MAHSO

MARKET AREA HEALTH SYSTEMS OPTIMIZATION

National Planning Strategy

Geriatrics

September 2021

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Executive Summary

The Department of Veterans Affairs (VA) Market Area Health Systems Optimization (MAHSO) effort developed 96 draft market assessments in the 18 VA Veterans Integrated Service Networks (VISNs) to produce opportunities for the design of high-performing integrated delivery networks. These market assessments were required by the VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018.

These market assessments will culminate with a report to the Asset and Infrastructure Review (AIR) Commission that will present Veterans Health Administration's (VHA's) plan for the future of VA health care, enabling Veterans to access the right high-quality care in the right location. Recommendations from the market assessments will be finalized and submitted by the Secretary of VA to the presidentially appointed AIR Commission for consideration. The AIR Commission will submit its recommendations to the President for review and approval, prior to the recommendations going to Congress for review and approval.

This Geriatrics National Planning Strategy establishes a consistent set of guidelines which will help to develop the opportunities that are specific to Geriatrics services. Using comprehensive VA data, the guidelines can facilitate improved alignment of special patient populations and home and community-based services capacity and capabilities with the evolving needs of Veterans.

The VHA Chief Strategy Office, committed to working with offices across the organization to create programs and services that best serve Veterans, developed the Geriatrics National Planning Strategy in consultation with the Offices of Geriatrics and Extended Care (GEC), Mental Health and Suicide Prevention, and Women's Health.

Geriatrics Program Overview

Common health care system challenges include balancing capacity with current and future demand; managing admission rates and wait times; optimizing inpatient length of stay and quality of care; and maximizing bed utilization. Additionally, VA must plan, fund, construct, and activate new programs across the various sites of care.

The GEC Program Mission is to honor Veterans' preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise, programs, and partnerships.

GEC oversees access to long-term services and supports (LTSS) in facilities, Veterans' homes, and the community. This includes facilitating aging in place with equitable access to necessary home care services, and accessible facility-based care if needed.

The March 2021 Community Living Centers (CLC) National Planning Strategy report focused on planning guidelines for opening new, maintaining/resizing, and relocating/modernizing CLCs. This follow-on Geriatrics National Planning Strategy provides recommended guidelines on improving consistent access to home and community-based services (HCBS) and organizing geriatric expertise and CLC beds to care for special patient populations.

Veterans identified as being vulnerable due to medical challenges, comorbidities, behavioral issues, and social risk factors are categorized in this report as special patient populations. Complex care seeks to improve the health and well-being of a relatively small, heterogenous group of individuals who repeatedly cycle through multiple health care and social systems without deriving lasting benefit factors. [1] The term “complex” is a component of the special populations.

Resulting Planning Guidelines

Planning guidelines and thresholds inform products of the market assessment process. The rationale for establishing VA planning guidelines and thresholds is rooted in the belief that quality of care or patient safety may be compromised when a service falls below identified measures.

VA is working to shift funding from facility-based to home and community-based care, an effort known as rebalancing. [2] Eleven different HCBS programs seek to address growing demand, often through purchased services. Specific planning guidelines for two HCBS programs, **Home-Based Primary Care (HBPC)** and **Veteran-Directed Care**, were developed with GEC.

The planning priority for special patient populations, including those requiring complex care, is to improve consistency of care for Veterans living in CLCs with care needs organized into the following categories:

- Neurocognitive/Dementia
- Mental Health
- Rehabilitation
- Ventilator-Dependent
- Women Veterans

The expectation is that all CLCs can accommodate residents with any diagnosis or clinical need. **Specialty-Focused Neighborhoods** can cohort residents within these categories to leverage staff expertise and resources. **Special Patient Population Clinical Resource Centers (CRC),** conceptually best located in dense urban areas with strong clinical resource capabilities and limited staff recruiting challenges, can provide geriatric expertise and training to CLCs within their VISN, as needed.

The Geriatrics National Planning Strategy developed quantitative and qualitative planning guidelines across demand, supply, access, quality, and other applicable domains for each service type. A summary of the primary demand planning guidelines for HCBS and complex special patient populations is as follows:

Geriatrics Planning Guidelines

Service	Primary Planning Guideline
Home-Based Primary Care (HBPC)	• Ten-year projected high risk/high need population is 50 or more Veterans within a 60-minute drive time from geographic information systems (GIS)-identified VA facilities
Veteran-Directed Care	• Expand availability to all VA Medical Centers (VAMCs)
Specialty-Focused Neighborhood within a CLC	• Ten-year projected average daily census (ADC) is ≥3.6 (four beds) • Ten-year projected ADC for the specialty service is ≥3.6 (four beds) ○ May be more than one in each market, facility
Clinical Resource Center (CRC) within a CLC	• Ten-year projected ADC is >14.4 (16 beds), with flexibility for lower in less densely populated VISNs ○ At least one per VISN for Neurocognitive/Dementia, Mental Health, and Rehabilitation

Future Program Planning

The four-step process for revisiting MAHSO draft opportunities describes how Geriatrics-specific market assessment opportunities will be reviewed and updated, if necessary:

1. Review Phase 1-3 market assessment data and Geriatrics opportunities.
2. Apply Geriatrics planning guidelines.
3. Update Geriatrics opportunities.
4. Review and finalize opportunities with VA Leadership.

VA will use the national planning guidelines to apply standard programmatic criteria to major strategic opportunities identified in the market assessments. The planning guidelines will also inform future quadrennial market assessments and other long-range planning exercises.

Conclusion

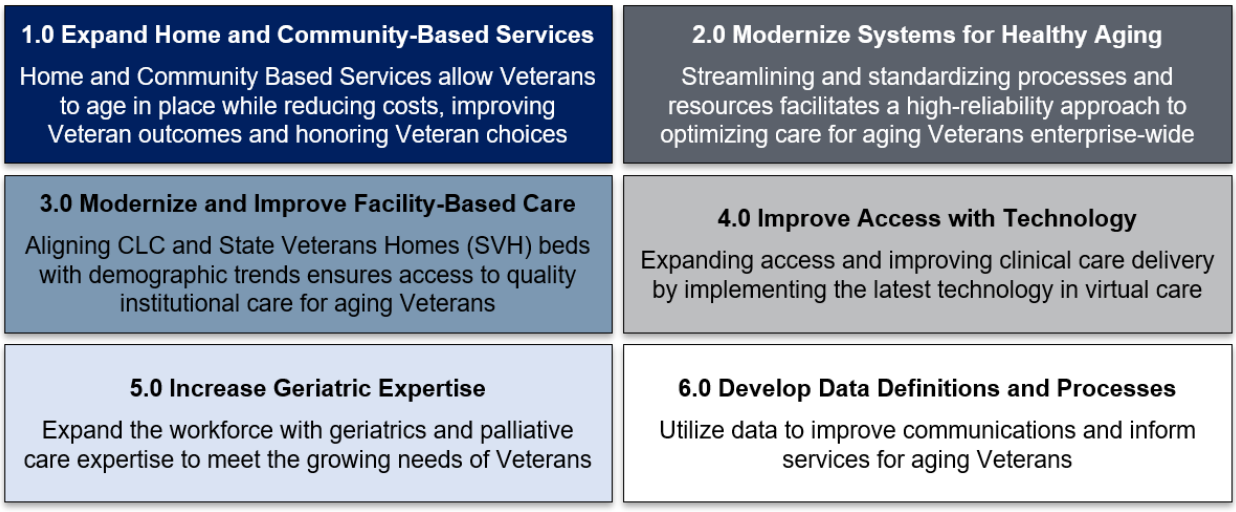
The National Planning Strategy guidelines and thresholds are to be support efforts to match capacity planning to Veteran demand and establish sound, Veteran-centric recommendations to inform and support the development of the AIR Commission Report. They are also intended to add to existing VA planning guidelines and be used for future planning activities.

1. Program Overview

There continues to be great interest from Veterans to seek out their care closer to home and their caregiver support system. The aging of Veterans, together with an increasing need for complex care with special populations, requires action to better prepare for and deploy resources. [3] VA vision for geriatrics and long-term care is to honor Veterans' preferences to age in place, with equitable access to home care services necessary to support Veterans in their choices safely. Achieving this vision requires providing a full range of services with accessibility to well-trained clinical staff to support Veteran needs across the continuum of care that include modern, facility-based care, should Veterans need it. [4]

VA is transforming how geriatric care is provided across the continuum. VA's Elder Care strategy seeks to shift from a more facility-based delivery system to one that supports the independence of Veterans and aging in place as long as possible, with appropriate Home and Community-Based Services (HCBS), virtual care, and innovative geriatric models of care. When facility-based services are needed for rehabilitation, palliative care, respite, or long-term care, VA can provide state of the art facility-based care. [5]

Figure 1: *Geriatrics and Extended Care Program Office Elder Care Strategy, 2021*



Source: Geriatrics and Extended Care (GEC) Program Office, 2021

Since the 1960s, VA has been authorized to provide long-term services and support (LTSS) to eligible Veterans in various settings, including their home, VA facilities, private nursing facilities contracted by VA, and State Veterans Homes. [6] In 1990, VA began reassessing the care it provided to aging Veterans and recognized the need to provide a continuum of care rather than discrete care settings. In the landmark 1998 report, "*VA Long Term Care at the Crossroads*," a shift in LTSS from inpatient facilities to home and community-based settings was recommended. [7] This shift was further

supported by the Veterans Millennium Health Care and Benefits Act of 1999, which set forth Congressionally-mandated benefits of home and community-based LTSS for all enrolled Veterans along with nursing home benefits for select Veterans [8]. In 2019, VA instituted the MISSION Act which gives Veterans even greater access to health care in VA facilities and the community. While the MISSION Act does not include specific access requirements for long-term extended care services, the shift to home and community-based settings coincides with the aging of Veterans, skilled workforce shortages, and Veteran-centered care.

1.1 Program Mission

VA's Geriatrics and Extended Care (GEC) Program Office mission is to honor Veterans' preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise, programs, and partnerships [9]. To support this mission, VA offers a variety of Veteran-centric long-term care services that focus on optimizing the health, independence, and well-being of Veterans.

VA strives to increase the delivery of LTSS in home and community-based settings, and to reduce preventable hospital and nursing home stays and emergency department visits. They also continue to focus on improving care quality and enhancing the experiences of Veterans through optimal care coordination and management, especially when home care is needed or during transitions between care settings. [10]

Opportunity Statement

The Geriatrics National Planning Strategy expands upon the previously completed CLC National Planning Strategy. That report, created in conjunction with the GEC program office, established a framework that provides a consistent service delivery planning methodology. The CLC report contains additional background information and guidelines to address the maldistribution of VA long-term facility-based care. It includes a rubric on establishing or relocating new sites, re-sizing and modernizing or replacing aging infrastructure, and recommends investing in state-of-the-art CLC facilities.

During the CLC National Planning Strategy development, Veterans Integrated Service Network (VISN) and market leaders shared their challenges with placing and caring for complex special population patients. This Geriatrics National Planning Strategy recommends organizing principles for this population to help planners allocate future CLC beds by addressing three key areas:

- Clinical profiles of special Veteran patient populations including those with complex needs;
- Utilization patterns of special Veteran patient populations including those with complex needs; and
- Market-specific restructuring approaches to best meet the current and future demand of special Veteran patient populations including those with complex needs.

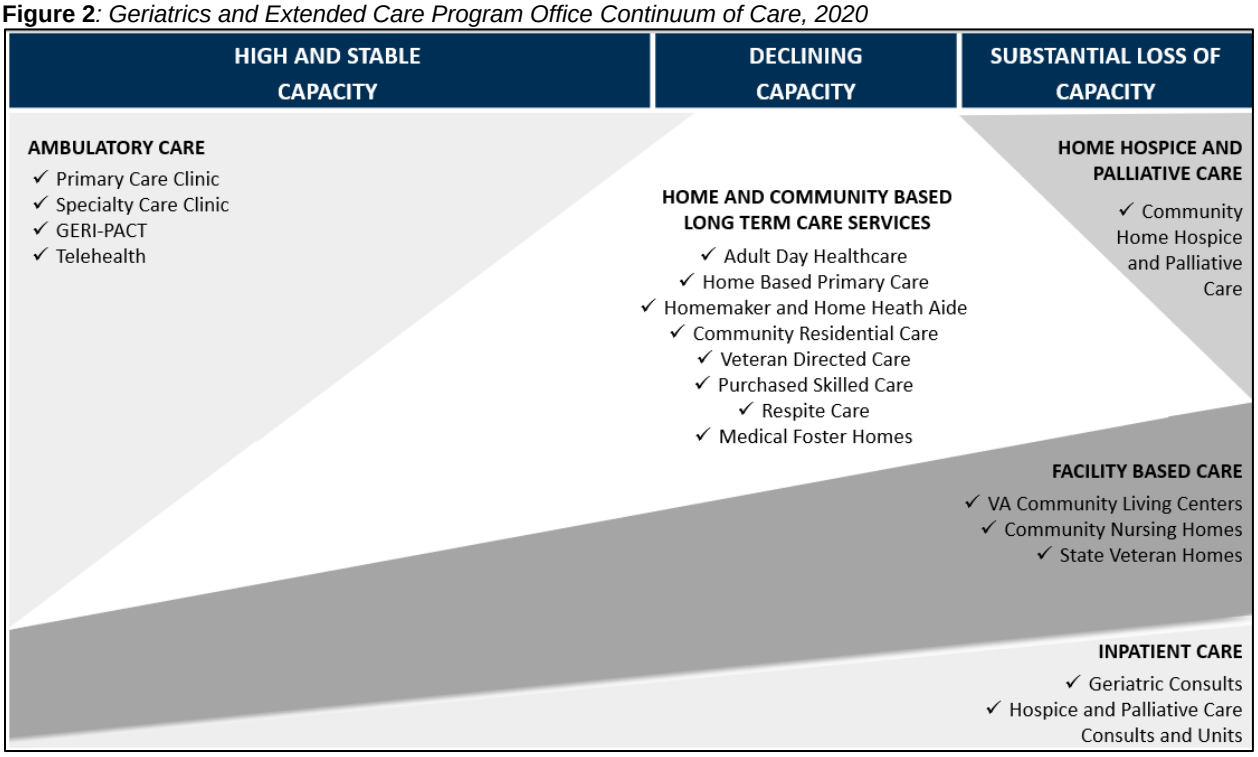
The special patient population cohorts identified are sub-sets of the overall CLC bed need projections, and guidelines from this strategy will not change the previously published CLC National Planning Strategy.

A secondary opportunity identified in the previous work was improving the consistency of HCBS usage. This Geriatrics National Planning Strategy includes some recommended guidelines to expand HCBS across the network.

2. Current State Overview

Since the 1990s, Congress has authorized VA to provide a variety of facility-based and home and community-based services to ensure Veterans receive the necessary LTSS in the least restrictive environment. [11] The GEC Veteran-Centered Framework reflects VA's continuum of LTSS that supports whole health and independence for aging Veterans. [12] As Veterans age, early detection and management of age-related health issues are important to promote self-management of care. The identification of community support services enables and empowers Veterans and their families to live as they choose in their settings of choice. Home and community-based services help Veterans and their caregivers manage progressing health conditions while remaining as independent as possible within their homes. For those who are unable to remain safely at home, there are a variety of options for Veterans including CLCs, State Veterans Homes (SVH), and Community Nursing Homes (CNH).

Figure 2*: Geriatrics and Extended Care Program Office Continuum of Care, 2020*



Source: GEC Strategic and Vision, 2020

2.1 Demographic and Programmatic Distribution Analysis

Home and Community-Based Services Characteristics

The Centers for Disease Control and Prevention (CDC) defines aging in place as "the ability to live in one's own home and community safely, and comfortably, regardless of age, income, or ability level." [13] A 2020 Aging in Place survey found that 90% of seniors intend to remain in their current homes for the next five to 10 years, rather than move to facility-based care. [14] VA planners can extrapolate this preference expressed by the general population to the Veteran enrollee population.

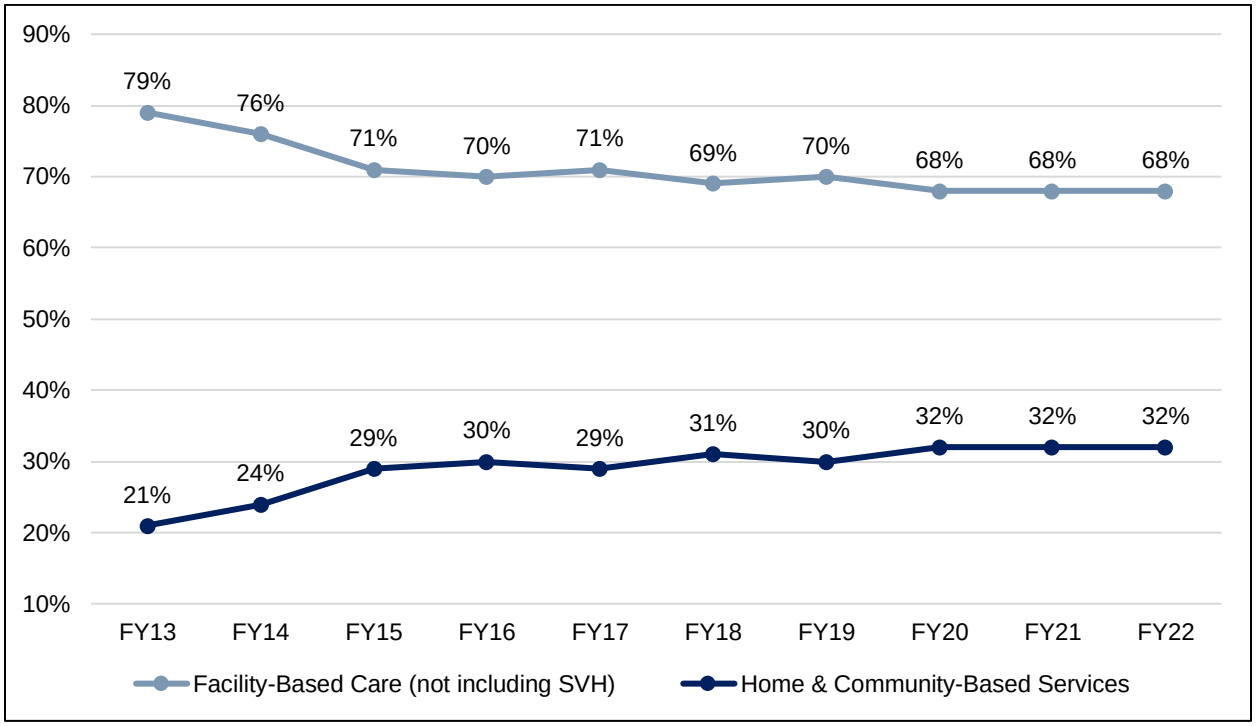
VA provides or purchases a variety of HCBS for Veterans, with key services summarized below, and detailed descriptions provided in Appendix B.

