

## **APPENDIX 3A**

### **FEASIBILITY TEST VERSION OF THE COCOA DATA SET**

This appendix contains the data collection forms that composed the COCOA data set used during the two-site feasibility test (the forms differ only slightly from those used in the pilot feasibility test). The 12 COCOA forms, which were completed by interdisciplinary team members during the feasibility test, include six discipline-specific forms (Primary Care Provider, Nursing, Social Work, Recreational Therapy, Rehabilitation Therapy, and Dietitian) and six content-specific forms (Intake Form, Home Environment Assessment Form, Participant Satisfaction Questionnaire, Caregiver Satisfaction Questionnaire, End of Life Questionnaire, and Utilization Form). The multi-form approach (rather than including all data items in a single assessment form) was designed to better manage data collection for PACE care providers and to fit more closely with the interdisciplinary assessment approach in place at PACE sites. Based on the experience and information gained during the feasibility test, the data items and forms were revised substantially prior to the subsequent phase of testing, the reliability test. (The version of the data set implemented during the reliability test can be found in Appendix 3B.)

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  
PRIMARY CARE PROVIDER FORM**

Conducted by:  
The Center for Health Services Research

for:

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

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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.

**DRAFT COCOA DATA SET  
PRIMARY CARE PROVIDER 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 primary care physicians providing direct care to the participant.

**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 provider's assessment of the participant (ideally, the form will be completed as part of the participant's routine assessment).

**INSTRUCTIONS:** This form contains items to be completed by the primary care provider (this includes direct response to items and administering items to PACE participants). The primary care provider will complete the items and will record responses directly on the form. The primary care provider should mark the correct response as appropriate or print numbers/answers where requested. All items should be completed 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 from the primary care provider. 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 6 in this form is included both in this form and the Nursing form, as indicated by [PCP, RN] next to the question stem for item 6. 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 PRIMARY CARE PROVIDER 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:** [ALL] \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_  
month day year

**Ask the participant to respond to items 4-6 below.**

4. **Participant Goals:** What would you like to change or accomplish over the next few months that we can help you with? [PCP, RN, REHAB, SW, RT, RD]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

5. Do you have requests or **Wishes for your Health Care** that you would like the staff here to know about? [PCP, SW]

- 0 - No
- 1 - Yes Describe: \_\_\_\_\_  
\_\_\_\_\_

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

6. **Self-Report of Health Status:** Compared to other persons your age, would you say that your health is excellent, good, fair, or poor? [PCP, RN]

- 1 - Excellent
- 2 - Good
- 3 - Fair
- 4 - Poor
- UA - This information could not be obtained due to participant's cognitive impairment.

Notes (optional): \_\_\_\_\_  
\_\_\_\_\_

7. **Participant's Current Health Concerns:** [PCP, RN]

- 0 - None stated
- 1 - Yes (specify: \_\_\_\_\_)

8. **Medical History: [PCP]**

Interval Medical History/Significant Changes in Past Several Months: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. **Diagnoses and Severity Index:** List each medical diagnosis or problem for which the participant is receiving care and ICD code category (three digits required; five digits optional – no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) Also indicate for each diagnosis whether it is an acute or chronic condition and if terminal. **[PCP]**

Severity Rating

- 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

<u>Diagnosis</u>	<u>ICD</u>	<u>Severity Rating</u>					<u>Acute or Chronic</u>		<u>Terminal</u>	
a. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
b. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
c. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
d. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
e. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
f. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
g. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1
h. _____	(____.____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1

10. **Malignant Neoplasm Status:** Does participant have a malignant neoplasm? **[PCP]**

- 0 - No
- 1 - Yes, malignancy in remission
- 2 - Yes, malignancy in early stage; treatment ongoing
- 3 - Yes, all treatment completed, still present with symptomatology but not in terminal phase
- 4 - Malignancy, terminal phase

11. **Benign Neoplasm Status:** Does participant have a benign neoplasm that affects his/her medical status/condition? **[PCP]**

- 0 - No
- 1 - Yes

12. **Overall Prognosis:** BEST description of participant's overall prognosis. **[PCP]**

