

APPENDIX 4A

SYSTEMATIC FIELD TEST VERSION OF THE COCOA-B DATA SET

The version of the data set that was implemented at 13 PACE sites during the systematic field test is presented in this appendix. Based on the findings of the feasibility and reliability tests and in consideration of input from the project Advisory Committee and National PACE Association leadership, administrative and payment considerations, and concerns related to burden and practicality, the size of the data set was reduced substantially (from 242 to 134 data items) prior to the systematic field test, resulting in a manageable set of items focused on measuring and risk adjusting outcomes while providing a set of standardized basic assessment items across sites. The reduced data set is referred to as the COCOA-B data set.

The draft COCOA-B data set implemented during the systematic field test was composed of ten item sets, including Participant Tracking and Demographic Items, Disenrollment Items, Primary Care Provider Items, Nursing Items, Social Work Items, Rehabilitation Therapy Items, Participant Satisfaction Questionnaire (PSQ), Caregiver Satisfaction Questionnaire (CSQ), End of Life Questionnaire (EOL), and Inpatient and Emergency Services Utilization Form. The COCOA-B clinical item sets were intended for integration with existing clinical assessment materials at PACE sites participating in the systematic field test.

DRAFT 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. Staff Member Name:

(Last)

(First) (MI) (Suffix)

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)
 - 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
 - 11a. (C0160_1) Primary Language:
☐ 1 - English
☐ 2 - Spanish
☐ 3 - Chinese (any dialect)
☐ 4 - Other (specify): _____

b. **(C0160_2) English Fluency:**

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

12. **(C0170)** From which of the following **Inpatient Facilities** was the participant discharged during the past 14 days? **(Mark all that apply.) [INITIAL ASSESSMENT ONLY]**

- ☐ 1 - Hospital
☐ 2 - Rehabilitation facility
☐ 3 - Skilled nursing home
☐ 4 - Other nursing home
☐ 5 - Other (specify): _____
☐ NA - Participant was not discharged from an inpatient facility during the past 14 days

13. **(C0180) Formal Services Received Prior to Enrollment** (during the past 14 days): **(Mark all that apply.) [INITIAL ASSESSMENT ONLY]**

- ☐ 0 - None
☐ 1 - Adult day care center
☐ 2 - Senior Center
☐ 3 - Nursing home
☐ 4 - Acute care hospital
☐ 5 - Home health care
☐ 6 - Personal care in home
☐ 7 - Home chore services
☐ 8 - Congregate or portable meals
☐ 9 - 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

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

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

☐ 0 - No

☐ 1 - Yes

5a. **(C0280_1)** Does the participant have a **Surgical Wound** (excluding ostomies)?

☐ 0 - No [Go to C0290_1]

☐ 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

b. **(C0280_2) 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

c. **(C0280_3)** Does the participant have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 - No

☐ 1 - Yes

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

d. **(C0280_4) Status of Most Problematic (Observable) Surgical Wound:**

☐ 1 - Fully granulating

☐ 2 - Early/partial granulation

☐ 3 - Not healing

☐ NA - No observable surgical wound

6a. (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					

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

7a. (C0300_1) Does the participant have a **Stasis Ulcer**?

- ☐ 0 - No [Go to C0310]
☐ 1 - Yes

b. (C0300_2) **Current Number of Observable Stasis Ulcer(s):**

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

c. (C0300_3) Does the participant have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

- ☐ 0 - No
☐ 1 - Yes

d. (C0300_4) **Status of Most Problematic (Observable) Stasis Ulcer:**

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

Participant Response Items (to be administered directly to participant by Primary Care Provider Staff)

8. (C0310) **Standardized Mini Mental Status Examination:** Record score for each question to the right, as indicated.

