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Long-Term Care Facilities in the United States

Jeanette M. Daly, RN, Ph.D., Jung-Yong Park, M.D., M.P.H., Gerald J. Jogerst, M.D.

Department of Family Medicine, University of Iowa

THE INTRODUCTION

Long-term care describes a range of health and housing services provided to people unable to care for themselves independently. It is a broad term that "describes a constellation of services used by people with disabilities to achieve a meaningful life according to their own expectations."[1] Services may be continuous or intermittent, but are delivered for a sustained period to individuals who have a demonstrated need. The purpose of this paper is to describe a component of long-term care, the nation's nursing homes and the role of primary care physicians demonstrated by physician-patient interactions and Medical Director responsibilities.

THE MAIN DISCLOSURE

1. Definition

The continuum of care for a person who is dependent ranges from very restrictive to least restrictive and can be institutional or community based. Institutional care of the least restrictive mode is housing called assisted living, group homes, personal care homes, retirement villages, boarding homes, and congregate care homes. These homes have different titles but provide limited services to specific populations. Most restrictive are mental health hospitals, acute care and rehabilitative hospitals and falling in the middle of the continuum is the nursing home. Nursing home is the common term used for describing long term institutional care, but specifically, a skilled nursing facility (SNF) is a section of an institution for residents meeting Medicare reimbursement requirements, and nursing facility (NF) is an institution or section of an institution for residents meeting Medicaid requirements for reimbursement.[2]

Funding for nursing home care is covered in part by Medicare and Medicaid. Medicare in the US is a health insurance program funded by the government. It is for persons 65 years or older, persons with certain disabilities under age 65 years, and people with end-stage renal disease requiring dialysis or kidney transplant. Medicare has two coverage parts; (1) hospital insurance which helps to cover inpatient hospitalization and skilled nursing care and (2) medical insurance which helps to cover doctors' services, outpatient hospital care, and some other medical services such as physical therapy and supplemental oxygen.[3] Medicaid is a federal program for certain persons with low income and resources that covers the cost of care in a long-term care facility, plus other medically necessary services, such as physicians, dentists, hospitals, prescribed drugs, ambulance services and eye glasses.[4]

Care provided in a nursing home is most appropriate for patients whose needs cannot be adequately met in a less acute, community-based setting. For those who do not need this level of care, other options are available depending on the person's level of acuity

Correspondence: Jeanette M. Daly
Tel: 319-384-8995
E-mail: jeanette-daly@uiowa.edu

and dependency. Options include assisted living facilities, residential care facilities, and retirement centers. Assisted living provides services associated with a resident's activities of daily living. Residential care, also known as sheltered care or board and care offers some services such a meals and assistance with taking medicine. Retirement centers provide no nursing or medical services and offer residents the opportunity to maintain their own lifestyle. Another component of the institutional care is subacute care, which provides services too intensive for the average skilled nursing facility. Subacute care addresses the needs of clients who have recovered from the acute phase of an illness or injury but still require ongoing nursing and medical monitoring and treatment.

2. History of long-term care

Prior to 1935, the elderly were not singled out as a discrete group of adults in the US health care system. That year, the Social Security Act was enacted which increased financial security for the elderly. During those times, the care of older persons was provided in the home with untrained family members or in almshouses for those with no family.[5] An almshouse was a residence devoted to the shelter of the poor and endowed by a benefactor for it's use. In many cases, the county government passed laws for the relief of the poor. In addition to serving the vagrants, rogues, and beggars, it also served as a hospital for those unable to afford private medical care. The purpose of the Social Security Act was to "alleviate the hazards of old age, unemployment, illness, and dependency, to establish a Social Insurance Board in the Department of Labor, to raise revenue, and for other purposes."[6] In the 1950s, there were amendments to the Social Security Act that allowed vendor payments to nursing homes caring for the elderly. Medicare and Medicaid additions to the Social Security Act were passed in 1965 and there was a national medical insurance for all older adults. Nursing homes began to proliferate.

