

Care Provider Name: \_\_\_\_\_  
Est. Form Completion Time: \_\_\_\_\_

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:  
The Center for Health Services Research

for:

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0791. The time required to complete this information collection is estimated to vary from 31 to 33 minutes with an average of 32 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment. Responses to the collection of the information are voluntary.

**DRAFT COCOA DATA SET  
NURSING FORM  
OVERVIEW/PROTOCOL**

**PURPOSE:** The information is being collected as part of a two-site feasibility test for the purpose of testing the feasibility of data collection using the draft core outcome and comprehensive assessment (COCOA) data set for PACE. Proposed data collection protocols will also be tested. The two-site feasibility test will result in the refinement of data items and protocols as appropriate. Findings from this project are intended to guide the anticipated implementation of a national approach for core comprehensive assessment of participants and outcome-based continuous quality improvement (OBCQI), in which PACE sites will collect data that will be used to determine and profile participant outcomes for their site.

**HOW COLLECTED:** This form will be completed by nurses providing direct care to the participant.

**WHEN COLLECTED:** This form will be completed for each participant at one time point during the two-site feasibility test.

Completion of the form should occur within 24 hours of the provider's assessment of the participant (ideally, the form will be completed as part of the participant's routine assessment).

**INSTRUCTIONS:** This form contains items to be completed by the nurse (this includes direct response to items and administering items to PACE participants). The nurse will complete the form and will record responses directly on the form. The nurse should mark the correct response as appropriate or print numbers/answers where requested. All items should be completed unless specifically directed to skip items based on a previous response. The Data Collection Coordinator (DCC) assigned at the site will receive the completed forms from the nurse. The DCC will submit completed forms to the Research Center.

**Note:** Some data items in this form are also included in other COCOA forms. The forms in which the item appears are noted in brackets next to each item. For example, item 6 in this form is included both in this form and the Primary Care Provider form, as indicated by [PCP, RN] next to the question stem for item 6. The abbreviations for each of the COCOA forms are listed below for quick reference.

Intake = Intake Form; HEA = Home Environment Assessment Form; PCP = Primary Care Provider Form; RN = Nursing Form; REHAB = Rehabilitation Therapy Form; SW = Social Work Form; RT = Recreational Therapy Form; RD = Dietitian Form; PSQ = Participant Satisfaction Form; CSQ = Caregiver Satisfaction Form; EOL = End of Life Form; UTIL = Utilization Form.

# Two-Site Feasibility Test

## DRAFT NURSING FORM

Site ID

Participant ID

1. Participant Name: [ALL]

(Last) (First) (MI) (Suffix)

2. Reason for Assessment: [HEA, PCP, RN, REHAB, SW, RT, RD, PSQ, CSQ]

- ☐ 1 - Initial assessment  
☐ 2 - Reassessment  
☐ 3 - Annual reassessment

3. Date Assessment Completed: [ALL] \_\_\_ / \_\_\_ / \_\_\_ [INTAKE, HEA, PCP, RN, REHAB, SW, RT, RD, EOL, UTIL]  
month day year

### PHYSIOLOGIC STATUS

4. Participant's Current Health Concerns: [PCP, RN]

- ☐ 0 - None stated  
☐ 1 - Yes - (specify: \_\_\_\_\_)

**Ask the participant to respond to Items 5 and 6 below.**

5. Participant Goals: What would you like to change or accomplish over the next few months that we can help you with? [PCP, RN, REHAB, SW, RT, RD]

---

---

---

---

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

6. Self-Report of Health Status: Compared to other persons your age, would you say that your health is excellent, good, fair, or poor? [PCP, RN]

- ☐ 1 - Excellent  
☐ 2 - Good  
☐ 3 - Fair  
☐ 4 - Poor  
☐ UA - This information could not be obtained due to participant's cognitive impairment

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

7. Allergies: [PCP, RN]

- ☐ 1 - Drug related - specify \_\_\_\_\_  
☐ 2 - Food related - specify \_\_\_\_\_  
☐ 3 - Environmental - specify \_\_\_\_\_  
☐ 4 - Seasonal - specify \_\_\_\_\_  
☐ 5 - None

8. **Tobacco Use/Abuse:** [PCP, RN]

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 9 ]

f. Has participant ever smoked or chewed tobacco?

☐ 0 - No ☐ 1 - Yes - For how many years? \_\_\_\_\_ Approximate date stopped: \_\_\_\_\_

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

9. **Alcohol Use/Abuse:** Ask participant about use of alcoholic beverages during the past year (at reassessment: since the last assessment). Explain what is meant by alcoholic beverages (i.e., beer, wine, liquor [vodka, whiskey, brandy, etc.]). [PCP, RN, SW]

a. How often do you have a drink containing alcohol?

☐ 0 - Never [ Go to Item c ]

☐ 1 - Monthly or less

☐ 2 - Two to four times a month

☐ 3 - Two to three times a week

☐ 4 - Four or more times a week

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

b. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 0 - One or two

☐ 1 - Three or four

☐ 2 - Five or six

☐ 3 - Seven to nine

☐ 4 - Ten or more

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

c. PROVIDER: Do you suspect the participant may have a problem with alcohol dependency or abuse?

