DAVID Y. IGE
GOVERNOR

CATHY BETTS
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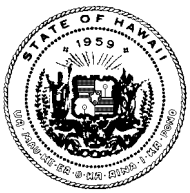

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 29, 2021

MEMO NO.
QI-2132 [Replaces QI-1406]

MEMORANDUM

TO: QUEST Integration (QI) Health Plans

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: AT RISK FOR INSTITUTIONAL LEVEL OF CARE CRITERIA

The purpose of this memorandum is to notify the health plans that this memo replaces QI-1406 which was previously issued on July 8, 2014. The following content is substantively unchanged from QI-1406 and will continue to apply under the QI contract RFP-MQD-2021-008.

The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to provide QUEST Integration (QI) health plans with criteria for individuals who are at-risk of deteriorating to institutional level of care as identified in Section 4.8, B. of the QUEST Integration RFP-MQD-2021-008.

As part of the QUEST Integration section 1115 demonstration waiver, MQD has expanded access to home and community-based services (HCBS) to individuals “at-risk” of institutional level of care.

At-risk criteria includes living outside of an institution or residential setting and being assessed to be at risk of deteriorating to the nursing facility level of care based on a functional assessment. This assessment will occur on a DHS Form 1147. The DHS Form 1147 includes a specific section to be completed when requesting at-risk services. MQD, or their delegate, Peer Review Organization Health Services Advisory Group (HSAG), will evaluate and determine whether a recipient meets criteria based on the information documented on the DHS Form 1147.

The DHS 1147 must be completed by a physician, registered nurse, or other recognized primary care provider, or by the health plan using the current submittal processes through the secure Web-application (HILOC), via faxing (808-440-6009), or mailing forms to HSAG. Hard copy versions of DHS 1147 may be accessed and downloaded/printed from the website at http://myhawaiieqro.com or www.med-quest.us provider forms.

There are (3) three levels of at-risk services based on the approved functional assessment score. Potentially available services include: Home-Delivered Meals, Personal Emergency Response System, Personal Care Services, Adult Day Care and Health, and Skilled or Private Duty Nursing Services. The available at-risk services by functional assessment score are attached.

If there are any questions or concerns, please email Ms. Kathleen Ishihara, Nurse Consultant at kishihara@dhs.hawaii.gov .

Attachments:
Criteria for At-Risk Population
Functional Status
DHS_1147_Form_Rev_01_2021
DHS_1147_Form_Rev_01_2021_Fillable
DHS_1147_Instructions_Rev_01_2021

Criteria for At-Risk Population

The "At- Risk" population is defined as those Hawaii Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NF LOC) but are assessed to be at risk of deteriorating to the institutional level of care if certain long term services and supports (LTSS) are not provided. To be eligible, the individual must reside in his/her home (may live in home with daughter/son/guardian/friend or other family member), and cannot be residing in a facility, e.g. care home, foster home, hospital, nursing facility, hospice facility. Individuals who reside in a community shelter (e.g., YMCA, YWCA, IHS) may receive at-risk services appropriate for their living environment as determined by the health plan. If services are provided by the community shelter (e.g. meals or cleaning of room), then the health plan shall not provide these services.

Individuals who do meet NF LOC and/or are receiving services in a facility do not qualify for inclusion in the at-risk population. The at-risk population also does not include individuals who meet the LOC criteria for intermediate care facility for persons with intellectual disabilities (ICF/ID) or are receiving services in the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

Eligible Medicaid beneficiaries shall receive at-risk services through their QUEST Integration health plan. A Medicaid beneficiary who meets at-risk criteria may be eligible to receive the following home and community based services: home-delivered meals, Personal Emergency Response System (PERS), personal assistance (levels I and II), adult day care, adult day health, and skilled nursing services. Eligibility for specific services will be based on the functional assessment score through the newly revised DHS Form 1147.

The Health Services Advisory Group (HSAG) is responsible for approving the functional assessment score. To meet criteria for the at-risk population, the lower limit for at-risk is five functional points. However, HSAG may approve at-risk criteria with lower than five functional points if need is demonstrated. The DHS Form 1147 must include additional documentation to support the functional status and needs. Health plans shall provide services based on medical necessity and needs of the member, regardless of the point score. Needs of the member include but are not limited to frailty, cognition, and behavioral status. The health plan must consider natural support systems when identifying needs of the member and determining at-risk services.