3. Nursing home & resident characteristics

The number of nursing homes has increased with a reported 18,000 nursing homes housing 1,900,000 beds in 1999 compared to 15,700 nursing homes in 1973. The average number of beds per nursing home is 105. Approximately 66% of the homes are under for-profit ownership, 27% are voluntary nonprofit, and the other 7% are government or other owned entities. Sixty-one percent of the homes are located in metropolitan areas while the remaining are in rural areas.[7] More than half of the financial support for nursing homes comes from public funds; Medicaid and Medicare.[8]

The average cost for a nursing home stay per day is $168 for a private room with a range from $88 to $347. The prices vary depending on the cost of living for the area and the supply and demand of the beds.[9] In 1998 the Health Care Financing Administration (HCFA) implemented a prospective payment system (PPS) for skilled nursing facilities Medicare beneficiaries. Medicare reimbursement rates for nursing home services are based on the resource utilization group (RUG) classification system that is set by the items included on the Minimum Data Set (MDS).[10] Medicare pays 100% of skilled nursing facility costs for the first 20 days, and the 80% every day thereafter as long as the resident remains eligible. See Appendix A for two nursing home case studies.

About 1 1/2 million persons age 65 years and older reside in nursing homes predominantly they are female (74%).[7] This is only 4% of the nation's almost 35 million population 65 years and older.[11] Placing a person in a long-term care facility is one of the most emotional subjects a family discusses. As consumers, there are guides to help families evaluate the different levels of care to determine which is appropriate and other guides to evaluate the specific facility where the resident may reside. Some of the features to be eval-

uated in a facility are the atmosphere, physical appearance, health care services, medication services, social activities, food services, ownership, and cost.[12] At the entrance of all licensed nursing homes, the most recent certification survey results are available for the public to review.

Nursing home resident characteristics have been provided as a summary from the On-line Survey Certification, and Reporting System (OSCAR) which is reported by the facility at each survey. On a scale of 1 (lowest need for assistance) to 3 (greatest need for assistance), the average nursing home resident's need for eating was 1.6 to 1.8, for toileting 2.1 to 2.2, and for transferring was 2.0 to 2.1 for the time period 1994~1997. In 1997, 48% of the residents were chair-bound, 8% were bedfast, 23% had contractures, 15% were being physically restrained, 46% were receiving psychoactive medications, and 7% had pressure sores. Dementia was diagnosed for 42% of the residents, urinary incontinence for 50% and bowel incontinence for 41%. Eight percent of the residents had indwelling catheters.[13]

4. Nursing home rules & regulations

Nursing homes are heavily regulated through licensure and certification requirements. In all states, long-term care facilities must be licensed to administer medications and provide assistance with activities of daily living. They must also be licensed by the federal government to receive Medicare and Medicaid funding.

In 1983, Congress asked the National Academy of Sciences and its' Institute of Medicine to investigate the quality of care provided in the nation's nursing homes. The impetus to the investigation was the concern that nursing home patients were receiving poor care that stemmed back to the 1960's. The 1986 Institute of Medicine (IOM) report, "Improving the Quality of Care in Nursing Homes," laid the foundations for major changes in the nursing home quality regulatory system. Many of the recommendations for changes made by the IOM Committee were enacted into law as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), which was implemented in 1990 and 1991. Major changes incorporated in the law included new requirements for nurse aide training, minimum registered nurse staffing, uniform national resident assessment system, assurance of quality of care, quality of life, and resident rights. "The Institute of Medicine Committee argued that a uniform, comprehensive assessment of each resident was essential to improving the quality of care in the nation's nursing homes".[14] The Resident Assessment Instrument (RAI) was designed to produce reliable data that would guide the development of the care plan for nursing home residents.[15] It has two components; the Minimum Data Set and the Resident Assessment Protocols (RAPS).

The MDS has seventeen core items for completion: identification and background information, cognitive patterns, communication/hearing patterns, vision patterns, mood and behavior patterns, psychosocial well-being, physical functioning and structural problem, 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, and discharge potential and overall status. Each section asks specific assessment questions (See Appendix B for an MDS section example). This assessment is completed within 14 days of admission and every three months thereafter unless there is a change in the resident's statuts warranting a new assessment for residents residing in intermediate care. For residents residing in skilled care, the assessment is completed within 5 days of admission for reimbursement purposes.