- **Home-Based Primary Care (HBPC):** VA teams provide coordinated interdisciplinary primary care to high need/high risk Veterans in their homes.
- **Homemaker/Home Health Aide (H/HHA):** Trained home health aides assist Veterans with daily activities in their homes. The aides are supervised by registered nurses. This is a purchased service.
- **Skilled Home Health Care:** Community-based home health agencies perform services including nursing, case management, physical/occupational/speech therapy, wound care, and infusions.
- **VA Adult Day Health Care (ADHC):** Veterans attend day programs for health monitoring, socialization, peer interactions, companionship, and recreation. Services provide respite to caregivers.
- **Community ADHC:** Purchased service, similar to VA programs provided by community agencies.
- **Palliative Care:** Comfort care to control symptoms and relieve suffering.
- **Home Hospice Care:** Palliative care and symptom management during the final six months of life.
- **Spinal Cord Injury and Disease (SCI/D) Home Care:** VA health care teams located at VAMCs that are SCI/D hubs provide services to Veterans in their homes.
- **Veteran-Directed Care:** Veterans are provided a flexible budget to purchase goods and services that allow them to manage and direct their own care as they age at home.
- **Home Respite Care**: A purchased service that temporarily relieves caregivers of responsibilities. The Veteran may attend an ADHC program, or a relief caregiver, such as an aide, provides care in the home environment.

- **Medical Foster Home:** A private home in which a VA-approved Medical Foster Home caregiver provides care to Veteran residents. No more than three Veterans are permitted per home. Caregivers provide 24-hour care and supervision and are enrolled in VA Home Based Primary Care to assist with medical monitoring. Veteran is responsible for payment of this care.

The first three programs account for more than 95% of all VA HCBS expenditures, totaling approximately $2.4 billion annually. Findings from the CLC National Planning Strategy suggest a 10% increase in expenditures over the past several years, while facility-based care expenditures decreased by 11% as documented in Figure 3 below.

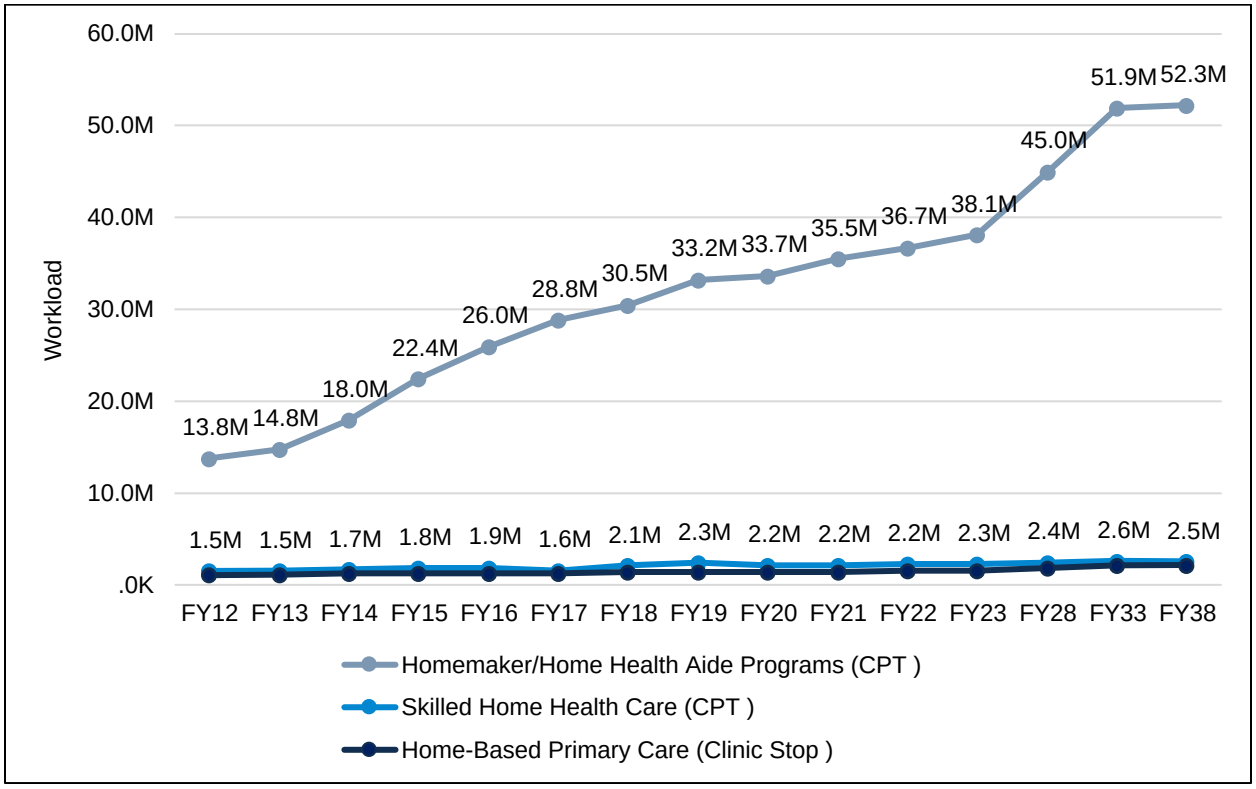
Figure 3: *VA LTSS Expenditures Fiscal Year (FY) 2013-22*



Source: GEC Elder Care Sequester Presentation, May 2021

VA anticipates HCBS demand to continue increasing until at least fiscal year (FY) 2038, with a projected 51% growth in all services from FY 2020-38. Projected workload for the top three programs, Homemaker/Home Health Aide (H/HHA) and Skilled Home Health Care, which are measured by current procedural terminology (CPT) codes, and HBPC, which is measured by clinic stops, is summarized in Figure 4.

Figure 4*: VA HCBS Utilization FY 2012-38*



Source: VA Enrollee Health Care Projection Model, 2020
*Based on CPT codes for Homemaker/Home Health Aide and Skilled Home Health Care and Clinic Stops for Home-Based Primary Care.

Special Patient Population Characteristics

Special patient populations are not specifically labeled as such in the clinical documentation. This report profiles special patient populations using primary diagnosis data provided by VA. The data reflect CLC resident information for FY 2019 and includes nearly 32,000 patient records, but the data do not include additional complex acute mental health patients that may require complex care ultimately in a long-term care setting. Each patient is assigned an International Classification of Disease, 10th Revision (ICD-10) code corresponding to their primary diagnosis. Three hundred thirty-one codes are incorporated into the four complex special patient population profiles. A detailed list with codes in each special patient population profile is included in Appendix G. A summary of diagnoses included in the four profiles are as follows:

- **Neurocognitive/Dementia diagnoses (25 codes) include:** Dementia, unspecified and vascular, with or without behavioral disturbance; Alzheimer's Disease; Parkinson's Disease; and Huntington's Disease.
- **Mental Health diagnosis (69 codes) include:** Serious mental illness, to include schizophrenia and psychotic disorders, bipolar disorder, major and other depressive disorders; and posttraumatic stress disorder.

- **Rehabilitation diagnoses (100 codes) include:** Paralysis; amputation; aftercare of any surgery; and aftercare of any cerebral injury.
- **Ventilator Dependent diagnoses (137 codes) include:** Spinal cord injury and disease; and amyotrophic lateral sclerosis (ALS).

Each record only represents the primary diagnosis, assumed to be at time of admission. This excludes secondary diagnoses which may better reflect resident conditions. The GEC, Office of Mental Health and Suicide Prevention, and Office of Women's Health stakeholders noted that mental health conditions are often co-occurring diagnoses, and the data likely understate the prevalence of mental illness among CLC residents. In addition, these categories are not mutually exclusive. For example, many individuals with neurocognitive disorders also have mental illness.

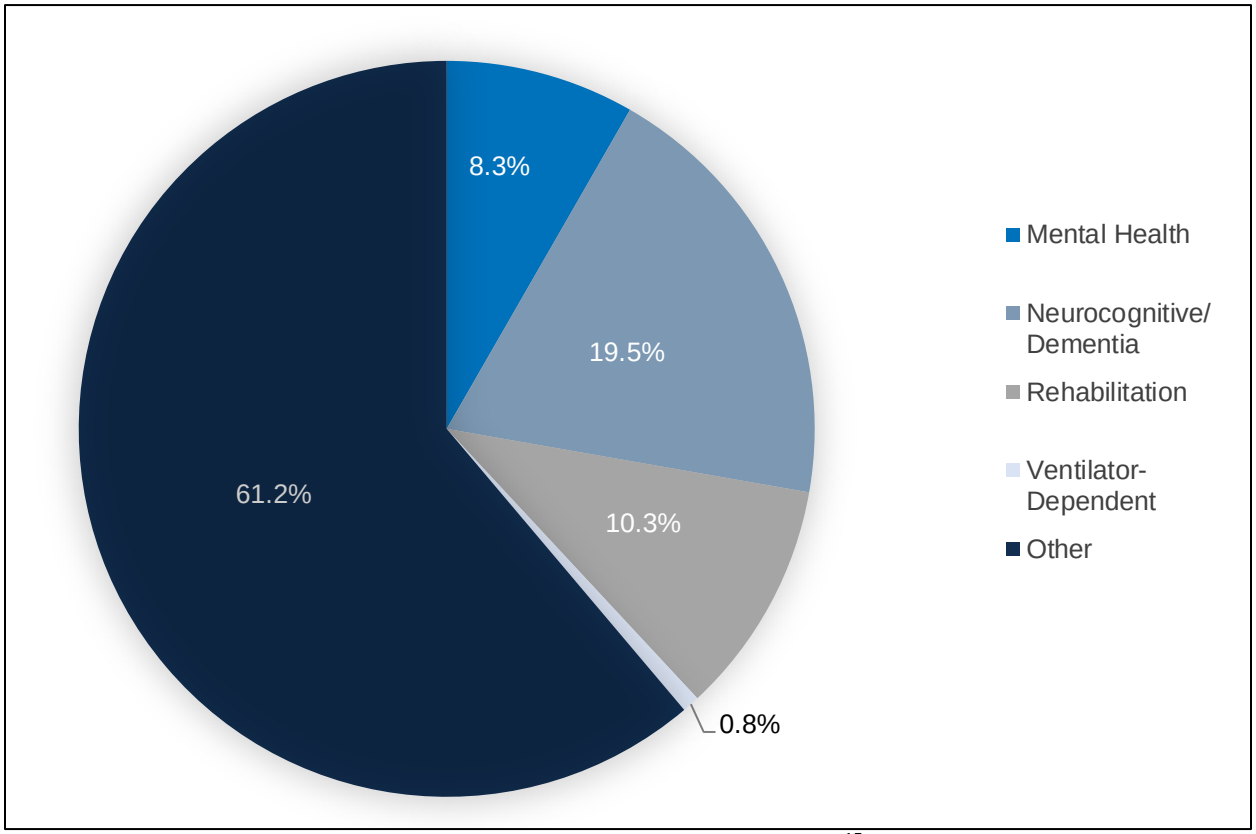
Social factors such as legal guardianship and homelessness were also considered as potential population cohorts, but data quantifying the number of residents facing those challenges was not readily available. This approach would also suggest that these social factors are a direct cause for admission, but that is not always true. If a Veteran's long-term and clinical needs can be met in a less restrictive setting than a CLC, the least restrictive setting of the Veteran's choosing is preferred.

Veterans receiving hospice/palliative care were also discussed as a potential cohort, but discussions with GEC, Office of Mental Health and Suicide Prevention, and Office of Women's Health stakeholders revealed the philosophy for hospice/palliative care is to deliver that service to patients in the settings they choose, wherever that may be.

During FY 2019, approximately 39% of the average daily census (ADC) of CLC residents had a primary diagnosis that aligned with one of the special patient population profiles. Neurocognitive/ Dementia was the most prevalent, followed by Rehabilitation, Mental Health, and Ventilator-Dependent conditions.

The remainder of the CLC population, approximately 61%, were assigned a primary diagnosis other than those included in the four profiles. This population is comprised of Veterans with primary conditions such as cancer, heart disease, respiratory illnesses, bone fractures, substance abuse, dialysis, wound care, and other challenges. In addition, over 5,000 primary diagnoses for CLC residents were listed as Unknown.

Figure 5: *FY 2019 Community Living Center ADC of Special Patient Populations*



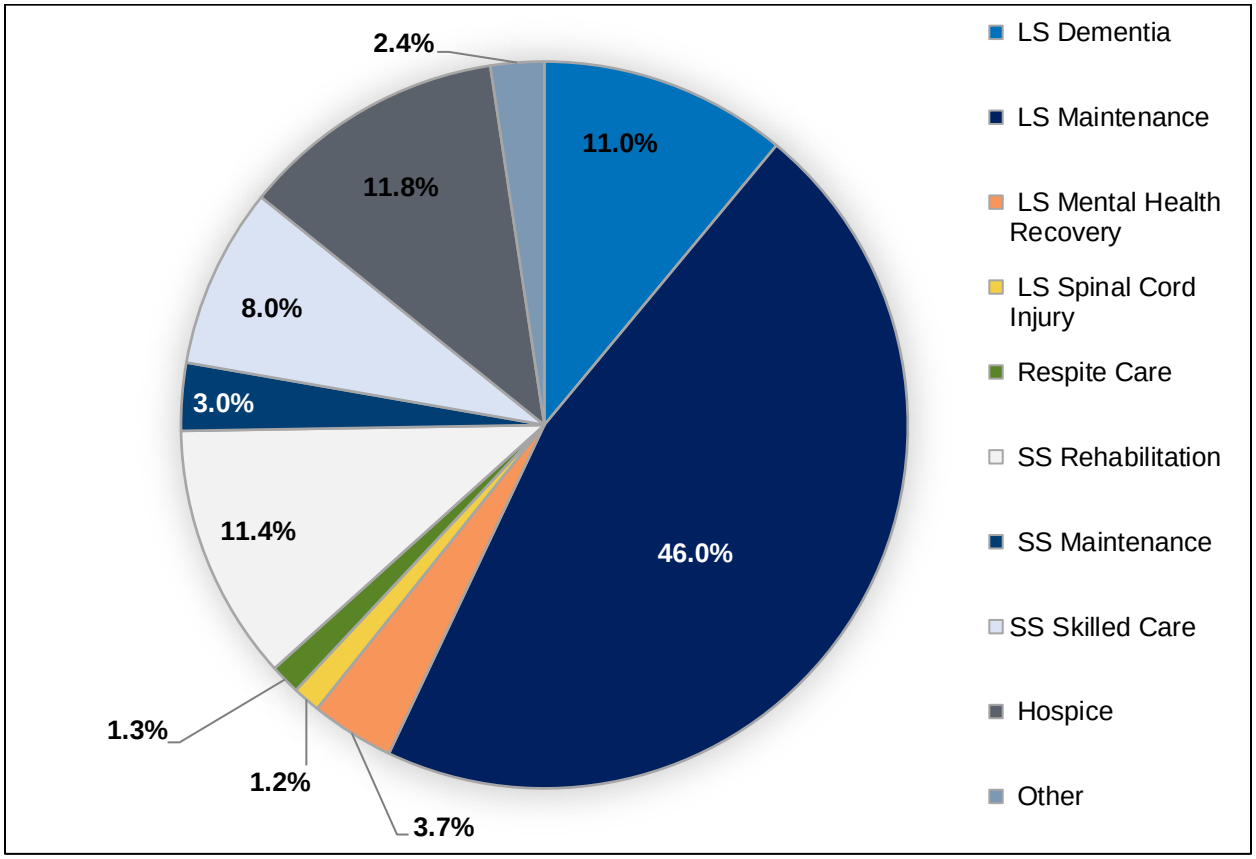
Source: VA Corporate Data Warehouse (CDW) Treating Specialty Cube, 2020 [15]

Another method of defining special patient populations is by treating specialty. VA frequently analyzes CLC workload data according to 13 distinct treating specialties. Residents may be assigned different specialties as their needs change.

Short Stay Treating Specialties	Long Stay Treating Specialties
Dementia Care	Dementia Care
Maintenance Care	Maintenance Care
Rehabilitation	Mental Health Recovery
Mental Health Recovery	Spinal Cord Injury
Restorative Care	
Skilled Nursing Care	
Geriatric Evaluation and Management	
Hospice	
Respite Care	

Long Stay Maintenance treating specialty is the most frequently used, representing nearly half the population on any given day. Given Long Stay Maintenance anecdotally includes a range of patients and services provided and appears to serve as a catch all suggests the staff are frequently caring for residents with a variety of long-term needs, it illustrates the challenge with leveraging data across treating specialties to cohort special patient populations.

