

Supplemental Core Comprehensive Assessment Data Items

DEMOGRAPHIC INFORMATION

D0050 1. Participant Address:

Street Address (include house/apt. number)

City State ZIP Code

County: _____

D0060 2. Participant Phone Number: (_____) _____ - _____ ext. _____

NA - Participant does not have telephone

D0170 3. Children (including stepchildren):

Name	Age	City of Residence	Notes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

D0180 4. Primary Contact Person:

a. Name: _____
(Last) (First) (MI) (Suffix)

Address: _____
Street Address (include house/apt. number)

City State ZIP Code

Phone Number: Day: (_____) _____ - _____

Eve: (_____) _____ - _____

Pager: (_____) _____ - _____ (optional)

E-mail address: _____ (optional)

b. Relationship to Participant:

- 1 - Spouse
- 2 - Daughter or son (including step)
- 3 - Daughter-in-law or son-in-law
- 4 - Sibling
- 5 - Other relative (specify): _____
- 6 - Friend
- 7 - Other (specify): _____

- c. Gender: 1 - Male
 2 - Female

d. Primary Languages Spoken: _____

- e. Interpreter Needed? 0 - No
 1 - Yes

D0190 5. Secondary Contact Person:

NA - No secondary contact person [**Go to Item ____**]

a. Name: _____
 (Last) (First) (MI) (Suffix)

Address: _____
 Street Address (include house/apt. number)

 City State ZIP Code

Phone Number: Day: (_____) _____ - _____

Eve: (_____) _____ - _____

Pager: (_____) _____ - _____ (optional)

E-mail address: _____ (optional)

b. Relationship to Participant:

- 1 - Spouse
 2 - Daughter or son (including step)
 3 - Daughter-in-law or son-in-law
 4 - Sibling
 5 - Other relative (specify): _____
 6 - Friend
 7 - Other (specify): _____

- c. Gender: 1 - Male
 2 - Female

d. Primary Languages Spoken: _____

- e. Interpreter Needed? 0 - No
 1 - Yes

D0200 6. Next of Kin/Closest Relative:

Same as primary or secondary contact person [**Go to Item ____**]

a. Name: _____
 (Last) (First) (MI) (Suffix)

Address: _____
 Street Address (include house/apt. number)

 City State ZIP Code

Phone Number: Day: (_____) _____ - _____

Eve: (_____) _____ - _____

Pager: (_____) _____ - _____ (optional)

E-mail address: _____ (optional)

D0165 13. **Additional Comments Regarding Participant History:**

D0450 14. **Cultural/Religious Affiliation:** Do you have any cultural or religious beliefs or practices that you think (PACE site) staff should know about?

- 0 – No
- 1 – Yes Describe: _____
- UA – This information could not be obtained due to participant's cognitive impairment

D0460 15. **Religious/Spiritual Affiliation:** _____

D0470 16. Do you participate in **Religious or Spiritual Activities/Services** as much as you would like?

- 0 - Yes, I participate as much as I would like
- 1 - Somewhat - I would like to be more involved
- 2 - No, I do not currently participate as much as I would like
- NA - I am not interested in participating in religious or spiritual activities/services
- UA - This information could not be obtained due to participant's cognitive impairment

INFORMAL SUPPORT

D0290 17. **Informal Caregiver Information:** List the three main individuals (family members, neighbors, friends, or other volunteers) providing **unpaid** care to help maintain the participant at home. This may include paid family members but no other paid care providers. Indicate who is the **primary** caregiver by checking the box. (Primary caregiver is defined as the individual taking **lead** responsibility for providing or managing the participant's care, providing the most frequent assistance, etc. [other than PACE program staff]). More than one person may share this role (if so, check Primary box for all who share primary responsibility).

- NA - No informal caregiver [Go to Item ____]

Caregiver 1 (Primary) Caregiver 2 (Primary) Caregiver 3 (Primary)

Name: _____

Telephone Number: _____

Age: _____

Lives w/Participant: 0 - No 1 - Yes 0 - No 1 - Yes 0 - No 1 - Yes

Notes (optional): _____

D0300 18. **Caregiver Relationship to Participant:**

	Caregiver 1	Caregiver 2	Caregiver 3
Spouse	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Daughter or son (including step)	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Daughter-in-law or son-in-law	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Sibling	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Other relative (specify)	<input type="checkbox"/> 5 _____	<input type="checkbox"/> 5 _____	<input type="checkbox"/> 5 _____
Friend	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
Other (specify)	<input type="checkbox"/> 7 _____	<input type="checkbox"/> 7 _____	<input type="checkbox"/> 7 _____

D0310 19. **Managing Care:**

a. Is there anything we need to know that makes it difficult for you to manage the care of (PARTICIPANT)?

- 0 - No
- 1 - Yes - Describe: _____

b. Would you like education or training to help you manage care of (PARTICIPANT)?

- 0 - No
- 1 - Yes - Describe: _____

c. How likely is it that you will continue to provide care to (PARTICIPANT)?

- 0 - Very likely
- 1 - Somewhat likely
- 2 - Unlikely

D0320 20. **Caregiver Willingness and Ability to Provide Care:**

a. **Motivated** to keep participant at home/in the community

- | | Caregiver 1 | Caregiver 2 | Caregiver 3 |
|---|---|---|---|
| <input type="checkbox"/> 0 - Not Motivated |
| <input type="checkbox"/> 1 - Somewhat Motivated |
| <input type="checkbox"/> 2 - Motivated |

b. **Physically Capable** of providing care

	Caregiver 1	Caregiver 2	Caregiver 3
<input type="checkbox"/> 0 - No			
<input type="checkbox"/> 1 - Yes			

c. **Emotionally Capable** of providing care

	Caregiver 1	Caregiver 2	Caregiver 3
<input type="checkbox"/> 0 - No			
<input type="checkbox"/> 1 - Yes			

Notes (optional): _____

HOME ENVIRONMENT/LIVING ARRANGEMENTS

D0350 21. **Sanitation Hazards** found in the participant's current place of residence: **(Mark all that apply.)**

Comments (if checked):

- 0 - None
- 1 - No running water
- 2 - Contaminated water
- 3 - No toileting facilities
- 4 - Outdoor toileting facilities only
- 5 - Inadequate sewage disposal
- 6 - Inadequate/improper food storage
- 7 - No food refrigeration
- 8 - No cooking facilities
- 9 - Insects/rodents present
- 10 - No scheduled trash pickup
- 11 - Cluttered/soiled living area
- 12 - Other (specify): _____

D0360 22. **Kitchen Safety:** Do you suspect the participant follows unsafe kitchen practices or has an unsafe kitchen environment?