The following array of services are available with guidelines provided for three levels of services:

I	5 to 7 functional points	▪ home-delivered meals* ▪ PERS
II	8 to 10 functional points	▪ home-delivered meals ** ▪ PERS ▪ Personal assistance (level I)
III	Greater than 10 functional points	▪ home-delivered meals** ▪ PERS ▪ personal assistance (both level I and II) ▪ adult day care ▪ adult day health ▪ skilled nursing services

* If home-delivered meals are not available in the area where the individual resides, the health plan may substitute personal assistance level I for meal preparation.

**As meal preparation is included as part of personal assistance level I (chore) services, an individual receiving personal assistance services cannot simultaneously receive home-delivered meals.

DHS will provide information on service limits and enacting waitlists for QUEST Integration 90-days prior to Commencement of Services to Members.

Additional documentation required to support meeting at-risk criteria:

In addition to the functional assessment scores, the DHS Form 1147 must contain documented evidence or examples of the individual's situation, functional deficits, and limitations, and must demonstrate how he/she would benefit from the LTSS. For example, the "comments" should describe one or more of the following:

- Caregiver support system is unable to provide 24/7 supervision and recipient cannot be left alone during day (e.g. family/caregiver support system works outside home during day).
- The individual requires assistance with medically necessary tasks (due to memory, mental status/behavior, or physical limitations), such as insulin administration or basic wound care.
- The individual requires assistance with IADLs, such as house cleaning, laundry, grocery shopping, or meal preparation, because of memory, mental status/behavior, or physical limitations.
- The individual may be unsteady and may have fallen previously, but is able to get self to restroom and/or change own incontinence pads.

Maximum length of approval is for a one-year period, based on individual needs, and may be renewed if medically necessary. The review and approval of an individual as meeting at-risk criteria will be based upon information contained on the DHS Form 1147 only (assessment, functional scores and needs, comments, etc.); DHS Form 1147A and DHS Form 1147E will not be reviewed for at-risk population criteria.

Functional Status related to Health Conditions:

Sections III – XII are scored. These sections primarily provide information about the resident's functional status as related to his/her health conditions. A critical component to assist with planning the best environment for a person with medical and/or physical disabilities is an assessment of these areas. In general, residents will meet the medical necessity criteria for long term care services with a total score of 15 or more points in these areas:

The following provides a description of each item per category.

Score	Status	Description
30	Comatose	Unable to be aroused by external stimuli.

Vision/Hearing/Speech:

Score	Status	Description
0	Has normal or minimally impaired vision/hearing/speech with or without a device.	May wear a hearing aid, glasses, or may have minimal speech impairment.
1	Needs some assistance with hearing, being able to see, and being able to speak.	Requires some help of another because of vision/hearing/speech impairment.
2	Has absence of hearing, vision, and/or speech.	Requires help of another, resident is deaf, is legally blind, and/or has complete absence of speech.

Communication:

Score	Status	Description
0	Adequately communicates needs/wants with or without the assistance of communication enhancing devices or techniques (i.e. sign board; sign language).	May wear glasses or hearing aids, and/or use communication devices, but impairment does not restrict self-care of communication.
1	Needs some assistance to communicate needs/wants.	Requires some help of another because of communication impairment.
2	Requires complete assistance in areas of communication.	Unable to communicate without help of another person.

Memory:

Score	Status	Description
0	Normal or minimal impairment of memory.	Able to recall recent and long term situations with cueing.
1	Problem with long term or short term memory	Unable to recall long term situations or unable to recall recent situations.
2	Individual has problems with both long term and short term memory.	Unable to recall long term and recent situation.

