# Hospital Level of Care Supplement Training Manual

## COLORADO LONG TERM SERVICES AND SUPPORTS (LTSS ASSESSMENT) TOOL


COLORADO
Department of Health Care Policy & Financing

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# Hospital Level of Care Supplement – Training

## Purpose

The purpose of the Hospital Level of Care (LOC) Supplement is to identify participants who may need additional supports because of medical complexity and/or fragility and meet Hospital LOC. By meeting Hospital LOC, participants may qualify for additional services and funding opportunities to allow them to live safely in the community.

## Overview of Contents

The Supplement consists of 17 items that assess medical conditions, needs, and equipment. A wide range of topics are covered within the Supplement, including:

- Medical isolation
- Dialysis
- Tube feeding
- IV medications
- Suctioning
- Central lines
- Sleep issues
- Oxygen issues
- Medical interventions and monitoring
- Skin issues
- Transfusions
- Airway issues and ventilator use

## General Instructions for Completing the Module

The Supplement is triggered by a "Yes" response to item 2.6 in the Assessment Summary module, "Is supervision needed to prevent a crisis due to a medical condition". Because most people enrolling in Medicaid waivers and State Plan services will meet Nursing Facility LOC (NF-LOC) but are not medically complex enough to justify Hospital LOC, the Supplement has been developed to be used on a specific subset of the long term service and support (LTSS) population.

If the assessor believes that the individual potentially meets Hospital LOC, he/she should complete the Supplement with the participant and other participating in the Assessment. Because the section deals with complex medical issues, assessors should also consult medical records, statement's and notes from medical professionals, and any other relevant materials in addition to consulting with the participant when responding to the items.

Because the Supplement contains complex medical topics that many assessors may not be familiar with, we have provided definitions for key terms within the instructions in the following section.

## Section Instructions

This portion of the manual provides specific discussion and guidance for sections and items in the module.

**Items 1 and 2** are tables that address a variety of medical issues that the participant requires (Item 1) and has (Item 2). Assessors should respond to each of the items using the "Yes", "No", or "N/A" single choice response options. The final column in the table identifies the information that was used to inform the response to the item. Check all that apply.

| Assessment Item | Guidance |
|---|---|
| **Hospital Level of Care (LOC) Supplement** | |
| **1a.** Physician ordered isolation to ensure his/her medical stability. | The participant's physician has ordered isolation, which may consist of modified contact procedures and/or isolation from all individuals. This may be due to an immunodeficiency disorder that impacts the body's ability to fight infectious disease or another medical condition that requires isolation to ensure the participant's health and safety. |
| **1b.** Peritoneal dialysis at least once per month. | Peritoneal dialysis is a treatment for kidney failure that uses the lining of the participant's abdomen to filter the blood inside his/her body.<br><br>Indicate "Yes" if this occurs at least once per month. |
| **1c.** Hemo-dialysis in the home. | Hemodialysis utilizes a dialysis machine to filter the wastes and liquids from the body when the participant has low-functioning kidneys. For many people, this may be a more familiar form of dialysis than peritoneal dialysis.<br><br>Indicate "Yes" if the hemo-dialysis occurs in the home, not at a clinic. |
| **1d.** Feeding at least daily via nasogastric tube. | A nasogastric tube is a feeding tube that is inserted down the nostril, through the esophagus, and into the stomach.<br><br>Indicate "Yes" to this item if the participant is fed by nasogastric tube at least once per day. |
| **1e.** Feeding at least daily via jejunostomy tube. | A jejunostomy tube is a plastic tube that is placed through the skin of the abdomen into the small intestine to deliver food and medication.<br><br>Indicate "Yes" to this item if the participant is fed by jejunostomy tube at least once per day. |
| **1f.** A licensed professional to evaluate feedings at least weekly because of a moderate to severe problem with a J, G or NG tube. | • **Jejunostomy (J) tube**- A plastic tube that is placed through the skin of the abdomen into the small intestine to deliver food and medication.<br>• **Gastrostomy (G) tube**- A tube inserted through the abdomen directly into the stomach for feeding.<br>• **Nasogastric (NG) tube-** A feeding tube that is inserted down the nostril, through the esophagus, and into the stomach. |