The MDS provides triggers to identify residents for whom specific RAPS will be completed. Each RAP section is a structured framework for organizing elements of the MDS to assist in the development of

the care plan. These sections cover the majority of areas addressed on a typical resident's care plan and include RAP problem areas: delirium, cognitive loos, visual function, communication, 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, dental care, pressure ulcers, psychotropic drug use, and physical restraints. The main intent of this process is to develop individualized plans of care based on the identified needs, strengths, and preferences of each resident.[16)]

After the completion of the MDS and RAP, a comprehensive care plan is developed for each resident by an interdisciplinary team that includes the attending physician, a registered nurse and other appropriate staff. Guidelines clarify that a physician may participate in the care plan preparation by alternative methods other than attending a care plan conference. Alternatives could be one-to-one discussions or conference calls.[16)] The physician also writes medical orders that are carried out through the care plan. Researchers have looked at change in quality care for nursing home residents since the implementation of the resident assessment instrument.[15,17)] Ouslander's[18)] review suggests that the RAI has "been associated with improvements in selected care process indicators, functional status measures, health conditions, and reductions in hospital rates". The pre/post-RAI implementation study of 1997 demonstrated an increase in the accuracy of the information in resident's medical records from 18% preRAI to 49% postRAI.[17)] There was increase in the comprehensiveness of the care planning with postRAI care plans being significantly more likely to address problems in 12 of the 18 resident assessment protocol (RAP) areas.

The MDS assessment is also used to assign patients to a RUG that establishes payments for Medicare. These MDS assessments for payment purposes for skilled care patients have to be completed within the first five days of the stay, during the 11th and 14th days of stay, and the 30th day of care to account for variations in severity of illness and warranted reimbursement.[10)] The accuracy and completeness of the MDS is critical for reimbursement and care planning. The assessment is also useful for physicians, nurse practitioners, dentists, podiatrists, and other health care providers to have a thorough assessment available for every resident.

5. Teaching Hospital's role in long-term care

The Department of Family Medicine University of Iowa was founded in 1970 to train physicians in family medicine. Within the specialty of family medicine, physicians will have their own specific specialties interests and expertise such as obstetrics, sports medicine, or geriatrics. Seven of the 25 physicians who are faculty in the department have a Certificate of Added Qualifications in Geriatrics and some of those physicians are medical directors of area nursing homes. It is mandated by law that each facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.[2)] As medical directors, physicians are members of the facility's quality assurance, safety, and pharmacy review committees. Usually, these committees meet on a quarterly basis.

Many medical directors are members of the American Medical Directors Association (AMDA) whose mission is committed to the continuous improvement of the quality of patient care by providing education, advocacy, information, and professional development for medical directors and other physicians who practice in the long term care continuum.[19)]

The Departments of Family Medicine and Internal Medicine at the University of Iowa have established

the Geriatrics Fellowship whose focus is on the care of elderly patients in the University's Geriatrics Assessment Clinic, long term care facilities, University's inpatient units, the nearby VA Medical Center, and patient's homes. Fellows become part of the clinically based multidisciplinary geriatrics team. Fellowship goals include developing advanced knowledge and skills in the management of geriatric patients and in the teaching of geriatric medicine, and increasing the fellow's knowledge of research methodology in geriatric medicine. The geriatrics fellow is responsible for the care of a group of long-term care residents.

The nursing home provides an environment for teaching residents and geriatric fellows the basics of geriatric medicine. The goal of the residency is to train physicians skilled in providing continuing and comprehensive personal care to patients and their families. The program includes education in all areas of family medicine: adult medicine, maternal and child health, behavioral science, surgical specialties and community medicine. As first year residents, assignments to care for persons who reside in nursing homes are made. The resident visits their new patient every month for the first three months then every two months thereafter and on an as needed basis. After each visit, the resident staffs with a geriatrician on their previous visit. As the resident progresses in the program, additional caseloads are assigned.

The residency program is organized as a progressive educational experience with increasing patient responsibilities over the three years of training as residents develop clinical skills and demonstrate medical judgment and competence. Each year, geriatric educational programs are provided the residents. The first session is an introduction to the nursing home, tour of the nursing homes, and the physician's role. Throughout he training program formal teaching, clinical experiences on assigned rotations, patient care in the Family Practice Center, and structured conferences are provided.