- 0 - No
- 1 - Yes
- NA - Participant does not have access to cooking facilities

Notes (optional): _____

D0380 23. **Caregiver Knowledge of What to Do In An Emergency:**

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

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

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

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

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

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

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

D0705 24. **Additional Caregiver Comments/Concerns:** Are there any other issues or concerns you would like to discuss?

D0390 25. **Participant's Ability to Respond in an Emergency:** PROVIDER: Select the options that best apply to the participant, based on your judgment. **(Mark all that apply.)**

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

D0400 26. **Telephone Access:** Does the participant have home access to a working telephone?

- 0 - No telephone access
- 1 - Phone accessible in home, apartment, or room
- 2 - Phone accessible in central facility area but not in own room

Notes (optional): _____

D0410 27. **Pets in Home:** **(Mark all that apply.)**

- 0 - No pets [Go to Item ____]
- 1 - Cat(s)
- 2 - Dog(s)
- 3 - Bird(s)
- 4 - Other (specify): _____

c. Does **Pet Interfere** with participant's ability to maneuver around his/her living environment safely?

- 0 - No
- 1 - Yes (Explain): _____

b. Is **Pet(s) Important to Participant** (e.g., emotional attachment, companionship)?

- 0 - No
- 1 - Yes

d. Does participant **Properly Care for Pet(s)**?

- 0 - No (Explain): _____
- 1 - Yes
- NA - Someone else is responsible for care of pet(s)

Notes (e.g., number of each, pet names): _____

Notes (e.g., other concerns regarding pets, etc.): _____

D0375 28. **Ramp:** Is there a ramp between outside and inside of house/residence?

- 0 - No
- 1 - Yes

Notes (optional): _____

D0420 29. **Firearms in Home:**

- a. Are firearms kept in the home? 0 - No [**Go to Item ____**] 1 - Yes
- b. Are firearms securely locked? 0 - No 1 - Yes
- c. Is the ammunition stored and locked away separately? 0 - No 1 - Yes

Notes (e.g., safety concerns regarding firearms, etc.): _____

D0430 30. **Special Equipment/Assistive Devices:** Does the participant have or need any of the following special equipment or aids? **(Mark all that apply.)**

	Has and uses	Has, but does not use	Needs and does not have	Needs training	Ownership		
					Client	Rental	PACE Site
Prosthesis (type): _____							
Cane, crutches							
Walker (type): _____							
Wheelchair							
Brace (leg/back)							
Hearing aid							
Glasses							
Contact lenses							
Dentures							
Lifeline							
Hospital bed							
Bedside commode							
Bathing equipment							
Toilet equipment							
Transfer equipment							
Adaptive eating equipment							
Dressing/grooming aids							
Grab bars							
Side rails							
Trapeze							
Pressure relief devices							
Specialized mattress							
Oxygen equipment							
Orthotic positioning device							
Disposable medical supplies							
Other (specify): _____							
Other (specify): _____							

- NA - Participant does not have or need any special equipment/assistive devices.

Notes (optional): _____

PARTICIPANT QUALITY OF LIFE

D0440 31. **Participant Goals:** What goals do you have related to your health that we can help you with over the next few months?

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

D0480 32. **Social Activities:** How often during the past week did you attend a social, religious, or recreational activity at home or away from home? (Examples might include going to church or temple, to a party, out to dinner, watching a movie or play, or just getting together with friends or family.)

1 - Every day

2 - Several times during the week, but not every day (2-6 times)

3 - One time

4 - Not at all

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

D0535 33. **Participant's Current Activity Involvement at the Day Health Center: (Mark all that apply.)**

Arts/Crafts

Baking/Cooking

Bingo

Board Games

Bowling

Cards

Current Events

Educational

Exercise

Games

Gardening

Intergenerational

Manicures

Movies

Music/Singing

Newsletter

Newspaper

Nutrition Club

Outings

Participant Council

Parties (including birthday)

Picnics

Puzzles

Reading

Religious/Spiritual Activities

Reminiscing Discussion

Sewing

Social Hour

Sports

Trivia

T.V.

Walking Club

Word Games

Writing

Independent Activities _____

Other _____

None

Notes (optional): _____

D0510 34. **Participant Leisure Activities:** What leisure activities is the participant involved in outside the Day Health Center?

D0540 35. **Participant Preferences:** Does the participant prefer individual activities, doing activities with one other person, a few others, or doing activities with a large group (five or more other people)? **(Mark all that apply.)**

0 - Individual

1 - One other person

2 - Small group (two to four others)

3 - Large group (five or more others)

4 - No preference

Notes (optional): _____

D0550 36. Do you feel you spend **Enough Time Talking with or Interacting with Other Participants** at the Center?

0 - Fine as is

1 - I would like to spend more time with others

2 - I would like to spend less time with others

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

Notes (optional): _____

D0560 37. Do you **Like the Activities** you participate in at the Center?