| Assessment Item | Guidance |
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| **Hospital Level of Care (LOC) Supplement** | |
| | Indicate "Yes" if a licensed professional (e.g., physician, physician's assistant (PA), advanced practice nurse (APN), or registered nurse (RN)) evaluates feedings, such as equipment or schedule, because of moderate to severe problems with the feeding, such as aspiration or infection, at least once per week. |
| **1g.** Care for his/her tracheostomy. | A tracheostomy is a surgically created hole in the front of the neck that goes into the windpipe.<br><br>Indicate "Yes" if the participant needs support from caregivers, including non-medical caregivers, to clean and care for the tracheostomy. If the participant can care for his/her tracheostomy, mark "No". If the participant does not have a tracheostomy, mark "N/A". |
| **1h.** Prescribed medication more often than every two hours during the day. | Indicate "Yes" if the participant takes medication at least every two hours during the day (do not need to count asleep time), regardless of the amount of support that is required to take the medication. |
| **1i.** Intramuscular (IM) or subcutaneous (SQ) medications for pain control at least 4 times per week, on average. | • **Intramuscular (IM)-** An injection directly into the muscle.<br>• **Subcutaneous (SQ)-** An injection into the area directly below the outer layers of skin (dermis and epidermis)<br><br>Indicate "Yes" if the participant requires these one or both these injections specifically for prescribed pain control on average at least four times per week, regardless of who administers the prescribed medication. If the frequency varies by week, average across the month. |
| **1j.** Intravenous (IV) medications for pain control at least 4 times per week on average. | • **Intravenous (IV)-** Delivery of liquids (including medications) directly into a vein.<br><br>Indicate "Yes" if the participant requires IV medications for prescribed pain control on average at least four times per week, regardless of who administers the prescribed medication. If the frequency varies by week, average across the month. |

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| **Hospital Level of Care (LOC) Supplement** | |
| **2a.** A non-diabetic metabolic disorder that if untreated could cause death or disability AND requires daily laboratory monitoring or weighing and recording of caloric and/or fluid intake. | • **Metabolic disorder-** A metabolic disorder occurs when abnormal chemical reactions in the body disrupts the metabolic process. When this happens, participants might have too much of some substances or too little of other ones to stay healthy. There are different groups of disorders. Some affect the breakdown of amino acids, carbohydrates, or lipids. Another group, mitochondrial diseases, affects the parts of the cells that produce the energy.<br><br>**Do not include diabetes when responding to this item.**<br><br>Indicate "Yes" if the disorder 1) could cause death or disability if treatment is not received AND 2) requires daily monitoring or weighing of food, including modified food consistency, or fluids. |
| **2b. Gastro-esophageal reflux diagnosed by a physician AND has required suctioning in the past 6 months or has had an episode of aspiration pneumonia within the past 6 months.** | This item is intended to identify individuals at risk of choking, aspiration, or other medical complications as a result of a diagnosis of Gastro-esophageal Reflux Disease (GERD). GERD occurs when stomach acid frequently flows back into the tube connecting the mouth and stomach (esophagus). |
| **2c- Central lines-** Vascular access to a major vein near the heart or to an artery on an ongoing basis.<br><br>**2d. Central Line with TPN-** A central line and receives total parental nutrition through that access. | Indicate whether the participant has a central line or a central line with Total Parental Nutrition (TPN). TPN is a way of supplying all the nutritional needs of the body by bypassing the digestive system and dripping nutrient solution directly into a vein. |
| **2e. Cyanosis**, defined as oxygen saturation of less than 88%, three or more times in the last 6 months, that requires a pulse oximeter. | Indicate if the participant has experienced Cyanosis at least three times in the past 6 months AND requires a pulse oximeter for the condition. |
| **2f. Physician-diagnosed bradycardia** | Bradycardia is abnormally slow movement of the heart, often identified by a slow heartbeat. |
| **2g. Physician-diagnosed sleep apnea** | Sleep apnea is a sleep disorder in which breathing repeatedly stops and starts. |
| **2h. Required resuscitation (CPR must include chest compressions or drug resuscitation) for inadequate** | Resuscitation, such as CPR, was needed in the past year due to issues with ventilation or cardiac output. Consult |

