care Financing Administration, the VA plans to adopt the Minimum Data Set for Nursing Home Resident Assessment and Care Screening (MDS) for all VA and community nursing home patients. They also are considering the newly developed MDS for home care for veterans who receive VA Home Based Primary Care.

Ideally, the clinical and utilization data bases could be connected to provide an extremely rich and useful data base of veterans in long term care.

Endnote

[1] Homemaker/chore data are from first six months of 1994.

Preface

In January of 1995, the Edward Hines, Jr. VA Hospital's Health Services Research and Development (HSR&D) Field Program began a service directed research project entitled, "Development of a VA Long Term Care Utilization Database." The purpose of the overall project is to develop and test a comprehensive VA Long Term Care (LTC) Database linking programs and services together, providing a mechanism to monitor veterans' use of these long term care programs in VA.

The Department of Veterans Affairs has one of the most comprehensive long term care programs in the U.S. However, currently there is no database that links these programs together, nor is there a mechanism to monitor and compare veterans' use of long term care services in VA. This lack of both patient and program specific information makes it difficult to ascertain whether the LTC needs of older veterans are being met by VA.

The development of this database will allow clinicians to track patients through long term care, provide investigators with valuable information for important research questions, and provide needed data for long term care managers and policy makers. Compilation of these data to aid individuals making policy decisions is particularly relevant with the advent of health care reform and the need for VA to be competitive in the health care arena.

An inventory of VA national databases was conducted in order to identify information currently available. An expert panel was formed; 102 participants representing 72 separate VA medical centers and six university/other participants were included. The panel was surveyed regarding (1) which variables they considered most important, desirable, and practical to collect, and (2) which LTC programs and services are provided at their VAMCs, the type of information kept on each program and how this information is being tracked (e.g., a personal computer, DHCP, paper only, etc.) for each program or service. As a product of the information gathering, this resource guide was compiled.

This resource guide is composed of three volumes.

Volume I: VA LTC Program and Database Descriptions provides a narrative of each service or program, information on any computerized databases including what information is lacking, paper records or other data, and some discussion of data quality.

Volume II: Database Content Statements & VA Forms provides copies of VA paper records and SAS content statements (including variable lists with labels and value codes) of VA computerized databases for each of the services and programs described in Volume I.

Volume III: HSR&D Research Project Abstracts & Articles is a reference guide for HSR&D research conducted on VA LTC programs and services. It contains a list of funded projects with abstracts and any journal articles, book chapters or related publications that resulted from these grants.

Together the three volumes of the VA LTC Programs and Services resource guide provide a comprehensive understanding of VA long term care to date.

In Volume I, one chapter is devoted to each VA LTC program/service. The chapters are sub-divided into specific components and are consistent throughout the resource guide:

- ❖ general description of the program/service,
- ❖ listing and description of any computerized data directly tied to this particular program/service, and if so,
    - unit of analysis,
    - data quality, what type of information is lacking,
    - reports generated,
    - who to contact for more information,

- ❖ listing and description of any paper records and forms used.

Additional information is provided on the Social Work Information Management System (SWIMS) which may provide helpful information regarding LTC case management activities, and the Geriatric Research, Education and Clinic Centers (GRECCs). Finally, VA's Office of Geriatrics and Extended Care is planning to implement the Minimum Data Set (MDS) for VA and community nursing home care and the MDS for home care for VA and community-based home care in the near future. These tools are also described in this volume.

Acknowledgments

The compilation of this resource guide would not have been possible without the assistance of a great many people both directly and indirectly involved with this project.

We would especially like to thank the VA Headquarters of Geriatrics and Extended Care for their assistance and guidance. Special mention is extended to Ruth Parry, JD, our former project manager who passed away unexpectedly this past summer, and Jay Freedman, Ph.D., our current project manager and Assistant Director of the VA Headquarters Research Initiatives and Analysis department. Ruth was a strong supporter of this research initiative and her input was instrumental in shaping this project.

We would also like to recognize the individual members of our Steering Committee for their expertise, helpful critiques and suggestions. This committee is composed of a diverse group of individuals, both VA and non-VA experts, with expertise in either long term care and/or information systems:

Lois Camberg, Ph.D.
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Brant Fries, Ph.D.
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Jerilyn Heinold, MPH
Boston Development Center

James Kelly, ACSW
Director, VA Headquarters Extended Care Service

Bruce Ripley
VA Planning Systems Support Group

Rebecca Silliman, MD
Boston University Medical Center

Nelda Wray, MD
Houston Center for Quality of Care and Utilization Studies

Special thanks are extended to the many individuals (more than 100) who served on our Expert Panel throughout the course of two separate survey tasks. These individuals provided many helpful comments and supplied the research team with the information necessary to attempt to fill in the details and lessen the gaps regarding which LTC programs and services

are provided at each of their individual VAMCs and how this information is being monitored.

The researchers also acknowledge the assistance of numerous individuals throughout the Chicago area VAs, including: Joan Cummings, MD, VISN 12 Director; John Demakis, MD, Director, Midwest Center for Health Services and Policy Research, Hines VAH; Alec Ulasevich, Health Research Scientist, HSR&D, Hines VAH; Mary Ann Naas, Extended Care & Geriatrics Service, Hines VAH; Sylvia Courtney, MAS, Chicago West Side VAMC; the many helpful individuals in the Social Work Service, Hines VAH; and the Chicago Area Network Fee Basis Task Force.

A word of thanks is extended to the individuals who man the phones at the help desk of the Austin Automation Center with special notice going out to Larry Hughes, Computer Specialist, for his limitless patience.

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Introduction

The Department of Veterans Affairs (VA) health care system provides for the health care of veterans across the continuum of care. Veterans may receive acute care, outpatient care, or long term care through a variety of services and programs provided directly by VA, or contracted or arranged with agencies in the community (refer to Figures 1 and 2).

Acute care services are provided through inpatient medical facilities at 152 medical care facilities across the country. A large array of outpatient clinic care services, including general medicine, specialty care, x-ray, laboratory and other services are provided in the outpatient clinics of VA medical center facilities or through satellite or freestanding clinics. Long term care services may be provided by a VA medical center, contracted with a community agency, or arranged by VA staff and provided in a non-VA setting. A veteran may utilize one or more of these services if he or she is eligible and medically needs these services.

This document is devoted to community and institutional-based long term care services provided by VA, arranged for by VA, or contracted out to community agencies. However, these services may be linked to other care provided to veterans in VA acute care and outpatient care settings utilizing patient *social security numbers*. It may be possible to track a veteran's utilization of services across the spectrum of care if dates of service are also used. As you will learn from this document, not all programs and services keep data that are easily accessible or in a format that is easy to use. Some programs only record program or facility level data, so patient-level data are not available. Nonetheless, attempts have been made to follow veterans over time and over care settings (e.g., Conrad, Weaver, Guihan, et al., 1994, Cummings, Hughes, and Weaver, 1992).

<u>Veteran Benefits Administration Databases</u>

In addition to health care services and utilization information on veterans who use the VA health care system, the Veteran Benefits Administration (VBA) maintains several databases of

potential interest to long-term care researchers. Of particular interest are: Compensation and Pension File (C&P), C&P Longitudinal File, C&P Minimaster, the Beneficiary Identification and Records Locator Subsystem (BIRLS), and the BIRLS Death File. Through these databases, all of which can be linked by Social Security Number, the researcher can gain information on veterans who died and obtained benefits from VA (for mortality studies), who receive a monetary benefit for Aid and Attendance (to defray, perhaps, the cost of the Community Residential Care program), who had accounts for VA educational benefits (to determine the extent of contact with VA for other services besides health care), type and amount of benefits paid to C&P recipients (a rich source for sampling veterans), as well as many other research applications. C&P files track recipients of VA health care services, as well as the benefits veterans may receive from a variety of VA programs (e.g., housing loans, GI bill/educational benefits, disability, etc.). To learn more about VBA databases refer to *Database Resource Guide, Volumes 1-5* (Beattie, Swindle & Tomko, 1992-1995).

Accessing the Austin Automation Center (AAC)

Many of the database listings that are contained in Volume II of the *Long Term Care Resource Guide* are housed at the Austin Automation Center (AAC) located in Austin, Texas. VA employees/researchers and, in some cases, Without Compensation (WOC) university-affiliated personnel, can apply for access to these data. VA Form 30-9957, "Timeshare User Access Request" must be filled out completely and submitted to the Customer Information and Assistance Staff (30B), VA Headquarters. For more information about filling in the form, please refer to the instructions provided by Beattie, Swindle, and Tomko in *VA Databases Resource Guide Volume I: Overview (1992)*. Of special note to researchers who want to link information by Social Security Number it is necessary to request both MEDIPP and MEDIPRO for the level of access required for each data set on item 5b of VA SF 30-9957. Processing the request for access generally takes two weeks. Approved users are then mailed their passwords, instructions for dialing into the AAC, and a VAccess Help book.

Health Care Financing Administration

Finally, researchers have linked VA and non-VA utilization of health care for elderly veterans using the Health Care Financing Administration's (HCFA) National Claims History Files and its predecessor, the Medicare Automated Data Retrieval System (Fleming, et al., 1991; Cummings, Hughes, Weaver, 1992; and, Weinberger & Oddone, 1992). Patient social security number, utilized by VA as the unique identifier number for a patient, can be used by HCFA to pull Medicare utilization and cost data. The HCFA unique identifier number consists of the nine digit social security number plus a 2-character value that indicates if the recipient is the primary recipient, spouse or dependent. Information about the HCFA databases can be obtained by contacting the Director, Office of Health Care Information Systems, Bureau of Data Management and Strategy, Health Care Financing Administration, 6325 Security Blvd., Baltimore, Maryland, 21207-5187.

Cost of Care

Researchers and policy makers are often interested in determining costs for a particular program, service or patient. Several research projects on VA long term care programs have attempted to determine costs using a variety of methods and data sources (see Volume III for examples). The VA's cost distribution report (CDR) provides both facility specific and national figures for inpatient units, NHCU, domiciliary, adult day health care- VA and contract, community nursing home care, Home based primary care, residential care (includes all direct care expenses incurred by VA for patients of the CRC program but does not include the expense of patient staying in the home or through any fee programs) and outpatient fee medical and nursing services. These reports are based on the distribution reports (RCS 10-1041) provided by each facility (refer to Appendix E for accounting codes specific to long term care services and programs). To learn more about the CDR and other related cost databases, we refer the reader to Beattie, et al. (1994). Non-VA costs can be captured using HCFA files for Medicare eligible veterans or state Medicaid files for veterans eligible for

Medicaid. The AAC has Medicaid data for several states. Contact the AAC for more information.

It is beyond the scope of the present study to address costs in any detail. Calculating costs is an evolving process in VA. If you are interested in pursing costs in your own project, we suggest you look at past research and contact relevant researchers to learn their techniques. Refer to *Medical Care Supplement, March 1996* (Swindle, Beattie, & Barnet).

This document is designed as a resource guide and research tool for those individuals wishing to learn more about particular VA long term care programs and services, and those persons who are hoping to conduct research on veterans in long term care. We have defined VA LTC programs and services to include both institution and community based care, i.e., nursing home care units, contract nursing home care, Home based primary care, contract skilled home care, homemaker/home health aide, adult day health care, domiciliary, community residential care, hospice, respite, and geriatric evaluation and management units (see Table 1). We also provide a brief description of the Geriatric Research, Education and Clinical Care (GRECC) Centers. Finally, we discuss two LTC assessment tools currently in non-VA settings: the Minimum Data Set (MDS) for long term care facilities, and the Minimum Data Set for Home Care (MDS-HC). There are plans to implement these clinical tools in the VA in the near future. To learn more about the inpatient and outpatient data available on veterans utilizing VA care, please refer to *Database Resource Guide, Volumes 1-5* (Beattie, Swindle & Tomko, 1992-1995).

Figure 1. VA LTC Services and Programs

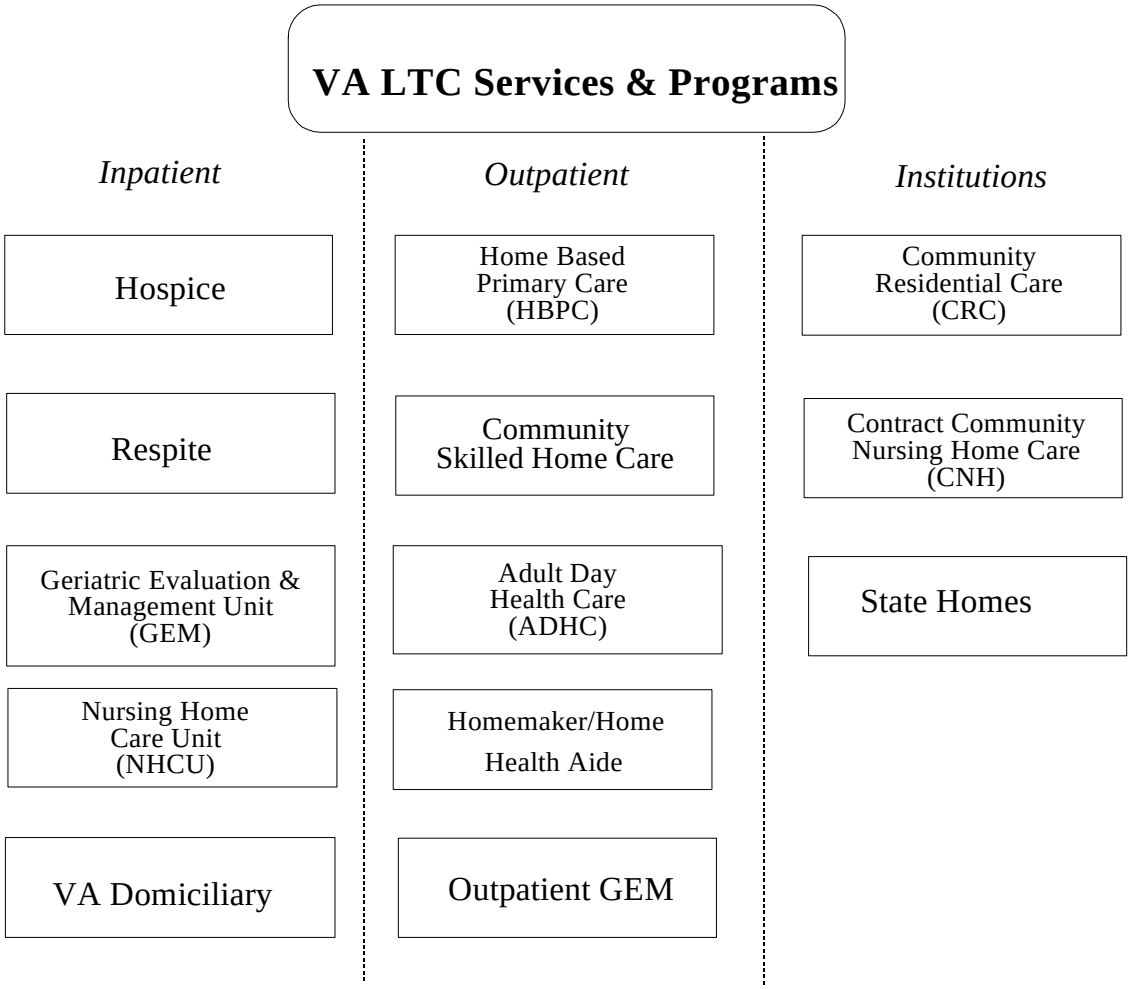
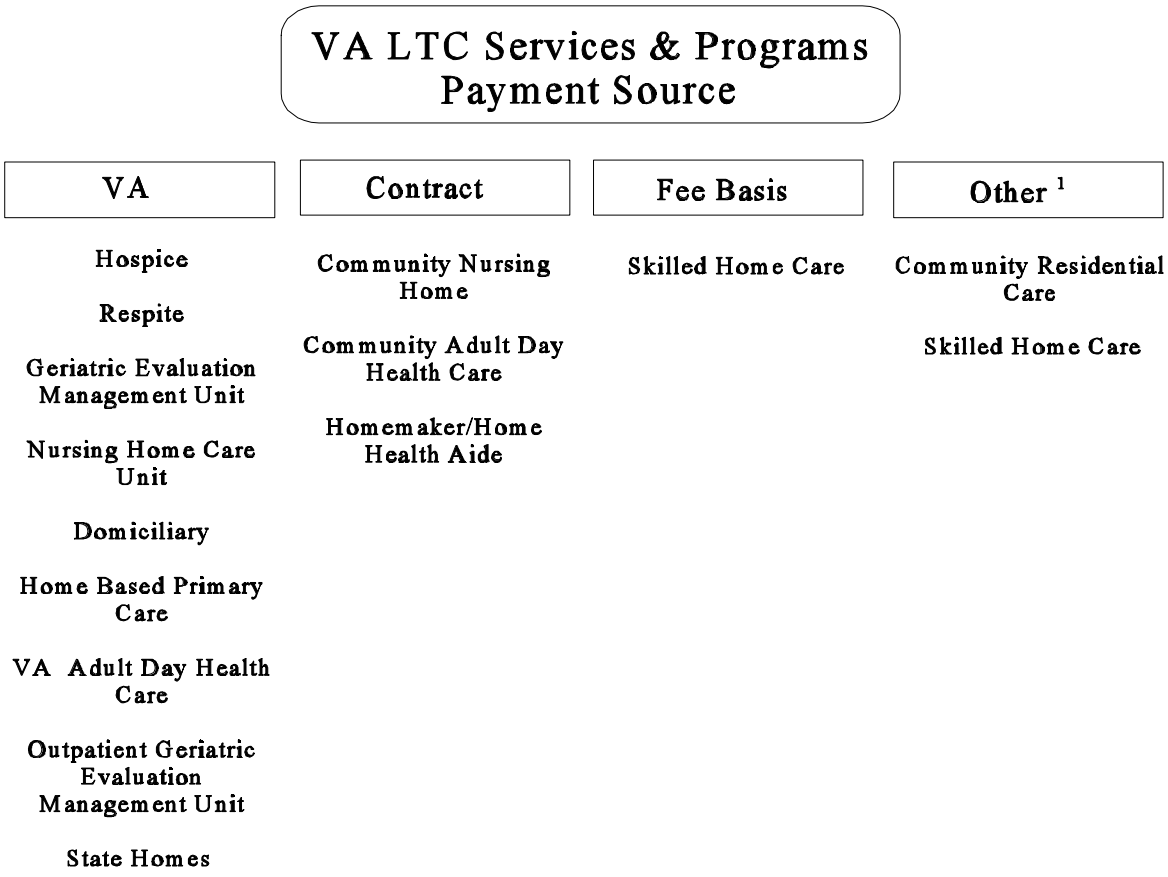


Figure 2. VA LTC Services and Programs Payment Sources



[1] Includes Medicare, private insurance and out-of-pocket costs.

