

## **APPENDIX 6A**

### **THE COCOA-B DATA SET: CONTRACTOR-RECOMMENDED DATA SET FOR PACE QUALITY MONITORING AND OBCQI**

The COCOA-B data set recommended for PACE is presented in this appendix. The data set, which was revised based on empirical findings and qualitative input resulting from the systematic field test conducted under this project, contains the 102 data items necessary to compute and risk adjust the 50 outcome measures recommended for the COCOA-B/OBCQI system.

To facilitate data collection by the interdisciplinary team and other PACE site staff, the COCOA-B data items are organized into four clinical item sets, grouped by relevance for completion by primary care provider, nursing, rehabilitation therapy, and social work staff, and five nonclinical item sets (tracking and demographic items, participant and informal caregiver satisfaction questionnaires, a utilization form, and a brief disenrollment form). Although the clinical items have been grouped under the heading of particular disciplines, responsibility for data collection for each data item can be assigned by individual PACE sites; our recommended approach for assigning the items for integration into clinical assessment materials is discussed in Chapter 6 and proposed guidelines for discipline assignments are presented in Appendix 6B.

Table 6A.1 (Contractor-Recommended COCOA-B Data Items: Original Item Source and Revision History) precedes the COCOA-B data set. The table lists the data items, documents the original source of each data item, and indicates whether the item has been revised from its original wording. References associated with the data item sources also are provided.

**TABLE 6A.1: Contractor-Recommended COCOA-B Data Items: Original Source and Revision History.**

	CO#	Item Name	Item Source <sup>a</sup>	Revised
<b>CLINICAL RECORD ITEMS</b>				
1.	C0010	Site ID	New	
2.	C0020	Participant ID	New	
3.	C0030	Participant Name	OASIS	X
4.	C0040	Reason for Assessment	New	
5.	C0050	Date Assessment Completed	OASIS	
6.		Scheduled Month of Assessment	New	
<b>TRACKING AND DEMOGRAPHIC ITEMS</b>				
7.	C0060	Program Enrollment Date (Date PACE Services Began)	DataPACE	X
8.	C0070	Gender	OASIS	
9.	C0080	Date of Birth	OASIS	
10.	C0090	Participant Social Security Number	OASIS	
11.	C0100_1	a. Medicare Number	OASIS	X
	C0100_2	b. Medicare Entitlement	DataPACE	X
12.	C0110_1	a. Medicaid Number	OASIS	X
	C0110_2	b. Medicaid Eligibility	DataPACE	X
13.	C0120	Ethnicity	OMB	
14.	C0130	Race	OASIS	
15.	C0140	Marital Status	DataPACE	
16.	C0150	Highest Level of Education Completed	Independent Living for Seniors	X
17.	C0160_1	a. Primary Language	Independent Living for Seniors	X
	C0160_2	b. English Fluency	Independent Living for Seniors	X
<b>DISENROLLMENT</b>				
18.	C0190	Disenrollment Date	New	
19.	C0200	Disenrollment Due to Death	New	
20.	C0210	Date of Death	DataPACE	X
21.	C0220	Reason for Disenrollment	DataPACE	X
22.	C0230	Referred to Following Disenrollment	DataPACE	X
<b>PRIMARY CARE PROVIDER</b>				
23.	C0240	Diagnosis and Severity Index	OASIS	X
24.	C0250	Overall Prognosis	OASIS	X
25.	C0260	Life Expectancy	New	
26.	C0270_1	a. Any Pain		
	C0270_2	b. Severity of Pain		
	C0270_3	c. Frequency of Pain	OASIS	X
	C0270_4	d. Pain Interfering with Daily Activities	OASIS	X
	C0270_5	e. Intractable Pain	OASIS	
<b>NURSING</b>				
27.	C0290	Pressure Ulcers (C0290_1 to C0290_4)	OASIS	X
28.	C0320	High Risk Factors	OASIS	X
29.	C0350	Flu Immunization Status	New	
30.	C0360	Vision	DataPACE	X
31.	C0370	Hearing	DataPACE	X
32.	C0410	Nutritional Risk	Independent Living for Seniors	X
33.	C0420	Dyspnea	OASIS	
34.	C0430	Edema	Independent Living for Seniors	X
35.	C0440_1	a. Bladder Continence	MDS	X
	C0440_2	b. When Urinary Incontinence Occurs	OASIS	
36.	C0450	Urinary Tract Infection	OASIS	X
37.	C0460	Bowel Incontinence Frequency	OASIS	X
38.	C0470_1	a. Number of Falls	Funk, 1992	X
	C0470_2	b. Number of Falls Resulting in Injury	Funk, 1992	X
39.	C0490	Management of Oral Medications	OASIS	X
40.	C0500	Adherence to Medications	MDS-HC	

**TABLE 6A.1: Contractor-Recommended COCOA-B Data Items: Original Source and Revision History. (Cont'd)**

	CO#	Item Name	Item Source <sup>a</sup>	Revised
41.	C0510	Adherence to Therapy/Medical Interventions	MDS-HC	
42.	C0520	Self-Report of Health Status	DataPACE	X
43.	C0530	Activity Difficulties	RTI <sup>b</sup>	
44.	C0540	Help from Another Person for Activities	RTI	
45.	C0550	Lifting or Carrying Objects	RTI	
46.	C0560	Walking a Quarter of a Mile	RTI	
<b>SOCIAL WORK</b>				
47.	C0570	Day Health Center Attendance	DataPACE	X
48.	C0580	Current Residence	DataPACE	X
49.	C0590	Participant Lives With	OASIS	X
50.	C0600	Informal (Unpaid) Caregivers	OASIS	X
51.	C0610	Number of Informal Caregivers	New	
52.	C0610	Frequency of Caregiver Assistance	OASIS	X
53.	C0630	Type of Caregiver Assistance	OASIS; DataPACE	X
54.	C0650	Advance Directives (C0650_1; C0650_2)	CICD Toolkit	X
55.	C0660	Frequency of Participant's Anxiety	OASIS	X
56.	C0670	Participant Stress/Concerns (C0670_1; C0670_2)	Kansas Department of Aging	X
57.	C0680	Depression, Depressive Symptoms, and Social Isolation	OASIS	X
58.	C0690	Frequency of Behavior Problems	OASIS	X
59.	C0700	Wandering	DataPACE	X
60.	C0710	Cognitive Functioning	OASIS	
61.	C0720	Memory Deficit	New	
62.	C0730	Judgment	State of Oregon	X
63.	C0740	Ability to Understand Others	OASIS	X
64.	C0750	Ability to Express Thoughts, Wants, Needs	OASIS	X
65.	C0760	Satisfaction with Amount of Interaction/Contact	New	
66.	C0780	Socialization/Isolation (C0770_1; C0770_2)	Independent Living for Seniors	X
67.	C0790	Self-Rated Quality of Life	New	
68.	C0800	Satisfaction with Care Provided for Pain (C0800_1; C0800_2)	CICD Toolkit	X
69.	C0810	Caregiver Stress	Hooyman et al., 1985	X
70.	C0820	Caregiver Coping (C0820_1; C0820_2)	Greene et al., 1982	X
<b>REHABILITATION THERAPY</b>				
71.	C0840	Endurance	State of Oregon	
72.	C0850	Ambulation/Locomotion	OASIS; DataPACE	X
73.	C0860	Transferring	OASIS; DataPACE	X
74.	C0870	Bathing	OASIS; DataPACE	X
75.	C0880	Grooming	OASIS; DataPACE	X
76.	C0890	Dressing Upper Body	OASIS; DataPACE	X
77.	C0900	Dressing Lower Body	OASIS; DataPACE	X
78.	C0910	Toileting	OASIS; DataPACE	X
79.	C0920	Feeding or Eating	OASIS; DataPACE	X
80.	C0930	Planning and Preparing Light Meals	OASIS	X
81.	C0940	Shopping	OASIS	X
82.	C0950	Housekeeping	OASIS	X
83.	C0960	Laundry	OASIS	X
84.	C0970	Telephone Use	OASIS	X
85.	C0980	Transportation	OASIS	X
86.	C0990	Functional Rehabilitative Prognosis	OASIS	X
87.	C1010	Structural Barriers in Participant's Residence	OASIS	X
<b>PARTICIPANT SATISFACTION</b>				
88.	C1020	Satisfaction with Communication with Site Staff	New	
89.	C1030	Satisfaction with Services, Help	New	
90.	C1040	Satisfaction with Other Services	New	
<b>CAREGIVER SATISFACTION</b>				
91.	C1070	Caregiver Satisfaction with Communication with Site Staff	New	

