

1147 and Level of Care Training

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Introduction and Objectives

A. Introduction

B. Objectives

- Complete a functional status assessment on the 1147 more accurately.
- Learn tips on meeting Skilled Nursing Facility (SNF) criteria for common SNF qualifiers.
- Learn how to submit technical support inquiries, when necessary.

Types of 1147 Forms

- 1147—3 pages (for Adults Only)
 - A comprehensive assessment of the individual
 - Initial entry into NF Level of Care (LOC) or at-risk
 - Annual Assessment
- 1147e—children, under the age of 21

The image shows a sample of the State of Hawaii 1147 form, titled "Level of Care (LOC) and At Risk Evaluation". The form is divided into several sections: 1. Patient Information (Name, Date of Birth, Sex, Race, Ethnicity, etc.), 2. Referral Information (Referring Party, Date, etc.), 3. Assessment Information (Assessor's Name, Date, etc.), 4. Medical Necessity Determination (Check one box: Nursing Facility, Hospice, etc.), 5. Approval (Signature, Date, etc.). The form is titled "STATE OF HAWAII Department of Human Services" and "HEALTH SERVICES ADVISORY GROUP".

Types of 1147 Forms (cont.)

- 1147a—short form (for Adults and Children)
 - Extension or change in LOC
 - Requires an approved 3 page 1147 (except at-risk approval)
 - Start date needs to fall within the 3 page 1147 approval dates
 - Cannot use if requesting long-term care placement after SNF approval for restorative therapy

1147 Form—HILOC

Page 1

Page 2

Page 3

Attachments

☐ Rush Priority

1. Request Type

Jump to [top] [bottom]

☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other Review

7. Present Address

Jump to [top] [bottom]

☐ HOME ☐ HOSPITAL ☐ NF ☐ CCFFH ☐ CARE HOME ☐ EARCH ☐ OTHER

1. Request Type:

- Initial—First request or first request of a different LOC
- Annual—Same LOC request yearly
- Reconsideration—Select if the previous one was denied
- Other review—Any other (i.e., change in LOC request)

2. Present Address: Be sure to indicate where patient currently is at.

For example: If patient is planning on being discharged to home but is currently in the hospital, you would select hospital.

If retrospective request, indicate where patient was at the time of the assessment.

- ☐ Nursing Facility (ICF)
- ☐ Nursing Facility (SNF)
- ☐ Nursing Facility (Hospice)
- ☐ Nursing Facility (Subacute I)
- ☐ Nursing Facility (Subacute II)
- ☐ Acute Waitlist (ICF)
- ☐ Acute Waitlist (SNF)
- ☐ Acute Waitlist (Subacute)
- ☐ At Risk

Start Date

End Date



13. Requesting:

- NF ICF: Individual is in a NF, foster home, EARCH, or home
 - The individual must require intermittent skilled nursing, daily skilled nursing assessment, and 24 hour supervision or significant assistance with ADLs.
- NF SNF: Individual is in a NF or at home
 - The Individual must require daily skilled nursing or daily restorative skilled rehabilitation
- NF Hospice: Individual is in a Medicaid certified NF
 - Must meet NF ICF level of care, consent for hospice care, certification of terminal illness by two physicians

1147 Form—HILOC (cont.)

13. Requesting (cont.):

- NF Subacute I and II:
Certain facilities that are subacute
 - Subacute I: Ventilator dependent more than 50%
 - Subacute II: Ventilator dependent less than 50%, trach care with suctioning at least 1–2 hours, etc. (refer to LOC Criteria)



1147 Form—HILOC (cont.)

13. Requesting (cont.):

- Acute Waitlist ICF and SNF: Individual is in the hospital (acute care bed) waitlisted for either discharge to home or placement in an alternative care environment (i.e., care home, foster home).
 - AW ICF: Requires intermittent skilled nursing, daily skilled nursing assessment, and 24-hour supervision or significant assistance with ADLs.
 - AW SNF: Receiving daily skilled nursing or restorative rehabilitative therapy

1147 Form—HILOC (cont.)

13. Requesting (cont.):

- At-risk: Individual is in a home, shelter, or group home
 - The individual does not meet NF ICF LOC and is at-risk of deteriorating to an institutional LOC if certain long-term services and support are not provided.