Some faculty have a caseload of patients in the area nursing home. They are responsible for the medical care of these patients and must meet the rules and regulation guidelines for physician visits. The physician must visit the patient in the nursing home and complete a history and physical for the patient within the first ten days of admission to a nursing home facility. Thereafter, the patient must be seen every 30 days for the next 90 days and every 60 days after that unless there is a change of status in the patient's condition which would warrant a physician visit.[2] The physician is also responsible for certifying the patient is in need of skilled services and completes documentation to this effect throughout the patients stay.

6. Nursing home problems

Long-term care facilities have many problems that are diverse and include poor staffing, lack of staff expertise, high costs, and resident abuse. Despite a variety of regulatory efforts to improve the quality of care in long-term care facilities, most agree that it continues to be a serious problem.[20-22] Shortage and turnover of staff, too few nurses with specific geriatric training, and insufficient availability of physicians, dentists, and other health professionals are acknowledged reasons for continued poor quality of care.[22-29]

Numerous studies have indicated higher staffing levels in nursing homes have been associated with higher quality of care.[30-32] In 1997, the average time a Registered Nurse (RN) spends with a resident per 8-hour shift is 6 to 8 minutes. Licensed Practical Nurses (LPNs) spend 12 minutes and nurse aides spend about 39 minutes per shift per resident.[13] This is evident because RNs often must direct the care of 30 to 50 and sometimes more residents. Rate of turnover varies and annual turnover rates have been reported 55 to 100%.[33]

Inequities in salary compensation for all personnel

in long-term care facilities compared to comparable hospital positions are evident across the country. "The direct consequences of inadequate wages and benefits for nursing personnel in nursing homes are: inadequate staffing levels, high staff turnover rates, lower educational levels of staff, poor quality of care, and higher costs".[13]

Medicaid provides the financial coverage for two-thirds of the nation's nursing home residents. On average a nursing home will receive $115/day for each resident with Medicaid coverage. This fee is different per state and ranges from $258 per day in Alaska to $77 per day in Arkansas. The nursing home industry is complaining that the Medicaid fees are too low and not covering the cost of the patient's care that includes nursing care, food and supplies, rent or mortgage, utilities, and salaries. They charge this impacts the quality of care provided.

Residents in long-term care have either physical and/or mental impairments and these residents are at risk for abuse and neglect. Thirty-six percent of 577 nursing home staff reported they have witnessed at least one incident of physical abuse in a 12-month period.[34] Other types of abuse are exploitation, emotional abuse, sexual abuse, and neglect. Neglect can be very detrimental to nursing home residents causing severe pain, decubitus ulcers, malnutrition, dehydration, infection, and death.

As a result of the abuse and neglect, the number of lawsuits against nursing homes has increased. Nursing home insurance is soaring and there is a new specialty of elder and nursing home law. A standard request during litigation is the nursing home's survey reports. Nursing facilities must continually monitor quality and the quality assessment mandate is one method to do this with the help of family, residents, staff, and legal counsel.[35]

CONCLUSION

Maintaining quality of care for residents in nursing homes is a challenge and must be done while maintaining licensure requirements. Family physicians contribute to the quality of care provided residents and have an important role providing medical care and teaching/learning experiences for medical students, residents, and fellows.

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Appendix A

1. Study: Ed

A case example of nursing home costs and how the system works is described for a resident who pays privately. Ed, a 72 year-old bachelor with a history of diabetes, coronary artery disease, poor lower extremity circulation, and obesity was living in his own home with a relative who provided assistance with all activities of daily living. Ed was receiving disability payments because of an immobile arm resulting form a fracture many years ago.

One evening, Ed was taken to the emergency department because he could not urinate. Dehydration contributed to the lack of urinary output and further assessment revealed, 95% occlusion of his circulation to his lower right extremity, a pulse of 33, and congestive heart failure. After admission to the hospital, above the knee amputation of the right leg and recovery, Ed was admitted to the county nursing home. He was considered a private pay patient. He was eligible for Medicare coverage on skilled care because he had been in the hospital for more than 3 days. He would be eligible for coverage if he continued to progress in his rehabilitation. Coverage would include medically necessary services, including room and board, nursing care, and ancillary services such as drugs, laboratory tests, physical and occupational therapy.