0 - No Why not? _____

1 - Yes

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

- D0570** 38. Would you like to **Change your Activities** (for example, drop or add activities, change frequency of participation)?
- 0 - No
- 1 - Yes - Describe: _____
- UA - This information could not be obtained due to participant's cognitive impairment
- D0580** 39. Do you feel the participant would **Benefit by Increasing or Decreasing Involvement in Activities?**
- 0 - No, maintain current level of involvement
- 1 - Yes, increased involvement
- 2 - Yes, decreased involvement
- Explain: _____
- D0590** 40. Do you feel the participant would **Benefit from Increasing or Decreasing Interaction with Others** at the Center?
- 0 - No, maintain current level of interaction
- 1 - Yes, increased interaction
- 2 - Yes, decreased interaction
- Explain: _____
- D0660** 41. **Description of Family Relationships/Informal Support Systems** (Note if close, distant, hostile, domestic violence, alcohol or drug abuse, medical problems, etc.):
- D0620** 42. **Satisfaction with Living Situation:** How satisfied are you with where you live?
- | | | | | | |
|--------------------------|--------------------------|--|---------------------------|--------------------------|---|
| 0 – Very satisfied | 1 – Somewhat satisfied | 2 – Neither satisfied nor dissatisfied | 3 – Somewhat dissatisfied | 4 – Very dissatisfied | UA – This information could not be obtained due to participant's cognitive impairment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Notes (optional): _____
- D0630** 43. **Worry About Support:** Do you worry about getting the support and care you need?
- 0 - No
- 1 - Yes, I worry a little
- 2 - Yes, I worry a lot
- UA - This information could not be obtained due to participant's cognitive impairment
- Notes (optional): _____
- D0600** 44. Describe **Participant's Social Behavior** since the last assessment based on your and others' observations and interactions with the participant. **(Mark all that apply.)**
- | | |
|--|---|
| <input type="checkbox"/> 1 - Friendly, cooperative | <input type="checkbox"/> 9 - Passive |
| <input type="checkbox"/> 2 - Interacts with other participants | <input type="checkbox"/> 10 - Confused |
| <input type="checkbox"/> 3 - Interacts with staff | <input type="checkbox"/> 11 - Unable to initiate interactions/participation |
| <input type="checkbox"/> 4 - Initiates recreational programs independently | <input type="checkbox"/> 12 - Unmotivated |
| <input type="checkbox"/> 5 - Helps other participants (as able) | <input type="checkbox"/> 13 - Uncooperative |
| <input type="checkbox"/> 6 - Prefers keeping to self | <input type="checkbox"/> 14 - Antisocial, withdrawn, acts out, abusive |
| <input type="checkbox"/> 7 - Needs quiet space for activities | <input type="checkbox"/> 15 - Focuses on illness/other problems |
| <input type="checkbox"/> 8 - Willing to try | <input type="checkbox"/> 16 - Other (specify): _____ |
- Notes (optional): _____

D0670 45. **Provider Suspicion of Participant Abuse:** Based on your experience and interactions with the participant, is there reason to suspect any of the following? **(Mark all that apply.)**

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

Notes (optional): _____

PARTICIPANT SATISFACTION

D0710 46. **Participant Expectations of Program** for next assessment period (include days of Center attendance, services expected, relevant care plan issues): _____

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

CAREGIVER SATISFACTION

D0890 47. **Caregiver Expectations of Program** for next assessment period (include days of Center attendance, services expected, relevant care plan issues): _____

END OF LIFE

PROVIDER: Complete items ___ and ___ below based on discussion with the participant or the informal caregiver if the participant is unable to respond.

D0980 48. Does the participant have requests or **Wishes for his/her Health Care** that (PACE site) staff should know about?

- 0 - No
- 1 - Yes Describe: _____

PROVIDER: Ask the participant to respond to items ___ and ___ below.

D0990 49. **Participant/Caregiver Conflict:**

a. Have you discussed your Living Will, DNR Status, and/or other health care wishes with your family?

- 0 - No [**Go to Item ___**]
- 1 - Yes
- UA - This information could not be obtained due to participant's cognitive impairment [**Go to Item ___**]

b. Did they agree with your decisions?

- 0 - No. Please explain: _____
- 1 - Yes [**Go to Item d**]

c. Which family members disagree with your decisions?

- 1) Name: _____ Relationship: _____
- 2) Name: _____ Relationship: _____
- 3) Name: _____ Relationship: _____

d. Do you have objections to our discussing your wishes with your family?

- 0 - No
- 1 - Yes

Notes (optional): _____

D1000 50. Funeral Arrangements/Plans:

a. Do you have plans/wishes for funeral or burial/cremation arrangements?

- 0 - No [**Go to Item c**]
- 1 - Yes
- UA - This information could not be obtained due to participant's cognitive impairment [**Go to Item ____**]
- R - Participant refuses to discuss [**Go to Item ____**]

Notes (optional): _____

b. Have you expressed your plans/wishes to your family or friends?

- 0 - No
- 1 - Yes [**Go to Item ____**]

Notes (optional): _____

c. Would you like help with considering your plans/wishes and/or communicating them to your family or friends?

- 0 - No
- 1 - Yes

Notes (optional): _____

Advance Directives

D1010 51. Did the participant have specific wishes or plans about the types of medical treatment he/she wanted while dying?

- 0 - No [**Go to Item ____**]
- 1 - Yes
- UK - Unknown

D1020 52. Did a doctor or other care provider talk with you or the participant about these wishes?

- 0 - No
- 1 - Yes
- UK - Unknown

D1030 53. Did a doctor or other care provider make a plan with you or the participant that ensured that the participant's wishes for medical treatment were followed?

- 0 - No
- 1 - Yes
- UK - Unknown

D1050 54. During the last week of the participant's life, did he/she prefer a course of treatment that focused on extending life as much as possible, even if it meant more pain and discomfort, or on a course of treatment that focused on relieving pain and discomfort as much as possible, even if that meant not living as long?

- 1 - Extend life as much as possible
- 2 - Relieve pain or discomfort as much as possible
- UK - Unknown

Pain and Symptom Management

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

D1070 55. Was there any time that members of the program staff did not do everything they could to help control the participant's pain?

- 0 - No, never
- 1 - Yes, a few times
- 2 - Yes, many times
- NA - The participant had no pain or refused pain medication [**Go to Item ____**]

D1080 56. Did the participant ever have to wait too long to receive pain medication?

- 0 - No, never
- 1 - Yes, a few times
- 2 - Yes, many times

- D1100** 57. For symptoms other than pain, for example shortness of breath or nausea, do you feel that the program staff should have done more to keep the participant comfortable?
- 0 - No
 - 1 - Yes, a little more
 - 2 - Yes, a lot more
 - NA - The participant had no symptoms other than pain
- D1110** 58. Taking into account medications or other types of assistance provided to the participant during the last week of life, how severe were pain and other symptoms he/she experienced?
- 0 - Not at all severe
 - 1 - Not very severe
 - 2 - Somewhat severe
 - 3 - Very severe
- D1120** 59. In the last week of life, did the participant take pain medications?
- 0 - No, he/she refused pain medication
 - 1 - No, due to reasons other than refusal
 - 2 - Yes
- D1130** 60. How difficult were the emotional symptoms and problems he/she experienced in the last week of life?
- 0 - Not at all difficult
 - 1 - Not very difficult
 - 2 - Somewhat difficult
 - 3 - Very difficult