- 0 - Poor: little or no recovery is expected and/or further decline is imminent
- 1 - Good/Fair: partial to full recovery is expected
- UK - Unknown

13. **Rehabilitative Prognosis:** BEST description of participant's prognosis for functional status. **[PCP]**

- 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- 1 - Good: marked improvement in functional status is expected
- UK - Unknown

14. **Life Expectancy:** Would you be surprised if the participant died in the next 12 months? **[PCP]**

- 0 - No
- 1 - Yes

15. Allergies: [PCP, RN]

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

16. Tobacco Use/Abuse: [PCP, RN]

a. Does participant currently smoke or chew tobacco?

- 0 - No [ Go to Item f ]
- 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 17 ]

f. Has participant ever smoked or chewed tobacco?

- 0 - No       1 - Yes - For how many years? \_\_\_\_\_      Approximate date stopped: \_\_\_\_\_

Notes (optional): \_\_\_\_\_  
\_\_\_\_\_

17. 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.]). [PCP, RN, SW]

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       3 - Seven to nine
- 1 - Three or four       4 - Ten or more
- 2 - Five or six       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

Notes regarding concerns, plans, etc. (optional): \_\_\_\_\_  
\_\_\_\_\_

d. Any history of abuse of alcoholic beverages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. **Immunizations** (To be completed at initial assessment and annually.) [PCP, RN]

a. **Flu Immunization Status:** Did the participant receive an influenza vaccination in the past year?

- 0 - No
- 1 - Yes
- 2 - Refused immunization - Date: \_\_\_\_\_

Date of most recent immunization: \_\_\_\_\_

b. **Pneumococcal Immunization Status:** Did the participant receive a pneumococcal vaccination in the past ten years?

- 0 - No
- 1 - Yes
- 2 - Refused immunization - Date: \_\_\_\_\_

Date of most recent immunization: \_\_\_\_\_

c. **History of Positive PPD:**

- 0 - No
- 1 - Yes - Reaction: \_\_\_\_\_ mm Date: \_\_\_\_\_

d. **Tetanus Immunization Status:** Has the participant received a tetanus immunization in the past ten years?

- 0 - No
- 1 - Yes
- 2 - Refused immunization - Date: \_\_\_\_\_

Date of most recent immunization: \_\_\_\_\_

19. **Appearance:** Describe participant's general appearance. (Mark all that apply.) [PCP, RN, SW]

- 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): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. **Pulses: [PCP]**

**INITIAL ASSESSMENT:**

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

21. **Chest Pains: [PCP, RN]**       0 - No [ Go to Item 22 ]       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**).  
                   1        2        3        4        5        6        7        8        9        10

22. **Lung Sounds: (Mark all that apply.) [PCP, RN]**

**Right:**     Clear       Rhonchi       Rales       Diminished       Wheezing  
**Left:**     Clear       Rhonchi       Rales       Diminished       Wheezing

Notes (optional): \_\_\_\_\_

23. **Cough: [PCP, RN]**

0 - No [ Go to Item 24 ]       1 - Yes - Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Productive?     0 - No       1 - Yes - Describe: \_\_\_\_\_  
 Duration: \_\_\_\_\_

24. **Dyspnea:** In the past week, when has the participant been dyspneic or noticeably **Short of Breath?** [PCP, RN, REHAB]

- 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)



29. **Skin Turgor (Hydration):** Pick up a fold of skin approximately 1 inch below the participant's clavicle. When released, note what happens to the skin. [PCP, RN]

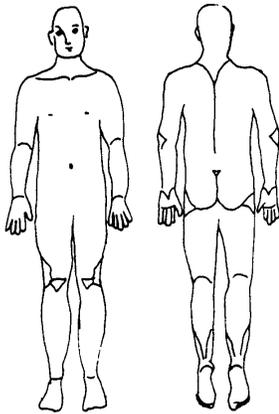
- 0 - Returns to place immediately upon release
- 1 - Returns slowly to place when released during a period of 5 seconds or less
- 2 - Skin remains in pinched position for more than 5 seconds