Figure 6: *FY 2019 Community Living Center ADC by Treating Specialty*



Source: VA CDW Treating Specialty Cube, 2020

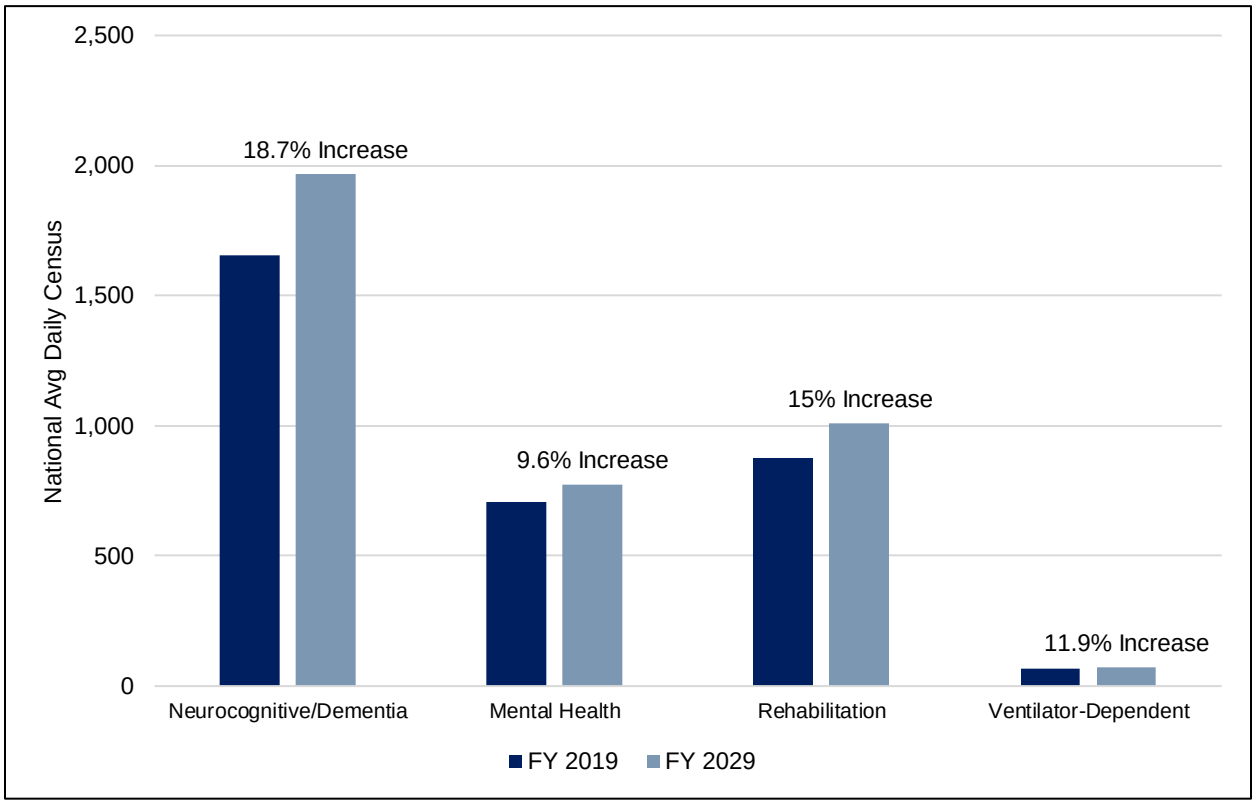
The next portion of the analysis considered how the number of special patient populations will change in the future. The VA Enrollee Health Care Projection Model (EHCPM) forecasts changes to FY 2029 based on age group and priority level, at the VISN and market levels. To estimate its effect on the special patient populations, two assumptions were applied:

- The number of special population patients will change at the same rate as priority 1 Veterans over the age of 65; and
- Utilization rates remain constant.

The potential for increased utilization rates for Mental Health special population patients was discussed, to accommodate unmet demand from inpatient platforms. Data were not available to quantify this potential increase, but the CLC report includes opportunities for additional CLC beds in the future, increasing overall capacity and flexibility to address this population.

The analysis estimated a special patient population ADC increase of approximately 16% by FY 2029.

Figure 7: FY 2019 and Estimated FY 2029 ADC by Special Populations



Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

Women Veteran Patient Characteristics

Women Veterans are another potential special population group identified. Unlike the commercial sector, where women represent more than 70% of facility-based long term care residents, [16] women Veterans represented less than 4% of the total CLC ADC population in FY 2019. However, based on the EHCPM, the number of priority 1 women Veterans over the age of 65 is projected to increase. Assuming the CLC population mirrors overall projected growth, an estimated 500 additional women will require CLC care on any given day by 2029. This shift is likely to heighten interest in women-only living arrangements or specialized women's units.

Table 1: *Estimated CLC Women Veteran Residents, Unique Patients and ADC, based on Projected Growth of Priority 1 65+ Population Veterans*

Measure	FY 2019		FY 2029		Increase
	Women	% of Total	Women	% of Total	
Unique Patients	1,261	6.5%	3,208	13.0%	1,947
ADC	321	3.6%	817	7.5%	496

Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

A woman-focused model may also offer social and health benefits to women accessing long-term care within a health system where they are consistently the minority gender. Being the minority gender can pose additional challenges for long-stay residents who seek a home-like environment and sense of belonging within the CLC setting. A women's only CLC, or dedicated neighborhood within a larger CLC, is a concept that may appeal to Veterans, particularly those with heightened fears of cohabitating with men because of sexual trauma, domestic/interpersonal violence, or other issues. A women's-only unit allows for more tailored delivery of health care to address the unique needs of women at the intersection of geriatric and gynecological care, with a focus on conditions that pose more frequent and higher risk to women. These units would likely and most ideally be staffed by women employees, especially those responsible for direct care, to promote a gender-focused setting.

Eligibility

The Veterans' Health Care Eligibility Reform Act of 1996 (Eligibility Reform Act) opened VHA enrollment to all Veterans and mandated that VA establish a priority-based enrollment system to manage access to care. VA's policy permits any eligible Veteran to sign up for health care services and potentially receive care from VA. Priority groups determine which eligible Veterans can access services and establishes rules for copayment of services and eligibility for additional health services. [17] Refer to Appendix C for additional information on VA priority groups.

VA provides LTSS to a range of enrolled Veterans, regardless of age. In 1999, the Veterans Millennium Health Care and Benefits Act (Millennium Act) required VA to provide home-based care and adult day health care to all enrolled Veterans. [8] The Act also mandated nursing home care benefits for eligible Veterans in need of long-term care for a service-connected disability and for Veterans who have a service-connected disability rating of 70% or more.

Priority level 1-3 enrollees, who tend to require greater health care services, are projected to increase from 53.4% of the enrollee population in FY 2019 to 74.9% by FY 2039. As enrollees continue to age and transition to higher priority levels, service demand and expenditures for facility-based care, which are not generally covered by private insurance or Medicare, will increase at VA. [18]

The number of Veterans with disability ratings of 70% or higher (labeled as Priority "1a" in VA data sets) is projected to increase dramatically from FY 2019-39. Priority 1a Veterans over the age of 65 are projected to increase 111.5%, from approximate 1.2 million to 2.6 million. The growth in the Priority 1a age 85 and older population is even more significant. This cohort is projected to increase 534.4%, from approximately 61,000 to 387,000.

Key Utilization Drivers

The projected increase of long-term care services is driven primarily by two enrollment dynamics that have a significant effect in both facility and HCBS settings: priority level transitions and the aging of the enrollee population. Along with the Millennium Act, the aging of the enrollee population is also having a significant effect on expenditures and utilization. Currently World War II and Korean War era enrollees are in the age bands that are the highest users of LTSS. Vietnam War era Veterans will be an increasing driver of LTSS, with most having aged beyond 75 by 2026.

2.2 Current VA Program Review and Analysis

Home and Community-Based Services

VA leverages geographic information systems (GIS) to identify Veterans living in remote areas who may benefit from HBPC services. GIS locations with 50 or more chronically ill Veterans within a 60-minute drive time are good candidates for HBPC resources, per GEC guidance.

GEC has three primary initiatives to increase HCBS utilization:

- Expand HBPC by 75 teams;
- Expand the Medical Foster Home program to all existing VA health care systems; and
- Expand the Veteran-Directed Care program to all existing VAMCs.

Availability of purchased Home and Community-Based Services varies widely by location. Some areas have robust resources in the commercial market, while others are underserved.

Special Patient Populations

VA currently provides facility-based care to special patient populations that are often complex or pays for their care in community nursing homes. There is currently no method of classifying them into special or complex categories within clinical documentation. Categories by diagnosis or treating specialty were identified as alternative approaches to capturing trending around a range of patient population cohorts. State Veteran Homes tend to accept mostly non-complex patients, according to GEC.

Categorization by diagnosis or treating specialty were identified as alternative approaches to capturing trending around a range of patient population cohorts. State Veteran Homes tend to accept mostly non-complex patients, according to GEC.

The previously developed CLC National Planning Strategy recommends a minimum of 16 operating beds for existing programs. This threshold is based on GEC guidance for efficient resourcing and operations. An ADC of 14.4 residents necessitates 16 beds, assuming 90% occupancy per VA space planning guidelines. These same planning parameters are applied to the special patient populations within CLCs, to determine where opportunities exist to cohort them into dedicated Clinical Resource Centers (CRC). GEC provided a planning framework for future CRCs, which includes the following characteristics:

- Typically located in large urban areas;
- Strong clinical resource capabilities and ability to recruit and retain staff;
- Have the potential to align with training/academic partners for train-the-trainer opportunities;
- Promotes evidence-based care; and
- Provides both in-person and virtual training to other CLCs.

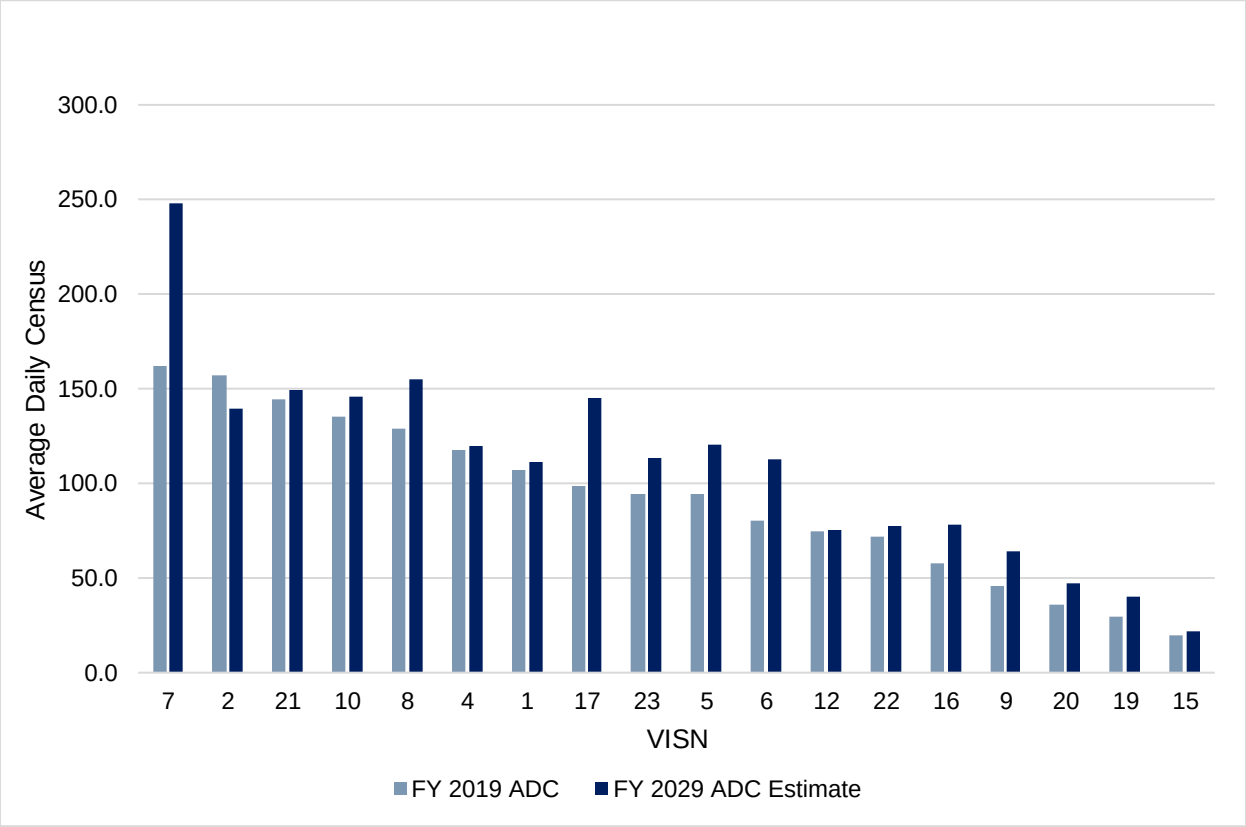
Geographical Distribution

VA's goal is to facilitate long-term care for Veterans within their communities. This fosters personal preference and promotes family caregiver involvement. It is important for VA to understand special patient population distribution to develop consistent planning guidelines.

Neurocognitive/Dementia

In FY 2019, the ADC of CLC residents with primary neurocognitive disorders/dementia diagnoses in each VISN ranged from 19.8 to 162.2, with VISNs 7, 2, and 21 recording the highest demand. By FY 2029, VISN 7's average daily census is estimated to reach 248 Veterans, with VISN 8 estimated at 155, and VISN 21 at 149.

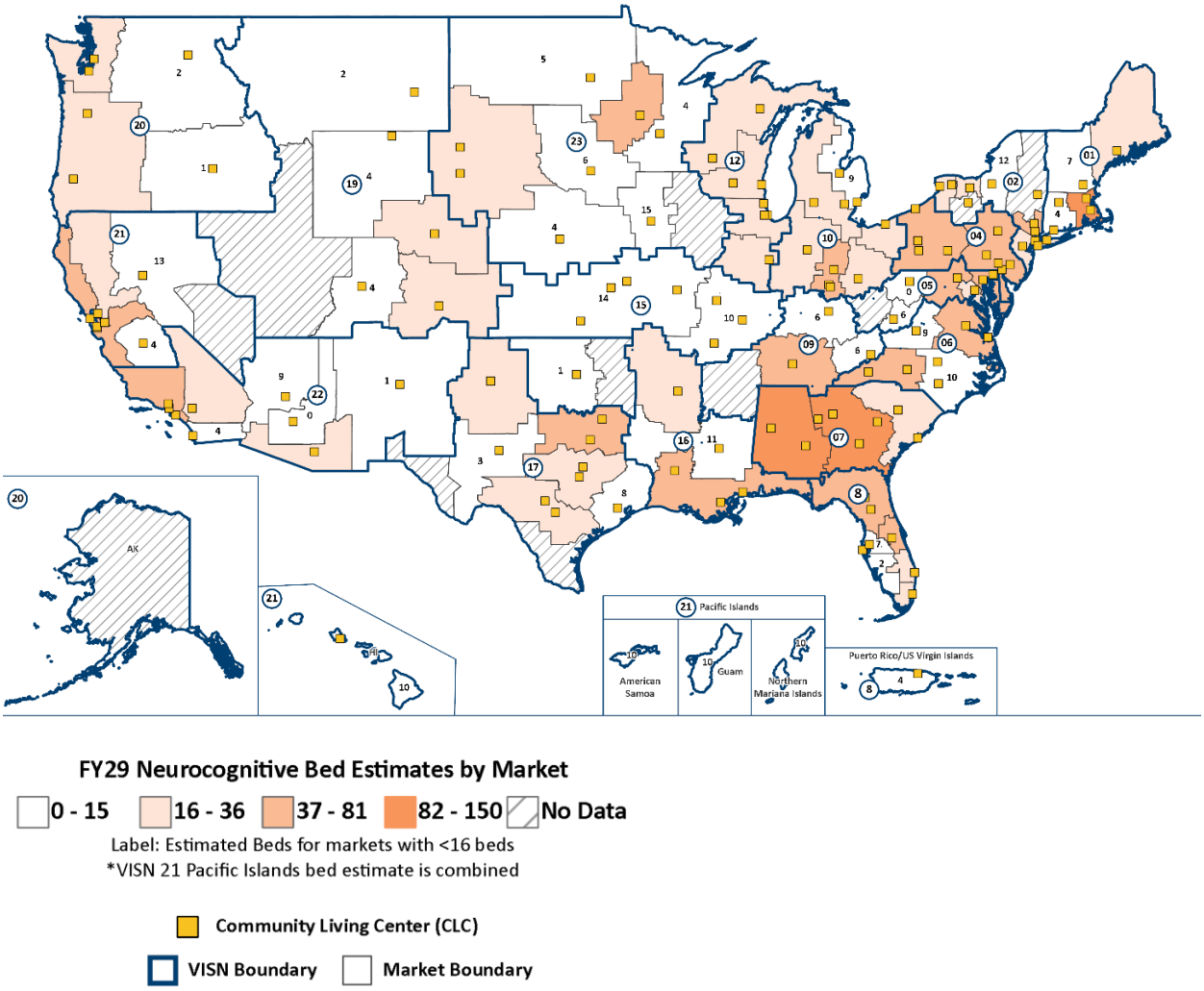
Figure 8: *Neurocognitive/Dementia Residents ADC by VISN*



Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

At the market level, by FY 2029, 49 of 96 markets are estimated to have at least 14.4 residents per day with neurocognitive disorders as their primary diagnosis. Two markets in VISN 7 (Georgia and Alabama) are estimated to require the most beds, followed by VISN 1 East, VISN 4 Eastern, and VISN 23 Minnesota Central.

