

**Attachment #1:  
Covariate Definitions**

**CHRONIC CARE**

<b>COVARIATE NAME</b>	<b>CODE NAME</b>	<b>DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)</b>
Age > 76	CCOG1_D	Indicator that resident age is greater than 76 on the assessment reference date (A3a) of the prior assessment: Covariate = 1 if age > 76. Covariate = 0 if age <= 76.
ALS/MS diagnosis	CNUT1_B	Indicator of Amyotrophic Lateral Sclerosis or Multiple Sclerosis on the prior assessment or most recent full assessment: Covariate = 1 if I3a through I3e = 335.20 for amyotrophic lateral sclerosis OR if I1w checked (value 1) for multiple sclerosis). Covariate = 0 if covariate not = 1 AND I1w not checked (value 0).
Any wandering	CFAL1_B	Indicator that resident wanders on the prior assessment: Covariate = 1 if E4a(A) = 1, 2, or 3. Covariate = 0 if E4a(A) = 0.
Bed mobility problem	CPRU4_C	Indicator of bed mobility problem on the prior assessment: Covariate = 1 if G1a(A) = 3, 4, or 8. Covariate = 0 if G1a(A) = 0, 1, or 2.
Bladder Incontinence	CCNT2_C	Indicator of bladder incontinence on the prior assessment: Covariate = 1 if H1b = 3 or 4. Covariate = 0 if H1b = 0, 1, or 2.
Bowel incontinence	CCAT1_A	Indicator that resident has bowel incontinence on the prior assessment: Covariate = 1 if H1a = 4. Covariate = 0 if H1a = 0, 1, 2, or 3.
Fall in last 30 days	CCOG1_B	Indicator that resident fell in the past 30 days on the prior assessment. Covariate = 1 if J4a is checked. Covariate = 0 if J4a is not checked.
Fall in last 180 days	CMOB1_A	Indicator of recent falls on the prior assessment: Covariate = 1 if J4a checked OR J4b checked. Covariate = 0 if J4a not checked AND J4b not checked.

<b>COVARIATE NAME</b>	<b>CODE NAME</b>	<b>DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)</b>
Independence in daily decision making	CPAIX_A	Indicator of independence or modified independence in daily decision making on the prior assessment: Covariate = 1 if B4 = 0 or 1. Covariate = 0 if B4 = 2 or 3.
Locomotion Problem	CPRU4_D	Indicator of locomotion problem or activity did not occur on the prior assessment: Covariate = 1 if G1e(A) = 3, 4, or 8. Covariate = 0 if G1e(A) = 0, 1, or 2.
Long term memory problem	CWGT1_A	Indicator of long term memory problem on the prior assessment: Covariate = 1 if B2b = 1. Covariate = 0 if B2b = 0.
Moderate/impaired decision making problem	CBEH4_B	Indicator of moderately or severely impaired cognitive skills for daily decision making on the prior assessment: Covariate = 1 if B4 > 1. Covariate = 0 if B4 = 0 or 1.
Modes of expression: speech	CBEH4_A	Indicator of modes of expression including speech on the prior assessment OR the most recent full assessment: Covariate = 1 if C3a = checked. Covariate = 0 if C3a = not checked.
More dependence in dressing	CCNT2_B	Indicator of dressing problem or dressing did not occur on the prior assessment: Covariate = 1 if G1g(A) = 3, 4, or 8. Covariate = 0 if G1g(A) = 0, 1, or 2.
More dependence in toileting	CMOB1_C	Indicator of extensive support or more dependence in toileting on the prior assessment: Covariate = 1 if G1i(A) = 3, 4, or 8. Covariate = 0 if G1i(A) = 0, 1, or 2.
Motor agitation	CBEH4_C	Indicator of motor agitation on the prior assessment: Covariate = 1 if E1n = 1 or 2. Covariate = 0 if E1n = 0.
Not totally dependent in transferring	CMOD3_A	Indicator of independent through extensive assistance transferring on the prior assessment: Covariate = 1 if G1b(A) = 0, 1, 2, or 3. Covariate = 0 if G1b(A) = 4 or 8.
Pain Present	CMOD3_B	Indicator of pain on the prior assessment: Covariate = 1 if J2a = 1 or 2. Covariate = 0 if J2a = 0.

