Department of Veterans Affairs **VHA DIRECTIVE 2004-059**
Veterans Health Administration
Washington, DC 20420 **October 21, 2004**

GERIATRICS AND EXTENDED CARE (GEC) REFERRAL

1. PURPOSE: This Veterans Health Administration (VHA) Directive implements a standardized referral tool to identify veterans' care needs and establish a level of care prior to placement in all Department of Veterans Affairs (VA)-paid, VA-provided, or VA-coordinated long-term care programs.

2. BACKGROUND

a. Public Law 106-117 establishes that the Veterans Health Administration (VHA) provide institutional, home-based, and community-based long-term care as a part of its continuum of care. As VHA expands access to these services, it is vital that:

(1) Long-term care services are carefully targeted toward veterans who need and will benefit from them,

(2) Veterans receive necessary long-term care services at the least restrictive level of care, and

(3) Accepting programs or agencies have sufficient clinical information to allow them to determine whether veterans' needs can be met within existing resources.

NOTE: *VHA's current methods of assessing patients to determine level of care required in extended care services are neither nationally standardized nor automated.*

b. **Definitions**

(1) **Long-term Care Services.** Long-term care services are all institutional, home- and community-based services that the VA provides, coordinates, or purchases. These programs include but are not limited to: Nursing Home Care Units, Contract Nursing Homes, Community Residential Care Homes, Home-Based Primary Care, Adult Day Health Care, Skilled Home Care, Homemaker/Home Health Aide, and in- or outpatient respite services. ***NOTE:*** *Completion of the GEC Referral tool is not a prerequisite for referral to geriatric primary care clinics, specialized geriatric evaluation and management clinics, inpatient or in-home hospice, or VA Domiciliary.*

(2) **Geriatric Extended Care (GEC) Referral Tool.** The GEC Referral tool, a nationally standardized and automated data set, will replace VA Form 10-7108, Nursing Care Referral Form, and VA Form 10-1204, Referral for Community Nursing Home Care. It will not replace other VHA standard forms used by long-term care programs for assessment or treatment planning, e.g., VA form 10-0014, HBHC Evaluation/Admission Form 3, or VHA Forms 10-0375a-c, the Resident Assessment Instrument/Minimum Data Set (RAI/MDS).

(a) The GEC Referral tool is not intended to serve as a comprehensive assessment tool or as a plan of care. In general, a referral implies transferring responsibility for care planning to the accepting program or agency. Comprehensive assessment and development of a plan of care is the responsibility of the accepting program or agency with appropriate consultation or concurrence by the referring clinician. In addition, completion of the GEC Referral tool is not intended to substitute for communication between the referring provider and the accepting program or agency. Communication between referring and accepting providers is encouraged, as the GEC Referral tool may not capture all information that may influence the treatment plan.

(b) The GEC Referral tool, integrated into Veterans Health Information Systems and Technology Architecture (**V***IST***A)** and Computerized Patient Record System (CPRS), is to be implemented throughout VHA for referral to VA Nursing Home Care Units, contract or community nursing homes, inpatient Geriatric Evaluation and Management units, Adult Day Health Care, Home-Based Primary, Skilled Home Care, Homemaker/Home Health Aide, Community Residential Care, and inpatient or in-home respite. Completion of the GEC Referral tool is not a prerequisite for referral to any geriatric outpatient clinics, inpatient or in-home hospice, or VA domiciliary. No new hardware or software is required to implement the GEC Referral tool.

1. Each section of the GEC Referral is a part of a CPRS interdisciplinary progress note. All sections should be attached together upon completion. When attached, all sections of the GEC Referral display and print as a unit, facilitating transmission to the accepting program or agency. Questions in the GEC Referral tool may not be modified, but additional information may be imported into any of the four GEC Referral note templates, using any patient data objects available in CPRS. Importantly, locally imported patient data objects, although visible to providers who view the tool in printed or electronic form, will not be available in the GEC Referral reports package in **V***IST***A**. For long-term care agencies or programs that require substantial additional information to process a referral, e.g., discharge summary, progress notes, immunization history, or laboratory and/or x-ray results, staff is encouraged to develop customized **V***IST***A** health summaries, consulting local Office of Information Technology staff for assistance in development if necessary.

2. Capture of data collected in the GEC Referral tool is automatic at the time of completion of the form. Standard reports for the GEC Referral by patient, provider, and location are available in the **V***IST***A** clinical reminders report package. Local staff can use data from the GEC Referral for needs assessment, performance improvement, and workload estimations. National roll-up of data from the GEC Referral tool will be possible after completion of phase II of the GEC Referral project. National policy makers may use data from the GEC Referral in assessing long-term care patient characteristics, formulating budget requests, and in performance assessment.

3. Training in the use of the screening tool should be directed primarily at nursing and social work services, particularly those staff in inpatient areas who make the majority of referrals to long-term care programs. VHA has opted for web-based training because it is expected that training will need to be available to all staff on-demand rather than in fixed-time sessions. Items that form the GEC Referral are self-explanatory, grounded in clinical areas familiar to all

clinicians, and written in straightforward language. To the extent possible, instructions for completion of the GEC Referral tool have been embedded into the CPRS GEC Referral tool templates so that they can be viewed at the time the tool is being completed. The web-based users' manual gives detailed definitions, interpretations, and coding instructions for each item. The step-by-step web-based training module for the GEC Referral tool, that will enable staff to work through the complete instrument with on-line help, can be accessed via the VA Learning Catalog at http://vaww.sites.lrn.va.gov/vacatalog/ .