Figure 9: *FY 2029 Neurocognitive/Dementia Bed Estimates by Market*



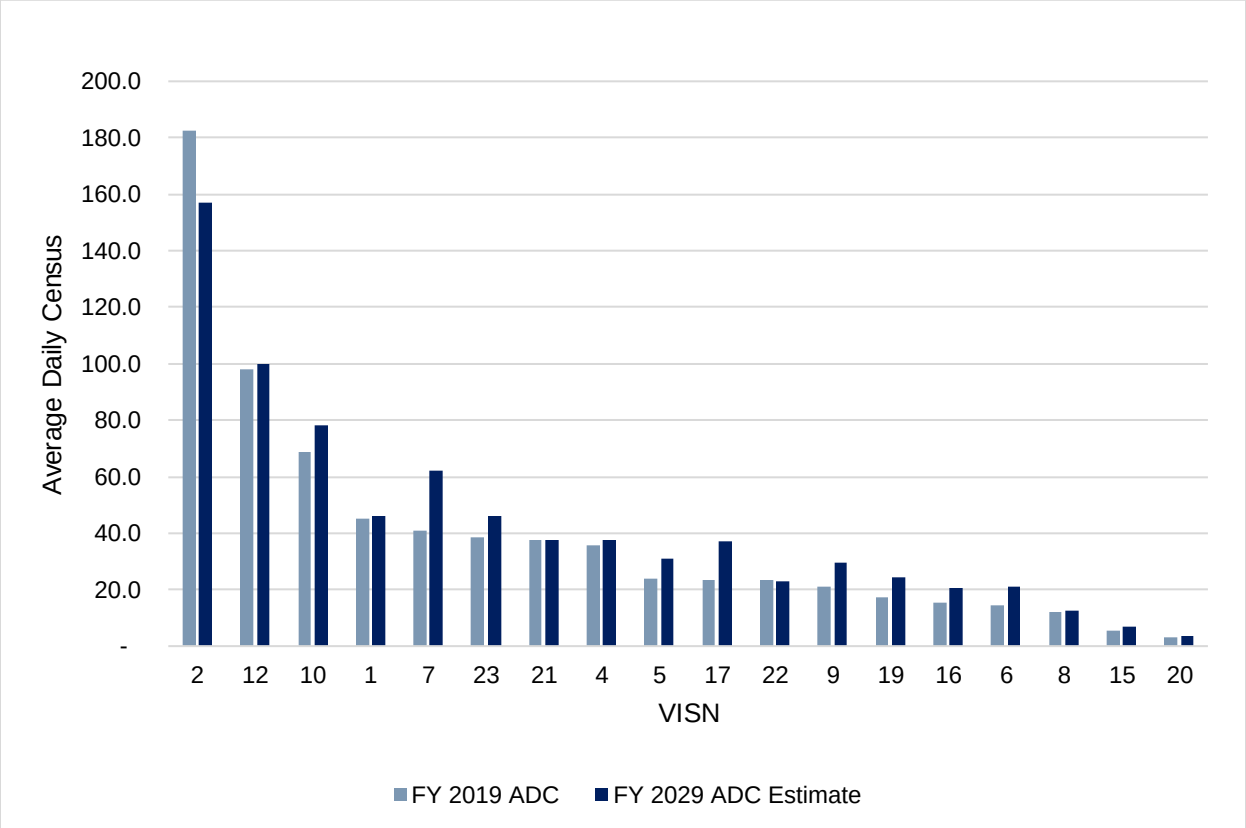
Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

Mental Health

In FY 2019, the ADC of CLC residents with primary mental health diagnoses ranged from 3.0 to 182.5 within each VISN, with VISNs 2, 12 and 10 recording the highest demand. By FY 2029, VISN 2 is still estimated to have the highest demand, with an ADC that decreases to 157.2 as the older Veteran population decreases in that region.

The GEC, Mental Health and Suicide Prevention, and Women's Health work group articulated that they believe the data significantly undercount residents with mental health conditions, perhaps because they are recorded as secondary diagnoses and thus not reflected in current data. The other challenge is that unmet market demand is not reflected in the data, because it is limited to demand associated to existing CLCs. According to the Office of Mental Health and Suicide Prevention, there exist a significant number of Veterans on acute inpatient mental health units and medical units who would be better served in the home-like, less restrictive CLC setting, but for various reasons, including capacity issues in CLCs, remain in more restrictive and expensive levels of care. This also creates barriers to care for Veterans who need acute inpatient mental health and hospital medical beds.

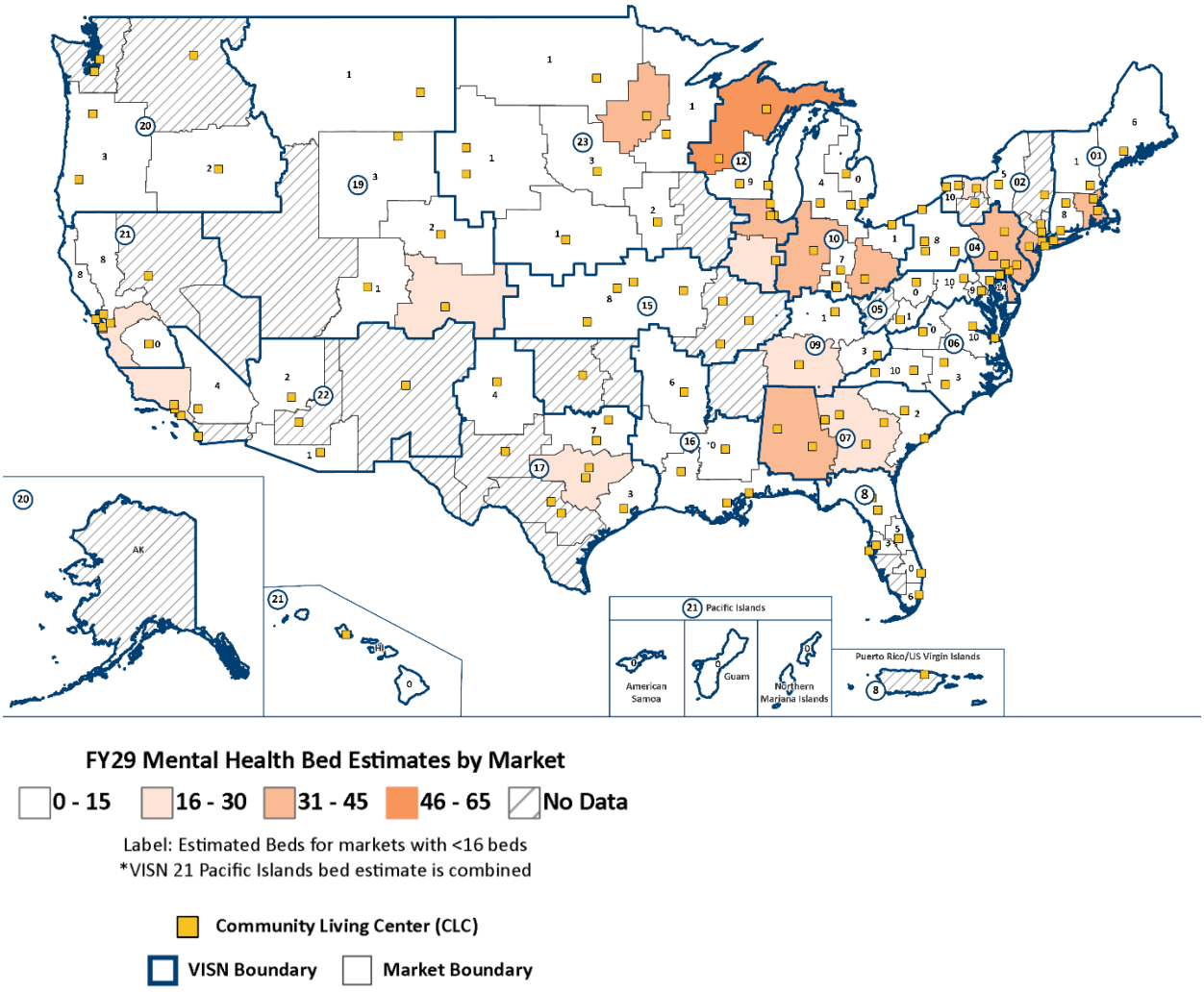
Figure 10: *FY 2019 Mental Health ADC by VISN*



Source: VA CDW Treating Specialty Cube, 2020

At the market level, by FY 2029, 18 of the markets are estimated to have at least 14.4 residents on average each day, meeting the 16-bed minimum planning guideline. VISN 2 Metro New York is estimated to require the most beds, followed by VISN 23 Minnesota Central, VISN 7 Alabama, VISN 1 East, and VISN 4 Eastern.

Figure 11: *FY 2029 Mental Health Bed Estimates by Market*

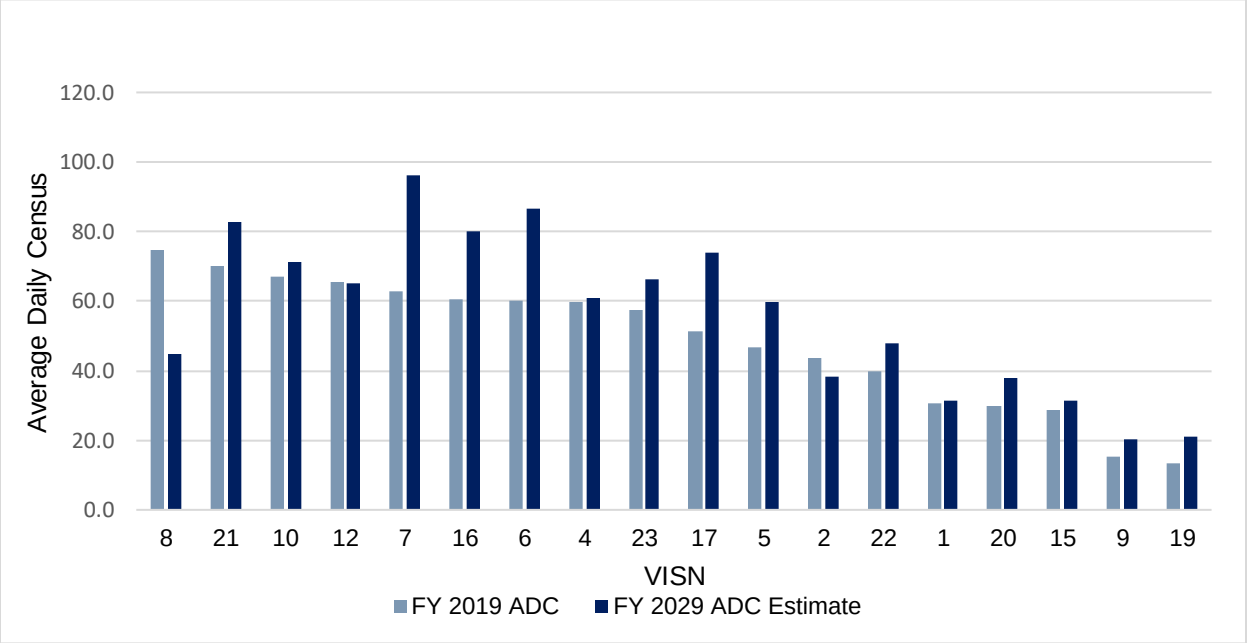


Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

Rehabilitation

In FY 2019, the ADC of residents identified with rehabilitation-based diagnoses ranged from 13.5 to 74.5 within each VISN, with VISNs 8, 21 and 10 recording the highest demand. VISNs 6, 7, and 21 have the highest estimated FY 2029 ADC.

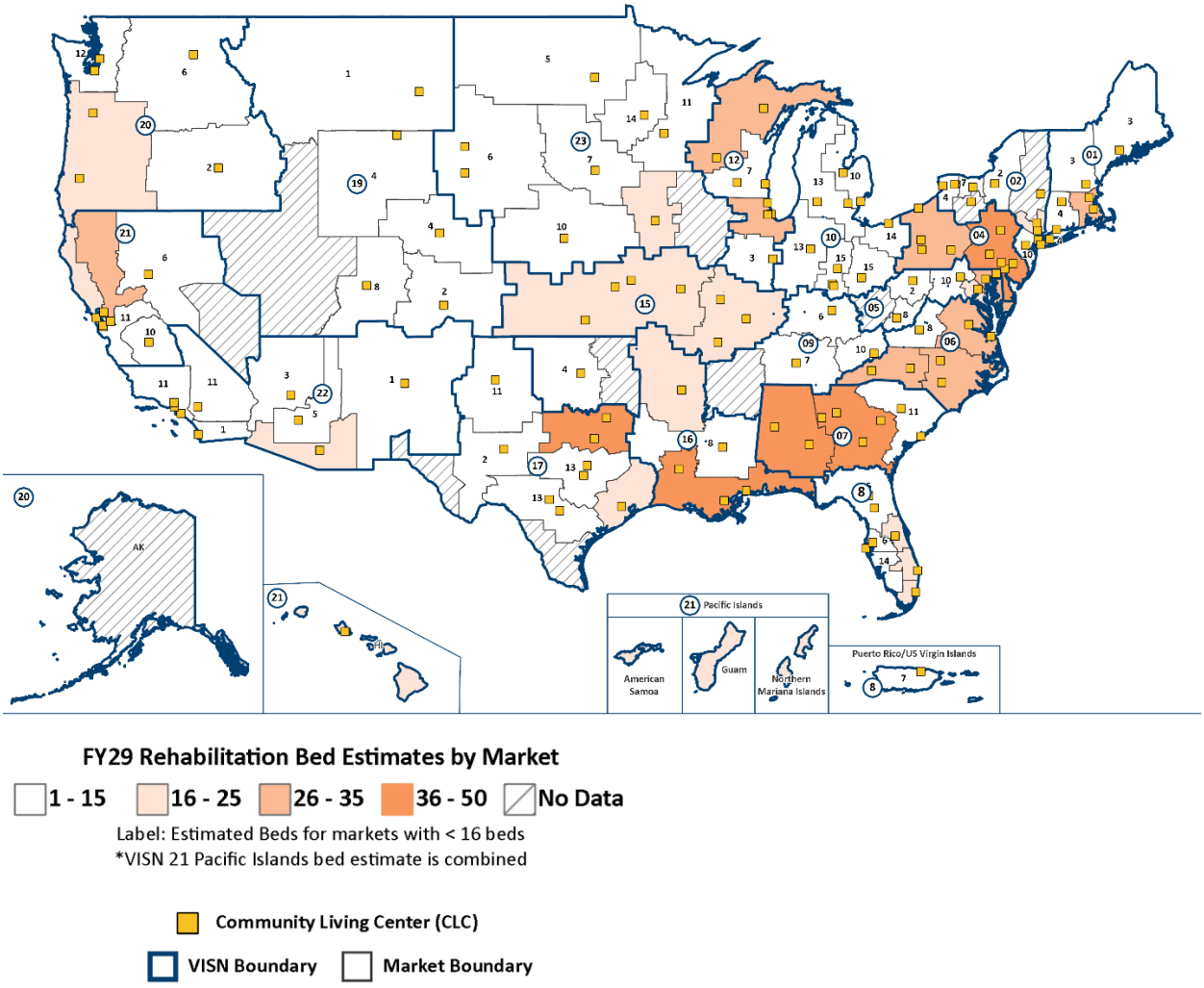
Figure 12: *FY 2019 Rehabilitation ADC by VISN*



Source: VA CDW Treating Specialty Cube, 2020

At the market level, by FY 2029, 28 markets are estimated to have at least 14.4 residents on average each day, meeting the 16-bed minimum threshold. Like neurocognitive/ dementia, the two markets in VISN 7 (Georgia and Alabama) have the highest estimated need, followed by VISN 16 Southern, VISN 17 North Texas, and VISN 4 Eastern.

Figure 13: *FY 2029 Rehabilitation Bed Estimates by Market*



Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

At the facility level, two facilities have enough estimated demand to support CRCs for all three complex special population cohorts, 14 have estimated demand to support both Neurocognitive/Dementia and Mental Health CRCs, and 13 have enough estimated demand for Neurocognitive/Dementia and Rehabilitation, summarized in Table 2.