Table 1: VA LTC Services and Programs

"--" = does not exist at nat'l level

✓= yes	NHCU	CNH	HBPC	Skilled Home Care	Homemaker/ Home Health Aide	ADHC	Domiciliary	Residential Care	Hospice	State Homes	Respite
SOURCES OF PAYMENT: VA/Contract	✓	✓	✓		✓ CNH alternative funds	✓	✓	VA pays for administrative costs only	✓	✓	✓
Fee Basis				✓							
Medicare		✓		✓					✓		
Other (includes out-of-pocket and private insurance)		✓		VBA Aid & Attendance	✓			VBA Aid & Attendance/out-of-pocket			
Existing Computerized Database: Patient Level	✓ (PTF & PAF)	✓ (Fee Basis)	✓	✓ (Fee Basis)		✓ (OPC)	✓ (PTF)		--	--	--
Program Level		✓						✓	--	--	--
Link to other Databases:	SSN	SSN	SSN	SSN	SSN	SSN	SSN	N/A	--	--	--
Eligibility:	All veterans	Veterans d/c from a VA hospital, HBPC or service connected	All veterans who live within HBPC catchment area	Veterans may access through VA Fee Basis, Medicare or other insurance	See chapter VI	All veterans discharged from a VA hospital or service connected	All veterans	All veterans	All veterans	All veterans	All veterans living at home and receiving care from VHA

TABLE 2: Database Comparison of Variables

LTC and Related Databases								
	VA DATA BASES						MINIMUM DATA SETS	
	Inpatient PTF	**Outpatient OPC**	**Social Work SWIMS**	**HBPC**	**NHCU Intermediate Care PAF (RUGS)**	**OASIS-B**	**Minimum Data Set-RAI Version 2.0 *Draft***	**MDS for Home Care RAI-HC *Draft***
PURPOSE	inpatient utilization	outpatient utilization	case management	assessment & visits	assessment	assessment home care	assessment - nursing home	assessment - home care
UNIT / FREQUENCY	patient/ at discharge	patient/ every clinic stop	patient/ as needed	patient/ at admission & discharge/every visit	patient/ at admission & semi-annual	patient-admission/ every 60 days/ discharge	patient/ at admission, quarterly, yearly, when changes occur	admission/ follow-up if changes occur, annual
ID	SSN	SSN	SSN	SSN	SSN	?	Medicare #/ SSN	Medicare #/ SSN
VARIABLES:								
Socio-demographic	yes	yes	yes	yes	yes	yes	yes	yes
Dates	yes	yes	yes	yes	yes	yes	yes	yes
Diagnosis	yes	no	no	yes	no	yes	yes	yes

LTC and Related Databases

	VA DATA BASES						MINIMUM DATA	
SETS								
Living Arrangement/ Social Support	no	no	yes	yes	no	yes	yes	yes
Communication	no	no	no	yes	no	yes	yes	yes
Functional Status	no	no	no	yes	yes	yes	yes	yes
	PTF	**OPC**	**SWIMS**	**HBPC**	**RUGS**	**OASIS**	**MDS**	**MDS/HC**
Behavior/ Psycho-social	no/no	no/no	yes/yes	yes/no	yes/no	yes/yes as well being	yes/yes as well-being	yes/no
Special Populations/ Health Conditions	no/no	no/no	yes/no	no/no	yes/no	yes/yes	yes/yes	yes/yes
Medical Treatments	no	no	no	no	yes	yes	yes	yes
Utilization	yes	yes	yes	yes	n/a	Hospital & ER use in 90 days prior	Hospital & ER use in 90 days prior	Hospital & ER use in 90 days prior
Special services - e.g. therapy	no	no	no	no	yes	yes	yes	yes

LTC and Related Databases

	VA DATA BASES					MINIMUM DATA		
SETS								
Advanced Directives	no	no	no	no	no	yes	yes	no
Customary Routine/ Involvement in Activities	no/no	no/no	no/no	no/no	no/no	no	yes/yes	yes/yes
Health Status	no	no	no	no	no	yes	yes	yes
Environmental Assessment	no	no	no	no	no	yes	no	yes

I. VA Nursing Home Care Unit (NHCU)

Description of the program:

Title 38 U.S.C. 610 authorizes VA to provide nursing home care to eligible veterans in VA owned nursing home care units. Nursing home care is defined as the coordination and delivery of interdisciplinary care to convalescents or other persons not in need of hospital care, but who require nursing care and related medical or psychosocial services. This care includes any professionally recommended services (dietetic services, social work, dental), supplies, and equipment. Medical services include direct medical intervention. Nursing services include the assessment, planning, intervention, and evaluation of nursing care.

Delivery of care typically occurs over an extended period of time, three months and longer, and is directed toward those patients who demonstrate a potential for improvement or toward patients whose rehabilitative goal is maintenance of existing function. Patients are discharged from the NHCU when the treatment goals have been reached and appropriate community resources are available to sustain the patient either at home or in an alternative level of care.

A. Computerized Database:

Of all the long term care programs and services, VA NHCU has one of the richest databases available for research. This is because NHCU information is contained in the Patient Treatment File (PTF) in a separate file called the PTF: Extended files. Additional information is contained in the Census Files and in the Patient Assessment File (PAF). Thus, both utilization and assessment data are available for NHCU patients.

Patient Treatment File

Data for NHCU episodes are recorded in the PTF: EXTENDED files. Data included in the PTF: Extended files are socio-demographics, diagnosis and procedure data, admission,

discharge, transfer and length of stay data. These files are in SAS database sets at the national and regional level:

- MDPPRD.MDP.SAS.XMfy (FY 1991 to present, fy= fiscal year);
- MDPPRD.MDP.SAS.EXTENDED.PMyy (FY 1984-89, yy= year).
- MDPPRD.MDP.SAS.XMfyRn (FY 1991 to present, n= region number);
- MDPPRD.MDP.SAS.RGn.EXTENDED.PMyyRn (FY 1984-89).

This data is available only for patients discharged in that fiscal year. This information is available from the Austin Automation Center (AAC). Valuable clinical information lacking from the PTF includes patient functional and cognitive status, patient communication, behavior, health status, nutritional/oral/dental information, and social support. To learn more about the PTF: EXTENDED files we refer the reader to *Database Resource Guide, Volume II: Patient Treatment File* (Beattie, Swindle, & Tomko, 1992).

Census Files

Due to the fact that the PTF records are based on discharge within the fiscal year, accessing another file may be necessary to capture data on all patients. The Census files consist of a survey conducted each year on September 30, the end of the fiscal year. This is done to record every inpatient on that particular day. As an example, to capture data on all Nursing Home patients for FY 95, it would be necessary to merge the PTF: EXT file with the Census file to capture all NHCU patients discharged in FY95 and those still in the NHCU on September 30, 1995. From 1993 on, the variables are identical to those in the PTF, except that discharge day is recorded as September 30th (though the patient may well have not been discharged at all). Prior to 1993, the files took on different variables each year and are not identical to PTF. These files are is SAS database sets:

- **MDPPRD.MDP.SAS.FYfy .CENSUS(FY 1985 to 1993, fy=fiscal year)**

❖**MDPPRD.MDP.SAS.CENSUS.PMfy (Main file, FY 1993 to present, fy=fiscal year)**

Patient Assessment Files/RUGs II

In April and October of each year, surveys are collected on all nursing home care unit residents using the Patient Assessment Instrument (PAI) form (see below). Information collected includes: administrative data (basic demographics, date of admission, etc.); medical treatments; medical events; diagnoses; activities of daily living; behaviors; specialized services; and chronic respiratory support data.

These data can be found in the Patient Assessment Files (PAF), also commonly referred to as the Resource Utilization Group (RUGs II) database (Fries & Cooney, 1985). Data are available from April of 1986 forward. These files are in a SAS database set that is accessible through the AAC:

- ❖ MDPPRD.MDP.SAS.mmmyy.PAF (mmm= OCT or APR, yy=year).

Data regarding admissions and transfers to and from the nursing homes during the year can be found in:

- ❖ MDPPRD.MDP.SAS.FYnn#AT.PAF (# = “1" for first half of fiscal year and “2" for the second half of the fiscal year).

Some of the information lacking from the PAF that would be valuable to clinicians and researchers alike are data on communication, psycho-social variables, IADLs (Instrumental Activities of Daily Living), health conditions, nutritional/oral/dental information, psycho-social, and patient activity data.

At some VAMCs (including the Edward Hines, Jr. VA Hospital), the NHCU also collects PAIs upon admission and/or transfer back to extended care from Absent Sick in Hospital

(ASIH) status. These may be available from local medical centers. It is not clear how frequently this is done across VA medical centers. Individual medical center DHCPs may contain additional data; the extent to which this occurs is unknown.

Unit of Analysis:

The PTF: Extended, Census and PAF are all at the patient level. They can all be aggregated to the facility and national levels.

Data Quality:

Analysis of the PTF national data revealed "that episodes involving Community Nursing Home stays and VA extended care were most likely to overlap, and there were some overlapping episodes where the patient was registered at two different facilities" (Beattie et al., 1995). In a survey those same researchers conducted in 1992, respondents reported "data entry errors in the form of overlapping of episode dates for inter-facility transfers (after taking into account the inpatient stays for nursing home patients)." **A note of warning concerning admission dates: there is some discrepancy between the PTF and PAF files. Quite often, a patient will be taken from the NHCU and admitted to another bed section due to illness (i.e. general medicine) and then transferred back to the NHCU after the acute care problem is addressed. The PTF will retain the original admission date to the NHCU as admission date. However, in the PAF file the admission date will now reflect the date the patient returned to the NHCU. This causes many complications when trying to merge records from the PTF: EXT files with PAF files by admission date.**

Reports:

The AAC provides a semi-annual report that only lists PAI transmissions that were accepted or rejected. The Boston Development Center provides VAMCs with the Annual Facility Reported Data Report which is a summary of RUGs grouping for a facility. This information is also available in local DHCPs under the RUGs Record Status Report option.

Contacts:

- At AAC:

  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

Minimum Data Set (MDS)

A growing number of VA NHCUs also collect data on residents using the Health Care Financing Administration's (HCFA) Resident Assessment Instrument (RAI) which includes the Minimum Data Set (MDS), a minimum core of defined and categorized patient assessment questions. Nationally, all non-VA nursing homes receiving Medicare and/or Medicaid funds are required to submit the RAI on each resident. However, VA was exempt from this requirement. An updated version of the MDS, MDS 2.0, is expected to be fully implemented nationwide in January of 1996. MDS 2.0 incorporates all of the RUGs III (Fries et al., 1994) patient classification items. The VA's PAF system currently uses RUGs II categories but could foreseeably be converted to RUGs III in the future. See Chapter 12 of this Volume for a more detailed explanation of the RAI/MDS.

A number of VA medical centers participated in a project entitled "MDS Demonstration Project" which was designed to test whether it would be feasible to use the MDS in all VA NHCUs. The project sites selected were VAMCs in Atlanta, Bay Pines, Fort Lyons, Fort Meade, Little Rock, Portland, San Antonio, St. Louis, Washington, D.C., White River Junction, Wilkes Barre, and Wilmington. In a VA Long Term Care Policy memo dated May

1995, and signed by Dr. Kizer, Deputy Under Secretary for Health, Statement No. 3 reads, "VHA will begin with use of the RAI (MDS) required by HCFA for all certified nursing homes." The VA Office of Extended Care and Geriatrics is hoping to implement the MDS in all VAs in the near future.

B. Paper Records:

The VA nursing home care units use:

- ❖ VA Form 10-0064a (RCS 10-0644)- Long Term Care Patient Assessment Instrument (PAI).

A copy of this form is included in Volume II. The data from the PAI comprise the body of the PAF. The data are sent to Austin directly from the local hospital's DHCP.

II. Community Nursing Homes (CNH)

Description of the program:

Public Law 88-450 was enacted in 1964 for the purpose of establishing a community nursing home (CNH) program in VA. Title 38 U.S.C. 620 authorizes VA to provide nursing home care to eligible veterans. The purpose of the CNH program is to obtain nursing home care for eligible veterans in the community at VA expense. The CNH program is targeted at veterans making the transition from an inpatient setting to less intensive or restorative levels of care. Community nursing home care is provided to veterans via contracts with licensed community nursing facilities meeting VA standards for high quality patient care. Most VA medical centers (n=161) have longstanding CNH programs at their facilities (refer to Appendix A for a complete listing). Facilities without a CNH program typically refer veterans needing nursing home care to a nearby VAMC facility with a CNH program for placement.

Veterans who require nursing home care for a service connected disability can receive care from a community facility for an indefinite time period at VA expense. Others may be placed for up to six months in a community facility at VA expense. After the VA placement ends, the veteran may be discharged or convert to another source of payment such as Medicaid.

A. Computerized Database:

The CNH program uses a number of computerized databases including: (1) Community Nursing Home program database; (2) AMIS to examine workload issues; (3) Obligations Report to examine costs; (4) VA Cost Distribution Report to examine cost and workload issues; **(5) PTF files**, and (6) DHCP-Fee to process CNH payments. For further information regarding items 2, 3, and 4, please refer to *Database Resource Guide, Volume IV: Costing of Health Care in VA Medical Centers* (Beattie, Swindle, Tomko, Greenbaum, & Racine, 1994). **For item 5, please refer to *Databases Resource Guide, Volume II: Patient Treatment***

File(Beattie, Swindle, Tomko, Greenbaum, & Racine, 1996). For item 6, please refer to the *Fee Basis Users Manual*. Only the CNH program database (item number 1 above) is specific to the CNH program.

CNH Program Database

The CNH Facility File is available through the Austin Automation Center (AAC). The CNH facilities file contains information about the community nursing homes under contract to the VA, including nursing facility name, quarter, state, county, skilled per diem rate, intermediate per diem rate, number of veterans receiving skilled care and number of veterans receiving intermediate care. Data are sent to Austin electronically. Only data from the current quarter can be abstracted from Austin. The file is updated and overwritten each quarter. Therefore, all facility data prior to the current quarter are available only on microfiche.

The CNH file is a flat file and is not configured in SAS. However, an input statement, available from the AAC, will allow these data to be converted into a SAS data set. The filename in Austin is:

- HCPDR.CNH.R200.MASTER(0).

The content statement for this file is provided in Volume II. Since the CNH database is at the facility level, no patient level data are available.

Unit of Analysis:

The CNH Facility File is at the facility level.

Contacts:

- At AAC:

  Doris Cox
  Medical Help Desk

(512) 326-6780
Interactive Voice Response selection ❶ and then ❸.