| Assessment Item | Guidance |
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| **Hospital Level of Care (LOC) Supplement** | |
| **ventilation or cardiac output within the past year AND the need for resuscitation is likely to recur.** | medical records and the participant/family to determine if the need for resuscitation is likely to reoccur. |
| **3. Sleep study has occurred:**<br>❍ Yes ❍No (Skip to Item 4)<br>a. Lowest 02 saturation:_____%<br>b. Highest 02 saturation:_____%<br>c. Average 02 saturation:_____% | If the participant has undergone a sleep study, provide the oxygen saturation statistics from the study. |
| **4. Participant requires medical intervention, such as changes or monitoring of equipment, changes of position, suctioning, or feeding, at least once per night.**<br>❍ Yes, no more than twice per night<br>❍ Yes, more than twice per night<br>❍ No | Indicate the frequency of medical intervention needed at night. If intervention is needed irregularly, respond "No". |
| **5. Participant needs medical interventions that require a licensed nurse at least 2 hours per week.**<br>❍ Yes, 2-10 hours per week<br>❍ Yes, more than 10 hours per week, but less than 10 hours per day<br>❍ Yes, 10 hours per day or more<br>❍ No | Consider the total amount of time nursing intervention is needed for any medical reasons during a typical week. |
| **6. Medically ordered vital-sign assessments, including taking of pulse, respiration, blood pressure, the assessment of orientation, level of consciousness, size of pupils and auscultation of lungs, are required at least once daily.**<br>❍ Yes, once daily to less than 4 hours per day<br>❍ Yes, 2-4 hours per day<br>❍ Yes, more often than every 2 hours<br>❍ No | Indicate "Yes" only if the vital-sign assessment is medically ordered AND needed at least once per day. |
| **7. Participant has one or more stoma(s) that require care, dressing, or cleaning at least weekly.**<br>❍ Yes, number of stomas:_____<br>❍ No | **Stoma-** the result of an operation that is meant to remove disease and relieve symptoms. It is an artificial opening that allows feces or urine either from the intestine or from the urinary tract to pass.<br><br>Indicate if the stomas require weekly care, dressing or cleaning, regardless of who performs the task. If "Yes", indicate the number of stomas. |

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| **8. Currently or in the past 12 months, the participant has had a Stage 3 or greater skin breakdown diagnosed by a medical professional, or has a physician order of high risk for such skin breakdown.**<br>❍ Yes, number of breakdown areas:_____<br>❍ No | For this question, the assessor should refer to medical records to confirm that the diagnosed skin breakdown is Stage 3 or greater or that the medical record or physician statement confirms that the participant is at high risk for this type of breakdown. |
| **9. Participant has a physician-diagnosed seizure disorder AND seizures occur at least once per week AND require intervention.**<br>❍ Yes, has mild-moderate seizures that occur at least weekly to once daily on average<br>❍ Yes, has mild-moderate seizures 2-4 times daily on average<br>❍ Yes, has mild-moderate seizures more than 4 times daily on average<br>❍ Yes, has moderate-severe seizures that occur at least weekly up to 6 times per day on average<br>❍ Yes, has moderate-severe seizures more than 6 times per day on average<br>❍ No, has seizure disorder but seizures occur less frequently than weekly and/or do not require intervention<br>❍ No, does not have seizure disorder | To respond "Yes" to this item, the diagnosis, frequency, AND intervention criteria must all be met.<br><br>If "Yes", indicate the type and frequency of the seizure disorder in the responses provided.<br>• Seizures meet mild-moderate criteria if:<br>○ a) require changes in oxygen or<br>○ b) child has had an episode of status (seizure lasting more than five minutes or two or more seizures within a five-minute period) treated by a physician in the past year.<br>• Seizures meet **moderate-severe** criteria if within the past month the child (any of the following):<br>○ a) required intervention to maintain an adequate airway; or<br>○ b) required application of antiepileptic drugs such as rectal valium/Diastat (other than regular scheduled antiepileptic) or<br>○ c) had an episode of status (seizure lasting more than five minutes or two or more seizures within a five-minute period) treated by a physician.<br><br>If the participant has a seizure disorder but it does not meet these criteria, select "No, has seizure disorder but seizures occur less frequently than weekly and/or do not require intervention". |
| **10. Participant requires a transfusion or IV medication in the home at least once per month.**<br>❍ Yes, once per month to less than daily<br>❍ Yes, daily to less than every 4 hours | If the participant requires this, indicate the frequency. Note that this does not include diabetic insulin pumps. |