☐ 0 - No      ☐ 1 - Yes

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

\_\_\_\_\_

d. Any history of abuse of alcoholic beverages: \_\_\_\_\_

\_\_\_\_\_

10. **Appearance:** Describe participant's general appearance. (Mark all that apply.) [PCP, SW, RN]

- ☐ 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.)? [RN, SW]

☐ 0 - No      ☐ 1 - Yes

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)? [RN, SW]

☐ 0 - No      ☐ 1 - Yes

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

\_\_\_\_\_

12. **Immunizations:** (To be completed at initial assessment and annually.) [PCP, RN]

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

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

Date of most recent immunization: \_\_\_\_\_

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

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

Date of most recent immunization: \_\_\_\_\_

c. **History of Positive PPD:**

- ☐ 0 - No  
☐ 1 - Yes - Reaction: \_\_\_\_\_ mm Date: \_\_\_\_\_

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

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

Date of most recent immunization: \_\_\_\_\_

13. **Height and Weight:** [RN, RD]

- a. Record actual **height** in inches (measured) HEIGHT (in.) \_\_\_\_\_  
b. Record actual **weight** in pounds or kilograms (measured) WEIGHT (lb.) \_\_\_\_\_ or WEIGHT (kg.) \_\_\_\_\_

14. **Weight Gained/Lost** since last assessment: (Please use "+" to indicate a weight gain or "-" to indicate a weight loss.) [RN, RD]

\_\_\_\_\_ lbs. OR \_\_\_\_\_ kg.

15. **Vital Signs:** [RN]

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ B/P \_\_\_\_\_ R / L (circle)  
AP \_\_\_\_\_ Reg/ Irreg Lie \_\_\_\_\_  
Resp \_\_\_\_\_ Reg / Irreg Sit \_\_\_\_\_  
Stand \_\_\_\_\_

16. **Chest Pains:** [PCP, RN] ☐ 0 - No [ Go to Item 17 ] ☐ 1 - Yes

Describe: \_\_\_\_\_

Location: \_\_\_\_\_

Frequency: \_\_\_\_\_

When Occurs: \_\_\_\_\_

Duration: \_\_\_\_\_

Severity: Ask participant to rate on a scale of 1-10 where 10 is the worst pain of your life.

(Circle) 1 2 3 4 5 6 7 8 9 10

17. **Edema:** [PCP, RN] Present ☐ 0 - No [ Go to Item 18 ] ☐ 1 - Yes

Legs/Feet ☐ Right ☐ Left Degree: \_\_\_\_\_ ☐ No edema legs/feet

Arms/Hands ☐ Right ☐ Left Degree: \_\_\_\_\_ ☐ No edema arms/hands

18. **Lung Sounds:** (Mark all that apply.) [PCP, RN]

**Right:** ☐ Clear ☐ Rhonchi ☐ Rales ☐ Diminished ☐ Wheezing

**Left:** ☐ Clear ☐ Rhonchi ☐ Rales ☐ Diminished ☐ Wheezing

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

19. **Dyspnea:** In the past week, when has the participant been dyspneic or noticeably **Short of Breath**? [PCP, RN, REHAB]

- ☐ 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)

20. **Cough:** [PCP, RN]

☐ 0 - No [ Go to Item 21 ] ☐ 1 - Yes - Describe: \_\_\_\_\_

Productive? ☐ 0 - No ☐ 1 - Yes - Describe: \_\_\_\_\_

Duration: \_\_\_\_\_

21. **Bowel Function:** [PCP, RN]

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: \_\_\_\_\_

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

22. **Bowel Incontinence Frequency:** [PCP, RN]

- ☐ 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

23a. **Urinary Problems: (Mark all that apply.)** [PCP, RN]

- ☐ 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: \_\_\_\_\_

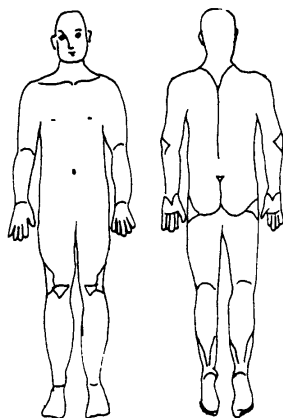
b. **Bladder Continence:** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants).

- ☐ 0 - Continent – Complete control [ Go to Item 24 ]
- ☐ 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

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

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

24. **Skin Condition:** (Record type number on body area. Indicate size to right of numbered category.) [PCP, RN]



- |    | <u>Type</u>            | <u>Size</u> |
|----|------------------------|-------------|
| 1. | Lesions                |             |
| 2. | Bruises                |             |
| 3. | Masses                 |             |
| 4. | Scars                  |             |
| 5. | Stasis Ulcers          |             |
| 6. | Pressure Ulcers        |             |
| 7. | Incisions              |             |
| 8. | Other (specify): _____ |             |

25. **Skin:** [PCP, RN]

- |           |                                     |  |                                       |                                   |                                    |
|-----------|-------------------------------------|--|---------------------------------------|-----------------------------------|------------------------------------|
| Color     | <input type="checkbox"/> 1 - Normal | <input type="checkbox"/> 2 - Pale        | <input type="checkbox"/> 3 - Jaundice | <input type="checkbox"/> 4 - Rash | <input type="checkbox"/> 5 - Dusky |
| Temp      | <input type="checkbox"/> 1 - Warm   | <input type="checkbox"/> 2 - Cool        | <input type="checkbox"/> 3 - Cold     |                                   |                                    |
| Condition | <input type="checkbox"/> 1 - Dry    | <input type="checkbox"/> 2 - Diaphoretic | <input type="checkbox"/> 3 - Clammy   |                                   |                                    |

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

26. **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. [PCP, RN]

- ☐ 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

27a. Does this participant have a **Skin Lesion** or an **Open Wound**? This excludes OSTOMIES. [PCP, RN]

- ☐ 0 - No [ Go to Item 28 ]
- ☐ 1 - Yes

b. Does this participant have a **Surgical Wound**?

