

Instruction Manual
GEC Referral Form
Office of Geriatrics and Extended Care
1/30/2005

Background

The GEC Referral Form was adapted from the MI-Choice or Michigan Choice Instrument. The MI choice was developed through a collaborative research study undertaken in 1997 with the State of Michigan, the University of Michigan, Institute of Gerontology (UoM/IoG), the Hebrew Rehabilitation Center, Boston, MA, and Michigan care management/waiver agencies.

The questions used in this instruments are simplified subsets of the more comprehensive items contained in the Minimum Data Set for Home Care (MDS-HC). In adapting the MI Choice, VHA recognized that many referrals for geriatric care come from an inpatient rather than an outpatient setting. Hence, items were added that describe skilled treatments, problem behaviors, performance of Instrumental Activities of Daily Living (IADLs), and prognosis. These items will be of assistance to providers and discharge planners as they attempt to make decisions about the level of care required for the patient.

The GEC Referral Form is fully automated and integrated with CPRS and VISTA. Providers can complete the form in CPRS. The GEC referral form is divided into four sections, each of which a section of an interdisciplinary note, which, when linked, form a completed GEC referral form. Data collection is automatic at the time the form is completed. Data and reports from the instrument will be available to local staff immediately. National roll-up of data will be possible when Phase II of the GEC referral project is completed. Local staff may use data from the GEC Referral Form for needs assessment, workload projections, performance improvement and workload estimations. These data will also help local and network staff assess need for of long term care so that they may make staffing and funding decisions. National policy makers will use data from the GEC Referral Form in assessing patient outcomes, formulating budget requests and in performance assessment.

The GEC Referral Form can be completed by one provider or by multiple providers. In some cases, a facility may choose to have care managers or discharge planners fill out the form by themselves. Others may choose to have the patient's social worker or nurse complete sections of the form.

The GEC Referral Form should be completed by providers who *know* the patient. If this task is delegated to staff who do not know the patient it will take longer to complete. Field trials of the GEC Referral Form have shown that total time to complete the GEC Referral Form by a provider who knows the patient is under 10 minutes.

About the Instructions for the GEC Referral Form

Some Key Things to Remember

1. The purpose of the GEC Referral Form

The purpose of the the GEC Referral Form instrument is to identify long term care needs and assure that each patient receives necessary services at the least restrictive level of care. Items were selected because they influence the services the patient needs and the level of care required to deliver them. The screen does not confer medical eligibility for any particular level of care, nor does it imply eligibility for VA services.

2. Performance versus Ability

Most items on the screen are to be scored on the basis of what the patient has actually done—that is, the patient's actual performance in recent days. While the patient's perceived ability to carry out a given item may be important information for future care planning, a patient's capacity to perform is not relevant to most screening questions. *Unless the instructions direct differently, only the patient's actual performance should be scored.*

3. Each Item Asks for Different Information

Consider each item distinctly and separately when completing the screen. Note that the items for IADLs ask about **difficulty** performing each task. The ADL questions ask about **help or supervision** required to perform the task. To conduct the screening assessment accurately the screener needs to recognize and become familiar with these fine distinctions.

4. Complete All Items

Do not skip items. Make every effort to answer each question.

5. What To Do If You Aren't Getting "Good" Information

There will be situations where the referral source, whether it is a family member, referring agency, or a prospective participant, cannot provide the screener with the specific information necessary to complete the form properly. In such instances, screeners are encouraged to speak to another information source, for instance, the patient's spouse or a direct care worker. If this is not practical, or the patient cannot or refuses to identify an additional information source, the screener is to complete the items as best s/he can.

1. Source of referral

Definition: This refers to the setting in which the referring provider is assessing the patient for home and community based long term care

Coding: Enter the setting from which the patient is being referred to home and community based long term care. For example, if the patient is in an outpatient primary care or specialty care service, enter outpatient.

- 1.1 Outpatient clinic** – any outpatient clinic setting
- 1.2 Hospital < 7 days** – to be used when the patient has been in the hospital fewer than 7 days at the time of the referral
- 1.3 Hospital > 6 days** – to be used when the patient has been in the hospital more than 6 days at the time of the referral
- 1.4 VA Nursing home** – to be used when the veteran is a resident of a VA nursing home
- 1.5 Community Nursing Home** – to be used when the patient is a resident of a community nursing home
- 1.6 Domiciliary** – to be used when the patient resides at a VA domiciliary care unit
- 1.7 HBPC** – to be used when the patient is followed by the VA Home-Based Primary Care Program
- 1.8 Other** – code if all other locations do not apply. Specify the site from which the referral is being made, e.g., ADHC

2. Living Situation

2.1 With whom does the patient live?

Intent: Documentation of person(s) with whom the patient's resides.

Coding: Check the single box that reflects who the patient was living with at the time of referral.

- 2.1.1 Alone** – No one else lives with patient
- 2.1.2 Spouse only** – The patient lives with his/her spouse and no other persons (includes a partner, regardless of legal marital status).
- 2.1.3 Spouse with others** – The patient lives with his spouse and other persons who may or may not be related.
- 2.1.4 Child (not spouse)** – Patient lives with any of his or his spouse's children but not with his spouse
- 2.1.5 Lives with others** (not spouse or children) – Patient lives with other persons who are not either spouse or children, but may be other family members or non-relatives
- 2.1.6 Group setting with non-relatives** – Patient lives with other adults who are not relatives, eg, shared housing, congregate care, unlicensed personal care facility, etc.