**TABLE 6A.1: Contractor-Recommended COCOA-B Data Items: Original Source and Revision History. (Cont'd)**

	<b>CO#</b>	<b>Item Name</b>	<b>Item Source<sup>a</sup></b>	<b>Revised</b>
92.	C1080	Caregiver Satisfaction with Services, Help	New	
93.	C1090	Caregiver Satisfaction with Other Services	New	
<b>UTILIZATION</b>				
94.	C1250	Type of Admission	DataPACE	
95.	C1260	Admission Date	DataPACE	
96.	C1270	Discharge Date	DataPACE	
97.	C1280	Length of Stay	DataPACE	
98.	C1290	Number of ICU or CCU Days	DataPACE	
99.	C1300	Discharge Disposition	DataPACE	
100.	C1310_1	Primary Discharge Diagnoses	DataPACE	
	C1310_2	Secondary Discharge Diagnoses	DataPACE	
101.	C1320	Hospital Admission Reason	OASIS	X
102.	C1330	Nursing Home Admission Reason	OASIS	

<sup>a</sup> References for the data item sources are listed below.

<sup>b</sup> These items were incorporated into the data set as part of a subcontract with Research Triangle Institute (RTI), a CMS contractor developing and testing data items that could be used to adjust payment based on participant frailty.

## REFERENCES FOR TABLE 6A.1

### **PACE Site Assessments and State Data Reporting Forms (Obtained in 1999)**

Independent Living for Seniors  
Rochester, NY

Kansas Department of Aging  
Topeka, KS

State of Oregon  
Department of Human Resources  
Senior and Disabled Services Division  
Salem, OR

### **References from the Literature**

Center to Improve Care for the Dying (CICD), George Washington University. Toolkit of Instruments to Measure End of Life Care. Instruments obtained from <http://www.gwu.edu/~cicd>, Fall 1998.

Funk S (1992). Accidental falls in old age. *Key Aspects of Elder Care: Managing Falls, Incontinence, and Cognitive Impairment*. New York, NY: Springer Publishing Company.

Greene JG, R Smith, M Gardiner & GC Timbury (1982). Measuring behavioral disturbance of elderly demented patients in the community and its effects on relatives: a factor analytic study. *Age Aging*, 11(2):121-6.

Hawes C, J Morris, C Phillips, V Mor, B Fries & S Nonemaker (1995). Reliability estimates for the Minimum Data Set (Hawes et al., 1995) for nursing home resident assessment and care screening (MDS). *The Gerontologist*, 35(2):172-178.

Hooyman N, J Goynea & R Montgomery (1985). The impact of in-home services termination on family caregivers. *The Gerontologist*, 25(2):141-145.

Morris JN, BE Fries, K Steel, N Ikegami, R Bernabei, GI Carpenter, R Gilgen, JP Hirdes, and E Topinkova (1997). Comprehensive Clinical Assessment in Community Setting: Applicability of the MDS-HC. *JAGS*, 45(8):1017-1024.

On Lok, Inc. (1993). *PACE Data Collection Manual*, 1993 edition. Prepared by K Rice-Trumble and CN Caughlan. San Francisco, CA: On Lok, Inc., July.

Shaughnessy PW, KS Crisler & RE Schlenker (1995). *Medicare's OASIS: Standardized Outcome and Assessment Information Set for home health care*. Distributed by the National Association for Home Care.

## CORE OUTCOME AND COMPREHENSIVE ASSESSMENT - BASIC (COCOA-B) DATA SET

### CLINICAL RECORD ITEMS

1. (C0010) \_\_\_\_\_  
Site ID
2. (C0020) \_\_\_\_\_  
Participant ID
3. (C0030) Participant Name:  
\_\_\_\_\_  
(Last)  
\_\_\_\_\_  
(First) (MI) (Suffix)
4. (C0040) Reason for Assessment:  
☐ 1 - Initial assessment  
☐ 2 - Reassessment
5. (C0050) Date Assessment Completed:  
\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
month day year
6. (C0055) Month Assessment Due:  
\_\_\_\_ - \_\_\_\_  
month year

### PARTICIPANT TRACKING AND DEMOGRAPHIC ITEMS

- ☐ No changes have occurred since the last assessment.
1. (C0060) Program Enrollment Date (Date PACE Services Began):  
\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
month day year
  2. (C0070) Gender: ☐ 1 - Male  
☐ 2 - Female
  3. (C0080) Date of Birth:  
\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
month day year
  4. (C0090) Participant Social Security Number:  
\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
☐ UK - Unknown or Not Available
  - 5a. (C0100\_1) Medicare Number:  
\_\_\_\_\_  
(including suffix)  
☐ NA - No Medicare [ Go to C0110\_1 ]
  - b. (C0100\_2) Medicare Entitlement:  
☐ 1 - Part A and Part B  
☐ 2 - Part A only  
☐ 3 - Part B only
  - 6a. (C0110\_1) Medicaid Number:  
\_\_\_\_\_  
☐ NA - No Medicaid [ Go to C0120 ]
  - b. (C0110\_2) Medicaid Eligibility:  
☐ 1 - Medicaid and SSI  
☐ 2 - Medicaid, no SSI
  7. (C0120) Ethnicity: Is the participant Hispanic or Latino (as identified by participant):  
☐ 0 - No  
☐ 1 - Yes  
☐ UK - Unknown
  8. (C0130) Race (as identified by participant): (Mark all that apply.)  
☐ 1 - American Indian or Alaska Native  
☐ 2 - Asian  
☐ 3 - Black or African-American  
☐ 4 - Hispanic or Latino  
☐ 5 - Native Hawaiian or Other Pacific Islander  
☐ 6 - White  
☐ 7 - Other (specify): \_\_\_\_\_  
☐ UK - Unknown
  9. (C0140) Current Marital Status:  
☐ 1 - Married ☐ 4 - Separated  
☐ 2 - Widowed ☐ 5 - Never married  
☐ 3 - Divorced

10. (C0150) Highest Level of Education Completed:

- ☐ 0 - No formal schooling  
☐ 1 - 8th grade or lower  
☐ 2 - Some High School  
☐ 3 - High School completed  
☐ 4 - Any College/Graduate Work

b. (C0160\_2) English Fluency:

- Spoken: ☐ 0 - None ☐ 1 - Limited ☐ 2 - Fluent  
 Reading: ☐ 0 - None ☐ 1 - Limited ☐ 2 - Fluent

11a. (C0160\_1) Primary Language:

- ☐ 1 - English  
☐ 2 - Spanish  
☐ 3 - Chinese (any dialect)  
☐ 4 - Other (specify): \_\_\_\_\_

## DISENROLLMENT ITEMS

1. (C0190) Disenrollment Date:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 month day year

2. (C0200) Was Disenrollment Due to Death?

- ☐ 0 - No [ If No, go to C0220 ]  
☐ 1 - Yes

3. (C0210) Date of Participant's Death:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 month day year

[The Disenrollment Items are complete.]

4. (C0220) Reason for Disenrollment: (Mark all that apply.)