I am going to ask you some questions and give you some problems to solve. Please try to answer the best you can.

a. (Allow 10 seconds for each reply)

MAX SCORE (5)

- 1) **What year is this?** (accept exact answer only) _____ 1
- 2) **What season is this?** (during the last week of the old season or the first week of a new season, accept either season) _____ 1
- 3) **What month of the year is this?** (on the first day of new month, or last day of the previous month, accept either) _____ 1
- 4) **What is today's date?** (accept previous or next date, e.g., on the 7th accept the 6th or 8th) _____ 1
- 5) **What day of the week is this?** (accept exact answer only) _____ 1

b. (Allow 10 seconds for each reply)

MAX SCORE (5)

- 1) **What country are we in?** (accept exact answer only) _____ 1
- 2) **What state/county are we in?** (accept exact answer only) _____ 1
- 3) **What city/town are we in?** (accept exact answer only) _____ 1
- 4) **(IN CLINIC) What is the name of this hospital/building?** (accept exact name of hospital or institution only)
(IN HOME) What is the street address of this house? (accept street name and house number or equivalent in rural areas) _____ 1

- 5) (IN CLINIC) What floor of the building are we on? (accept exact answer only) _____ 1
(IN HOME) What room are we in? (accept exact answer only) _____
- c. I am going to name three objects. After you have said all three objects, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.
(say them slowly at approximately 1 second intervals)
Ball Car Man
For repeated use
Bell Jar Fan
Bill Tar Can
Please repeat the three items for me.
(Score 1 point for each correct reply on the first attempt)
Allow 20 seconds for reply, if participant did not repeat all three, repeat until they are learned or up to a maximum of five times. _____
MAX SCORE (3)
- d. Spell the word WORLD (you may help subject to spell world correctly). Say "Now spell it backwards, please."
(Allow 30 seconds to spell backwards. If the participant cannot spell world even with assistance – score 0.) _____
MAX SCORE (5)
- e. Now what were the three objects that I asked you to remember?
Ball Car Man
Score 1 point for each correct response regardless of order, allow 10 seconds _____
MAX SCORE (3)
- f. Show wristwatch. Ask: What is this called?
Score 1 point for each correct response. Accept "wristwatch" or "watch". Do not accept "clock," "time," etc. (allow 10 seconds) _____
MAX SCORE (1)
- g. Show pencil. Ask: What is this called?
Score 1 point for each correct response, accept pencil only, --score 0 for pen. _____
MAX SCORE (1)
- h. I'd like you to repeat a phrase after me: "no ifs, ands, or buts"
Allow 10 seconds for response. Score 1 point for a correct repetition. Must be **exact**, e.g., no ifs or buts -- score 0. _____
MAX SCORE (1)
- i. Read the words on this page and then do what it says:
Hand participant the laminated sheet with CLOSE YOUR EYES on it.
CLOSE YOUR EYES
If participant just reads and does not then close eyes – you may repeat: **read the words on this page and then do what it says** to a maximum of three times. Allow 10 seconds, score 1 point if participant closes eyes. Participant does not have to read aloud. _____
MAX SCORE (1)
- j. Ask if the participant is right or left-handed. Alternate right/left hand in statement, e.g., if the participant is right-handed, say, "Take this paper in your left hand." Take a piece of paper – hold it up in front of the participant and say the following:
"Take this paper in your right/left hand, fold the paper in half once with both hands and put the paper on the floor."
Takes paper in correct hand 1
Folds it in half 1
Puts it on the floor 1
Allow 30 seconds. Score 1 point for each instruction correctly executed. _____
MAX SCORE (3)
- k. Hand participant a pencil and paper. Say: "Write any complete sentence on this piece of paper."
Allow 30 seconds. Score 1 point. The sentence should make sense. Ignore spelling errors. _____
MAX SCORE (1)

- I. Place design (two five-sided figures intersected by a four-sided figure), pencil, eraser, and paper in front of the participant.

Say: **"Copy this design please."**

Allow multiple tries until participant is finished and hands it back. Score 1 point for correctly copied diagram. The participant must have drawn a 4-sided figure between two 5-sided figures. Maximum time – 1 minute.

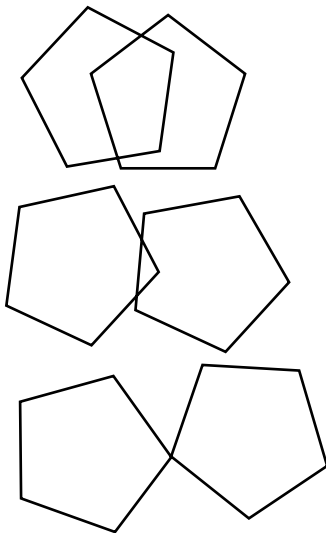
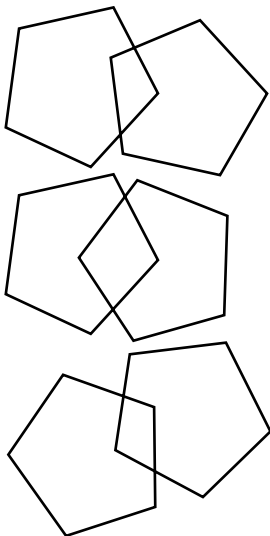
MAX SCORE (1)

Scoring the Figure

The subject must draw two five-sided figures intersected by a four-sided figure.

