

A PROJECT TO DEVELOP AN OUTCOME-BASED CONTINUOUS  
QUALITY IMPROVEMENT SYSTEM AND CORE OUTCOME AND  
COMPREHENSIVE ASSESSMENT DATA SET FOR PACE

**DRAFT COCOA DATA SET  
NURSING FORM**

Conducted by:  
Center for Health Services Research  
University of Colorado Health Sciences Center

for:

Department of Health and Human Services  
Centers for Medicare & Medicaid Services

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9. **Tobacco Use/Abuse:**

a. Does participant currently smoke or chew tobacco?

- ☐ 0 - No [ Go to Item f ]  
☐ 1 - Yes (Mark all that apply.)  
☐ 1 - Smokes ☐ 2 - Chews

b. How much does participant smoke/chew tobacco in an average day? \_\_\_\_\_

c. For how many years has participant smoked/chewed tobacco? \_\_\_\_\_

d. Would participant consider decreasing or stopping smoking/chewing?

- ☐ 0 - No ☐ 1 - Yes

e. PROVIDER: Are you concerned about the participant being a careless smoker?

- ☐ 0 - No ☐ 1 - Yes

Notes regarding safety concerns, etc. (optional): \_\_\_\_\_

[ Go to Item 10 ]

f. Has participant ever smoked or chewed tobacco?

- ☐ 0 - No ☐ 1 - Yes

For how many years? \_\_\_\_\_

Approximate date stopped: \_\_\_\_\_

10. **Appearance:** Describe participant's general appearance. (Mark all that apply.)

- ☐ 1 - No concerns  
☐ 2 - Inappropriately clothed for setting (e.g., for weather, trips outside the home)  
☐ 3 - Physically unkempt  
☐ 4 - Poor hygiene  
☐ 5 - Other (specify): \_\_\_\_\_

Comments (consider posture, clothes, grooming, hair, nails): \_\_\_\_\_

11a. **Personal Hygiene Affecting Socialization:** Does the participant's personal hygiene have a negative impact on his/her social interaction with others (e.g., others avoid talking to or spending time with participant because of skin hygiene, scalp problems, bad breath, etc.)?

- ☐ 0 - No ☐ 1 - Yes

Notes (optional): \_\_\_\_\_

b. **Personal Hygiene Affecting Health:** Does the participant's personal hygiene have a negative impact on his/her health (e.g., not brushing teeth resulting in gum problems, inadequate bathing resulting in skin rashes)?

- ☐ 0 - No ☐ 1 - Yes

12. **Immunizations:** (To be completed at initial assessment and annually.)

a. **Flu Immunization Status:** Has the participant received an influenza vaccination in the past year?

- ☐ 0 - No  
☐ 1 - Yes - Date of most recent immunization: \_\_\_\_\_  
☐ 2 - Refused immunization - Date: \_\_\_\_\_

c. **Tuberculosis Screening Status:** Has the participant ever received a TB screening test?

- ☐ 0 - No  
☐ 1 - Yes - Date of most recent TB test: \_\_\_\_\_  
Reaction: \_\_\_\_\_ mm

b. **Pneumococcal Immunization Status:** Has the participant received a pneumococcal vaccination in the past ten years?

- ☐ 0 - No  
☐ 1 - Yes - Date of most recent immunization: \_\_\_\_\_  
☐ 2 - Refused immunization - Date: \_\_\_\_\_

d. **Tetanus Immunization Status:** Has the participant received a tetanus immunization in the past ten years?