Table 2: *Facilities with Projected Demand to Support CRCs for Special Patient Population Cohorts*

VISN	Market and CLC	Neurocognitive/ Dementia	Mental Health	Rehabilitation
1	East: Bedford, Massachusetts	✓	✓	
	Far North: Togus, Maine	✓		
2	Western: Batavia, New York	✓		
	Finger Lakes: Canandaigua, New York	✓		
	VA Long Island: Northport, New York	✓	✓	
	VA Metro New York: Montrose, New York		✓	
	VA Metro New York: St Albans, New York	✓	✓	
	VA New Jersey: Lyons, New Jersey	✓	✓	
4	Eastern: Coatesville, Pennsylvania	✓		
	Eastern: Philadelphia, Pennsylvania	✓		✓
	Eastern: Wilkes-Barre, Pennsylvania	✓		
	Western: Heinz, Pennsylvania	✓		✓
5	Baltimore: Loch Raven, Maryland	✓		✓
	Baltimore: Perry Point, Maryland	✓		
	Martinsburg: Martinsburg, West Virginia	✓		
	Washington: Washington, District of Columbia	✓		✓
6	Northeast: Hampton, Virginia	✓		
	Northeast: Richmond, Virginia			✓
	Southwest: Asheville, North Carolina			✓
	Southwest: Salisbury, North Carolina	✓		✓
	Southeast: Fayetteville, Virginia			✓
7	Alabama: Tuscaloosa, Alabama	✓	✓	✓
	Alabama: Tuskegee, Alabama	✓		
	Georgia: Atlanta, Georgia	✓		
	Georgia: Augusta Uptown, Georgia	✓		
	Georgia: Dublin, Georgia	✓		✓
	Georgia: Trinka Davis Veterans Village – Carrollton, Georgia	✓		

VISN	Market and CLC	Neurocognitive/ Dementia	Mental Health	Rehabilitation
7	South Carolina: Columbia, South Carolina	✓		
8	Miami: Miami, Florida	✓		✓
	North: Lake City, Florida	✓		
	Orlando: Orlando-Lake Nona, Florida	✓		✓
	Atlantic: West Palm Beach, Florida	✓		✓
9	Central: Murfreesboro, Tennessee	✓	✓	
10	Central Ohio: Chillicothe, Ohio	✓	✓	
	Western Ohio: Dayton, Ohio	✓		
	Northeast Ohio: Cleveland, Ohio	✓		
	Indiana: Marion, Indiana	✓	✓	
	Michigan Erie: Battle Creek, Michigan	✓		
12	Central: Milwaukee, Wisconsin	✓		
	Central Illinois: Danville, Illinois	✓	✓	
	Southern: Hines-Illinois, Illinois			✓
	Southern: North Chicago, Illinois	✓	✓	
	Northern: Tomah, Wisconsin	✓	✓	✓
16	Northern: North Little Rock, Arkansas	✓		
	Southern: Alexandria, Louisiana	✓		✓
	Southern: Biloxi, Mississippi	✓		✓
17	Central: Waco, Texas	✓	✓	
	North Texas: Bonham, Texas	✓		✓
	North Texas: Dallas, Texas			✓
	Southern: Kerrville, Texas	✓		
	Northwest Texas: Amarillo, Texas	✓		
	East Texas: Houston, Texas			✓
19	Cheyenne: Cheyenne, Wyoming	✓		
	Denver: Pueblo, Colorado	✓	✓	
20	South Cascades: Portland, Washington			✓

VISN	Market and CLC	Neurocognitive/ Dementia	Mental Health	Rehabilitation
20	South Cascades: Roseburg, Oregon	✓		
21	South Coast: Palo Alto, California	✓	✓	
	North Coast: Palo Alto, California	✓	✓	
	North Coast: San Francisco, California	✓		
	North Valley: Martinez, California	✓		✓
	Pacific Islands: Honolulu, Hawaii			✓
22	Loma Linda: Loma Linda, California	✓		
	Greater Los Angeles: West Los Angeles, California	✓		
	Tucson: Tucson, Arizona			✓
23	Minnesota Central: St. Cloud, Minnesota	✓	✓	
	Iowa Central: Des Moines, Iowa			✓

Sources: VA CDW Treating Specialty Cube, 2020 and VA EHCPM, 2020

Access

Under the MISSION Act, new eligibility criteria for Veterans to receive care in the community became effective June 6, 2019. Although the MISSION Act does not specify drive times for LTSS, the drive time to a CLC, SVH or CNH is important to Veteran enrollees and family caregivers. With HCBS, drive time for caregivers is crucial for the resident to receive prompt care.

Quality

As part of its transparency and accountability efforts, VA publicly released CLC quality ratings in June 2018. [19] There are no specific quality ratings for special patient population patients, but the quality of care provided to those cohorts is included in the overall ratings [20].

VA monitors the quality of purchased care and requires at least average Centers for Medicare & Medicaid Services (CMS) Star ratings for purchased home health services, in both the quality of patient care and patient survey categories.

Geriatrics Program and VA's Fourth Mission

VHA provides emergency management response and disaster relief in times of crisis. The 1982 VA/Department of Defense (DoD) Health Resources Sharing and Emergency Operation Act (P.L. 97-174) initiated VA's authority to provide emergency management response support. This authority was further expanded by the Federal Response Plan in

1992. The creation of these laws led to what would become VA's "Fourth Mission," which is defined as VA's effort "to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts." [21]

During the COVID-19 pandemic, VA provided Fourth Mission support in many communities. This support included placing both clinical and non-clinical staff on-site in a community or VA facility, training in infection control measures, and providing personal protective equipment to other health care organizations.

COVID-19 affected VA geriatric care significantly. Prior to the pandemic, VA operated 13 ADHC programs. All ceased operations during the pandemic, and as of July 2021 none had re-opened, however all are working on their operational plans toward reopening in limited capacity. VA is currently assessing the effect of the COVID-19 pandemic on CLCs. One observation is staffing shortages at some locations, as staff who left during the pandemic have not been replaced, resulting in reduced capacity.

Program Challenges

On top of program and service challenges identified in the CLC National Planning Strategy report, several key challenges have been noted for HCBS and facility-based services. For HCBS, the most significant challenge is the way funding is allocated through the Veterans Equitable Resource Allocation (VERA) model. Currently, VISN leaders are incentivized to provide facility-based care. Rebalancing VERA to provide a greater portion of funds for HCBS would allow greater flexibility for aging in place solutions. However, this approach does not increase total funds available for LTSS, so VISNs with large facility-based care populations may be at risk of reduced funding. Another potential avenue to realign funding to future Veteran demands is Congressional action to increase total funding for LTSS.

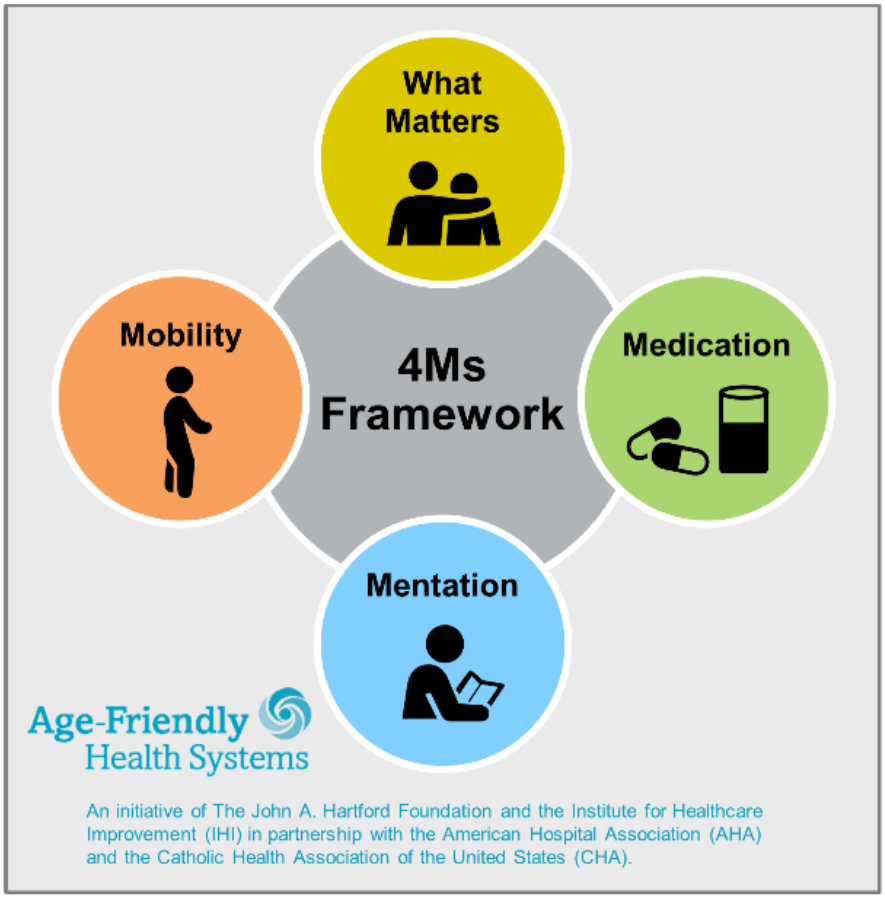
For facility-based services, the CLC report noted the challenges VA faces with meeting the needs of Veterans with complex needs. VA, like the Unites States overall, has a national shortage of geriatric psychiatrists, psychologists, geriatricians, nurses, social workers, pharmacists, and other professionals with geriatric training, especially in rural areas. Communities are also experiencing shortages in nursing assistants and home health aides. These workforce shortages make it difficult to apply consistent planning guidelines because local communities may be unevenly affected

The other challenge specific to mental health is identifying potential unmet demand from patients who remain on inpatient units longer than appropriate because they either do not meet the criteria for CLC placement or there are no CLC beds available. The CLC National Planning Strategy identifies opportunities to expand capabilities as needed across VA, providing additional capacity for residents with stable conditions.

2.3 Commercial and other Federal Provider Trends

VA joined the Age-Friendly Health Systems initiative, also adopted by commercial systems, to ensure Veterans receive safe, high-quality care. [4] The John A. Hartford Foundation and the Institute for Healthcare Improvement partnered with other associations to start the Age-Friendly Health Systems initiative. The three goals of the initiative are to follow an essential set of evidence-based practices, cause no harm, and align with what matters to the older adult and their family caregivers. [22]

Figure 14: *4Ms Framework Diagram*



Source: GEC Eldercare Sequester Presentation, May 2021

Age-Friendly Health Systems reliably provide four elements of care to older adults:

- **What Matters**: Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care and across settings of care.
- **Mobility**: Ensure older adults move safely every day to maintain function and do what matters.

- **Medication**: If medication is necessary, use Age-Friendly medications that do not interfere with what matters to the older adult, mobility, or mentation across settings of care.
- **Mentation**: Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.

Another commercial trend is the establishment of Continuing Care Retirement Communities (CCRCs). A CCRC, or life plan community, provides independent living and an amenity-rich lifestyle with access to higher-level care, if necessary, as residents age. A CCRC provides residents with the stability and care they need to age in place. Levels of care can include independent living, assisted living, memory care, and skilled nursing care. These communities typically require substantial entry and monthly fees but were discussed as a potential future innovative VA solution to both housing and long-term care needs.

2.4 Current Program Summary

VA provides a comprehensive set of home and community-based programs and provides nursing home care to Veterans in CLCs, CNHs, and SVHs. VA is committed to lead the country in geriatrics and extended care from individualized home care programs to standard-setting facility-based care. This means being prepared to provide appropriate HCBS through growth of current evidence-based programs and innovating new models of home-based care. It also means providing the right facility-based settings to meet Veteran needs, including special patient populations. [4]

3. Leading Practices

As noted in the CLC National Planning Strategy, VA continues to rebalance its long-term care program with an emphasis on serving Veterans in their homes and communities. Furthering services such as telehealth demonstrates a commitment to increase Veterans' access to services that are timely, person-centered, cost-effective, and in the least restrictive setting. VA has also recognized the need to expand and enhance HCBS services that promote Veterans' independence and divert premature or avoidable facility-based care. These interventions will help to better manage complex health issues, prevent hospitalization, and combat social isolation and caregiver fatigue, promoting favorable health outcomes for Veterans.

Given this growing commitment, analysis of leading practices of care in homes and communities is critical in realizing the full benefit of these options for Veterans. These include design of resources that are robust and tailored to Veteran needs, that incorporate the needs of families and caregivers and their needed supports, and that are fully integrated in supporting all aspects of independent living and thriving in home and community settings.

3.1 Leading Practices Analysis

VA continues to advance its Veteran-centered long-term care model, through ongoing integration of person-centered care and the implementation of evidence-based guidelines and best practices. These approaches incorporate person-centeredness in assessment and care planning, care delivery, workforce engagement, quality measurement, and Veteran feedback. Several key aspects are to:

- **Acknowledge the Veteran's personhood**. Seek to understand and respect who the Veteran is as an individual, their value and belief system, and integrate their family/caregiver.
- **Incorporate the Veteran's preferences and consider those of his or her caregiver and family** while ensuring the Veteran's complex care issues are addressed and managed according to VHA's quality standards.
- Recognize that **the Veteran's family and caregivers are the primary support system** and structure the care experience in a home and community environment.

These influential leading age-friendly practices include a robust set of home and community-based services, caregiver support, person-centered care, and integrated care management. They were identified because they support the needs of geriatric special patient populations.

Home and Community-Based Services

Home-based care offers patients with greater independence, affordability, comfort and convenience by providing personalized care across a range of services. [23] Primary care providers are part of a broader continuum of care to the aging population and providers must know about resources in their communities, share this information with others, and utilize frequently.

According to CMS, the benefits of HCBS include [24]:

- Usually less than half the cost of residential care;
- Availability of spiritual and cultural activities and support;
- Patient enjoys the comfort of their own home or small residential facility in the community;
- Some models (self-directed) permit family members to be paid caregivers and/or allow the individual to retain full employment authority; and
- Better health outcomes, particularly in a time of crisis.

Some challenges of HCBS include:

- Lack of consistent access to providers and caregivers, particularly in rural or highly rural settings;
- Risk of caregiver burnout and higher dependence on informal support to maintain the plan of care; and
- Risk of cultural bias or barriers in the assessment process.

Caregiver Support

Caregiver support is an important part of geriatric care and families are the primary source of support for older adults according to the Administration for Community Living. [25] Many caregivers also work and experience conflicts between their competing responsibilities. Nearly half of all caregivers are over the age of 50 and providing care can take a substantial emotional, physical, and financial toll. Many caregivers are vulnerable to a decline in their own health, well-being, and financial stability. As such, a coordinated approach to caregiver support is essential because it can reduce anxiety, stress and depression among caregivers and can enable them to provide care longer and more effectively.

The VA network currently provides a substantial amount of resources and support for caregivers. Caregiver Support Program teams assist caregivers in finding and enrolling in caregiver programs and services. The teams, which are available at each VA medical center, include clinical professionals who connect caregivers with VA and other programs and community services. [26] The Program of Comprehensive Assistance for Family Caregivers provides educational and financial resources, health insurance, mental health counseling, and other support to caregivers of eligible Veterans.

Additionally, through the Resources Enhancing Alzheimer's Caregiver Health (REACH) program, VA provides in-person and virtual coaching and support to caregivers during four sessions delivered over a period of 2 to 3 months. The program, which is a modified version of one developed by the Rosalynn Carter Institute for Caregiving, includes education and skills building to help caregivers manage patient issues and decrease their own stress. [27] REACH VA is available to caregivers providing care to a Veteran or a Veteran caring for a loved one. Veterans and caregivers can access resources where they receive VA services. [28] Caregivers who complete programs such as REACH report feeling more confident in their abilities and increased satisfaction with life. [29]

Hospice of the Valley, in Phoenix, Arizona, is one of many programs nationwide that has developed a home-based case management and psychosocial support program for caregivers of people living with dementia. The central component of this particular program is a home visit from a social worker, termed a Dementia Educator (DE) with expertise in dementia care, including behavior and medication management strategies. [30] During home visits, the DE, establishes a relationship with the patient and their caregiver to assess and try to address their most immediate needs. Once a DE has identified a caregiver's preferences and needs, they provide them with a support toolkit that includes connections with respite care, additional in-home help, legal services, and other resources in the community.

The VA Office of Rural Health developed similar pilot program to support Veterans with moderate to severe dementia living at home with a caregiver. The Caring for Older Adults and Caregivers at Home (COACH) program is a home-based care approach that provides education on dementia and behavioral management, referrals and assistance with resources, and home safety recommendations to Veterans living within 50 miles of a VAMC or Community-Based Outpatient Clinic (CBOC). [31] The COACH was designed to keep Veterans living at home for as long as possible and has demonstrated positive results since it began in 2010, including:

- Reduced burdens on caregivers;
- Decreased health care costs;
- Improved quality of life for Veterans; and
- Enhanced VERA related to Veterans' needs, supporting the program's sustainability.

Person-Centered Care

Person-centered care represents a shift from a paternalistic approach to treating a symptom or illness to collaborate with patients to focus on their overall health and wellness. Person-centered care is focused on a person's emotional needs and care preferences, uses a strengths-based approach to leverage a person's abilities and existing resources, is consistent with their lifestyle and decisions are made with the person's goals as the foremost priority. [32]

Veterans living with dementia have a particularly complex set of needs based on their experiences and diagnoses, and a one-size-fits-all solution will not meet the dynamic needs of everyone within the patient population. As a result, creating, sustaining, and supporting the range of services needed is a challenge. [33] These patients are best served when their care plans meet their environmental, social, functional, and clinical needs. Successful programs meet these needs when they conduct comprehensive assessments prior to developing a care plan. The purpose of such assessments is to identify the holistic range of a person's needs and communicate those needs with a multidisciplinary team to support the Veteran and their family to live their best possible life. [34]

The VA Hospice and Palliative Care Initiative manages the national Hospice-Veteran Partnerships program and seeks to improve Veteran access to care, strengthen the relationships between VA facilities and community hospice, and develop comprehensive end-of-life community engagement plans with Veterans. [35] These coalitions, which may be local, regional, or statewide, work together to provide excellent end of life care for Veterans and their families.

Integrated Care Management

The coordination of primary and mental health services as well as support along the care continuum is essential given the unique and complex needs of older adults. Effective care coordination and integration can be achieved through regular monitoring and adjustment. [36] Additionally, VA should consider if striving for LTSS-related accreditation for case management via the National Council for Quality Assurance (NCQA) can further bolster comprehensive and integrated care management approaches. [37]

VHA works to meet these needs through the Care Coordination and Integrated Case Management (CC&ICM) Initiative. Established in 2019, this initiative provides the structure and standards to support collaboration and optimal utilization of resources across the continuum of care. [38] With its focused program intersections, care transitions, and provider and patient match, the VHA CC&ICM initiative adopts a whole-health approach to Veteran care as it seeks to help Veterans and their families navigate an increasingly complex provider and care network. [39]

The Program for All-Inclusive Care for the Elderly (PACE) is another coordinated program to provide all needed preventive primary, acute, and long-term care services to adults under 65 with disabilities, frail older adults, people with multiple chronic conditions, and people with serious illness. [40] PACE programs treat the whole person, rather than specific medical conditions. The goal of these programs is to help participants live as independently as possible for as long as possible. Studies have shown that participation in this program leads to reduced hospital readmissions, lower emergency department utilization, reductions in the use of facility-based care, cost savings, and high level of enrollee satisfaction. [41] This program, which is not specific to

VA, is an optional benefit under both Medicare and Medicaid and eligibility is based on clinical need and service availability.

4. Service Planning Framework

As an extension of the CLC National Planning Strategy, this effort recommends principles for national and facility-level VA planners and GEC leaders to expand and deliver both home and facility-based care.

While the CLC National Planning Strategy provides planning guidelines for infrastructure, this strategy provides guidelines for how to operationally organize that infrastructure in a way that meets complex VISN special patient population needs.