CORRECT - Score 1

INCORRECT - Score 0



Total Test Score _____

**MAX SCORE
30**

NURSING ITEMS

1. **(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

2. **(C0330) Therapies** the participant receives at his/her residence: (Mark all that apply.)

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

3. **(C0340) Respiratory Treatments** utilized at participant's residence: (Mark all that apply.)

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous positive airway pressure
- ☐ 4 - None of the above

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

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

5. **(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.

6. **(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.

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

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

HEIGHT (in.): _____

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

WEIGHT (lb.): _____

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

- ☐ 0 - 6 cups or more (more than 1200 cc or 48 oz.)
- ☐ 1 - 2-5 cups (480-1200 cc or 16-48 oz.)
- ☐ 2 - Less than 2 cups (less than 480 cc or 16 oz.)
- ☐ NA - Unable to drink fluids

9. **(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

10. **(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"/> |
| 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"/> |

11. **(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)
12. **(C0430) Edema:**
- a. Legs/Feet ☐ None ☐ Right ☐ Left
- b. Facial ☐ None ☐ Present
- c. Sacral ☐ None ☐ Present
- 13a. **(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
14. **(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
15. **(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
- 16a. **(C0470_1)** Indicate the **Number of Falls** experienced by the participant during the past four months:
- ☐ 0 - None [**Go to C0480**]
- ☐ 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 four months.
- ☐ 0 - None
- ☐ 1 - One
- ☐ 2 - Two to five
- ☐ 3 - More than five
17. **(C0480)** Indicate the six primary **Prescription Medications** the participant is taking at time of assessment. For each medication, include the associated diagnosis and prescribed dosage and frequency. (If available, please also provide a list of all prescription medications being taken by participant.) If participant currently is not taking prescription medications, mark NA.

Prescription Medications	Associated Diagnosis	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

☐ NA - No prescription medications currently being taken

18. **(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
- ☐ 1 - Takes oral medications, but receives some assistance
- ☐ 2 - Receives total assistance to take oral medications
- ☐ NA - No oral medications prescribed
- Independently takes correct oral medication(s) and proper dosage(s) at the correct times without any assistance or supervision, all of the time.
 - 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.
 - 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).

19. **(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

20. **(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)

21. **(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

22. **(C0530_P)** 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
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

23. **(C0540_P)** Do you receive help from another person with any of these activities?

	Yes, I receive help	No, I do not receive help	I do not 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
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

24. **(C0550_P)** 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

25. (C0560_P) 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 four 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 - PACE program-related housing
- ☐ 6 - Group home except foster care (provides around-the-clock personal care and supervision)
- ☐ 7 - Foster care in a group home
- ☐ 8 - Nursing home (temporary)
- ☐ 9 - Nursing home (permanent)
- ☐ 10 - 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 C0640]
- ☐ 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. (C0640) **Financial Concerns:** Do you have any concern regarding the participant's ability to afford the following?

- a. Rent/utility bills ☐ 0 - No ☐ 1 - Yes
- b. Necessary food/meals ☐ 0 - No ☐ 1 - Yes

9. **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) 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

10. **(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

11. **Participant Stress/Concerns**

- a. **(C0670_1)** Has the participant had any major changes or disruptions in his/her life over the past four months?

- ☐ 0 - No [**Go to C0680**]
☐ 1 - Yes

- b. **(C0670_2)** Over the past four 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

12. **(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 four 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
k. Other (specify): _____	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4

13. **(C0690) Frequency of Behavior Problems** (Reported or Observed): Has the participant exhibited any of the following behaviors over the past four 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

14. **(C0700) Wandering:** Has the participant wandered over the past four 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 four 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 four months OR wanders once a week or more from some locations, but not others.

