

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  
UTILIZATION 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 four to six minutes with an average of five 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.

**DRAFT COCOA DATA SET  
UTILIZATION FORM  
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 site administrative staff based on utilization data collected over the two-site feasibility test period.

**WHEN COLLECTED:** This form will be completed for participants at one time point during the two-site feasibility test, based on data collected on an ongoing basis during the feasibility test period.

**INSTRUCTIONS:** The Utilization Form will be completed by site administrative staff at the end of the pilot feasibility test, based on participant utilization during the pilot feasibility test period. The staff member will record answers directly on the form and 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 answer. The Data Collection Coordinator (DCC) assigned at the site will receive the completed forms from the assigned staff member. 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 1 in this form is included in all of the forms, as indicated by [ALL] next to the question stem for item 1. 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 UTILIZATION FORM

Site ID \_\_\_\_\_ Participant ID \_\_\_\_\_

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

\_\_\_\_\_  
(Last) (First) (M) (Suffix)

2. **Reporting Period Dates (Start and End Dates):** [UTIL] \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year month day year

### Emergent Care

3. **Emergent Care:** During the most recent reporting period, has the participant utilized any of the following services for emergent care (including care from a PACE physician in a hospital emergency department)? **(Mark all that apply.)** [UTIL]

- 0 - No emergent care services **[Go to Item 5]**
- 1 - Hospital emergency room (includes 23-hour holding)
- 2 - PACE physician emergency visit/house call
- 3 - Outpatient department/clinic emergency (includes urgicenter sites)
- UK - Unknown **[Go to Item 5]**

4. **How Many Times** did the participant receive **Emergent Care** during the most recent reporting period? [UTIL]

\_\_\_\_\_

### Inpatient Facility Admissions

5. To which **Inpatient Facility** has the participant been admitted during the most recent reporting period? **(Mark all that apply.)** [UTIL]

- 1 - Hospital **[Go to Item 6]**
- 2 - Rehabilitation unit or facility **[If Rehabilitation unit or facility only, this form is complete.]**
- 3 - Licensed nursing home (including skilled nursing facility [SNF]) **[Go to Item 10]**
- 4 - Hospice **[If Hospice only, this form is complete.]**
- 5 - NA – No inpatient facility admission **[This form is complete.]**

### Hospitalization

6. **How Many Times** was the participant admitted to an acute care **Hospital** with an overnight stay during the most recent reporting period? \_\_\_\_\_ [UTIL]

7. **Hospital Admission #1**

a. For what **Reason** was the participant admitted to an acute care **Hospital**? [UTIL]

- 1 - Hospitalization for emergent (unscheduled) care
- 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- UK - Unknown

b. Acute care **Hospital Length of Stay (LOS)** (to calculate length of stay, the date of admission is counted, but the discharge date is not counted). [UTIL]

Admission Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

Length of Stay (days): \_\_\_\_\_

8. **Hospital Admission #2**

a. For what **Reason** was the participant admitted to an acute care **Hospital**? [UTIL]

- 1 - Hospitalization for emergent (unscheduled) care
- 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- UK - Unknown

b. Acute care **Hospital Length of Stay (LOS)** (to calculate length of stay, the date of admission is counted, but the discharge date is not counted). [UTIL]

Admission Date: \_\_\_\_\_  
 Discharge Date: \_\_\_\_\_  
 Length of Stay (days): \_\_\_\_\_

9. **Hospital Admission #3**

a. For what **Reason** was the participant admitted to an acute care **Hospital**? [UTIL]

- 1 - Hospitalization for emergent (unscheduled) care
- 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- UK - Unknown

b. Acute care **Hospital Length of Stay (LOS)** (to calculate length of stay, the date of admission is counted, but the discharge date is not counted). [UTIL]

Admission Date: \_\_\_\_\_  
 Discharge Date: \_\_\_\_\_  
 Length of Stay (days): \_\_\_\_\_

**IF THE PARTICIPANT HAD MORE THAN THREE HOSPITAL STAYS DURING THE REPORTING PERIOD, PLEASE COPY AND COMPLETE INFORMATION FOR THOSE STAYS.**

**Nursing Home Use**

10. **How Many Times** was the participant admitted to a **Nursing Home** during the most recent reporting period? [UTIL]

\_\_\_\_\_

11. **Nursing Home Stay #1**

a. For what **Reason(s)** was the participant **Admitted** to a **Nursing Home**? (Mark all that apply.) [UTIL]

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

b. **Nursing Home Length of Stay (LOS)** (to calculate length of stay, the date of admission is counted, but the discharge date is not counted). [UTIL]

Admission Date: \_\_\_\_\_  
 Discharge Date: \_\_\_\_\_  
 Length of Stay (days): \_\_\_\_\_

12. **Nursing Home Stay #2**

a. For what **Reason(s)** was the participant **Admitted** to a **Nursing Home**? (Mark all that apply.) [UTIL]

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

b. **Nursing Home Length of Stay (LOS)** (to calculate length of stay, the date of admission is counted, but the discharge date is not counted). [UTIL]

Admission Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

Length of Stay (days): \_\_\_\_\_

**IF THE PARTICIPANT HAD MORE THAN TWO NURSING HOME STAYS DURING THE REPORTING PERIOD, PLEASE COPY AND COMPLETE INFORMATION FOR THOSE STAYS.**

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

**Thank you for your participation.**