Mental/Behavior (circle all that apply). Make only one selection for orientation – score 0 through 2. Aggressive and/or abusive and wandering may also be checked with the appropriate orientation:

Score	Status	Description
0	Oriented (mentally alert and aware of surroundings).	Oriented to person, place, time; understands and if needed, can direct needs that must be met to maintain self-care. Does not exhibit behavior that is disruptive, aggressive or dangerous to self/others.
1	Disoriented (partially or intermittently).	Intermittently confused and/or agitated. Behavior is sporadic with an unpredictable pattern. Need occasional reminders as to person, place, or time. May have difficulty understanding needs that must be met but will cooperate when given direction or explanation. No major safety concern.
2	Disoriented and/or disruptive.	Recurrent episodes (1-3 times per day) of being confused, forgetful, agitated, disruptive or aggressive (either physically or verbally). Needs special tolerance/management and assistance with reorientation. Has difficulty understanding needs that must be met but will cooperate when given direction or explanation. Past history or present problem of substance abuse, including alcohol or prescription drugs, alone or combined. No major safety concerns.
3	Aggressive, abusive or disruptive.	Recurrent episodes (1-3 times per day). Requires intensive supervision and physical/mechanical/medication intervention because of behavior. **Caregiver judgment is required to determine appropriate intervention, based on MD order (e.g. when to apply restraints).** Episodes documented daily with MD intervention(s) documented monthly.
4	Ambulatory Wanderers and/or in danger of self-inflicted harm or self-neglect.	Recurrent episodes (1-3 times per day). Serious safety concerns because of forgetfulness and/or wandering. Causes harm to self because of physical or mental condition i.e. repetively hits self. Judgment is poor and requires environmental/physical/mechanical/medication intervention. **Needs constant caregiver protection and intensive supervision because of unsafe or inappropriate behavior.** Episodes documented daily with

		MD intervention(s) documented quarterly. Non Ambulatory wanderers will be given consideration if the individual has documented elopement(s) off caregiver's site within one year from assessment date.

Scenarios for aggressive, abusive or disruptive

Requirement: Recurrent episodes (1-3 times per day). Requires intensive supervision and physical/mechanical/medication intervention because of behavior. Caregiver judgment is required to determine appropriate intervention, based on MD order (e.g. when to apply restraints). Episodes documented daily with MD intervention(s) documented monthly.

Scenario #1: Recipient can ambulate and is physically aggressive, abusive and/or disruptive to others during all hours of the day. Caregiver is constantly at the side of the recipient when he/she is ambulating to ensure that the recipient does not harm others. Restraints may be needed to ensure safety of others.

Scenario #2: Recipient pushes his wheelchair into others, throws objects in order to hit others, throws human waste at others during all hours of the day. Caregiver has to provide constant supervision ensuring the safety of others. Restraints may be needed to ensure safety of others.

Scenarios for wanders and/or in danger of self-inflicted harm or self-neglect

Requirement: Recurrent episodes (1-3 times per day). Serious safety concerns because of forgetfulness and/or wandering. Causes harm to self because of physical or mental condition i.e. restively hits self. Judgment is poor and requires environmental/physical/mechanical/medication intervention. Recipient requires constant caregiver protection and intensive supervision because of unsafe of inappropriate behavior. Episodes documented daily with MD intervention(s) documented quarterly.

Scenario #1: Recipient wanders either during the day, evening, and/or night. There is a risk for serious safety concerns due to the recipient wandering off a caregiver's location/site. Constant caregiver protection needed to ensure safety of the recipient.

Scenario #2: Recipient ambulates and will drink and/or eat inappropriate items, i.e. Drano, gasoline, small jacks, marbles, etc. all hours of the day. Caregiver must consistently provide supervision to ensure that the recipient does not ingest any harmful items. Constant caregiver protection needed to ensure safety of the recipient.

Scenario #3: Recipient constantly hurts self by punching his/her head. Recipient requires a helmet and mitten for self-protection, but constantly takes the helmet and mitten off. Caregiver must constantly tend to recipient all hours of the day to ensure that the recipient does not hurt himself/herself. Constant caregiver protection needed to ensure safety of the recipient.

Feeding. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independent with or without an assistive device.	Independently feeds self. Needs no intervention.
1	Needs supervision or assistance to assure nutritional needs are met.	Unable to plan and prepare meals. May need constant encouragement and prompting to eat.
2	Is spoon/syringe/tube fed and does not participate.	Cannot or will not feed self. Requires constant attention and hand feeding by assistant. Tube feeding prepared and administered by another person.

