COLORADO
Department of Health Care Policy & Financing

MEDICAID PILOT
PDN ACUITY TOOL

TO: All potential Private Duty Nursing Providers

FROM: Janet L. Dauman, BSN, Program Administrator Home Health, Hospice, and Private Duty Nursing DATE: November 13, 2003

The Department is piloting the use of an Acuity Tool as a result of last year's legislative interest in the Private Duty Nursing (PDN) program. The purpose of the tool is two-fold. It is important to collect data about the needs of the clients in the program. It is also important to determine the appropriate number of hours of service for Private Duty Nursing clients. This information will allow us to defend the cost of PDN while demonstrating the ability to utilize the benefit for the most needy.

Based upon the PDN regulations and medical necessity criteria for the program, the sections of the Acuity Tool have an impact upon the amount of care necessary. Providers are requested to utilize the Tool for each new admission into Private Duty Nursing for a period of at least six (6) months. This Tool will not replace any of the currently required paperwork. You should send the Tool in with the remainder of your paperwork to Dual Diagnosis Management.

The Acuity Tool is designed to be easy to use. Just circle the points to the left of the skill needed for the client's care. When finished, add down the columns of points, and then across the bottom of the page from left to right. Add the subtotals together for the grand total.

Thank you for your participation in this Pilot Acuity Tool.

PDN ACUITY SCALE

Grand Total Points

MEMBER NAME..... HEALTH FIRST COLORADO ID..... DATE.....

POINT	CARE ELEMENT	POINT	CARE ELEMENT	POINT	CARE ELEMENT
WEIGHT- choose one		***MOBILTY***		***SLEEP***	
.5	<65 lbs. No or partial lift	1	Back brace	1	Awake<3x/noc
1	>100 lbs. No or partial lift	1.5	fracture or cast-UE	1.5	awake>3x/noc
1	<55 lbs. Total lift	2	fracture or cast-LE	1.25	sleep hours< 5 consecutive
2	>55 lbs total lift	2	body cast	2	sleep hours< 3 consecutive
2.5	>125lbs partial or total lift	1.5	missing limb	***ELIMINATION***	
NUTRITION		1.5	short/dysfunctional limb	.5	Incontinent stool occasionally
1	special diet or prolonged oral feeding	.5	AFOs/splints/orthotics	1.5	Incontinent stool daily
1.5	reflux/dysphagia	1	OT/PT daily regimen (not ROM)	.5	Incontinent urine occasionally
1.5	NGT	2	walker/WC/crutch dep.	1.25	Incontinent urine daily
1.5	Gastrostomy	1	ROM	1	Trip training(Bowel/Bladder)
2	enteral pump	1.5	turn>Q2H	2	total assist. Perineal care
INTEGUMENTARY		1.25	lift device	1.5	urinary catheter
1	stoma	***NEUROLOGICAL***		****	peritoneal dialysis
1.5	wound care general	1	seizures mild, min. mgmt.	***COMMUNICATION***	
				(see last page for more)	
2	decubitus care	1.5	seizures mod., med. Admin.	1	Communication limited difficulty communicating needs expressive/receptive/augmented
2	bum care	I	intervene>3x/wk	2	Non-verbal Unable to communicate needs
2	complex dressing	1.5	intervene daily		
1	skin treatment > q4h	2	seizures severe, Meds/airway/injury		
		1.5	Palsies		
	Subtotal		Subtotal		Subtotal

NARRATIVE:

INSTRUCTIONS: circle points to the left of the client care need, add down each column to the subtotal, add subtotals both pages for grand total.
15-25 points=basic care 4-&hrs/day 35-40 points=high care 14-20hrs/day
25-35 points=moderate care 8-14hrs/day >40 points=intense up to 24hrs/day
NOTES: < means less than;> means greater than; ****Automatic Intense; *Give points for each type of assessment/Neb/CPT; ** Give points for each IV or blood draw to max. 10 points