<b>COVARIATE NAME</b>	<b>CODE NAME</b>	<b>DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)</b>
Physically abusive behavior	CWGT1_C	Indicator of physically abusive behavior on the prior assessment: Covariate = 1 if E4c(A) = 2 or 3. Covariate = 0 if E4c(A) = 0 or 1.
Planned discharge: 30-90 days	CMOD3_C	Indicator of discharge planned in 3 months on the prior assessment or most recent full assessment: Covariate = 1 if Q1c = 1 or 2. Covariate = 0 if Q1c = 0 or 3.
Pressure ulcers (stage 3 or 4)	CCAT1_B	Indicator of pressure ulcers on the prior assessment: Covariate = 1 if M2a = 3 or 4. Covariate = 0 if M2a = 0.
Requires much assistance for eating	CCOM1_A	Indicator that resident requires extensive assistance or is totally dependent in eating on the prior assessment: Covariate = 1 if G1h(A) = 3, 4, or 8. Covariate = 0 if G1h(A) = 0, 1, or 2.
Resident not bedfast	CFAL1_A	Indicator that resident is not bedfast on the prior assessment: Covariate = 1 if G6a not checked. Covariate = 0 if G6a is checked.
Severe decision making problem	CCNT3_C	Indicator of severe decision making problem on the prior assessment: Covariate = 1 if B4 = 3. Covariate = 0 if B4 = 0, 1, or 2.
Short term memory problem	CCNT2_A	Indicator that resident has a short term memory problem on the prior assessment: Covariate = 1 if B2a = 1. Covariate = 0 if B2a = 0.
Swallowing problem	CNUT1_A	Indicator of swallowing problem on the prior assessment or most recent full assessment: Covariate = 1 if K1b checked (value 1) for swallowing problem. Covariate = 0 if K1b not checked (value 0).
Transferring problem	CPRU4_A	Indicator of transfer problem or transfer did not occur on the prior assessment: Covariate = 1 if G1b(A) = 3, 4, or 8. Covariate = 0 if G1b(A) = 0, 1, or 2.
Unstable condition	CPRU4_B	Indicator of unstable functional status on the prior assessment: Covariate = 1 if J5a = checked (value 1). Covariate = 0 if J5a = not checked (value 0).

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
Unsteady gait/cognitive impairment	CFAL1_C	Indicator that resident has an unsteady gait and is cognitively impaired on the prior assessment. Covariate = 1 if J1n checked (value 1) AND CPS >=2. (CPS is defined in the Technical Comments for COG01 in the Numerator and Denominator column.) Covariate = 0 if J1n not checked (value 0) OR CPS < 2.
Weight loss (5%, past 30 days; 10%, past 180 days)	CCNT3_D	Indicator of weight loss on the prior assessment: Covariate = 1 if K3a = 1. Covariate = 0 if K3a = 0.
<b>Nursing Severity Index (NSI)</b>		
Weighted NSI	NSIDX	The individual diagnoses comprising the NSI include: <b>Group 1: Overall Health and Perceptions</b> Potential for injury Infection/contagion Prolonged disease Instability Impaired life support systems <b>Group 2: Nutrition and Metabolism</b> Excess fluid volume Fluid volume deficit Bleeding Less nutrition than required Potential skin impairment Alterations in oral mucous membranes Altered body temperature <b>Group 3: Urinary and Fecal Function</b> Urinary incontinence Other altered urinary elimination problem Constipation Diarrhea Bowel incontinence <b>Group 4: Activity and Exercise</b> Activity intolerance Ineffective airway clearance Altered breathing pattern Impaired gas exchange Decreased cardiac output Altered health maintenance Impaired mobility Self-care deficit

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
		<p><b>Group 5: Psychosocial Concerns</b>            Disturbed self-concept            Depression            Grieving            Altered family process            Social isolation            Impaired verbal communication            Ineffective individual coping            Potential for growth in family coping            Spiritual distress</p>
Unweighted NSI	NSIUNWT	<p>The individual diagnoses comprising the NSI include:</p> <p><b>Group 1: Overall Health and Perceptions</b>            Potential for injury            Infection/contagion            Prolonged disease            Instability            Impaired life support systems</p> <p><b>Group 2: Nutrition and Metabolism</b>            Excess fluid volume            Fluid volume deficit            Bleeding            Less nutrition than required            Potential skin impairment            Alterations in oral mucous membranes            Altered body temperature</p> <p><b>Group 3: Urinary and Fecal Function</b>            Urinary incontinence            Other altered urinary elimination problem            Constipation            Diarrhea            Bowel incontinence</p> <p><b>Group 4: Activity and Exercise</b>            Activity intolerance            Ineffective airway clearance            Altered breathing pattern            Impaired gas exchange            Decreased cardiac output            Altered health maintenance            Impaired mobility            Self-care deficit</p>