4.1 Program Priorities

The Geriatrics and Extended Care Strategy priorities that this planning effort supports are:

- Expand Home and Community-Based Services;
- Modernize Systems for Health Aging;
- Modernize and Improve Facility-Based Care; and
- Increase Geriatric Expertise.

Expand Home and Community-Based Services

VA offers 11 different HCBS programs and intends to expand and standardize access for all Veterans. Additional funding levels through VERA rebalancing or Congressional action will incentivize VISN leaders to shift even more residents from facility-based to aging-in-place models of care.

Modernize Systems for Health Aging

This report focuses on the LTSS component of the health care continuum, but support for Veterans to age in a healthy manner begins when they are younger. Preventive services and screening tools used in the primary care setting help identify future high need/high risk patients. VA is starting to leverage new technology and tools to advance the process, according to GEC. When long-term geriatric care is needed, VA philosophy has shifted from facility-centric placement support to helping Veterans age in place for as long as possible.

Modernize and Improve Facility-Based Care

When facility-based care becomes the best option for Veterans, the Small House Neighborhood Model, described in the CLC National Planning Strategy report, is the preferred solution. This model is designed to support approximately 16 residents with

similar health conditions. The VA Small House Model aligns with evidence-based design models that provides a home-like atmosphere with private rooms and a kitchen at the heart of each house. Converting aging infrastructure, both stand-alone CLC and hospital-based units, to a Small House Model is a VA priority documented in the CLC report and incorporated in this follow-up framework.

Increase Geriatric Expertise

The shortage of geriatric specialists, including physicians/psychiatrists, psychologists, nurses, and many others, was mentioned several times during both the CLC National Planning Strategy development work and this effort. VA, like the United States overall, is experiencing a shortage of geriatric specialists. [42] The planning guidelines developed around complex special patient populations suggest ways to leverage limited geriatric expertise needed to support quality care for older Veterans with specialized care needs.

4.2 Geographical Service Areas

This strategy uses VISNs and markets as the primary geographic regions for planning resources.

Each VISN should include at least one Neurocognitive/Dementia, one Mental Health, and one Rehabilitation CRC. The CRCs can all be co-located in one CLC, or distributed, depending on regional geography, population characteristics, and referral patterns.

Each market will likely have enough high need/high risk patients to require one or more HBPC teams. The Veteran Directed Care program is also managed by VAMCs at the market level.

Within each market, individual CLCs may establish specialty-focused neighborhoods for residents living with neurocognitive disorders/dementia, mental health diagnoses, rehabilitation needs, and conditions requiring ventilator dependency. CLCs may also consider women-only neighborhoods as well as spousal or partner accommodations if Veteran demand exists.

All CLCs should be capable of providing care to special population Veterans, with training and other support provided by CRCs.

4.3 Planning Guidelines and Thresholds

Planning guidelines and thresholds seek to inform the market assessment process. The rationale for establishing VA planning guidelines and thresholds is rooted in the belief that where a VA service falls below the identified measure, quality, patient safety, or operational efficiency may be compromised. Therefore, a service must be carefully examined to ensure that Veteran needs are appropriately met. Planning guidelines and thresholds focus on a broad range of access, demand, staffing, quality, and facilities/

environment of care considerations and are meant to help identify areas where the teams should carefully consider available innovative delivery options. The guidelines and thresholds developed are not meant as standalone decision criteria to be used to make specific recommendations.

When conducting the market assessments, the opportunities developed were standardized across a range of move (or strategic task) types. Those developed included major moves as well as opportunities defined to be addressed during the ordinary course of business. Major moves represent the platform which will be vetted with senior VA leadership, the VHA Under Secretary of Health, the Secretary of VA, the AIR Commission, and ultimately with Congress.

Planning guidelines derived from these efforts have been designed to assist in the standardization of major market moves. The CLC report includes details on recommended opportunities. This report augments that information by providing additional guidelines on home and community-based services and complex special patient populations.

Planning Guidelines

Home and Community-Based Services

All HCBS programs were reviewed to determine if planning guidelines are applicable. Two emerged as good candidates because expansion goals are quantifiable and can be consistently applied. The other nine programs are summarized in Table 4, with general information on approaches or initiatives to expand utilization.

Special Patient Populations

Organizing special patient populations into cohorts within CLCs is an opportunity for VA to leverage limited workforce expertise, design infrastructure, and provide quality care. Through an iterative process with GEC, Office of Mental Health and Suicide Prevention, and Office of Women's Health, the following organizational planning framework was developed:

- **Specialty-Focused Neighborhoods**: Cohorts residents with short- and long-stay complex specialty care. More than one specialty-focused neighborhood within a CLC or market is possible. This is already a concept well embraced across the network, referenced in VA guidelines, and further reinforced by this planning strategy effort.
- **Special Patient Population Clinical Resource Center**: Supports the high demand for special patient population services. These are typically located in large urban areas, with strong clinical resource capabilities, strong recruitment and retention potential. Often, these Centers would have the potential to align with training/academic partners for train-the-trainer opportunities and additional

specialty training for VA staff. Promotes evidence-based care. Provides both in-person and virtual training to CLCs that are either General or have Specialty-Focused neighborhoods.

- **General CLC**: All CLCs other than CLCs that have at least one specialty neighborhood and/or serve as a CRC are considered general CLCs, providing cross-continuum services for complex special populations at the Veteran's locale of choice. The expectation is that all CLCs have staff competencies to care for these residents.

Table 3 provides a summary of HCBS and CLC complex special patient population guidelines developed collaboratively with VA program offices.

Table 3*: Geriatrics Planning Guidelines*

Program/Population	Market-Level	VISN-Level
Home-Based Primary Care (HBPC)	• Expand to all GIS-identified VA facilities with 50 or more high need/high risk patients within a 60-minute drive time	• Not applicable
Veteran-Directed Care	• Expand to offer at all VAMC locations	• Not applicable
Neurocognitive/ Dementia	• CLCs with demand for at least four beds for this population may designate a Neurocognitive/ Dementia neighborhood (or neighborhoods) within the CLC. This neighborhood should include all the capabilities, support services, and staff with competencies to care for this population.	• Each VISN designates at least one Neurocognitive/ Dementia CRC to provide both in-person and virtual staff training and consultation. • Ideally the CRC includes at least 16 Neurocognitive/Dementia beds, but VISNs have the flexibility to dedicate fewer, depending on patient demand. • CRC site selection criteria should include adequate Veteran demand and demonstrated ability to recruit and retain staff for a sustainable program.

Program/Population	Market-Level	VISN-Level
Mental Health	• CLCs with demand for at least four beds for this population may designate a Mental Health neighborhood (or neighborhoods) within the CLC. This neighborhood should include all the capabilities, support services, and staff with competencies to care for this population.	• Each VISN designates at least one Mental Health CRC to provide both in-person and virtual staff training and consultation. • Ideally the CRC includes at least 16 Mental Health beds, but VISNs have the flexibility to dedicate fewer, depending on patient demand. • CRC site selection criteria should include adequate Veteran demand and demonstrated ability to recruit and retain staff for a sustainable program.
Rehabilitation	• CLCs with demand for at least four beds for this population may designate a Rehabilitation neighborhood (or neighborhoods) within the CLC. This neighborhood should include all the capabilities, support services, and staff with competencies to care for this population.	• Each VISN designates at least one Rehabilitation CRC to provide both in-person and virtual staff training and consultation. Ideally the CRC includes at least 16 Rehabilitation beds, but VISNs have the flexibility to dedicate fewer, depending on patient demand. • CRC site selection criteria should include adequate Veteran demand and demonstrated ability to recruit and retain staff for a sustainable program.
Ventilator-Dependent	• CLCs with demand for at least four beds for this population may designate a Ventilator-Dependent neighborhood (or neighborhoods) within the CLC. This neighborhood should include all the capabilities, support services, and staff with competencies to care for this population.	• Not applicable

Program/Population	Market-Level	VISN-Level
Women's Health	• CLCs may have dedicated Women-Only neighborhood* (or neighborhoods) within the CLC. • The number of beds will vary based on facility design and the ability to separate resident rooms by gender. Common areas may be gender-specific or shared.	• Not applicable

* Note that many of these programs/services are currently available, and will help inform VISN/Market strategy with the market assessments

Table 4 includes additional information on HCBS programs and initiatives.

Table 4: *Other HCBS Initiatives*

Program	Current State	Future Considerations
Homemaker/Home Health Aide (H/HHA)	• 100% purchased	• Markets with few resources in the commercial market may consider a make vs. buy pilot program • Standardize services based on case mix index
Skilled Home Health Care	• 100% purchased • Typically associated with post-surgery and post-rehabilitation care	• Will likely continue to be the fastest-growing HCBS program
VA ADHC	• Twelve sites currently, with plans to re-open at 50% capacity in August 2021, following COVID-19-related closures • Each site determines their ADC based on available staff and space	• Each VISN identifies opportunities based on make vs. buy analyses • Locations determined by population density clusters • Can be co-located with CBOCs or Health Care Centers, in addition to VAMCs
Community ADHC	• Nearly 6,000 programs nationwide • 35% increase between 2002 and 2020 • Participating organizations must have access to higher level medical care • Drive time standards are 30-minutes (urban) and 60-minutes (rural)	• None noted
Palliative Care	• Provide at Veteran's setting of choice	• None noted

Program	Current State	Future Considerations
Home Hospice Care	• Provide at Veteran's setting of choice	• None noted
SCI/D Home Care	• Provided at VAMCs with SCI/D hubs	• None noted
Home Respite Care	• Typically provided by Homemaker/Home Health Aide staff	• Increased flexibility for caregiver on how the service is used, with more choices and control
Medical Foster Homes	• Veterans pay for this service • State licensing may be required • Currently at 116 VAMCs in 43 states	• Ideally available in every market

Detailed Planning Guideline Rationale

In collaboration with the GEC Program Office, planning guidelines were driven by data analysis and ongoing discussions, including an Elder Care Sequester in May 2021.[1] The GEC program office Elder Care Strategy, discussed in detail during the Sequester, also informed the guidelines.

Key planning considerations are as follows:

- The GEC-established HBPC guideline expands this program to meet demand at GIS-identified VA facilities with 50 or more high need/high risk Veterans within a 60-minute drive. The number of Veterans per team was based on the HBPC staffing model and provider capacity.
- Population and demand were based on the 2020 VA EHCPM.
- Target minimum numbers of beds was based on the CLC National Planning Strategy report and guidelines previously agreed upon and discussions with GEC, Mental Health and Suicide Prevention, and Women's Health leadership.
- Target CLC occupancy rate of 90% was based on VA standards and the CLC National Planning Strategy report and guidelines.
- Cohorting special patient population needs within and across markets was based on current VA health care models of care and GEC guidance. The resulting guidelines can be used to ensure needed services are provided within population centers and resources are leveraged.

The guidelines are not intended to be rigid requirements but serve as inputs for more detailed planning work. Unique market dynamics should be considered, including the local leadership's understanding of the structure that best supports Veterans. Current

[1] The Office of Geriatrics and Extended Care, Chief Strategy Office, Office of Mental Health and Suicide Prevention, and Office of Women's Health reviewed this document and helped to inform guidelines.

VA planning guidelines, to include clear CLC admission criteria and appropriate resident cohorting, should also be incorporated as planning considerations.

5. Future Program Planning

5.1 Applying the Geriatrics National Planning Strategy to VA Market Assessments

The VA MAHSO effort completed an assessment of VA markets, facilities, and service lines to produce recommendations for the design of high-performing integrated delivery networks. Select service lines, studied during the market assessments, did not have a standard national strategy or approach to planning and maintaining programs. Geriatrics was identified as a service line requiring further review to define a set of national planning guidelines that would be applicable for use in current (MAHSO) and future planning efforts.

This document, the Geriatrics National Planning Strategy, in concert with the CLC National Planning Strategy report and guidelines, fulfills this requirement and establishes the definitive, consistent, planning guidelines to be used for all VA Geriatrics planning efforts moving forward.

The national planning guidelines will be used to ensure the final market assessments apply standard programmatic criteria across the nation. The guidelines will be useful for VA planners to inform future quadrennial market assessments and other planning exercises.

How will MAHSO apply the Geriatrics National Planning Strategy?

The four-step process for revisiting MAHSO draft opportunities describes how Geriatrics-specific opportunities will be reviewed and updated, if necessary.

1. Review Phase 1-3 Market Assessment Data and Geriatrics Opportunities

The scope of review will include revisiting Phase 1-3 markets and re-assessing opportunities that were specific to Geriatrics using new thresholds and data (as applicable).

2. Apply Geriatrics Planning Guidelines

For applicable draft Geriatrics opportunities, the planner will review market assessment data and apply Geriatrics planning guidelines. The reassessment will include any new data sources in the updated methods described previously.

3. Update Geriatrics Opportunities

As needed, existing market optimization or opportunities will be revised.

4. Review and Finalize with VA Leadership

Once draft opportunities are revised and are ready for VA Leadership approval, a review with the Chief Strategy Office, VHA Leadership, and VISN Directors will move the opportunities towards finalization.

Future Recommendations for Consideration

Throughout the development of the Geriatrics National Planning Strategy, areas of consideration for future planning efforts were identified. The following recommendations for future market assessments are provided:

- Evaluate strategies to incentivize HCBS rebalancing, to include VERA changes and other options.
- Identify the gap between required and existing HBPC teams and Veteran-Directed Care programs.
- Quantify the number of Veterans who remain on inpatient mental health environments longer than clinically necessary and determine if they are potential candidates for future CLC Mental Health special population neighborhoods.
- Explore the feasibility of adding additional diagnoses data fields to CLC electronic records, to identify Veterans with multiple needs.
- Assess Veteran interest in women-only CLC neighborhoods, and spousal or partner accommodations.

Conclusion

The Geriatrics National Planning Strategy, created in conjunction with GEC, Office of Mental Health and Suicide Prevention, and Office of Women's Health, is a framework for designing consistent service delivery planning for Geriatrics services. Based on program office priorities, the Geriatrics National Planning Strategy provides guidance on how Geriatrics programs can respond to varied market demands and trends while optimizing VA resources in a Veteran-centric framework. These guidelines will be used to ensure that service delivery planning is matched to Veteran demand and a consistent set of recommendations is established to inform and support the development of the AIR Commission Report.

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Appendix B: Definitions

Home and Community-Based Services[2]	
Home-Based Primary Care (HBPC)	• Home Based Primary Care is coordinated interdisciplinary primary care provided to Veterans in their home. A VA physician leads the health care team who provides the services. Home Based Primary Care is for Veterans who have complex health care needs for whom routine clinic-based care is not effective. • The program targets Veterans who need team based in-home support for ongoing diseases and illnesses. Veterans usually have difficulty making and keeping clinic visits because of the severity of their illness. Home-Based Primary Care can be used in combination with other HCBS.
Homemaker/Home Health Aide (H/HHA)	• A Homemaker or Home Health Aide is a trained person who can come to a Veteran's home and help the Veteran take care of themselves and their daily activities. Homemakers and Home Health Aides are not nurses, but they are supervised by a registered nurse who will help assess the Veteran's daily living needs. • This program is for Veterans who need personal care services and help with activities of daily living. This program is also for Veterans who are isolated, or their caregiver is experiencing burden. • Homemaker and Home Health Aide services can be used in combination with other HCBS. Services may vary by location. • Homemaker Home Health Aides work for an organization that has a contract with VA. Homemaker or Home Health Aide services can be used as a part of an alternative to nursing home care, and to get Respite Care at home for Veterans and their family caregiver. The services of a Homemaker or Home Health Aide can help Veterans remain living in their own home and can serve Veterans of any age.
Skilled Home Health Care	• Skilled Home Health Care is for Veterans needing short-term care as they are moving from a hospital or nursing home back to their home. It can also be used to provide continuing care to people with ongoing needs. • The program is for Veterans who need skilled services such as: skilled nursing, case management, physical therapy, occupational therapy, speech therapy, wound care, or IV antibiotics. • Skilled Home Health Care can be used in combination with other Home and Community Based Services. • The care is delivered by a community-based home health agency that has a contract with VA.

[2] These Home and Community-Based Services were identified by the Office of Geriatrics and Extended Care.

Home and Community-Based Services	
VA Adult Day Health Care (ADHC)	• Adult Day Health Care is a program Veterans can go to during the day for medical care, socialization, peer interactions, companionship, and recreation. • The program is for Veterans who need help with activities of daily living. Examples include help with bathing, dressing, or fixing meals. This program is also for Veterans who are isolated, or their caregiver is experiencing burden. ADHC can be used in combination with other HCBS. • Health services such as care from nurses, therapists, social workers, and others may also be available. Adult Day Health Care can provide respite care for a family caregiver and can also help Veterans and their caregiver gain skills to manage the Veteran's care at home
Community ADHC	• Same as above but purchased in the community.
Home Palliative/Hospice Care	• Palliative Care uses comfort care with a focus on relieving suffering and controlling symptoms so patients can perform day-to-day activities and continue to do what is most important to them. Palliative care aims to improve quality of life. • Palliative Care can be combined with treatment that is aimed at curing or controlling illness. It can be started at the time of diagnosis and may be provided throughout the course of the illness. Hospice care is palliative care provided during the last six months of life. It can also be provided in outpatient or inpatient settings.
Spinal Cord Injury and Disease (SCI/D) Home Care	• VA health care teams located at VAMCs with SCI/D hubs provide services to Veterans in their homes
Veteran-Directed Care	• Veteran Directed Care gives Veterans of all ages the opportunity to receive the HCBS they need in a consumer-directed way. • This program is for Veterans who need personal care services and help with activities of daily living. Examples include help with bathing, dressing, or fixing meals. This program is also for Veterans who are isolated, or their caregiver is experiencing burden. • Veterans in this program are given a budget for services that is managed by the Veteran or the Veteran's representative. With the help of a counselor, Veterans hire their own workers to meet their daily needs to help them live at home or in their community
Home Respite Care	• Provides short-term care at home or at an adult day care program when family caregivers need a break.
Medical Foster Home	• A unique form of long-term care for Veterans who are more medically complex and disabled and who would otherwise require nursing home placement. The Medical Foster Home program combines VA placement in a personal care home, with no more than three Veterans receiving care, with an interdisciplinary care team of HBPC or Spinal Cord Injury Home Care. The Medical Foster Home offers a safe alternative to nursing home placement in a community home that may be a more acceptable care environment to Veterans and those responsible for their care.