15. **(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.
16. **(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
17. **(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.
18. **(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.
19. **(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)

20. **(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
21. **(C0770) Satisfaction with Quality of Interaction/Contact:**
Do you typically enjoy the time you spend with 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
22. **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

23. **(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

24. **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 (Social Work)

- ☐ NA - No informal caregiver [Skip C0810 through C0830]

25. **(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

26. **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

27. **(C0830) Caregiver Support:** Caregiving can be difficult and challenging. Do you feel that you have adequate social and emotional support to meet your current needs?

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

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

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.

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

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

- | | |
|--|--|
| <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"> • Bathes self in <u>shower or tub</u> independently, <u>without any</u> human assistance, supervision, or assistive device, all of the time. • 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. • Bathes in shower or tub with the assistance of another person: <ul style="list-style-type: none"> (a) for intermittent supervision or encouragement or reminders, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas. • Bathes independently some of the time and receives assistance at other times (e.g., in the shower at the Day Health Center). • Sponge bathes self independently (entire body). • Participates in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision. • Does not use shower or tub and is bathed (by sponge bath) in bed or bedside chair. • Does part of bathing activity (e.g., sponges self in easy to reach areas). • Is completely bathed by another person all of the time. • Receives physical assistance for the entire activity, i.e., does not do any part independently any of the time. |
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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"> • Does all grooming activities independently, without assistance or supervision, all of the time. • Grooms self, but requires assistive device. • Does some (but not all) grooming activities independently and receives assistance from others (e.g., shampooing). • Grooming utensils (e.g., comb, toothbrush, razor) must be placed within reach to complete grooming activities. • Participant grooms self if constantly receiving human assistance. • All grooming activities are done by another person all of the time. |
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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"> • 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. • Dresses self with assistive devices (e.g., velcro fasteners on clothing, adaptive clothing and special equipment such as a reacher). • Dresses upper body without assistance if clothing is laid out or handed to the participant. • 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. • Dresses or undresses self some of the time and receives assistance at other times. • Receives stand-by supervision for safety. • Someone must help the participant put on upper body clothing. • Participant depends entirely upon another person to dress the upper body all of the time. |
|---|--|

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

- | | |
|--|--|
| <input type="checkbox"/> 0 - Dresses <u>independently</u> | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> Obtains, puts on, and removes clothing and shoes without assistance or supervision, all of the time. Dresses self with assistive devices (e.g., velcro fasteners on shoes, adaptive clothing, and special equipment such as a reacher). Dresses lower body without assistance if clothing and shoes are laid out or handed to the participant. 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. Dresses or undresses some of the time and receives assistance at other times. Receives stand-by supervision for safety. Someone must help the participant put on undergarments, slacks, socks or nylons, and shoes. Participant depends entirely upon another person to dress the lower body all of the time. |
| <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"> Gets to and from toilet independently, toilets self <u>without assistive devices or human assistance/supervision</u>, all of the time. Gets to and from toilet and toilets self with assistive devices (e.g., grab bars, raised toilet seat), but without human assistance. Gets to and from toilet when reminded, assisted, or supervised by another person. May also use assistive devices. Does part of the toileting, but receives assistance for other parts of the activity (e.g., to get to the toilet room, clean self). Toilets self independently some of the time and receives assistance at other times (e.g., at the Day Health Center or home). Requires constant human assistance; <u>OR</u> Does not go to and from toilet but uses a bedside commode (with or without assistance). Does not go to and from toilet but uses a bedpan/urinal independently. Receives physical assistance for all toileting activities, i.e., does not do any of the toileting activities independently any of the time. |
| <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.

- | | |
|--|---|
| <input type="checkbox"/> 0 - Feeds/eats independently | <p>Definitions and illustrative circumstances:</p> <ul style="list-style-type: none"> Feeds self/eats without any assistance or supervision all of the time. Feeds self independently but requires: <ul style="list-style-type: none"> (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision (e.g., cueing) from another person; <u>OR</u> (c) an assistive device (e.g., utensil with built-up handle, plate guard, or cup with spout to prevent spilling); <u>OR</u> (d) a liquid, pureed or ground meat diet. Must be assisted or supervised throughout meal/snack. Takes in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy or other artificial opening to the GI tract. Receives total parenteral nutrition (TPN). |
| <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. **(C1000) Safety Hazards** found in the participant's current place of residence: **(Mark all that apply.)**