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
		<p><b>Group 5: Psychosocial Concerns</b></p> <ul style="list-style-type: none"> <li>Disturbed self-concept</li> <li>Depression</li> <li>Grieving</li> <li>Altered family process</li> <li>Social isolation</li> <li>Impaired verbal communication</li> <li>Ineffective individual coping</li> <li>Potential for growth in family coping</li> <li>Spiritual distress</li> </ul>
<b>Personal Severity Index (PSI)</b>		
Full PSI	PSI	<ul style="list-style-type: none"> <li>▪ Scale Components Include:</li> <li>▪ Age 90 or older</li> <li>▪ Cognitive decision making: severely impaired (B4=3)</li> <li>▪ Delirium: Periods of lethargy (B5E=2)</li> <li>▪ Ability to understand: sometimes/rarely (C6=2,3)</li> <li>▪ Transfer – extensive, total, did not occur (G1Ba=3,4,8)</li> <li>▪ Locomotion – extensive, total, did not occur (G1eA=3,4,8)</li> <li>▪ Eating -- extensive, total, did not occur (G1hA=3,4,8)</li> <li>▪ Personal hygiene – total, did not occur (G1jA=4,8)</li> <li>▪ Sad mood – daily repetitive verbalizations (E1c=2)</li> <li>▪ Sad mood – something terrible about to happen – daily (E1g=2)</li> <li>▪ Acute episode – yes (J5b=1)</li> <li>▪ Unstable – yes (J5a=1)</li> <li>▪ Change in care needs – deteriorated (Q2=2)</li> <li>▪ End stage disease – yes (J5c=1)</li> <li>▪ Bowel – occasional, frequent incontinent (H1b=2,3,4)</li> <li>▪ Weight loss – yes (K3a=1)</li> <li>▪ Pressure ulcer – stages 1 through 4 (M2a=1,2,3,4)</li> <li>▪ Stasis ulcers – yes (M2b=1,2,3,4)</li> </ul>
PSI: Subset 1 – Diagnoses	PSIS1	<ul style="list-style-type: none"> <li>▪ Age 90 or older</li> <li>▪ Acute episode – yes (J5b=1)</li> <li>▪ Unstable – yes (J5a=1)</li> <li>▪ Change in care needs – deteriorated (Q2=2)</li> <li>▪ End stage disease – yes (J5c=1)</li> <li>▪ Bowel – occasional, frequent incontinent (H1b=2,3,4)</li> <li>▪ Weight loss – yes (K3a=1)</li> <li>▪ Pressure ulcer – stages 1 through 4 (M2a=1,2,3,4)</li> <li>▪ Stasis ulcers – yes (M2b=1,2,3,4)</li> </ul>

<b>COVARIATE NAME</b>	<b>CODE NAME</b>	<b>DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)</b>
PSI: Subset 2 – Non-Diagnoses	PSIS2	<ul style="list-style-type: none"> <li>▪ Age 90 or older</li> <li>▪ Cognitive decision making: severely impaired (B4=3)</li> <li>▪ Delirium: Periods of lethargy (B5E=2)</li> <li>▪ Ability to understand: sometimes/rarely (C6=2,3)</li> <li>▪ Transfer – extensive, total, did not occur (G1Ba=3,4,8)</li> <li>▪ Locomotion – extensive, total, did not occur (G1eA=3,4,8)</li> <li>▪ Eating -- extensive, total, did not occur (G1hA=3,4,8)</li> <li>▪ Personal hygiene – total, did not occur (G1jA=4,8)</li> <li>▪ Sad mood – daily repetitive verbalizations (E1c=2)</li> <li>▪ Sad mood – something terrible about to happen –daily (E1g=2)</li> </ul>
<b>Resource Utilization Group (RUG)</b>		
RUG Nursing CMI	R_CMIC	Case Mix Index based on RUG-III Grouper.
RUG Late Loss ADL	R_ADL	Split into physical functioning groups based on the ADL index and whether the number of nursing rehab activities is 2 or more **
RUG Behavior Problems	R_BEH	Resident must have an ADL index of 10 or less and the presence of delusions, hallucinations, or one of more of the following 4 or more days per week: wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate/disruptive behavior, resisting care.**
RUG Clinically Complex	R_CLN	Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include any of the following: feeding tube with high parenteral/enteral intake; comatose and not awake and ADL dependent; septicemia; second or third degree burns; dehydration; hemiplegia/hemiparesis and an ADL index of 10 or more; internal bleeding; pneumonia; end stage disease; chemotherapy; dialysis; physician order changes on 4 or more days and physicians visits on 1 or more day; physician order changes on 2 or more days and physician visits on 7 days; diabetes and injections on 7 days and physician order changes on 2 or more days; transfusions; oxygen therapy; application of dressing to foot and injection on foot or open lesion on foot. **