1147 Form—HILOC (cont.)

13. Requesting (*cont.*):

- Individual may be eligible to receive home and community-based services (HCBS):
 - Home-delivered meals
 - Personal Emergency Response System (PERS)
 - Personal assistance (levels I and II)
 - Adult day care
 - Adult day health
 - Skilled nursing services



1147 Form—Functional Status

Page 1 Page 2 Page 3 Attachments

3. Functional Status Related To Health Conditions

I. Select Significant Current Diagnosis(es): [Jump to \[top \] \[bottom \]](#)

Primary Diagnosis

Secondary Diagnoses [Add Diagnosis](#)

I. Select Significant Current Diagnosis(es):

- Do not enter diagnosis codes, enter the name of the medical condition or disease
- Primary diagnosis—Should be the main diagnosis relating to the LOC requested and explaining functional deficits
- Secondary diagnosis—Enter these diagnoses. Gives a better understanding of patient's various conditions or if patient has multiple comorbidities

II. Comatose

[Jump to \[top \] \[bottom \]](#)

☐ No ☐ Yes If "Yes", go to [XVIII](#)

III. Vision / Hearing/ Speech

[Jump to \[top \] \[bottom \]](#)

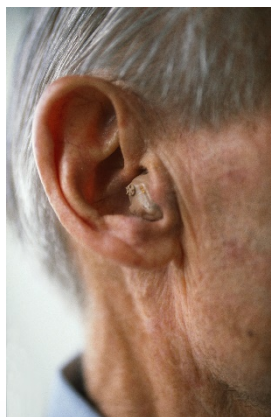
☐ Vision ☐ Hearing ☐ Speech

- ☐ a. Individual has normal or minimal impairment (with/without corrective device)
- ☐ b. Individual has impairment (with/without corrective device)
- ☐ c. Individual has complete absence of hearing/vision/speech

II. Comatose

III. Vision/Hearing/Speech:

- If the patient has more than one type of sensory impairment and one is worse than the other, select according to the worse one.



IV. Communication

- ☐ a. Adequately communicates needs/wants
- ☐ b. Has difficulty communicating needs/wants
- ☐ c. Unable to communicate needs/wants

V. Memory

- ☐ a. Normal or minimal impairment of memory
- ☐ b. Problem with long-term or short-term memory.
- ☐ c. Individual has a problem with both long-term and short-term memory

VI. Mental Status / Behavior

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Oriented (mentally alert and aware of surroundings).
- ☐ b. Disoriented (partially or intermittently; requires supervision).
- ☐ c. Disoriented and/or disruptive.
- ☐ d. Aggressive and/or abusive.
- ☐ e. Wanders ☐ Day ☐ Night ☐ Both and/or ☐ In danger of self-inflicted harm or self-neglect.



VI. Mental Status/Behavior

- a. Oriented (mentally alert and aware of surroundings): Oriented to person place or time; can direct needs that must be met to maintain self-care. No behaviors.
- b. Disoriented (partially or intermittently, requires supervision): Intermittently confused/and/or agitated.
- c. Disoriented and/or disruptive: Recurrent episodes (1–3 times a day) or being confused, forgetful, agitated, disruptive, and/or aggressive. No major safety concerns.

Aggressive and/or abusive

- Should be recurrent episodes (1–3 times a day), requiring intensive supervision and physical/mechanical/medication interventions to manage behaviors

VI. Mental Status / Behavior

Jump to [top] [bottom]


- ☐ a. Oriented (mentally alert and aware of surroundings).
- ☐ b. Disoriented (partially or intermittently; requires supervision).
- ☐ c. Disoriented and/or disruptive.
- ☐ d. Aggressive and/or abusive.
- ☐ e. Wanders ☐ Day ☐ Night ☐ Both and/or ☐ In danger of self-inflicted harm or self-neglect. 🚨

VI. Mental Status/Behavior—(cont.)

Wanders—Day, Night, or Both (day and night)

- Should be occurring at least daily and causing a safety concern requiring intensive supervision. Provide a wandering log.
- Assessment needs to make sense (i.e., patient should be ambulatory if able to wander [not needing one-person assistance]).



VI. Mental Status / Behavior		Jump to [top] [bottom]
<input type="checkbox"/> a. Oriented (mentally alert and aware of surroundings).		
<input type="checkbox"/> b. Disoriented (partially or intermittently; requires supervision).		
<input type="checkbox"/> c. Disoriented and/or disruptive.		
<input type="checkbox"/> d. Aggressive and/or abusive.		
<input type="checkbox"/> e. Wanders <input type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Both and/or	<input type="checkbox"/> In danger of self-inflicted harm or self-neglect. 	