2.2 Where does the patient live?

Intent: Documentation of patient's **permanent** living arrangement at time of referral.

Process: Enter the patient's *permanent* living arrangement at the time of referral.

Definitions:

2.2.1 Private home/apartment— Any house or condominium in the community whether owned by the patient or another person.

2.2.2 Board and care/assisted living/group home — A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.

2.2.3 Nursing home — A licensed health facility that provides 24-hour skilled or intermediate nursing care.

2.2.4 Domiciliary – A VA domiciliary program

2.2.5 Homeless – Patient has no domicile and does not live in temporary housing for homeless

2.2.6 Homeless shelter – Patient is homeless but is residing in temporary housing for the homeless.

2.2.7 Other –Living arrangement that does not meet any of the above definitions

PRIMARY UNPAID CAREGIVER INFORMATION

3. Primary Unpaid Caregiver

Intent: To assess the **informal** (unpaid) caregiver support system. This is different from a formal (paid) relationship that the patient may have with a health care agency. An informal caregiver is unpaid.

Definition: Primary informal caregiver. Primary caregiver may be a family member, friend or neighbor but **not** a paid provider. It is **not** required that the caregiver actually live with the patient, rather that s/he visits regularly, or would respond to needs that the patient may have. This is the person who is most helpful to the patient, who s/he could most rely upon.

Process: Ask the patient if s/he can identify an informal caregiver. The patient may identify several people who "would help" if asked. Shape the questions with specific statements: "Who helps you shop?" "Who helps with cleaning around the house?" "Who helps you with your meals, bathing, dressing etc.." "Who helps you pay your bills?" "Who drives you when you need a ride?" If the patient doesn't receive any support, ask if there is someone who "would help" if needed. If patient is not able to understand or respond to questions, or gives responses that are unclear, evasive or untrue (e.g. refers to husband when you know the husband is deceased), review any available documentation or ask informal helpers if available.

It is important to understand that some helpers may not be described as caregivers. They do things in line with normal social relationships — it is what a daughter or wife is expected to do. Thus, it is useful to concentrate on what support is provided, rather than the label "caregiver."

Coding:

3.1 No Caregiver

Code no caregiver **ONLY** when there is no caregiver at all for the patient, including friends, family neighbors, etc.

3.2 Last Name – Code primary informal caregiver's last name

3.3 First Name - Code primary informal caregiver's first name

3.4 Street Address - Code primary informal caregiver's street address

3.5 City - Code primary informal caregiver's city

3.6 State - Code primary informal caregiver's State

3.7 Zip Code - Code primary informal caregiver's zip code

3.8 Telephone number – Area code followed by seven digit phone number

3.9 Caregiver's relationship to veteran

Definition: This refers to the nature of the relationship between the patient and the informal helper(s). Consider the quality of the relationship, not simply as the relationship is defined by the law or social customs. For example, if the patient has a non-related "partner" and it appears (and they consider) that the relationship is "like a marriage" but is not legally recognized, code as "1" spouse. (For example: a "common-law marriage")

Process: Ask the patient and the helper(s) about the nature of their relationship. Validate the significance of their relationship, as they define it.

Coding: Code with the category that best describes the relationship.

3.9.1 Spouse (includes a partner, regardless of legal marital status)

3.9.2 Child or child-in-law (include partner's child, even if not married)

3.9.3 Other Relative

3.9.4 Friend/neighbor

3.9 Areas of help

Definition: **Advice or emotional support.** Helper provides guidance or support. This advice or support may be task centered (e.g. balancing check book, tax advice, directions for dealing with a specific problem) or more loose (e.g. "being there" when needed, listening). Emotional support refers to time spent providing non-physical support around emotional issues such as loss, anxiety about the future, and change of body image. Advice and emotional support goes beyond simply being physically present.

IADL care. IADL areas include such activities as meal preparation, ordinary house work, managing finance or medications, phone use, shopping and transportation.

ADL care. ADL areas include such activities as bed mobility, transferring, locomotion in the home, dressing, eating, toilet use, personal hygiene and bathing.

Process: For emotional support, ask patient if he/she receives advice or emotional support from helper(s). Listen carefully to the responses. If the patient is not able to recognize the support and advice being provided, ask patient pointed questions such as: ask to describe how major decisions are made. Identify a challenging time for the patient and ask if anyone was there to provide advice/support. Use best clinical judgment to determine if advice/support was felt by the patient.

For IADLs, ask patient and informal helper if support is given in meal preparation, ordinary house work, managing finance or medications, phone use, shopping and transportation. Support can range from the helper doing light house work, to doing all of the shopping and housework.

For ADLs, ask patient and informal helper if support is given in any ADL areas such as bed mobility, transferring, locomotion in the home, dressing, eating toilet use, personal hygiene and bathing. Support can range from the helper "being there just in case", for safety, to the helper providing complete ADL care.

Coding: Check each box that represents an area the caregiver is providing help to the patient.

3.11 Primary caregiver lives with patient

Intent: Documentation of whether the primary caregiver resides with the patient or does not

Coding: Code **YES** if caregiver lives with patient
Code **NO** if caregiver does not live with patient

3.12 Primary caregiver accessible to patient

Intent: This question refers to the availability of the primary caregiver to the patient. That is, does the caregiver live close enough to the patient to be able to see him/her and provide care on a regular basis? Note that there is no traveling time or distance specified.