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

c. **Current Number of (Observable) Surgical Wounds:** (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

d. Does this participant have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

- ☐ 0 - No
- ☐ 1 - Yes



e. **Status of Most Problematic (Observable) Surgical Wound:**

- ☐ 1 - Fully granulating  
☐ 2 - Early/partial granulation  
☐ 3 - Not healing  
☐ NA - No observable surgical wound

f. Does this participant have a **Pressure Ulcer**?

- ☐ 0 - No [ **Go to Item j** ]  
☐ 1 - Yes

g. Current **Number of Pressure Ulcers** at Each Stage: (Circle one response for each stage.)

Pressure Ulcer Stages		Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts?					
	<input type="checkbox"/> 0 - No					
	<input type="checkbox"/> 1 - Yes					

h. **Stage of Most Problematic (Observable) Pressure Ulcer:**

- ☐ 1 - Stage 1  
☐ 2 - Stage 2  
☐ 3 - Stage 3  
☐ 4 - Stage 4  
☐ NA - No observable pressure ulcer

i. **Status of Most Problematic (Observable) Pressure Ulcer:**

- ☐ 1 - Fully granulating  
☐ 2 - Early/partial granulation  
☐ 3 - Not healing  
☐ NA - No observable pressure ulcer

j. Does this participant have a **Stasis Ulcer**?

- ☐ 0 - No [ **Go to Item 28** ]  
☐ 1 - Yes

k. **Current Number of Observable Stasis Ulcer(s):**

- ☐ 0 - Zero  
☐ 1 - One  
☐ 2 - Two  
☐ 3 - Three  
☐ 4 - Four or more

- l. Does this participant have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 - No ☐ 1 - Yes

m. **Status of Most Problematic (Observable) Stasis Ulcer:**

- ☐ 1 - Fully granulating  
☐ 2 - Early/partial granulation  
☐ 3 - Not healing  
☐ NA - No observable stasis ulcer

28. **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. [PCP, RN]*

- ☐ 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.

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

29. **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. [PCP, RN]*

- ☐ 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.

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

30a. **Oral Status and Disease Prevention: (Mark all that apply.) [PCP, RN]**

- ☐ 1 - Debris (soft, easily movable substances) present in mouth
- ☐ 2 - Has dentures or removable bridge      Indicate if:    Fit properly ☐    or 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

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

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

- ☐ 0 - No                      ☐ 1 - Yes

31. **Pain Description: [PCP, RN, REHAB]**                      ☐ NA - No pain [ Go to Item 32 ]

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

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

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

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

Controlled/Uncontrolled by pain medication (*circle one*)                      Pain medication: \_\_\_\_\_

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

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

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

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

Controlled/Uncontrolled by pain medication (*circle one*)                      Pain medication: \_\_\_\_\_

32. **Pain:** If participant has pain in multiple locations, respond based on the most severe or interfering pain. [PCP, RN]

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.)

- |  |   |
|--|---|
| <input type="checkbox"/> 0 - Participant had no pain during the past week.   | <input type="checkbox"/> 2 - At times, but not every day.   |
| <input type="checkbox"/> 1 - Pain does not get in the way of normal routine. | <input type="checkbox"/> 3 - Every day, but not constantly. |
|  | <input type="checkbox"/> 4 - All of the time.               |

b. **Frequency of Pain:**

- |  |  |
|--|--|
| <input type="checkbox"/> 0 - Participant has no pain | <input type="checkbox"/> 2 - Daily, but not constantly |
| <input type="checkbox"/> 1 - Less often than daily   | <input type="checkbox"/> 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

**PROVIDER: Ask the participant to respond to items 33 and 34 below.**

33a. **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.) [RN]

- ☐ 0 - You had no pain during the past week
- ☐ 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: If participant states level of pain has changed in past week, answer should be based on most recent level of pain.)

- ☐ 0 - No 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

**34. Physical Symptoms Other Than Pain: [PCP, RN]**

- |   | <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<br/>in Past Week</u> | <u>2-6 Times<br/>in Past Week</u> | <u>At Least Once a Day<br/>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>More Than<br/>Once a Day</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      |
| 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      |
- ☐ UA - This information could not be obtained due to participant's cognitive impairment

35. **Sleep Behaviors:** [PCP, RN]

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: \_\_\_\_\_

36. **Exercise/Activity Level:** Describe participant's usual level of activity or exercise. For example, does he/she walk often, do household tasks, participate in swimming or exercise class, or do other activities that require physical exertion? [RN, REHAB, RT]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

37a. **Falls:** [PCP, RN, REHAB] Record the total **Number of Falls** since the last assessment: \_\_\_\_\_

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 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

38. **Restraints:** Have physical restraints been used on the participant since the last assessment? [PCP, RN, REHAB, RT]

☐ 0 - No ☐ 1 - Yes

If yes, specify frequency, type, and reason:

Frequency of use: \_\_\_\_\_

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

Reason: \_\_\_\_\_

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

\_\_\_\_\_

39. **Nutrition:** Which response best describes the participant's usual food intake pattern? [RN, RD]

- ☐ 0 - **Excellent** – Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.
- ☐ 1 - **Adequate** – Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen that probably meets most of nutritional needs.
- ☐ 2 - **Probably Inadequate** – Rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.
- ☐ 3 - **Very Poor** – Never eats a complete meal. Rarely eats more than a third of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Does not take a liquid dietary supplement, OR is NPO and/or maintained on clear liquids or IVs for more than five days.

