excerpt - pp. 1 - 57 (does not include Supplements)

Community Health Assessment
Functional Supplement
Mental Health Supplement

Reference Manual
August 2022 Edition
Software Version 1.13

New York State Department of Health
Office of Health Insurance Programs
Division of Long-Term Care

Acknowledgements and Regulations

The Uniform Assessment System for New York (UAS-NY) Community Health Assessment (CHA) is based on research and development conducted by interRAI. interRAI is a collaborative network of researchers in more than **30 countries** committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote **evidence-based clinical practice and policy decisions** through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. For information about interRAI, visit www.interRAI.org.

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This reference manual, in conjunction with the UAS-NY Training Environment and related NYS DOH official communication, is the only guidance sanctioned by the NYS DOH for the Community Health Assessment, Functional Supplement, and Mental Health Supplement located in the UAS-NY. In order to maintain the integrity of the data for quality assurance and uniformity of quality measures, use of alternative reference manuals or guidance on assessment response option coding must align with DOH and interRAI guidance.

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Disclaimer

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UAS-NY Community Health Assessment Reference Manual

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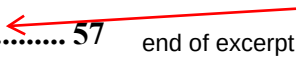

INTRODUCTION TO THE UAS-NY

The Uniform Assessment System for New York (UAS-NY) is a web application that allows qualified assessors to securely conduct standardized health assessments which generate outcomes that are used to determine eligibility and service level authorization, as well as guide care planning for New York State residents.

Mission Statement

The UAS-NY's mission is to maintain and advance the leading repository for health information and assessment instruments while providing exceptional communication, training, and support to our 10,000 users and 1,800 organizations. We make the first step in developing individualized service plans efficient and easy to ensure New York State residents receive the right care, within the right setting, at the right time.

The UAS-NY Application

The UAS-NY is housed in the New York State (NYS) Department of Health's (DOH) Health Commerce System (HCS). The UAS-NY contains electronic adult and pediatric assessment instruments for individuals being served in a number of New York State programs under the oversight of various NYS Agencies including: the Department of Health, the Office for People With Developmental Disabilities, the Office of Mental Health, the Office of Addiction Services and Supports, and the Office of Children and Family Services.

The UAS-NY includes the following long-term care assessment instruments:

- The UAS-NY Community Health Assessment (CHA), and related Functional and Mental Health Supplements (where applicable) constitute a comprehensive assessment used for adults, age 18 and over, in home and community-based long-term care programs
- The UAS-NY Pediatric 4-17 Assessment
- The UAS-NY Pediatric 0-3 Assessment

The overall goal of the UAS-NY is to utilize a comprehensive assessment system within all community-based long-term care services and programs which:

- Evaluates individuals' health status, strengths, care needs, and preferences and guides the development of individualized long-term care service plans
- Assists with program eligibility determinations
- Improves care coordination and facilitates service delivery
- Ensures that individuals with long-term care needs receive the right care, within the right setting, and at the right time

In one location, health care providers have access to an individual's demographic information, residential and service delivery addresses, assessment information, and assessment outcome information. The availability of information to the appropriate providers supports care planning and service delivery for an individual.

The UAS-NY contains reporting functionality for information on individuals assessed, as well as aggregate or organization-wide data, which is immediately available to users during and upon completion of the assessment. The UAS-NY also includes an ad hoc reporting function that enables users to create customized reports and to download information from the UAS-NY. This data can then be uploaded to an organization's local management system.

Organizations and users who utilize the UAS-NY and corresponding assessment instruments are required to follow current Federal, State, and local laws, regulations, policies, and guidance.

UAS-NY Support Desk

For questions regarding the contents of this manual, please contact the UAS-NY Support Desk:

Via E-mail: uasny@health.ny.gov

Telephone: 518-408-1021 (option 1)

Support Desk Availability

Staff is available Monday through Friday 8:30 AM – 4:00 PM except during holidays, other prescheduled closures, exceptional inclement weather, and during any building safety drill or emergency situation. Notification of unanticipated closures will typically be sent via a system message which will appear upon logging in to the UAS-NY.