Coding: Code **YES** if caregiver lives close enough to see the patient and provide care regularly
Code **NO** if caregiver does **not** live close enough to see the patient and provide care regularly

3.13 Willingness to Increase Help Provided

Intent: To determine if informal helpers would be willing/able to respond to an increase in patient's needs

Process: This question should be asked of the helper in private, away from the patient. Ask the question in a sensitive manner by acknowledging the implications of the support they are currently providing and the prospect for more help. Try to determine whether the helper is being realistic when considering his/her ability to deliver more care. Ask the patient separately about his/her perception of the helper's willingness to increase support, if needed. Listen carefully to what's being said. The helper may be willing and able to continue, but the patient may feel differently based on his/her perception of their current relationship and future needs. Weigh both perceptions and use best clinical judgment to code appropriately

Coding: Code for willingness (with ability) to increase help.

4. Language

Intent: To identify the primary language that the patient both speaks and understands

- 4.1 Code the language that the patient speaks and understands. If the language is not listed, please write it in the space following *other*.

5. HOMEBOUND STATUS

5.1 Is patient homebound?

Intent: This question refers to the ability of the patient to leave the house for other reasons than for medical appointments (including adult day health care) or religious services. Absences from the home must be infrequent or of relatively short duration. This question assists in determining whether the patient will be eligible for Medicare home health services. It is NOT intended to restrict eligibility to VA programs.

Coding: Code **YES** if patient is unable to leave the home except on an infrequent basis and for short periods of time.

Code **NO** if the patient is able to leave the home for longer periods of time or on a frequent basis.

6. IADLs: Has the patient had any difficulty in performing the following activities within the last 7 days?

Determine the answer to each of these items by evaluating how **difficult** it **is**, or **would have been**, for the Patient to perform these IADL activities on his/her own. The inquiry focuses on whether the patient **has** performed, or **could have** performed without difficulty, the specified activities of daily living around the home or in the community in the last 7 days. **Note:** If the patient is unable to do the activity, it should be coded as **YES**.

Note: This may be a judgment call by the assessor as patient may never have performed the activity, e.g. a man who has never cooked meals.

6.1 Preparing Meals:

How have meals been prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils) in the last 7 days? If the patient were to perform activities related to meal preparation, would he or she have any difficulty?

Coding: Answer **Yes**, when patient had any difficulty in preparing meals in the last 7 days or would have been unable to prepare meals by self without difficulty.

Answer **No**, when patient has been able or would have been able to prepare meals without any difficulty.

6.1.1 Are meals prepared by others

Coding: Answer **YES** when patient him/herself has NOT prepared meals, even if you believe s/he could.

Answer **NO** when patient him/herself has prepared meals.

6.2 Ordinary housework

How has ordinary work around the house been performed (e.g., doing dishes, dusting, making bed, tidying up) in the last 7 days? If the patient were to perform ordinary housework, would he or she have any difficulty?

Coding: Answer **YES** when patient had any difficulty in performing ordinary housework activities in the last 7 days or would have had difficulty.

Answer **NO** when patient has been able or would have been able to perform ordinary housework without any difficulty.

6.3 Shopping

How has shopping for food and household items (e.g., selecting items, managing money while shopping) been accomplished in the last seven days. When patient shops, has she/he had any difficulty?

Coding: Answer **YES** when patient had or would have had difficulty shopping for self.

Answer **NO** when patient had or would have had no difficulty shopping for self.

6.4 Transportation

How has patient traveled by vehicle in last seven days? Includes driving vehicle him/herself; traveling as a passenger in a car, bus or subway. Does patient have any difficulty getting to places beyond walking distance?

Coding: Answer **YES** when the patient had or would have had difficulty in transporting self to places beyond walking distance.

Answer **NO** when the patient had or would have had no difficulty in transporting self to places beyond walking distance.

6.5 Phone use

How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed.)

Coding: Answer **YES** when the patient had or would have had difficulty in making or receiving telephone calls.

Answer **NO** when the patient had or would have had no difficulty making or receiving telephone calls.

6.6 Managing medications

How have medications been managed (e.g., does patient remember to take medicines, refill medicines, open bottles, take correct dosage of pills, injections, ointments) in the last 7 days? If the patient were to manage their own medications would s/he have any difficulty?

Coding: Answer **YES** when patient had any difficulty or would have been unable to manage his/her medications in the last 7 days.

Answer **NO** when patient is able or would have been able to manage his/her own medications.

6.7 Managing Finances

How finances have been managed (e.g., does the patient manage all his/her own financial affairs, maintain checkbook, pay routine bills, etc.) in the last 7 days? If the patient were to manage all his/her own financial affairs would s/he have any difficulty?

Coding: Answer **YES** when patient had any difficulty or would have been unable to manage their medications in the last 7 days.

Answer **NO** when patient is able or would have been able to manage their own medications.

6.8 Acute change in change in function

Intent: To describe whether the patient's function has worsened significantly over the last few months. For instance, a hospitalized patient may not be able to perform these tasks because of illness but might have been able to perform them prior to admission.

Coding: Code **YES** if the patient's if the patient's function has worsened over the last few months.

Code **NO** if the patient's function has not worsened over the last few months.

7. Services in the home

Has the patient received help from any of the following providers within the last 14 days?

Determine the answer to this question by evaluating the extent of specified formal care provided in last 14 days from the following paid care providers.