Appendix C: VA Priority Groups

The Veterans' Health Care Eligibility Reform Act of 1996 (Eligibility Reform Act) was established to open enrollment to all Veterans and mandated that VA establish a priority-based enrollment system to manage access to care. There are eight priority groups, based on military service history, disability rating, income level, Medicaid qualification, and other VA benefits. [17]

Priority Group	Eligibility Requirements
1	• Veteran has a service-connected disability rated as 50% or more disabling, **or** • Veteran has a service-connected disability VA concluded makes the Veteran unemployable, **or** • Veteran received the Medal of Honor.
2	• Have a service-connected disability rated as 30% or 40% disabling
3	• Veteran is a former prisoner of war, **or** • Veteran received the Purple Heart medal, **or** • Veteran was discharged for a disability caused by, or got worse because of, active-duty service, **or** • Veteran has a service-connected disability rated as 10% or 20% disabling, **or** • Veteran was awarded special eligibility classification under Title 38, U.S.C. § 1151, "Benefits for individuals disabled by treatment or vocational rehabilitation"
4	• Veteran is receiving VA aid and attendance or housebound benefits, **or** • Veteran received a VA determination of catastrophic disability.
5	• Veteran has no service-connected disability, or a non-compensable service-connected disability rated as 0% disabling, **and** an annual income level below adjusted income limits (based on resident zip code), **or** • Veteran is receiving VA pension benefits, **or** • Veteran is eligible for Medicaid programs.
6	• Veteran has compensable service-connected disability rated as 0% disabling., **or** • Veteran was exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, **or** • Veteran is participating in Project 112/SHAD, **or** • Veteran served in the Republic of Vietnam between Jan. 9, 1962 and May 7, 1975, **or** • Veteran served in the Persian Gulf War between Aug. 2, 1990 and Nov. 11, 1998, **or** • Veteran served on active duty at Camp Lejeune for at least 30 days between Aug 1, 1953 and Dec 31, 1987, or • Veteran is currently or newly enrolled in VA health care **and** served in a theater of combat operations after Nov. 11, 1998 or were discharged from active duty on or after Jan. 28, 2003; **and** were discharged less than five years ago.

Priority Group	Eligibility Requirements
7	• Veteran's gross household income below geographically adjusted income limits (GMT) where Veteran lives **and** agree to copays.
8	• Veteran's gross household income above GMT where Veteran lives **and** agree to copays.

Appendix D: Rural-Urban Commuting Areas Definition

This report uses the Rural-Urban Commuting Areas (RUCA) system used by VA to define rurality. Developed by the Department of Agriculture (USDA) and the Department of Health and Human Services (HHS) the RUCA system assigns each U.S. Census tract a RUCA code based on population density, urbanization, and daily commuting patterns. [43]

Enrollees within each county are counted as either urban or rural based on the RUCA code for the tract in which they live. This allows each county to have a "Percent Rural" metric (percent of rural enrollees in county of total county enrollees), which is used throughout MAHSO and this report.

- **Urban Areas** are census tracts with at least 30% of the population residing in an urbanized area as defined by the Census Bureau are defined as urban.
- **Rural Areas** are land areas not defined as urban.
    - **Insular Islands (considered Rural)** include the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.
    - **Highly Rural Areas (considered Rural)** are sparsely populated areas in which less than 10% of the working population commutes to any community larger than an urbanized cluster, which is typically a town of no more than 2,500 people.

For MAHSO planning purposes, geographic designations such as counties, submarkets, and markets are classified as either rural or urban based on where most enrollees live. For example, if greater than 50% of enrollees within a county live in a rural area, the county is considered a rural county. If 50% or fewer enrollees live in rural areas, the county is considered an urban county.

Appendix E: Meetings with VA Program Offices

Meetings were conducted with the Office of Geriatrics and Extended Care, Office of Mental Health and Suicide Prevention, and Office of Women's Health.

Meeting Date
April 14, 2021
April 19, 2021
April 26, 2021
April 27, 2021
May 3, 2021
May 10, 2021
May 12, 2021
May 14, 2021
May 17, 2021
May 19, 2021
May 20, 2021[3]
May 24, 2021
June 1, 2021
June 7, 2021
June 14, 2021
June 21, 2021
June 24, 2021
June 28, 2021
July 6, 2021
July 12, 2021
July 19, 2021
August 2, 2021
August 16, 2021

[3] The Elder Care Sequester occurred on May 20, 2021, and included key senior leadership, medical center leadership, and program offices. Offices invited to the Elder Care Sequester included: Office of Community Care, VA Office of Capital Asset Management and Engineering Support (OCAMES), VA Office of Construction and Facilities Management (CFM), VHA Finance, Geriatric and Extended Care Program Office, VHA Chief Strategy Office, Office of Nursing Service, Social Work, Caregiver Support Program, Office of Primary Care, Office of Mental Health and Suicide Prevention, Office of Rehabilitation Services, Office of Rehabilitation, Extended and Community Care (RECC), Office of Women's Health, Office of Connected Care, Office of Rural Health, Office of Caregiver Support, and Office of Analytics and Performance Integrity.

Appendix F: Acronyms

Acronym	Definition
ADC	Average Daily Census
ADHC	Adult Day Health Care
AIR	Asset and Infrastructure Review
ALS	Amyotrophic Lateral Sclerosis
CBOC	Community-Based Outpatient Clinic
CC&ICM	Care Coordination and Integrated Case Management
CCRC	Continuing Care Retirement Communities
CDC	Centers for Disease Control and Prevention
CDW	Corporate Data Warehouse
CLC	Community Living Centers
CMS	Centers for Medicare and Medicaid Services
CNH	Community Nursing Home
COACH	Caring for Older Adults and Caregivers at Home
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CRC	Clinical Resource Center
DoD	Department of Defense
EHCPM	Enrollee Health Care Projection Model
FY	Fiscal Year
GEC	Geriatrics and Extended Care
GIS	Geographic Information System
HBPC	Home-Based Primary Care
HCBS	Home and Community-Based Services
HHS	Department of Health and Human Services
H/HHA	Homemaker/Home Health Aide
ICD-10	International Classification of Disease, 10th Revision
LTSS	Long-Term Services and Support
MAHSO	Market Area Health System Optimization
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
NCQA	National Council for Quality Assurance
PACE	Program for All-Inclusive Care for the Elderly
REACH	Resources Enhancing Alzheimer's Caregiver Health
RUCA	Rural-Urban Commuting Area
SCI/D	Spinal Cord Injuries and Disorders

Acronym	Definition
SVH	State Veterans Homes
USDA	Department of Agriculture
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Appendix G: ICD-10 Codes for Special Patient Populations

Mental Health Population ICD-10 Codes	
Code	**Description**
F06.0	PSYCHOTIC DISORDER WITH HALLUCINATIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION
F06.1	CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F06.8	OTHER SPECIFIED MENTAL DISORDERS DUE TO KNOWN PHYSIOLOGICAL CONDITION
F06.30	MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION, UNSPECIFIED
F06.31	MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES
F06.33	MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MANIC FEATURES
F07.0	PERSONALITY CHANGE DUE TO KNOWN PHYSIOLOGICAL CONDITION
F09.0	UNSPECIFIED MENTAL DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F20.0	PARANOID SCHIZOPHRENIA
F20.1	DISORGANIZED SCHIZOPHRENIA
F20.2	CATATONIC SCHIZOPHRENIA
F20.3	UNDIFFERENTIATED SCHIZOPHRENIA
F20.5	RESIDUAL SCHIZOPHRENIA
F20.89	OTHER SCHIZOPHRENIA
F20.9	SCHIZOPHRENIA, UNSPECIFIED
F22.0	DELUSIONAL DISORDERS
F25.0	SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE
F25.1	SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
F25.8	OTHER SCHIZOAFFECTIVE DISORDERS

Mental Health Population ICD-10 Codes	
Code	**Description**
F25.9	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
F28.	OTHER PSYCHOTIC DISORDER NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION
F29.	UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION
F31.0	BIPOLAR DISORDER, CURRENT EPISODE HYPOMANIC
F31.10	BIPOLAR DISORDER, CURRENT EPISODE MANIC WITHOUT PSYCHOTIC FEATURES, UNSPECIFIED
F31.13	BIPOLAR DISORDER, CURRENT EPISODE MANIC WITHOUT PSYCHOTIC FEATURES, SEVERE
F31.2	BIPOLAR DISORDER, CURRENT EPISODE MANIC SEVERE WITH PSYCHOTIC FEATURES
F31.30	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD OR MODERATE SEVERITY, UNSPECIFIED
F31.31	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD
F31.32	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MODERATE
F31.4	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, SEVERE, WITHOUT PSYCHOTIC FEATURES
F31.5	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, SEVERE, WITH PSYCHOTIC FEATURES
F31.60	BIPOLAR DISORDER, CURRENT EPISODE MIXED, UNSPECIFIED
F31.64	BIPOLAR DISORDER, CURRENT EPISODE MIXED, SEVERE, WITH PSYCHOTIC FEATURES
F31.70	BIPOLAR DISORDER, CURRENTLY IN REMISSION, MOST RECENT EPISODE UNSPECIFIED
F31.81	BIPOLAR II DISORDER
F31.89	OTHER BIPOLAR DISORDER

Mental Health Population ICD-10 Codes	
Code	**Description**
F31.9	BIPOLAR DISORDER, UNSPECIFIED
F32.0	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD
F32.1	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE
F32.2	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE WITHOUT PSYCHOTIC FEATURES
F32.3	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE WITH PSYCHOTIC FEATURES
F32.89	OTHER SPECIFIED DEPRESSIVE EPISODES
F32.9	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
F33.0	MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD
F33.1	MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
F33.2	MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES
F33.3	MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC SYMPTOMS
F33.8	OTHER RECURRENT DEPRESSIVE DISORDERS
F33.9	MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED
F34.1	DYSTHYMIC DISORDER
F34.9	PERSISTENT MOOD [AFFECTIVE] DISORDER, UNSPECIFIED
F40.01	AGORAPHOBIA WITH PANIC DISORDER
F41.0	PANIC DISORDER [EPISODIC PAROXYSMAL ANXIETY] WITHOUT AGORAPHOBIA
F41.1	GENERALIZED ANXIETY DISORDER
F41.8	OTHER SPECIFIED ANXIETY DISORDERS
F41.9	ANXIETY DISORDER, UNSPECIFIED

Mental Health Population ICD-10 Codes	
Code	**Description**
F42.9	OBSESSIVE-COMPULSIVE DISORDER, UNSPECIFIED
F43.0	ACUTE STRESS REACTION
F43.10	POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED
F43.12	POST-TRAUMATIC STRESS DISORDER, CHRONIC
F43.21	ADJUSTMENT DISORDER WITH DEPRESSED MOOD
F43.23	ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD
F60.0	PARANOID PERSONALITY DISORDER
F60.1	SCHIZOID PERSONALITY DISORDER
F60.2	ANTISOCIAL PERSONALITY DISORDER
F60.5	OBSESSIVE-COMPULSIVE PERSONALITY DISORDER
F60.9	PERSONALITY DISORDER, UNSPECIFIED
F63.9	IMPULSE DISORDER, UNSPECIFIED
F91.9	CONDUCT DISORDER, UNSPECIFIED

Neurocognitive/Dementia Population ICD-10 Codes	
Code	**Description**
F01.50	VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F01.51	VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE
F02.80	DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITHOUT BEHAVIORAL DISTURBANCE
F02.81	DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCE
F03.90	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F03.91	UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE
F10.27	ALCOHOL DEPENDENCE WITH ALCOHOL-INDUCED PERSISTING DEMENTIA
F10.97	ALCOHOL USE, UNSPECIFIED WITH ALCOHOL-INDUCED PERSISTING DEMENTIA
G10.	HUNTINGTON'S DISEASE
G20.	PARKINSON'S DISEASE
G21.11	NEUROLEPTIC INDUCED PARKINSONISM
G21.19	OTHER DRUG INDUCED SECONDARY PARKINSONISM
G21.4	VASCULAR PARKINSONISM
G21.8	OTHER SECONDARY PARKINSONISM
G21.9	SECONDARY PARKINSONISM, UNSPECIFIED
G30.0	ALZHEIMER'S DISEASE WITH EARLY ONSET
G30.1	ALZHEIMER'S DISEASE WITH LATE ONSET
G30.8	OTHER ALZHEIMER'S DISEASE
G30.9	ALZHEIMER'S DISEASE, UNSPECIFIED
G31.09	OTHER FRONTOTEMPORAL DEMENTIA
G31.83	DEMENTIA WITH LEWY BODIES
G31.84	MILD COGNITIVE IMPAIRMENT, SO STATED
I69.118	OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE

Neurocognitive/Dementia Population ICD-10 Codes	
Code	**Description**
I69.315	COGNITIVE SOCIAL OR EMOTIONAL DEFICIT FOLLOWING CEREBRAL INFARCTION
I69.318	OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING CEREBRAL INFARCTION
I69.319	UNSPECIFIED SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING CEREBRAL INFARCTION
I69.919	UNSPECIFIED SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE
R41.81	AGE-RELATED COGNITIVE DECLINE
R41.9	UNSPECIFIED SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS AND AWARENESS

Rehabilitation Population ICD-10 Codes	
Code	**Description**
344.00	QUADRIPLEGIA, UNSP
344.1	PARAPLEGIA NOS
G04.1	TROPICAL SPASTIC PARAPLEGIA
G11.4	HEREDITARY SPASTIC PARAPLEGIA
G23.1	PROGRESSIVE SUPRANUCLEAR OPHTHALMOPLEGIA [STEELE-RICHARDSON-OLSZEWSKI]
G81.01	FLACCID HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G81.03	FLACCID HEMIPLEGIA AFFECTING RIGHT NONDOMINANT SIDE
G81.11	SPASTIC HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G81.12	SPASTIC HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G81.14	SPASTIC HEMIPLEGIA AFFECTING LEFT NONDOMINANT SIDE
G81.90	HEMIPLEGIA, UNSPECIFIED AFFECTING UNSPECIFIED SIDE
G81.91	HEMIPLEGIA, UNSPECIFIED AFFECTING RIGHT DOMINANT SIDE
G81.92	EMIPLEGIA, UNSPECIFIED AFFECTING LEFT DOMINANT SIDE
G81.94	HEMIPLEGIA, UNSPECIFIED AFFECTING LEFT NONDOMINANT SIDE
G82.20	PARAPLEGIA, UNSPECIFIED
G82.21	PARAPLEGIA, COMPLETE
G82.22	PARAPLEGIA, INCOMPLETE
G82.50	QUADRIPLEGIA, UNSPECIFIED
G82.51	QUADRIPLEGIA, C1-C4 COMPLETE

Rehabilitation Population ICD-10 Codes	
Code	**Description**
G82.52	QUADRIPLEGIA, C1-C4 INCOMPLETE
G82.53	QUADRIPLEGIA, C5-C7 COMPLETE
G82.54	QUADRIPLEGIA, C5-C7 INCOMPLETE
G83.24	MONOPLEGIA OF UPPER LIMB AFFECTING LEFT NONDOMINANT SIDE
G83.32	MONOPLEGIA, UNSPECIFIED AFFECTING LEFT DOMINANT SIDE
G83.4	CAUDA EQUINA SYNDROME
G83.5	LOCKED-IN STATE
G83.84	TODD'S PARALYSIS (POSTEPILEPTIC)
G83.9	PARALYTIC SYNDROME, UNSPECIFIED
I69.054	HEMIPLEGIA AND HEMIPARESIS FOLLOWING NONTRAUMATIC SUBARACHNOID HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE
I69.151	HEMIPLEGIA AND HEMIPARESIS FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE AFFECTING RIGHT DOMINANT SIDE
I69.154	HEMIPLEGIA AND HEMIPARESIS FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE
I69.164	OTHER PARALYTIC SYNDROME FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE
I69.193	ATAXIA FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE
I69.251	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER NONTRAUMATIC INTRACRANIAL HEMORRHAGE AFFECTING RIGHT DOMINANT SIDE
I69.252	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER NONTRAUMATIC INTRACRANIAL HEMORRHAGE AFFECTING LEFT DOMINANT SIDE
I69.254	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER NONTRAUMATIC INTRACRANIAL HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE
I69.331	MONOPLEGIA OF UPPER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE
I69.334	MONOPLEGIA OF UPPER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE
I69. 341	MONOPLEGIA OF LOWER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE
I69.342	MONOPLEGIA OF LOWER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT DOMINANT SIDE
I69.344	MONOPLEGIA OF LOWER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE
I69.351	HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE
I69.352	HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT DOMINANT SIDE
I69.353	HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT NON-DOMINANT SIDE