- ☐ 0 - None
☐ 1 - Inadequate floor, roof, or windows
☐ 2 - Inadequate lighting
☐ 3 - Unsafe gas/electric appliance
☐ 4 - Inadequate heating
☐ 5 - Inadequate cooling
☐ 6 - Lack of fire safety devices
☐ 7 - Unsafe floor coverings (e.g., throw rugs)
☐ 8 - Inadequate stairs or stair railings
☐ 9 - Unsafe bathing facilities
☐ 10 - Lack of security locks on doors and windows
☐ 11 - Electrical cords improperly placed
☐ 12 - Improperly stored poisonous or otherwise hazardous materials
☐ 13 - Pets in home (e.g., dogs, cats) posing safety issues
☐ 14 - Other (specify): _____

18. **(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 four 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. (C1020) Problems communicating with (PACE site) staff					
a. Communicating with primary care providers (doctors, NP, PA) at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
b. Communicating with social workers at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
c. Communicating with clinic nurses at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA
d. Communicating with therapists (OT, PT) at (Day Health Center)	<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 (Day Health Center) and bring you home from (Day Health Center)	<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. Your level of involvement in making decisions about your care	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<input type="checkbox"/> - UA

	<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>
2. (C1030) Problems with services and help from (PACE site) staff					
a. Getting the medications and treatments that you need	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2		<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"/> - UA
c. Getting help from (PACE site) 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"/> - UA
d. Getting help from (PACE site) staff to help do things at (Day Health Center) (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"/> - UA
3. (C1040) Problems with other services at (Day Health Center)					
a. The meals you have at (Day Health Center) or take home with you from (Day Health Center)	<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 (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
c. The safety of the (PACE site) vans that take you to (Day Health Center) 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 (PACE site) transportation or vans	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA	<input type="checkbox"/> - UA
4. (C1050) All things considered, how satisfied are you with the care you received from (PACE site) in the past four months?			5. (C1060) Would you recommend (PACE site) to your friend or family member?		
<input type="checkbox"/> 0 - Very satisfied			<input type="checkbox"/> 0 - No		
<input type="checkbox"/> 1 - Somewhat satisfied			<input type="checkbox"/> 1 - Yes, probably		
<input type="checkbox"/> 2 - Neither satisfied nor dissatisfied			<input type="checkbox"/> 2 - Yes, definitely		
<input type="checkbox"/> 3 - Somewhat dissatisfied			<input type="checkbox"/> UA - Participant was asked this question and was unable to answer due to cognitive impairment		
<input type="checkbox"/> 4 - Very dissatisfied					
<input type="checkbox"/> UA - Participant was asked this question and was unable to answer due to cognitive impairment					

CAREGIVER SATISFACTION ITEMS

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

	<u>No problem</u>	<u>Small problem</u>	<u>Serious problem or problems</u>	<u>Does not receive service</u>
1. (C1070) Communicating with (PACE site) staff				
a. Communicating with primary care providers (doctors, NP, PA) at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
b. Communicating with social workers at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
c. Communicating with nurses at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
d. Communicating with therapists (OT, PT) at (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
e. Communicating with the van drivers who take (participant) to and from (Day Health Center)	<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 (participant) <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 (participant) <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 (participant's) care	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	

	<u>No problem</u>	<u>Small problem</u>	<u>Serious problem or problems</u>	<u>Does not receive service</u>
2. (C1080) Services and help from (PACE site) staff				
a. Getting the medications and treatments that (participant) needs	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	
b. Getting the equipment (participant) 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 (PACE site) staff to help (participant) 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 (PACE site) staff to help (participant) do things while at (Day Health Center) (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	
3. (C1090) Other services at (Day Health Center)				
a. The meals (participant) has at (Day Health Center) or takes home from (Day Health Center)	<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 (Day Health Center)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
c. The safety of the (PACE site) vans that take (participant) to (Day Health Center) and back home	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
d. The timeliness of the (PACE site) transportation or vans	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - NA
4. (C1100) All things considered, how satisfied are you with the care (participant) has received over the past four months?				
<input type="checkbox"/> 0 - Very satisfied				
<input type="checkbox"/> 1 - Somewhat satisfied				
<input type="checkbox"/> 2 - Neither satisfied nor dissatisfied				
<input type="checkbox"/> 3 - Somewhat dissatisfied				
<input type="checkbox"/> 4 - Very dissatisfied				
5. (C1110) Would you recommend (PACE site) to your friend or family member?				
<input type="checkbox"/> 0 - No				
<input type="checkbox"/> 1 - Yes, probably				
<input type="checkbox"/> 2 - Yes, definitely				