7.1 Home health aides

Traditionally, these aides provide hands-on ADL support and carry out simple monitoring tasks like taking blood pressure. For the purpose of this item, a yes answer can include any other paid home care that the patient has previously received in the 14 (fourteen) days before this referral.

Coding: Answer **YES** when the patient has received formal home care in the last **14 days**.

Answer **NO** when the patient has received no formal home care services during the past **14 days**.

7.2 Social worker in home

Social worker provided psychosocial support/assessment to patients in the home, in the areas of loss, coping with disability, treatment of depression, family distress, etc.

Coding: Answer **YES**, when the patient has received social worker care at home in the last 14 days. Do not score yes, when the patient is living at home or in the community and receives care from a social worker at a clinic, hospital or other non home setting.

Answer **NO**, when the patient has received no social worker care at home in the last 14 days.

7.3 RN Services in the home

Has the patient received help from an RN? Did an RN provide monitoring or care in the home at any time in the last **30 days** OR is an RN scheduled or authorized to provide care in the home in the next **30 or more days**?

Coding: Answer **YES** when the patient has received the services of a registered nurse at home in the last 30 days OR if a nurse is scheduled or authorized to provide care in the home over the next 30 or more days.

Answer **NO** when the patient has received no social worker care at home in the last 14 days.

8. ADDITIONAL INFORMATION

8.1 Living Arrangements

Change in Living Situation: Has the patient moved in with others, or have others moved in with the patient in the **last 90 days**?

Intent: Determine the answer to this question by evaluating whether in the last three months there has been a change in the patient's living arrangements, that is, the patient has **gone from living by him/herself to living with others**.

Coding: Answer **YES** when the patient has experienced a change in living arrangement in the last 90 days.

Answer **NO** when the patient has not experienced a change in living arrangements in the last 90 days.

8.2 Hazards

Are there any hazards that make it difficult for the patient to enter or leave the home?

Determine the answer to this question by evaluating whether there are **physical problems with the building** that limit access, for example, the patient lives on the second floor and must enter or leave on unstable outside stairs; the patient lives in a multi-story building in which the elevator is often broken, the patient must travel up and down stairs and uses an assistive device that make stairs hazardous. This does not refer to poor lighting or carpeting.

Coding: Answer **YES** when there are hazards that make it difficult for the patient to enter or leave the home.

Answer **NO** when there are no hazards that make it difficult for the patient to enter or leave the home.

8.3 Living Arrangement

Does either the patient or primary caregiver believe that the patient would be better off in another living environment?

Determine the answer to this question by evaluating whether the patient or primary caregiver feels or believes that there should be a change in living arrangement. *Be cautious and considerate when asking this question as changes in living situation may not be desired or are not currently being considered.*

Coding: Answer **YES** when either the patient or the primary caregiver believe that there should be a change in living arrangement for the patient.

Answer **NO** when neither the patient nor the primary caregiver believes that there should be a change in living arrangement for the patient.

8.4 Stamina/Physical Activity

In the last 7 days, has the patient engaged in 2 or more hours of physical activity; such as walking, cleaning the house or exercising?

Determine the answer to this question by evaluating the hours of physical activities in the last 7 days the patient performed

Coding: Answer **Yes**, when the patient performed physical activities for 2 or more hours in the last 7 days.

Answer **No**, when the patient did not engage in 2 or more hours of physical activity such as walking, cleaning the house or exercising or performed less than 2 hours of physical activities in the last 7 days.

8.5 Isolation

In the last 7 days, has the patient been left alone in the mornings or afternoons?

Determine the answer to this question by evaluating if the patient is ever left alone during the day. The intent is to discover if the patient is **literally** left alone without any other person present. If the patient resides in a board and care facility, congregate housing, or other situation where there are other persons in their own rooms, consider any time alone in a room by him/herself as time alone. Ask if the patient is ever left alone, even for only one hour.

Coding: Answer **YES** when the patient has been left alone, even if only for about an hour, in the last 7 days.

Answer **NO** when the patient has never or hardly ever been left alone in the last 7 days.

8.6 Surrogate Decision Maker

Definition: A person or persons whom the patient has chosen to speak for him in various capacities

Coding: Code each type of surrogate decision maker known.

Process: Ask the patient or caregiver whether s/he has any of the following types of decision makers designated.

Guardian: A person appointed by the courts to manage the legal, personal and financial affairs of the patient.

Fiduciary/Conservator: A person appointed by the courts or, in the case of VA compensation or pension, by the VA to manage the patient's income/finances.

Durable Power of Attorney (DPOA): A document executed by the patient designating the person or persons who may make decisions for him in the event s/he becomes incapacitated or unable to speak for himself. An ordinary power of attorney expires automatically when the person becomes unable to speak for himself. A durable power of attorney remains valid in the event of incapacity.

DPOA for Health Care: Assigns medical decision making authority to a designated person in the event that the patient is unable to speak for him/herself.

DPOA for Finances: Assigns financial decision making authority to a designated person in the event

8.7 Advance Directives

Definition: A document that outlines the patient's preferences for care at the end of life.

Coding: Code yes if the patient has executed an advance directive. Check no if the patient has not.

Process: Ask the patient whether an advance directive has been completed and for a copy of any completed directives for the record.

NURSING

9. Skilled Care

Definition: Treatments that will remain part of the patient's therapeutic regimen after referral is completed.

Coding: Check yes only if the patient will continue to receive the specified treatment as a part of his ongoing care after referral is completed. Check no for any treatments that the patient will not be receiving after referral

For example, if the patient has been receiving IV antibiotics in the hospital, and they will be **continued** after s/he is discharged, they **are** a part of the patient's continuing care after hospitalization. In this case, **check YES**.

