

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
RECREATIONAL THERAPY 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

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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.

Site ID

Participant ID

FIRST PHASE RELIABILITY TEST DRAFT RECREATIONAL THERAPY FORM

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

2. **Reason for Assessment:**

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

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

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

ACTIVITY INTERESTS AND INVOLVEMENT

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

6. Does the participant typically **Attend the Day Health Center at Least Once a Month?**

- 0 - No [Skip remaining data items and complete information box at end of form]
- 1 - Yes

7. **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): _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Arts/Crafts | <input type="checkbox"/> Manicures | <input type="checkbox"/> Religious/Spiritual Activities |
| <input type="checkbox"/> Baking/Cooking | <input type="checkbox"/> Movies | <input type="checkbox"/> Reminiscing Discussion |
| <input type="checkbox"/> Bingo | <input type="checkbox"/> Music/Singing | <input type="checkbox"/> Sewing |
| <input type="checkbox"/> Board Games | <input type="checkbox"/> Newsletter | <input type="checkbox"/> Social Hour |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Cards | <input type="checkbox"/> Nutrition Club | <input type="checkbox"/> Trivia |
| <input type="checkbox"/> Current Events | <input type="checkbox"/> Outings | <input type="checkbox"/> T.V. |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Participant Council | <input type="checkbox"/> Walking Club |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Parties (including birthday) | <input type="checkbox"/> Word Games |
| <input type="checkbox"/> Games | <input type="checkbox"/> Picnics | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Puzzles | <input type="checkbox"/> Independent Activities _____ |
| <input type="checkbox"/> Intergenerational | <input type="checkbox"/> Reading | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> None |

Notes (optional): _____

PROVIDER: Ask participant to answer Items 9-11 below.

9. 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

10. 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

11. 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): _____

PROVIDER: Complete the remaining items based on your assessment, including your observations and interactions with the participant and/or informal caregiver.

12. 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: _____

13. 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: _____

EMOTIONAL/MENTAL HEALTH STATUS

14. 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): _____

15a. **Frequency of Behavior Problems (Reported or Observed):** Has the participant exhibited any of the following behaviors since the last assessment? (Respond for each item below.)

	<u>Never</u>	<u>Once/month or less</u>	<u>Several times a month</u>	<u>Several times a week</u>	<u>Every day</u>
1) Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
2) Physical aggression: aggressive/combatative to self or others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
3) Disruptive, infantile, regressive, or socially inappropriate behavior (other than above)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
4) Delirium, confusion, delusional, hallucinatory, or paranoid behavior	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
5) Agitated (pacing, fidgeting, argumentative)	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4
6) Withdrawn/isolated	<input type="checkbox"/> - 0	<input type="checkbox"/> - 1	<input type="checkbox"/> - 2	<input type="checkbox"/> - 3	<input type="checkbox"/> - 4

b. **For any Behavior Present as indicated above, Describe Typical Circumstances** (e.g., time of day, location/setting):

Circumstances

- 1) Verbal disruption

- 2) Physical aggression

- 3) Disruptive, infantile, regressive, or socially inappropriate behavior (other than above)

- 4) Delirium, confusion, delusional, hallucinatory, or paranoid behavior

- 5) Agitated

- 6) Withdrawn/isolated

16. **Wandering:** Has the participant wandered since the last assessment? (Wandering is defined as straying or becoming lost in the community due to impaired judgment. Example: A confused participant leaves home unattended and is not able to find his or her way back.) *Assess the participant using the ratings below.*

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

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

- 0 - No [**Go to Item 18**] 1 - Yes [**Specify frequency, type, and reason below.**]

Frequency of use: _____

Type: _____

Reason: _____

Notes (optional): _____

PHYSIOLOGIC/FUNCTIONAL STATUS

18a. Describe any **Functional Impairments or Other Factors** that might affect the participant's ability to take part in recreational activities (e.g., paralysis, weakness, communication issues):

b. **Assistive/Adaptive Devices** (e.g., wheelchair, cane) or **Human Assistance Needed** to participate in recreational activities: _____

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.**