- ☐ 1 - Dissatisfaction with quality of services  
☐ 2 - Dissatisfaction with quantity of services  
☐ 3 - Preference for own physician  
☐ 4 - Financial reason; to avoid share of cost  
☐ 5 - Unwilling to comply with treatment plan  
☐ 6 - Moved out of catchment area  
☐ 7 - Other (specify: \_\_\_\_\_)

5. (C0230) Referral Following Disenrollment:

- ☐ 1 - Nursing home  
☐ 2 - Hospital  
☐ 3 - Adult day health care center  
☐ 4 - Community service program (e.g., meals program, Senior Center)  
☐ 5 - Home health agency  
☐ 6 - In-home supportive services (e.g., attendant care)  
☐ 7 - Case management program  
☐ 8 - Other (specify: \_\_\_\_\_)

## PRIMARY CARE PROVIDER ITEMS

1. (C0240) Diagnoses and Severity Index: List each of the participant's current medical diagnoses and the associated ICD-9-CM code at the level of highest specificity (no surgical codes). E-codes or V-codes may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. Rate each diagnosis using the severity rating described below. (Choose one value that represents the most severe rating appropriate for each diagnosis.) Also indicate for each diagnosis whether it is an acute or chronic condition.

Severity Rating (Choose a value that represents most severe rating for each diagnosis.)

- 0 - Asymptomatic, no treatment needed at this time  
 1 - Symptoms well controlled with current therapy  
 2 - Symptoms controlled with difficulty, affecting daily functioning; participant needs ongoing monitoring  
 3 - Symptoms poorly controlled, participant needs frequent adjustment in treatment and dose monitoring  
 4 - Symptoms poorly controlled, history of rehospitalizations

Acute or Chronic Condition: For each medical diagnosis listed, indicate if the condition is acute or chronic.

- 0 - Acute  
 1 - Chronic

<u>Diagnosis</u>	<u>ICD-9-CM</u>	<u>Severity Rating</u>	<u>Acute (0) or Chronic (1)</u>
a. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
b. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
c. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
d. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
e. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
f. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
g. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1
h. _____	(_____.____)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1

2. **(C0250) Overall Prognosis:** BEST description of participant's overall prognosis.

☐ 0 - Poor: imminent decline likely  
☐ 1 - Fair: maintenance likely  
☐ 2 - Good: some improvement expected

3. **(C0260) Life Expectancy:** Would it be unexpected if the participant died in the next six months?

☐ 0 - No  
☐ 1 - Yes

4. **Participant Pain:** If participant has pain in multiple locations, respond based on the most severe or intrusive pain.

a. **(C0270\_1)** Has the participant experienced **Any Pain** in the past week?

☐ 0 - No [ If No, go to C0280\_1 ]  
☐ 1 - Yes

b. **(C0270\_2) Severity of Pain:** How would the participant rate his/her worst pain in the past week, on a scale of 1 to 10? (Circle rating)

(Minimal Pain)    1   2   3   4   5   6   7   8   9   10    (Extreme Pain)

☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

c. **(C0270\_3) Frequency of Pain** (in the past week):

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

d. **(C0270\_4) Pain Interfering with Daily Activities:** 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.)

☐ 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

e. **(C0270\_5) 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

## NURSING ITEMS



1a. (C0290\_1) Does the participant have a **Pressure Ulcer**?

- ☐ 0 - No [ Go to C0300\_1 ]  
☐ 1 - Yes

b. (C0290\_2) **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					

4. (C0360) **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.*

Definitions and illustrative circumstances:

- ☐ 0 - No Impairment
- 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.
  - Able to read newsprint or see fine detail and 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
- 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
- Cannot see at all, even with corrective device.
  - Sees some light or shadows, but vision is so poor that participant is not able to see obstacles in his/her path.

c. (C0290\_3) **Stage of Most Problematic (Observable) Pressure Ulcer:**

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

d. (C0290\_4) **Status of Most Problematic (Observable) Pressure Ulcer:**

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

2. (C0320) **High Risk Factors** characterizing this participant: (Mark all that apply.)

- ☐ 1 - Heavy smoking  
☐ 2 - Obesity  
☐ 3 - Alcohol dependency  
☐ 4 - Drug dependency  
☐ 5 - None of the above

3. (C0350) **Flu Immunization Status:** Has the participant received an influenza vaccination in the past year?

- ☐ 0 - No  
☐ 1 - Yes  
☐ 2 - Refuses immunization

5. **(C0370) Hearing:** How well the 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.*

Definitions and illustrative circumstances:

- ☐ 0 - No Impairment Hears adequately in most situations (with a hearing aid, if customarily worn).
- ☐ 1 - Partial Impairment
- 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
- Cannot hear at all, even with corrective device.
  - Hearing is so poor that participant does not hear speech, even with repeated efforts by the person speaking.

6. **(C0380) Height and Weight:**

- a. Record actual **Height** in inches (measured)

HEIGHT (in.): \_\_\_\_\_

- b. Record actual **Weight** in pounds (measured)

WEIGHT (lb.): \_\_\_\_\_

7. **(C0390) Hydration:** In the past 24 hours, the participant's approximate **Oral Fluid Intake** was:

- ☐ 0 - 6 cups or more (more than 1400 cc or 48 oz.)
- ☐ 1 - 2-5 cups (480-1400 cc or 16-40 oz.)
- ☐ 2 - Less than 2 cups (less than 480 cc or 16 oz.)
- ☐ NA - Unable to drink fluids

8. **(C0400) 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

9. **(C0410) Nutritional Risk:**

- |   | 0 - No                   | 1 - Yes                  |
|---|--------------------------|--------------------------|
| 1. Do the medical conditions or illnesses limit or change the amount of food the participant eats? .....                                  | <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 more than two drinks of beer, liquor or wine 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"/> |

10. **(C0420) Dyspnea:** When is the participant 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)

11. **(C0430) Edema:** (Legs/Feet) ☐ None ☐ Right ☐ Left

- 12a. **(C0440\_1) Bladder Continence:** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants).

- ☐ 0 - Continent – Complete control [ **Go to C0450** ]
- ☐ 1 - Usually continent, incontinence 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
- ☐ 5 - Participant has catheter [ **Go to C0450** ]

- b. **(C0440\_2) When does Urinary Incontinence occur?**

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

13. **(C0450)** Has this participant been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Participant on prophylactic treatment

14. **(C0460) 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

15a. **(C0470\_1)** Indicate the **Number of Falls** experienced by the participant during the past six months:

- ☐ 0 - None [ Go to C0490 ]  
☐ 1 - One  
☐ 2 - Two to five  
☐ 3 - More than five

b. **(C0470\_2) Number of Falls Resulting in Injury:** Indicate the number of falls that resulted in injury requiring medical intervention/treatment by a primary care provider (e.g., skin tears, fracture, head trauma, other physical injury) during the past six months.

- ☐ 0 - None  
☐ 1 - One  
☐ 2 - Two to five  
☐ 3 - More than five

16. **(C0490) Management of Oral Medications:** Performance (what the participant actually does) 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.** (Assess based on performance during the past week.)

- ☐ 0 - Takes oral medications independently • Independently takes correct oral medication(s) and proper dosage(s) at the correct times without any assistance or supervision, all of the time.
- ☐ 1 - Takes oral medications, but receives some assistance • Takes oral medication(s) at correct times if:  
 (a) individual dosages are prepared in advance by another person (e.g., Medisets); OR  
 (b) given daily reminders; OR  
 (c) someone develops a drug diary or chart.  
 • Takes oral medication(s) independently some (but not all) of the time.
- ☐ 2 - Receives total assistance to take oral medications • 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).
- ☐ NA - No oral medications prescribed

17. **(C0500) Adherence to Medications:** Based on your knowledge, observation and/or examination, how closely is the participant's prescribed medication regimen adhered to (e.g., takes appropriate dosage, adheres to medication schedule, etc.)?

- ☐ 0 - Poorly (medications taken appropriately less than 40% of the time)  
☐ 1 - Fairly well (medications taken appropriately 40-80% of the time)  
☐ 2 - Completely (medications taken appropriately over 80% of the time)  
☐ NA - Participant does not have prescription medications

18. **(C0510) Adherence to Therapy/Medical Interventions:** Based on your knowledge, observation, and/or examination, how closely is the participant's therapy or medical intervention (other than medications) adhered to? (For example, prescribed diet, rehab therapy, etc.)