If the patient has been receiving IV antibiotics, but these will be **stopped** before hospital discharge, they are **not** a part of the patient's continuing care after hospitalization. In this case, **check NO**.

9.1 CPAP/BiPap or Ventilator

Assures adequate ventilation in patients who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices.

9.2 Oxygen

Either the intermittent or continuous use of oxygen to support, promote or maintain vital functions and comfort.

9.3 Suctioning

The patient requires suctioning to clear secretions from nose, mouth or other site. This refers **only** to care that requires nursing assistance, **self-care is excluded**.

9.4 Tracheostomy care

Includes cleansing of tracheostomy and cannula. Refers only to care that requires nursing assistance, **self care is excluded**.

9.5 Ostomy care (not tracheostomy)

Includes all methods of collecting body fluids attached to the body, for example colostomy, ileostomy, gastrostomy feeding. Do not include tracheostomy care. Code only for care requires nursing assistance, **self care is excluded**.

9.6 Dysphagia diet

Special dietary or swallowing techniques that minimize the chance of aspiration.

9.7 Tube feeding

Patient is fed by tube, includes: NG, gastrostomy, and jejunostomy tubes.

9.8 Parenteral feeding

Includes both central and peripheral intravenous means of delivering nutrition

9.9 IV Infusion

Central or peripheral — Drug given by intravenous push or drip.

9.10 Medication by injection

Medication delivered through a needle, IM, SQ, ID.

9.11 Urinary catheter care

Includes care of urinary catheter that requires **nursing** assistance, **self-care is excluded**.

Dialysis (includes hemodialysis and peritoneal dialysis)

Hemodialysis is a method for removing unwanted byproducts from the blood of patients with renal insufficiency or failure through the use of a machine (dialyzer). Peritoneal dialysis (CAPD) is a method of removing unwanted byproducts from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

9.12 Center-based dialysis.

Center-based dialysis – the patient receives dialysis at a center outside of home.

9.13 Home-based dialysis

Home-based dialysis. The patient receives dialysis at home.

9.14 Wound care other than pressure ulcer (debcubitus)

Includes surgical or traumatic wounds, stasis or diabetic ulcers, etc. Skin treatments or moving/turning treatments performed by others for the prevention or treatment of a wound other than a decubitus. For example, cleansing and dressing of wounds, including application of topical agents. **Self-care is excluded.**

9.15 Pressure Ulcer (Decubitus) care

Includes all treatments performed by others for the care of a decubitus ulcer, eg, turning, moving, cleansing, dressing of wounds. Includes only care performed by others, self-care is excluded.

9.16 Stage of worst ulcer

Code the stage of the **worst** decubitus ulcer the patient has.

1. Non-blanching erythematic of the skin
2. A partial thickness loss of the skin layers (epidermis) that presents clinically as an abrasion, blister, or shallow crater
3. A full thickness of the skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining tissue
4. A full thickness of both skin and subcutaneous tissue is lost, exposing muscle or bone.

9.17 Frequent nurse observation (more than once/week)

The patient requires a registered nurse to visit more than once per week for any purpose.

9.18 Therapies

Intent: This section is intended to capture all therapies that are delivered to the patient by certified or licensed therapists (or assistants, when supervised by a the certified or licensed therapist)

Definition: Occupational therapy — Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy.

Physical therapy OR Kinesiotherapy — Therapy services that are provided or directly supervised by a qualified physical therapist or kinesiotherapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy.

Speech Therapy— Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy.

Coding: Check if the patient will receive any of the above therapies

9.19 Alcohol/drug treatment program

Chemical dependency treatment program where psychological/emotional support and/or medication is provided.

9.20 Other (Specify) If a patient requires a skilled treatment different from those listed above, please specify this treatment in the blank space.

10. Physical Functioning - Self performance of ADLs: In the last 7 days has the patient required any **help or supervision** to perform any of the following activities?

Determine the answers to these questions by evaluating the patient's self-care **performance** (what the patient **actually did** and/or how much help was required by others) during the last seven days. Determine if patient did **not** perform the activity in the last seven days.

A patient's ADL self-performance may vary from day to day, or within days. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a daughter he or she likes, but not the daughter-in-law), medications, alcohol consumption, etc. The responsibility of the screener is to **consider the total picture of the patient's ADL self-performance** for these items over the seven-day period, 24 hours a day.

10.1 Bathing, including showering, a full tub bath, or sponge bath.

Coding: Answer **YES** when the patient required **help or supervision** to bathe during the last 7 days **OR** patient **has not** bathed in the last seven days.

Answer **NO** when the patient needed help or supervision to bathe.

10.1.1 Did the patient need physical assistance with bathing?

Coding: Answer **YES** when requires physical assistance with bathing **or** has not bathed within last seven days.

Answer **NO** when The patient has required **no** physical assistance with bathing.

10.2 Dressing, including laying out of clothes, putting them on, and taking them off.

Coding: Answer **YES** when the patient required **help or supervision** to dress **OR** patient **has not** dressed himself in the last seven days.

Answer **NO** when the patient did **NOT** require help or supervision or required rare (1-2 times) help or supervision during the last seven days.

10.3 Eating — Including taking in food by any method, including tube feedings.

Coding: Answer **YES** when the patient required **help or supervision** to eat during the last seven days **OR** patient ate by tube or other method during the last 7 days.