Transferring (How a person moves between surfaces – to/from: bed, chair, wheelchair, car standing position, excludes to and from bath). Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independently able to transfer with or without a device.	Does not require assistance of another person.
2	Transfers with minimal/stand by help or another person.	Able to transfer with minimal or stand by assistance due to occasional loss of balance on transferring.
3	Transfer with supervision and physical assistance of another person.	Requires the presence of another when transferring because of e.g. unsteadiness and/or weakness.
4	Does not assist in transfer or is bedfast.	Completely dependent due to physical or mental condition. Frequent transfer and/or positioning. May require 2-person transfer of lifting equipment because of person's size or disability.

Mobility/Ambulation. Check a maximum of 2 for score 1 through 4. If an individual is either mobile or unable to walk, no other selections can be made. Activity observed and documented to occur at least daily:

Score	Status	Description
0	Independently mobile with or without device.	May use cane, crutches, walker or wheelchair and does not require assistance of another person.
1	Ambulates with or without device but unsteady/subject to falls	Can walk/be mobile, but requires stand by assistance.
2	Able to walk/be mobile with minimal assistance.	Can walk/be mobile, but requires the presence of another person for minimal assistance.
3	Able to walk/be mobile with one assist.	Requires assistance in mobility and requires another person for physical assistance.
4	Able to walk/be mobile with more than one assist.	Requires assistance in mobility and requires more than one person physically for assistance to walk/be mobile.
5	Unable to walk.	Unable to walk/be mobile.

Bowel Function/Continence:

Score	Status	Description
0	Continent	Resident is able to perform bowel care/needs, including colostomy without the assistance of another person.
1	Continent with cues.	Resident only requires cues/reminders to perform bowel care/needs.
2	Incontinent (at least once daily).	Occasional incontinence requires toileting or reminders by another; needs help to clean self. Requires the help of another on a regular basis to maintain bowel cleanliness.
3	Incontinent (more than once daily, # of times _____).	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bowel care.

Bladder Function/Continence:

Score	Status	Description
0	Continent	Resident is able to perform bladder care/needs, including ileostomy or indwelling catheter care without the assistance of another person.
1	Continent with cues.	Resident only requires cues/reminders to perform bladder care/needs.
2	Incontinent (at least once daily).	Occasional or stress incontinence requires toileting or reminders by another; needs help to clean self. Requires the help of another on a regular basis to maintain bladder cleanliness.
3	Incontinent (more than once daily, # of times _____).	Frequent to total incontinence; unable to participate in a training program; completely dependent upon another for bladder care.

Bathing. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Independent bathing	May require someone to prepare bathroom.
1	Unable to safely bathe without minimal assistance and supervision.	Needs supervision while bathing to ensure safety. Needs assistance to maintain cleanliness.
3	Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).	Totally dependent for bathing because of physical or mental disability.

Dressing and Personal Grooming. Observation of this activity occurred at least five out of seven days:

Score	Status	Description
0	Appropriate and independent dressing, undressing, and grooming.	Can perform dressing and personal grooming activities with little or no assistance.

1	Can groom/dress self with cueing (can dress, but unable to choose or lay out clothes).	Can dress, but unable to choose or lay out clothes or manipulated fasteners. Can brush teeth, wash face, comb/brush hair with some assistance.
2	Physical assistance needed on a regular basis.	Always requires help in most areas of dressing and grooming. Can do small tasks alone.
3	Requires total help in dressing, undressing, and grooming.	Cannot dress or undress or groom without help or another.

Complete for At-Risk only:
Housecleaning:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
2	Needs Assistance	Member able to complete some tasks with some assistance, includes oversight/cueing.
3	Unable to safely clean the home	Member unable to complete task on own and needs assistance to complete task.

Shopping:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
2	Needs Assistance	Member able to complete but needs assistance to complete task.
3	Unable to safely go shopping	Member unable to complete task on own and needs assistance to complete task.