- ☐ 0 - No  
☐ 1 - Yes - Date of most recent immunization: \_\_\_\_\_  
☐ 2 - Refused immunization - Date: \_\_\_\_\_

13. **Height and Weight:**

a. Record actual **height** in inches (measured) HEIGHT (in.) \_\_\_\_\_ or feet \_\_\_\_\_ in. \_\_\_\_\_

b. Record actual **weight** in pounds or kilograms (measured) WEIGHT (lb.) \_\_\_\_\_ or WEIGHT (kg.) \_\_\_\_\_

14. **Weight Gained/Lost** since last assessment:

**Gained:** \_\_\_\_\_ lbs. OR \_\_\_\_\_ kg.

**Lost:** \_\_\_\_\_ lbs. OR \_\_\_\_\_ kg.

Notes (optional): \_\_\_\_\_

15. **Vital Signs:**

Temp \_\_\_\_\_ Pulse \_\_\_\_\_

AP \_\_\_\_\_ Reg / Irreg

Resp \_\_\_\_\_ Reg / Irreg

B/P \_\_\_\_\_ R / L (circle)

Sit \_\_\_\_\_

Lie (initial) \_\_\_\_\_

Stand (initial) \_\_\_\_\_

16. **Edema:**

a. Legs/Feet ☐ None ☐ Right ☐ Left Degree: \_\_\_\_\_

b. Arms/Hands ☐ None ☐ Right ☐ Left Degree: \_\_\_\_\_

17. **Dyspnea:** In the past week, when has the participant been dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Never, participant is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

18. **Bowel Function:**

a. Frequency of BM (times a day): \_\_\_\_\_

b. Diarrhea or Watery: ☐ 0 - No ☐ 1 - Yes  
Notes (optional): \_\_\_\_\_

c. Constipated: ☐ 0 - No ☐ 1 - Yes  
Notes (optional): \_\_\_\_\_

d. Change in Bowel Habits: ☐ 0 - No ☐ 1 - Yes  
Describe: \_\_\_\_\_

e. Use of Laxatives: ☐ 0 - No ☐ 1 - Yes  
Notes (optional): \_\_\_\_\_

19. **Bowel Incontinence Frequency:**

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Participant has ostomy for bowel elimination
- ☐ UK - Unknown

20a. **Urinary Problems: (Mark all that apply.)**

- ☐ 1 - None
- ☐ 2 - UTIs Describe: \_\_\_\_\_
- ☐ 3 - Frequency Describe: \_\_\_\_\_
- ☐ 4 - Nocturia Describe: \_\_\_\_\_
- ☐ 5 - Hematuria Describe: \_\_\_\_\_
- ☐ 6 - Dysuria Describe: \_\_\_\_\_
- ☐ 7 - Urgency Describe: \_\_\_\_\_
- ☐ 8 - Decreased stream Describe: \_\_\_\_\_
- ☐ 9 - Dribbling Describe: \_\_\_\_\_

Notes (optional): \_\_\_\_\_

b. **Bladder Continence:** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants).

- ☐ 0 - Continent – Complete control [ **Go to Item 21** ]
- ☐ 1 - Usually continent, incontinent episodes once a week or less
- ☐ 2 - Occasionally incontinent, 2+ times a week but not daily
- ☐ 3 - Frequently incontinent, tends to be incontinent daily, but some control present
- ☐ 4 - Incontinent – Has inadequate control, multiple daily episodes
- ☐ NA - Participant has catheter

Notes (optional): \_\_\_\_\_

c. **When does Urinary Incontinence occur?**

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

21. **Skin Turgor (Hydration):** Pick up a fold of skin approximately 1 inch below the participant's clavicle. When released, note what happens to the skin.

- ☐ 0 - Returns to place immediately upon release
- ☐ 1 - Returns slowly to place when released during a period of 5 seconds or less
- ☐ 2 - Skin remains in pinched position for more than 5 seconds