COGNITIVE STATUS

- D1140** 61. **Recent Memory:**
- a. Does the participant remember events from one day to the next (for example, visits by family members or participation in recreational events)?
- 0 - No
 - 1 - Yes
- b. Is the participant able to remember when to take medications?
- 0 - No
 - 1 - Yes
- D1150** 62. **Remote Memory:**
- a. Ask participant the following personally relevant verifiable questions:
- What is your birthplace? _____
- What was your first job? _____
- What is your date of birth? _____
- b. Based upon responses to **item a**, rate remote memory level.
- 0 - Good
 - 1 - Moderately impaired
 - 2 - Severely impaired
- D1160** 63. **Ability to Sustain Attention:** Assess the participant's ability to sustain attention during structured and unstructured activity.
- a. Structured Activity (recreation, self-care, daily household activities)
- 0 - Independent – requires no cues or redirection to task
 - 1 - Supervised – requires occasional verbal cues to redirect attention to task appropriately
 - 2 - Assisted – requires consistent verbal and/or tactile cues to maintain attention to task
 - 3 - Unable – unable to sustain attention sufficiently to be productive in most minimal sense
- b. Unstructured Activity (free conversation, free time)
- 0 - Independent – requires no cues or redirection to task
 - 1 - Supervised – requires occasional verbal cues to redirect attention to task appropriately
 - 2 - Assisted – requires consistent verbal and/or tactile cues to maintain attention to task
 - 3 - Unable – unable to sustain attention sufficiently to be productive in most minimal sense

Notes (optional): _____

D1170 64. Reasoning:

- a. Abstract Reasoning (Ask participant to respond to the following question.)

What would you do if your home caught on fire while you were there? (Prompt participant for explanation of response, how he/she came to the conclusion.)

Describe response: _____

- b. Reasoning Skills (as observed in daily functioning at the Day Health Center)

- 0 - Excellent Reasoning - able to apply reasoning skills appropriately throughout the day.
 1 - Slightly Impaired - occasionally exhibits lapses in reasoning, requiring redirection.
 2 - Impaired - frequently exhibits lapses in reasoning, requiring redirection.

D1190 65. Awareness of Own Needs: Identify the participant's level of understanding of his/her needs relating to health, safety, and welfare.

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

D1200 66. Behavioral Dyscontrol Scale (BDS): Rate the participant's performance in response to the instructions below.

Instructions to Interviewer: (Read aloud statements in bold face to participant.)

I want you to tap twice with your right hand and once with your left like this. Demonstrate on table top or other surface. **Keep going until I tell you to stop.** Give participant 3-5 practice trials. **Now try to go as fast as you can.** Keep track of participant's performance for 10 consecutive repetitions. (If the participant is left-handed, alter the instructions to tap twice with left hand and once with right.)

- a. Tap twice with the right hand and once with the left in a series. (10 repetitions after allowing practice.)

- 3 - Learned quickly and *performed rapidly* with no errors
 2 - Smooth but slower performance with no errors, *or* faster performance with no more than two errors
 1 - Three or four perseverative errors, *or* poor timing and slow, effortful performance with fewer errors
 0 - Poor performance, five or more errors

Instructions to Interviewer: (Read aloud statements in bold face to participant.)

Take the participant's dominant hand as though shaking hands. **I want you to take my hand, and if I say "red," squeeze my hand like this.** Demonstrate a quick, light squeeze. **If I say "green," don't do anything.** Allow the participant to practice a few times, giving the stimulus ("red" and "green") in random order at a rate of about 1 per second. If the participant delays before squeezing on red, encourage him or her to squeeze more quickly. If the participant holds the squeeze for more than a very brief time (> 0.5 second), demonstrate a quick squeeze once again and ask the participant to perform the activity quickly and briefly. During practice, make sure the participant has the right idea, correcting mistakes if he or she seems not to understand the task. After enough practice to determine that the participant understands the task, begin keeping track of errors for 15 repetitions. In randomizing the order of stimuli, it is good to mix alternating stimuli with several consecutive repetitions of either *red* or *green*. For example: **red red green red green red green green green red green red red green red.**

- b. If I say "red," squeeze my hand. If I say "green," do nothing. (15 repetitions)

- 3 - Rapid responses to verbal stimuli with no errors
 2 - Slower responses to verbal stimuli and no errors, *or* rapid responses and no more than one error
 1 - Two to four errors, including self-corrected errors
 0 - More than four errors of either inhibition or initiation

Instructions to Interviewer: (Read aloud statements in bold face to participant.)

I am going to tap on the table. If I tap two times, you tap once. If I tap one time, you tap twice. Do the opposite of what I do. Do you understand? Allow the participant to practice a few times, giving the stimulus in random order at a rate of about 1 per second. As soon as the participant has responded, give a new stimulus. If the participant delays before responding, encourage him or her to tap more quickly. During practice, make sure the participant has the right idea, correcting mistakes if he or she seems not to understand the task. After enough practice to determine that the task is understood, begin counting errors for 10 repetitions of the task.

- c. If I tap twice, you tap once. If I tap once, you tap twice. (10 repetitions)

- 3 - Rapid responses to stimuli with no errors
 2 - Rapid responses to stimuli with one error, *or* slow responses and no errors
 1 - Two or three errors
 0 - More than three errors

Instructions to Interviewer: (Read aloud statements in bold face to participant.)

Now I'd like you to watch me, and make the same hand movements I make. The examiner should ask the participant to use the dominant hand, and demonstrate the movements, performing them along with the participant. **First make a fist, like this.** Place the fist with knuckles on the table, as though knocking on a door. **Now put your hand on the edge, like this.** Place the edge of the hand, with fingers extended, on the table. **Now put your palm flat on the table, like this.** Place the palm down on table, fingers extended and together. **Now do that with me a few times.** Slowly at first (about one movement per second, or less if necessary for the particular participant), the examiner should cue the participant verbally while performing the movements himself or herself. **Fist ... Edge ... Palm ... Fist ... Edge ... Palm.** Continue for 2-5 trials to make sure participant has the idea. Then the examiner should ask the participant to say the words while the participant and examiner perform the task together. **Now we'll keep doing it together, but you say the words as we do it.** The examiner should let the participant cue himself or herself aloud, while simultaneously performing the movements, for 2-3 trials. **Now do it by yourself. Keep saying the words.** Allow the participant to perform the task independently from this point on. Occasional coaching is permissible, but must be taken into consideration when scoring. As (or if) the participant improves, ask him or her to speed up. **Now go as fast as you can, without saying anything. You might make some errors, but that's okay. Just try to go as fast as you are able to go.**

d. Fist - Edge - Palm

- 3 - Rapid performance with no errors or hesitancy. Movements quickly becoming automatic.
- 2 - Learns task with only a few errors. Movements becoming relatively automatic with practice.
- 1 - Difficulty in learning the task. Makes many errors (even if self-corrected), or best performance remains deliberate and effortful, never automatic.
- 0 - Failure to learn the task, no improvement following practice without the examiner as a model.