Resource Utilization Groups (RUGs)

As of October 1, 1995, all VAMCs were due to begin collecting RUGs data for all patients receiving CNH program services. To date however, this has not occurred. This information will be collected on each VAMC's DHCP. This information will be rolled up (much as the PTF data are currently done) and sent to Austin. At the point that the CNH program switches from RUGs-II to RUGs-III, RUGs-III data will be collected. Because this data collection effort has just begun, we are unable to provide any additional information at this time.

Minimum Data Set (MDS)

According to Mr. Dan Schoeps, Chief, Community Care Programs, Office of Geriatrics and Extended Care, VA Headquarters, to facilitate the VA's ability to compare veterans placed in nursing facilities through the CNH program with the general nursing home population, local CNH coordinators will obtain MDS information from each community facility after a CNH placement is made. Because this data collection effort is new, we are unable to provide specific details regarding collection methods nor any additional information at this time.

Exceptions Report

At present, a report is made to VA Headquarters of each facility that requests and is granted a reimbursement rate that differs from the standard Medicaid+15% rate. Information regarding exceptions made prior to 1996 can be obtained from Mr. Schoeps. According to Mr. Schoeps, with the decentralization efforts currently underway, information contained in the exceptions report will continue to be collected but only at the local level. In the future, exceptions will be approved locally by each hospital director. Central Office will continue to monitor exceptions by use of the "Rate Certification Reports" (also available from Mr. Schoeps).

❖ At Extended Care & Geriatrics, VA Headquarters:

Dan Schoeps, MS
Chief
Community Care Programs
(202) 273-8546

Data Quality:

The data quality of the CNH Facility file data is unknown. Data are sent to Austin electronically by the CNH program administrators. To our knowledge, a report (named VA Report RCS 10-0168- Community Nursing Home Report, see below) is generated by AAC quarterly and sent to VA Headquarters and to each hospital director. It is not clear whether this information is shared with CNH staff on any systematic basis. To our knowledge, this file is not audited. Our experience is that the quality of data may vary. In one study of 16 CNH sites, facility file data were only available for 15 of the 16 sites (*Evaluation of the Enhanced Prospective Payment System (EPPS) for VA Contract Nursing Homes*, Conrad & Weaver, 1994). For purposes of another study, we experienced great difficulty in trying to match the CNH facility file (n=2553) to VA nursing facility vendor file (n=8972). First, there is no unique identifier which can be easily used to match or link records. There is a great deal of duplication among facilities in terms of facility names. Because these data are at the level of the facility, there is no simple way to tie facility records to those of individual veteran patients. We achieved a match rate of about 80% using a combination of name, city and state *(Subacute Care in the VA: Estimating Need, Availability and Cost*, Conrad, 1995). **Note: the PTF: EXT files contain records for some CNH patients, however it is our understanding that these records are collected randomly and that there is no systematic collection of CNH data for PTF**

Reports:

There is a quarterly report generated from the CNH Facility database:

❖ VA Report RCS 10-0168 (formerly RCS 18-3)- Community Nursing Home

Reports.

This RCS report contains breakdowns of the following variables: quarter, medical district number, name of community nursing home, city, state, level of care, number of skilled and intermediate beds, certification (e.g., Medicare, Medicaid or both), date of the last VA assessment, skilled and intermediate per diem rates, and a one-day count of the number of veterans under care. The nomenclature of "skilled" and "intermediate" care has fallen by the wayside with the advent of case mix or prospective reimbursement schemes for nursing home care. However, the terms "skilled" and "intermediate" serve as rough methods for distinguishing between two levels of care.

B. Paper Records:

The CNH program uses forms:

- VA Form 10-1204- Referral For Community Nursing Home Care;
- VA Form 10-7400-4 (AMIS)- Community Nursing Home Care Activity.

Copies of these forms are included in Volume II.

Local VAMC CNH programs also have created their own data collection tools. These tools include additional information such as tracking of utilization and other additional patient information. Most of these are paper records but a few sites have computerized these tools (using Excel or other spreadsheet applications). For example, the Albuquerque, NM, CNH program used Paradox (for RUGs scores and per diem rate information on all CNH patients) and Quattro Pro to collect information on patient CNH days.

III. Home Based Primary Care (HBPC)

Description of the program:

The HBPC program was established by VA Headquarters in 1972. The number of VA medical centers with HBPC programs has varied over time, but currently there are 73 VAMCs with HBPC programs (refer to Appendix A for a complete listing). The HBPC program provides interdisciplinary team home health care services to homebound, chronically or terminally ill veterans who require services from two or more disciplines. VA provides direct medical, nursing, social, rehabilitation and dietetic services in the home, and educates family members in the care of the patient. The family provides the necessary personal care under the coordinated supervision of the interdisciplinary treatment team.

HBPC is a VA program funded by VA and provided to veterans in need of post discharge care or those veterans who can no longer utilize VA outpatient care without great difficulty. Services are provided to veterans in a limited geographic area in close proximity to the VAMC, a VA outpatient clinic, or a satellite office.

A. Computerized Database:

The HBPC database was created in 1985 and consists of two files, the admission/discharge record and the visit log record. Data on all HBPC programs are available through the AAC.

These data can be abstracted from Austin by individuals with access to the AAC. The HBPC files are flat files and are not configured in SAS. However, an input statement, available from the AAC, will allow you to convert these data to SAS format. Two files are available:

- $RMTPRD.SYS.HBC.MASTER - contains admission and discharge records
- $RMTPRD.SYS.HBC.VISITS - contains information on visits

The content statements for both files are provided in Volume II. The master file contains patient socio-demographic information including age, gender, race, marital status, living situation, admission date to the program, and last agency providing care. Clinical data include primary diagnosis (ICD-9), vision/hearing, communication, activities of daily living, behavior, mood and memory limitations, and caregiver limitations. If a patient is evaluated for HBPC but is not accepted, the reason is recorded. When a patient is discharged from HBPC, the functional assessment is repeated and the discharge status is recorded (e.g., patient died, transferred to another provider, etc.).

The visit file contains the provider type (e.g., nurse, physician, social worker, etc.), the date the visit was made, and the type of visit made (e.g., home visit, pre-placement visit in the hospital, post-discharge follow-up visit with ex-HBPC patient and/or caregiver such as bereavement visit, etc.). The HBPC files are lacking patient level data on instrumental activities of daily living, medical treatments, and health condition, health status, and home environmental assessment.

Outpatient Care File (OPC)

VA HBPC visits by provider are also recorded as such in the Outpatient Care File (OPC). Researchers should be aware that these recorded visits in the OPC are theoretically the same visits recorded in the HBPC database and should not be double counted. Procedures for collecting and submitting these data to OPC vary among medical centers. Data can be abstracted from Austin if an individual has access to the AAC. Data regarding VA HBPC visits can be found in the Outpatient Care File (OPC): Visits, under clinic stop codes:

170- HBPC Physician;
171- HBPC RN/RNP/PA;
172- HBPC Nurse Extender;
173- HBPC Social Worker;
174- HBPC Therapist;
175- HBPC Dietitian;
176- HBPC Clinical Pharmacist;
177- HBPC Other;

178- HBPC Telephone.

Information gathered includes demographics (SSN, sex, date of birth, etc.),VA location, and visit information (date of visit, purpose of visit, clinic stop, etc.). The OPC record does not have other, more detailed, "clinical" data than the HBPC database has. The OPC: Visits files, kept by fiscal year of discharge, are in SAS database sets:

- MDPPRD.MDP.SAS.SFyy (1991 to present);
- MDPPRD.MDP.SAS.OPC.FYyyF(0) - (1986 - 1990);
- MDPPRD.MDP.STAFF.Syy (1980 - 1985).

For more detailed information regarding VA OPC files and clinic stops, we refer the reader to *Databases Resources Guide, Volume III: Outpatient Care File* (Beattie, Swindle, & Tomko, 1992).

Unit of Analysis:

The HBPC Master file is at the patient level and can be aggregated to the facility level. The HBPC Visit file is at the individual provider visit level. It may be aggregated to the patient level and/or facility level. Both files can be aggregated to the national level.

The OPC: Visits file is at the visit date level.

Data Quality:

For the HBPC database, prior to FY 1995, data were entered on paper records and then sent to Austin to be keypunched. This procedure resulted in many errors that had to be corrected locally and then returned to Austin. Data are now entered directly into the local VAMC's DHCP by HBPC staff. In addition, prior to FY 1995, the coding for primary diagnosis was a convention that was unique to the program. It could not be compared directly to ICD-9s or DRGs. Now, all sites use ICD-9 codes for diagnosis.

Researchers should be aware that the clinic stop codes for the OPC: Visits regarding HBPC visits were expanded in FY 1995 from only one stop code (170) to include 170-178. This expansion allows stations to code for more detailed information regarding exactly who made the visit.

Prior to FY 1986, VA OPC records were kept on only a 20% sample of patients; only patients with social security numbers ending in either "1" or "5"- a pseudo-random sample. Since 1986, a 100% sample is maintained.

Reports:

Reports are generated by AAC on a monthly and quarterly basis and sent to all HBPC programs. The monthly report is site specific and provides information on patient admissions and discharges. The quarterly report provides information on all variables at the site level and the national level. This report allows a particular program to compare itself to the HBPC program nationally, i.e., primary diagnosis and ADL scores on admission by facility number, patient characteristics on admission by facility, length of stay in HBPC for each diagnostic group based on primary diagnosis on admission and by facility.

Contacts:

For HBPC Database-

- At AAC:

  Alice Garcia
  Programmer/Analyst
  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

- At Extended Care & Geriatrics, VA Headquarters:

  James Kelly, ACSW

Director
Extended Care Service
(202) 273-8542

For OPC-

- At AAC:

Medical Help Desk
(512) 326-6780
Interactive Voice Response selection ❶ and then ❸.

B. Paper Records:

HBPC has three paper forms:

- VA Form 10-10014- Evaluation/Admission;
- VA Form 10-10014A- Home Based Primary Care Discharge; and
- Home Based Primary Care Visit Log.

These records are essentially the same as the computerized records. Copies of these forms are included in Volume II.

Local VAMC HBPC programs also have created their own data collection tools. These tools include patient history, physical examination, educational tools, nutritional status, etc. Most of these records are paper records. Many programs are also creating encounter forms for purposes of measuring workload and for medical cost recovery (i.e., third party billing). These forms include CPT (i.e., medical procedures) codes.

IV. Skilled Home Care - Community Based

Description of the program:

Veterans requiring post-discharge home health care services may receive these services from a community agency. Referrals to community health agencies are typically made by VA community health nurses. In some instances, these services may be purchased (fee basis) and in others, provided by VA through HBPC (see Chapter III), or under the veteran's Medicare entitlement or other insurance. Fee basis care is based on the patient's eligibility and the medical needs of the patient and may be approved for up to one year, but may be extended, contingent on medical review. This program is primarily used for post-acute hospital patients whose health care needs are short-term, usually for a specific problem. Care also may be provided to eligible outpatients requiring short term intensive home health services provided they have eligibility for fee basis, or private insurance/Medicaid.

Payment for contract skilled home care may be provided through the fee basis program. Fee basis care is usually administered through a hospital's Clinic of Jurisdiction (COJ) which may be located at another area VA hospital. COJs receive the funds for all the hospitals under their jurisdiction and process payments to vendors. Appendix C contains a list of the COJs and the hospitals/clinics under their jurisdiction. Questions regarding Fee Basis care should be directed to the Chief, MAS or their equivalent counterparts at your local facility.

The Fee Basis program can only pay for skilled home care services or care provided through a specialized Bowel and Bladder program. The majority of veterans who receive community home health care services utilize their Medicare Part A & B benefits to cover this care.

A. Computerized Database:

No national VA computerized database currently exists for veterans who utilize community-

based home health services not purchased by VA. Data on skilled home care use and cost is available from HCFA for veterans who use Medicare to obtain these services. HCFA data, however, contains accounting information. It is not possible to obtain information at the visit level. Data are aggregated for billing purposes.

FEE Basis

All VA medical centers have a DHCP-Fee Basis program menu. As fee-basis claims are processed for payment, fee information is automatically transmitted from each COJ to the AAC. Fee data are available through a number of Fee-Basis Reports (see below and also refer to Appendix D for a list of reports currently available). Additionally, fee data may be abstracted from Austin by individuals with access to AAC. Since fiscal year 1987, information regarding activity in this program has been stored in the Central FEE Basis Files at the AAC. Information collected includes CPT codes, purpose of visit, vendor ID, parent station number, and treatment date, among other data. The Veteran Master Files contain cumulative data regarding the dollar amounts spent on care throughout the year whereas the Medical Payment Files contain data regarding a specific medical treatment/visit. These files are SAS Database sets (1987 to present):

- MDPPRD.MDP.SAS.FEN.FYnn.VET- Veteran Master File (nn= year);
- MDPPRD.MDP.SAS.FEN.FYnn.MED- Medical Payment File.

For data in 1986 - 87 (FY 87):

- MDPPRD.MDP.SAS.FEE.FYnn.type- (type= VET or MED).

The content statements for all these above files are provided in Volume II. Fee Basis files can be linked with the PTF and the OPC files through scrambled social security numbers. Programs that are paid using DHCP-Fee show what services were provided through use of CPT codes.

What is lacking from the Fee Basis files is information on patient functional and cognitive status, social support, environmental assessment, patient communication, behavior issues, health status, and special needs. The fee basis files are also very limited in socio-demographic data.

Clinics of jurisdiction may also maintain customized locally developed fee reports in their local personal computer systems.

It should also be noted that Austin links Fee Basis files with FMS (Financial Management System) for payment generation and accounting purposes. Previous to October 1, 1995, Fee Basis files were also linked to CALM (Centralized Accounting for Local Management) before it was replaced by FMS. For more information regarding how this is done, refer to *Databases Resource Guide, Volume IV: Costing of Health Care in VA Medical Centers* (Beattie, et al., 1994).

Unit of Analysis:

The fee basis database sets are at the patient level.

Data Quality:

Unknown.

Reports:

There are numerous new and revised DHCP outputs available in the Fee Basis software. These reports can be used to identify and track patient-specific, program-specific, or vendor-specific information within your COJ. Other reports are generated by the AAC and sent to

facilities. There are separate sources for each subgroup of reports. Austin generated report data are retrieved from the Central Fee File. Fee Basis report data are retrieved from the local DHCP files. For a listing of the fee basis reports of interest to long term care researchers refer to Appendix D.

Contacts:

- At AAC:

  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

- At MAS-VA Headquarters:

  Roscoe Butler
  (202) 273-8302
  or,
  Anna Franks
  (202) 273-8305

B. Paper Records:

The Skilled Home Health Care program uses form:

- VA Form 10-7108- Nursing Care Referral.

A copy of this form is included in Volume II.

V. Adult Day Health Care (ADHC)

Description of the program:

This is a therapeutically oriented outpatient medical care program (both VA and contract) providing health maintenance and rehabilitation services in a congregate setting during day time hours. The VA ADHC program was authorized in 1983 by Public Law 98-160 (US Congress. PL 98-160 Title 1. Veterans Administration Health Programs. HR 2920. November 21, 1983), as a substitute for nursing home care. The primary goal of ADHC is to maintain or improve the health and functional status of frail elderly veterans. In doing so, ADHC is designed to assist participants to remain in the community, enabling families and other care givers to continue home care for their impaired family member. Currently, there are only 15 in-house VA ADHC programs (refer to Appendix A for a complete listing). The other VA medical centers provide this program to veterans through a contractual basis with community-based ADHC programs.

The ADHC program is primarily targeted to veterans at high risk of nursing home admission due to functional impairments, cognitive impairment, behavior problems, advanced age and frailty. Examples of services that some programs provide include: clinical therapies, training in activities of daily living (ADLs) and personal care, health and dietary education, discussion groups and reality orientation, individual and group activities for the cognitively impaired, intergenerational experiences, activities to develop creative capacities, involvement in community events and activities, outdoor activities as appropriate, and caregiver training in ADL support and behavior management.

Service-connected and non-service connected veterans who are patients in the VA system are eligible for ADHC. ADHC also takes HBPC patients who are no longer homebound and thus discharged from HBPC but still require care. Patients may not be co-enrolled in HBPC and ADHC. Contract ADHC is under the same authority as ambulatory care and considered an

outpatient service. Prior to FY 1994, VAMCs had a separate line item in their budgets for contract ADHC. However, as a result of VHA Directive 10-93-022 (Implementation Plan for Alternative Use of CNH Funds), all funds now are sent as contract nursing home funds from which VAMCs draw upon for contract ADHC and contract homemaker/home health aide care. Contract ADHC functions like the contract nursing home program. VA establishes contracts with a number of community providers. A veteran may receive adult day health care services through VA contract for up to one year.