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
RUG Extensive Care	R_EXT	Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include receipt of parenteral/IV feeding, IV medication, the special care category, the clinically complex category, and the impaired cognition category. ADL index score must be 7 or higher otherwise classify resident into special care. **
RUG Cognitive Impairment	R_IMP	Resident must have an ADL index of 10 or less and a Cognitive Performance Scale of 3 or more, indicating moderate, moderately severe, severe, or very severe impairment). **
RUG Rehabilitation	R_REHC	<p><b>Ultra high rehabilitation</b> (At least 720 minutes of therapy received per week with 5 or more days for one type of therapy and at least 3 days for a second type)</p> <p><b>Very high rehabilitation</b> (At least 500 minutes of therapy received per week with 5 or more days for one type of therapy)</p> <p><b>High rehabilitation</b> (At least 325 minutes of therapy received per week with 5 or more days per week for one type of therapy)</p> <p><b>Medium rehabilitation</b> (At least 150 minutes of therapy received per week with 5 or more days of some type of therapy)</p> <p><b>Low rehabilitation</b> (At least 45 minutes of therapy received per week with 3 or more days of some type of therapy and 2 or more nursing rehabilitation activities at least 6 days per week each.</p>
RUG Special Care	R_SPC	<p>Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include an ADL index of 7 or more plus any of the following: **</p> <ul style="list-style-type: none"> <li>• Two or more ulcers of any type or a stage 3 or 4 pressure ulcer and two or more selected skin care treatments;</li> <li>• Feeding tube with enteral intake and aphasia;</li> <li>• Surgical wounds or open lesions other than ulcers, rashes, or cuts and surgical wound care or application of dressings or ointments;</li> <li>• Respiratory therapy for 7 days;</li> </ul>

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
		<ul style="list-style-type: none"> <li>• Cerebral palsy and an ADL score of 10 or more;</li> <li>• Fever, plus any one of vomiting or weight loss or tube feeding with high; parenteral/enteral intake, pneumonia, or dehydration;</li> <li>• Multiple sclerosis and an ADL score of 10 or more;</li> <li>• Quadriplegia and an ADL score of 10 or more; and</li> <li>• Radiation therapy)</li> </ul>
<b>Other Scales</b>		
Cardiopulmonary Severity Scale	CARDIO	<p><b>CARDIO = 0</b> if ASHD (I1d), CHF (I1f), Cardiac Dysrhythmia (I1e), Other Cardio (I1k) and COPD(I1ii) all = 0.</p> <p><b>CARDIO = 1</b> IF ASHD or CHF or Cardiac Dysrhythmia or Other Cardio or COPD = 1 and none of the other characteristics for <b>CARDIO = 2</b> or 3.</p> <p><b>CARDIO = 2</b> IF ASHD or CHF or Cardiac Dysrhythmia or Other Cardio or COPD = 1 AND any one of the following:</p> <ol style="list-style-type: none"> <li>1. Weight gain or loss (j1a=1) AND Independent in Walk (G1cA=0)</li> <li>2. Oxygen therapy (P1ag=1) AND Independent in Walk (G1cA=0)</li> <li>3. Shortness of breath (J1l=1)</li> <li>4. Inability to lie flat (J1b=1)</li> <li>5. Chest pain (J3c=1)</li> <li>6. Walk in room (G1cA&gt;2)</li> <li>7. Edema (j1g=1)</li> <li>8. COPD (I1ii=1) and either CHF(I1f=1) or ASHD(I1d=1)</li> </ol> <p><b>CARDIO = 3</b> IF ASHD or CHF or Cardiac Dysrhythmia or Other Cardio or COPD = 1 and any one of the following:</p> <ol style="list-style-type: none"> <li>1. Weight gain or loss (j1a=1) and Supervision in Walk (G1cA= 1,2,3,4,8)</li> <li>2. Oxygen therapy (P1g=1) AND Supervision in Walk (G1cA= 1,2,3,4,8)</li> <li>3. Ventilator or respirator (P1l=1)</li> <li>4. Syncope (J1m=1)</li> </ol>

