

APPENDIX 3B

RELIABILITY TEST VERSION OF THE COCOA DATA SET

The reliability test version of the COCOA data set presented in this appendix consisted of 242 data items, organized into the same six discipline-specific forms (Primary Care Provider, Nursing, Social Work, Recreational Therapy, Rehabilitation Therapy, and Dietitian) and five content-specific forms (Intake Form, Home Environment Assessment Form, Participant Satisfaction Questionnaire, Caregiver Satisfaction Questionnaire, and Utilization Form) used in the feasibility test. After careful consideration, the End of Life Questionnaire was not included in the reliability test due to the subject matter of the questionnaire and the data collection protocols (the questionnaire is mailed to informal caregivers of deceased participants).

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

**DRAFT COCOA DATA SET
PRIMARY CARE PROVIDER FORM**

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

for:

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0791. The time required to complete this information collection is estimated to vary from 23 to 25 minutes with an average of 24 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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

FIRST PHASE RELIABILITY TEST DRAFT PRIMARY CARE PROVIDER FORM

1. **Participant Name:** _____ (Last) _____ (First) _____ (MI) _____ (Suffix)

2. **Date Assessment Completed:** ____ / ____ / ____
month day year

3. **Reason for Assessment:**

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

4. **Staff Member Completing Assessment (Name):** _____ (Last) _____ (First)

5. **Participant's Current Health Concerns:**

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

6. **Medical History:** Interval Medical History/Significant Changes in Past Several Months: _____

7. **Allergies: (Mark all that apply.)**

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

8. **Tobacco Use/Abuse:**

a. Does participant currently smoke or chew tobacco? **(Mark all that apply.)**

- 0 - Does not currently smoke or chew tobacco [Go to Item f]
- 1 - Yes, smokes
- 2 - Yes, 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 or other staff concerned about the participant being a careless smoker?

- 0 - No
- 1 - Yes Concerns: _____

[Go to item 9]

f. Has participant ever smoked or chewed tobacco?

- 0 - No
- 1 - Yes

For how many years? _____

Approximate date stopped: _____

Notes (optional): _____

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

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: _____

10. **Pain Experienced by Participant:** NA - No pain [Go to Item 13d]

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: _____

11. **Pain Rating:** 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)

12. **Provider Assessment of Participant Pain:** PROVIDER: If participant has pain in multiple locations, respond to items for the most severe or interfering pain.

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

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

- 1 - Pain does not get in the way of normal routine
- 2 - At times, but not every day
- 3 - Every day, but not constantly
- 4 - All of the time

b. **Frequency of Pain:**

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

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

- 0 - No
- 1 - Yes

13. **Satisfaction with Care Provided for Pain and Symptom Management**

- a. Has there ever been any time that members of the (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
- b. 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
 - NA - No pain or refuses pain medication
- c. 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
 - NA - No pain or refuses pain medication
- d. For symptoms other than pain, for example shortness of breath or nausea, do you feel that the (PACE site) staff should be doing more to keep you comfortable?
 - 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
 - NA - No pain or refuses pain medication

14. **Sleep Behaviors:**

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

Excessive daytime fatigue: _____
Other: _____

15. **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): _____

16. **Bowel Incontinence Frequency:**

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

17a. **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: _____

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

- 0 - Continent – Complete control [**Go to Item 18**]
- 1 - Usually continent, incontinent episodes once a week or less
- 2 - Occasionally incontinent, 2+ times a week but not daily
- 3 - Frequently incontinent, tends to be incontinent daily, but some control present
- 4 - Incontinent – Has inadequate control, multiple daily episodes
- NA - Participant has catheter

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

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

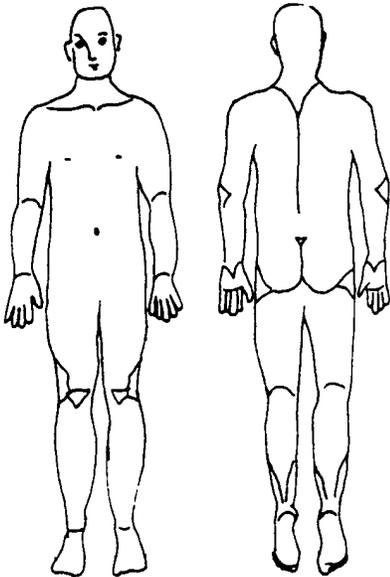
Ask participant to respond to Item 18.

18. 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): _____

19. **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)		

20. **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): _____

- 21a. Does this participant have a **Surgical Wound** (excluding ostomies)?
- 0 - No [**Go to Item 22**]
 1 - Yes
- b. **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. Does this participant have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?
- 0 - No
 1 - Yes
- d. **Status of Most Problematic (Observable) Surgical Wound:**
- 1 - Fully granulating
 2 - Early/partial granulation
 3 - Not healing
 NA - No observable surgical wound

22a. Does this participant have a **Pressure Ulcer**?

- 0 - No [**Go to Item 23**]
 1 - Yes

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

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

23a. Does this participant have a **Stasis Ulcer**?

- 0 - No [**Go to Item 24**]
 1 - Yes

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

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

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

- 0 - No
- 1 - Yes

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

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

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

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

Notes (optional): _____

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

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

Notes (optional): _____

26a. **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

27. **Lung Sounds: (Mark all that apply.)**

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

Notes (optional): _____

28. **Cough:** Does the participant have a cough?

- 0 - No [**Go to Item 29**]
- 1 - Yes - Describe: _____

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

Duration: _____

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

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

30. **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)				

31. **Chest Pains:** Has the participant experienced chest pain since the last assessment?

- 0 - No [**Go to Item 32**]
- 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.

32. **Edema:**

a. Legs/Feet None Right Left Degree: _____

b. Legs/Feet None Right Left Degree: _____

33. **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	

34. **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				

35a. **Falls:** Record the total number of falls since the last assessment. (NOTE: If no falls, please record "0".) _____

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

Number of injuries due to falls: _____

c. **Fall Risk: (Mark all factors 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

EMOTIONAL/MENTAL HEALTH STATUS

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

37a. **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): _____

38. **Anxiety:** The following two items refer to anxiety, which can be manifested in tension, nervousness, and/or apprehension. Assess the participant's anxiety in the past week.

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

- 0 - Never [**Go to Item 39**]
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time

b. **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): _____

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

PROVIDER: Respond to Items 40 to 45 below.

40. **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): _____

41. **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): _____

42. **Diagnoses and Severity Index:** List each of the participant's current medical diagnoses and the associated ICD code (three digits required; five digits optional - not surgical or V-codes). Rate each diagnosis using the severity rating described below. Also indicate for each diagnosis whether it is an acute or chronic condition and if the condition is terminal.

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

Terminal Disease: For each medical diagnosis listed, indicate if the condition is terminal.

- 0 - No
- 1 - Yes

Diagnosis	ICD	Severity Rating					Acute (0) or Chronic (1)		Terminal No (0) or Yes (1)	
		0	1	2	3	4	0	1	0	1
a. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
b. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
c. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
d. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
e. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
f. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
g. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							
h. _____	(____.____)	<input type="checkbox"/>	<input type="checkbox"/>							

43. **Overall Prognosis:** BEST description of participant's overall prognosis.

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

44. **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
- UK - Unknown

45. **Life Expectancy:** Would it be unexpected if the participant died in the next 12 months?

- 0 - No
- 1 - Yes

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

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

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

Thank you for your participation.