40. **Nutritional Risk:** [RN, RD]

	0 - No	1 - Yes
1. Do the medical conditions or illnesses limit or change the amount of food the participant eats? (list conditions) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the participant eat fewer than two meals per day?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the participant eat few fruits, vegetables and/or milk products?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the participant have poor dentition that makes eating difficult?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the participant consume alcohol on a daily basis?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the participant lack funds to purchase food?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the participant usually eat alone?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the participant take more than three prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the participant lost or gained more than 5% of their body weight in the last month, or more than 10% in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the participant lack the means or ability to procure, store or prepare foods?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the participant unable to feed him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the participant's appetite poor?	<input type="checkbox"/>	<input type="checkbox"/>

Assessment of Nutritional Risk (Sum of "Yes" Responses): \_\_\_\_\_

Scoring:

- 0 "Yes" responses = person unlikely at nutritional risk
- 1-2 "Yes" responses = person likely at low nutritional risk
- 3-5 "Yes" responses = person likely at moderate nutritional risk
- 6+ "Yes" responses = person likely at high nutritional risk

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

## FUNCTIONAL STATUS

**ADLs:** *The ADL and IADL items should be answered based on the past week. Mark one box for performance and one box for ability.*

41. **Ambulation/Locomotion:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. [RN, REHAB]

Performance	Ability	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Walks</u> independently	<ul style="list-style-type: none"> <li>Walks on even and uneven surfaces, inside or outside, and climbs stairs (with or without railings) without any human assistance or assistive device.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Walks</u> , but needs <u>some</u> assistance	<ul style="list-style-type: none"> <li>Walks alone but requires use of a device (e.g., cane, walker).</li> <li>Walks without assistance some of the time and receives assistance at other times.</li> </ul> <p>Examples: (a) Participant walks independently at home, but requires assistance or supervision when walking at the day health center. (b) Participant needs help negotiating stairs or steps or uneven surfaces.</p>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Walks</u> , but needs <u>constant</u> assistance	<ul style="list-style-type: none"> <li>Walks only with the supervision or assistance of another person at all times.</li> <li>Uses wheelchair some of the time but walks with continuous physical support.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Does not walk but uses <u>wheelchair</u> independently	<ul style="list-style-type: none"> <li>Does not walk but does wheel self independently (includes manual wheeling and electronic wheeling).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	4 - Does not walk but uses <u>wheelchair with assistance</u>	<ul style="list-style-type: none"> <li>Does not walk; confined to a wheelchair and does not wheel self (needs human assistance).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	5 - <u>Bedfast</u>	<ul style="list-style-type: none"> <li>Does not walk, does not sit up in a chair.</li> </ul>

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

\_\_\_\_\_

- 42a. **Transferring:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to move from bed to chair, on and off toilet or commode, into and out of tub and shower, and to turn and position self in bed if participant is bedfast. **[RN, REHAB]**

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Transfers</u> independently	<ul style="list-style-type: none"> <li>Transfers self to and from bed, chair, toilet, tub/shower <u>without any</u> assistance, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Transfers</u> , but needs <u>some</u> assistance	<ul style="list-style-type: none"> <li>Transfers with minimal human assistance or use of an assistive device.</li> <li>Participant transfers independently from bed to chair, but requires assistance to transfer to and from toilet or tub.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - Does not transfer but <u>bears weight</u> and <u>pivots</u>	<ul style="list-style-type: none"> <li>Participant needs assistance to stand but pivots and sits down without assistance.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Does not transfer and <u>does not</u> bear weight or pivot	<ul style="list-style-type: none"> <li>Transferred by another person or persons at all times but <u>is not bedfast</u>.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	4 - <u>Bedfast</u> , but turns and positions self in bed	<ul style="list-style-type: none"> <li>Unable to transfer, is bedfast but turns and repositions self in bed.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	5 - <u>Bedfast</u>	<ul style="list-style-type: none"> <li>Unable to transfer, is bedfast, does not turn or reposition self in bed.</li> <li>Is transferred by mechanical lift.</li> </ul>

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

- b. If participant requires human **Assistance with Transferring**, indicate assistance needed.

- ☐ 1 - One person assist  
☐ 2 - Two person assist  
☐ NA - Participant transfers independently or does not transfer



43. **Bathing:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to wash entire body. (**Excludes grooming, washing only face and hands.**) [RN, REHAB]

Performance	Ability	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Bathes</u> independently in shower or tub	<ul style="list-style-type: none"> <li>Bathes self in <u>shower or tub</u> independently, <u>without any</u> human assistance, supervision, or assistive device, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Bathes</u> self in shower or tub but needs <u>assistive device</u>	<ul style="list-style-type: none"> <li>With the use of devices (e.g., shower or tub seat, grab bars, hand-held sprayer, long-handled bathing brush), bathes self in shower or tub independently.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Bathes</u> self in shower or tub but needs <u>some human assistance/supervision</u>	<ul style="list-style-type: none"> <li>Bathes in shower or tub with the assistance of another person:               <ul style="list-style-type: none"> <li>(a) for intermittent supervision or encouragement or reminders, <u>OR</u></li> <li>(b) to get in and out of the shower or tub, <u>OR</u></li> <li>(c) for washing difficult to reach areas.</li> </ul> </li> <li>Bathes independently some of the time and receives assistance at other times (e.g., in the shower at the day health center).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Bathes self in shower or tub but needs constant human assistance/supervision	<ul style="list-style-type: none"> <li>Participates in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	4 - Must be bathed in bed or bedside chair	<ul style="list-style-type: none"> <li>Does not use shower or tub and is bathed in bed or bedside chair.</li> <li>Does part of bathing activity (e.g., sponges self in easy to reach areas).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	5 - Completely dependent	<ul style="list-style-type: none"> <li>Is completely bathed by another person all of the time.</li> <li>Receives physical assistance for the entire activity, i.e., does not do any part independently any of the time.</li> </ul>