Answer **NO** when the patient did not require help or supervision **OR** required rare (1-2 times) help or supervision.

10.4 Toilet Use — Including using the toilet room or commode, bedpan, urinal; transferring on/off toilet; cleaning self after toilet use (includes cleansing after incontinence episode); managing any special devices required (Ostomy or catheter), and adjusting clothes.

Coding: Answer **YES** when the patient required **help or supervision** to use the toilet **OR** patient **has not** used the toilet in the last seven days.

Answer **NO** when the patient did **NOT** require help or supervision to use the toilet **OR** required rare (1-2 times) help or supervision during the last seven days.

10.5 Moving in bed including turning side to side and moving to and from a lying position.

Coding: Answer **YES** when the patient required **help or supervision** to move in bed during the last 7 days **OR** patient **has not** moved in bed in the last seven days.

Answer **NO** when the patient required help or supervision to move in bed or required rare (1-2 times) help or supervision during the last seven days.

Note: be sure to inquire specifically how the patient moves to and from a lying position, how the patient turns from side to side, and how the patient positions himself or herself while in bed. A patient can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect.

10.6 Transfers - Moving from one level surface to another, getting from the chair to a bed or toilet or getting from the toilet to the wheelchair.

Coding: Answer **YES** when the patient required **help or supervision** to transfer during the last 7 days **OR** patient **has not** transferred in the last seven days.

Answer **NO** when the patient required help or supervision to transfer or required rare (1-2 times) help or supervision during the last seven days.

10.7 Moving around indoors

Intent: Determine the answer to this question by evaluating whether the patient moves around indoors **without** the use of a wheelchair.

Coding: Answer **YES** when the patient required **help or supervision** to move around indoors even if with a cane, walker or scooter, but **without** the use of a wheelchair.

Answer **NO** when the patient does **NOT** require help or supervision to move around indoors **OR** the patient uses a wheelchair.

10.8 Moving around in a wheelchair

Coding: Code **YES** when the patient required **help or supervision** to propel and maneuver his/her wheelchair (even if it is a powered wheelchair) during the last 7 days.

Code **NO** when the patient does **NOT** require help or supervision to propel and maneuver his/her wheelchair even if it is a powered wheelchair.

10.9 Acute change in change in function

Intent: To describe whether the patient's function has worsened significantly over the last few months. For example, a hospitalized patient may not be able to perform these tasks because of illness, but may have been able to perform them prior to admission.

Coding: Code **YES** if the patient's function has worsened over the last few months.

Code **NO** if the patient's function has **not** worsened over the last few months.

11. Continence

11.1 Is the patient incontinent of urine?

Intent: To describe whether the patient is incontinent of urine.

Coding: Code **YES** if patient is incontinent of urine

Code **NO** if the patient is continent of urine

11.2 Is the patient incontinent of bowel?

Intent: To describe whether the patient is incontinent of bowel.

Coding: Code **YES** if patient is incontinent of bowel

Code **NO** if the patient is continent of bowel

12. Skin

Has the patient experienced and troubling skin problems like burns, bruises, or itching in the last 30 days?

Intent: To describe whether the patient has had the appearance of skin problems that have occurred over the last month.

Coding: Code yes if the patient has experienced any burns, bruising or itching in the last 30 days.

Note: Some skin problems may indicate self-neglect, neglect by others, or abuse.

13. Patient Behaviors and Symptoms

13.1 Wandering

Definition: Wandering — Moved about with no discernible, rational purpose, seemingly oblivious to needs or safety. A wandering patient may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry patient moving about the apartment in search of food). Wandering may be by walking or by wheelchair. Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering.

Coding: Code **YES** if the wandering was present in the last seven days.

Code **NO** if the wandering was not exhibited in the last seven days.

13.2 Verbally Abusive Behavior

In the last 7 days, has the patient threatened, screamed at, or cursed at others?

Determine the answer to this question by evaluating whether the patient has been verbally abusive in the last seven days.. This item is designed to pick up challenging behaviors exhibited by the patient at home. Such behaviors include those that are potentially harmful to the patient or disruptive to others

This item asks if a specified behavior, threatening, screaming, or cursing at others, occurred. This item focuses on the patient's actions, not intent. The fact that family members have become used to the behavior and minimize the patient's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened") is not pertinent. Whether the patient manifests the behavioral symptom or not is the test screeners should use in evaluating this item

Coding: Answer **YES** when the patient was verbally abusive in the last 7 days.

Answer **NO** when the patient demonstrated no verbal abuse in the last 7 days.

13.3 Physically Abusive Behavior

Definition: Others were hit, shoved, scratched, or sexually abused.

Coding: Code **YES** if physically abusive behavior was present in the last seven days.

Code **NO** if physically abusive behavior was not exhibited in the last seven days.

13.4 Resists Care

Resists taking medications/injections, pushed caregiver during ADL assistance in eating or changes in position. This category does not include instances where patient has made an informed choice not to follow a course of care (e.g., patient has exercised his right to refuse treatment, and reacts negatively as others try to re-institute treatment).

Signs of resistance may be verbal or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the patient's responses to interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the patient's behavioral symptoms. The coding for this item focuses on the patient's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that family members have become used to the behavior and minimize the patient's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened") is not pertinent to this coding. Does the patient manifest the behavioral symptom or not — that is the test you should use in coding these items.