**PROVIDER: Ask the participant to respond to items 22 and 23 below.**

22. **Physical Symptoms Other Than Pain:**

	<u>None</u>	<u>A Little</u>	<u>A Lot</u>	
a. How much energy do you have?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
b. How much appetite do you have?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
c. How much nausea do you experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
d. How much mouth soreness do you experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	<u>Never</u>	<u>One Time in Past Week</u>	<u>2-6 Times in Past Week</u>	<u>At Least Once a Day in Past Week</u>
e. In the past week, how often have you had insomnia (sleeplessness)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. In the past week, how often have you vomited?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. In the past week, how often have you been constipated?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. In the past week, how often have you had swelling of feet or legs?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	<u>Never</u>	<u>Once a Day</u>	<u>Several Times a Day</u>	<u>Most of the Time</u>
i. On a typical day in the past week, how often did you feel short of breath?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. On a typical day in the past week, how often did you cough?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

☐ UA - This information could not be obtained due to participant's cognitive impairment

23a. **Pain Interfering with Daily Activities (Participant Response):** In the past week, how often has pain gotten in the way of your normal routine? (NOTE: If participant states level of pain has changed in past week, answer should be based on the most recent level of pain.)

- ☐ 0 - You had no pain during the past week [ Go to Item 24 ]
- ☐ 1 - Your pain does not get in the way of your normal routine
- ☐ 2 - At times, but not every day
- ☐ 3 - Every day, but not constantly
- ☐ 4 - All of the time
- ☐ UA - This information could not be obtained due to participant's cognitive impairment

b. **Severity of Pain:** During the past week, how much bodily pain have you had? (NOTE TO PROVIDER: If participant states level of pain has changed in past week, answer should be based on most recent level of pain.)

- ☐ 1 - Very mild pain
- ☐ 2 - Mild pain
- ☐ 3 - Moderate pain
- ☐ 4 - Severe pain
- ☐ UA - This information could not be obtained due to participant's cognitive impairment

24. **Provider Assessment of Participant Pain:** PROVIDER: If participant has pain in multiple locations, respond based on the most severe or interfering pain.

a. **Pain Interfering with Daily Activities (Provider Response):**

In the past week, how often has pain gotten in the way of participant's normal routine? (NOTE: If the participant's level of pain has changed in the past week, answer should be based on the most recent level of pain.)

- ☐ 0 - Participant had no pain during the past week  
[ Go to Item 26 ]
- ☐ 1 - Pain does not get in the way of normal routine
- ☐ 2 - At times, but not every day
- ☐ 3 - Every day, but not constantly
- ☐ 4 - All of the time

b. **Frequency of Pain:**

- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

c. **Intractable Pain:** Is the participant experiencing pain that is not easily relieved, occurs at least daily, and affects the participant's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

- ☐ 0 - No
- ☐ 1 - Yes

25. **Pain Experienced by Participant:**

a. Location: \_\_\_\_\_

Type: \_\_\_\_\_

Positions/activities that aggravate pain: \_\_\_\_\_

Position/activities that alleviate pain: \_\_\_\_\_

Can pain be controlled by pain medication?

- ☐ 0 - No
- ☐ 1 - Yes - Which pain medication(s): \_\_\_\_\_

Notes: \_\_\_\_\_

b. Location: \_\_\_\_\_

Type: \_\_\_\_\_

Positions/activities that aggravate pain: \_\_\_\_\_

Position/activities that alleviate pain: \_\_\_\_\_

Can pain be controlled by pain medication?

- ☐ 0 - No
- ☐ 1 - Yes - Which pain medication(s): \_\_\_\_\_

Notes: \_\_\_\_\_

26. **Sleep Behaviors:**

Sleep pattern: Bedtime: \_\_\_\_\_ Wake-up time: \_\_\_\_\_ Naps: \_\_\_\_\_

Use of sleep aid: \_\_\_\_\_

Difficulties (e.g., difficulty getting to sleep, waking during night): \_\_\_\_\_

Excessive daytime fatigue: \_\_\_\_\_

Other: \_\_\_\_\_

27a. **Falls:** Record the total **Number of Falls** since the last assessment (If no falls, please record "0".):

\_\_\_\_\_

b. **Injuries Due to Falls:** Record the **number of injuries due to falls that resulted in medical intervention/treatment by a primary care provider** (e.g., skin tears, fracture, head trauma, other physical injury) since the last assessment. (NOTE: If no injuries due to falls, please record "0".)