After 33 days on skilled care, the care plan team made the assessment that Ed was no longer progressing in recovery and would have to stop Medicare payment for services. He was a permanent resident of the home and would have to pay privately to stay. The cost to him would be $98 per day. He had a lifetime savings of $25,000 and his own home for financial resources. Ed's monthly income was $1,035 from social security, and $665 from his factory retirement plan. This left a $1,240 deficit per month which he would need to pay for nursing home care. Ed's sister-in-law called on the Veterans Administration (VA) to check if they cover nursing home cost for veterans. She completed the paper work and within 3 months Ed was being covered for $1,328 from the VA. In addition to the nursing home bill, Ed has other monthly expenses that amount to $100 to $200 per month.

Four months after Ed had been admitted to the private pay section of the nursing home, he developed a persistent productive cough and a high fever. He was transported to the hospital via ambulance for a cost of $636 (round trip). Medicare will pay for part of this cost. Ed was admitted to the hospital, diagnosed with pneumonia. His hospitalization was for 7 days. When he returned to the nursing home, he was eligible for skilled nursing care covered by Medicare Part A until his recovery. This hospitalization was a new spell of illness for Ed. A spell of illness is a period that begins when a Medicare beneficiary is admitted to a hospital or a skilled nursing facility and ends when a beneficiary has not been an inpatient of a hospital or a skilled nursing facility for 60 consecutives days. A beneficiary may have more than one spell of illness per year and maintain Medicare coverage.

2. Case Study: Lilly Mae

A case example of nursing home costs and how the system works is described for a resident whose nursing home costs are paid by Medicaid. Lilly Mae is a 64 year-old widow with a history of coronary artery disease, hypertension, and headaches. She was living alone in her own home where she rented her garage to a neighbor who kept her lawn work for her. He was in the habit of calling on her each day and one day she yelled at him when he knocked and said she had fallen on the floor and would be alright with no help. He broke the locked door and entered to find she couldn't get up and walk. He called the ambulance and she was taken to the hospital.

After a complete work up at the hospital, Lilly Mae was admitted to the local nursing home with a diagnosis of dementia, hypertension, coronary artery disease, and headaches. She was a permanent resident of the nursing home as she was unable to care for herself financially or physically. The nursing home social worker had a lawyer appointed for her financial affairs. Because Lilly Mae was a permanent resident of the nursing home and lived alone, her home had to be sold to be eligible for Medicaid. The lawyer sold her home for $14,000 and was able to pay her bills but her social security income would not cover the total cost of the nursing home. He applied for Medicaid coverage for her and because she was institutionalized and her resources were below poverty level she was eligible. As a recipient of Medicaid her nursing home costs would be covered and she would receive $30 for personal use. Any monthly income such as social security would be applied towards her nursing home bill.

Appendix B

Section B. Cognitive Patterns

1. Comatose	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to section G)
2. Memory	(Recall of what was learned or known) a. Short-term memory OK-seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK-seems/appears to recall long past 0. Memory OK 1. Memory problem
3. Memory/ recall ability	(Check all that resident was normally able to recall during last 7 days) Current season That he/she is in a nursing home Location of own room None of the above are recalled Staff names/faces
4. Cognitive skills for daily decision-making	(Made decisions regarding tasks of daily life) 0. Independent-decisions consistent/reasonable 1. Modified independence-some difficulty in new situations only. 2. Moderately impaired-decisions poor; sues/supervision required 3. Severely impaired-never/rarely made decisions
5. Indicators of delirium-periodic disordered thinking/ awareness	(Code for behavior in the last 7 days.) [Note: Accurate assessment require conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning 9e.g., new onset or worsening) a. Easily distracted-(e.g., difficulty paying attention; gets sidetracked) b. Periods of altered perception or awareness of surroundings-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. Episodes of disorganized speech-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. Periods of Restlessness-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. Periods of lethargy-(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. Mental function varies over the course of the day-(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6. Change in cognitive status	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated