NJ Level of Care and Assessment Process

CODING GUIDELINES AND LEVEL OF CARE

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Goals

- To understand the assessment process
- To understand NJ nursing facility level of care criteria
- To recognize cognitive and physical factors that contribute to the clinical qualification of an individual for NF level of care
- To document concise, accurate, and meaningful information on the individual

The Role of the Assessor

The role of the assessor is to complete a comprehensive assessment that will:

- Identify care needs
- Identify consumer goals and preferences
- Counsel consumers on potential service options and program eligibility based on identified needs and financial eligibility
- Outline an interim plan of care

Assessment Process

- Review consumer information.
- Setup appointment. Explain assessment process. Gather preliminary information.
- Visit one-on-one. Gather information from all present participants. Identify next steps.
- Further information seeking. Confirm/clarify information with third-party if necessary.
- Review coding/documentation. Confirm accuracy and congruency.

Skills for Administering Assessments

- Good Communication – clearly outline your role and the assessment process. Use understandable language.
- Critical Thinking – use all aspects of your skills to gather information for use in responding and documenting in tool.
- Observation – environmental, interpersonal, physical. How does it relate to stated and non-stated information? Critical information for assessment narrative.
- Interviewing skills – develop a structured approach to the assessment which is comfortable.

Activities of Daily Living

- Activities of daily living (ADL) and cognitive capability are the basis of NJ nursing facility (NF) Level of Care (LOC).
- Assess the individual based on self-performance, which means what the individual actually does for themselves.
- There are guidelines and time frames for coding ADLs.

The ADLs Assessed

- Eating
- Personal Hygiene
- Bathing (includes bathing transfers)
- Dressing Upper Body
- Dressing Lower Body
- Transfer Toilet
- Toilet Use
- Bed Mobility
- Transfers (chair and bed only)
- Walking
- Locomotion – coded for all, regardless of mode of locomotion

Coupled ADLs that Count as One

- Dressing upper and/or lower body = one ADL.
- Transfer toilet and/or toilet use= one ADL

Excluded ADLs From Level Of Care

- Personal hygiene
- Walking
  - While assessed, they are not factored into clinical eligibility when determining NJ NF LOC.

ADLs to Determine Level of Care

- Eating
- Bathing
- Dressing upper and/or lower body (counts as 1 ADL)
- Transfer toilet and/or toilet use (counts as 1 ADL)
- Bed mobility
- Transfers
- Locomotion

ADL Coding Guidelines

- Focus on the three most dependent episodes
- If the most dependent episode is setup (1), code setup regardless of least dependent episode
- If the most dependent episode is higher than setup (1), code the least dependent of the three (will be 2,3,4, or 5)
- To code an ADL independent (0), total dependence (6), or activity did not occur (8), ALL episodes in the three day period must be at that level
- If any episode, but not all episodes were total dependence (6), code maximal assist (5) regardless of level of the other 1-2 episodes
- If an ADL is performed fewer than 3 times, code based on the number of episodes that occur

Cognition

Use observation in conjunction with critical thinking and effective communication skills to determine any cognitive deficits. Be mindful of individuals memory throughout the assessment and go back and re code if necessary.

When determining NF Level of Care, the DoAS looks at the individual's ability for daily decision making, short term memory and making one's self understood. However, DoAS assesses all aspects of cognition.

Cognition

Daily decision making encompasses all tasks related to all daily events, including but not limited to: choosing clothing for the weather, knowing when to eat, awareness of one's abilities and limitations.

- 0. Independent
- Modified Independence- some difficulty in new situations only
- Minimally impaired: in specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
- Moderately Impaired: The person's decisions were consistently poor or unsafe requiring reminders, cues/supervision at all times.
- Severely impaired: never or rarely makes decisions
- Individual has no discernable consciousness (coma), the assessor can skip to Section G of the assessment

Cognition

- Short term memory – conduct ST memory test (i.e. ask the client to recall three objects)
- Procedural Memory- conduct sequential activity test (i.e. ask the client the steps they take to dress or make a meal)
- Situational Memory- the person must both recognize names/faces of frequently encountered people and know the location of places regularly visited (i.e. bathroom, bedroom, etc.) to score “Memory Ok”.

Cognition

Making Self Understood is the ability to express or communicate requests, needs, opinions, and problems and to engage in social conversations. This can take place in the form of speech, writing, sign language, or a combination of these.

- 0. Understood
- 1. Usually understood-has difficulty finding the right words or thoughts but if given enough time requires little or no prompting.
- 2. Often understood- has difficulty finding words or finishing thoughts and prompting is usually required
- 3. Sometimes understood- has limited ability, but is able to express concrete requests regarding basic needs
- 4. Rarely or never understood

NF LOC

- **A consumer meets the clinical criteria for NF LOC in NJ one of three ways:**

1. The consumer needs at least limited assistance in at least 3 areas of eligible ADL's **OR**
2. The consumer has cognitive deficits with decision making = minimally impaired (2) or greater ***and*** short term memory = problem (1) ***and*** needs supervision or greater assistance in 3 areas of eligible ADLs. **OR**
3. The consumer has cognitive deficits with decision making = minimally impaired (2) or greater ***and*** making self understood = often understood (2) or greater **and** needs supervision or greater assistance in 3 areas of eligible ADLs.