Number of injuries due to falls: \_\_\_\_\_

c. **Fall Risk:** (Mark all factors below that apply to participant.)

- ☐ 0 - None
- ☐ 1 - History of falls
- ☐ 2 - Confusion
- ☐ 3 - Impaired judgment
- ☐ 4 - Sensory deficit
- ☐ 5 - Unable to ambulate independently
- ☐ 6 - Unable to transfer independently
- ☐ 7 - Increased anxiety/emotional lability
- ☐ 8 - Incontinence/urgency
- ☐ 9 - CV/respiratory disease affecting perfusion and oxygenation
- ☐ 10 - Postural hypotension with dizziness

## **MEDICATION ADHERENCE**

28a. **Participant Adherence:** Based on your knowledge, observation and/or examination of the participant, how closely does he/she adhere to the prescribed medication regimen?

- ☐ NA - Participant does not have prescription medications [ Go to Item 29 ]
- ☐ 0 - Poorly (less than 40%)
- ☐ 1 - Fairly well (40-80%)
- ☐ 2 - Completely (over 80%)

b. **Responsibility for Participant Medications:** Indicate who is routinely responsible for administering medications to the participant. (Mark all that apply.)

- ☐ 1 - Participant administers medications to himself/herself [ Complete Item c ]
- ☐ 2 - A family member or other nonpaid caregiver [ Complete Items d, e, and f ]
- ☐ 3 - A PACE staff member [ Go to Item 29 ]
- ☐ 4 - A paid provider who is not affiliated with PACE [ Go to Item 29 ]

**PROVIDER: Ask the participant to respond to Item c.**

c. Sometimes it can be hard to take medicine exactly as prescribed. In the past week, did you ever forget to take your medicine or choose not to take your medicine for some other reason?

- ☐ 0 - No
- ☐ 1 - Yes (Explain reasons): \_\_\_\_\_
- ☐ UA - This information could not be obtained due to participant's cognitive impairment

**PROVIDER: Ask the informal caregiver identified as responsible for the participant's medications to respond to Items d to f below.**

d. **Caregiver Facilitation of Medication Adherence:** Are you in charge of giving (PARTICIPANT) (his/her) medicine?

- ☐ 0 - No [ Go to Item 29 ]
- ☐ 1 - Yes

f. Did (PARTICIPANT) not receive all the medicine (he/she) was supposed to take in the past week for any other reason?

- ☐ 0 - No
- ☐ 1 - Yes (Explain reasons): \_\_\_\_\_
- ☐ UK - Unknown

e. Sometimes it can be hard to make sure that (PARTICIPANT) takes (his/her) medicine exactly as prescribed. In the past week, did you ever forget to give (PARTICIPANT) (his/her) medicine?

- ☐ 0 - No
- ☐ 1 - Yes

## **FUNCTIONAL STATUS**

**IADLs: To be assessed by clinic or home care nurse. The IADL items should be assessed based on the past week. Mark one box for performance and one box for ability.**

29. **Planning and Preparing Light Meals:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to plan and prepare light meals such as cereal, sandwich or reheat delivered meals.

Perfor-  
mance

Ability

Definitions and illustrative circumstances:

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Independently plans and prepares all light meals for self or reheats delivered meals; <u>OR</u><br>(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Does not prepare light meals on a regular basis due to physical, cognitive, or mental limitations.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Does not prepare any light meals or reheat any delivered meals due to physical, cognitive, or mental limitations.  |

Notes (optional): \_\_\_\_\_

30. **Heavy Chores:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to SAFELY do heavy tasks such as washing windows, home repairs, yard work, lawn mowing and shoveling snow.