ABOUT THIS REFERENCE MANUAL

The purpose of this Reference Manual is to provide users with the information necessary to conduct the UAS-NY Community Health Assessment. As with any assessment, the underlying goal is to ensure a consistent interpretation and approach for conducting the assessment. This consistency is critical for the individuals being assessed, and for assessors.

To support a standardized and uniform approach, the following information is provided for **most** of the items included in the UAS-NY Community Health Assessment.

Intent	Reason(s) for including the item (or set of items) in the UAS-NY Community Health Assessment, including discussions of how the information will be used by clinical staff to identify problems and develop a plan of care.
Definition	Explanation of key terms.
Process	Sources of information and methods for determining the correct response for an item. Depending upon the item and the individual being assessed, sources include: • Interview and observation of the person • Discussion with the person's family, other caregivers, and the person's physician

- Review of any clinical records or other administrative documentation

Coding — Proper method of recording the response for each item, with explanations of the individual response options.

Some of the items included in the UAS-NY Community Health Assessment are self-explanatory. In these cases, only additional relevant material is presented.

Future Use of This Reference Manual

In addition to being available in the UAS-NY Training Environment, the information presented in this Reference Manual is available to users in the UAS-NY. When conducting the assessment, assessors may select the blue help icon  to access the UAS-NY Community Health Assessment Reference Manual. Using this feature, as well as having the Reference Manual readily available, will support and promote the integrity and consistency of the UAS-NY Community Health Assessment data.

Additional DOH Authorized Reference Manuals and User Guides

To support the understanding and use of the UAS-NY, additional reference manuals and user guides have been developed by the Department of Health. These resources include:

- UAS-NY Pediatric 4-17 Assessment Reference Manual
- UAS-NY Pediatric 0-3 Assessment Reference Manual
- UAS-NY User Guide
- UAS-NY Recording Demographic and Program Information

UAS-NY COMMUNITY HEALTH ASSESSMENT

The UAS-NY Community Health Assessment (CHA), and related Functional and Mental Health Supplements (where applicable) constitute a comprehensive assessment that is conducted by a licensed registered nurse (RN) and utilized by health care professionals.

The UAS-NY Community Health Assessment is comprised of the:

- Community Health Assessment, which enables an assessor to review multiple domains of function, health, social support, and service use, as well as medications, diseases, and other health-related information for an individual
- Functional Supplement, which provides assessors with additional data related to health, function, and support
- Mental Health Supplement, which captures additional information related to mental health service history, mental state, and social relations

The Community Health Assessment, Functional Supplement, and Mental Health Supplement will be hereafter referred to collectively as either the "Community Health Assessment" or as the "assessment(s)."

The responses to the UAS-NY Community Health Assessment measure an individual's objective performance and capacity in a variety of areas. Once completed, the UAS-NY Community Health Assessment is used to generate assessment outcomes for the individual. Together, the UAS-NY Community Health Assessment and the generated outcomes enable assessors to view the whole person at *a given point in time*. The UAS-NY Community Health Assessment is not intended to serve as an open-ended electronic health record, subject to ongoing updates.

The comprehensive nature of the UAS-NY Community Health Assessment supports the development of an individualized plan of care that builds on the strengths of an individual. The result is that individuals receive the right care, at the right time, and in the right setting.

The Community Health Assessment, Functional Supplement, and the Mental Health Supplement

Following the applicable laws, regulations, policy, and guidance for a program or plan, an assessor will conduct the UAS-NY Community Health Assessment by administering the Community Health Assessment and compiling information on medications and disease diagnoses. Many of the "items" included in the Community Health Assessment serve as "triggers" for the two supplements. Depending upon the response to an item, one or both of the supplements may be triggered for completion.

If triggered, the assessor is required to complete the Functional Supplement and/or the Mental Health Supplement. These supplements enable the assessor to capture additional, relevant information about an individual to more fully understand and document the goals and needs of the individual. It is important to note that not all individuals will trigger one or both of the supplements. Assessors may opt to conduct one or both of the supplements if not triggered.

When conducting the UAS-NY Community Health Assessment, assessors must remember that this instrument is not a questionnaire. The UAS-NY Community Health Assessment is not designed for the assessors to read the questions and potential responses and have the individual being assessed chose the most appropriate answer. Rather, this instrument should be used as a guide to structure a clinical and social assessment in planning for community-based care and services. Note that additional information not captured in the UAS-NY Community Health Assessment may be needed to support care planning.

Critical Assessor Skills

Assessors should engage the individual, as well as family members or caregivers, in a conversation about the goals and needs of the individual. Conducting the UAS-NY Community Health Assessment requires assessors to draw upon their communication, interpersonal, analytical, clinical, and reasoning skills.

- Assessors require **strong speaking and listening skills** to promote communication with the individual being assessed, as well as with the primary caregiver or family member if available. The individual being assessed is the primary source of information, and strong communication skills enable the assessor to present the items in an appropriate, understandable, and meaningful way.
- Assessors require **strong inter-personal skills** to keep an individual engaged throughout the assessment process. Equally important is for assessors to be aware of potentially

sensitive items or issues and how to address those items in a respectful and sensitive manner.

- Assessors require **strong analytical skills** to balance what is stated with what is observed, and what is included in a review of secondary documents. Not all information gathered will be consistent, which requires an assessor have further discussions in an attempt to resolve any discrepancies. Ultimately, an assessor will need to determine the appropriate response.
- Assessors require **strong clinical skills** to determine the presence and extent of health-related issues that will affect the services and care for an individual.
- The UAS-NY Community Health Assessment includes a number of items, each with a different intent, set of definitions, procedures, and coding options. Assessors are required to draw on **strong reasoning skills** to understand the assessment, as well as to become both fluent and proficient in its use. This goes a long way in supporting the consistency and accuracy of the assessments.

Basic Principles of the UAS-NY Community Health Assessment

When conducting an assessment, assessors are a guest in the individual's home, with the express purpose of completing a comprehensive assessment. The goal of the assessment is to:

- Maximize the individual's functional capacity and quality of life
- Identify and address health problems and care needs
- Ensure that the individual remains in his or her home for as long as possible

To accomplish this goal, assessors should:

- Identify the purpose of the visit
- Identify functional, medical, and social issues that are presently limiting or likely will become limiting
- Identify the individual's strengths and assets
- Integrate what is observed and heard in order to accurately code each of the UAS-NY Community Health Assessment items

Information collected using the UAS-NY Community Health Assessment can serve to:

- Determine the individual's appropriate level of care and program options
- Facilitate care coordination and an individual's admission to, discharge from, and transition between long-term care services
- Provide a basis for further evaluation of unrecognized or unmet needs
- Inform care planning and ensure that each limiting or potentially limiting factor is viewed in the context of the life circumstances unique to that individual and managed so as to maximize that individual's quality of life and function

Do not expect that all functional, medical, and social matters identified will be fully and comprehensively addressed during the visit. It is more important that all major functional, medical, and social circumstances that limit the individual's quality of life be identified in order to develop a plan for further evaluation or management.

Any acute medical matter should be brought to the attention of the individual immediately, and the individual should be vigorously counseled to seek appropriate medical care, whether or not that can be provided in the home setting.

In accordance with the laws of New York State, if there is evidence of abuse or neglect, referral to an appropriate agency/authority and immediate intervention may be warranted.

Conducting the UAS-NY Community Health Assessment

The initial UAS-NY Community Health Assessment should be completed after the person is referred for service by an agency.

The items on the UAS-NY Community Health Assessment flow in a logical sequence and can be completed in the order in which they appear. However, the assessor is not bound by this sequence. Items may be reviewed in any order that works for the assessor and the individual being assessed.