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

44. **Grooming:** Performance (what participant actually does) and ability (what participant is capable of doing) to tend to personal hygiene needs (e.g., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). [RN, REHAB]

Performance	Ability	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Grooms</u> independently	<ul style="list-style-type: none"> <li>Does all grooming activities independently, without assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Grooms</u> self but needs <u>some</u> assistance	<ul style="list-style-type: none"> <li>Grooms self, but requires assistive device.</li> <li>Does some (but not all) grooming activities independently and receives assistance from others (e.g., shampooing).</li> <li>Grooming utensils (e.g., comb, toothbrush, razor) must be placed within reach to complete grooming activities.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Grooms</u> self but needs <u>constant</u> human assistance	<ul style="list-style-type: none"> <li>Participant grooms self if constantly receiving human assistance.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Completely dependent	<ul style="list-style-type: none"> <li>All grooming activities are done by another person all of the time.</li> </ul>

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

45. **Dressing Upper Body:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Dresses</u> independently	<ul style="list-style-type: none"> <li>Gets clothes out of closets and drawers, puts them on and removes them from the upper body without assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Dresses</u> self but needs assistive device or <u>some</u> human assistance	<ul style="list-style-type: none"> <li>Dresses self with assistive devices (e.g., velcro fasteners on clothing, adaptive clothing and special equipment such as a reacher).</li> <li>Dresses upper body without assistance if clothing is laid out or handed to the participant.</li> <li>Does part of dressing, but receives assistance for other parts of the activity, e.g., to put on or take off some items of clothing, manage fasteners.</li> <li>Dresses or undresses some of the time and receives assistance at other times.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Dresses</u> self but needs <u>constant</u> human assistance	<ul style="list-style-type: none"> <li>Receives stand-by supervision for safety.</li> <li>Someone must help the participant put on upper body clothing.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Completely dependent	<ul style="list-style-type: none"> <li>Participant depends entirely upon another person to dress the upper body.</li> <li>Is completely dressed by another person all of the time.</li> <li>Receives physical assistance for the entire activity, i.e., does not do any part of the activity independently any of the time.</li> </ul>

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

46. **Dressing Lower Body:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to dress lower body including undergarments, slacks, socks or nylons, shoes. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - <u>Dresses</u> independently	<ul style="list-style-type: none"> <li>Obtains, puts on, and removes clothing and shoes without assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Dresses</u> self but needs assistive device or <u>some</u> human assistance	<ul style="list-style-type: none"> <li>Dresses self with assistive devices (e.g., velcro fasteners on shoes, adaptive clothing, and special equipment such as a reacher).</li> <li>Dresses lower body without assistance if clothing and shoes are laid out or handed to the participant.</li> <li>Does part of dressing, but receives assistance for other parts of the activity, e.g., to put on or take off some items of clothing, manage fasteners.</li> <li>Dresses or undresses some of the time and receives assistance at other times.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Dresses</u> self but needs <u>constant</u> human assistance	<ul style="list-style-type: none"> <li>Receives stand-by supervision for safety.</li> <li>Someone must help the participant put on undergarments, slacks, socks or nylons, and shoes.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Completely dependent	<ul style="list-style-type: none"> <li>Participant depends entirely upon another person to dress lower body.</li> <li>Is completely dressed by another person all of the time.</li> <li>Receives physical assistance for the entire activity, i.e., does not do any part of the activity independently any of the time.</li> </ul>

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

47. **Toileting:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to get to and from the toilet or bedside commode, get on and off toilet, clean self and adjust clothes. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - Toilets independently	<ul style="list-style-type: none"> <li>Gets to and from toilet independently, toilets self without assistance or supervision, all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - Toilets with some assistance	<ul style="list-style-type: none"> <li>Gets to and from toilet when reminded, assisted, or supervised by another person.</li> <li>Does part of the toileting, but receives assistance for other parts of the activity (e.g., to get to the toilet room, clean self).</li> <li>Toilets self independently some of the time and receives assistance at other times (e.g., at the day health center).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - Uses bedside commode	<ul style="list-style-type: none"> <li>Does not go to and from toilet but uses a bedside commode (with or without assistance).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Uses bedpan/urinal	<ul style="list-style-type: none"> <li>Does not go to and from toilet but uses a bedpan/urinal independently.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	4 - Completely dependent	<ul style="list-style-type: none"> <li>Receives physical assistance for all toileting activities, i.e., does not do any of the toileting activities independently any of the time.</li> </ul>

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

48. **Feeding or Eating:** Performance (what participant actually does) and ability (what participant is capable of doing) to feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, NOT preparing the food to be eaten. [RN, REHAB, RD]

<u>Performance</u>	<u>Ability</u>		Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/>	0 - Feeds/eats independently	<ul style="list-style-type: none"> <li>Feeds self/eats without any assistance or supervision all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	1 - Feeds/eats independently but needs <u>some</u> assistance	<ul style="list-style-type: none"> <li>Feeds self independently but requires:               <ul style="list-style-type: none"> <li>(a) meal set-up; <u>OR</u></li> <li>(b) intermittent assistance or supervision (e.g., cueing) from another person; <u>OR</u></li> <li>(c) an assistive device (e.g., utensil with built-up handle, plate guard, or cup with spout to prevent spilling);</li> <li>(d) a liquid, pureed or ground meat diet.</li> </ul> </li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	2 - Does not feed/eat independently and <u>needs assistance</u>	<ul style="list-style-type: none"> <li>Must be assisted or supervised throughout meal/snack.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3 - Takes in nutrients orally and by tube feeding	<ul style="list-style-type: none"> <li>Takes in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	4 - Completely dependent on nasogastric tube or gastrostomy	<ul style="list-style-type: none"> <li>Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	5 - Does not take in nutrients orally or by tube feeding	<ul style="list-style-type: none"> <li>Receives total parenteral nutrition (TPN).</li> </ul>

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

## IADLs

49. **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. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>	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> (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): \_\_\_\_\_

50. **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. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>	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> This rating is used for any of the following circumstances: <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> <u>Example:</u> Participant does yard work independently and other heavy chores are done by another person.
<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): \_\_\_\_\_

51. **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. [RN, REHAB]

<u>Performance</u>	<u>Ability</u>	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 go</u> 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): \_\_\_\_\_

52. **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). [RN, REHAB]

Perfor-  
mance

Ability

Definitions and illustrative circumstances:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Independently performs all housekeeping tasks; <u>OR</u><br>(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): \_\_\_\_\_

53. **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. [RN, REHAB]

Perfor-  
mance

Ability

Definitions and illustrative circumstances:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Independently takes care of all laundry tasks; <u>OR</u><br>(b) Physically, cognitively, and mentally able to do laundry and access facilities, <u>but</u> has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). |
| <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): \_\_\_\_\_

- 54a. **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. [RN]

Perfor-  
mance

Ability

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</u> independently                      | <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</u> , but needs <u>some</u> assistance | <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</u> to take oral medications           | <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</u> independently	<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</u> , but needs some assistance	<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</u> to take inhalant/mist medications	<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</u> independently	<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</u> , but needs <u>some</u> assistance	<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</u> to take injectable medications	<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>

55. **Telephone Use:** Performance (what participant actually does) and ability (what participant is capable of doing) to answer the phone, dial numbers, and effectively use the telephone to communicate. **[RN, REHAB, SW]**

<u>Performance</u>	<u>Ability</u>	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	NA	Participant does not have a telephone.
<input type="checkbox"/>	<input type="checkbox"/>	0	Dials numbers and answers calls appropriately and as desired.
<input type="checkbox"/>	<input type="checkbox"/>	1	Uses a specially adapted telephone (e.g., large numbers on the dial, teletype phone for the deaf) and calls essential numbers.
<input type="checkbox"/>	<input type="checkbox"/>	2	Answers the telephone and carries on a normal conversation but has difficulty with placing calls.
<input type="checkbox"/>	<input type="checkbox"/>	3	Answers the telephone only some of the time or carries on only a limited conversation.
<input type="checkbox"/>	<input type="checkbox"/>	4	Does not answer the telephone at all but listens if assisted with equipment.
<input type="checkbox"/>	<input type="checkbox"/>	5	Does not use the telephone at all.

## **COGNITIVE FUNCTIONING**

**56. Recent Memory:** [RN, SW]

- a. Does the participant remember events from one day to the next (for example, visits by family members or participation in recreational events)?

☐ 0 - No ☐ 1 - Yes

- b. Is the participant able to remind self about when to take medications?

☐ 0 - No ☐ 1 - Yes

**57. Judgment (Puts Self At Risk):** Identify the participant's ability to use judgment and make decisions that affect his/her ability to function independently. [RN, REHAB, SW, RT]

- ☐ 1 - Judgment is good. Makes appropriate decisions.  
☐ 2 - Judgment is occasionally poor. May make inappropriate decisions in complex or unfamiliar situations; needs monitoring and guidance in decision making.  
☐ 3 - Judgment is frequently poor; needs oversight and supervision because makes unsafe or inappropriate decisions.  
☐ 4 - Judgment is always poor; cannot make any appropriate decisions for self. Makes judgments that constantly put self at risk.

**58. Awareness of Own Needs:** Identify the participant's level of understanding of his/her needs relating to health, safety, and welfare. [RN, SW]

- ☐ 1 - Understands those needs which must be met for self-maintenance.  
☐ 2 - Sometimes has difficulty understanding those needs which must be met, but will cooperate when given direction or explanation.  
☐ 3 - Does not understand those needs which must be met for maintenance AND will not consistently cooperate even though given direction or explanation.

**59. Awareness of Illness:** (Ask participant.) Please tell me in your own words what you know about any medical conditions you have. [RN]

---

---

---

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

**60. Speech:** [RN] ☐ 1 - Slurred ☐ 2 - Slow ☐ 3 - WNL ☐ 4 - Other (specify: \_\_\_\_\_)

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

---

**61. Ability to Understand Others** in participant's primary language (understanding information content -- however able; e.g., understanding spoken language, sign language, writing, or other means): [RN, SW, RT]

- ☐ 0 - No observable impairment. Understands complex or detailed instructions and participates normally in conversation.  
☐ 1 - With mild difficulty, understands one-step instructions and simple multi-step instructions. Able to participate in ordinary conversation.  
☐ 2 - Has moderate difficulty understanding simple, one-step instructions and participating in conversation; may need frequent prompting or assistance.  
☐ 3 - Has severe difficulty understanding simple instructions and conversation. May require multiple repetitions, restatements, demonstrations.  
☐ 4 - Unable to understand even simple language.