D1220 67. **Awareness of Illness:** (Ask participant.) If you have any medical conditions, please tell me what you know about them.

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

D1230 68. **Speech:** 1 - Slurred 2 - Slow 3 - WNL 4 - Other (specify): _____

Notes (optional): _____

PHYSIOLOGIC STATUS & SYMPTOM MANAGMENT

D1320 69. **Participant's Current Health Concerns:**

- 0 - None stated
- 1 - Yes (specify): _____

D1330 70. **Allergies: (Mark all that apply.)**

- 1 - Drug related (specify): _____
- 2 - Food related (specify): _____
- 3 - Environmental (specify): _____
- 4 - Seasonal (specify): _____
- 5 - None

D1340 71. **Medications**

a. **Medication Allergies:** Does the participant have allergies to any medications?

- 0 - No
- 1 - Yes - Which medications? _____

Notes (optional): _____

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

- 1 - Participant administers medications to himself/herself
- 2 - A family member or other nonpaid caregiver - Name of caregiver: _____
- 3 - A PACE staff member
- 4 - A paid provider who is not affiliated with PACE

c. Does the participant use a medipak provided by (PACE site)?

- 0 - No
- 1 - Yes

Notes (optional): _____

d. Does the participant use illicit drugs?

- 0 - No
- 1 - Yes

Notes (optional): _____

e. PROVIDER: Do you have any concerns regarding use of medications or drugs by the participant?

- 0 - No
- 1 - Yes

If yes, what concerns: _____

f. Information recorded in the following tables obtained from: **(Mark all that apply.)**

- 1 - Participant
- 2 - Informal caregiver - Name: _____
- 3 - Other (specify): _____

Prescription Medications

Prescription Medications	Associated Diagnosis	Dosage	Frequency	Type of reminder, if any.	Does participant/caregiver know how to administer and purpose of each medication?		Are participant's medications being administered as prescribed?		If not taking, reason given.	Comments
					Yes	No	Yes	No		
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										

Over-the-Counter Medications

Over-the-Counter Medications	Associated Diagnosis	Dosage	Frequency	Type of reminder, if any.	Does participant/caregiver know how to administer and purpose of each medication?		Are participant's medications being administered as prescribed?		Comments
					Yes	No	Yes	No	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Other Medications

Herbal Medications/Preparations	Dosage	Frequency	Comments
1.			
2.			
3.			
4.			
5.			
6.			

Home Remedies	Dosage	Frequency	Comments
1.			
2.			
3.			
4.			
5.			
6.			

D1350 72. Tobacco Use/Abuse:

- a. Does participant currently smoke or chew tobacco?
 0 - No [**Go to Item ____**]
 1 - Yes (**Mark all that apply.**)
 1 - Smokes 2 - Chews
- b. How much does participant smoke/chew tobacco in an average day? _____
- c. For how many years has participant smoked/chewed tobacco?

- d. Would participant consider decreasing or stopping smoking/chewing?
 0 - No 1 - Yes

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

- 0 - No 1 - Yes

Notes regarding safety concerns, etc. (optional): _____

[**Go to Item ____**]

f. Has participant ever smoked or chewed tobacco?

- 0 - No 1 - Yes

For how many years? _____

Approximate date stopped: _____

D1360 73. Alcohol Use/Abuse: Ask participant about use of alcoholic beverages during the past year (at reassessment: since the last assessment). Explain what is meant by alcoholic beverages (i.e., beer, wine, liquor [vodka, whiskey, brandy, etc.]).

- a. How often do you have a drink containing alcohol?
 0 - Never [**Go to Item c**]
 1 - Monthly or less
 2 - Two to four times a month
 3 - Two to three times a week
 4 - Four or more times a week
 UA - Participant was asked this question and was unable to answer due to cognitive impairment
- b. How many drinks containing alcohol do you have on a typical day when you are drinking?
 0 - One or two
 1 - Three or four
 2 - Five or six
 3 - Seven to nine
 4 - Ten or more
 UA - Participant was asked this question and was unable to answer due to cognitive impairment
- c. PROVIDER: Do you suspect the participant may have a problem with alcohol dependency or abuse?
 0 - No 1 - Yes - Describe: _____
- d. Any history of abuse of alcoholic beverages:
 0 - No 1 - Yes - Describe: _____

D1370 74. Medical History: Interval Medical History/Significant Changes in Past Several Months: _____

D1390 75. Appearance: Describe participant's general appearance. (**Mark all that apply.**)

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

Comments (consider posture, clothes, grooming, hair, nails): _____

D1400 76a. Personal Hygiene Affecting Socialization: Does the participant's personal hygiene have a negative impact on his/her social interaction with others (e.g., others avoid talking to or spending time with participant because of skin hygiene, scalp problems, bad breath, etc.)?

0 - No 1 - Yes

Notes (optional): _____

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

0 - No 1 - Yes

D1420 77. Weight Gained/Lost since last assessment:

Gained: _____ lbs. OR _____ kg.

Lost: _____ lbs. OR _____ kg.

Notes (optional): _____

D1430 78. Vital Signs:

Temp _____ Pulse _____

B/P _____ R / L (*circle*)

AP _____ Reg / Irreg

Sit _____

Resp _____ Reg / Irreg

Lie (initial) _____

Stand (initial) _____

D1440 79. Exercise/Activity Level: Describe participant's usual level of activity or exercise. For example, does he/she walk often, do household tasks, participate in swimming or exercise class, or do other activities that require physical exertion?

D1460 80. Chest Pains: Has the participant experienced chest pain since the last assessment?