When conducting an assessment in an individual's home, the assessor needs to consider the order in which the items in the assessment will be addressed. It is generally helpful to assess the individual's cognitive status and ability to communicate early on. This will help gauge the reliability of the information that is gathered from the individual. There is also a need to be sensitive to the individual's reaction to the assessment process and particular issues. There is no one correct order in which the sections of the UAS-NY Community Health Assessment should be addressed. Assessors should take cues from the individual's responses to the "icebreaker" questions for prioritizing areas for assessment.

Remember, the UAS-NY Community Health Assessment is not a questionnaire. Although assessors must gather all the information to complete the UAS-NY Community Health Assessment, the needs of the individual should set the pace and priorities for the assessment process. More than one interview with the individual, or follow-up contacts with family members, other caregivers, or the individual's physician, may be necessary.

Whenever possible, the assessment should be performed in the person's home. Parts of the assessment can be completed in settings other than the person's home, such as a hospital, day care center, or outpatient clinic, with no loss in information quality. However, certain critical items, such as environmental factors, can best be assessed in the home. In any circumstance, the Community Health Assessment must be completed in person, face-to-face. Telephonic, Skype, Face Time, or any other alternative method are not permitted. (Please see UAS-NY Policy 19.1, *Conducting the UAS-NY Community and Pediatric Assessments* for complete information.)

Assessments must be completed according to New York State guidelines. It is expected that the UAS-NY Community Health Assessment be completed in its entirety. An assessment is only considered valid when the RN who conducted the assessment has entered their responses into the UAS-NY Online or Offline Application and has signed and finalized the assessment in the UAS-NY Online Application. Unsigned/unfinalized assessments are not recognized as valid and cannot be used for any purpose, including, but not limited to, eligibility determination, level of service need, care planning, authorization of services, or billing.

Assessors are encouraged to use the "Comments" field at the end of each domain. These open text fields are designed for the assessor to record additional information or observations.

Initiating the UAS-NY Community Health Assessment Process

When introducing the UAS-NY Community Health Assessment to a person, emphasize that the assessment is an integral part of the overall service program of the district or provider agency. If service options are limited, be realistic in channeling the conversation.

Address the person directly whenever possible. When talking with others, it is not necessary to use the word "person," which is used on the UAS-NY Community Health Assessment. Assessors may substitute words such as "older adult," "patient," or "client," or use phrases such as "Mrs. X" or "your mother."

Initially, some assessors may not be fully comfortable conducting the assessment. If this is the case, be sure to let the individual being assessed know that you just started using the assessment and would appreciate their patience.

Ice Breaker Questions

You can begin the assessment process with a series of optional "icebreaker" questions designed to begin a dialogue with the person and family. This may elicit much of the information required to complete the assessment. These questions are not included in the electronic assessment and may vary as appropriate. Some examples:

- How are you (is the person) doing?
- How do you (does he/she) get around in the house?
- How do you perceive your (his/her) present health as compared to a year ago (or when last seen)?
- Do you (does he/she) feel well enough to do what you want (he/she wants) to do?
- Can you (he/she) do the things that you want (he/she wants) to do?
- What type of assistance or services do you (does he/she) need?

COMMUNITY HEALTH ASSESSMENT

Section A. Intake and History

Community Health Assessment Reference Date

Intent — To establish a common period of observation as a reference point for each completed assessment.

Definition — The designated end point of the common observation period for items on the Community Health Assessment. Except where otherwise noted, all information gathered about the person pertains to the 3-day period prior to and including the Community Health Assessment Reference Date for items pertaining to the person's status or performance.

Home-based assessments are usually completed using information gathered during a single visit. However, when an assessment carries over to a second visit, information for the remaining items must be for the time period established by the original Community Health Assessment Reference Date.

Others Present at Assessment

Intent — To identify other individuals who were present at the time of the assessment.

Coding — Enter the names of each individual present. This does not include the assessor.