In danger of self-harm and self-neglect:

- Should be examples that are beyond what is already captured in the functional assessment (i.e., “not able to do ADLs” is already reflected in assessment).
- Should be occurring at least daily and causing a safety concern requiring intensive supervision


Some examples:

- Patient constantly hurts self by punching his/her head, does not wear a helmet or mittens, requires constant supervision
- Drinks and/or eats inappropriate items (i.e., Drano, gasoline, small jacks, marbles). Caregiver must consistently provide constant supervision to ensure that the patient does not ingest any harmful items.

Mental Status/Behavior—(cont.)

VI. Mental Status / Behavior		Jump to [top] [bottom]
<input type="checkbox"/> a. Oriented (mentally alert and aware of surroundings).		
<input type="checkbox"/> b. Disoriented (partially or intermittently; requires supervision).		
<input type="checkbox"/> c. Disoriented and/or disruptive.		
<input type="checkbox"/> d. Aggressive and/or abusive.		
<input type="checkbox"/> e. Wanders <input type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Both and/or <input type="checkbox"/> In danger of self-inflicted harm or self-neglect.		

Message from webpage



You must provide specific behavioral examples, frequency of occurrence, and interventions used to ensure safety to patient and others.

OK

New verbiage for pop-up window as a reminder.

VII. Feeding

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Independent with or without an assistive device.
- ☐ b. Needs supervision or assistance with feeding.
- ☐ c. Is spoon / syringe / tube fed, does not participate.

VIII. Transferring

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Independent with or without a device.
- ☐ b. Transfers with minimal /stand-by help of another person.
- ☐ c. Transfers with supervision and physical assistance of another person.
- ☐ d. Does not assist in transfer or is bedfast.

VIII. Transferring:

- a. Does not require assistance of another person
- b. Able to transfer with minimal or stand by assistance due to occasional loss of balance on transferring
- c. Requires the presence of another when transferring because of unsteadiness and/or weakness
- d. Completely dependent due to physical or mental condition. Frequent transfer and/or positioning. May require 2-person transfer or lifting equipment because of person's size or disability

- ☐ a. Independently mobile with or without device.
- ☐ b. Ambulates with or without device but unsteady / subject to falls.
- ☐ c. Able to walk / be mobile with minimal assistance.
- ☐ d. Able to walk / be mobile with one assist.
- ☐ e. Able to walk / be mobile with more than one assist.
- ☐ f. Unable To Walk

IX. Mobility/Ambulation

Key Points:

- a. Patient who can **self propel** in a wheelchair would count for this selection.
- b. Can walk/be mobile, but requires stand by assistance and subject to falls.
- c. Requires the presence of another person for minimal assistance.
- d. One assist refers to needing someone to provide **physical** assistance.
- e. Requires more than one person for **physical** assistance.
- f. Unable to walk/be mobile

Note: The assessment should reflect patient's status at home or facility, not what assistance the patient needs out in the community.

X. Bowel Function / Continence

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Continent
- ☐ b. Continent with cues.
- ☐ c. Incontinent (at least once daily).
- ☐ d. Incontinent (more than once daily)

XI. Bladder Function / Continence

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Continent
- ☐ b. Continent with cues.
- ☐ c. Incontinent (at least once daily).
- ☐ d. Incontinent (more than once daily).

X. & XI. Bladder & Bowel Function/Continence:

- a. Continent: Patient is able to perform bladder or bowel care/needs independently, including Foley or colostomy
- b. Continent with cues: Patient requires cues/reminders to perform bladder or bowel care/needs
- c. Incontinent (at least once daily): Incontinence not frequent and needs help on a regular basis to clean self or needs assistance with Foley or colostomy
- d. Incontinent (more than once daily): Frequently incontinent and needs help on a regular basis to clean self; Foley or colostomy shows complications (i.e., leaking)

XII. Bathing

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Independent bathing.
- ☐ b. Unable to safely bathe without minimal assistance and supervision.
- ☐ c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath)

XII Bathing:

- a. Patient is independent and doesn't need any assistance. May require someone to prepare bathroom/shower.
- b. Patient needs supervision while bathing to ensure safety. Patient can bathe some parts of their body (i.e. face and chest) but needs assistance with completing most of his/her bath.
- c. Patient is totally dependent with bathing and is not able to bathe any part of his/her body due to physical or mental disability

XIII. Dressing and Personal Grooming

[Jump to \[top \] \[bottom \]](#)

- ☐ a. Appropriate and independent dressing, undressing and grooming.
- ☐ b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
- ☐ c. Physical assistance needed on a regular basis.
- ☐ d. Requires total help in dressing, undressing, and grooming.