A. Computerized Database:

There is no national database for VA contract ADHC.

Outpatient Care File (OPC)

VA on-site ADHC is considered an outpatient program and, as such, reports patient visits in the same manner as an outpatient clinic. Procedures for collecting and submitting data vary among medical centers. Data collection may be completed using the Outpatient Routing and Statistical Record, which is a manual form, or by direct computer entry. Data can be abstracted from Austin if an individual has access to the AAC. Data regarding VA ADHC visits can be found in the Outpatient Care File (OPC): Visits. OPC data is only for outpatient in-house care and *not* for contract program care. Information gathered includes demographics (SSN, sex, date of birth, etc.),VA location, and visit information (date of visit, purpose of visit, clinic stop, etc.). These files, kept by fiscal year of discharge, are in SAS database sets:

- MDPPRD.MDP.SAS.SFyy (1991 to present);
- MDPPRD.MDP.SAS.OPC.FYyyF(0) - (1986 - 1990);
- MDPPRD.MDP.STAFF.Syy (1980 - 1985).

For more detailed information regarding VA OPC files, we refer the reader to *Databases Resources Guide, Volume III: Outpatient Care File* (Beattie, Swindle, & Tomko, 1992).

Unit of Analysis:

The OPC is at the visit level.

Data Quality:

Prior to FY 1986, VA OPC records were kept on only a 20% sample of patients; only patients with social security numbers ending in either “1" or “5"- a pseudo-random sample. Since 1986, a 100% sample is maintained.

Reports:

There are no reports to or from VA Headquarters regarding contracted ADHC.

Contacts:

- At AAC:

  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

B. Paper Records:

The contracted ADHC programs may use form:

- VA Form 10-7108 - Nursing Care Referral (used only for contract services).

A copy of this form is included in Volume II.

Patient records include: patient name, address, telephone number, SSN, responsible party,

initial referral, dated initial assessment results, treatment plan and schedule, quarterly reassessment, discharge plan, progress notes, discharge notes and summary, referrals, and pertinent documents from the medical record. This is a paper record.

Many ADHC Program Directors also keep local information on PCS. This may be done on a number of spreadsheet packages. At the San Antonio VAMC, for example, information is kept on the local DHCP. None of these data are available nationally.

VI. Homemaker/Home Health Aide

Description of the program:

Homemaker/Chore is the newest program within the VHA system of institutional and non-institutional services. Until recently, VA had no authority to provide supportive non-medical care services to the veteran in the community.

Public Law 101-366 authorized VA to conduct a pilot program (alternative use of CNH funds) to provide medical, rehabilitative and health-related services in non-institutional settings. VHA decided to consider a program that would include home health aide and homemaker services provided by contracted agencies but coordinated by VA staff. Public Law 102-389 allowed VAMCs to use up to 15% of their community nursing home budgets to purchase these services. The goal of providing these services is to prevent or delay institutional placement. Services provided are non-medical which include home health aide for bathing, grooming and bowel and bladder care and homemaker services including housekeeping, laundry and meals.

The pilot program began in FY 1993 with 119 facilities approved for participation. A veteran is eligible for care if he or she meets the following criteria*:

- must be in need of nursing home care and meet at least two of the following:
  - residence in nursing home
  - dependent in two or more activities of daily living
  - dependent in two or more instrumental activities of daily living
  - age 75 or older
  - three or more hospitalizations in past year
  - 12 or more outpatient clinic or emergency evaluation visits in past year
  - clinical depression
  - lives alone
  - recent discharge from a nursing home
  - significant cognitive impairment and/or multiple behavioral problems

* (Note: Prior to November 1994, a patient had to be service-connected disabled 50% or more

to be eligible, but this requirement was dropped.)

A. Computerized Database:

At present there is no national database that tracks homemaker/home health aide patients as such. Authorization and payment for homemaker/home health aide is accomplished through the alternative use of CNH funds and may be processed for payment as a short term service through DHCP-Fee.

Reports:

Refer to Appendix D for listing of Fee Basis Reports.

Contacts:

- At AAC:

  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

B. Paper Records:

Facility level Workload Reports - RCS 10-0867 are submitted to the Office of Geriatrics and Extended Care (VA Headquarters) every quarter. Patient specific information is not available. This report provides basic information on utilization and funding issues. Included in the report are: number of patients placed, patients discharged, number currently receiving services, number of homemaker visits during quarter, number of home health aide visits, funds obligated for homemaker and for home health aide visits, and number of agencies providing services.

The Homemaker/Chore program uses form:

- ❖ VA Form 10-7108- Nursing Care Referral.

This form is at the patient level but is not computerized. A referral form must be completed for every veteran referred for homemaker or home health aide services. This paper record contains patient demographic information, next-of-kin information, diagnosis, physician recommendations, notes from the hospital nurse, and name of the community nursing agency to which the patient is being referred. A copy of this form is included in Volume II.

Several other data collection tools were developed for an evaluation of the homemaker/home health aide program conducted by researchers from the Bedford VAMC Health Services Research program (Kern, Hickey, Davidson & Davidson, 1995). Additional data were collected for six months (1/94 - 6/95) representing 906 veterans receiving care. These forms included a patient registry form (name, social security number, date of entry, new or renewal, dates service(s) began and ended); a monthly agency registry form (agency name, tax ID number, number of patients receiving homemaker and/or home health aide services and the cost per patient); and a supplementary intake data form to the VA SF-10-7108 (Nursing Care Referral). The Supplementary form includes a section to be completed by the case manager and a patient interview section. The case manager section includes information on patient eligibility for the program, source of referral, disabilities, cognitive status, social and informal support at home, services requested, other services provided, impairments, and self care assessment. The patient interview includes the SF-36 form, from the Medical Outcomes Study (Ware & Sherbourne, 1992), which includes an assessment of quality of life using eight subscales including physical functioning, emotional functioning and pain. Unfortunately, these data are no longer collected.

VII. Domiciliary

Description of the program:

The Domiciliary care program has been functioning within VA since the beginning of this century and primarily provided long term care to disabled veterans (Chung et al., 1993). Since its inception, many changes have taken place to move the program toward a more clinical focus. The VA Domiciliary Care for Homeless Veterans (DCHV) program began in 1987 with the passing of Public Law 100-71 (Rosenheck & Leda, 1991). Currently, a VA domiciliary is a residential rehabilitation and health maintenance center for veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities. Veterans must be homeless or in living situations that compromise their ability to maintain residential stability (i.e., living in a car, a shelter, a drug house, etc.). Eligible ambulatory veterans receive necessary medical and psychiatric care, rehabilitative assistance, and other therapeutic interventions on an outpatient basis from the host hospital, while residing in the structured, therapeutic, homelike environment of the domiciliary. The goal of the program is to return the veteran to independent functioning in the community. At present there are 41 VA Domiciliaries in the VA health care system; for a list please refer to Appendix A.

Some of the specialized therapeutic programs offered include: restoration, alcohol abuse treatment and education, post-psychiatric care adjustment, geriatric care, behavior modification, health promotion, TIGER (training in group effectiveness relations) or human relations training, patient advisory councils, and post-discharge community support and aftercare. Patients may be assigned Incentive Therapy wherein they will receive nominal remuneration for therapeutic work assignments throughout the medical center or domiciliary. Patients may also participate in training and/or work-out/live-in programs.

A. Computerized Database:

The Domiciliary Care Program does not have its own VA database. Information can be gathered from the PTF, and from each site's local DHCP. Program level information can be requested from the Northeast Program Evaluation Center (NEPEC, see below).

Patient Treatment File

Data regarding inpatient episodes of care in VA domiciliary are located in the Extended Care files of the Patient Treatment File (PTF) similar to NHCUs. Information collected in the PTF includes demographics, diagnosis, and length of stay. Data can be abstracted by individuals with access to the AAC. These files are in SAS Database sets:

- MDPPRD.MDP.SAS.XMfy - FY 1991 to present (fy= fiscal year);
- MDPPRD.MDP.SAS.EXTENDED.PMyy - FY 1984-89 (yy= year).
- MDPPRD.MDP.SAS.XMfyRn - FY 1991 to present (n= region number);
- MDPPRD.MDP.SAS.RGn.EXTENDED.PMyyRn.

The PTF variables for Bedsection, Sation Type and Station Number (with suffix) can be used to identify domiciliary care. Valuable clinical information lacking from the PTF includes patient functional and cognitive status, patient communication, behavior, health status, nutritional/oral/dental information, and social support. To learn more about the PTF and PTF:Extended files we refer the reader to *Database Resource Guide, Volume II: Patient Treatment File* (Beattie, Swindle, & Tomko, 1992).

Unit of Analysis:

The PTF is at the patient level and can be aggregated to the facility and national level.

Data Quality:

Analysis of the PTF national data revealed "that episodes involving Community Nursing Home stays and VA extended care were most likely to overlap, and there were some overlapping episodes where the patient was registered at two different facilities" (Beattie et al., 1995). In a survey those same researchers conducted in 1992, respondents reported "data entry errors in the form of overlapping of episode dates for inter-facility transfers (after taking into account the inpatient stays for nursing home patients)." If and how this affects domiciliary stay data in the Extended files is unclear.

Reports:

Workload is reported using the AMIS Report RCS 10-0021 which is then transmitted to the AAC. The "VA Domiciliary Activity" segment 346 contains a variety of patient census data on admissions, discharges, transfers, deaths, absent sick in hospital status, female patient count, average daily census, turnover rate, patients remaining, bed occupancy rate, etc. Data are also compared with prior fiscal year information

An Annual Report of Domiciliary Care Program RCS 10-0172 (Narrative Report) is also submitted to the Chief, Domiciliary Care Programs, VA Headquarters.

Contacts:

- At AAC:

  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

Northeast Program Evaluation Center (NEPEC)

Since their initiation, all domiciliary programs have sent demographic data regarding

individual residents, as well as, information regarding staffing and workload levels on a monthly basis to the Northeast Program Evaluation Center (NEPEC) located at the West Haven VAMC. The NEPEC has been monitoring the DCHV, Domiciliary Care for Homeless Veterans, program since its inception. Annual progress reports and quarterly summaries are provided to each Domiciliary by NEPEC. These reports review overall program performance, report sociodemographic and diagnostic characteristics of domiciliary residents, identify critical monitors and identify outlier program sites.

In 1992, NEPEC conducted a thorough survey of the existing DCHV program sites. This survey focused on (1) the sociodemographic characteristics of the domiciliary residents, (2) the therapeutic process, and (3) the outcome of treatment (Chung et al., 1993).

To learn more about the work of NEPEC, the reader should contact the NEPEC directly:

- at NEPEC:

  Robert Rosenheck, MD
  Director, NEPEC
  VAMC West Haven, CT
  (203) 932-5711

B. Paper Records:

The Chief, Domiciliary Operations must keep a daily census and maintain accountability records for all patients. Medical Administration Service initiates and maintains the necessary records which are required during a patient's stay at a domiciliary.

There is a VA standard application for care form. This is not a mandatory form for domiciliary care and some domiciliary programs do not use it. Depending on station preference and local conditions, there may be local forms used in place of the VA standard form in an attempt to capture more information. VA also uses a patient photo-identification card to monitor patients in the domiciliary programs.

VIII. Community Residential Care

Description of the program:

The Community Residential Care program is designed for veterans who do not require hospital or nursing home care but who, because of medical and/or psychosocial health conditions, are unable to live independently and are without suitable support systems to provide the needed supervision and supportive care. This program includes room, board, personal care and general health care supervision and oversight. The services provided to veterans include monthly follow-up visits from VA health care professionals and case management services by VA social workers. The cost of care is financed by the veteran's own resources. The VBA's Aid and Attendance benefits also may be used to defray the cost of the CRC program in a small number of cases.

All veterans who have been VA outpatients or are receiving VA medical center, domiciliary, or nursing home care are eligible for residential care. Although there is no formal contractual agreement between VA and a CRC facility, all community residential care homes are inspected by VA prior to incorporation of the homes into the program, and annually thereafter. Quality of care is monitored by VA professionals who visit the homes and the veteran residents at least once a month. Administrative costs for running the CRC program come out of each medical center's budget but the cost of the program is paid for by the veteran out-of-pocket.

A. Computerized Database:

The CRC Facilities Report, RCS 10-0173 (previously the RCS 18-8) is prepared electronically by each participating VAMC CRC program and submitted to Austin on a quarterly basis using VA Form 10-5502. This report is the only source of data regarding individual CRC homes/facilities and is used mainly by VA Headquarters. Information

gathered includes facility name, city, state, and number of veterans at the facility. There is no patient level data. The AMIS data are in a flat file format under the name of Residential Home Care:

- HCPRD.RHC.R001.Master.

Only current quarter data of the master file are available at a given time. Prior quarters of information are microfiched. Access to this file is limited; contact VA Headquarters for further information. The variable list of this file is in Volume II. Additional information about veterans who utilize residential care homes may be obtained through the Social Work Information Management System (SWIMS) described in chapter XIII.

Unit of Analysis:

The Residential Home Care flat file is at the facility level.

Data Quality:

Unknown.

Reports:

Workload is reported using the AMIS Reports 10-9017 and 10-9017a which is then transmitted to the AAC. AMIS Segment 257 is submitted to Austin quarterly as a report of Residential Care Program placements & losses. AMIS Segment 258 is submitted quarterly as a summary report of the status of the veterans in each Residential Care Program.

Contacts:

- At AAC:

  Larry Hughes
  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

- At Extended Care & Geriatrics, VA Headquarters:

  Dan Schoeps, MS
  Chief
  Community Care Programs
  (202) 273-8546

Social Work Information Management System (SWIMS)

Patient level information regarding services used, resources, and outcomes, is kept by the Social Work Service on all patients enrolled in the CRC Program. However, this information is not tied to the above RHC database. The SWIMS data does not identify the specific residential care facility/home that a patient has used. For more information regarding the SWIMS database, refer to Chapter XIII below.

B. Paper Records:

The Residential Care program uses forms:

- VA Form 10-2406- Recommendation for Release of Patient in Home Other Than His Own;
- VA Form 10-2407- Residential Care Home Program: Sponsor Application;
- VA Form 10-2408- Outline for Obtaining Information as to Suitability of Home Other Than Patient's Own;

❖ VA Form 10-2409- Patient's Agreement with Hospital in Relation to a Home Other Than His Own;

❖ VA Form 10-2410- Agreement to Provide Home Care for Patient.

Copies of these forms are included in Volume II.

IX. Hospice

Description of the program:

As of fiscal year 1993, all VA medical centers were required to have a hospice program and a Hospice Consultation Team in place. Hospice is a coordinated program of palliative and supportive care (physical, psychosocial and spiritual) for patients and their families in the last phases of incurable disease. Hospice addresses issues such as alleviation of distressing symptoms, pain management, quality of life, grief and bereavement counseling. Within VA hospice, care can be provided in a variety of settings: an inpatient Hospice unit; HBPC[1]; or NHCU. The VA can also contract with a community-based agency to provide hospice care services. However, many veterans choose to utilize their Medicare benefits for hospice care.

A. Computerized Database:

Regardless of where hospice is provided within VA, there is no way of identifying patients receiving VA hospice care. Neither the PTF nor the HBPC databases have identifiers indicating that a patient is receiving hospice care. Local records are kept by medical facilities; these may be on a PC database or a paper record. At Edward Hines, Jr. VAH, the local IRM staff have added a "Hospice Menu" to the local DHCP. This way, if a hospice patient is classified as deceased by MAS staff, the hospice team will automatically be notified regardless of which unit the patient may be on at the time of death. Veterans who utilize Medicare benefits for hospice may be identified using the HCFA hospice files. Keep in mind, however, that HCFA does not have a variable that indicates veteran status.

B. Paper Records:

Facilities may keep their own local records/lists of hospice patients as there are no standard VA hospice care forms. At Hines VAMC, the only paper work required includes: 1) a completed consultation sheet or progress note, and 2) a completed Inter-Ward Transfer in the patient's medical record. These data are not available nationally.

Endnote

[1] Technically, HBPC does not provide hospice care because it can not provide 24-hour care, volunteers, etc. However, it does provide home care for terminally ill veterans.

X. Respite

Description of the program:

The Respite Care Program, Title 38 U.S.C. Section 1720B, is designed to provide prescheduled, brief admissions to chronically ill veterans usually cared for at home. The primary purpose is to provide a period of relief for the informal caregiver providing care to the veteran at home in an effort to prevent long term institutionalization. Veterans requiring skilled nursing care and living with an unpaid caregiver are eligible for VA respite care. Respite services may include routine medical supervision, 24 hour skilled nursing care, dietetic consultation, recreational programs, psychological evaluation or services, and social work consultation.