Performance	Ability	Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - Does heavy chores <u>independently</u> <ul style="list-style-type: none"> <li>Does all heavy chores without assistance all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - Does heavy chores with <u>some assistance</u> <p>This rating is used for any of the following circumstances:</p> <ul style="list-style-type: none"> <li>Does heavy chores independently some (but not all) of the time; another person does heavy chores some of the time.</li> <li>Does some (but not all) heavy chores independently and other chores are done by another person.</li> </ul> <p><u>Example:</u> Participant does yard work independently and other heavy chores are done by another person.</p>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Does not do</u> heavy chores <ul style="list-style-type: none"> <li>All heavy chores are done by another person all of the time.</li> </ul>

Notes (optional): \_\_\_\_\_

31. **Shopping:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to plan for, select, and purchase items in a store and carry them home or arrange delivery.

Performance	Ability	Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - (a) Plans for shopping needs and independently performs shopping tasks, including carrying packages; <u>OR</u> (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Shops, but needs some assistance: (a) By self does only light shopping and carries small packages, but needs someone to do occasional major shopping; <u>OR</u> (b) <u>Does not</u> go shopping alone, but goes with someone to assist.
<input type="checkbox"/>	<input type="checkbox"/>	2 - Does not go shopping, but identifies items needed, places orders, and arranges home delivery.
<input type="checkbox"/>	<input type="checkbox"/>	3 - Needs someone to do all shopping due to physical, cognitive, or mental limitations.

Notes (optional): \_\_\_\_\_

32. **Housekeeping:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to safely and effectively perform light housekeeping (e.g., dusting, wiping kitchen counters) and heavier cleaning tasks (e.g., dishwashing, vacuuming, sweeping).

Performance	Ability	Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - (a) Independently performs all housekeeping tasks; <u>OR</u> (b) Physically, cognitively, and mentally able to perform <u>all</u> housekeeping tasks but has not routinely participated in housekeeping tasks in the past.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Performs only <u>light</u> housekeeping tasks independently.
<input type="checkbox"/>	<input type="checkbox"/>	2 - Performs housekeeping tasks with intermittent assistance or supervision from another person.
<input type="checkbox"/>	<input type="checkbox"/>	3 - <u>Does not</u> consistently perform any housekeeping tasks unless assisted by another person throughout the process.
<input type="checkbox"/>	<input type="checkbox"/>	4 - <u>Does not</u> effectively participate in any housekeeping tasks due to physical, cognitive, or mental limitations.

Notes (optional): \_\_\_\_\_

33. **Laundry:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to do own laundry such as carry laundry to and from washing machine, use washer and dryer, wash small items by hand.

Performance	Ability	Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - (a) Independently takes care of all laundry tasks; <u>OR</u> (b) Physically, cognitively, and mentally able to do laundry and access facilities, <u>but</u> has not routinely participated in laundry tasks in the past.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Does only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Does not</u> do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.

Notes (optional): \_\_\_\_\_



- 34a. **Management of Oral Medications:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable, inhalant/mist, and IV medications.**

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	NA	<ul style="list-style-type: none"> <li>No oral medications prescribed.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Takes oral medications independently</u>	<ul style="list-style-type: none"> <li>Independently takes correct oral medication(s) and proper dosage(s) at the correct times <u>without any</u> assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Takes oral medications, but needs some assistance</u>	<ul style="list-style-type: none"> <li>Takes oral medication(s) at correct times if:               <ul style="list-style-type: none"> <li>(a) individual dosages are prepared in advance by another person (e.g., Medisets); <u>OR</u></li> <li>(b) given daily reminders; <u>OR</u></li> <li>(c) someone develops a drug diary or chart.</li> </ul> </li> <li>Takes oral medication(s) independently some (but not all) of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Needs total assistance to take oral medications</u>	<ul style="list-style-type: none"> <li>Does not take oral medication(s) unless administered by someone else (e.g., participant is demented or physically unable and all medications are administered by another person all of the time).</li> </ul>