(c) The GEC Referral form is designed to be completed by one or more than one health care professional who is familiar with the patient.

1. Responsibility for completion of the Referral tool may be delegated to a single discipline or a group of disciplines. It is divided into four sections that address:

a. Activities of Daily Living and skilled care needs (most easily completed by a nurse),

b. Care giving resources and Instrumental Activities of Daily Living (most easily completed by a social worker),

c. Goals of care (most easily completed by the referring clinician), and

d. Administrative information required to complete a referral to the selected program/agency (most easily completed by GEC screening or accepting staff).

2. Field trials of the GEC Referral have shown that total time to complete the GEC Referral by a single provider who knows the patient is approximately 10 minutes. Time for completion substantially lengthens when the task is delegated to staff who are not familiar with the patient.

(d) The GEC Referral tool is intended to serve as a single referral tool for all GEC long-term care programs, but not for referral to geriatric primary care clinics, specialized geriatric evaluation and management clinics, inpatient or in-home hospice, or VA domiciliary programs. Implementation of the GEC Referral tool is intended to streamline referrals to long-term care programs, allowing referring clinicians to complete a single set of information that can be used by all programs or agencies to evaluate the patient for acceptance. The GEC Referral tool encourages a unified GEC screening process so that referring clinicians do not have to submit multiple referrals to multiple programs. Using the GEC referral information, GEC screening staff can more easily evaluate whether the patient's needs can be met within existing resources, promoting rapid referral turn-around time and timely feedback to referring clinical staff.

(e) The GEC Referral tool was developed using standard methods of assessment of health, functioning, and social resources familiar to all nurses, social workers and physicians. Items were selected to identify care needs, suggest the level of care at which services can be provided, and to conform to other standardized assessments for long-term care. In part, the GEC Referral tool was adapted from one of the family of instruments of which the Resident Assessment Instrument(RAI)/Long-Term Care Minimum-Data Set is a member. As a part of VHA's

agreement with interRAI, wording that is used in the GEC Referral tool may not be altered from that of its parent instrument.

(f) Completion of the GEC Referral tool does not confer medical eligibility for any particular level of care, nor does it imply eligibility for VA-paid services. Links to a Managers Manual, and Installation and Setup Guide are available under Clinical Reminders at the **V*IST*A** library page (http://www.va.gov/vdl/). Links to the instruction manual can also be found at the clinical reminders home page (http://vista.med.va.gov/reminders). ***NOTE:*** *Web addresses referred to in this document are subject to change but may still be found by searching for the home page title.*

(g) The Geriatric and Extended Care Strategic Healthcare Group (GEC SHG) does not require that workload of professionals who complete the GEC Referral tool be transmitted to Austin. Should facilities desire to capture workload for personnel who complete the GEC Referral tool, facilities will need to carefully integrate workload capture with existing DSS and business office practices and may require new clinic set for inpatient data collection. For workload performed in the inpatient setting, the primary stop code should represent the acute care service (e.g., General Medicine - 301, Physical Medicine and Rehabilitation - 201, General Surgery - 401, Spinal Cord Injury - 210, Neurology - 315, Psychiatry - 502, etc.) and the credit stop should be 370 (Long-term care screening/assessment). If completion of the GEC Referral tool is performed in the outpatient setting, the primary stop code should represent the clinic where the form is completed and the credit stop code should be 370, e.g., 323/370 for completion in a primary care clinic.

(h) Each VHA facility has the option to define its own business processes for implementation of the GEC Referral tool. It is expected that business processes to ensure completion and review of the GEC Referral tool before placement in long-term care programs will vary from facility to facility. This Directive does not specify by whom the GEC Referral tool will be completed, or by whom it will be reviewed prior to placement of the veteran. These selections are the responsibility of each VISN or facility. It is strongly recommended that health care providers who are familiar with the patient and are directly involved with the patient's care complete the GEC Referral tool. Since providers who are referring the patient are likely to know the patient best, it is strongly recommended that the referring clinicians complete the form.

3. POLICY: It is VHA policy to implement a standardized referral tool in all VA facilities that assess patients' needs for long-term care services.

4. ACTIONS: Each medical center director is responsible for ensuring that:

a. All veterans referred for any long-term care services (whether VA provided, coordinated or paid) are assessed using the GEC Referral tool prior to referral and,

b. The information from the GEC Referral tool is reviewed by the appropriate staff for medical need and level of care determination prior to placement in any long-term care program.

c. Workload capture is properly integrated into standard business processes at the facility.

5. REFERENCES

a. Public Law 106-117 Veterans Millennium Health Care and Benefits Act, Title I – Access to Care.

b. VHA Executive Decision Memo dated September 8, 2000.

c. Policy Board Minutes dated October 19, 2000.

6. FOLLOW-UP RESPONSIBILITY: The Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Directive. Questions may be referred to 202-273-8540.

7. RECISSIONS: None. This VHA Directive expires October 31, 2009.

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