Observe the patient during your assessment. Observe how the patient responds to attempts by family members to deliver care. Consult with family members who provide direct care. Ask if they know what occurred throughout the day and night for past seven days. Question the family member. Try to do this when the patient is not in the room (if possible). Recognize that answers given with the patient present may need to be validated later. Also the presence of 2 or 3 caregivers during the assessment may discourage caregivers from answering as accurately as we would like.

Coding: Code **YES** if resistance to care was present in the last seven days.

Code **NO** if resistance to care was not exhibited in the last seven days.

13.5 Hallucinations or delusions

Definitions: False perceptions that occur in the absence of any real stimuli.

Hallucinations are sensory experiences that are NOT REAL. They may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

Delusions are ideas or beliefs that are held even though there is no evidence to support them or evidence that shows them to be false.

Coding: Code **YES** if the patient has experienced hallucinations OR delusions in the last 7 days

Code **NO** if the patient has not experienced hallucinations OR delusions in the last 7 days

14. Cognitive Status

14.1 Cognitive Skills for Decision Making

In the last 7 days, was the patient able to make decisions that are reasonable, even if with difficulty?

Determine the answer to this question by evaluating the patient's **actual performance** in making everyday decisions about activities of daily living (e.g., when to get up or have meals, which clothes to wear or activities to do).

The inquiry should focus on whether the patient is actively making these decisions, and NOT whether there is belief that the patient might be capable of doing so. Remember the intent of this item is to record what the patient is *doing* (performance). When a family member takes decision-making responsibility away from the patient regarding tasks of everyday living, or the patient does not participate in decision-making, whatever his or her level of capability may be, the patient should be considered to have impaired performance in decision-making.

Coding: Answer **YES** when the patient has not experienced difficulty making decisions, or decisions were poor or patient did not make decisions in the last 7 days.

Answer **NO** when the patient has experienced some difficulty making decisions, or decisions were poor or patient did not make decisions in the last 7 days.

14.2 Making Self Understood

In the last 7 days, has the patient usually been able to make him/herself understood?

Determine the answer to this question by evaluating how the patient expresses or communicates requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard). Does the patient express ideas clearly, without difficulty? If the patient does have difficulty finding the right words or finishing thoughts, resulting in delayed responses, if given time with little or no prompting was the Patient usually understood?

Coding: Answer **YES** when the patient was understood even if he/she was had difficulty finding words or finishing thoughts in the last 7 days.

Answer **NO** when the patient's was rarely or never understood or he/she was limited in making concrete requests in the last 7 days.

14.3 Disoriented

In the past 90 days, has the patient become agitated or disoriented? If yes, was the patient's safety endangered OR did patient require protection by others as a result of the agitation/disorientation?

Determine the answer to this question by evaluating whether there was ever agitation/disorientation in the past 90 days, regardless of the cause, that endangered the patient's safety or required protection by others. The screener may need to seek the statements of family or the referring agency to get this information.

Coding: Answer **YES** when the patient was agitated or disoriented in the last 90 days AND the patient's safety was endangered.

Answer **NO** when the patient was not agitated or disoriented in the last 90 days OR if the patient was agitated/disoriented, the patient's safety was not endangered.

15. PROGNOSIS AND HEALTH STATUS

15.1 Health Status

In the last 7 days, has the patient experienced a flare up of a recurrent or chronic health problem?

Intent: Determine the answer to this question by evaluating whether the patient has any recurrent or chronic health problems, and whether these have flared up in the last 7 days

Coding: Answer **NO** when the patient has not experienced a flare up of a recurrent or a chronic health problem in the last 7 days.

Answer **YES** when the patient has experienced a flare up of a recurrent or chronic health problem in the last 7 days.

15.2 Rehabilitation Potential

Intent: To describe likelihood that patient may have capacity for greater independence and involvement in his or her care, it is important to identify the health care provider's (physician or mid-level practitioner) opinion about the patient's potential to increase his independence in ADLs, IADLs or mobility.

Process: Determine the answer to this question by asking the responsible physician or therapist whether he/she believes that the patient's function will improve over time, **with or without rehabilitation services**.

Coding: Answer **YES** if the physician believes the patient's function will improve

Answer **NO** if the physician does not believe the patient's function will improve.

15.3 Limited life expectancy (approximately six or fewer months to live)

Intent: To determine whether the patient is nearing the end of his/her life because of chronic, end stage or terminal illness.

Definition: The physician believes or the patient or family has been told that the patient has end-stage disease with **approximately** six or fewer months to live. A different way to consider this question is, "Would it be a surprise if the patient were to die in the next six months?"

Coding: Code **YES** if the physician believes **or** has told the patient and/or family that life expectancy is very limited.

Code **NO** if the physician does not believe that life expectancy is very limited

16. Weight Bearing Status

Intent: To determine whether there are any restrictions on weight bearing, particularly for patients who have fractures or wounds.

Coding: Code **Full** if there are no restrictions on weight bearing and patient can bear his/her full weight.

Code **Partial** if the patient may bear some weight, but not his/her full weight.

Code **None** if the patient is not to bear any weight

17. Diet

Intent: To determine whether the patient requires a therapeutic diet.

17.1 Regular/modified

18. What equipment does the patient need?

Code all equipment that the patient will need after referral is complete

Note: Prosthetics requests must be placed so that equipment will be available when referral complete

18.1 Hospital Bed

18.2 Special Mattress

18.3 Trapeze

18.4 Walker

18.5 Cane

18.6 Wheelchair

18.7 ADL

18.8 Orthotic or Splint

18.9 Other (Specify)

19.