Reason for Assessment

Intent — To document the reason for completing the assessment.

Coding — Select the appropriate reason for assessment.

First assessment – This is the first assessment that is done at the time of first contact or entry into the home or program, or when initially determining eligibility for home care/home health services. This indicates it is the first assessment ***this organization*** is conducting for the individual. It is not necessarily the first assessment for the individual.

Routine reassessment – A regularly scheduled follow-up assessment to ensure that the care/service plan is appropriate and current.

Return assessment — An assessment conducted when the person returns from the hospital or otherwise re-enters the same organization after a discharge or disenrollment.

Significant change in status reassessment – A comprehensive reassessment conducted at any time during the uninterrupted course of care because the person's status or condition has significantly changed. If the change in status is accompanied by a hospital stay, select "Return assessment" instead.

Discharge assessment, covers last 3 days of service – Use this response only if the program or plan is required to complete a comprehensive assessment upon discharge.

Other – An assessment conducted outside of the established assessment schedule for any reason other than the selections above (e.g., confirmation of the appropriateness of the current plan [not the routine "follow-up" reassessment]). When "Other" is selected, please specify the reason.

Immediate need assessment

Intent — To document that the individual to be assessed has a Statement of Need indicating they are in immediate need of services. Cases of Immediate Need must be referred from a Local Social Services District. This designation allows for the individual's process of enrollment in services to be handled expeditiously. This is only applicable to Initial Assessments.

Definition — An individual is in immediate need of either Personal Care or Consumer Directed Personal Assistance Program services per a medical statement and has attested that they are eligible for Medicaid or are currently enrolled in Medicaid. This is only applicable to Initial Assessments.

Coding — Select the most appropriate response.

- No Selection
- No
- Yes

Referral Source (First Assessment Only)

Intent — To determine how an individual was referred to an organization. This is only recorded for individuals if the "Reason for Assessment" selected above is "first assessment."

Coding — Select the appropriate response.

- Hospital
- Nursing Home
- Out-of-state Nursing Home
- Certified Home Health Agency
- Licensed home care services agency
- Other home and community-based service provider
- Assisted living or adult care facility
- Social or adult day health care program
- Local District or Agency
- Area agency on aging
- Physician or clinic
- Self
- Family or Friend
- Other - When "Other" is selected, please specify.

Caregiver assistance during assessment

Intent — To document assistance provided by any caregiver during the course of the assessment process.

Definition — For this assessment item, a caregiver is anyone present who is assisting the individual during the course of the assessment process. Assistance may include facilitation of the assessment via interactive video teleconference.

Coding — Select the appropriate response.

- No selection
- No
- Yes

Person's Expressed Goals of Care

Intent — The person being assessed is an important member of the health care team. It is essential to ask him/her to identify what his/her goals of care might be. By doing so, the person is encouraged to be an active member of the team. This can also be a starting point to develop a person-centered plan of care or services.

Process — Use this box to document outcomes that the person hopes to achieve as a result of receiving services. These outcomes may relate to almost anything, including improved functional performance, a return to health, increased independence, an ability to maintain community residence, improved social relations, etc.

Talk to the person and phrase your questions about goals of care in the most general way possible. For example, ask, "How can we help you?" "Why are you getting (or applying for) services?" "What benefits do you expect to get?" "What changes in yourself do you hope will occur?" Encourage the person to express personal goals in his or her own words.

Some persons will be unable to articulate a goal, an expected outcome, or even a reason for seeking services. They may say they do not know or that they are getting service at the request of a relative. All of these are reasonable responses. Do not make inferences based on what you or other clinicians believe **should** be goals of care. If the person asks you for clarification on what he or she might expect from services, follow your usual agency policy.

Coding — Record the person's verbatim response in the text box. Abbreviate if necessary. Enter "NONE" if the person is unable to articulate a goal of care.