VA may provide respite to a veteran only on an inpatient basis either in the hospital or in the nursing home care unit. It is up to the discretion of each medical center as to where and how many respite care beds will be available at any given time in the medical center or NHCU. Federal guidelines allow for up to 30 days of respite in a calender year. It is again left to the discretion of each medical center as to how this time will be split. If there are unusual circumstances, an exception of more than 30 days of respite care may be allowed.

A. Computerized Database:

The PTF database has no identifier indicating that a patient is receiving respite care, and there is no other national VA database for respite care. However, individual medical centers may choose to monitor respite patients on local PCS using a variety of software programs and/or paper records such as is done at the Edward Hines, Jr. VA Hospital. In addition, the local hospital DHCP has a 'losing specialty' code for respite care (code=83) within the Admission, Discharge, Transfer (ADT) portion of the Patient Information Management System (PIMS) module. This information does not get transferred to the Austin database, however. To learn

more about the DHCP system we refer the reader to *Database Resource Guide, Volume V: Decentralized Hospital Computer Program (DHCP)* (Beattie, et al., 1995).

B. Paper Records:

There are no standard VA respite care forms. Many VA medical centers use their own overprints of other forms and may keep a variety of local records.

XI. Geriatric Evaluation and Management (GEM) Unit

Description of the program:

Geriatric assessment is both a diagnostic tool and an intervention that has been shown to be effective in targeted older adults. Sepulveda VAMC was the first VA to set up a geriatric evaluation and management unit (GEM) as a demonstration project in the early 1980s. As of 1990, 93 VAMCs have established GEM programs in their facilities (refer to Appendix A for a complete listing). The VA defines geriatric evaluation to encompass the following: a multi disciplinary assessment of basic and instrumental activities of daily living; psychological functioning including cognitive and affective status; social, physical and economic supports; and medical assessment. The assessment itself has four components: functional, psychological, socioeconomic and medical (Geriatrics & Extended Care Geriatric Evaluation & Management Program Guide, G-2, M-5, Part VI; Aug. 25, 1992). The GEM unit involves a multi-disciplinary team that includes at a minimum a physician, social worker, and nurse/nurse practitioner. It is designed to assess a frail elderly person's medical, psychosocial and functional capacities and limitations in order to develop a plan for treatment, rehabilitation and long term follow-up. Patients are selectively admitted or targeted based on their perceived ability to benefit from assessment and follow-up.

Geriatric assessment can be performed in a variety of settings including a patient's home. The goal of GEM programs is to eliminate frail elderly patients' need for nursing home care. VA geriatric assessment can occur either on an inpatient unit or through the outpatient clinic. Most inpatient GEM units are located on acute and/or intermediate care wards, but some have been situated in psychiatry and nursing home units (Wieland, Hedrick et al. 1994; Wieland, Rubenstein et al., 1994). Outpatient GEMs are utilized by some VAMCs. These programs require less space and staff resources but have less control of the care management of the patient.

Veterans most likely to benefit from GEM included those age 65 and over, who have multiple medical, functional and/or psychosocial problems and who could benefit from an interdisciplinary team approach to care; and patients who have particular geriatric problems such as dementia, urinary incontinence, malnutrition, depression, falls and/or gait problems, and elder abuse. Availability of informal social support also is an important criterion for veterans who could benefit from GEM services.

A. Computerized Database:

Information regarding the inpatient GEM episodes can be found in the PTF. The bed section codes for inpatient GEM are:

1620 - GEM intermediate care
1320 - GEM psychiatry
1520 - GEM domiciliary
1420 - GEM nursing home care unit.

There is also a code for outpatient GEM episodes in the OPC (clinic stop code = 319). Refer to Beattie, et al., 1992 (*Database Resource Guide, Volume III- OPC*) for more information regarding OPC files and OPC clinic stop codes.

In addition, local hospital DHCPs contain a module called the Patient Information Management System (PIMS). Within the PIMS is a package called Admission, Discharge, and Transfer (ADT) which allows you to do several things including tracking patient movements during inpatient stays. One of the variables is called the "Losing Specialty" variable. This variable identifies the name of the treating specialty in which the patient received treatment prior to transfer or discharge rather than the physical location of the patient's bed. Several codes are specific to GEM treatment:

31 - GEM general medicine
32 - GEM intermediate
33 - GEM psychiatry
34 - GEM neurology

35 - GEM rehabilitation medicine
81 - GEM nursing home
87 - GEM domiciliary.

These are the same codes used for a related variable called “Discharge Specialty” with the exception of codes 81 and 87 which are not available for the discharge specialty variable. This is the bed section from which the patient was discharged. To learn more about the DHCP system and what is available, please refer to *Database Resource Guide, Volume V: DHCP* (Beattie et al., 1995).

XII. Geriatric Research, Education and Clinical Center (GRECC)

Description of the program:

The GRECC program was conceived in 1973 to focus on aging as a special interest for VA. The purpose of GRECCs is to give visibility to the study of geriatrics or diseases of the elderly, and the study of the aging process-gerontology. As the name implies, GRECCs support a multi-disciplinary approach to research, education, and clinical care at each center.

The first GRECC was established in 1975. There are currently 16 GRECCs located at the following VAMCs: Ann Arbor, MI; Baltimore, MD; Boston/Bedford, MA: Durham, NC; Gainesville, FL; Little Rock, AR; Los Angeles, CA; Madison, WI; Miami, FL; Minneapolis, MN; Palo Alto, CA; Salt Lake City, UT; Seattle/American Lake, WA; Sepulveda, CA; and St. Louis, MO. Each GRECC has its own set of research priorities (refer to Appendix B).

Research conducted within the GRECCs may encompass basic science, clinical, rehabilitative, and/or health services research. In order to learn more about a particular GRECC's research, contact the GRECC director. Some of these programs and researchers may have data bases or information relevant to a particular area of interest.

XIII. Social Work Information Management System (SWIMS)

Description:

The Social Work Information Management System (SWIMS) was developed by the VA social work technical expert group as a case management tool. The current Version 3 has been implemented nationally at *all* field sites since the first quarter of FY 1995. The patient data is entered directly in the computer or a patient data code sheet is completed for every episode of social work assessment, screening, treatment, or referral made by a professional social worker. Although this database covers a range of services provided by VA social workers, it also contains some information that may be useful for individuals interested in examining long term care use. Every SWIMS record contains patient name and SSN, admission and discharge dates, gender, patient age (within age categories), station number, worker ID number, date case opened, date case closed, and CDR location of services provided.

Every SWIMS episode records problems, outcomes, direct services, and resources. When a social worker closes a case, up to eight patient problems can be selected. There are 38 problems to choose from, broken into the following eight categories:

1) Problems related to care (e.g., placement of patient, home health care, need for structured day activities such as adult day health care);

2) Patient/Family adjustment (e.g., adjustment to terminal illness/death, adjustment to placement);

3) Environmental problems (e.g., housing needs, financial problems);

4) Problems related to abuse;

5) Relationship problems (e.g., marital/partner problem, nonexistent or inadequate social support systems);

6) Problems of behavior, cognition, and mental disorders (e.g., substance dependency, affective disorders)

7) Vocational/Education problems;

8) Legal problems.

For each case, an outcome for each problem treated must be recorded. There are eight outcome codes for the problems listed above. This outcome determination is based on the judgement of the social worker regarding the results of social work treatment of the problem or problems that were identified. Outcomes include: decision not to treat, planned results attained, partial attainment of outcome as a result of either patient/family barriers, community barriers or VAMC barriers, and outcome not attained as a result of same barriers mentioned before.

Any direct services provided to the veteran also are coded. There are 16 services to choose from; a social worker may select up to eight for each case closed. Direct services include, but are not limited to, discharge planning, psycho-social assessment, post-discharge follow-up, and home visit.

Of most interest to the researcher, clinician or policy maker examining VA LTC use, is the section on *resources*. If a resource or referral for care was provided to a patient, then that resource or referral should be identified. Furthermore, the social worker should indicate whether the resource/referral was used (1) or needed but unable to access (0). Once again, the social worker may select up to eight resources. Resources are broken down into three categories: "other institutional", "residential structured environment", and "other". "Other institutional" refers to any institution other than the VA medical center (i.e., VA NHCU, CNH, community nursing home-not paid by VA, VA domiciliary, state veteran's home). The "residential structured environment" section includes: VA community residential care program, halfway house, group housing, transitional living or other residential program.

Finally, the "other" category refers to other community based resources including home/day care (ADHC), home without supports, home with support (i.e., HBPC, community home care, homemaker/chore services and meals-on-wheels), and community follow-up services. Unfortunately, since many of these categories contain several long term care options, it is not possible to distinguish specifically what type(s) of home with support services a veteran may be receiving, for example.

Additional data is collected for veterans who are provided services through the Community Residential Home Care program (refer to Chapter VIII of this guide for more details regarding this VA program). Information on veteran race/ethnicity, prior living arrangements, diagnostic categories, and level of care required are recorded. Information on the name of the home, date placed in the residential home, monthly rate, and date removed are also recorded.

A. Computerized Database:

Prior to FY 1994, data transmitted to Austin was kept in the Old Social Work Service Master Record; this is an entirely different database than SWIMS. These historical data, available from the AAC, are flat files and are not configured in SAS. However, an input statement, available from the AAC, will allow you to convert these data to SAS format. Two files are available:

- HCPPRD.SWS.HISTORY.MASTER.RECORDS;
- HCPPRD.SWS.HISTORY.PURGED.RECORDS.

These data go back as far as January of 1984. The researcher should be aware that Social Work Service had their own station numbering system at that time which was different from the current SWIMS system. For content statement and variable list, please refer to *Volume II*.

Currently, data on all closed cases are transmitted electronically to Austin on a quarterly basis

from all sites in two different queues. The first queue, SWIMS AMIS, is composed of AMIS data Segments 208, 209, 210, 211, and 256, and is used to write basic reports (see below). Data are available from FY 1993 (just a few stations), FY 1994, FY 1995, and FY 1996. These data are also in flat file format but only used for report generation.

The second type of transmission, SWIMS medical, is patient specific. The data from this transmission is unedited with scrambled social security numbers; it is collected and a SAS copy of each Fiscal Year is made. The data are in SAS database files:

- MDPPRD.MDP.SAS.FYnn.SWIMS (nn= year, FY 1993-present).

Refer to *Volume II* for content statement and variable list.

One very useful trait of the SWIMS data set is that it has been structured so that information can be merged with the PTF for each individual patient and thereby offers a more complete picture of medical care, services received and outcomes.

Unit of Analysis:

The SWIMS medical file is at the patient level. It can be aggregated to the VISN level and the national level. The AMIS data is at the local program level and can be aggregated to the national level.

Data Quality:

A reliability study of SWIMS data was conducted in three phases, using case scenarios of typical cases that social workers would encounter. The first two phases were pilot studies, used for developing and refining the materials and procedures used in the national study which was conducted during May 1995. Materials were distributed to 159 VA medical

centers and completed materials were returned by 136 (86%) of the VAMCs. Among the eligible social workers, 93% (n=2379) participated in the study. Overall agreement rates for "problems" was 71%; agreement rates for "direct services" was 67%. The researchers, headed by Roger Maddigan, Chief SWS, Buffalo VAMC, have completed a final report which is in publication. The Executive Summary states "levels of agreement between VA social workers and the gold standard were, on the whole, moderate to high." (Refer to Murphy, et al., 1996)

Our attempts to understand the SWIMS data have led us to question the overall validity of the SWIMS database. Discrepancies between the variable labels in the SWIMS user manual and the actual data downloaded from Austin were found. Some hospitals were given permission to create locally used value labels for particular variables. It is not clear which sites are creating their own variable labels and if these sites are communicating this information to the other sites and/or to the SWIMS database caretakers.

Reports:

Reports can be run locally through DHCP from each VAMC. These reports include:

- A-01 SWIMS Report - summary of all variables;
- A-02 SWIMS Residential Care Program Report - summary of patient specific data on individuals who used CRC services;
- A-04 SWIMS Quality Management Monitor I Report - summary of patients receiving discharge planning and/or post discharge follow-up;
- A-05 SWIMS Quality Management Monitor II Report - summary of patients receiving discharge planning and/or family conferencing;
- A-06 SWIMS Quality Management Monitor III Report - summary of patients receiving discharge planning by CDR location code;
- A-07 SWIMS Quality Management Monitor IV Report - summary of psycho-social problems and outcome codes.

Austin can provide individual sites with VISN and national data.

Contacts:

- At AAC:

  Larry Hughes
  Computer Specialist
  Medical Help Desk
  (512) 326-6780
  Interactive Voice Response selection ❶ and then ❸.

- At Extended Care & Geriatrics, VA Headquarters:

  Roger Maddigan
  Chief, Social Work Service
  VAMC Buffalo
  (716) 862-3625

B. Paper records:

Social Work Service may use the following form when opening or closing a case:

- VA Form 10-7946 - SWIMS Patient Data Code Sheet.

Many sites may not use this form because the data can be entered directly onto the computer. A copy of this form is included in Volume II.

XIV. Resident Assessment Instrument (RAI)/ Minimum Data Set (MDS)

Description:

Congress mandated (Omnibus Budget Reconciliation Act of 1987, Public Law 100-303) that all Medicare and Medicaid certified long term care facilities conduct periodic assessments on each of their residents. In response, the Health Care Financing Administration (HCFA) created a uniform patient assessment instrument, the Resident Assessment Instrument (RAI) which includes the Minimum Data Set (MDS or MDS+), a minimum core of defined and categorized patient assessment questions, and the resident assessment protocols (RAPs). All states have been using the RAI since 1991.

The latest version, RAI/MDS 2.0, is to be fully implemented nationwide by January 1, 1996, and will be electronically transmitted to HCFA on a quarterly basis in order to establish a national RAI/MDS database. This updated version of the MDS incorporates all of the Resource Utilization Groupings (RUGs III, Fries et al., 1994), patient classification items, and all information from the original MDS and the MDS+. In this way, all states will be using the same uniform assessment instrument. Those states that want to add additional data elements can include these in a separate addendum section (Briggs, 1995); but the core instrument must remain the same. The RAI/MDS 2.0 is designed to identify significant changes in resident status over time.

The MDS 2.0 is divided into two parts, a face sheet and an assessment, with an additional addendum section if needed. The face sheet contains resident identification information, demographic information, and a patient customary routine section. The second part is referred to as the Full Assessment Form and contains all of the resident assessment and care screening information. The assessment form is separated into sections as follows: identification and background information, cognitive patterns, communication/hearing

patterns, vision patterns, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence in last 14 days, disease diagnoses, health conditions, oral/nutritional status, oral/dental status, skin condition, activity pursuit patterns, medications, special treatments and procedures, discharge potential and overall status, assessment information, and a final resident assessment protocol (RAPs) summary.

The RAI contains specific MDS trigger elements that prompt RAPs for further assessment. Currently, there are 18 RAP problem areas: delirium, cognitive loss, visual function, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, feeding tubes, dehydration/fluid maintenance, oral/dental care, pressure ulcers, psychotropic drug use, and physical restraints. For each RAP that is triggered, an indication is required of whether a new care plan, care plan revision, or continuation of the current care is necessary to address the problem(s) identified in the assessment.

VA is exempt from the HCFA MDS requirement. However, as previously discussed in Chapter I, a number of VA medical centers participated in a project entitled "MDS Demonstration Project" which was designed to test whether it would be feasible to use the MDS in all VA NHCUs (refer to Chapter I). In a VA Long Term Care Policy memo dated May 1995, and signed by Dr. Kizer, Deputy Under Secretary for Health, Statement No. 3 reads, "VHA will begin with use of the RAI (MDS) required by HCFA for all certified nursing homes." As was mentioned earlier, the VA Office of Geriatrics and Extended Care is planning to implement the MDS for all VA and contract nursing home patients sometime in the future.

Although there is no gold standard for what information should be collected for long term care residents, the MDS provides a comprehensive assessment tool. The MDS provides a model that other databases can be compared with.

XV. RAI/MDS-Home Care (MDS-HC)

Description:

Following the lead of the RAI/MDS 2.0 for long term care facilities, the RAI/MDS Home Care is an assessment instrument designed for use in a home setting. The RAI/MDS-HC is composed of two parts, the MDS-HC, a fixed minimum core of functional assessment questions, and the client assessment protocols (CAPs). Undergoing development since 1993, it is currently in draft form and undergoing final revisions and field testing. Unlike its predecessor, the RAI/MDS-HC was not mandated by Congress.