- b. **Management of Inhalant/Mist Medications:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes oral, injectable, and IV medications.**

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	NA	<ul style="list-style-type: none"> <li>No inhalant/mist medications prescribed.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Takes inhalant/mist medications independently</u>	<ul style="list-style-type: none"> <li>Independently takes correct inhalant/mist medication(s) and proper dosage(s) at the correct times <u>without any</u> assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Takes inhalant/mist medications, but needs some assistance</u>	<ul style="list-style-type: none"> <li>Takes inhalant/mist medication(s) at correct times if:               <ul style="list-style-type: none"> <li>(a) individual dosages are prepared in advance by another person; <u>OR</u></li> <li>(b) given daily reminders.</li> </ul> </li> <li>Takes inhalant/mist medication(s) independently some (but not all) of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Needs total assistance to take inhalant/mist medications</u>	<ul style="list-style-type: none"> <li>Does not take inhalant/mist medication(s) unless administered by someone else (e.g., participant is demented or physically unable and all medications are administered by another person all of the time).</li> </ul>

- c. **Management of Injectable Medications:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes oral, inhalant/mist, and IV medications.**

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	NA	<ul style="list-style-type: none"> <li>No injectable medications prescribed.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Takes injectable medications independently</u>	<ul style="list-style-type: none"> <li>Independently takes correct injectable medication(s) and proper dosage(s) at the correct times <u>without any</u> assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Takes injectable medications, but needs some assistance</u>	<ul style="list-style-type: none"> <li>Takes injectable medication(s) at correct times if:               <ul style="list-style-type: none"> <li>(a) individual dosages are prepared in advance by another person; <u>OR</u></li> <li>(b) given daily reminders.</li> </ul> </li> <li>Takes injectable medication(s) independently some (but not all) of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Needs total assistance to take injectable medications</u>	<ul style="list-style-type: none"> <li>Does not take injectable medication(s) unless administered by someone else (e.g., participant is demented or physically unable and all medications are administered by another person all of the time).</li> </ul>

35. **Vision:** How well the participant sees in good light, with corrective lenses if customarily worn. When a participant has glasses, but does not wear them, base rating on how well he or she sees without glasses. *Assess participant's level of impairment, with corrective device, if used on a regular basis.*

- ☐ 0 - *No Impairment* This rating is used for any of the following circumstances:
- Has adequate near and distant vision in all or most situations, in good light; does not complain of visual fatigue or difficulty reading or distinguishing objects.
  - Is able to read newsprint or see fine detail and is able to read a wall clock or see objects at a reasonable distance.
  - Uses a magnifying glass (or non-prescription magnifying glasses) to read, reads without difficulty and has adequate distant vision.
- ☐ 1 - *Partial Impairment* This rating is used for any of the following circumstances:
- Can read and/or see fine detail, but has difficulty with distant vision (i.e., is near-sighted).
  - Has difficulty reading newsprint or seeing fine detail, but is able to see objects at a reasonable distance (i.e., is far-sighted).
  - Has difficulty reading and with distant vision, but sees well enough to get around safely (e.g., can see obstacles in path).
  - Can count fingers at arm's length.
- ☐ 2 - *Total Impairment* This rating is used for any of the following circumstances:
- Cannot see at all, even with corrective device.
  - Sees some light or shadows, but vision is so poor that the participant is not able to see obstacles in his or her path.

36. **Hearing:** How well a participant hears, with a hearing aid if one is customarily worn. When a participant has a hearing aid, but does not usually wear it, base rating on how well he or she hears without the hearing aid. *Assess participant's level of impairment, with hearing aid, if used on a regular basis.*

- ☐ 0 - *No Impairment* Hears adequately in most situations (with a hearing aid, if customarily worn).
- ☐ 1 - *Partial Impairment* This rating is used for any of the following circumstances:
- Has difficulty hearing; speaker must raise voice and/or repeat phrases in order to be heard.
  - Hears well in some situations, but not in others.  
*Example:* Participant hears well in a quiet setting, but has difficulty when there is background noise, e.g., in a room where other conversations are taking place.
  - Hears some voices well, but has difficulty hearing certain voices.
- ☐ 2 - *Total Impairment* This rating is used for any of the following circumstances:
- Cannot hear at all, even with corrective device.
  - Hearing is so poor that the participant does not hear speech, even with repeated efforts by the person speaking.