END OF LIFE QUESTIONNAIRE ITEMS

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

____ month ____ day ____ year ____

2. (C1120) Caregiver's Relationship to Participant:

☐ 1 - Spouse

☐ 2 - Daughter or son

☐ 3 - Sister or brother

☐ 4 - Daughter-in-law or son-in-law

☐ 5 - Other relative

☐ 6 - Friend

☐ 7 - Guardian or other legal appointee (specify: _____)

☐ 8 - Other (specify: _____)

3. (C1130) Name of Informal Caregiver Responding to Questionnaire:

(Last)

(First)

(MI)

(Suffix) (optional)

4. (C1140) Caregiver Gender: ☐ 1 - Male ☐ 2 - Female

5. (C1150) Caregiver Ethnicity: Is the informal caregiver Hispanic or Latino (as identified by informal caregiver):

☐ 0 - No

☐ 1 - Yes

6. (C1160) Caregiver Race (as identified by informal caregiver):
(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 Pacific Islander

☐ 6 - White

☐ 7 - Other (specify): _____

7. (C1170) Where did the participant spend his/her last two weeks of life? (Mark all that apply.)

☐ 1 - His/her home living environment

☐ 2 - Hospital

☐ 3 - Nursing home

☐ 4 - Other (specify: _____)

Please answer the following questions considering the last two weeks of the participant's life.

8. **(C1180)** To what extent were the participant's wishes followed in the medical treatment he/she received during the last two weeks of life? Were they followed...
- ☐ 1 - A great deal
 - ☐ 2 - Very much
 - ☐ 3 - Moderately/somewhat
 - ☐ 4 - Very little
 - ☐ 5 - Not at all
 - ☐ UK - Unknown
9. **(C1190)** Do you feel that the **(PACE site)** staff should have done more to keep the participant free from pain?
- ☐ 0 - No
 - ☐ 1 - Yes, a little more
 - ☐ 2 - Yes, a lot more
10. **(C1200)** Were the **(PACE site)** staff open and forthcoming in communication with the participant and your family?
- ☐ 1 - Extremely
 - ☐ 2 - Moderately/somewhat
 - ☐ 3 - Not at all
11. **(C1210)** Were the **(PACE site)** staff sensitive, respectful, and compassionate?
- ☐ 1 - Extremely
 - ☐ 2 - Moderately/somewhat
 - ☐ 3 - Not at all
12. **(C1220)** Did the participant feel peaceful and ready to accept the end of life?
- ☐ 1 - Yes, definitely
 - ☐ 2 - For the most part
 - ☐ 3 - Sometimes, but not very often
 - ☐ 4 - No, not at all
13. **(C1230)** Did you feel peaceful and ready to accept the end of the participant's life?
- ☐ 1 - Yes, definitely
 - ☐ 2 - For the most part
 - ☐ 3 - Sometimes, but not very often
 - ☐ 4 - No, not at all
14. **(C1240)** How satisfied were you with the care the participant received from **(PACE site)** for illnesses during the last two weeks of the participant's life?
- ☐ 0 - Very satisfied
 - ☐ 1 - Somewhat satisfied
 - ☐ 2 - Neither satisfied, nor dissatisfied
 - ☐ 3 - Somewhat dissatisfied
 - ☐ 4 - Very dissatisfied

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]^a Type of Admission or Visit

- Type of Admission or Visit
- 1 - Acute care hospital
 - 2 - Nursing home (SNF/ICF)
 - 3 - Program transitional housing
 - 4 - Rehabilitation unit/facility
 - 5 - Psychiatric unit/facility
 - 6 - Hospice
 - 7 - Emergency department visit
 - 8 - Emergent physician visit

^b 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.

^c 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.

^d 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

^e 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.

^f 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

⁹ Nursing Home Admission Reason

- 1 - Therapy services
2 - Respite care
3 - Hospice care
4 - Permanent placement
5 - Unsafe for care at home
6 - Other
9 - Unknown