National Field Test Assessment Protocol: Non-Communicative

Current as of November 2017

Project Title:

Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data

Dates:

- The national assessment field period will run from November 2017 through May 2018.
- The formal report from this national test is anticipated to be available by the end of 2018.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with the RAND Corporation to develop standardized assessment-based data elements to meet the requirements as set forth under the IMPACT Act of 2014, Section 2(a). The contract name is "Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data". The contract number is HHSM-500-2013-13014I. As part of its data element development process, RAND is conducting a national test of the data elements that are currently being considered for standardization.

Project Objective:

The project objective is to develop standardized patient assessment data elements to meet the requirements of the IMPACT Act of 2014, Section 2(a). These data elements may be used to inform a number of important things, including case-mix adjustment, medical complexity, interoperable exchange, clinical decision support, and measure development.

Information About the National Test:

- The goal of the national test is to obtain a nationally representative sample from which assessment data can be collected and analyzed to explore potential data elements for inclusion in the four currently administered PAC instruments
- The national test is targeted to include 210 PAC facilities across 14 randomly selected U.S. markets
- Testing includes admission and discharge assessment protocols for assessing communicative patients/residents and a set of 3 data elements designed specifically for use with patients/residents who are unable or unwilling to communicate. Data elements being tested include interview items, observational items, and items that utilize multiple information sources such as chart abstraction.
- The clinical categories being considered for standardized assessment are:
    - Cognitive status (including cognitive function, delirium, expression and understanding, and behavior)
    - Mental status (including depression and anxiety)
    - Impairments (including continence, vision, and hearing)
    - Medical conditions (including pain)
    - Special Services Treatments and Interventions
    - Other clinical categories:

- Global health
- Care preferences
- Medication reconciliation

About this Document: The National Field Test Assessment Protocol:

- To delineate the items being assessed in the National Beta test, CMS is posting this protocol to increase transparency and to allow researchers, providers, and consumers more information on the testing protocol.
- This assessment protocol is for non-communicative patients/residents at admission.
- This protocol is assessing items for standardization. This protocol is not in the final format of the commonly-leveraged CMS assessment instruments.
- We would lke to stress that these are items that are being explored for use in standardization efforts. CMS has not finalized or adopted any standardized patient assessment data elements at the current time.

MODULE B: COGNITION II

B3. Staff Assessment of Mental Status

B3a. Short-term Memory OK: Seems or appears to recall after 5 minutes

- ☐ 0 = Memory OK
- ☐ 1 = Memory problem
- ☐ 9 = **Unknown or unable to assess**

B3b. Long-term Memory OK: Seems or appears to recall long past

- ☐ 0 = Memory OK
- ☐ 1 = Memory problem
- ☐ 9 = **Unknown or unable to assess**

B3c. Memory/Recall Ability: Is the patient/resident normally able to recall:

B3c1. Current season

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess**

B3c2. Location of own room

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess**

B3c3. Staff names and faces

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess**

B3c4. That he or she is in a nursing facility/hospital bed/rehabilitation facility/home

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess**

B3d. Cognitive Skills for Daily Decision Making: Made decisions regarding tasks of daily life:

- ☐ 0 = Independent – decisions consistent/reasonable
- ☐ 1 = Modified independence – some difficulty in new situations only
- ☐ 2 = Moderately impaired – decisions poor; cues/supervision required
- ☐ 3 = Severely impaired – never/rarely made decisions
- ☐ 9 = **Unknown or unable to assess**

MODULE D. PAIN II

D7. Observational Assessment of Pain or Distress

D7. Observational Assessment of Pain or Distress

FOR ALL PATIENTS/RESIDENTS WHO ARE UNABLE TO PARTICIPATE IN THE PAIN INTERVIEW, PLEASE NOTE WHETHER ANY OF THE FOLLOWING BEHAVIORS WERE OBSERVED.

PATIENTS/RESIDENTS SHOULD BE OBSERVED TWICE DAILY (MORNING AND EVENING) DURING CARE ACTIVITIES (I.E., DURING TRANSFER PROCEDURES, REPOSITIONING, BATHING, TOILETING, WOUND CARE/DRESSING CHANGES, RANGE OF MOTION, AMBULATING, OR OTHER EXERCISES, ETC.), WHEN BEHAVIORAL SIGNS OF POTENTIAL PAIN OR DISTRESS ARE MOST LIKELY TO BE EXPRESSED, OVER THE COURSE OF 3 CONSECUTIVE DAYS.