<b>COVARIATE NAME</b>	<b>CODE NAME</b>	<b>DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)</b>
Cognitive Performance Scale (CPS)	CPS	The CPS was created to generate the RUG Cognitive Impairment Scale. The following represent the CPS code used: 0 = intact 1 = borderline intact 2 = mild impairment 3 = moderate impairment 4 = moderately severe impairment 5 = severe impairment 6 = very severe impairment
<b>MDS Diagnosis Indicators</b>		
Acute Episode or Flare-up	J5B	J5b = checked
Combination Alzheimer's Disease / Other Dementia	I1QU	I1q and u = checked
Arteriosclerotic Heart Disease (AHSD)	I1D	I1d = checked
Arthritis	I1L	I1l = checked
Cancer	I1PP	I1pp = checked
Congestive Heart Failure (CHF)	I1F	I1f = checked
Depression	I1EE	I1ee = checked
Emphysema/COPD	I1II	I1ii = checked
Hip Fracture in last 180 days	J4C	J4c = checked
Osteoporosis	I1O	I1o = checked
Renal Failure	I1QQ	I1qq = checked

## POST-ACUTE CARE

COVARIATE NAME	CODE NAME	DEFINITION (WITH MDS ITEM LOCATION WHERE APPLICABLE)
Bowel incontinence	PPRUX_C	Indicator of bowel incontinence at least one/week on the SNF PPS 5-day assessment: Covariate = 1 if H1a 2, 3, or 4. Covariate = 0 if H1a = 0 or 1.
Diabetes or peripheral vascular disease	PPRUX_D	Indicator of diabetes or peripheral vascular disease on the SNF PPS 5-day assessment: Covariate = 1 if I1a checked (value 1) OR I1j checked (value 1). Covariate = 0 if I1a not checked (value 0) AND I1j not checked (value 0).
Indicator of asthma on prior assessment	PRSPX_A	Indicator of asthma on the SNF PPS 5-day assessment: Covariate = 1 if I1hh checked (value 1). Covariate = 0 if I1hh not checked (value 0).
Indicator of emphysema/COPD on prior assessment	PRSPX_B	Indicator of Emphysema/COPD on the SNF PPS 5-day assessment: Covariate = 1 if I1ii checked (value 1). Covariate = 0 if I1ii not checked (value 0).
Low body mass index	PPRUX_E	Indicator of low Body Mass Index (BMI) on the SNF PPS 5-day assessment: Covariate = 1 if BMI $\geq 12$ AND $\leq 19$ . Covariate = 0 if BMI $> 19$ AND $\leq 40$ . Where: $\text{BMI} = \text{weight (Kg)} / \text{height}^2 (\text{m}^2) = ((\text{K2b} * 0.45) / (((\text{K2a} * .0254)^2))$ (Note: An implausible BMI value $< 12$ or $> 40$ will be treated as a missing value on this covariate.)
Needs bed mobility assistance	PPRUX_B	Indicator of requiring limited or more assistance in bed mobility on the SNF PPS 5-day assessment: Covariate = 1 if G1a(A) = 2, 3, 4, or 8. Covariate = 0 if G1a(A) = 0 or 1.