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| ❍ Yes, at least every 4 hours<br>❍ No | |
| **11. Participant requires physician-ordered deep pharyngeal or tracheal suctioning at least once per day.**<br>❍ Yes, once per day to less than every 4 hours<br>❍ Yes, every 4 hours to less than 1 hour<br>❍ Yes, at least every hour<br>❍ No | • **Suctioning** is the mechanical aspiration of pulmonary secretions from a patient with an artificial airway in place.<br>• **Pharyngeal suctioning** is suctioning of the portion of the throat that is behind the mouth and nasal cavity and above the esophagus and larynx.<br>• **Tracheal suctioning** is suctioning to clear an airway from secretions of the lungs when the participant cannot cough or void them.<br><br>If either type of suctioning is needed, indicate frequency. |
| **12. Participant has a tracheal diversion:**<br>❍ Does not have a tracheal diversion<br>❍ Has a tracheal diversion and is unable to physically remove an obstruction to his/her stoma because he/she is too young to understand how to<br>❍ Has a tracheal diversion and is unable to physically remove an obstruction to his/her stoma because of a medical condition, such as seizures, or a developmental, cognitive, physical condition<br>❍ Has a tracheal diversion and is able to physically remove an obstruction to his/her stoma | • **Tracheal diversion-** A procedure that creates an opening in the participant's throat to bypass the trachea and deliver nutrition and/or medication directly to the esophagus and clear secretions.<br><br>If the participant has a tracheal diversion, indicate if he/she is able to remove obstructions. If the participant cannot remove obstructions, indicate whether this is due to the participant being too young to understand or because of a medical, developmental, cognitive or physical condition. |
| **13. Participant needs support to maintain his/her airway:**<br>❍ Yes, needs non-continuous support<br>❍ Yes, needs continuous support<br>❍ No | Participant requires an appliance, equipment, or physical support or another person to maintain an adequate airway due to an unstable airway. Identify if this support is continuous or not. |
| **14. Participant has a physician's order for a ventilator, CPAP, or BIPAP to be present in the residence.**<br>❍ Yes<br>❍ No (End of Supplement) | Indicate whether there is a physician ordered ventilator, CPAP, or BiPAP *present* at the residence. This does not require that it is continuously in use. If "No", this is then end of the Supplement. |
| **15. Participant has effective respiratory effort and without active ventilation would survive at least one hour.**<br>❍ Yes, number of hours per day on ventilator:_____<br>❍ No | Indicate whether the participant could breathe on his/her own without active ventilation for at least an hour. |

| Assessment Item | Guidance |
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| **Hospital Level of Care (LOC) Supplement** | |
| **16. Participant requires changes in ventilation that are not planned at least daily because of levels of oxygenation.**<br>❍ Yes ❍ No | Oxygenation relates to the blood's content of oxygen. Indicate whether unscheduled ventilator changes are required due to fluctuations in levels of oxygenation. Indicate "Yes" if this occurs at least daily. If less than daily, indicate "No". |
| **17. Participant has both 1) written documentation of Central Hypoventilation syndrome as currently diagnosed by a pulmonologist or neurologist; and 2) written notes documenting assisted ventilation and interventions by another person in the past month.**<br>❍ Yes ❍ No | **Central hypoventilation syndrome** is a disorder of the autonomic nervous system that affects breathing. It causes a person to hypoventilate (especially during sleep), resulting in a shortage of oxygen and a buildup of carbon dioxide in the blood.<br><br>Consult medical records to establish this diagnosis and speak with the family to determine whether intervention by another person was needed to address symptoms of central hypoventilation syndrome. If intervention was needed, confirm that there are written notes documenting this assistance. |

## Section 2: Health Care Provider Information

Section 2 is used to collect information about all health care providers that the individual currently has or may need. This section is divided into five parts, and they are described below. The assessor should try to obtain information about the primary care physician and dentist, while information about other health care providers should be included if it is easily available.