CHECK ALL THAT APPLY

- ☐ a = Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ b = Vocal complaints of pain (e.g., "that hurts, ouch, stop")
- ☐ c = Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, rapid eye blinking; tightly closed eyes)
- ☐ d = Body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, rigid, tense body posture; withdrawing an extremity to an external stimulus; fidgeting; increased pacing, rocking; restricted movement; gait or mobility changes)
- ☐ z = None of these signs observed or documented. **[SKIP TO DNC-TIME]**

D8. Frequency of Indicators of Pain or Distress

D8. For patients/residents who demonstrated any indicators of potential pain or distress listed in D7: Observational Assessment of Pain or Distress, identify the frequency with which patient/resident complains or shows evidence of potential pain or distress over the past 3 days.

- ☐ 1 = Indicators of potential pain or distress observed less than daily
- ☐ 2 = Indicators of potential pain or distress observed daily (at least once per day on each day of the assessment window)
- ☐ 3 = Indicators of potential pain or distress observed more than daily (multiple times per day on each day of the assessment window)
- ☐ 9 = **Unknown or unable to assess**

D9. Did Indicators of Pain or Distress Resolve/Diminish with Pain Medications or Treatment

D9. For patients/residents who demonstrated any indicators of potential pain or distress listed in F7: Observational Assessment of Pain or Distress, is there any evidence that these indicators resolved or diminished in response to pain medications or treatments over the past 3 days?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 8 = **Not applicable** – patient/resident has not received pain medications or treatments within the past 3 days
- ☐ 9 = **Unknown or unable to assess**

MODULE E: MOOD II

E4. Staff Assessment of Patient/Resident Mood (PHQ-9-OV©)

E4a1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident have little interest or pleasure in doing things?

- ☐ 0 = No **[SKIP TO E4b1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4b1]**

E4a2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident have little interest or pleasure in doing things?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4b1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident feel or appear down, depressed, or hopeless?

- ☐ 0 = No **[SKIP TO E4c1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4c1]**

E4b2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident feel or appear down, depressed, or hopeless?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4c1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident have trouble falling or staying asleep, or sleeping too much?

- ☐ 0 = No **[Skip to E4d1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [Skip to E4d1]**

E4c2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident have trouble falling or staying asleep, or sleeping too much?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4d1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident feel tired or have little energy?

- ☐ 0 = No **[SKIP to E4e1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP to E4e1]**

E4d2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident feel tired or have little energy?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4e1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident have a poor appetite or overeating?

- ☐ 0 = No **[SKIP TO E4f1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4f1]**

E4e2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident have a poor appetite or overeating?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4f1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident indicate that s/he feels bad about self, is a failure, or has let self or family down?

- ☐ 0 = No **[SKIP TO E4g1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4g1]**

E4f2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident indicate that s/he feels bad about self, is a failure, or has let self or family down?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4g1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident have trouble concentrating on things, such as reading the newspaper or watching television?

- ☐ 0 = No **[SKIP TO E4h1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4h1]**

E4g2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident have trouble concentrating on things, such as reading the newspaper or watching television?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4h1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident move or speak so slowly that other people have noticed? Or the opposite, being so fidgety or restless that s/he has been moving around a lot more than usual?

- ☐ 0 = No **[SKIP TO E4i1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4i1]**

E4h2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident move or speak so slowly that other people have noticed. Or the opposite, being so fidgety or restless that s/he has been moving around a lot more than usual?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4i1. SYMPTOM PRESENCE: Over the last 2 weeks, did the patient/resident state that life isn't worth living, wishes for death, or attempts to harm self?

- ☐ 0 = No **[SKIP TO E4j1]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO E4j1]**

E4i2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often did the patient/resident state that life isn't worth living, wishes for death, or attempts to harm self?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

E4j1. SYMPTOM PRESENCE: Over the last 2 weeks, was the patient/resident being short-tempered, easily annoyed?

- ☐ 0 = No **[SKIP TO PHQ-9 TOTAL SCORE]**
- ☐ 1 = Yes
- ☐ 9 = **Unknown or unable to assess [SKIP TO PHQ-9 TOTAL SCORE]**

E4j2. SYMPTOM FREQUENCY: Over the last 2 weeks, how often was the patient/resident being short-tempered, easily annoyed?

- ☐ 0 = Never or 1 day
- ☐ 1 = 2-6 days (several days)
- ☐ 2 = 7-11 days (half or more of the days)
- ☐ 3 = 12-14 days (nearly every day)
- ☐ 9 = **Unknown or unable to assess**

PHQ-9 OV TOTAL: Add values from E4a2, E4b2, E4c2, E4d2, E4e2, E4f2, E4g2, E4h2, E4i2, E4j2 →

K. FINAL CHECKS [Assessor Only]

K1. ASSESSOR: Is this an incomplete assessment due to any of the following reasons? **[CHECK ALL THAT APPLY]**

- ☐ patient/resident refused/opted out
- ☐ patient/resident transfer
- ☐ patient/resident death
- ☐ change in communication status
- ☐ change in eligibility
- ☐ other:_____