



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
<i>WEIGHT- choose one</i>	<i>MOBILITY</i>	<i>SLEEP</i>
.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	<i>ELIMINATION</i>
<i>NUTRITION</i>	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
<i>INTEGUMENTARY</i>	1.25 lift device	1.5 urinary catheter
1 stoma	<i>NEUROLOGICAL</i>	**** peritoneal dialysis
1.5 wound care general	1 seizures mild, min. mgmt.	<i>COMMUNICATION</i>
2 decubitus care	1.5 seizures mod., med. Admin.	<i>(see last page for more)</i>
2 bum care	1 intervene>3x/wk	1 Communication limited difficulty communicating needs expressive/receptive/augmented
2 complex dressing	1.5 intervene daily	2 Non-verbal Unable to communicate needs
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	POINT	CARE ELEMENT	POINT	CARE ELEMENT
HYDRATION/SPECIALTY CARE		AIRWAY MANAGEMENT		MED. ADMINISTRATION	
2	PIV/GT/Enteral therapy <q4h	1	tracheostomy	I	Injectable med. <lx/wk
1.5	PIV/GT/Enteral therapy >q4h	1	oxygen, continuous>4hrs	1.5	Injectable med. >lx/wk
2	PIV/GT/Ent. therapy cont.>4hrs	.5	oxygen, intermittent/week	1.5	complex med admin, and/or RX>q2hr intervals
1.5	PIV/GT/Ent. therapyintermittent	.5	PRN oxygen	I	routine med admin
2.5	TPN central	.5	humidification	.5	CPT or Nebulizer>q4h
2	central line care	.5	oronasal suctioning intermit.	1	CPT or Nebulizer>q2h
I	blood product admin q month	1	tracheal suctioning occasional	ACUTE CARE EPISODES	
2	IV pain control	1.5	tracheal suctioning >q3h	2	New or revised trach within 30 days
1	lab draw ea. Peripheral	2	CPAP	2.5	abdominal surgery within 45 days
1.5	lab draw ea. Central	3.5	Ventilator	1.5	bone surgery within 45 d
2	chemotherapy IV or injection	****	respiratory effort absent	2.5	ventricular shunt new or revised within 30 days
ASSESSMENTS		2	SIMV < 10hrs/day	ORIENTATION/BEHAVIORS/COGNITION	
1	general assess q visit	3	SIMV > 10hrs/day	.5	oriented
1.5	Intermittent asses(mod.)	1	Vent on standby	1	<x3
2	continual assess. Line of sight	2	respiratory assist mode	1.5	Confused
I	min. 3 hr/wkRN manager intervent (Lab, MD contact, care planning).	1	aspiration prec.	2	Cognitive impaired-ADL interference
2	> 3hr/wk RN manager intervention	1.5	apnea	1.5	cognitive impaired- dependent/uncooperative
1	assess VS/neuro/resp/GIq8h	1	pulse oximetry	1.5	combative
1.5	assess VS/neuro/resp/GIq4h	DEVELOPMENTAL		1	requires occasional redirection
2	assess VS/neuro/resp/GIq2Mess	1	developmental delay<4yrs	1	req. frequent redirection
1	attend community activity w/RN	1	developmental disability 4-+ years old (biological age)	1.5	self-abusive behavior mild-no injury
ACUTE INTERVENTION CA'TEGORY		SENSORY DEFICITS		1.5	self-abusive behavior moderate-injury
2	LOW-routine care manages symptoms Well with Minimal risk of acute care	.5	visual	2	self-abusive beh. severe injury/intervention
5	MODERATE-routine care with adjustments based on nurse assess and Interventions reduce risk of acute care	.5	auditory		
1	1-HIGH-course of care with adjustment based on nurse	.5	Tactile		
0	assess significantly reduces risk of acute care				
I Subtotal		I 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