Laundry:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
1	Needs Assistance	Member able to complete but needs assistance to complete task.
2	Unable to safely do the laundry	Member unable to complete task on own and needs assistance to complete task.

Meal Preparation:

Score	Status	Description
0	Independent	Member able to do and does not require assistance.
1	Needs Assistance	Member able to complete but needs assistance to complete task.
2	Unable to safely prepare a meal	Member unable to complete task on own and needs assistance to complete task.

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	6. MEDICAID ELIGIBLE? ☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____
Phone: ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE): _____
Phone ( )_____ Fax ( ) _____ Email _____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. RESPONSIBLE PERSON
Name _____
Last First MI
Relationship _____
PHONE ( )_____ FAX ( )_____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE _____/_____/_____

B. ASSESSOR'S NAME
Name _____
Last First MI
Title _____
Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: _____

13. REQUESTING

CHECK ONE BOX:
[ ] 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

BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL:

[ ] 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

BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information [ ] Clinical Question

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XVIII.**

III. VISION / HEARING / SPEECH:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:
[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:
[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.) *

[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive. (Examples required in section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

VII. FEEDING:
[0] a. Independent with or without an assistive device.
[1] b. Needs supervision or assistance with feeding.
[2] c. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:
[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bowel care.
[1] b. Continent with cues / requires reminders to perform bowel care.
[2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:
[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

Complete questions XIV to XVII for At Risk requests only:

XIV. HOUSECLEANING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely clean the home

XV. SHOPPING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely go shopping

XVI. LAUNDRY:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely do the laundry

XVII. MEAL PREPARATION:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely prepare a meal

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____

_____

_____

_____

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

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Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XXI. SKILLED PROCEDURES: **D** = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day}: _____
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency):_____
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed} _____
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. _____
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): _____
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.):_____
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): _____
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) _____
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : _____
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): _____
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): _____

☐ Yes ☐ No Therapeutic Diet (Describe): _____

☐ Yes ☐ No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech

☐ Yes ☐ No The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A

B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver: _____

C. Caregiver name:

Name: _____ Relationship: _____
Last First MI

Address: _____ Phone: (___) _____ Fax (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____

_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.

PHYSICIAN/PCP/RN SIGNATURE: _____

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ____/_____/_____

Physician/PCP/RN Name (PRINT): _____

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

INSTRUCTIONS

DHS 1147 (Rev. 01/2021)

LEVEL OF CARE (LOC) AND AT RISK EVALUATION

PURPOSE:

A Medicaid Provider or QUEST Integration Health Plan shall use the DHS 1147 "Level of Care (LOC) and At Risk Evaluation" form to evaluate an applicant or Medicaid recipient level of care as documentation for requested Medicaid long-term care eligibility and long-term services and supports.

SPECIFIC INSTRUCTIONS:

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual, reconsideration or other review, i.e. 3-month review to determine continued stay.

2. ***Patient Name***: Self-explanatory.

3. ***Birthdate***: Self-explanatory.

4. ***Gender***: Indicate whether the patient is "M" for male or "F" for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the

Department of Human Services which include Patients at a care home and nursing facility level of care.
Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
Other: Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.
9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. **Source(s) of Information**: Identify the source(s) of patient information received.

    B. **Responsible Person**: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. **Assessment Date**: Indicate the date of the most current assessment.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting***: Check what is being requested (either level of care or at risk). Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach

the hospice election and physician certification of terminal illness form signed by two different physicians. *Hospice services in other settings do not require an 1147 form.*

Indicate the length of approval requested. Check one box.

14. ***Medical Necessity Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Self-explanatory.
2. ***Birthdate***: Self-explanatory.
3. ***Functional Status Related to Health Conditions***: Complete all sections.

   I. **List significant current diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long- term care.

   II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.

   III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

   Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.

   XIV. **House Cleaning through XVII Meal Preparation:** Complete these for At Risk requests only.

   XVIII. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

   XIX. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.

XX. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XXI. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. **Social Situation**:

a. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

b. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

c. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XXIII. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician, the primary care provider, or the registered nurse has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician, primary care provider, or registered nurse. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

FILING/DISTRIBUTION:

Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1011 Kamokila Blvd., Suite 311
Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009