62. **Ability to Express Thoughts, Wants, Needs** in primary language (expressing information content -- however able; e.g., using spoken language, sign language, writing, or other means): [RN, SW, RT]

- ☐ 0 - Able to express complex ideas, feelings, and needs clearly, completely, and easily in most situations.
- ☐ 1 - Has mild difficulty in expressing ideas and needs (choice of words, word order, or grammar may sometimes be unclear or confusing; may need minimal prompting or assistance).
- ☐ 2 - Has moderate difficulty in expressing simple ideas or needs (choice of words, word order, or grammar commonly unclear or confusing; needs prompting or assistance).
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires considerable assistance.
- ☐ 4 - Unable to express basic needs even with considerable prompting or assistance (e.g., communication is nonsensical or unintelligible).

63. **Participant's Ability to Respond in an Emergency:** [RN]

a. Ask participant: What would you do in case of a fire? (narrative):

---



---



---



---

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

b. 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**

64a. **Mood** (Dominant Feeling State): Ask participant to describe his/her mood over the past week. **(Mark all that apply.)** [PCP, RN, SW]

- |   |  |
|---|--|
| <input type="checkbox"/> 1 - Depressive | <input type="checkbox"/> 5 - Happy   |
| <input type="checkbox"/> 2 - Irritable  | <input type="checkbox"/> 6 - Content   |
| <input type="checkbox"/> 3 - Anxious    | <input type="checkbox"/> 7 - Neutral   |
| <input type="checkbox"/> 4 - Angry      | <input type="checkbox"/> 8 - Other: _____  |
|   | <input type="checkbox"/> UA - This information could not be obtained due to participant's cognitive impairment |

b. PROVIDER: Indicate if observed mood congruent with statements:

- ☐ 0 - No [ **Go to Item 65** ]
- ☐ 1 - Yes [ **Go to Item 66** ]

65. **Provider Perceived Affect:** Participant's affect appears to be: **(Mark all that apply.)** [PCP, RN, SW]

- |   |  |
|---|--|
| <input type="checkbox"/> 1 - Flat                 | <input type="checkbox"/> 7 - Anxious       |
| <input type="checkbox"/> 2 - Depressed            | <input type="checkbox"/> 8 - Nervous       |
| <input type="checkbox"/> 3 - Sad                  | <input type="checkbox"/> 9 - Calm          |
| <input type="checkbox"/> 4 - Angry                | <input type="checkbox"/> 10 - Happy        |
| <input type="checkbox"/> 5 - Restricted/Withdrawn | <input type="checkbox"/> 11 - Other: _____ |
| <input type="checkbox"/> 6 - Fearful              |  |

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



66. **Anxiety:** The following two items refer to anxiety, which can be manifested in tension, nervousness, and/or apprehension. [PCP, RN, SW]

a. **Frequency of Anxiety (Reported or Observed):**

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Participant nonresponsive

b. **Severity of Anxiety** experienced by participant (record the most severe level experienced) **(Reported or Observed):**

- ☐ 0 - No anxiety
- ☐ 1 - Mild (experienced slight nervousness/apprehension)
- ☐ 2 - Moderate (experienced a significant amount of nervousness/apprehension)
- ☐ 3 - Severe (experienced overwhelming nervousness/apprehension)
- ☐ NA - Participant nonresponsive

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

67. **Observed Depression or Depressive Symptoms:** Which of the following have you observed in the participant in the past week? **(Mark all that apply.)** [PCP, RN, SW, RT]

- ☐ 1 - Decreased level of energy and activity
- ☐ 2 - Slowing of thinking, language, and behavior
- ☐ 3 - Decrease in appetite
- ☐ 4 - Expressions of feelings of worthlessness or futility
- ☐ 5 - Crying spells
- ☐ 6 - Consistent sadness
- ☐ 7 - Sleep disturbances, insomnia, or excessive sleeping
- ☐ 8 - Other \_\_\_\_\_
- ☐ 9 - None of the above

68a. **Frequency of Behavior Problems** (Reported or Observed): Has the participant exhibited any of the following behaviors since the last assessment? **(Respond for each item below.)** [RN, SW, RT]

	Never	Once/month or less frequently	Several times each month	Several times a week	At least daily
1) Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
2) Physical aggression: aggressive/combatative to self or others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
3) Disruptive, infantile, regressive, or socially inappropriate behavior (other than above)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
4) Delirium, confusion, delusional, hallucinatory, or paranoid behavior	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
5) Agitated (pacing, fidgeting, argumentative)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
6) Withdrawn/isolated	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4

b. **For any behavior present, describe circumstances** (e.g., time of day, location/setting).