- ☐ 0 - Poorly (adhered to as directed less than 40% of the time)  
☐ 1 - Fairly well (adhered to as directed 40-80% of the time)  
☐ 2 - Completely (adhered to as directed over 80% of the time)  
☐ NA - No therapy or medical intervention (not including medications) prescribed

## Participant Response Items (to be administered directly to participant by Nursing Staff)

19. **(C0520) Self-Report of Health Status:** Compared to other people your age, would you say that your health is excellent, good, fair, or poor?

- ☐ 1 - Excellent  
☐ 2 - Good  
☐ 3 - Fair  
☐ 4 - Poor  
☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

20. **(C0530)** Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?

	No, I do not have difficulty	Yes, I have difficulty	I am unable to do this activity	Participant was asked this question and was unable to answer due to cognitive impairment
a. Bathing or showering	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
b. Dressing	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
c. Eating	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
d. Getting in or out of bed or chairs	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
e. Walking	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
f. Using the toilet	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA

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- |  |                              |                              |                              |                               |
|--|------------------------------|------------------------------|------------------------------|-------------------------------|
| g. Going shopping, such as food or clothing shopping | <input type="checkbox"/> - 0 | <input type="checkbox"/> - 1 | <input type="checkbox"/> - 2 | <input type="checkbox"/> - UA |
| h. Doing light housekeeping                          | <input type="checkbox"/> - 0 | <input type="checkbox"/> - 1 | <input type="checkbox"/> - 2 | <input type="checkbox"/> - UA |
| i. Spending time with your family and friends        | <input type="checkbox"/> - 0 | <input type="checkbox"/> - 1 | <input type="checkbox"/> - 2 | <input type="checkbox"/> - UA |

21. **(C0540)** Do you receive help from another person with any of these activities?

	<u>Yes, I receive help</u>	<u>No, I do not receive help</u>	<u>I do not do this activity</u>	<u>Participant was asked this question and was unable to answer due to cognitive impairment</u>
a. Bathing or showering	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
b. Dressing	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
c. Eating	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
d. Getting in or out of bed or chairs	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
e. Walking	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
f. Using the toilet	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
g. Going shopping, such as food or clothing shopping	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA
h. Doing light housekeeping	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - UA

22. **(C0550)** How much difficulty, if any, do you have lifting or carrying objects as heavy as 10 pounds, such as a sack of potatoes?

- ☐ 1 - No difficulty at all  
☐ 2 - A little difficulty  
☐ 3 - Some difficulty  
☐ 4 - A lot of difficulty  
☐ 5 - Not able to do it  
☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

23. **(C0560)** How much difficulty, if any, do you have walking a quarter of a mile – that is about two or three blocks?

- ☐ 1 - No difficulty at all  
☐ 2 - A little difficulty  
☐ 3 - Some difficulty  
☐ 4 - A lot of difficulty  
☐ 5 - Not able to do it  
☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

## SOCIAL WORK ITEMS

1. **(C0570)** In the past six months, how often did the participant typically **Attend the Day Health Center?** [REASSESSMENT ONLY]
  - ☐ 0 - Less than once a month
  - ☐ 1 - One to three times per month
  - ☐ 2 - Once a week
  - ☐ 3 - Two to three days per week
  - ☐ 4 - Four or more days per week
  
2. **(C0580) Current Residence:** Indicate the participant's residence at the current time.
  - ☐ 1 - Participant's owned or rented residence (house, apartment or mobile home owned or rented by participant/couple/significant other)
  - ☐ 2 - Family member's residence
  - ☐ 3 - Boarding home or rented room (not PACE housing)
  - ☐ 4 - Assisted living or board and care facility (may provide congregate meals but no personal care or supervision; not PACE housing)
  - ☐ 5 - Assisted living or board and care facility **with** personal care or supervision; not PACE housing
  - ☐ 6 - PACE program-related housing
  - ☐ 7 - Group home except foster care (provides around-the-clock personal care and supervision)
  - ☐ 8 - Foster care in a group home
  - ☐ 9 - Nursing home (temporary)
  - ☐ 10 - Nursing home (permanent)
  - ☐ 11 - Other (specify): \_\_\_\_\_
  
3. **(C0590) Participant Lives With:** (Mark all that apply.)
  - ☐ 1 - Lives alone
  - ☐ 2 - With spouse or significant other
  - ☐ 3 - With other family member
  - ☐ 4 - With a friend
  - ☐ 5 - With paid family caregiver
  - ☐ 6 - With paid help other than PACE staff or family caregiver (includes foster care)
  - ☐ 7 - With other than above (specify): \_\_\_\_\_
  
4. **(C0600) Informal (Unpaid) Caregiver(s)** who regularly (at least once a month) provide assistance to the participant: (Mark all that apply.)
  - ☐ 0 - No informal caregiver [ If No informal caregiver, go to C0650\_1 ]
  - ☐ 1 - Relatives, friends, or neighbors living outside the home
  - ☐ 2 - Person residing in the home (EXCLUDING paid help)
  
5. **(C0610)** Indicate **Number of Informal Caregivers:**
  - ☐ 1 - One
  - ☐ 2 - Two
  - ☐ 3 - More than two
  
6. **(C0620) Frequency of Informal Caregiver Assistance:** How often does the participant receive assistance from informal caregivers?
  - ☐ 0 - Less often than weekly
  - ☐ 1 - One to two times per week
  - ☐ 2 - Three or more times per week
  - ☐ 3 - Once daily
  - ☐ 4 - Several times during day or night
  - ☐ 5 - Several times during day and night
  
7. **(C0630) Type of Informal Caregiver Assistance Received:** (Mark all that apply.)
  - ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
  - ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
  - ☐ 3 - Transportation to locations outside the home
  - ☐ 4 - Environmental support (housing, home maintenance)
  - ☐ 5 - Psychosocial support (socialization, companionship, recreation)
  - ☐ 6 - Advocates or facilitates participant's participation in appropriate medical care
  - ☐ 7 - Financial agent, power of attorney, or conservator of finance
  - ☐ 8 - Health care agent, conservator of person, or medical power of attorney
  
8. **Advance Directives:**
  - a. **(C0650\_1)** Does the participant **Have a Signed Living Will (or Advance Directive)** giving directions for the kind of medical treatment desired if ever the participant could not speak for him or herself?
    - ☐ 0 - No [ If No, go to C0660 ]
    - ☐ 1 - Yes
  - b. **(C0650\_2)** If the participant has a signed Living Will (or Advance Directive), has the participant or informal caregiver **Discussed the Living Will (or Advance Directive)** with the health care team (for example, doctors, nurses, social workers) at **(PACE site)**?
    - ☐ 0 - No
    - ☐ 1 - Yes
    - ☐ NA - Discussion not possible because participant is cognitively impaired and has no informal caregiver
  
9. **(C0660)** Indicate **Frequency of Participant's Anxiety** (Reported or Observed) over the past week.
  - ☐ 0 - Never
  - ☐ 1 - Less often than daily
  - ☐ 2 - Daily, but not constantly
  - ☐ 3 - All of the time

10. **Participant Stress/Concerns**

- a. **(C0670\_1)** Has the participant had any major changes or disruptions in his/her life over the past six months?

☐ 0 - No [ Go to C0680 ]  
☐ 1 - Yes

- b. **(C0670\_2)** Over the past six months, how stressed, concerned, or worried has the participant been related to these major changes or disruptions?

☐ 0 - Not at all  
☐ 1 - Somewhat  
☐ 2 - Extremely

11. **(C0680) Reported or Observed Depression or Depressive Symptoms and Social Isolation:** Has the participant exhibited or expressed any of the following symptoms over the past six months? **(Respond for each item below.)**

	<u>Never</u>	<u>Once/month or less</u>	<u>Several times a month</u>	<u>Several times a week</u>	<u>Every day</u>
a. Decreased level of energy and activity	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
b. Slowing of thinking, language, and behavior	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
c. Decrease in appetite	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
d. Expressions of feelings of worthlessness or futility	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
e. Crying spells	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
f. Consistent sadness	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
g. Sleep disturbances, insomnia, or excessive sleeping	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
h. Recurrent fear of death	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
i. Withdrawn/isolated	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
j. Loneliness	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4

12. **(C0690) Frequency of Behavior Problems** (Reported or Observed): Has the participant exhibited any of the following behaviors over the past six months? **(Respond for each item below.)**

	<u>Never</u>	<u>Once/month or less</u>	<u>Several times a month</u>	<u>Several times a week</u>	<u>Every day</u>
a. 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
b. 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
c. 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
d. 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
e. Agitated (pacing, fidgeting, argumentative)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4

13. **(C0700) Wandering:** Has the participant wandered over the past six months? (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.)