30. **Edema:** [PCP, RN] Present  0 - No [ Go to Item 31 ]  1 - Yes

Legs/Feet  Right  Left Degree: \_\_\_\_\_  No edema legs/feet

Arms/Hands  Right  Left Degree: \_\_\_\_\_  No edema arms/hands

31. **Skin Condition:** (Record type number on body area. Indicate size to right of numbered category.) [PCP, RN]



- | <u>Type</u>               | <u>Size</u> |
|---------------------------|-------------|
| 1. Lesions                |             |
| 2. Bruises                |             |
| 3. Masses                 |             |
| 4. Scars                  |             |
| 5. Stasis Ulcers          |             |
| 6. Pressure Ulcers        |             |
| 7. Incisions              |             |
| 8. Other (specify): _____ |             |

32. **Skin:** [PCP, RN]

- |           |                                     |  |                                       |                                   |                                    |
|-----------|-------------------------------------|--|---------------------------------------|-----------------------------------|------------------------------------|
| Color     | <input type="checkbox"/> 1 - Normal | <input type="checkbox"/> 2 - Pale        | <input type="checkbox"/> 3 - Jaundice | <input type="checkbox"/> 4 - Rash | <input type="checkbox"/> 5 - Dusky |
| Temp      | <input type="checkbox"/> 1 - Warm   | <input type="checkbox"/> 2 - Cool        | <input type="checkbox"/> 3 - Cold     |                                   |                                    |
| Condition | <input type="checkbox"/> 1 - Dry    | <input type="checkbox"/> 2 - Diaphoretic | <input type="checkbox"/> 3 - Clammy   |                                   |                                    |

Notes (optional): \_\_\_\_\_

33a. Does this participant have a **Skin Lesion** or an **Open Wound**? This excludes OSTOMIES. [PCP, RN]

- 0 - No [ Go to Item 34 ]
- 1 - Yes

b. Does this participant have a **Surgical Wound**?

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

c. **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

d. 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

e. **Status of Most Problematic (Observable) Surgical Wound:**

- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable surgical wound

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

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

g. 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					

h. **Stage of Most Problematic (Observable) Pressure Ulcer:**

- 1 - Stage 1
- 2 - Stage 2
- 3 - Stage 3
- 4 - Stage 4
- NA - No observable pressure ulcer

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

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

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

- 0 - No [ **Go to Item 34** ]
- 1 - Yes

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

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

l. 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

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

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

34. **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. [PCP, RN]*

- 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): \_\_\_\_\_  
\_\_\_\_\_

35. **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. [PCP, RN]*

- 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): \_\_\_\_\_  
\_\_\_\_\_

36a. **Oral Status and Disease Prevention: (Mark all that apply.) [PCP, RN]**

- 1 - Debris (soft, easily movable substances) present in mouth
- 2 - Has dentures or removable bridge
- 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

37. **Pain Description: [PCP, RN, REHAB]**  NA - No pain [ Go to Item 38 ]

a. Location: \_\_\_\_\_

Type: \_\_\_\_\_

Positions/activities that aggravate pain: \_\_\_\_\_

Position/activities that alleviate pain: \_\_\_\_\_

Controlled/Uncontrolled by pain medication (*circle one*) Pain medication: \_\_\_\_\_

Notes: \_\_\_\_\_

b. Location: \_\_\_\_\_

Type: \_\_\_\_\_

Positions/activities that aggravate pain: \_\_\_\_\_

Position/activities that alleviate pain: \_\_\_\_\_

Controlled/Uncontrolled by pain medication (*circle one*) Pain medication: \_\_\_\_\_

Notes: \_\_\_\_\_

38. **Pain:** If participant has pain in multiple locations, respond to items for the most severe or interfering pain. [PCP, RN]

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.)