0 - No [**Go to Item ____**]

1 - Yes

Describe: _____

Location: _____

Frequency: _____

When Occurs: _____

Duration: _____

Severity: Ask participant to rate on a scale of 1-10 where 10 is the worst pain of your life (**circle one number**).

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

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

D1480 81. Pulses:

INITIAL ASSESSMENT:

EXAMINATION	NORM.	ABN.	NOT EXAM.	FINDINGS (Description/Measurement)
PERIPHERAL VESSELS				
Carotids: (R) (L)				
Brachial: (R) (L)				
Radial: (R) (L)				
Femorals: (R) (L)				
Popliteals: (R) (L)				
DPs: (R) (L)				
PTs: (R) (L)				

REASSESSMENT:				
EXAMINATION	NORM.	ABN.	NOT EXAM.	FINDINGS (Description/Measurement)
PERIPHERAL VESSELS				
DPs: (R) (L)				
PTs: (R) (L)				

D1490 82. Lung Sounds: (Mark all that apply.)

- Right: Clear Rhonchi Crackles Diminished Wheezing
 Left: Clear Rhonchi Crackles Diminished Wheezing

Notes (optional): _____

D1510 83. Cough: Does the participant have a cough?

- 0 - No [**Go to Item ____**]
 1 - Yes - Describe: _____

Productive? 0 - No
 1 - Yes - Describe: _____

Duration: _____

D1520 84. Are you experiencing any difficulties or issues related to **Sexuality or Sexual Activity that you would like to discuss?**

- 0 - No
 1 - Yes
 UA - Participant was asked this question and was unable to answer due to cognitive impairment

Notes (optional): _____

D1530 85. Bowel Function:

a. Frequency of BM (times a day): _____

- b. Diarrhea or Watery: 0 - No 1 - Yes

Notes (optional): _____

- c. Constipated: 0 - No 1 - Yes

Notes (optional): _____

- d. Change in Bowel Habits: 0 - No 1 - Yes

Describe: _____

- e. Use of Laxatives: 0 - No 1 - Yes

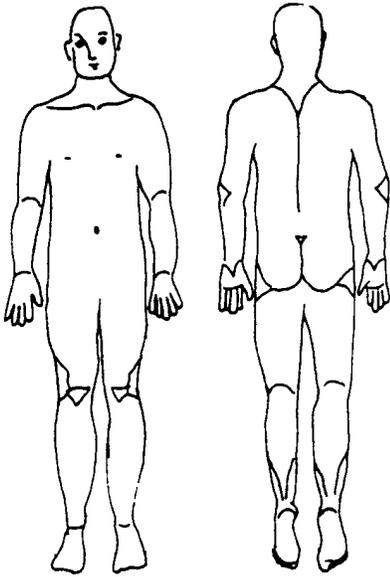
Notes (optional): _____

D1550 86. Urinary Problems: (Mark all that apply.)

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

Notes (optional): _____

D1560 87. Skin Condition: For each type of condition present, record type number on body area where located. Provide size and description to right of numbered category. (Mark all that apply.)



Type	Size	Description
<input type="checkbox"/> 0 - None		
<input type="checkbox"/> 1 - Lesions (including age spots)		
<input type="checkbox"/> 2 - Bruises		
<input type="checkbox"/> 3 - Masses		
<input type="checkbox"/> 4 - Scars		
<input type="checkbox"/> 5 - Stasis Ulcers		
<input type="checkbox"/> 6 - Pressure Ulcers		
<input type="checkbox"/> 7 - Incisions		
<input type="checkbox"/> 8 - Other (specify)		

D1570 88. Skin:

- Color 1 - Normal 2 - Pale 3 - Jaundice 4 - Rash 5 - Dusky
 Temp 1 - Warm 2 - Cool 3 - Cold
 Condition 1 - Dry 2 - Diaphoretic 3 - Clammy

Notes (optional): _____

D1620 89a. Oral Status and Disease Prevention: (Mark all that apply.)

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

Notes (optional): _____

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

- 0 - No
- 1 - Yes

D1650 90a. Pain Interfering with Daily Activities (Participant Response): In the past week, how often has pain gotten in the way of your normal routine? (NOTE: If participant states level of pain has changed in past week, answer should be based on the most recent level of pain.)

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

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

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

D1670 91. Caregiver Observed Pain Interfering with Daily Activities: In the past week, how often has pain gotten in the way of (**participant's**) normal routine? (NOTE: If [PARTICIPANT'S] level of pain has changed in the past week, answer should be based on the most recent level of pain.)

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

D1630 92. Pain Experienced by Participant:

a. Location: _____
 Type: _____
 Positions/activities that aggravate pain: _____

 Position/activities that alleviate pain: _____
 Can pain be controlled by pain medication?
 0 - No
 1 - Yes - Which pain medication(s): _____
 Notes: _____

b. Location: _____
 Type: _____
 Positions/activities that aggravate pain: _____

 Position/activities that alleviate pain: _____
 Can pain be controlled by pain medication?
 0 - No
 1 - Yes - Which pain medication(s): _____
 Notes: _____

D1680 93. Physical Symptoms Other Than Pain:

- | | <u>None</u> | <u>A Little</u> | <u>A Lot</u> | |
|---|----------------------------|----------------------------------|-----------------------------------|---|
| a. How much energy do you have? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | |
| b. How much appetite do you have? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | |
| c. How much nausea do you experience? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | |
| d. How much mouth soreness do you experience? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | |
| | <u>Never</u> | <u>One Time
in Past Week</u> | <u>2-6 Times
in Past Week</u> | <u>At Least Once a Day
in Past Week</u> |
| e. In the past week, how often have you had insomnia (sleeplessness)? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. In the past week, how often have you vomited? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. In the past week, how often have you been constipated? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. In the past week, how often have you had swelling of feet or legs? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| | <u>Never</u> | <u>Once a Day</u> | <u>Several
Times a Day</u> | <u>Most of the Time</u> |
| i. On a typical day in the past week, how often did you feel short of breath? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| j. On a typical day in the past week, how often did you cough? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
- UA - This information could not be obtained due to participant's cognitive impairment

D1690 94. Sleep Behaviors:

Sleep pattern: Bedtime: _____ Wake-up time: _____ Naps: _____
 Use of sleep aid: _____
 Difficulties (e.g., difficulty getting to sleep, waking during night): _____

 Excessive daytime fatigue: _____
 Other: _____

D1720 95. **Joint Deformity and Stiffness:** Check if present for each joint (right and left) and describe if present.