The MDS-HC has two parts, the face sheet and the functional assessment form. The assessment is divided into the following sections: assessment information, cognitive patterns, communication/hearing patterns, mood and behavior patterns, social functioning and support, physical functioning (self performance of instrumental (IADL) and personal (ADL) activities of daily living), continence in last 14 days, disease diagnoses, health conditions and preventive health measures, nutrition/hydration status, dental status (oral health), skin condition, medications, treatments and adherence, overall status in last 90 days, and environmental assessment. There is also a separate section on client assessment protocols (CAPs).

There are data elements in the MDS-HC that trigger specific CAPs which call for further client assessment. The thirty elements are: FUNCTIONAL PERFORMANCE: ADL/Rehabilitation Potential, Instrumental Activities of Daily Living (IADLs), Institutional Risk. SENSORY PERFORMANCE: Communication Disorders, Visual Function. MENTAL HEALTH: Alcohol Abuse & Hazardous Drinking, Cognition, Behavior, Depression and Anxiety, Elder Abuse, Social Function. HEALTH PROBLEMS/SYNDROMES: Cardio-Respiratory, Dehydration, Falls, Nutrition, Oral Health, Pain, Pressure Ulcers, Skin and Foot Conditions. SERVICE OVERSIGHT: Adherence, Brittle Support System, Medication

Management, Palliative Care
Preventive Health Measures(Immunization and Screening) , Psychotropic Drugs, Reduction of Formal Services, Environmental Assessment. CONTINENCE: Bowel Management, Urinary Incontinence and Indwelling Catheter.

The VA Office of Geriatrics and Extended Care is hoping to implement the MDS-HC in all VAMCs for patients receiving HBPC sometime in the future.

XVI. State Homes

Description of Program:

According to VA Manual of Policies, M-1, Part I, Chapter 3, "'State home' means a home approved by the VA which was established by a State primarily for veterans disabled by age, disease or otherwise, who by reason of such disability are incapable of earning a living. The term State home includes facilities for domiciliary and/or nursing home care. Hospital care may be included when provided in conjunction with domiciliary or nursing home care. A home which furnishes different levels of care must provide care in clearly designated areas within the home so that patients receiving separate levels of care are not intermingled. The Chief of Medical Administration at health care facilities is responsible for administrative aspects including determination of eligibility, maintenance and reconciliation of records, review of claims for payment, compliance with VA regulations and general coordination of the program."

Payment for care provided to the veteran at a State Home comes from various sources. Payment from the VA comes from a Grants program which provides a flat rate to the Home for nursing and domiciliary care. The State and/or State Home collects a financial worksheet from the veteran determining ability to pay. The VA has no involvement in the determination of ability to pay. The remainder of the cost is divided between the State and the veteran out-of-pocket.

Computerized Databases:

There is no National Database for State Home Care. There are, however, several variables available in the PTF file to identify veterans receiving care at a State Home. These variables are: DISTO, STATYP, AND STA3N. For further information, consult Beattie, Swindle, et al. Volume II: Patient Treatment File.

Reports:

There are no national reports regarding State Home Care.

Contacts:

Local MAS departments at individual facilities.

Paper Records:

State Homes use the following form to obtain demographic information about veterans they treat, for whom the VA is paying per diem.

- **VA Form 1010-**

This information is generally stored in the hospital computer system at the local VA facility associated with the State Home.

XVII. The Outcome and Assessment Information Set (OASIS)

The OASIS is a standard core assessment data tool for adult home care patients. It was developed by the Center for Health Care Policy Research (CHPR). OASIS is the outgrowth of a five year study jointly funded by HCFA and the Robert Wood Johnson Foundation to develop outcome measures for home care. However, it was not designed as a comprehensive assessment instrument. Rather, it was developed to measure outcomes of adult home care patients.

OASIS-B is a 79-item questionnaire that is administered during initial patient assessment for home care, at specified intervals to coincide with Medicare recertification (i.e., every 60 days), and at discharge. Questions include: patient demographics, history, living arrangements, support/assistance in the home, activities of daily living, medications, management of equipment, and status of body systems (i.e., sensory, integumentary, respiratory, elimination, neurological, emotional and behavioral). The questions measure changes in the physical and mental status of home health patients over time. All data are examined at the home care agency level. For example, OASIS can be used to examine improvements in ambulation and/or transferring over time. Collection of these data at multiple agencies allows for comparable across agencies and for developing benchmarks for home health care.

The instrument has gone through three revisions with (A1-A3), prior to OASIS - B which was released this year (i.e., 1997). Software is available for purchase to compute outcome measures based on the OASIS items. Further versions may occur as home care practices, patient conditions, and policies change, although none are expected for at least the next 18 months.

HCFA has announced that as part of the revised Medicare Conditions for Participation for Home Health Agencies, agencies will be required to collect OASIS on all of the Medicare patients. Controversy exists as to whether HFCA should adopt the OASIS or consider another tool such as the MDS-HC, which would allow for comparability with the Medicare nursing home population which is assessed using the MDS. Currently, an agency's decision to use OASIS is strictly voluntary.

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Appendix A:

LTC Programs and Services by VA Medical Center

Inpatient Services/Programs :

NHCU = VA Nursing Home Care Unit
RESP = VA Inpatient Respite
HOSP = VA Inpatient Hospice Unit
GEM = VA Inpatient Geriatric Evaluation & Management Unit
DOM = VA Domiciliary

Outpatient Services/Programs :

CNH = Community Nursing Home Program
HBPC = VA Home Based Primary Care
CHC = Community Skilled Home Care
ADHC = VA Adult Day Health Care
H/HHA = Homemaker/Home Health Aide
CRC = Community Residential Care
GEMCL = VA Outpatient GEM Clinic

LTC Programs & Services by VA Medical Center[1]

X= Program offered at facility R=referred to another VA C=contracted to non-VA N=refer to non-VA P= program pending

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Anchorage, AK	363					X	X				X			
Togus, ME	402	X	X	X	X		C		C	X	C	C		
White River Junction,	405		X	X	X		X	X		C	X	X	X	
Fort Harrison, MT	436		X	X	X		X		X			X	X	
Fargo, ND	437	X	X	X	R		C		C		X		R	
Sioux Falls, SD	438	X	X	X	X		X		X	X	X	X	X	
Cheyenne, WY	442	X	X	X	R		X				X	X	R	
Wichita, KS	452													
Wilmington, DE	460	X	X	X			N		X			X		
Albany, NY	500	X	X	X	X		C	X	X	*X	X	C	X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Albuquerque, NM	501	X	X	X	X		X	X			X	X	X	
Alexandria, LA	502	X	X				X							
Altoona, PA	503	X	P	X			C		X			X		
Amarillo, TX	504	X	R	C			X			R		R		
American Lake, WA	505	X	X	X	X	X	C	X	X	C	X		X	X
Ann Arbor, MI	506	X	X	X	X		C		X		C			X
Decatur (Atlanta), GA	508	X	X		X		X	X	X	C	X	X	X	
Augusta, GA	509	X	X	X			C		C	X	X	X		
Baltimore, MD	512	X	R	R	X	X	C	X	X	C	C	X		X
Batavia, NY	513	X	R		X		X	P	C		X		X	
Bath, NY	514	X	X	X	X	X	X	X		X	X	X		
Battle Creek, MI	515	X	X	R			X		X		X	P		
Bay Pines, FL	516	X	X	X	X	X	X	X	X	X	X		X	
Beckley, WV	517		X				C	X				X		
Bedford, MA	518	X	X	X	X	X	X	C		X	X	X	X	X
Big Spring, TX	519	X	X	X		X	X		X		X	X		
Biloxi, MS	520	X	X	X		X	X	X	X	X	X	X		
Birmingham, AL	521						X	X					X	
Bonham, TX	522	X	X	P		X	X						R	
Boston, MA	523	X	X	X	X	X	X	X	X	*X	X	X	X	
Brockton, MA	525	X	X	X	X	X	N		X		X	X	X	X
Bronx, NY	526	X			X		X	X	C		X		X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Brooklyn, NY	527	X	X		X		X	X	X	X				
Buffalo, NY	528	X	X		X	X	X	X	X	*X	X			
Butler, PA	529	X	X	X		X	C		C	*X	X	X		
Boise, ID	531	X	X	X	X		X	X	C		C	C	X	
Canandaigua, NY	532	X	X	X		X	X					X		
Castle Point, NY	533	X	X	X	X	X	X	X	X		X	X		
Charleston, SC	534	P	X		X		C	X	X	C	X		X	
Chicago Lakeside, IL	535	X	X	X	X	X	X	X	X	X	X	X	X	
Chicago West Side, IL	537		X	C	X		X	X	C	C	C			
Chillicothe, OH	538	X	X	X			C		C	X	X	X	X	
Cincinnati, OH	539	X	X	X		X	X		X	X	X	X	X	
Clarksburg, WV	540													
Cleveland, OH	541	R	X		X	X	X	X	X	X	X	X	X	
Coatesville, PA	542	X	X	X	X	X	X	X		C	C	X		
Columbia, MO	543	X	X	X	X		X	X	X	X	X		X	
Columbia, SC	544	X	X	X			C	X	X	C	X	X		
Miami, FL	546	X	X	X	X		X	X		*X	X	X	X	X
West Palm Beach, FL	548									X	X			
Dallas, TX	549	X	X	X	X	X	X	X	X	X	X	X	X	
Danville, IL	550	X	X		X		X	X	X	C	C	X		
Dayton, OH	552	X	X	X	X	X	C	X	X	*X	X	X	R	
Allen Park, MI	553	X	X	X	X		N	X	N	X	X	N	X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Denver, CO	554	X	X	X			N	X	X	X	X	X		
Des Moines, IA	555	C	X	X		X	C	X	C		C			
North Chicago, IL	556	X	X	X	X	X	C	X		*X	X	X	X	
Dublin, GA	557	X	X	X		X	X	X	X		X	X		
Durham, NC	558	X	X	X	X		N	X	X		X	X	X	X
East Orange, NJ	561	X					X	X		C	C			
Erie, PA	562	X	X	X	X	N	C	X	N		X		X	
Fayetteville, AR	564		X		R		X						X	
Fayettevelle, NC	565	X	X	X	X		X		X				X	
Fort Howard, MD	566	X	X	X	R	X	X		X	X	X	X	R	
Fort Lyon, CO	567	X	X	X	R	X	X				X		R	
Fort Meade, SD	568	X	X	X	R	X	X		X	X	X	X	R	
Fort Wayne, IN	569	X	X	X	X		C	X	C		C		X	
Fresno, CA	570	X	X	X	R		X	X	X		X		R	
Gainesville, FL	573	X	X	C	X		X	X	X		X	X	X	X
Grand Island, NE	574	X	X	X			X	X	X	C	X	X		
Grand Junction, CO	575		X		X		X		C					
Hines, IL	578	X	X	X	X	X	X	X	X	X	X	X	X	
Hot Springs, SD	579		X	X		X	X		C	C	C			
Houston, TX	580	X	X	X			X	X	C		C			
Huntington, WV	581			N		N	X	N			X	X		
Indianapolis, IN	583	X			X		P	X	C	X	X	X		

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Iowa City, IA	584		X	X	R	N	C			C	X			
Iron Mountain, MI	585	X	X	X	R	X	X		X		X	X	R	
Jackson, MS	586	X	X	X			X		X	X	X			
Kansas City, MO	589		X		X		X		C	X	X	X	X	
Hampton, VA	590	X	X	X	X	X	X	C	C			N	X	
Kerrville, TX	591	X	X	X	X		X				X	X		
Knoxville, IA	592	X	X	X		X	X		X	X	X	X	R	
Lake City, FL	594	X	X	X			X		X		X	X		
Lebanon, PA	595	X	X	X	X	X	X		X		X	X	X	
Lexington, KY	596	X	X	X	X		X					X	X	
Lincoln, NE	597	N		N			X	X	C		X	C		
Little Rock, AR	598	X	X	X	X	X	X	X	X	*X	X	X	X	X
Livermore, CA	599	X	X	R	X	R	X	X	X			R	R	
Long Beach, CA	600	X	X		X		X	X	C			X	X	
Louisville, KY	603		X	X	X		X				X		X	
Lyons, NJ	604	X	X		X	X	X	X	X	X	X	X		
Loma Linda, CA	605	X	X	X			X	X	C		C	X		
Madison, WI	607		X	X	X			X	X		X		X	X
Manchester, NH	608	X	X	X	X		C	X	X	C	X	X		
Marion, IL	609	X	X	X		X	X		X		X	X		
Marion, IN	610		X	X	X		X	X	X	C	C		X	
Marlin, TX	611	X	X	X	R	X	X			X	X	X		

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Martinez, CA	612	X	X		R		X	X		X	X			
Martinsburg, WV	613	X	X			X	X				X	N		
Memphis, TN	614				X		C	X	X	P		C	X	
Miles City, MT	617	X			R		X						R	
Minneapolis, MN	618		X				X	X		*X	C	X	X	X
Montgomery, AL	619		X	X	R		X	X				X	R	
Montrose, NY	620	X	X	X	X	X	X		X	X	X	X		
Mountain Home, TN	621	X	X	X	X	X	X					X	X	
Murfressboro, TN	622	X	X	X			X		X					
Muskogee, OK	623						X	X	C	C	N	N		
Nashville, TN	626	X	X	X	X	X	X		X	X	X	X	X	
Newington, CT	627		X	X	X		X	X	X	X		X	X	
New Orleans, LA	629	C	X	X	X		C	X	X	X		C	X	
New York, NY	630						X	X	X	C				
Northampton, MA	631	X			X		C	X		X	X	X		
Northport, NY	632	X	X	X	X		X	X	X	C	C	X	X	
Oklahoma City, OK	635	X		N	X		C	X		C	C	X	X	
Omaha, NE	636				X		X			C			X	
Asheville, NC	637	X	X	X	X		X	X	C	C	X	X		
Palo Alto, CA	640	X	X	X	X	X	X	X	X	X		X	X	X
Perry Point, MD	641	X	X	X	X	X	X		X	X	X	X	X	
Philadelphia, PA	642	X	X	X	X		X	X	X		X		X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Phoenix, AZ	644	X	X	C	X		X	X	X	C	X	X	X	
Pittsburgh Highland	645	X	X	X		X	C	X	C	X	X			
Pittsburgh University Dr.	646	X	X	X	X	X	X	X	X	X	X	X	X	
Poplar Bluff, MO	647	X	X				C	X	X	X	C	C	X	
Portland, OR	648	X	X	X	X	X	C	X	X	*X	X		X	
Prescott, AZ	649	X	X		X	X	X			X			X	
Providence, RI	650		X	X	X		X	X	X		X		X	
Richmond, VA	652	X		X	X		X		X		X		X	
Roseburg, OR	653	X	X	X	R		X	C	C	X	X	X	X	
Reno, NV	654	X	X		X		X	P	X	X	X	X		
Saginaw, MI	655	X	X		R		X		N		X		X	
St. Cloud, MN	656	X	X	X		X	X			*X		X	X	
St. Louis, MO	657	X	X	X	X	X	X	X	X	C	X	X	X	X
Salem, VA	658	X	X		X		X		X	X	X	X	X	
Salisbury, NC	659	X	X	X	X		X		X	X	X	X	X	
Salt Lake City, UT	660		X	X	X		X	X	X		X		X	X
San Francisco, CA	662	X	X	X	X		X	X	X				X	
Seattle, WA	663	X	X	X	X	X	X	X	X	C	X		X	
San Diego, CA	664		X	X			X	X	X	C	X	N	X	
Sepulveda, CA	665	X	X	X	X		C	X	C	X	C	C	X	X
Sheridan, WY	666	X	X	X	X		N			X		X	X	
Shreveport, LA	667	R	X				X	X			X		X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
Spokane, WA	668	X	X	X	R		X		C	C	C	X	X	
Syracuse, NY	670	X	X		X		C	X	X	C	X	X	X	
San Antonio, TX	671	X	X	X			C	X	X	*X		C	X	X
San Juan, PR	672	X	X	X			X	X	X		X	X	X	
Tampa, FL	673	X	X	X			C	X	X	X	X	N		
Temple, TX	674	X	X	X	X	X	C			C	C	X		
Tomah, WI	676	X	X	X			X	X			X	X		
Topeka, KS	677	X	X	X	X		X		X	X	X			
Tucson, AZ	678	X	X	X			X	X	X	X	X	X		
Tuscaloosa, AL	679	X	X	X	X		X		C			X	X	
Tuskegee, AL	680	X	X	X	X	X	X	X	X		C	X		
Waco, TX	685	X	X	X	X	X	X			X	X	X		
Leavenworth, KS	686	X	X	X	X	X	X		X	X	X	X	X	
Walla Walla, WA	687	X	X	X	X		C				C	X		
Washington, DC	688	X	X	X	X		C	X		C	C	X	X	
West Haven, CT	689		X		X		X	X	C	X	X	X	X	
West Los Angeles, CA	691	X		X	X	X		X	C	C		X	X	X
White City, OR	692			X	X	X	X				X	X	X	
Wilkes Barre, PA	693	X	X	X	R		X	X	X		X	X	X	
Milwaukee, WI	695	X	X	X	X	X	X	X	X	*X	X			
Honolulu, HI	696		X	X			X	X	X	X	X	X		
Los Angeles, CA	752				R		X					X	X	

LTC Programs & Services by VA Medical Center

VAMC	#	NHCU	RESP	HOSP	GEM	DOM	CNH	HBPC	CHC	ADHC	H/HHA	CRC	GEMCL	GRECC
El Paso, TX	756						X					X	X	
Columbus, OH	757				R					*X			R	

This table was completed using a variety of data sources (Clinical Inventory database, VA Headquarters program listings, 1995 Directory of VA & DOD Health Care Facilities, *Community Based Long Term Care: Resource Guide* compiled for the SOTA Conference by the VA's Management Decision and Research Center (MDRC), Expert Panel survey of local VAMC programs/services, etc.).