No prior residential history	PADLX_A	<p>Indicator of NO prior residential history preceding the current SNF stay for the patient:</p> <p>Covariate = 1 if there is NO prior residential history indicated by the following condition being satisfied:</p> <ol style="list-style-type: none"> <li>1) There is a recent admission assessment (AA8a = 01) available for the patient AND AB5a through AB5e are not checked (value 0) AND AB5f is checked (value 1) on that assessment.</li> </ol> <p>Covariate = 0 if there is prior residential history indicated by either of the following conditions being satisfied:</p> <ol style="list-style-type: none"> <li>1) There is a recent admission assessment (AA8a = 01) AND any of the items AB5a through AB5e are checked (value 1) OR AB5f is not checked (value 0) on that assessment.</li> <li>2) There is no recent admission assessment (AA8a = 01).</li> </ol>
Ulcer resolved	PPRUX_A	<p>Indicator of history of resolved pressure ulcer on the SNF PPS 5-day assessment:</p> <p>Covariate = 1 if M3 = 1. Covariate = 0 if M3 = 0.</p>
<b>Nursing Severity Index (NSI)</b>		
Weighted NSI	NSIDX	<p>The individual diagnoses comprising the NSI include:</p> <p><b>Group 1: Overall Health and Perceptions</b></p> <ul style="list-style-type: none"> <li>Potential for injury</li> <li>Infection/contagion</li> <li>Prolonged disease</li> <li>Instability</li> <li>Impaired life support systems</li> </ul> <p><b>Group 2: Nutrition and Metabolism</b></p> <ul style="list-style-type: none"> <li>Excess fluid volume</li> <li>Fluid volume deficit</li> <li>Bleeding</li> <li>Less nutrition than required</li> <li>Potential skin impairment</li> <li>Alterations in oral mucous membranes</li> <li>Altered body temperature</li> </ul>

		<p><b>Group 3: Urinary and Fecal Function</b>  Urinary incontinence  Other altered urinary elimination problem  Constipation  Diarrhea  Bowel incontinence</p> <p><b>Group 4: Activity and Exercise</b>  Activity intolerance  Ineffective airway clearance  Altered breathing pattern  Impaired gas exchange  Decreased cardiac output  Altered health maintenance  Impaired mobility  Self-care deficit</p> <p><b>Group 5: Psychosocial Concerns</b>  Disturbed self-concept  Depression  Grieving  Altered family process  Social isolation  Impaired verbal communication  Ineffective individual coping  Potential for growth in family coping  Spiritual distress</p>
Unweighted NSI	NSIUNWT	<p>The individual diagnoses comprising the NSI include:</p> <p><b>Group 1: Overall Health and Perceptions</b>  Potential for injury  Infection/contagion  Prolonged disease  Instability  Impaired life support systems</p> <p><b>Group 2: Nutrition and Metabolism</b>  Excess fluid volume  Fluid volume deficit  Bleeding  Less nutrition than required  Potential skin impairment  Alterations in oral mucous membranes  Altered body temperature</p>

		<p><b>Group 3: Urinary and Fecal Function</b>          Urinary incontinence          Other altered urinary elimination problem          Constipation          Diarrhea          Bowel incontinence</p> <p><b>Group 4: Activity and Exercise</b>          Activity intolerance          Ineffective airway clearance          Altered breathing pattern          Impaired gas exchange          Decreased cardiac output          Altered health maintenance          Impaired mobility          Self-care deficit</p> <p><b>Group 5: Psychosocial Concerns</b>          Disturbed self-concept          Depression          Grieving          Altered family process          Social isolation          Impaired verbal communication          Ineffective individual coping          Potential for growth in family coping          Spiritual distress</p>
<b>Personal Severity Index (PSI)</b>		
Full PSI	PSI	<ul style="list-style-type: none"> <li>▪ Scale Components Include:</li> <li>▪ Age 90 or older Cognitive decision making: severely impaired (B4=3)</li> <li>▪ Delirium: Periods of lethargy (B5E=2)</li> <li>▪ Ability to understand: sometimes/rarely (C6=2,3)</li> <li>▪ Transfer – extensive, total, did not occur (G1Ba=3,4,8)</li> <li>▪ Locomotion – extensive, total, did not occur (G1eA=3,4,8)</li> <li>▪ Eating -- extensive, total, did not occur (G1hA=3,4,8)</li> <li>▪ Personal hygiene – total, did not occur (G1jA=4,8)</li> <li>▪ Sad mood – daily repetitive verbalizations (E1c=2)</li> <li>▪ Sad mood – something terrible about to happen – daily (E1g=2)</li> <li>▪ Acute episode – yes (J5b=1)</li> <li>▪ Unstable – yes (J5a=1)</li> <li>▪ Change in care needs – deteriorated (Q2=2)</li> <li>▪ End stage disease – yes (J5c=1)</li> <li>▪ Bowel – occasional, frequent incontinent (H1b=2,3,4)</li> <li>▪ Weight loss – yes (K3a=1)</li> <li>▪ Pressure ulcer – stages 1 through 4 (M2a=1,2,3,4)</li> <li>▪ Stasis ulcers – yes (M2b=1,2,3,4)</li> </ul>