Additional Questions for At-Risk

Complete questions XIV to XVII for At Risk only:

XIV. House Cleaning

- ☐ a. Independent.
- ☐ b. Needs Assistance.
- ☐ c. Unable to safely clean the home.

XV. Shopping

- ☐ a. Independent.
- ☐ b. Needs Assistance.
- ☐ c. Unable to safely go shopping.

XVI. Laundry

- ☐ a. Independent.
- ☐ b. Needs Assistance.
- ☐ c. Unable to safely do the laundry.

XVII. Meal Preparation

- ☐ a. Independent.
- ☐ b. Needs Assistance.
- ☐ c. Unable to safely prepare a meal.



XIX. Medication / Treatments

Jump to [top] [bottom]

☐ Administers Independently

☐ Requires Supervision / Monitoring

☐ Requires Admin

Add Medication

Frequency

Add Medication

Medications

Remove Selection

XX. Additional Information Concerning Patient's Functional Status

Jump to [top] [bottom]

XIX. Medication/Treatments: If providing attachment, enter “See Attachment”

XX. Additional Information: Describe significant decline. Add additional information that will justify LOC (especially for initial or reconsideration request).

XXI. Skilled Procedures

Jump to [top] [bottom]

Number of Times Per DayProfessional Nursing Assessment/Care Related To Management of:

- ☐ Daily #
- ☐ Less than once/day
- ☒ N/A - Never

Tracheostomy care/suctioning in ventilator dependent person

- ☐ Daily #
- ☐ Less than once/day
- ☒ N/A - Never

Tracheostomy care/suctioning in non-ventilator dependent person.

- ☐ Daily #
- ☐ Less than once/day
- ☒ N/A - Never

Nasopharyngeal suctioning in persons with no tracheostomy

- ☐ Daily #
- ☐ Less than once/day
- ☒ N/A - Never

Total Parenteral Nutrition (TPN).
Specify number of hours per day.

- ☐ Daily #
- ☐ Less than once/day
- ☒ N/A - Never

Maintenance of peripheral/central IV lines

Skilled Nursing Facility (SNF) Tips

- Restorative Therapy (PT/OT/SP):
 - Must provide at least 3 goals for at least one therapy type.
 - Must participate at least 45 mins per day 5 times per week. OK to combine sessions in one day. Can't combine therapy types.



Skilled Nursing Facility (SNF) Tips (cont.)

- Respiratory Care: Required at least 4 times a day (single or combination or respiratory care)
 - Trach care and suctioning
 - Nasopharyngeal suction
 - Nebulizer treatments



Skilled Nursing Facility (SNF) Tips (cont.)

- IV Meds
 - Must be given daily.
 - Provide IV med name, dose, frequency.
- Complex wound care
 - Daily skilled nursing assessment and complex intervention
 - Daily packing, sterile dressing change, and etc.
 - Wound vacuum therapy




Skilled Nursing Facility (SNF) Tips (cont.)

- Oxygen
 - Initial phases involving titration of O₂
- Tube feeding
 - Continuous tube feeding
 - New tube feeders: Provide start date
 - Aspiration pneumonia: Provide date of episodes and nursing interventions to prevent aspiration



Skilled Nursing Facility (SNF) Tips

- Others: Refer to Level of Care Criteria



State of Hawaii LOC Criteria

Criteria for LOC Decisions

The following examples of clinical indications for the different levels of care are listed; the patient's overall medical status and functional limitations should be considered when determining the appropriate level of care.