- ☐ 0 - Never, with no special precautions. Has not wandered away from home, the Day Health Center, or other locations and no special precautions are in place or needed.
- ☐ 1 - Never, because special precautions are in place. Has not wandered away from home, the Day Health Center, or other locations because special precautions have been instituted, such as continuous supervision and/or secured exits.
- ☐ 2 - Seldom (once/week or less). Has wandered away from home, the Day Health Center or other locations occasionally (once a week or less) over the past six months.
- ☐ 3 - Often (more than once/week). Has wandered away from home, the Day Health Center or other locations more than once a week over the past six months OR wanders once a week or more from some locations, but not others.

14. **(C0710) Cognitive Functioning:** Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance even in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

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15. **(C0720) Memory Deficit: (Mark all that apply.)**

- ☐ 1 - Failure to recognize familiar persons/places
- ☐ 2 - Inability to recall events of past 24 hours
- ☐ 3 - Significant memory loss so that supervision is required
- ☐ 4 - None of the above

16. **(C0730) Judgment (Puts Self At Risk):** Identify the participant's ability to use judgment and make decisions that affect his/her ability to function independently.

- ☐ 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.

17. **(C0740) 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):

- ☐ 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.

18. **(C0750) 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):

- ☐ 0 - No observable impairment. 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).

**Participant Response Items (to be administered directly to participant by Social Work staff)**

19. **(C0760) Satisfaction with Amount of Interaction/Contact:**  
Do you feel you spend enough time with your family, friends, and others?

- ☐ 0 - No
- ☐ 1 - For the most part
- ☐ 2 - Yes
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

20. **Socialization/Isolation:**

a. **(C0780\_1)** During the past week, how many times did you talk to or visit with family or friends (not including your time at [PACE site])?

- ☐ 1 - At least once every day
- ☐ 2 - Several times during the week, but not every day
- ☐ 3 - One time during the past week
- ☐ 4 - Not at all
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

b. **(C0780\_2)** How often do you feel lonely?

- ☐ 0 - Never
- ☐ 1 - A little of the time
- ☐ 2 - Some of the time
- ☐ 3 - Most of the time
- ☐ 4 - All of the time
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

21. **(C0790) Self-Rated Quality of Life:** Thinking about what is important to you, how would you rate your quality of life overall?

- ☐ 1 - Excellent, things couldn't be better
- ☐ 2 - Very good
- ☐ 3 - Fair
- ☐ 4 - Poor, things couldn't be much worse
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

22. **Satisfaction with Care Provided for Pain**  
**[REASSESSMENT ONLY]**

- a. **(C0800\_1)** Has there ever been any time that **(PACE site)** staff did not do everything they could to help control your pain?
- ☐ 0 - No, never
  - ☐ 1 - Yes, a few times
  - ☐ 2 - Yes, many times
  - ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment
  - ☐ NA - No pain or refuses pain medication [ **Go to C0810** ]

- b. **(C0800\_2)** Have you ever had to wait too long to get pain medication?

- ☐ 0 - No, never
- ☐ 1 - Yes, a few times
- ☐ 2 - Yes, many times
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

- c. **(C0800\_3)** Do you feel that the **(PACE site)** staff should be doing more to keep you free from pain?

- ☐ 0 - No
- ☐ 1 - Yes, a little more
- ☐ 2 - Yes, a lot more
- ☐ UA - Participant was asked this question and was unable to answer due to cognitive impairment

**Informal Caregiver Response Items (to be administered directly to informal caregiver by Social Work staff)**

- ☐ NA - No informal caregiver [ **Skip C0810 through C0820** ]

23. **(C0810) Caregiver Stress:** Almost everyone feels some degree of stress from time to time. Please indicate the amount of stress you are presently feeling as you take care of and try to help **(participant)**.

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

24. **Caregiver Coping:**

- a. **(C0820\_1)** How often do you find it difficult to cope with caring for **(participant)**?

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

- b. **(C0820\_2)** 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

**REHABILITATION THERAPIST ITEMS (OT OR PT)**

1. **(C0840) Endurance:** Identify the participant's ability to complete routine activities because of limitations of stamina, endurance, shortness of breath or pain.

- ☐ 0 - Has adequate stamina/endurance to complete tasks within reasonable time frame. Does not need to take rest breaks and does not become extraordinarily weakened or tired after completing tasks.
- ☐ 1 - Has slightly limited stamina/endurance to complete tasks but is able to do so within a reasonable time frame. Needs rest periods and becomes slightly tired or weakened when tasks completed.
- ☐ 2 - Has limited physical stamina/endurance to complete tasks and may take considerably longer periods of time to complete tasks. Even with frequent rest breaks becomes very tired or weakened when tasks are completed. Must rest for long periods after any exertion.
- ☐ 3 - Does not have the physical stamina to complete tasks. Even with frequent rest cannot complete tasks.



**ADLs: *The ADL items should be assessed based on performance during the past week.***

2. **(C0850) Ambulation/Locomotion:** Performance (what the participant actually does) to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- |  |  |
|--|--|
| <input type="checkbox"/> 0 - Walks <u>independently</u>  | Definitions and illustrative circumstances: <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"/> 1 - Walks, but receives <u>some human assistance or uses assistive device</u> | <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. 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.</li></ul> |
| <input type="checkbox"/> 2 - Walks, but <u>receives constant assistance</u>                            | <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"/> 3 - <u>Does not walk</u> but <u>uses wheelchair independently</u>             | <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"/> 4 - Does not walk but <u>uses 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"/> 5 - <u>Bedfast</u>  | <ul style="list-style-type: none"><li>• Does not walk, does not sit up in a chair.</li></ul>   |

3. **(C0860) Transferring:** Performance (what the participant actually does) to safely 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.

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|--|--|
| <input type="checkbox"/> 0 - Transfers <u>independently</u>  | Definitions and illustrative circumstances: <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"/> 1 - Transfers, but receives <u>some human assistance or uses assistive device</u> | <ul style="list-style-type: none"><li>• Transfers with minimal human assistance or use of an assistive device.</li><li>• Transfers without assistance some of the time and receives assistance at other times. Examples: a) Participant transfers independently at home, but requires assistance or supervision when transferring at the Day Health Center; b) Participant transfers independently from bed to chair, but requires assistance to transfer to and from toilet or tub.</li></ul> |
| <input type="checkbox"/> 2 - Does not transfer but <u>bears weight and 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"/> 3 - Does not transfer and <u>does not bear weight or pivot</u>                    | <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"/> 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"/> 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>  |

4. **(C0870) Bathing:** Performance (what the participant actually does) to safely wash entire body. (**Excludes grooming, washing only face and hands.**)

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| <p><input type="checkbox"/> 0 - Bathes <u>independently</u> in shower or tub</p> <p><input type="checkbox"/> 1 - Bathes self in shower or tub but uses <u>assistive device</u></p> <p><input type="checkbox"/> 2 - Bathes self in shower or tub but receives <u>some human assistance/supervision</u></p> <p><input type="checkbox"/> 3 - Bathes self in shower or tub but receives <u>constant human assistance/supervision</u></p> <p><input type="checkbox"/> 4 - Must be <u>bathed in bed or bedside chair</u></p> <p><input type="checkbox"/> 5 - Completely <u>dependent</u></p> | <p>Definitions and illustrative circumstances:</p> <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> <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> <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> <li>• Sponge bathes self independently (entire body).</li> <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> <li>• Does not use shower or tub and is bathed (by sponge bath) in bed or bedside chair.</li> <li>• Does part of bathing activity (e.g., sponges self in easy to reach areas).</li> <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> |
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5. **(C0880) Grooming:** Performance (what participant actually does) to safely tend to personal hygiene needs (e.g., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