POINT	CARE ELEMENT
HYDRATION/SPECIALTY CARE	
2	PIV/GT/Enteral therapy <q4h
1.5	PIV/GT/Enteral therapy >q4h
2	PIV/GT/Ent. therapy cont.>4hrs
1.5	PIV/GT/Ent. therapy intermittent
2.5	TPN central
2	central line care
I	blood product admin q month
2	IV pain control
1	lab draw ea. Peripheral
1.5	lab draw ea. Central
2	chemotherapy IV or injection
ASSESSMENTS	
1	general assess q visit
1.5	Intermittent asses (mod.)
2	continual assess. Line of sight
I	min. 3 hr/wk RN manager intervent (Lab, MD contact, care planning).
2	> 3hr/wk RN manager intervention
1	assess VS/neuro/resp/GIq8h
1.5	assess VS/neuro/resp/GI q4h
2	assess VS/neuro/resp/GIq2Mess
1	attend community activity w/RN

POINT	CARE ELEMENT
AIRWAY MANAGEMENT	
1	tracheostomy
1	oxygen, continuous>4hrs
.5	oxygen, intermittent/week
.5	PRN oxygen
.5	humidification
.5	oronasal suctioning intermit.
1	tracheal suctioning occasional
1.5	tracheal suctioning >q3h
2	CPAP
3.5	Ventilator
****	respiratory effort absent
2	SIMV < 10hrs/day
3	SIMV > IO hrs/day
1	Vent on standby
2	respiratory assist mode
1	aspiration prec.
1.5	apnea
1	pulse oximetry
DEVELOPMENTAL	
1	developmental delay<4yrs
1	developmental disability 4-+ years old (biological age)

POINT	CARE ELEMENT
MED. ADMINISTRATION	
I	Injectable med. <lx/wk
1.5	Injectable med. >lx/wk
1.5	complex med admin, and/or RX>q2hr intervals
I	routine med admin
.5	CPT or Nebulizer>q4h
1	CPT or Nebulizer>q2h
ACUTE CARE EPISODES	
2	New or revised trach within 30 days
2.5	abdominal surgery within 45 days
1.5	bone surgery within 45 d
2.5	ventricular shunt new or revised within 30 days
ORIENTATION/BEHAVIORS/COGNITION	
.5	oriented
1	<x3
1.5	Confused
2	Cognitive impaired-ADL interference
1.5	cognitive impaired- dependent/uncooperative
.5	combative
1	requires occasional redirection
1	req. frequent redirection
1.5	self-abusive behavior mild-no injury
2	self-abusive behavior moderate-injury
	self-abusive beh. severe injury/intervention

ACUTE INTERVENTION CA'T'EGORY	
2	LOW-routine care manages symptoms Well with Minimal risk of acute care
5	MODERATE-routine care with adjustments based on nurse assess and Interventions reduce risk of acute care
1	1-IlGH-course of care with adjustment based on nurse
0	assess significantlv reduces riskofacute care

SENSORY DEFICITS	
.5	visual
.5	auditory
.5	Tactile

	Subtotal		Subtotal		Subtotal

NARRATIVE:

MEMBER NAME

COMMUNICATION PATTERNS If rated a three in any one of these choices then score an additional 2 points.

Hearing
0=hears adequately
1=minimal difficulty
2=hears in special situations only
3=highly impaired/absence of useful hearing

Communication Devices/Techniques
Hearing aid
Other receptive techniques used (e.g.lip reading)

Modes of expression
Speech
Signs/gestures/sounds
Writing Communication
Board
American Sign Language or Braille
Dynavox or other device

Making self understood
0=understood
1=usually understood-difficulty finding words or finishing thoughts
2=sometimes understood-ability is limited to making concrete requests
3=rarely/ never understood

Speech Clarity
0=clear speech
1=unclear speech-slurred, mumbled words 2=no speech-absence of spoken words 3=unable to make needs known by any means

Ability to Understand
0=understands
1=usually understands-may miss some part/intent of message
2=sometimes understands-responds adequately to simple, direct communication
3=rarely/never understands