Circumstances

- 1) Verbal disruption  
\_\_\_\_\_
- 2) Physical aggression  
\_\_\_\_\_
- 3) Disruptive, infantile, regressive, or socially inappropriate behavior (other than above)  
\_\_\_\_\_
- 4) Delirium, confusion, delusional, hallucinatory, or paranoid behavior  
\_\_\_\_\_
- 5) Agitated  
\_\_\_\_\_
- 6) Withdrawn/isolated  
\_\_\_\_\_

69. **Wandering:** Has the participant wandered since the last assessment? (Wandering is defined as straying or becoming lost in the community due to impaired judgment. Example: A confused participant leaves home unattended and is not able to find his or her way back.) *Assess the participant using the ratings below.* [RN, SW, RT]

- ☐ 0 - *Never* This rating is used for any of the following circumstances (if mark 0, check the appropriate response [a, b, or c]):
- ☐ a. Never wanders away from home, the day health center, or other locations.
  - ☐ b. Has not wandered since the last assessment.
  - ☐ c. Has not wandered because special precautions have been instituted, such as continuous supervision and/or secured exits.
- ☐ 1 - *Seldom (once/week or less)* Has wandered away from home, day health center, or other locations occasionally (less than once a week) since the last assessment.
- ☐ 2 - *Often (more than once/week)* This rating is used for any of the following circumstances:
- Has wandered away from home, day health center, or other locations once a week or more since the last assessment.
  - Wanders once a week or more, from some locations, but not others.

70. **Description of Family Relationships/Informal Support Systems** (Note if close, distant, hostile, domestic violence, alcohol or drug abuse, medical problems, etc.): [RN, SW, RT]

---

---

---

---

---

---

---

71. **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.)** [PCP, RN, REHAB, SW, RT, RD]

- ☐ 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): \_\_\_\_\_

---

---

---

---

## **MEDICATION ADHERENCE**

72a. **Participant Adherence:** Based on your knowledge, observation and/or examination of the participant, how closely does he/she adhere to the prescribed medication regimen? [RN]

- ☐ NA - Participant does not have prescription medications [ Go to Item 73 ]
- ☐ 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.

- ☐ 1 - Participant administers medications to himself/herself
- ☐ 2 - A family member or other nonpaid caregiver [ Go to Item d ]
- ☐ 3 - A PACE staff member [ Go to Item 73 ]
- ☐ 4 - A paid provider who is not affiliated with PACE [ Go to Item 73 ]

**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 73 ]
- ☐ 1 - Yes

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

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

## **CAREGIVER ITEMS**

**PROVIDER: Ask the participant's primary informal caregiver to respond to Items 73 to 77.**

- ☐ NA - No informal caregiver [ This form is complete. ]

73. **Pain Interfering with Daily Activities:** In the past week, how often has pain gotten in the way of (PARTICIPANT'S) normal routine? (NOTE: If [PARTICIPANT'S] level of pain has changed in the past week, answer should be based on the most recent level of pain.) [RN]

- ☐ 0 - Participant had no pain during the past week
- ☐ 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

74. **Caregiver Knowledge of What to Do In An Emergency:** [RN]

**Instructions to Interviewer:** Ask the participant's primary informal (unpaid) caregiver to respond to the following questions. **DO NOT READ THE RESPONSE OPTIONS TO THE CAREGIVER.** Simply ask the question and mark the responses given by the caregiver (without prompting). If the caregiver's response(s) are not listed, mark "Other responses" and write in the response(s) on the line provided. **If the caregiver responds "I don't know," mark "Unknown."**

a. If (PARTICIPANT) needed help in a life-threatening emergency, what would you do? **(Mark all that apply.)**

- ☐ 1 - Call 911
- ☐ 2 - Call PACE doctor
- ☐ 3 - Follow emergency instructions as provided by PACE
- ☐ 4 - Stay with (PARTICIPANT) and make sure he/she is safe until help arrives
- ☐ 5 - Adhere to advance directive
- ☐ 6 - Other responses (specify: \_\_\_\_\_)
- ☐ UK - Unknown

b. If (PARTICIPANT) needed urgent care (in a non-life-threatening situation), what would you do? **(Mark all that apply.)**

- ☐ 1 - Call PACE doctor
- ☐ 2 - Follow emergency instructions as provided by PACE
- ☐ 3 - Stay with (PARTICIPANT) and make sure he/she is safe until help arrives
- ☐ 4 - Other responses (specify: \_\_\_\_\_)
- ☐ UK - Unknown

c. PROVIDER: Based on the caregiver's responses to questions a and b above, do you feel the caregiver needs further education on how to respond in a life-threatening or non-life-threatening situation?

- ☐ 0 - No, knowledge appears adequate
- ☐ 1 - Yes, needs further education

75. **Caregiver Stress:** Almost everyone feels some degree of stress from time to time. At times you may feel no problem with anything; at other times, things seem to pile up and you feel tense, angry, or afraid. Let's call that feeling stress. Please indicate the amount of stress you are presently feeling as you take care of and try to help (PARTICIPANT). [RN, SW]

- ☐ 0 - No stress
- ☐ 1 - A little stress
- ☐ 2 - Some stress
- ☐ 3 - A good bit of stress
- ☐ 4 - A great amount of stress

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

76. **Caregiver Support:** Caregiving can be difficult and challenging. Do you feel that you have adequate social and emotional support to meet your current needs? [RN, SW]

- ☐ 1 - Yes, always
- ☐ 2 - Yes, most of the time
- ☐ 3 - No, frequently inadequate
- ☐ 4 - No, I often feel overwhelmed

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

77. **Caregiver Coping:** [RN, SW]

a. How often do you find it difficult to cope with caring for (PARTICIPANT)?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Frequently
- ☐ 4 - Always

b. Do you ever feel that you need a break and don't feel you can take one?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Frequently
- ☐ 4 - Always

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

**Please respond to the evaluation questions and return completed materials to the Data Collection Coordinator at your site.**

**Thank you for your participation.**