CLINICAL INDICATIONS FOR LEVEL OF CARE

	ACUTE M.D. Daily Visits	SUBACUTE*	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF Professional Nurse Daily Assessment MAINTENANCE CARE
Ostomy care.	Initial teaching of ostomy care; operative admission; irrigation initiated.	Does not qualify.	Uncomplicated ostomy care does not qualify.	Maintenance care.
Parenteral therapy.	Adjunct therapy.	If complicated, RN Supervision 5 hours per day.	For hydration (potassium, vitamins, etc. can be included.	Not appropriate.
Hyperalimentation.	Initial administration; adjunct therapy.	If complicated, RN Supervision 5 hours per day.	Some hospital based SNFs may provide.	Not appropriate.
Chemotherapy.	24 hr infusion or observation.	Infusion more than 4 hours, RN supervision 5 hours per day.	Short term infusion less than 4 hours or PO, RN supervision.	Not appropriate.
Radiation therapy.	Initial treatments (daily for 1 week) in debilitated patients.	Daily treatments in patients requiring RN supervision 5 hours per day.	Daily treatments in patients requiring RN supervision.	Occasionally appropriate.
Decubitus care/Wound care.	For Graft or Surgical debridement; Aggressive therapy both surgical and intravenous antibiotics.	Complex wound care such as debridement, packing dressing, and irrigation requiring more than 5 hours per day of RN care.	Complex wound care involving daily skilled nursing assessment and daily complex intervention(s) such as wound debridement, soaks, irrigation, whirlpool, packing, wound vacuum therapy, and/or complex dressing changes requiring sterile (aseptic) technique.	Wound care that is not complex, such as dressing changes requiring CLEAN technique, wet to dry dressings, dry dressings, occlusive dressings.
TUBE FEEDING				
1) Nasogastric.	Initial acute care and initial teaching.	1) Appropriate if there is a history of aspiration pneumonia, history of multiple episodes of aspiration pneumonia; patient incapable of self-administration and/or incapable of learning and following aspiration precautions - i.e., dementia and total skilled nursing needs exceed 5 hours per day.	1) Appropriate if the patient is pump fed or there is a history of aspiration pneumonia in past 12 months or history of multiple episodes of aspiration pneumonia while on NG tube feedings or if patient requires specific skilled nursing services to prevent aspiration. Also appropriate for new NG feeders.	Appropriate for patients with no history of aspiration pneumonia on NG/GT feedings and patients who are stable on chronic, bolus feedings on stable schedule. Appropriate for patients who are able to self-administer and capable of learning and performing aspiration precautions.

Care Home Level of Care

- **Care Home:**
 - 1147 is not required for care home LOC
 - Generally custodial care but includes individuals with medical needs
- **Examples:**
 - Needs assistance with ADLs during the day and evening, but not at night
 - Needs supervision less than 24 hours
 - Wanders during the day and evening, not at night



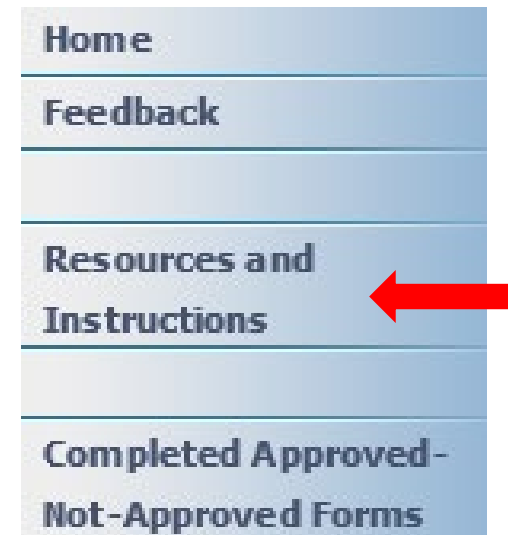
Care Home Level of Care (cont.)

- Examples (cont.):
 - Stable medical conditions: Diabetics on routine insulin, kidney disease, COPD, etc.
 - Stable equipment usage: CPAP, BiPAPs, ostomies, wheelchairs, oxygen, nebulizer treatments, etc.
 - Self preserving, can exit a home with minimal assistance in an event of a fire



1147/LOC Resources

- HILOC Resources and Instructions:
 - 1147 forms and 1147 instructions
 - Form quick tips sheet
 - Criteria for at-risk
 - Functional status assessment instructions
 - Guide for HILOC users and FAQs
 - Hospice guidelines
- Website: www.myhawaiieqro.com



Technical Support

- **Technical Assistance**

- Email: HILOCSupport@hsag.com
- Call HSAG Hawaii Office: 808.941.1444
 - (Office hours 7:45 a.m.—4:30 p.m. HST)
 - HSAG Help Desk: 1.866.316.6974
- Use Feedback in HILOC



Contacts

Health Service Advisory Group (HSAG)

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Med-QUEST

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Questions?





If we were unable to answer your questions in the chat box, please contact:

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dmizuno@hsag.com | 808.941.1444

Please complete the evaluation at:

<http://bit.ly/2Pa1Bmt>

If you registered online for this event,
you will also receive the link via email.