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| <p><input type="checkbox"/> 0 - Grooms <u>independently</u></p> <p><input type="checkbox"/> 1 - Grooms self but receives <u>some human assistance or uses assistive device</u></p> <p><input type="checkbox"/> 2 - Grooms self but receives <u>constant human assistance</u></p> <p><input type="checkbox"/> 3 - Completely <u>dependent</u></p> | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> <li>• Does all grooming activities independently, without assistance or supervision, all of the time.</li> <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> <li>• Participant grooms self if constantly receiving human assistance.</li> <li>• All grooming activities are done by another person all of the time.</li> </ul> |
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6. **(C0890) Dressing Upper Body:** Performance (what the participant actually does) to safely dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

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|---|--|
| <p><input type="checkbox"/> 0 - Dresses <u>independently</u></p> <p><input type="checkbox"/> 1 - Dresses self but uses <u>assistive device or receives some human assistance</u></p> <p><input type="checkbox"/> 2 - Dresses self but receives <u>constant human assistance</u></p> <p><input type="checkbox"/> 3 - Completely <u>dependent</u></p> | <p>Definitions and illustrative circumstances:</p> <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> <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 self some of the time and receives assistance at other times.</li> <li>• Receives stand-by supervision for safety.</li> <li>• Someone must help the participant put on upper body clothing.</li> <li>• Participant depends entirely upon another person to dress the upper body all of the time.</li> </ul> |
|---|--|

7. **(C0900) Dressing Lower Body:** Performance (what the participant actually does) to safely dress lower body including undergarments, slacks, socks or nylons, shoes.

- |  |  |
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| <input type="checkbox"/> 0 - Dresses <u>independently</u>  | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> <li>Obtains, puts on, and removes clothing and shoes without assistance or supervision, all of the time.</li> <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> <li>Receives stand-by supervision for safety.</li> <li>Someone must help the participant put on undergarments, slacks, socks or nylons, and shoes.</li> <li>Participant depends entirely upon another person to dress the lower body all of the time.</li> </ul> |
| <input type="checkbox"/> 1 - Dresses self but uses <u>assistive device or receives some human assistance</u> |  |
| <input type="checkbox"/> 2 - Dresses self but receives <u>constant human assistance</u>                      |  |
| <input type="checkbox"/> 3 - Completely <u>dependent</u>   |  |

8. **(C0910) Toileting:** Performance (what the participant actually does) to safely get to and from the toilet or bedside commode, get on and off toilet, clean self and adjust clothes.

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| <input type="checkbox"/> 0 - Toilets <u>independently</u>  | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> <li>Gets to and from toilet independently, toilets self <u>without assistive devices or human assistance/supervision</u>, all of the time.</li> <li>Gets to and from toilet and toilets self with assistive devices (e.g., grab bars, raised toilet seat), but without human assistance.</li> <li>Gets to and from toilet when reminded, assisted, or supervised by another person. May also use assistive devices.</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 or home).</li> <li>Requires constant human assistance; <u>OR</u></li> <li>Does not go to and from toilet but uses a bedside commode (with or without assistance).</li> <li>Does not go to and from toilet but uses a bedpan/urinal independently.</li> <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> |
| <input type="checkbox"/> 1 - Toilets with <u>assistive device</u>                                  |   |
| <input type="checkbox"/> 2 - Toilets with <u>some human assistance</u>                             |   |
| <input type="checkbox"/> 3 - Toilets with <u>constant human assistance or uses bedside commode</u> |   |
| <input type="checkbox"/> 4 - Uses <u>bedpan/urinal</u>   |   |
| <input type="checkbox"/> 5 - Completely <u>dependent</u>   |   |

9. **(C0920) Feeding or Eating:** Performance (what participant actually does) to safely feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, NOT preparing the food to be eaten.

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|--|---|
| <input type="checkbox"/> 0 - Feeds/eats independently  | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> <li>Feeds self/eats without any assistance or supervision all of the time.</li> <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); <u>OR</u></li> <li>(d) a liquid, pureed or ground meat diet.</li> </ul> </li> <li>Must be assisted or supervised throughout meal/snack.</li> <li>Takes in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.</li> <li>Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy or other artificial opening to the GI tract.</li> <li>Receives total parenteral nutrition (TPN).</li> </ul> |
| <input type="checkbox"/> 1 - Feeds/eats independently but receives <u>some human assistance or uses assistive device</u>         |   |
| <input type="checkbox"/> 2 - Does not feed/eat independently and <u>receives constant human assistance</u>                       |   |
| <input type="checkbox"/> 3 - Takes in nutrients orally <u>and</u> by tube feeding  |   |
| <input type="checkbox"/> 4 - Completely dependent on nasogastric tube or gastrostomy or other artificial opening to the GI tract |   |
| <input type="checkbox"/> 5 - Does not take in nutrients orally or by tube feeding  |   |

**IADLs: *The IADL items should be assessed based on performance during the past week.***

10. **(C0930) Planning and Preparing Light Meals:** Performance (what the participant actually does) to safely and effectively plan and prepare light meals such as cereal, sandwich or reheat delivered meals.
- ☐ 0 - Independently plans and prepares all light meals for self or reheats delivered meals; OR Is physically, cognitively, and mentally able to prepare light meals but does not need or choose to do so.
  - ☐ 1 - Does not prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
  - ☐ 2 - Does not prepare any light meals or reheat any delivered meals due to physical, cognitive, or mental limitations.
11. **(C0940) Shopping:** Performance (what the participant actually does) to plan for, select, and purchase items in a store and carry them home or arrange delivery.
- ☐ 0 - Plans for shopping needs and independently performs shopping tasks, including carrying packages; OR Is physically, cognitively, and mentally able to take care of shopping, but does not need to do so.
  - ☐ 1 - Shops, but receives some assistance:
    - (a) By self does only light shopping and carries small packages, but needs someone to do occasional major shopping; OR
    - (b) Does not go shopping alone, but goes with someone to assist.
  - ☐ 2 - Does not go shopping, but identifies items needed, places orders, and arranges home delivery.
  - ☐ 3 - Needs someone to do all shopping due to physical, cognitive, or mental limitations.
12. **(C0950) Housekeeping:** Performance (what the participant actually does) to safely and effectively perform light housekeeping (e.g., dusting, wiping kitchen counters) and heavier cleaning tasks (e.g., dishwashing, vacuuming, sweeping).
- ☐ 0 - Independently performs all housekeeping tasks; OR Is physically, cognitively, and mentally able to perform all housekeeping tasks but does not need to do so.
  - ☐ 1 - Performs only light housekeeping tasks independently.
  - ☐ 2 - Performs housekeeping tasks with intermittent assistance or supervision from another person.
  - ☐ 3 - Does not consistently perform any housekeeping tasks unless assisted by another person throughout the process.
  - ☐ 4 - Does not effectively participate in any housekeeping tasks due to physical, cognitive, or mental limitations.
13. **(C0960) Laundry:** Performance (what the participant actually does) to do own laundry such as carry laundry to and from washing machine, use washer and dryer, wash small items by hand.
- ☐ 0 - Independently takes care of all laundry tasks; OR Is physically, cognitively, and mentally able to do laundry and access facilities, but does not need to do so.
  - ☐ 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.
  - ☐ 2 - Does not do any laundry due to physical limitations or needs continual supervision and assistance due to cognitive or mental limitations.
14. **(C0970) Telephone Use:** Performance (what participant actually does) to answer the phone, dial numbers, and effectively use the telephone to communicate.
- ☐ 0 - Dials numbers and answers calls appropriately and as desired.
  - ☐ 1 - Uses a specially adapted telephone (e.g., large numbers on the dial, teletype phone for the deaf), effectively places calls and carries on normal conversation.
  - ☐ 2 - Answers the telephone and carries on a normal conversation but has difficulty with placing calls.
  - ☐ 3 - Answers the telephone only some of the time or carries on only a limited conversation.
  - ☐ 4 - Does not answer the telephone at all but listens if assisted with equipment.
  - ☐ 5 - Does not use the telephone at all.
  - ☐ NA - Participant does not have a telephone.
15. **(C0980) Transportation:** Performance (what the participant actually does) to safely use a car, taxi, or public transportation (bus, train, subway).
- ☐ 0 - Independently drives a regular or adapted car; OR uses a regular or handicap-accessible public bus.
  - ☐ 1 - Rides in a car only when driven by another person; OR uses a bus or handicap van only when assisted or accompanied by another person.
  - ☐ 2 - Does not ride in a car, taxi, bus, or van, and requires transportation by ambulance.