| Assessment Item | Guidance |
|---|---|
| **Section 2: Health Care Provider Information** | |
| **Type of Health Care Provider**<br>☐ Primary Care Provider/Pediatrician<br>☐ Psychiatrist<br>☐ Psychologist/Therapist<br>☐ Specialty Clinic/Specialist<br>☐ Dentist<br>☐ Optometrist/Vision Specialist<br>☐ Pharmacy (Primary)<br>☐ Pharmacy (Other)<br>☐ Home Health Agency<br>☐ Medical Case Manager<br>☐ RAE Case Manager<br>☐ Other:_____<br>☐ None | Select all of the health care providers the individual has. Primary Care Provider (PCP) or, for participants under the age of 18, Pediatrician if applicable, and dentist are mandatory items because they are central in maintaining an individual's overall health.<br><br>If the individual does not have a PCP and/or dentist or would like to change any of his/her providers, including facility health care providers, assessors should select the corresponding "Needs or Needs to Change" box and identify that a referral for change and/or for a PCP/Pediatrician and/or dentist should be made as part of the support planning process. |

| Assessment Item | Guidance |
|---|---|
| **Section 2: Health Care Provider Information** | |
| | Below are definitions and/or examples for each of the types of providers:<br>• **Primary Care Provider -** A health care practitioner who sees people, typically adults, that have common medical problems. This person is usually a doctor, but may be a physician assistant or a nurse practitioner.<br>• **Pediatrician -** A health care practitioner who sees infants, children, and adolescents that have common medical problems.<br>• **Psychiatrist -** A medical practitioner specializing in the diagnosis and treatment of mental illness.<br>• **Psychologist/Therapist -** A practitioner who is trained in treating mental or emotional problems. Practitioners can include PhD psychologists, MSW/BSW counselors, or others licensed to practice in specific types of behavioral support therapies.<br>• **Specialty Clinic/Specialist -** Includes a variety of treatments the participant may be receiving outside of primary care. Clinics can include treatments for issues around pain, vision, hearing, and neurology.<br>• **Dentist -** A person qualified to treat the diseases and conditions that affect the teeth and gums.<br>• **Optometrist/Vision specialist -** A person who is qualified to examine the eyes and prescribe and supply spectacles and contact lenses.<br>• **Pharmacy (Primary) -** The primary location where individuals have prescriptions filled.<br>• **Pharmacy (Other) -** The secondary location where individuals have prescriptions filled.<br>• **Home Health Agency -** Agencies that provide health care services and supports in an individual's home. This includes home based supports provided under health insurance (including Medicare), private pay, or Medicaid services (includes consumer directed supports as well as traditional services).<br>• **Medical Case Manager -** Support personnel who help an individual specifically with obtaining and coordinating medical services.<br>• **RAE Case Manager -** Support personnel located at one of Regional Accountability Entities (RAEs) that help individuals with obtaining and coordinating medical services.<br>• **Other -** Any other health care providers the individual may have. |

| Assessment Item | Guidance |
|---|---|
| **Section 2: Health Care Provider Information** | |
| | • **None -** Select if the participant has no health care providers. If this option is selected, assessors should also select the option for "Needs or Needs to Change" for Primary Care Provider/Pediatrician to generate a referral. |
| **Name/Clinic** | Use this item to document the practitioner and/or clinic name for each of the health care providers selected in the "Health Care Providers" item.<br><br>Assessors should try to collect this information for Primary Care Provider/Pediatrician, and if accessible for other health care providers. |
| **Contact Information** | Document the practitioner/clinic contact information. This can include phone number, location address, email address, and any other relevant contact information.<br><br>Assessors should collect this information for Primary Care Provider/Pediatrician, and if accessible for other health care providers. |
| **Needs or Needs to Change** | This item should be used for each practitioner that the participant **does not currently have but probably should have** based on presenting needs or practitioners that the participant **would like to change**. This item will be used to inform the support planning process and generate a referral to health care providers that the participant may need or want to change.<br><br>As assessors complete the remainder of the Health module, the need for additional practitioners may arise. Assessors should revisit this item prior to closing out the module and select any additional needed practitioners. |
| **Comments** | Use the Comments to document additional information about the health care provider or a need to access additional practitioners. This can include how often the participant sees the practitioner, services provided by the practitioner (e.g., Specialty clinic provides pain treatment), and rationale for why the participant does not have a practitioner but may need one. |