

Care Provider Name: _____
Est. Form Completion Time: _____

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

**DRAFT COCOA DATA SET
HOME ENVIRONMENT ASSESSMENT FORM**

Conducted by:
The Center for Health Services Research

for:

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

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

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

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OVERVIEW/PROTOCOL**

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

HOW COLLECTED: This form will be completed by the home care nurse visiting the participant's home.

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

Completion of the form should occur within 24 hours of the care provider's assessment of the participant's home environment.

INSTRUCTIONS: The form contains items to be completed by a PACE home care nurse based on a visit to a participant's home. The care provider completing this form should mark the correct response as appropriate or print numbers/answers where requested. All items should be answered unless specifically directed to skip items based on a previous response. The Data Collection Coordinator (DCC) assigned at the site will receive the completed forms. The DCC will submit completed forms to the Research Center.

Note: Some data items in this form are also included in other COCOA forms. The forms in which the item appears are noted in brackets next to each item. For example, item 10 in this form is included both in this form and the Rehabilitation Therapy form, as indicated by [HEA, REHAB] next to the question stem for item 10. The abbreviations for each of the COCOA forms are listed below for quick reference.

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

Two-Site Feasibility Test

DRAFT HOME ENVIRONMENT ASSESSMENT FORM

Site ID _____ Participant ID _____

1. **Participant Name:** [ALL]

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

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

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

3. **Date Assessment Completed:** [INTAKE, HEA, PCP, RN, REHAB, SW, RT, RD, EOL, UTIL]

__ __ / __ __ / __ __ __
month day year

4. **Structural Barriers** in the participant's environment limiting independent mobility: **(Mark all that apply.)** [HEA]

Comments (if checked):

- 0 - None
- 1 - Stairs inside home which must be used by the participant (e.g., to get to toileting, sleeping, eating areas)
- 2 - Stairs inside home which are used optionally (e.g., to get to laundry facilities)
- 3 - Stairs leading from inside house to outside
- 4 - Narrow or obstructed doorways
- 5 - Narrow or obstructed walkways
- 6 - Other (specify)

5. **Kitchen Safety:** Do you suspect the participant follows unsafe kitchen practices or has an unsafe kitchen environment? [HEA]

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

Notes (optional): _____

6. **Telephone Access:** Does the participant have home access to a working telephone? [HEA]

- 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): _____

7a. **Safety Hazards** found in the participant's current place of residence: **(Mark all that apply.) [HEA]**

Comments (if checked):

- 0 - None _____
- 1 - Inadequate floor, roof, or windows _____
- 2 - Inadequate lighting _____
- 3 - Unsafe gas/electric appliance _____
- 4 - Inadequate heating _____
- 5 - Inadequate cooling _____
- 6 - Lack of fire safety devices _____
- 7 - Unsafe floor coverings _____
- 8 - Inadequate stairs or stair railings _____
- 9 - Improperly stored hazardous materials _____
- 10 - Lead-based paint _____
- 11 - Lack of security locks on doors and windows _____
- 12 - Electrical cords improperly placed _____
- 13 - Other (specify) _____

b. **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) _____

8a. **Pets in Home: (Mark all that apply.) [HEA]**

- 0 - No pets [Go to Item 9]
- 1 - Cat(s)
- 2 - Dog(s)
- 3 - Bird(s)
- 4 - Other (specify: _____)

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

- 0 - No
- 1 - Yes

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

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

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

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., other concerns regarding pets, etc.): _____

9. **Firearms in Home: [HEA]**

- a. Are firearms kept in the home? 0 - No [Go to Item 10] 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.): _____

10. **Special Equipment/Assistive Devices:** Does the participant have or need any of the following special equipment or aids? (Mark all that apply.) [HEA, REHAB]

	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): _____

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

Thank you for your participation.