Joint	R	Describe	L	Describe
Shoulder				
Neck				
Elbow				
Wrist				
Fingers				
Back				
Hip				
Knee				
Ankle				
Toes				

D1700 96. **Spinal Impairment/Posture:**

	WFL	Describe Impairment
Cervical spine	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes	
Thoracic spine	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes	
Lumbar spine	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes	

D1710 97a. **Extremity Strength:**

	Upper Extremity Strength	
	Grade	
	R	L
<u>Shoulder</u>		
Flexion		
Abduction		
<u>Elbow</u>		
Flexion		
Extension		
<u>Wrist</u>		
Flexion		
Extension		
<u>Grip</u>		
Strong =0		
Weak =1		

	Lower Extremity Strength	
	Grade	
	R	L
<u>Hip</u>		
Flexion		
Abduction		
Extension		
Adduction		
<u>Knee</u>		
Flexion		
Extension		
<u>Ankle</u>		
Plantar Flexion		
Dorsiflexion		

Use grading scale below for Upper and Lower Extremity Strength.

Grade	Description	Percent Normal	Assessment
5	Full ROM against gravity, full resistance	100	Normal
4	Full ROM against gravity, some resistance	75	Good
3	Full ROM with gravity	50	Fair
2	Full ROM with gravity eliminated (passive motion)	25	Poor
1	Slight contraction	10	Trace
0	No contraction	0	Zero

ROM = range of motion.

b. **Range of Motion:** Indicate whether the participant has **Range of Motion Within Functional Limits (0)** or **Limited Range of Motion (1)** for each area below.

Upper Extremities	AROM		PROM		Comments
	R	L	R	L	
Cervical					
Shoulder					
Elbow					
Wrist					
Fingers					
Thumb					

Notes (optional): _____

Lower Extremities	AROM		PROM		Comments
	L	R	L	R	
Lumbar					
Hip					
Int. Rotators					
Ext. Rotators					
Knee					
Ankle					
Toe					

Notes (optional): _____

D1730 98. Fall Risk: (Mark all factors below that apply to participant.)

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

D1770 99. Nutritional Risk: Circle the item scores that best represent the participant's status.

<u>Risk Factors</u>	<u>Score</u>
<i>Unintentional</i> weight loss	
If >10% of usual weight in 3 months	5
Percentage of IBW:	
10-15% below	3
>15% below	5
20-30% over.....	1
>30% over.....	2
Albumin (within yr) 3.0-3.4 gm/dL	3
<3.0 gm/dL.....	4
Tube feeding	2
Impaired skin integrity	
Stage 1	1
Stage 2	2
Stage 3	6
Stage 4	7
<hr/>	
Identified swallowing problem	3
Oral/dental problem contributing to inability to eat.....	1
Uncontrolled Diabetes Mellitus	3
(CBG consistently over 250mg/dL or wide fluctuations in readings)	
<hr/>	
Living independently - unable to meet nutritional needs (meal planning, shopping, cooking).....	2
<hr/>	
Increased nutritional needs (due to acute illness, deconditioning/hospitalization, etc.).....	3
<hr/>	
Consistently inadequate P.O. intake (<50% over one month)	2
<hr/>	
TOTAL SCORE (add up item scores): _____	
11 or above = High Risk	
6-10 = Moderate Risk	
3-5 = Low Risk	
0-2 = Stable Nutritional Status	

D1750 100. Typical Diet: (Ask participant or informal caregiver if participant is unable to respond due to cognitive impairment.) Describe what you usually eat and drink during a typical day (including snacks and food on weekends):

Breakfast: _____

A.M. Snack: _____

Lunch: _____

Aft. Snack: _____

Dinner: _____

P.M. Snack: _____

D1740 101. Special Diet: Indicate type of special diet recommended for or followed by the participant. **(Mark all that apply.)**

	Check if Health Care Provider recommended	<u>Comments</u>
<input type="checkbox"/> 0 - No special diet	<input type="checkbox"/>	_____
<input type="checkbox"/> 1 - Tube feeding (type): _____	<input type="checkbox"/>	_____
<input type="checkbox"/> 2 - Low sodium (salt)	<input type="checkbox"/>	_____
<input type="checkbox"/> 3 - Low sugar	<input type="checkbox"/>	_____
<input type="checkbox"/> 4 - Low fat/cholesterol	<input type="checkbox"/>	_____
<input type="checkbox"/> 5 - Renal	<input type="checkbox"/>	_____
<input type="checkbox"/> 6 - Lactose intolerant	<input type="checkbox"/>	_____
<input type="checkbox"/> 7 - Calorie controlled	<input type="checkbox"/>	_____
<input type="checkbox"/> 8 - Nutrition supplements	<input type="checkbox"/>	_____
<input type="checkbox"/> 9 - Six small meals daily	<input type="checkbox"/>	_____
<input type="checkbox"/> 10 - Ground	<input type="checkbox"/>	_____
<input type="checkbox"/> 11 - Soft	<input type="checkbox"/>	_____
<input type="checkbox"/> 12 - Thickened Liquids	<input type="checkbox"/>	_____
<input type="checkbox"/> 13 - Pureed	<input type="checkbox"/>	_____
<input type="checkbox"/> 14 - Vegetarian	<input type="checkbox"/>	_____
<input type="checkbox"/> 15 - Ethnic/religious	<input type="checkbox"/>	_____
<input type="checkbox"/> 16 - Other (specify): _____	<input type="checkbox"/>	_____

Notes (optional): _____

D1780 102. **Restraints:** Have physical restraints been used on the participant since the last assessment?

- 0 - No
- 1 - Yes [Specify frequency, type, and reason below.]

Frequency of use: _____

Type: _____ Reason: _____

Notes (optional): _____

FUNCTIONAL STATUS

D1790 103a. Has the **Participant Moved** (i.e., changed living environment) since the last assessment?

- 0 - No [If No, go to Item ____]
- 1 - Yes

b. Did participant move for the **Purpose of Changing the Level of Supervision or Assistance**?