PSI: Subset 1 – Diagnoses	PSIS1	<ul style="list-style-type: none"> <li>▪ Age 90 or older</li> <li>▪ Acute episode – yes (J5b=1)</li> <li>▪ Unstable – yes (J5a=1)</li> <li>▪ Change in care needs – deteriorated (Q2=2)</li> <li>▪ End stage disease – yes (J5c=1)</li> <li>▪ Bowel – occasional, frequent incontinent (H1b=2,3,4)</li> <li>▪ Weight loss – yes (K3a=1)</li> <li>▪ Pressure ulcer – stages 1 through 4 (M2a=1,2,3,4)</li> <li>▪ Stasis ulcers – yes (M2b=1,2,3,4)</li> </ul>
PSI: Subset 2 – Non-Diagnoses	PSIS2	<ul style="list-style-type: none"> <li>▪ Age 90 or older</li> <li>▪ Cognitive decision making: severely impaired (B4=3)</li> <li>▪ Delirium: Periods of lethargy (B5E=2)</li> <li>▪ Ability to understand: sometimes/rarely (C6=2,3)</li> <li>▪ Transfer – extensive, total, did not occur (G1Ba=3,4,8)</li> <li>▪ Locomotion – extensive, total, did not occur (G1eA=3,4,8)</li> <li>▪ Eating -- extensive, total, did not occur (G1hA=3,4,8)</li> <li>▪ Personal hygiene – total, did not occur (G1jA=4,8)</li> <li>▪ Sad mood – daily repetitive verbalizations (E1c=2)</li> <li>▪ Sad mood – something terrible about to happen –daily (E1g=2)</li> </ul>
<b>Resource Utilization Group (RUG)</b>		
RUG Nursing CMI	R_CMIP	Case Mix Index based on RUG-III Grouper.
RUG Late Loss ADL	R_ADL	Split into physical functioning groups based on the ADL index and whether the number of nursing rehab activities is 2 or more. **
RUG Behavior Problems	R_BEH	Resident must have an ADL index of 10 or less and the presence of delusions, hallucinations, or one of more of the following 4 or more days per week: wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate/disruptive behavior, resisting care. **
RUG Clinically Complex	R_CLN	Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include any of the following: feeding tube with high parenteral/enteral intake; comatose and not awake and ADL dependent; septicemia; second or third degree burns; dehydration; hemiplegia/hemiparesis and an ADL index of 10 or more; internal bleeding; pneumonia; end stage disease; chemotherapy; dialysis; physician order changes on 4 or more days and physicians visits on 1 or more day; physician order changes on 2 or more days and physician visits on 7 days; diabetes and injections on 7 days and physician order changes on 2 or more days; transfusions; oxygen

		therapy; application of dressing to foot and injection on foot or open lesion on foot. **
RUG Extensive Care	R_EXT	Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include receipt of parenteral/IV feeding, IV medication, the special care category, the clinically complex category, and the impaired cognition category. ADL index score must be 7 or higher otherwise classify resident into special care. **
RUG Cognitive Impairment	R_IMP	Resident must have an ADL index of 10 or less and a Cognitive Performance Scale of 3 or more, indicating moderate, moderately severe, severe, or very severe impairment). **
RUG Rehabilitation	R_REHC	<p><b>Ultra high rehabilitation</b> (At least 720 minutes of therapy received per week with 5 or more days for one type of therapy and at least 3 days for a second type)</p> <p><b>Very high rehabilitation</b> (At least 500 minutes of therapy received per week with 5 or more days for one type of therapy)</p> <p><b>High rehabilitation</b> (At least 325 minutes of therapy received per week with 5 or more days per week for one type of therapy)</p> <p><b>Medium rehabilitation</b> (At least 150 minutes of therapy received per week with 5 or more days of some type of therapy)</p> <p><b>Low rehabilitation</b> (At least 45 minutes of therapy received per week with 3 or more days of some type of therapy and 2 or more nursing rehabilitation activities at least 6 days per week each.</p>
RUG Special Care	R_SPC	Resident qualifies for extensive services on the basis of clinical indicators. Qualifications include an ADL index of 7 or more plus any of the following: ** <ul style="list-style-type: none"> <li>• Two or more ulcers of any type or a stage 3 or 4 pressure ulcer and two or more selected skin care treatments;</li> <li>• Feeding tube with enteral intake and aphasia;</li> </ul>