Documentation Guidelines

- The assessment summary/narrative is intended to capture the overall picture of the consumer. It should provide a snapshot of the consumer's functional capabilities, support systems, and identified areas of need. It should not include biased statements, information which does not impact level of care, or abbreviations.

Narrative

All narratives must be congruent with assessment and provide pertinent information:

Demographics and Descriptors

- ✓ Client age, where and when the assessment took place, if others were present and who, language if other than English, identify translator or service used.
- ✓ Identify court appointed guardian with contact information.

Cognitive Functioning

- ✓ Document cognitive status at the time of the assessment for deficits and independence. If the assessor triggers deficits then document the evidence to support the finding.

ADL Deficits

- ✓ Identify ADLs as independent or requiring supervision and/or hands on assistance.
- ✓ Record observations of individual, and those reported to assessor, by whom, and relationship to individual.
- ✓ Skilled nursing needs.

Frequently Asked Questions and Answers (FAQs) for the NJ Choice Assessment Tool

Q. Section A.

6. Facility/Agency Provider Number- What number is used?

A. The provider number is used for an Assisted Living, Nursing Facility and Medical Day Care. For community visits, the code of “0100000” is used.

9. Assessment Reference Date- What date is used?

A. This is the date you start working on the assessment. (Refer to page 12 in the manual.)

Q. Section B.

1. Date Case Opened- What date is used?

A. At this time please fill in with zeros. We will not be using this question(OCCO policy).

FAQs Continued

Q. Section C.

2. Memory/Recall Ability: How do you assess for procedural memory?

A. This item refers to the cognitive ability needed to perform sequential activities. The person must be able to perform or remember to perform all or most of the steps in order to be score 0 for Memory OK. If the person demonstrates difficulty in two or more steps, code as 1 for memory impaired. (Refer to page 20 in the manual.)

Pick a task that is common and easily explained. Throughout the assessment, be mindful of procedural memory. When the client answers other questions, you might see some deficits in procedural memory especially when medications and medication management are discussed. The assessor can always go back and change the answer to previous questions especially cognition.

FAQs Continued

Q. Section D.

1. Making self understood (expression): what if there is a language barrier?

A. To document the person's ability to express or communicate requests, needs, opinions, and urgent problems. This item is not intended to address difference in language understanding." Please assess how the client communicates and if it is effective. If another language is spoken ask family or friends if the client is making sense in his/her own language. (Refer to page 25 in the manual.)

Q. Section G.

2. K. Locomotion- what do I code for if the client alternates with walking and wheelchair at different levels of help?

A. Consider all episodes over the last three days and focus on the three most dependent episodes and follow the coding rules. i.e. if the client was independent in the wheelchair four times and needed extensive assistance walking with a walker three times, you would code locomotion as extensive assistance. (Refer to Page 42 in the manual.)

FAQs Continued

Q. Section I.

2. Other disease diagnoses: How many diagnoses do we have to put in and do we need to put the disease code in?

A. To document the presence of any diseases or infections not listed in Item I1 that are relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. (Refer to page 57 in manual.) OCCO requires at least one diagnosis and the disease code must be completed.

FAQs Continued

Q. Section K.

2. Nutritional Issues: What if the BUN/creatine level is unknown?

A. Record your clinical judgment based upon signs and symptoms of dehydration. (Refer to page 70 in manual.)

Q. Section M.

1.f PRN: do we have to put in whether it is a PRN medication for every medicine?

A. Yes, it is a required field in the assessment. Remember, only document PRN medications if they were taken in the last 3 days. (Refer to page 78 in manual.)

FAQs Continued

Q. Section M.

1. How do you code for someone on a sliding scale insulin dosage?

A. Medications-These include all prescribed, non-prescribed, and over-the-counter medications that the person consumed in the last three days. (Refer to Page 77 in the manual.) There is an order to check blood sugar daily and based upon the result is when the medication is given. The order is daily so the coverage would not be PRN. Look at examples of how to code frequency and PRN on page 81 and coding exercise for Item M1 on pages 84-86. In the examples, the client has a sliding scale insulin which is documented by how many times insulin was needed in the three-day assessment period. For example, on page 81 the client needed the sliding scale insulin on day one and day three, so the frequency was coded Q3D. On page 86, the sliding scale dose was given on two days in the last three day period and was coded as Q2D.

FAQs Continued

Q. Section N.

3. Formal Care: How do I code for informal versus formal hours especially if someone is in a group home or an Assisted Living?

A. The manual specifies direct services provided to the person (ADL and IADL), the management of care received (i.e. medication schedules, care plans), and the provision of care by any service provider under each category. Therefore, I'd estimate that someone in a group home may have seven days of home health aide for seven hours (hands on ADL care and simple monitoring-i.e. blood pressure) and seven days of homemaking services for 21 hours (includes IADLS such as housekeeping, transportation, and meal prep). That's assuming the person has three hours/day of IADL/ADL personal care. A home nurse would not code unless the individual has complex interventions of skilled treatments. Meals wouldn't get coded because they are not delivered for later consumption. (Refer to page 91 in manual.)

FAQs Continued

Q. Section N.

3. Formal Care: what is coded for meals?

A. Only code for meals that are delivered to the person for immediate or later consumption. (i.e. Meals on Wheels) page 91 in manual.

Q. Section N.

N3. Formal Care: What if the client is paying privately for a service? Is that counted?

A. Coding: “Do not code for care that the person received privately (i.e. from source other than the agency)” page 92 in the manual.

QUESTIONS?