16. **(C0990) Functional Rehabilitative Prognosis:** BEST description of participant's prognosis for functional status.

- ☐ 0 - Poor: imminent decline likely  
☐ 1 - Fair: maintenance/functional stability likely  
☐ 2 - Good: some improvement in functional status expected

17. **(C1010) Structural Barriers:** Indicate any structural barriers present in the participant's home environment that limit independent mobility:  
**(Mark all that apply.)**

- ☐ 0 - None  
☐ 1 - Outside stairs leading to entrance of home  
☐ 2 - Stairs inside home which must be used by the participant (e.g., to get to toileting, sleeping, eating areas)  
☐ 3 - Stairs inside home which are used optionally (e.g., to get to laundry facilities)  
☐ 4 - Narrow or obstructed doorways  
☐ 5 - Narrow or obstructed walkways inside the home  
☐ 6 - Other (specify): \_\_\_\_\_

## **PARTICIPANT SATISFACTION ITEMS**

Have you had any problems or concerns with any of the following over the past six months:

	<u>No problem</u>	<u>Small problem</u>	<u>Serious problem or problems</u>	<u>Does not receive service</u>	<u>Participant was asked this question and was unable to answer due to cognitive impairment</u>
1. <b>(C1020) Problems communicating with (PACE site) staff</b>					
a. Communicating with primary care providers (doctors, NP, PA) at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
b. Communicating with social workers at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
c. Communicating with clinic nurses at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
d. Communicating with therapists (OT, PT) at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
e. Communicating with the van drivers who take you to <b>(Day Health Center)</b> and bring you home from <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
f. Communicating with the home health <u>nurses</u> who help you <u>in your home</u> (for example, with caring for illnesses, wounds, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
g. Communicating with the home care <u>aides</u> who help you <u>in your home</u> (for example, with moving around, getting dressed, taking a shower or bath, doing chores in the house, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
h. Being as involved as you want in making decisions about your care	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
2. <b>(C1030) Problems with services and help from (PACE site) staff</b>					
a. Getting the medications and treatments that you need	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
b. Getting the equipment you need to help do things <u>in your home</u> (for example, moving around, getting dressed, taking a shower or bath, doing chores in the house, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
c. Getting help from <b>(PACE site)</b> staff to help do things <u>in your home</u> (for example, moving around, getting dressed, taking a shower or bath, doing chores in the home, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
d. Getting help from <b>(PACE site)</b> staff to help do things at <b>(Day Health Center)</b> (for example, moving around, taking showers or baths at the Day Health Center, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
3. <b>(C1040) Problems with other services at (Day Health Center)</b>					
a. The meals you have at <b>(Day Health Center)</b> or take home with you from <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
b. The activities and social events that are offered at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA

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	<u>No problem</u>	<u>Small problem</u>	<u>Serious problem or problems</u>	<u>Does not receive service</u>	<u>Participant was asked this question and was unable to answer due to cognitive impairment</u>
c. The safety of the <b>(PACE site)</b> vans that take you to <b>(Day Health Center)</b> and back home	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
d. The timeliness of the <b>(PACE site)</b> transportation or vans	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA

## **CAREGIVER SATISFACTION ITEMS**

Have you had any problems or concerns with any of the following over the past six months:

	<u>No problem</u>	<u>Small problem</u>	<u>Serious problem or problems</u>	<u>Does not receive service</u>
1. <b>(C1070)</b> Communicating with <b>(PACE site)</b> staff				
a. Communicating with primary care providers (doctors, NP, PA) at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
b. Communicating with social workers at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
c. Communicating with nurses at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
d. Communicating with therapists (OT, PT) at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
e. Communicating with the van drivers who take <b>(participant)</b> to and from <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
f. Communicating with the home health <u>nurses</u> who help <b>(participant)</b> <u>in his/her home</u> (for example, with caring for illnesses, wounds, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
g. Communicating with home care <u>aides</u> who help <b>(participant)</b> <u>in his/her home</u> (for example, with moving around, getting dressed, taking a shower or bath, doing chores in the home, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
h. Your level of involvement in making decisions about <b>(participant's)</b> care	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
2. <b>(C1080)</b> Services and help from <b>(PACE site)</b> staff				
a. Getting the medications and treatments that <b>(participant)</b> needs	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
b. Getting the equipment <b>(participant)</b> needs to help do things <u>in his/her home</u> (for example, moving around, getting dressed, taking a shower or bath, doing chores in the house, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
c. Getting help from <b>(PACE site)</b> staff to help <b>(participant)</b> do things <u>in his/her home</u> (for example, moving around, getting dressed, taking a shower or bath, doing chores in the house, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
d. Getting help from <b>(PACE site)</b> staff to help <b>(participant)</b> do things while at <b>(Day Health Center)</b> (for example, moving around, taking showers or baths at the Day Health Center, etc.)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
3. <b>(C1090)</b> Other services at <b>(Day Health Center)</b>				
a. The meals <b>(participant)</b> has at <b>(Day Health Center)</b> or takes home from <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
b. The activities and social events that are offered at <b>(Day Health Center)</b>	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
c. The safety of the <b>(PACE site)</b> vans that take <b>(participant)</b> to <b>(Day Health Center)</b> and back home	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
d. The timeliness of the <b>(PACE site)</b> transportation or vans	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA

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Month: \_\_\_\_\_

## Inpatient and Emergency Services Utilization

All inpatient and transitional housing stays and emergency department or emergent physician visits that occur any time during the month are to be recorded on this form in the following manner:

1. List all participants in inpatient facilities at the start of the month (information may be transferred from the previous month's form).
2. List all inpatient admissions and emergency department or emergent physician visits as they occur during the month.
3. When participant is admitted (or has emergency visit), fill out the participant number, admission date, and type of admission. When participant is discharged, fill out the rest of the information.
4. List each admission or visit separately and use a new line for each. If participant is transferred from one institution to another, use a separate line for each stay.
5. If participant remains in the hospital, nursing home, or transitional housing at the end of the month, place an "\*" in the Discharge Date box and enter the stay on the Inpatient and Emergency Services Utilization Form for the following month.

[illegible]

<sup>a</sup> Type of Admission or Visit

- 1 - Acute care hospital
- 2 - Nursing home (SNF/ICF)
- 3 - Transitional housing (short-stay skilled care)
- 4 - Rehabilitation unit/facility
- 5 - Psychiatric unit/facility
- 6 - Hospice
- 7 - Emergency department visit
- 8 - Emergent physician visit

<sup>b</sup> Length of Stay, ICU/CCU Days

To calculate LOS and number of ICU or CCU days, the date of admission to the institution is counted, but the date of discharge is *not* counted. If Type of Admission is option 7 (ED Visit) or option 8 (Emergent Physician Visit), Length of Stay is not applicable and should be left blank.

<sup>c</sup> Number of ICU or CCU days applies to hospital admissions only.

To calculate number of ICU or CCU days, the date of admission is counted, but the date of discharge is *not* counted.