[1] Includes several outpatient clinics. Since the creation of this chart, realignment and consolidation of some VA facilities has occurred.

*Note: The information in this chart was gathered by a survey in Spring 1997 any changes made after that time or failure to provide survey information may result in discrepancies between this chart and program availability.

Appendix B:

Research Focus of VA GRECCs

1. Ann Arbor, MI GRECC

Basic Biomedical: Neuroscience and Metabolism/Nutrition
Applied Clinical: Autonomic Function, Diabetes Mellitus, Hypertension
Health Services: Cost and Quality of Health Care

2. Baltimore, MD GRECC

Basic Biomedical: Hormonal regulation of lipoprotein lipid, glucose, adipose
Applied Clinical: Effects of interdisciplinary treatment of risk factors for cardiovascular disease in older veterans with abdominal obesity, type II diabetes and dyslipoproteinemia through exercise and nutrition intervention.
Health Services: Survey of prevalence and current treatment of risk factors for cardiovascular disease in community dwellings where veterans are using VA facilities.

3. Boston, MA GRECC (Bedford Division)

Basic Biomedical: Neuroscience/Cognitive Disorders
Applied Clinical: Dementia
Health Services: Decision Support Technology

4. Boston, MA GRECC (Brockton/West Roxbury Division)

Basic Biomedical: Metabolism, Cardiovascular Physiology and Pharmacology
Applied Clinical: Genito-Urinary, Dehydration, Cognition
Health Services: Epidemiology/Health Policy

5. Durham, NC GRECC

Basic Biomedical: Neoplasm and Aging, Cardiovascular Disease and Aging, Bone Joints and Dysmobility
Applied Clinical: Cancer and Cardiovascular Disease; Bones, Joints and Dysmobility
Health Services: Health Promotion and Disease Prevention

6. Gainesville, FL GRECC

Basic Biomedical: Gero-pharmacology
Applied Clinical: Gero-pharmacology

Health Services: Exercise physiology and wellness program for health and sick elderly

7. Little Rock, AR GRECC

Basic Biomedical: Cellular and Molecular Biology of Aging
Applied Clinical: Cancer, Nutrition and Chronic Disease in the Elderly
Health Services: Evaluation of Geriatric and Long Term Care Health Delivery

8. Madison, WI GRECC

Basic Biomedical: Cancer/Immunity/Nutrition
Applied Clinical: Swallowing, Geriatric Oncology
Health Services: Critical Junctures in the continuum of Long Term Care

9. Miami, FL GRECC

Basic Biomedical: Bone, cartilage, and mineral metabolism, neurodegeneration
Applied Clinical: Osteoporosis and osteoarthritis; Parkinson's disease, movement disorders; geriatric endocrinology.
Health Services: Rehabilitation, use of claims data; cost-effectiveness studies; mental HSR; preventive services; continuous quality improvement.

10. Minneapolis, MN GRECC

Basic Biomedical: Aging Nervous System; Neurobiology, Neurology, Psychiatry
Applied Clinical: Alzheimer's Disease, Delirium, Potential Learning in Dementia, Neuropsychological Assessment, Sexuality in Alzheimer's Disease
Health Services: Medical Ethics, New Models of Health Care Delivery, Education and Training Program Evaluation, Urinary Catheter Management.

11. Palo Alto, CA GRECC

Basic Biomedical: Endocrinological and metabolic aspects of aging, biomechanics of mobility patterns, regulation of bone mass, acquisition of bone, ethnic contributions to skeletal health, exercise effects in elderly.
Applied Clinical: Emphasis on endocrinological and metabolic diseases of the

elderly.

Health Services: Advanced care directives; chemical and physical restraints in LTC, predictors of adverse outcome and re-hospitalization, resource utilization for frail hospitalized patients, cost-effective programs for low vision elders, and family caregiving issues.

12. St. Louis, MO GRECC

Basic Biomedical: Physiology and Metabolic Concomitants of Aging
Applied Clinical: Effects of Exercise and Nutrition on Physiological and Metabolic Parameters
Health Services: Health Care Utilization and Program Evaluation; Nursing Home Care and Health Care Delivery for African Americans.

13. Salt Lake City, UT GRECC

Basic Biomedical: Clarification, at the molecular, cellular and physiologic levels, of factors which account for the phenotype of aging as it pertains to cellular proliferation, immunity and cytokine production.
Applied Clinical: Evaluation of strategies intended to reverse the phenotype of aging, such as administration of deficient cytokines and hormones, application of aerobic exercise as a means of improving cognitive function.
Health Services: Development of innovative approaches to quality assurance in a real-time mode.

14. San Antonio, TX GRECC

Basic Biomedical: Metabolism/Endocrinology, Nutrition, Oral/Health Dentistry
Applied Clinical: Metabolic Diseases, Cognitive Sensory Impairment, Oral Health/Dentistry
Health Services: Health Care Utilization, Functional Status and Ethnicity, Quality Assessment and Cost Benefit Analysis, Long Term Care.

15. Seattle/American Lake, WA GRECC

Basic Biomedical: Neurobiologic and Neuroendocrine Aspects of Aging and

Alzheimer's Disease

Applied Clinical: Metabolic Diseases and Cognitive /Sensory Impairment

Health Services: Bioethical Aspects of Medical Decision Making in Elderly

16. Sepulveda, CA GRECC

Basic Biomedical: Molecular Biology, Endocrinology, Psychoneuroimmunology

Applied Clinical: Falls and Mobility Problems, Long Term Care, Exercise, Pain, Sleep, Quality of Care

Health Services: Cost-Effective Health Care Delivery; Geriatric Assessment

17. West Los Angeles, CA GRECC

Basic Biomedical: Immunology, Infectious Disease and Endocrinology

Applied Clinical: Infectious Disease, Osteoporosis

Health Services: Health Care Utilization, rehabilitative medicine.

Appendix C:

VA Clinics of Jurisdiction

Table received from VA Headquarters Medical Administration Service and was last revised 10/25/94. VA is undergoing changes that may affect the manner in which the clinics of jurisdiction function; how, and in what manner, has yet to be fully determined.

* = facilities submitting fee-basis requests to more than one clinic of jurisdiction.

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
Alabama 01	**Montgomery**	**Montgomery***	**619**
		Birmingham	521
		Huntsville Clinic	521
		Tuscaloosa	679
		Tuskegee*	680
		Biloxi, MS*	520
	Tuskegee	**Tuskegee***	**680**
Alaska 02	**Anchorage**	**Anchorage**	**463**
Arizona 04	**Phoenix**	**Phoenix**	**644**
		Tuscon	687
		Prescott	649
Arkansas 05	**Little Rock**	**Little Rock**	**598**
		North Division	598
		Fayetteville*	564
		Mt. Vernon Clinic	564
		Memphis, TN*	614
		Shreveport, LA*	667
		Poplar Bluff, MO*	647
California 06	**Fresno**	**Fresno**	**570**
		Livermore	599
	Loma Linda	**Loma Linda**	**605**
	Long Beach	**Long Beach**	**600**
	Los Angeles	**Los Angeles OPC**	**752**
	Northern California System of Clinics (NCS): Benecia/Martinez	**NCS**	**612**
		Oakland Clinic	612
		Sacramento Clinic	612

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
	Palo Alto	**Palo Alto**	**640**
		Menlo Park OPC	640
		San Jose Clinic	640
	San Diego	**San Diego**	**664**
		Mission Valley Clinic	664
	San Francisco	**San Francisco**	**662**
	Sepulveda	**Sepulveda**	**665**
		Bakersfield Clinic	665
	West Los Angeles	**West Los Angeles**	**691**
		Santa Barbara	691
Colorado 08	**Denver**	**Denver**	**554**
		Colorado Springs Clinic	554
		Fort Lyon	567
	Grand Junction	**Grand Junction**	**575**
Connecticut 09	**Newington**	**Newington**	**627**
		West Haven	689
Delaware 10	**Wilmington**	**Wilmington**	**460**
Florida 12	**Bay Pines**	**Bay Pines**	**516**
		Ft. Myers Clinic	516
		Gainesville	573
		Daytona Beach	573
		Jacksonville Clinic	573
		Lake City	594
		Tallahassee Clinic	594
		Miami	546
		Key West	546
		Oakland Park Clinic	546
		Riviera Beach Clinic	546
		Tampa	673
		Orlando Clinic	673
		Port Richey Clinic	673
		Pensacola*	520

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Montgomery, AL*	619
		West Palm Beach	548
	Lake City	**Lake City***	**546**
Georgia 13	**Atlanta**	**Decatur(Atlanta)***	**508**
	Augusta	**Augusta**	**509**
	Dublin	**Dublin**	**557**
Hawaii 15	**Honolulu**	**Honolulu OPC**	**459**
		American Samoa 60	
		Guam 66	
		Marshall Islands 68	
		Northern Mariana Islands 69	
		Palau 70	
		Johnston Atoll 74	
Idaho 16	**Boise**	**Boise**	**531**
Illinois 17	**Chicago Westside**	**Chicago Westside**	**537**
		St. Louis, MO*	657
		Columbia, MO*	543
		Iowa City, IA*	584
		Madison, WI*	607
		Chicago Lakeside	535
		Crown Point Clinic	535
		Hines	578
		North Chicago	556
Indiana 18	**Indianapolis**	**Indianapolis**	**583**
		Marion, IN	610
		Ft. Wayne*	569
		Evansville Clinic*	609
		Danville, IL	550
		Peoria, IL	550
		Marion, IL	609
Iowa 19	**Des Moines**	**Des Moines**	**555**
		Iowa City*	584
		Quad Cities Clinic	584

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Knoxville	592
		Sioux Falls, SD*	438
Kansas 20	**Leavenworth**	**Leavenworth**	**686**
	Topeka	**Topeka**	**677**
	Wichita	**Wichita**	**452**
Kentucky 21	**Louisville**	**Louisville**	**603**
		Lexington	596
		Nashville, TN*	626
		Mtn. Home, TN*	621
Louisiana 22	**New Orleans**	**New Orleans**	**629**
		Baton Rouge Clinic	629
		Alexandria*	502
	Shreveport	**Shreveport**	**667**
		Alexandria*	502
		Jackson, MS*	586
		Dallas, TX*	549
		Little Rock, AR*	548
Maine 23	**Togus**	**Togus**	**402**
Maryland 24	**Baltimore**	**Baltimore**	**512**
		Ft. Howard	566
		Perry Point	641
		Cambridge Clinic	641
		Martinsburg, WV*	613
		Cumberland Clinic*	613
Massachusetts 25	**Boston**	**Boston**	**523**
		Boston Clinic	523
		Lowell Clinic	523
		Bedford	518
		Brockton	525
		Worchester Clinic	525
		West Roxbury	525
		Northampton	631
		Springfield Clinic	631
Michigan 26	**Allen Park**	**Allen Park**	**553**

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Ann Arbor	506
		Toledo OPC*	506
		Battle Creek	515
		Grand Rapids Clinic	515
	Iron Mountain	**Iron Mountain**	**585**
		Saginaw	655
		Gaylord Clinic	655
Minnesota 27	**Minneapolis**	**Minneapolis**	**618**
		Superior Clinic	618
	St. Cloud	**St. Cloud**	**656**
Mississippi 28	**Jackson**	**Jackson**	**586**
		Biloxi*	520
		Mobile Clinic	520
		Pensacola Clinic*	520
		Memphis, TN*	614
Missouri 29	**Kansas City**	**Kansas City**	**589**
		Columbia*	543
		Poplar Bluff*	647
		St. Louis*	657
	St. Louis	**St. Louis***	**657**
		Poplar Bluff*	647
		Columbia*	543
Montana 30	**Ft. Harrison**	**Ft. Harrison**	**436**
		Miles City	617
		Billings Clinic	617
Nebraska 31	**Lincoln**	**Lincoln**	**597**
		Omaha	636
		Grand Island	574
Nevada 33	**Reno**	**Reno**	**654**
	Las Vegas	**Las Vegas OPC**	**758**
New Hampshire 33	**Manchester**	**Manchester**	**608**
New Jersey 34	**East Orange**	**East Orange**	**561**
		Brick Clinic	561
		Ocean City Clinic	561

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Lyons	604
New Mexico 35	**Albuquerque**	**Albuquerque**	**501**
New York 36	**Albany**	**Albany**	**500**
	Bronx	**Bronx**	**526**
	Brooklyn	**Brooklyn**	**527**
		Brooklyn Clinic	527
		St. Albans Clinic	527
	Buffalo	**Buffalo**	**528**
		Batavia	513
		Rochester Clinic	513
		Bath*	514
		Canandaigua	532
	Castle Point	**Castle Point**	**533**
	Montrose	**Montrose**	**620**
	New York	**New York**	**630**
		New York Clinic	630
	Northport	**Northport**	**632**
	Syracuse	**Syracuse**	**670**
		Bath*	514
		Sayre Clinic (PA)*	693
North Carolina 37	**Winston-Salem**	**Winston-Salem**	**659**
		Asheville	637
		Durham	558
		Fayetteville*	565
		Salisbury	659
		Mtn. Home, TN*	621
North Dakota 38	**Fargo**	**Fargo**	**437**
Ohio 39	**Cincinnati**	**Cincinnati**	**539**
	Brecksville	**Brecksville**	**541**
		Cleveland	541
		Canton Clinic	541
		Chillicothe	538
		Toledo OPC*	506
	Columbus	**Columbus**	**757**

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Dayton	552
		Ft. Wayne, IN*	569
Oklahoma 40	**Muskogee**	**Muskogee**	**623**
		Tulsa Clinic	623
		Oklahoma City	635
		Lawton Clinic	635
		Amarillo, TX*	504
		Bonham, TX*	522
		Fayetteville, AR*	564
Oregon 41	**Portland**	**Portland**	**648**
		Portland Clinic	648
	Roseburg	Roseburg	653
		Brandon Clinic	653
		Eugene Clinic	653
		White City VA	692
Pennsylvania 42	**Altoona**	**Altoona**	**503**
	Butler	**Butler**	**529**
	Coatesville	**Coatesville**	**542**
	Erie	**Erie**	**562**
	Lebanon	**Lebanon**	**595**
		Harrisburg OPC	595
	Philadelphia	**Philadelphia**	**642**
		Philadelphia Clinic	642
	Pittsburgh	**Pittsburgh (HD)**	**645**
	Pittsburgh	**Pittsburgh (UD)**	**646**
	Wilkes-Barre	**Wilkes-Barre**	**693**
		Allentown Clinic	693
		Sayer Clinic*	693
Philippine Islands	**Manila**	**Manila OPC**	**358**
Puerto Rico 72	**San Juan**	**San Juan**	**672**
		Mayaguez Clinic	672
		Ponce Clinic	672
Rhode Island 44	**Providence**	**Providence**	**650**
		New Bedford Clinic	650

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
South Carolina 45	**Columbia**	**Columbia**	**544**
		Greenville Clinic	544
		Charleston	534
		Savannah Clinic	534
		Fayetteville, NC*	565
		Atlanta, GA*	508
	Charleston	**Charleston***	**534**
South Dakota 46	**Sioux Falls**	**Sioux Falls**	**438**
		Ft. Meade	568
		Hot Springs	579
Tennessee 47	**Nashville**	**Nashville***	**626**
		Knoxville Clinic	626
		Memphis	614
		Mountain Home*	621
		Murfreesboro	622
		Chattanooga Clinic	622
	Mountain Home	**Mountain Home***	**621**
Texas 48	**Amarillo**	**Amarillo**	**504**
		Lubbock Clinic	504
	Big Springs	**Big Springs**	**519**
	Dallas	**Dallas**	**549**
		Ft. Worth Clinic	549
		Bonham*	522
	El Paso	**El Paso OPC**	**756**
	Houston	**Houston**	**580**
		Beaumount Clinic	580
		Lufkin Clinic	580
	San Antonio	**San Antonio**	**671**
		Corpus Christi	671
		Laredo Clinic	671
		McAllen Clinic	671
		San Antonio Clinic	671
		Victoria Clinic	671
		Kerrville	591

Clinics of Jurisdiction

State/Code	Clinics of Jurisdiction	VA Facility	#
		Big Spring*	519
	Waco	**Waco**	**685**
		Marlin	611
		Temple	674
		Austin Clinic	674
Utah 49	**Salt Lake City**	**Salt Lake City**	**660**
Vermont 50	**White Rive**	**White River**	**405**
Virginia 51	**Hampton**	**Hampton**	**590**
	Richmond	**Richmond**	**652**
	Salem	**Salem**	**658**
		Beckley, WV*	517
		Martinsburg, WV*	613
Washington 53	**Tacoma**	**Tacoma (Am.**	**505**
	Seattle	**Seattle**	**663**
	Spokane	**Spokane**	**668**
	Walla Walla	**Walla Walla**	**687**
Washington DC 11	**Washington DC**	**Washington DC**	**688**
West Virginia 54	**Huntington**	**Huntington***	**581**
		Prestonsburg Clinic	581
		Beckley*	517
		Clarksburg	540
		Martinsburg*	613
	Martinsburg	**Martinsburg***	**613**
	Beckley	**Beckley***	**517**
Wisconsin 55	**Milwaukee**	**Milwaukee**	**695**
		Madison*	607
		Tomah	676
		Iron Mountain	585
Wyoming 56	**Cheyenne**	**Cheyenne**	**442**
		Sheridan	666

Appendix D:

VA Fee Basis Reports*

* Information provided to us by MAS VA Headquarters 12/95.