		<ul style="list-style-type: none"> <li>• Surgical wounds or open lesions other than ulcers, rashes, or cuts and surgical wound care or application of dressings or ointments;</li> <li>• Respiratory therapy for 7 days;</li> <li>• Cerebral palsy and an ADL score of 10 or more;</li> <li>• Fever, plus any one of vomiting or weight loss or tube feeding with high; parenteral/enteral intake, pneumonia, or dehydration;</li> <li>• Multiple sclerosis and an ADL score of 10 or more;</li> <li>• Quadriplegia and an ADL score of 10 or more; and</li> <li>• Radiation therapy)</li> </ul>
<b>Other Scales</b>		
Cardiopulmonary Severity Scale	CARDIO	<p><b>CARDIO = 0</b> IF ASHD (I1d), CHF (I1f), Cardiac Dysrhythmia (I1e), Other Cardio (I1k) and COPD(I1ii) all = 0.</p> <p><b>CARDIO = 1</b> IF ASHD or CHF OR Cardiac Dysrhythmia or Other Cardio or COPD = 1 and none of the other characteristics for <b>CARDIO = 2</b> or 3.</p> <p><b>CARDIO = 2</b> IF ASHD or CHF or Cardiac Dysrhythmia or Other Cardio or COPD = 1 and any one of the following:</p> <ol style="list-style-type: none"> <li>9. Weight gain or loss (j1a=1) and Independent in Walking (G1cA=0)</li> <li>10. Oxygen therapy (P1ag=1) and Independent in Walking (G1cA=0)</li> <li>11. Shortness of breath (J1l=1)</li> <li>12. Inability to lie flat (J1b=1)</li> <li>13. Chest pain (J3c=1)</li> <li>14. Walking in room (G1cA&gt;2)</li> <li>15. Edema (j1g=1)</li> <li>16. COPD (I1ii=1) and EITHER CHF (I1f=1) OR ASHD(I1d=1)</li> </ol> <p><b>CARDIO = 3</b> IF ASHD or CHF or Cardiac Dysrhythmia or Other Cardio or COPD = 1 and any one of the following:</p> <ol style="list-style-type: none"> <li>5. Weight gain or loss (j1a=1) and Supervision in Walking (G1cA= 1,2,3,4,8)</li> <li>6. Oxygen therapy (P1g=1) and Supervision in Walking (G1cA= 1,2,3,4,8)</li> <li>7. Ventilator or respirator (P1l=1)</li> <li>8. Syncope (J1m=1)</li> </ol>

Cognitive Performance Scale (CPS)	CPS	The CPS was created based on the RUG Cognitive Impairment Scale. The following represent the CPS code used: 0 = intact 1 = borderline intact 2 = mild impairment 3 = moderate impairment 4 = moderately severe impairment 5 = severe impairment 6 = very severe impairment
<b>MDS Diagnosis Indicators</b>		
Acute Episode or Flare-up	J5B	J5b = checked
Combination Alzheimer's Disease / Other Dementia	I1QU	I1q and u = checked
Arteriosclerotic Heart Disease (ASHD)	I1D	I1d = checked
Arthritis	I1L	I1l = checked
Cancer	I1PP	I1pp = checked
Congestive Heart Failure (CHF)	I1F	I1f = checked
Depression	I1EE	I1ee = checked
Emphysema/COPD	I1II	I1ii = checked
Hip Fracture in last 180 days	J4C	J4c = checked
Osteoporosis	I1O	I1o = checked
Renal Failure	I1QQ	I1qq = checked

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\*\* The ADL index is based on the amount of support required for the following ADL activities: bed mobility, transferring, toilet use, and eating. It ranges from 4 (fully independent) to 8 (totally dependent, needs two-person assistance where applicable)