<sup>d</sup> Disposition Following Discharge

- 1 - Acute care hospital or psychiatric unit/facility
- 2 - Nursing home (SNF/ICF) or rehabilitation unit/facility
- 3 - Home *with* home health nursing or rehab therapy
- 4 - Home *without* home health nursing or rehab therapy
- 5 - Congregate living (group home)
- 6 - Program transitional housing
- 7 - Deceased
- 8 - Other

<sup>e</sup> Record ICD-9-CM codes for primary and secondary discharge diagnoses.

Record ICD-9-CM codes for primary and secondary discharge diagnoses. These are usually available from the hospital discharge summary, hospital medical records department, or physician.

<sup>f</sup> Hospital Admission Reason

- Hospital Admission Reason**  
 1 - Emergent (unscheduled)  
 2 - Urgent (scheduled within 24 hours of admission)  
 3 - Elective (scheduled more than 24 hours before admission)  
 9 - Unknown

<sup>9</sup> Nursing Home Admission Reason

- Nursing Home Admission Reason**
- 1 - Therapy services  
2 - Respite care  
3 - Hospice care  
4 - Permanent placement/Skilled nursing services  
5 - Other  
9 - Unknown

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## APPENDIX 6B

### PROPOSED GUIDELINES FOR ASSIGNING COCOA-B CLINICAL DATA ITEMS

Under the recommended protocol (resulting from this project) regarding which interdisciplinary team members are responsible for COCOA-B data collection, PACE sites can determine who will collect each data item but should assign items for collection by the same discipline on an ongoing basis (rather than permitting different disciplines to collect various items at each reassessment). After PACE sites select the responsible discipline for each clinical item, the items should be integrated into the relevant clinical assessment materials from the outset of COCOA-B implementation and, from that point forward, should be collected as part of routine clinical assessment of participants.

The proposed guidelines for assigning the COCOA-B clinical data items are presented in this appendix. The guidelines were developed based on quantitative and qualitative information (e.g., discipline-specific reliability data, input from PACE clinicians) acquired during this project. The guidelines include recommendations for a primary and, for some data items, alternate discipline(s) or staff type(s) for each data item. The table does not include the data items in the nonclinical item sets in COCOA-B [Participant Tracking and Demographic Items, Participant Satisfaction Questionnaire, Caregiver Satisfaction Questionnaire, Utilization, and Disenrollment], as those items are not necessarily integrated into existing site documentation. Recommendations for data collection responsibility for the nonclinical item sets are presented in Chapter 6.

The data items are organized within Table 6B.1 below by the primary recommended discipline (i.e., primary care provider, nursing, social work, and rehabilitative therapy). The discipline(s)/staff member(s) recommended to collect each item is presented on the right side of the table, indicated by an X in the appropriate column (a bold **X** indicates the primary recommendation).



**TABLE 6B.1: Proposed Guidelines for Discipline/Staff Assignments for COCOA-B Data Items.<sup>a</sup>**

		Discipline/Staff <sup>b</sup>							
C0 #	Item Name	PCP	RN <sup>c</sup>	SW	REHAB <sup>d</sup>	RD	RT	Speech Therapy	Pharmacy
<b>PRIMARY CARE PROVIDER</b>									
C0240	Diagnoses and Severity Index	X							
C0250	Overall Prognosis	X							
C0260	Life Expectancy	X							
C0270	Participant Pain (C0270_1 to C0270_5)	X	X						
<b>NURSING</b>									
C0290	Pressure Ulcers (C0290_1 to C0290_4) <sup>e</sup>	X	X						
C0320	High Risk Factors	X	X						
C0350	Flu Immunization Status		X						
C0360	Vision	X	X						
C0370	Hearing	X	X						
C0410	Nutritional Risk		X			X			
C0420	Dyspnea	X	X		X				
C0430	Edema	X	X						
C0440	Bladder Continence/When Urinary Incontinence Occurs (C0440_1; C0440_2)	X	X						
C0450	Urinary Tract Infection	X	X						
C0460	Bowel Incontinence Frequency	X	X						
C0470	Number of Falls/Number of Falls Resulting in Injury (C0470_1; C0470_2)	X	X		X				
C0490	Management of Oral Medications	X	X						X
C0500	Adherence to Medications	X	X						X
C0510	Adherence to Therapy/Medical Interventions		X		X	X			
C0520	Self-Report of Health Status	X	X	X					
C0530 <sup>e</sup>	Activity Difficulties		X						
C0540 <sup>e</sup>	Help from Another Person for Activities		X						
C0550 <sup>e</sup>	Lifting or Carrying Objects		X						
C0560 <sup>e</sup>	Walking a Quarter of a Mile		X						
<b>SOCIAL WORK</b>									
C0570	Day Health Center Attendance			X			X		
C0580	Current Residence			X					
C0590	Participant Lives With			X					
C0600	Informal (Unpaid) Caregivers			X					
C0610	Number of Informal Caregivers			X					
C0620	Frequency of Informal Caregiver Assistance			X					
C0630	Type of Informal Caregiver Assistance			X					
C0650	Advance Directives (C0650_1; C0650_2)	X	X	X					
C0660	Frequency of Participant's Anxiety	X		X					
C0670	Participant Stress/Concerns (C0670_1; C0670_2)	X		X					
C0680	Depression, Depressive Symptoms, and Social Isolation	X		X					
C0690	Frequency of Behavior Problems			X					
C0700	Wandering	X		X					
C0710	Cognitive Functioning	X		X					
C0720	Memory Deficit	X		X					
C0730	Judgment	X		X					
C0740	Ability to Understand Others			X				X	
C0750	Ability to Express Thoughts, Wants, Needs		X	X				X	
C0760	Satisfaction with Amount of Interaction/Contact			X					
C0780	Socialization/Isolation (C0780_1; C0780_2)			X					
C0790	Self-Rated Quality of Life			X					
C0800	Satisfaction with Care Provided for Pain (C0800_1 to C0800_3)			X					
C0810	Caregiver Stress			X					
C0820	Caregiver Coping (C0820_1; C0820_2)			X					

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**TABLE 6B.1: Proposed Guidelines for Discipline/Staff Assignments for COCOA-B Data Items.<sup>a</sup> (Cont'd)**

		Discipline/Staff <sup>b</sup>							
C0 #	Item Name	PCP	RN <sup>c</sup>	SW	REHAB <sup>d</sup>	RD	RT	Speech Therapy	Pharmacy
<b><u>REHABILITATION THERAPY</u></b>									
C0840	Endurance		X		X				
C0850	Ambulation/Locomotion		X		X				
C0860	Transferring		X		X				
C0870	Bathing		X		X				
C0880	Grooming		X		X				
C0890	Dressing Upper Body		X		X				
C0900	Dressing Lower Body		X		X				
C0910	Toileting		X		X				
C0920	Feeding or Eating		X		X				
C0930	Planning and Preparing Light Meals		X		X				
C0940	Shopping		X		X				
C0950	Housekeeping		X		X				
C0960	Laundry		X		X				
C0970	Telephone Use		X		X				
C0980	Transportation		X		X				
C0990	Functional Rehabilitative Prognosis	X	X		X				
C1010	Structural Barriers in Participant's Residence		X	X	X				

<sup>a</sup> Only the data items intended for integration into existing clinical assessment documentation are presented in this table (the items contained in the nonclinical item sets are not listed). Each clinical form also will need to include the six clinical record items (Site ID, Participant ID, Participant Name, Reason for Assessment, Date Assessment Completed, and Care Provider Name).

<sup>b</sup> PCP = Primary Care Provider; RN = Nursing (clinic or home care); SW = Social Work; REHAB = Rehabilitation Therapy (physical therapy or occupational therapy); RD = Dietitian; RT = Recreational Therapy.

<sup>c</sup> RN items may be assigned to the clinic or home care nurse.

<sup>d</sup> REHAB items may be assigned to the physical therapist or occupational therapist.

<sup>e</sup> Items C0530 - C0560 were developed for calculating a frailty adjuster for potential payment and were tested as part of the COCOA-B SYFT (under a subcontract with Research Triangle Institute). The items -- which can be used for outcome measurement, risk adjustment, and for the frailty adjuster -- were retained as part of the recommended COCOA-B data set.