37a. **Oral Status and Disease Prevention: (Mark all that apply.)**

- ☐ 1 - Debris (soft, easily movable substances) present in mouth
- ☐ 2 - Has dentures or removable bridge  
Indicate if: ☐ 0 - Fit properly or ☐ 1 - Loose fit
- ☐ 3 - Some/all natural teeth lost – does not have or does not use dentures (or partial plates)
- ☐ 4 - Broken, loose, or carious teeth
- ☐ 5 - Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes
- ☐ 6 - Daily cleaning of teeth/dentures or daily mouth care
- ☐ 7 - None of above

b. **Dental Visits:** Has the participant seen the dentist in the last year?

- ☐ 0 - No
- ☐ 1 - Yes

Notes (optional): \_\_\_\_\_

## COGNITIVE FUNCTIONING

38. **Awareness of Illness:** (Ask participant.) If you have any medical conditions, please tell me what you know about them.

\_\_\_\_\_

\_\_\_\_\_

☐ UA - This information could not be obtained due to participant's cognitive impairment.

39. **Speech:** ☐ 1 - Slurred ☐ 2 - Slow ☐ 3 - WNL ☐ 4 - Other (specify): \_\_\_\_\_

Notes (optional): \_\_\_\_\_

40. **Participant's Ability to Respond in an Emergency:** PROVIDER: Select the options that best apply to the participant, based on your judgment. **(Mark all that apply.)**

- ☐ 1 - Participant appears capable of summoning help in an emergency.
- ☐ 2 - Participant is aware of and able to use telephone to access an emergency phone number.
- ☐ 3 - Participant appears capable of exiting dwelling in an emergency situation (e.g., fire).
- ☐ 4 - Participant has and appears physically and cognitively capable of using Lifeline or other emergency response device when needed.
- ☐ 5 - Participant is physically or cognitively unable to access emergency assistance or exit the dwelling without help.

## **EMOTIONAL/MENTAL HEALTH STATUS**

41. **Provider Suspicion of Participant Abuse:** Based on your experience and interactions with the participant, is there reason to suspect any of the following? **(Mark all that apply.)**

- ☐ 1 - Physical Abuse: beating, over-medication, restraining, etc.
- ☐ 2 - Denial of Basic Needs: withholding of food, clothing, hygiene, lack of supervision, abandonment
- ☐ 3 - Psychological Abuse: verbal assaults, insults, threats, and isolation
- ☐ 4 - Material Abuse: thefts, misuse of funds, fraud, etc.
- ☐ 5 - Violation of Rights: coercion, locking in, etc.
- ☐ 6 - Self-Neglect: substandard housing, failure to obtain adequate medical care, food, or protection
- ☐ 7 - None

Notes (optional): \_\_\_\_\_

**The following information should be completed by the PACE care provider or staff member after completing the COCOA form.**

1. Estimated form completion time (in minutes): \_\_\_\_\_
2. Approximate time of day assessment completed:
  - ☐ 1 - Morning
  - ☐ 2 - Afternoon
  - ☐ 3 - Evening
3. Location where assessment was completed:
  - ☐ 1 - Day health center [ **Go to Item 4** ]
  - ☐ 2 - Participant residence [ **Stop Here** ]
4. Is this a day the participant typically attends the day health center?
  - ☐ 0 - No
  - ☐ 1 - Yes

**Please return the completed form to your site's Data Collection Coordinator.**

**Thank you for your participation.**