- 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

b. **Frequency of Pain:**

- 0 - Participant has no 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

39. **Physical Symptoms Other Than Pain:** (Ask participant to respond to the following items.) [PCP, RN]

	<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>More Than Once a Day</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	
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	

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

40. **Sleep Behaviors:** [PCP, RN]

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: \_\_\_\_\_

41. **Posture:** [PCP, REHAB]

	WFL	Significant Impairment	Describe Impairment
Cervical spine			
Thoracic spine			
Lumbar spine			

42. **Joint Deformity and Stiffness:** Check if present for each joint (right and left) and describe if present. [PCP, REHAB]

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

43a. **Falls:** Record the total number of falls since the last assessment: \_\_\_\_\_  
[PCP, RN, REHAB]

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**

44. **Interval Mental Health History** (include mental health hospitalizations, treatments, relevant family history): [PCP, SW]

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45a. **Chronic Mental/Emotional Condition:** Is there a history of any of the following (include currently inactive conditions)? (Mark all that apply.) [PCP, SW]

- 1 - Schizophrenia
- 2 - Major depression
- 3 - Mania/bipolar
- 4 - Personality disorder
- 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): \_\_\_\_\_  
\_\_\_\_\_

46a. **Mood (Dominant Feeling State):** Ask participant to describe his/her mood over the past week. **(Mark all that apply.)**  
[PCP, RN, SW]

- 1 - Depressive
- 2 - Irritable
- 3 - Anxious
- 4 - Angry
- 5 - Happy
- 6 - Content
- 7 - Neutral
- 8 - Other: \_\_\_\_\_
- UA - Participant was asked this question and was unable to answer due to cognitive impairment

b. PROVIDER:

- Indicate if observed mood congruent with statements:  0 - No [ Go to Item 47 ]  
 1 - Yes [ Go to Item 48 ]

47. **Provider Perceived Affect:** Participant's affect appears to be: **(Mark all that apply.)** [PCP, RN, SW]

- 1 - Flat
- 2 - Depressed
- 3 - Sad
- 4 - Angry
- 5 - Restricted/Withdrawn
- 6 - Fearful
- 7 - Anxious
- 8 - Nervous
- 9 - Calm
- 10 - Happy
- 11 - Other: \_\_\_\_\_

Notes (optional): \_\_\_\_\_  
\_\_\_\_\_

48. **Anxiety:** The following two items refer to anxiety, which can be manifested in tension, nervousness, and/or apprehension.  
[PCP, RN, SW]

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

- 0 - None of the time
- 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):**

- 0 - No anxiety
- 1 - Mild (experienced slight nervousness/apprehension)
- 2 - Moderate (experienced a significant amount of nervousness/apprehension)
- 3 - Severe (experienced overwhelming nervousness/apprehension)

Notes (optional): \_\_\_\_\_  
\_\_\_\_\_

49. PROVIDER: **Observed Depression or Depressive Symptoms:** Which of the following have you observed in the participant in the past week? **(Mark all that apply.) [PCP, RN, SW, RT]**

- 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: \_\_\_\_\_
- 9 - None of the above

50. **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. **[PCP, SW]**

- |   |                                  |                                   |
|---|----------------------------------|-----------------------------------|
| 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.

**Ask participant to respond to Items 51-52 below.**

51. **Worry About Support:** Do you worry about getting the support and care you need? **[PCP, SW]**

- 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): \_\_\_\_\_  
 \_\_\_\_\_

52. **Participant Stress/Concerns about Own Life: (Ask participant.) [PCP, SW]**

a. Have there recently been any major changes or disruptions in your life that you would like to talk about?

- 0 - No **[ Go to Item 53 ]**
- 1 - Yes Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- UA - This information could not be obtained due to participant's cognitive impairment. **[ Go to Item 53 ]**

b. Are you experiencing stress, concern, or worry related to these changes?

0 - No [ Go to Item 53 ]

1 - Yes Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. If yes, how upsetting are these concerns to you? \_\_\_\_\_  
\_\_\_\_\_

**PROVIDER: Respond to Items 53 and 54 below.**

53. **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.) [PCP, RN, REHAB, SW, RT, RD]

- 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): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

54. **Restraints:** Have physical restraints been used on the participant since the last assessment? [PCP, RN, REHAB, RT]

0 - No                       1 - Yes

If yes, specify frequency, type, and reason:

Frequency of use: \_\_\_\_\_

Type: \_\_\_\_\_

Reason: \_\_\_\_\_

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.**