- 0 - No, move was due to reason(s) other than changing the level of supervision or assistance [Go to Item c]
- 1 - Yes, purpose of move was to increase level of supervision or assistance [Go to Item ____]
- 2 - Yes, purpose of move was to decrease level of supervision or assistance [Go to Item ____]

c. **Reason for Move if Not to Change Level of Supervision or Assistance:**

104./105. **Tinetti Balance and Gait Evaluation:**

- NA - Participant cannot stand or walk due to paralysis or other reason - specify reason: _____ [Go to Item ____]

D1800 **Balance** (Instructions: Participant is seated in hard, armless chair. The following maneuvers are tested.)

Note below if done with or without walking aid:

- 0 - No walking aid used
- 1 - Walking aid used

- a. Sitting Balance Leans or slides in chair = 0
Steady, safe = 1 _____
- b. Attempts to arise Unable without help = 0
Able, but requires more than 1 attempt = 1
Able to arise with 1 attempt = 2 _____
- c. Arises (score of 1 if slides forward in chair to edge of seat) Unable without help = 0
Able, but uses arms to help = 1
Able without use of arms = 2 _____
- d. Immediate Standing Balance (First 5 seconds) (make sure participant is not leaning against chair) Unsteady (staggers, moves feet, marked trunk sway) = 0
Steady, but uses walker or cane or grabs objects for support = 1
Steady without walker, cane or other support = 2 _____
- e. Standing Balance (ask participant if they can put feet together; score of 1 if they cannot put feet together) Unsteady = 0
Steady, but wide stance (Medial heels more than four inches apart)
or uses cane, walker, or other support = 1
Narrow stance without support = 2 _____
- f. Nudged (participant at maximum position with feet as close together as possible, examiner pushes lightly on participant's sternum with palm of hand three times) (score of 1 if participant moves feet) Begins to fall = 0
Staggers, grabs but catches self = 1
Steady = 2 _____
- g. Eyes Closed (at maximum position #6) (score of 0 if participant sways) Unsteady = 0
Steady = 1 _____
- h. Turning 360 Degrees (score of 0 if participant uses walker) Discontinuous steps = 0
Continuous = 1
Unsteady (grabs, staggers) = 0
Steady = 1 _____

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

D1940 107. Heavy Chores: Performance (what the participant actually does) and ability (what the participant is capable of doing) to SAFELY do heavy tasks such as washing windows, home repairs, yard work, lawn mowing and shoveling snow.

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

Notes (optional): _____

D1980 108a. Management of Inhalant/Mist Medications: Performance (what the participant actually does) and ability (what the participant is capable of doing) to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes oral, injectable, and IV medications.**

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

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

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

EMOTIONAL/MENTAL HEALTH STATUS

D2020 113a. Chronic Mental/Emotional Condition: Is there a history of any of the following (include currently inactive conditions)? **(Mark all that apply.)**

- 1 - Schizophrenia
- 2 - Major depression
- 3 - Mania/bipolar
- 4 - Personality disorder (specify): _____
- 5 - Other (specify): _____
- 6 - None of the above
- UK - Unknown

b. **Acute Mental/Emotional Condition:** Is there current behavioral or emotional evidence that the participant has any of the following? **(Mark all that apply.)**

- 1 - Schizophrenia or paraphrenia
- 2 - Psychotic depression
- 3 - Mania/bipolar
- 4 - Significant emotional instability or volatility
- 5 - None of the above

Notes (optional): _____

D2030 114. Interval Mental Health History (e.g., mental health hospitalizations, treatments, relevant family history, dementia):

D2040 115. Mood (Dominant Feeling State): Ask participant to describe his/her mood over the past week. **(Mark all that apply.)**

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

Notes (optional): _____

D2050 116. Provider Perceived Affect: Participant's affect appears to be: **(Mark all that apply.)**

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

Notes (optional): _____

D2060 117. Severity of Anxiety experienced by participant (record the most severe level experienced) **(Reported or Observed):**

- 1 - Mild (experienced slight nervousness/apprehension)
- 2 - Moderate (experienced a significant amount of nervousness/apprehension)
- 3 - Severe (experienced overwhelming nervousness/apprehension)

Notes (optional): _____

D2070 118. Geriatric Depression Scale: (Ask participant.) The next questions are about how you have felt over the past week. Please answer yes or no to each question.

- a. Are you basically satisfied with your life? 0 – No* 1 – Yes
- b. Have you dropped many of your activities and interests? 0 – No 1 – Yes*
- c. Do you feel that your life is empty? 0 – No 1 – Yes*
- d. Do you often get bored? 0 – No 1 – Yes*
- e. Are you in good spirits most of the time? 0 – No* 1 – Yes
- f. Are you afraid that something bad is going to happen to you? 0 – No 1 – Yes*
- g. Do you feel happy most of the time? 0 – No* 1 – Yes
- h. Do you often feel helpless? 0 – No 1 – Yes*
- i. Do you prefer to stay at home, rather than going out and doing new things? 0 – No 1 – Yes*
- j. Do you feel you have more problems with memory than most? 0 – No 1 – Yes*
- k. Do you think it is wonderful to be alive now? 0 – No* 1 – Yes
- l. Do you feel pretty worthless the way you are now? 0 – No 1 – Yes*
- m. Do you feel full of energy? 0 – No* 1 – Yes
- n. Do you feel that your situation is hopeless? 0 – No 1 – Yes*
- o. Do you think that most people are better off than you are? 0 – No 1 – Yes*

Score: _____ (number of "depressed" [denoted by asterisk] answers)

- 1-4 No cause for concern
- 5-9 Strong probability of depression
- 10+ Indicative of depression

Five or more depressed responses warrants further evaluation.

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

Notes (optional): _____

D2085 119. Caregiver Observed Depression or Depressive Symptoms: Which of the following have you observed in (PARTICIPANT) in the past week? (Mark all that apply.)

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

KNOWLEDGE AND ADHERENCE

D2130 120a. Responsibility for Participant Medications: Indicate who is routinely responsible for administering medications to the participant. (Mark all that apply.)

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

PROVIDER: Ask the participant to respond to item b.

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

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

PROVIDER: Ask the informal caregiver identified as responsible for the participant's medications to respond to Items c to e below.

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

- 0 - No [Go to Item ____]
- 1 - Yes

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

- 0 - No
- 1 - Yes

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

- 0 - No
- 1 - Yes (Explain reasons): _____
- UK - Unknown