Rehabilitation Population ICD-10 Codes	
Code	**Description**
I69.354	HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE
I69.359	HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING UNSPECIFIED SIDE
I69.364	OTHER PARALYTIC SYNDROME FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE
I69.365	OTHER PARALYTIC SYNDROME FOLLOWING CEREBRAL INFARCTION, BILATERAL
I69.391	DYSPHAGIA FOLLOWING CEREBRAL INFARCTION
I69.393	ATAXIA FOLLOWING CEREBRAL INFARCTION
I69.851	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER CEREBROVASCULAR DISEASE AFFECTING RIGHT DOMINANT SIDE
I69.853	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER CEREBROVASCULAR DISEASE AFFECTING RIGHT NON-DOMINANT SIDE
I69.854	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER CEREBROVASCULAR DISEASE AFFECTING LEFT NON-DOMINANT SIDE
I69.931	MONOPLEGIA OF UPPER LIMB FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING RIGHT DOMINANT SIDE
I69.951	HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING RIGHT DOMINANT SIDE
I69.952	HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING LEFT DOMINANT SIDE
I69.954	HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING LEFT NON-DOMINANT SIDE
I69.959	HEMIPLEGIA AND HEMIPARESIS FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING UNSPECIFIED SIDE
I69.962	OTHER PARALYTIC SYNDROME FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE AFFECTING LEFT DOMINANT SIDE
I69.965	OTHER PARALYTIC SYNDROME FOLLOWING UNSPECIFIED CEREBROVASCULAR DISEASE, BILATERAL
R53.2	FUNCTIONAL QUADRIPLEGIA
S68.114A	COMPLETE TRAUMATIC METACARPOPHALANGEAL AMPUTATION OF RIGHT RING FINGER, INITIAL ENCOUNTER
S78.111D	COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN RIGHT HIP AND KNEE, SUBSEQUENT ENCOUNTER
S78.112D	COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN LEFT HIP AND KNEE, SUBSEQUENT ENCOUNTER
S88.011D	COMPLETE TRAUMATIC AMPUTATION AT KNEE LEVEL, RIGHT LOWER LEG, SUBSEQUENT ENCOUNTER
S88.012D	COMPLETE TRAUMATIC AMPUTATION AT KNEE LEVEL, LEFT LOWER LEG, SUBSEQUENT ENCOUNTER

Rehabilitation Population ICD-10 Codes	
Code	**Description**
S88.111A	COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN KNEE AND ANKLE, RIGHT LOWER LEG, INITIAL ENCOUNTER
S88.111D	COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN KNEE AND ANKLE, RIGHT LOWER LEG, SUBSEQUENT ENCOUNTER
S88.112D	COMPLETE TRAUMATIC AMPUTATION AT LEVEL BETWEEN KNEE AND ANKLE, LEFT LOWER LEG, SUBSEQUENT ENCOUNTER
S88.921A	PARTIAL TRAUMATIC AMPUTATION OF RIGHT LOWER LEG, LEVEL UNSPECIFIED, INITIAL ENCOUNTER
T87.33	NEUROMA OF AMPUTATION STUMP, RIGHT LOWER EXTREMITY
T87.42	INFECTION OF AMPUTATION STUMP, LEFT UPPER EXTREMITY
T87.43	INFECTION OF AMPUTATION STUMP, RIGHT LOWER EXTREMITY
T87.44	INFECTION OF AMPUTATION STUMP, LEFT LOWER EXTREMITY
T87.53	NECROSIS OF AMPUTATION STUMP, RIGHT
T87.54	NECROSIS OF AMPUTATION STUMP, LEFT LOWER EXTREMITY
T87.81	DEHISCENCE OF AMPUTATION STUMP
T87.89	OTHER COMPLICATIONS OF AMPUTATION STUMP
Z47.1	AFTERCARE FOLLOWING JOINT REPLACEMENT SURGERY
Z47.31	AFTERCARE FOLLOWING EXPLANTATION OF SHOULDER JOINT PROSTHESIS
Z47.32	AFTERCARE FOLLOWING EXPLANTATION OF HIP JOINT PROSTHESIS
Z47.33	AFTERCARE FOLLOWING EXPLANTATION OF KNEE JOINT PROSTHESIS
Z47.81	ENCOUNTER FOR ORTHOPEDIC AFTERCARE FOLLOWING SURGICAL AMPUTATION
Z47.82	ENCOUNTER FOR ORTHOPEDIC AFTERCARE FOLLOWING SCOLIOSIS SURGERY
Z47.89	ENCOUNTER FOR OTHER ORTHOPEDIC AFTERCARE
Z48.22	ENCOUNTER FOR AFTERCARE FOLLOWING KIDNEY TRANSPLANT
Z48.23	ENCOUNTER FOR AFTERCARE FOLLOWING LIVER TRANSPLANT
Z48.288	ENCOUNTER FOR AFTERCARE FOLLOWING MULTIPLE ORGAN TRANSPLANT
Z48.3	AFTERCARE FOLLOWING SURGERY FOR NEOPLASM
Z48.810	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE SENSE ORGANS
Z48.811	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE NERVOUS SYSTEM
Z48.812	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE CIRCULATORY SYSTEM
Z48.813	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE RESPIRATORY SYSTEM
Z48.815	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE DIGESTIVE SYSTEM

Rehabilitation Population ICD-10 Codes	
Code	**Description**
Z48.816	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE GENITOURINARY SYSTEM
Z48.817	ENCOUNTER FOR SURGICAL AFTERCARE FOLLOWING SURGERY ON THE SKIN AND SUBCUTANEOUS TISSUE
Z48.89	ENCOUNTER FOR OTHER SPECIFIED SURGICAL AFTERCARE
Z51.89	ENCOUNTER FOR OTHER SPECIFIED AFTERCARE

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S02.91XD	UNSPECIFIED FRACTURE OF SKULL, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S06.0X1A	CONCUSSION WITH LOSS OF CONSCIOUSNESS OF 30 MINUTES OR LESS, INITIAL ENCOUNTER
S06.0X9D	CONCUSSION WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.2X0D	DIFFUSE TRAUMATIC BRAIN INJURY WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.2X0S	DIFFUSE TRAUMATIC BRAIN INJURY WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA
S06.2X6D	DIFFUSE TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS GREATER THAN 24 HOURS WITHOUT RETURN TO PRE-EXISTING CONSCIOUS LEVEL WITH PATIENT SURVIVING, SUBSEQUENT ENCOUNTER
S06.2X6S	DIFFUSE TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS GREATER THAN 24 HOURS WITHOUT RETURN TO PRE-EXISTING CONSCIOUS LEVEL WITH PATIENT SURVIVING, SEQUELA
S06.2X9S	DIFFUSE TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S06.309A	UNSPECIFIED FOCAL TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, INITIAL ENCOUNTER
S06.309S	UNSPECIFIED FOCAL TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S06.310D	CONTUSION AND LACERATION OF RIGHT CEREBRUM WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.349D	TRAUMATIC HEMORRHAGE OF RIGHT CEREBRUM WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.360D	TRAUMATIC HEMORRHAGE OF CEREBRUM, UNSPECIFIED, WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.360S	TRAUMATIC HEMORRHAGE OF CEREBRUM, UNSPECIFIED, WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA
S06.369A	TRAUMATIC HEMORRHAGE OF CEREBRUM, UNSPECIFIED, WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, INITIAL ENCOUNTER

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S06.369S	TRAUMATIC HEMORRHAGE OF CEREBRUM, UNSPECIFIED, WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S06.4X0D	EPIDURAL HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.5X0A	TRAUMATIC SUBDURAL HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, INITIAL ENCOUNTER
S06.5X0D	TRAUMATIC SUBDURAL HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.5X0S	TRAUMATIC SUBDURAL HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA
S06.5X1D	TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF 30 MINUTES OR LESS, SUBSEQUENT ENCOUNTER
S06.5X6S	TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS GREATER THAN 24 HOURS WITHOUT RETURN TO PRE-EXISTING CONSCIOUS LEVEL WITH PATIENT SURVIVING, SEQUELA
S06.5X9A	TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, INITIAL ENCOUNTER
S06.5X9D	TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.5X9S	TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S06.6X0D	TRAUMATIC SUBARACHNOID HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.6X0S	TRAUMATIC SUBARACHNOID HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA
S06.6X9A	TRAUMATIC SUBARACHNOID HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, INITIAL ENCOUNTER
S06.6X9D	TRAUMATIC SUBARACHNOID HEMORRHAGE WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.890A	OTHER SPECIFIED INTRACRANIAL INJURY WITHOUT LOSS OF CONSCIOUSNESS, INITIAL ENCOUNTER
S06.890D	OTHER SPECIFIED INTRACRANIAL INJURY WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER
S06.890S	OTHER SPECIFIED INTRACRANIAL INJURY WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S06.899D	OTHER SPECIFIED INTRACRANIAL INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.899S	OTHER SPECIFIED INTRACRANIAL INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S06.9X0A	UNSPECIFIED INTRACRANIAL INJURY
S06.9X0D	UNSPECIFIED INTRACRANIAL INJURY
S06.9X0S	UNSPECIFIED INTRACRANIAL INJURY WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA
S06.9X3A	UNSPECIFIED INTRACRANIAL INJURY WITH LOSS OF CONSCIOUSNESS OF 1 HOUR TO 5 HOURS 59 MINUTES, INITIAL ENCOUNTER
S06.9X9D	UNSPECIFIED INTRACRANIAL INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER
S06.9X9S	UNSPECIFIED INTRACRANIAL INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SEQUELA
S12.000A	UNSPECIFIED DISPLACED FRACTURE OF FIRST CERVICAL VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S12.001D	UNSPECIFIED NONDISPLACED FRACTURE OF FIRST CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.100D	UNSPECIFIED DISPLACED FRACTURE OF SECOND CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.100S	UNSPECIFIED DISPLACED FRACTURE OF SECOND CERVICAL VERTEBRA, SEQUELA
S12.101D	UNSPECIFIED NONDISPLACED FRACTURE OF SECOND CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.110D	ANTERIOR DISPLACED TYPE II DENS FRACTURE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.112D	NONDISPLACED TYPE II DENS FRACTURE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.300D	UNSPECIFIED DISPLACED FRACTURE OF FOURTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.400D	UNSPECIFIED DISPLACED FRACTURE OF FIFTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.401D	UNSPECIFIED NONDISPLACED FRACTURE OF FIFTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S12.401D	UNSPECIFIED NONDISPLACED FRACTURE OF FIFTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.450D	OTHER TRAUMATIC DISPLACED SPONDYLOLISTHESIS OF FIFTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.490D	OTHER DISPLACED FRACTURE OF FIFTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.500D	UNSPECIFIED DISPLACED FRACTURE OF SIXTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.500S	UNSPECIFIED DISPLACED FRACTURE OF SIXTH CERVICAL VERTEBRA, SEQUELA
S12.501D	UNSPECIFIED NONDISPLACED FRACTURE OF SIXTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.600D	UNSPECIFIED DISPLACED FRACTURE OF SEVENTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.601D	UNSPECIFIED NONDISPLACED FRACTURE OF SEVENTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.690D	OTHER DISPLACED FRACTURE OF SEVENTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.691D	OTHER NONDISPLACED FRACTURE OF SEVENTH CERVICAL VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S12.9XXD	FRACTURE OF NECK, UNSPECIFIED, SUBSEQUENT ENCOUNTER
S13.4XXD	SPRAIN OF LIGAMENTS OF CERVICAL SPINE, SUBSEQUENT ENCOUNTER
S14.101D	UNSPECIFIED INJURY AT C1 LEVEL OF CERVICAL SPINAL CORD, SUBSEQUENT ENCOUNTER
S14.109D	UNSPECIFIED INJURY AT UNSPECIFIED LEVEL OF CERVICAL SPINAL CORD, SUBSEQUENT ENCOUNTER
S14.114A	COMPLETE LESION AT C4 LEVEL OF CERVICAL SPINAL CORD, INITIAL ENCOUNTER
S14.124A	CENTRAL CORD SYNDROME AT C4 LEVEL OF CERVICAL SPINAL CORD, INITIAL ENCOUNTER
S14.124D	CENTRAL CORD SYNDROME AT C4 LEVEL OF CERVICAL SPINAL CORD, SUBSEQUENT ENCOUNTER
S14.2XXA	INJURY OF NERVE ROOT OF CERVICAL SPINE, INITIAL ENCOUNTER

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S14.153D	OTHER INCOMPLETE LESION AT C3 LEVEL OF CERVICAL SPINAL CORD, SUBSEQUENT ENCOUNTER
S19.89XA	OTHER SPECIFIED INJURIES OF OTHER SPECIFIED PART OF NECK, INITIAL ENCOUNTER
S20.20XD	CONTUSION OF THORAX, UNSPECIFIED,
S20.212D	CONTUSION OF LEFT FRONT WALL OF THORAX, SUBSEQUENT ENCOUNTER
S20.219A	CONTUSION OF UNSPECIFIED FRONT WALL OF THORAX, INITIAL ENCOUNTER
S20.219D	CONTUSION OF UNSPECIFIED FRONT WALL OF THORAX, SUBSEQUENT ENCOUNTER
S22.000A	WEDGE COMPRESSION FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.000D	WEDGE COMPRESSION FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.039D	UNSPECIFIED FRACTURE OF THIRD THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.051D	STABLE BURST FRACTURE OF T5-T6 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.060D	WEDGE COMPRESSION FRACTURE OF T7-T8
S22.061D	STABLE BURST FRACTURE OF T7-T8
S22.062D	UNSTABLE BURST FRACTURE OF T7-T8 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.068D	OTHER FRACTURE OF T7-T8 THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.069A	UNSPECIFIED FRACTURE OF T7-T8 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.069D	UNSPECIFIED FRACTURE OF T7-T8 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.070A	WEDGE COMPRESSION FRACTURE OF T9-T10 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.070D	WEDGE COMPRESSION FRACTURE OF T9-T10 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.072D	UNSTABLE BURST FRACTURE OF T9-T10 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.078A	OTHER FRACTURE OF T9-T10 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S22.079A	UNSPECIFIED FRACTURE OF T9-T10 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.079D	UNSPECIFIED FRACTURE OF T9-T10 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.080A	WEDGE COMPRESSION FRACTURE OF T11-T12 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.080D	WEDGE COMPRESSION FRACTURE OF T11-T12 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.081D	STABLE BURST FRACTURE OF T11-T12 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.082B	UNSTABLE BURST FRACTURE OF T11-T12 VERTEBRA, INITIAL ENCOUNTER FOR OPEN FRACTURE
S22.089A	UNSPECIFIED FRACTURE OF T11-T12 VERTEBRA, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.089D	UNSPECIFIED FRACTURE OF T11-T12 VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.20XA	UNSPECIFIED FRACTURE OF STERNUM, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.31XA	FRACTURE OF ONE RIB, RIGHT SIDE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.31XD	FRACTURE OF ONE RIB, RIGHT SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.32XA	FRACTURE OF ONE RIB, LEFT SIDE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.32XD	FRACTURE OF ONE RIB, LEFT SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.39XD	FRACTURE OF ONE RIB, UNSPECIFIED SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.41XA	MULTIPLE FRACTURES OF RIBS, RIGHT SIDE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.41XD	MULTIPLE FRACTURES OF RIBS, RIGHT SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.43XA	MULTIPLE FRACTURES OF RIBS, BILATERAL, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.43XD	MULTIPLE FRACTURES OF RIBS, BILATERAL, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S22.49XA	MULTIPLE FRACTURES OF RIBS, UNSPECIFIED SIDE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S22.49XD	MULTIPLE FRACTURES OF RIBS, UNSPECIFIED SIDE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S22.5XXA	FLAIL CHEST, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S24.102A	UNSPECIFIED INJURY AT T2-T6 LEVEL OF THORACIC SPINAL CORD, INITIAL ENCOUNTER
S24.103D	UNSPECIFIED INJURY AT T7-T10 LEVEL OF THORACIC SPINAL CORD, SUBSEQUENT ENCOUNTER
S24.133D	ANTERIOR CORD SYNDROME AT T7-T10 LEVEL OF THORACIC SPINAL CORD, SUBSEQUENT ENCOUNTER
S27.808D	OTHER INJURY OF DIAPHRAGM, SUBSEQUENT ENCOUNTER
S42.001A	FRACTURE OF UNSPECIFIED PART OF RIGHT CLAVICLE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S42.001D	FRACTURE OF UNSPECIFIED PART OF RIGHT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.002A	FRACTURE OF UNSPECIFIED PART OF LEFT CLAVICLE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S42.002D	FRACTURE OF UNSPECIFIED PART OF LEFT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.002G	FRACTURE OF UNSPECIFIED PART OF LEFT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH DELAYED HEALING
S42.021D	DISPLACED FRACTURE OF SHAFT OF RIGHT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.022D	DISPLACED FRACTURE OF SHAFT OF LEFT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.024D	NONDISPLACED FRACTURE OF SHAFT OF RIGHT CLAVICLE, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.034A	NONDISPLACED FRACTURE OF LATERAL END OF RIGHT CLAVICLE, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S42.102A	FRACTURE OF UNSPECIFIED PART OF SCAPULA, LEFT SHOULDER, INITIAL ENCOUNTER FOR CLOSED FRACTURE
S42.111D	DISPLACED FRACTURE OF BODY OF SCAPULA, RIGHT SHOULDER, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING

Ventilator-Dependent Population ICD-10 Codes	
Code	**Description**
S42.115D	NONDISPLACED FRACTURE OF BODY OF SCAPULA, LEFT SHOULDER, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.121D	DISPLACED FRACTURE OF ACROMIAL PROCESS, RIGHT SHOULDER, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.141D	DISPLACED FRACTURE OF GLENOID CAVITY OF SCAPULA, RIGHT SHOULDER, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
S42.155D	NONDISPLACED FRACTURE OF NECK OF SCAPULA, LEFT SHOULDER, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING
T20.24XD	BURN OF SECOND DEGREE OF NOSE (SEPTUM), SUBSEQUENT ENCOUNTER
T20.29XD	BURN OF SECOND DEGREE OF MULTIPLE SITES OF HEAD, FACE, AND NECK, SUBSEQUENT ENCOUNTER
T20.30XD	BURN OF THIRD DEGREE OF HEAD, FACE, AND NECK, UNSPECIFIED SITE, SUBSEQUENT ENCOUNTER
T21.02XD	BURN OF UNSPECIFIED DEGREE OF ABDOMINAL WALL, SUBSEQUENT ENCOUNTER