Central Fee Basis Reports

Listed below are the reports generated by the Austin Automation Center (AAC). Some of these reports are initiated in order to alert the medical facility of action required on transactions submitted either by that facility or another Clinic of Jurisdiction (COJ). To obtain a complete description of each report please refer to the Fee Basis User Manual.

Note: (04) - indicates report requires action by Fiscal Service
MT - indicates Management Tools

Central Fee Basis Reports		
Report #	REPORT NAME	Action
03001	Fee Basis Listing (Vendors)	Yes
03002	Fee Basis Listing (Veterans)	Yes
10001	Fee Basis MRA and Header Rejects	Yes
10001A	Fee Basis MRA and Header Rejects (By your facility)	Yes
10001B	Fee Basis MRA and Header Rejects (By another COJ)	Yes
10002	Fee Basis Medical Control Register Listing	Yes
10003	Fee Basis Control Register Listing (Pharmacy)	Yes
12001	Fee Basis Control Reject Listing	(04)
12002	Outpatient Fee Payment Listing (Pharmacy)	(04)
12004	Outpatient Fee Payment Listing (Travel)	Yes
12005	Vendor File Update Listing (Received by Austin Finance ONLY)	No
12006	Linkage Input Control File Deletion Records	(04)
12007	Stored Linkage Input Processing Status	(04)
12008	Fee Basis Generated Type 942 Input	(04)
12009	Fee Basis Input - Reject Listing	(04)
16001	AMIS/Fee Basis Segment 228 Report	No
16002	Fee Basis System AMIS Flash Count	Yes
25001	Fee Basis List of Veterans With More Than 36 Months of No Payment Activity	Yes
26001	Veterans Whose Fee Basis Validity Period Needs Review (Upcoming Expiration Dates)	Yes
26002	Veterans Whose Validity Period Needs Review (End-of-Validity Follow-up Requirements)	Yes
28001	Fee Basis System Veteran Records Updated with Date of Death Resulting from BIRLS Match	Yes
29000	Fee Basis Interest Report	MT
60001	Fee Basis Veteran Payment Analysis Station Status Report (Qtrly)	MT
60002	Fee Basis Veterans Payment Analysis Medical Center Status Report (Semi-Annual)	MT
70001	Cost Analysis of Fee Basis Medical Vouchers and by Average Monthly Cost Range for all Data Processing during Fiscal Year (Yearly)	MT

Central Fee Basis Reports		
70002	Physician/Pharmacy Earnings Report - Participant (Medical) Detailed Summary (Semi-Ann.)	MT
70003	Physician/Pharmacy Earnings Report - Participant (Pharmacy) Detailed Summary (Semi)	MT
70004	Consolidated Physician/Pharmacy Earnings Report - Medical Participants Paid by More than One Fee COJ (Distributed to VA Headquarters and AAC)	No
70005	Consolidated Physician/Pharmacy Earnings Report - Pharmacy Participants Paid by More than One Fee COJ (Distributed to VA Headquarters and AAC)	No
70006	Cost Analysis of Fee Basis Medical Vouchers by Veterans and by Average Monthly Range for All Data Processed During Fiscal Year (Does not equal data in 70001 due to COJ)	No
70007	Fee Veterans - Costs by Facility, State, County and Purpose of Visit by Fiscal Year	MT
70008	Fee Veterans and Costs by Region, National, and Purpose of Visit by Fiscal Year (VA Headquarters)	No
80002	Participants Earning Report Fee Medical Programs (Semi-Annual)	MT
IUE1	Report of Outpatient Visits and Invoices by Purpose and Type Fee	MT
IVC1	Fee Management Report	MT
S0101	Fee No Match-Non Zero/Stub Name Mismatch Listing - Physicians and Clinics	Yes
S0102	Fee No Match-Non Zero/Stub Name Mismatch Listing - Pharmacies	Yes
S0103	Fee No Match-Zero Listing - Physicians and Clinics	Yes
S0104	Fee No Match-Zero Listing - Pharmacies	Yes
S0105	MD/PR File Summary of Purged and Non-Zero/Mismatched Records (VA Headquarters, Austin Finance, and AAC ONLY)	No

DHCP Fee Basis reports

Listed below are new and revised Decentralized Hospital Computer Program (DHCP) outputs available in the Fee Basis software. These reports can be used to identify workload incurred by each Primary Service Area (PSA) within a Clinic of Jurisdiction (COJ). They can be used to track patient-specific, program-specific, or vendor-specific information. To obtain a complete description of each report please refer to the Fee Basis User Manual.

DHCP Fee Basis reports	
All Claims by Vendor/Veteran/Other	**This is a summation of all unauthorized claims and all information relative to the claim, includes treatment dates, status, and program type. Fee Basis users can use this to respond quickly to telephone inquiries from veterans and vendors concerning payments.**
CNH Stays in Excess of 90 Days	**This report is useful in managing the Length of Stay for the Contract Nursing Home Program and can be used to assist in reporting requirements mandated by VA Headquarters .**
Cost Report for Contract Nursing Home	**This report can also be used to compare costs listed on the Austin-generated Report # 60001. The 60001 Report is a cumulative fiscal-year-to-date report, therefore an automated monthly tally should be maintained for validation purposes.**
Outpatient Cost Report	**This report can be run monthly and used to review those payments that have been finalized for an individual veteran. It is useful in providing insight on the types of services being offered, such as eye exams, psychotherapy, laboratory, etc. It can also be used for statistical projections based on the average cost per patient and per payment provided.**
Potential Cost Recovery Report	**This is an excellent tool that can be utilized by Medical Care Cost Recovery (MCCR) in identifying those cases that represent potential billable episodes. It provides insurance information as well as Fee Basis program information.**

DHCP Fee Basis reports	
Report of Admissions/Discharges for CNH	**This report can be used to ensure the appropriate entry of all admissions and discharges to/from the CNH. It can also be used for comparison when completing the AMIS Segment 349.**
Vendor Payment Output	**This report is available for all Fee Basis Programs. It can be used to obtain a historical analysis of one or all vendor(s). Comparison may be made with the Austin-generated Report # 80002. User can use to answer vendor/veteran inquiries about status of payment(s).**
Veteran Payment Output	**This report is available for all Fee Basis Programs. It can be used to obtain a historical analysis of one or all veteran(s) or it may be used as a validation tool for the Austin-generated Report # 60002. Dates of payments should be reviewed when comparing these reports.**

Description of selected Management Tools Reports

These are Central Fee Basis Reports of particular interest to long term care researchers.

Central Fee Basis Management Tools Reports		
60001	**Fee Basis Veterans Payment Analysis Station Status**	Quarterly report for all Fee Basis programs. Useful in obtaining the workload encountered and unique veterans for each individual program as well as the entire Fee Basis Program.
60002	**Fee Basis Veterans Payment Analysis Status Report VAMC**	Semi-annual report and differs from the 60001 in that it is veteran specific. Only those veterans with payments of $600 or more that have been identified as high-cost users are listed and should be reviewed for accuracy. Identifies the specific veteran, funds expended by Fee Program, and total amount expended for the fiscal year to date. It also calculates the number of visits in ratio to the days of care or prescriptions provided.
70001	**Cost Analysis of Fee Basis Medical Vouchers by Veterans and by Average Month Cost Range for all Data Processing during Fiscal Year**	Annual report for Fee Basis Medical, Contract Hospitalization, and Home Health Services. Can be used in comparing costs incurred on a monthly basis for the number of veterans placed on the program. Can also be used to identify the average cost per veteran as well as the total number of veterans serviced for the year. Emphasis should be placed on the number of veterans exceeding the monthly $125 limit.
70007	**Fee Veterans Costs by Facility, State, Country, and Purpose of Visit**	Monthly report of the number of visits, payments, and vouchers by purpose of visit. The report is separated by state and county and can be used by COJ's to show each facility within their jurisdiction the status of the Fee Basis Medical, Travel, Pharmacy, and Home Health Service programs. A listing of all counties within each Primary Service Area should be obtained prior to attempting to compile statistics.

Central Fee Basis Management Tools Reports

IUE1 & IVC1	**Outpatient Visits and Invoices by Purpose and Type & Fee Management Control Report**	These reports can be used in conjunction with one another. The source of each is the AMIS 228 report. The 1VC1 report shows the same information as the 1UE1 report, but also shows each month within the fiscal year, cumulative totals, and fiscal year to date totals. This report can be used to monitor the monthly activity, which can assist in detailed comparisons. It should be noted that the number of invoices is not shown on this report. Although the 1UE1 report is almost identical to the 1VC1 report, the 1UE1 report shows the number of invoices and the number of visits by purpose of visits and type of patient. It can be used to ensure the percentage of service-connected visits dominates the majority of the workload accrued. The COJ can also use this report to illustrate status of workload incurred versus workload projected as well as money expended versus money allocated. The types of patients seen can also be provided in clinical management reports.
8ZG1	**Medical Administration Field Station Workload Detail Report**	A brief breakdown of the outpatient visits by purpose of visits. Statistics for the month, fiscal year to date, end of year projection, number of invoices, and number of visits per invoice are provided. Source is the AMIS 228.

Appendix E:

Cost Distribution Report (CDR) Accounting Codes

Cost Distribution Report (CDR) Account Codes

The Cost Distribution Report (RCS 10-0141) details the cost of patient care provided through the VA system and is also used for work-load reporting purposes[1]. CDR account codes reflect recognized VA hospital bed sections and outpatient clinics (clinic stops). We are providing only those codes reflecting *long term care* program and services as we have defined them previously in this volume. Distribution account codes are periodically updated to reflect new accounts and/or clinic stops, therefore it is imperative that the researcher obtain the latest version of accepted account codes. Please note that these accounting codes are many times also referred to as 'CDR location codes.'

CDR Acct. #	**Description**
1120.00	GEM Unit Medical Beds (patient treating speciality codes 31, 34, 35)
1130.00	Acute Medicine GEM
1320.00	GEM Unit Psychiatry (code 33)
1410.00	VA Nursing Home Care Unit
1420.00	GEM Unit Nursing Home Care (code 81)
1510.00	Domiciliary Bed Section
1520.00	GEM Unit Domiciliary (code 87)
1620.00	GEM Unit Intermediate Care (code 32)
2110.00	GEM Clinic (clinic stop 319)
2510.00	Adult Day Health Care (clinic stop 190)
3410.00	Community Nursing Home Care
3411.00	State Home Nursing Home Care
3510.00	State Domiciliary Home Care
4112.00	Contract ADHC
5110.00	Home Based Primary Care (clinic stops 170-178)
5113.00	Residential Care Home Program (clinic stops 121, 503)
5116.00	Homemaker/Home Health Aide Program

Endnote:

[1] For more information regarding the cost accounting databases we refer the reader to 1) *Database Resource Guide Volume IV- Costing of Health Care in VAMCs: National Cost Accounting and Medical Cost Distribution Systems*, Beattie, Swindle, et al., 1994, and 2) *CDR Handbook* easily attained from your local Fiscal Service.

Appendix F:

List of State Homes

State Homes and Authorized Bed Capacity

STATE HOME	CITY	DOM	NHC	HOSP
Alabama	Alexander City	0	150	0
	Bay Minette	0	150	0
	Huntsville	0	150	0
Arizona	Phoenix	0	200	0
Arkansas	Little Rock	55	61	0
California	Barstow	220	180	0
	Yountville	817	570	46
Colorado	Florence	0	120	0
	Homelake	50	60	0
	Rifle	0	100	0
	Walsenburg	0	120	0
Connecticut	Rocky Hill	650	0	350
Florida	Daytona Beach	0	120	0
	Lake City	150	0	0
Georgia	Augusta	0	192	0
	Milledgeville	288	386	0
Idaho	Boise	46	136	0
	Lewiston	0	66	0
	Pocatello	0	66	0
Illinois	Anna	12	50	0
	LaSalle	0	120	0
	Manteno	12	300	0
	Quincy	150	629	0
Indiana	Lafayette	115	465	0
Iowa	Marshalltown	113	691	26

State Homes and Authorized Bed Capacity

STATE	CITY	DOM	NHC	HOSP
Kansas	Fort Dodge	165	86	0
Kentucky	Wilmore	0	300	0
Louisiana	Jackson	100	145	0
Maine	Augusta	0	120	0
	Bangor	0	120	0
	Caribou(Annex)	0	40	0
	Scarborough(Annex)	0	120	0
	South Paris	0	90	0
Maryland	Charlotte Hall	100	278	0
Massachusetts	Chelsea	305	68	166
	Holyoke	50	259	27
Michigan	Grand Rapids	140	545	0
	Marquette	59	184	0
Minnesota	Hastings	200	0	0
	Luverne	0	85	0
	Minneapolis	78	346	0
	Silver Bay	0	89	0
Mississippi	Jackson	0	150	0
Missouri	Cape Girardeau	0	150	0
	Mexico	0	150	0
	Mount Vernon	0	99	0
	Saint James	0	146	0
	Saint Louis	0	200	0
Montana	Columbia Falls	60	90	0
	Glendive	0	80	0
Nebraska	Grand Island	35	414	0

State Homes and Authorized Bed Capacity

	Norfolk	33	126	0
STATE	**CITY**	**DOM**	**NHC**	**HOSP**
Nebraska (cont'd)	Omaha	33	159	0
	Scottsbluff	90	50	0
New Hampshire	Tilton	0	150	0
New Jersey	Menlo Park	0	240	0
	Paramus	0	336	0
	Vineland	0	300	0
New Mexico	Fort Bayard	0	47	0
	Truth or Consequences	20	164	0
New York	Batavia	0	120	0
	Oxford	0	242	0
	Saint Albans	0	250	0
	Stoneybrook	0	350	0
North Dakota	Lisbon	112	38	0
Ohio	Sandusky	210	350	0
Oklahoma	Ardmore	35	141	0
	Claremore	0	250	0
	Clinton	31	145	0
	Norman	0	194	0
	Sulphur	30	132	0
	Talihina	0	200	0
Pennsylvania	Erie	100	75	0
	Hollidaysburg	167	348	0
	Scranton	16	184	0
	Spring City	150	192	0
Rhode Island	Bristol	79	260	0

State Homes and Authorized Bed Capacity

STATE	CITY	DOM	NHC	HOSP
South Carolina	Anderson	0	220	0
	Columbia	0	150	0
South Dakota	Hot Springs	275	50	0
Tennessee	Humboldt	0	120	0
	Murfreesboro	0	120	0
Vermont	Bennington	31	185	0
Virginia	Roanoke	60	180	0
Washington	Orting	54	148	0
	Retsil	145	273	0
West Virginia	Barboursville	195	0	0
Wisconsin	King	122	627	0
Wyoming	Buffalo	123	0	0