20. Goals of Care

Intent: To document patient and/or family understanding of goals of care.

Definition:

- 20.1. Rehabilitation** — Care is directed towards the attainment of baseline (or prior to the precipitating event) level of function in a selected area or areas, e.g., activities of daily living, instrumental activities of daily living, cognitive status, communication status, psychosocial functioning.
- 20.2 Skilled nursing care** — Aspects of care requiring a licensed nurse (registered nurse or licensed practical nurse) to assist the patient. These treatments include dressing changes, medication (including IV), indwelling catheters, wound care, and assessment.
- 20.3** Monitoring or supervision to avoid clinical complications — Patient needs monitoring to prevent clinical complications. Monitoring activities can include some of the following: vital signs, observation of wound characteristics, obtaining and reviewing blood sugar levels, review of lab work, etc.
- 20.4 Improve compliance with medications or treatments** – Patients need a structured approach to management of medications and treatments. This might involve setting up mechanisms to improve compliance, e.g, medication cassettes, or assisting the patient in remembering and scheduling appointments, etc.
- 20.5 Patient/family education** — Teaching a patient or family member to participate in care activities such as medication management, nutrition, wound management, rehabilitation techniques. This category includes teaching patient or a family member to carry out certain skilled nursing treatments, such as medications and tube feedings.
- 20.6 20.6 Respite** — Goal of care is to relieve family caregiver of some of the care of the patient. The respite service may be provided in a short intensive period (a week, or two) or over a lengthier time period.
- 20.7 20.6 Palliative care** — A primary goal of care is to provide comfort and quality of life through the prevention and control of symptoms near the end of life. Palliative care often includes active treatment of associated conditions in an effort to promote a sense of well-being at the end of life (e.g., antidepressant drugs/psychotherapy for depression; physical therapy as an adjunct to pain management and prevention of pressure ulcers; nutritional counseling).
- 20.8 Reduce Hospital or Emergency Room Visit**
- 20.9 Supervised/supportive living** – The patient is unable to live without some assistance in daily activities. S/he may need assistance only with IADLs, e.g, housework, meal preparation, or may also require assistance with ADLs, e.g, personal care. A supervised/supportive living situation provides this assistance from non-family members.
- 20.10 Behavior stabilization** – The patient has been exhibiting troubling behaviors that make it difficult to care for him/her in his present situation. Care is directed at stabilizing or eliminating those behaviors that make it difficult for others to care for him.

Coding: Code for patient/family understanding of goals of care. Code each possible goal with one of the following responses, as appropriate

21. Reason for Referral

Definition:

- 21.1 **Skilled home nursing care.** Referral to obtain skilled nursing services in the home.
- 21.2 **Home-Based Primary Care** – Referral to obtain skilled nursing services AND primary medical care in the home from the VA Home-Based Primary Care Program.
- 21.3 **ADL assistance in home** – Referral for assistance with performing ADLs in home, eg, bathing, dressing, etc.
- 21.4 **Chore assistance in the home** – Referral for assistance with performing IADL tasks in home, e.g., housekeeping, meal preparation, etc. In some states these are called homemakers, on others, providers.
- 21.5 **Adult Day Health Care** – Referral to a VA Adult Day Health Care Program.
- 21.6 **Residential Care-Personal Care Home**– Referral to a VA or non-VA Community Residential Care Program or Personal Care Home (board, room and medication supervision).
- 21.7 **Assisted Living** – Referral to VA or non-VA assisted living (board, room, medication supervision and personal care)
- 21.8 **Domiciliary Care** – Referral to a VA Domiciliary Program.
- 21.9 **Short-term nursing home or subacute care** – Referral to a VA or non-VA facility that provides care aimed at completing treatment and restoring function.
- 21.10 **Long-term nursing home care** – Referral to VA or non-VA nursing homes for permanent nursing home placement.
- 21.11 **Outpatient Respite Care** – Referral to VA nursing home or non-institutional respite care program.
- 21.12 **Inpatient Respite Care** – Referral to VA nursing home or non-institutional respite care program.
- 21.13 **Specialized Dementia/Geropsychiatry Care** – An in or outpatient unit where specialized care is available for persons with Alzheimer's disease or other dementias.
- 21.14 **Inpatient Palliative/Hospice Care** – Referral to a VA or non-VA hospice or palliative care inpatient unit.
- 21.15 **Outpatient Palliative/Hospice Care** – Referral to a VA or non-VA hospice or palliative care inpatient outpatient/home program.
- 21.16 **Program of All Inclusive Care** – Referral to a community PACE program or to a VA All-Inclusive Care Program.
- 21.17 **Home Telehealth** (sometimes called care coordination)

21.18 Other – This is a free text field where you can enter any other program that you wish the patient to be placed in.

22. Estimated Duration of Services

Intent: To provide the referral program with an estimate of how long the patient will require the services.

Coding: Check the box that most closely matches your best estimate of how long the patient will need services. For example, a patient may need skilled home health services for wound care for only a week in order to teach wound care. Other patients, e.g., those being referred for community nursing home placement, might require indefinite care.

23. Other Comments

Intent: To provide any additional information that may be required to take care of the patient.

24. Place consult to geriatrics and extended care.

Intent: If checked, this box will automatically bring up a consult order to be placed.

Coding: In general, all three sections of the GEC referral form should be completed before the consult is placed.