One or More Care Goals Met in the Last 90 Days (or Since Last Assessment if Less Than 90 Days Ago)

Intent — To identify if any of the person's treatment goals, established by the person or members of the care team (e.g., by nurses, social workers, therapists, or medical doctors), have been achieved in the last 90 days (or since the last assessment, if that was less than 90 days ago).

Process — Confer with the person and clinical professionals, and review any clinical documentation. Question the person to determine his or her perception regarding

an improvement in function or return to health. Keep in mind that discussions with professionals may be biased by payment category (e.g., fee for service) or the nature of the care (e.g., open-ended maintenance program).

Residential/Living Status at Time of Assessment

Intent — To document the person's living arrangement at the time of the current assessment. The person's living arrangement may be long-standing or temporary.

Process — Ask the person or family if you are unsure of where the person is currently living, or consult the person's administrative records.

Coding — Select the one most appropriate response.

Private home/apartment/rented room – Any house, condominium, apartment, or room in the community, whether owned or rented by the person or another party. Also included in this category are retirement communities and independent housing for older adults or the disabled.

Adult care facility **–** An entity established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator.

Adult care facility with assisted living services –An adult care facility that is also approved to provide or arrange for home health services.

Adult housing offered by the Office of Mental Health – For example, psychiatric group home. A residential setting for adults with mental health problems who need supervision and limited services (meals, housekeeping).

Housing offered through the Office for People with Developmental Disabilities – A setting that provides services to persons with physical disabilities. Typically, persons live in a group setting with 24-hour staff presence. Individuals are encouraged to be as independent and active as possible.

Psychiatric hospital or unit – A psychiatric hospital that focuses on the diagnosis and treatment of psychiatric disorders and which is separate from other inpatient facilities, such as an acute care, rehabilitation, or chronic care hospital. A psychiatric unit is a single unit, located in a general hospital, which is dedicated to the diagnosis and treatment of psychiatric disorders.

Nursing Home – A licensed health-care facility that provides 24-hour skilled or intermediate-level nursing care.

Rehabilitation hospital/unit – A licensed rehabilitation hospital that focuses on the physical and occupational rehabilitation of individuals who have experienced disease or injury with a subsequent decline in physical function. A rehabilitation unit is located within an acute care hospital and focuses on the acute rehabilitation of individuals who have experienced disease or injury with a subsequent decline in physical function.

Hospice facility/palliative care unit – A hospice facility (or unit within a facility providing care that is more general) provides care to persons who have a terminal

illness with a prognosis of less than 6 months to live, as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief, without precluding use of life-prolonging treatments. Palliative care is often provided from the time a person is diagnosed with a life-threatening illness.

Acute care hospital – A facility licensed as an acute care hospital that focuses primarily on the diagnosis and treatment of acute medical disorders.

Correctional facility – A jail, penitentiary, or halfway house operated by a local, state, or federal government to care for and house persons who have been sentenced to incarceration by a criminal court.

Homeless (with or without shelter) – A homeless person does not have a fixed residence (a house, apartment, room, or other place to stay on a regular basis). The person may live on the streets, or outside in wooded or open areas. The person may sleep in cars, in abandoned buildings, under bridges, etc. Persons who are homeless may or may not take advantage of existing homeless shelters.

Other – Any other type of setting not listed above.

When "Other" is selected, please specify.

Living Arrangement

Intent — To record with whom the person lives and the duration of this arrangement. These items will help determine the need for more, fewer, or different services.

Process — Ask the person or family member.

Coding — Select the one most appropriate response that reflects with whom the person is presently living. Note that this excludes any temporary living arrangements made while services are being set up.

- Alone – Includes person who lives only with a pet, lives on the streets, or is homeless (whether or not the person uses shelters).
- With spouse/partner only – Includes spouse/partner, girlfriend or boyfriend, common-law marriage, or long-term same-sex relationship.
- With spouse/partner and other(s) – Lives with spouse or partner and any other individual(s), whether family or unrelated.
- With child (not spouse/partner) – Lives with child(ren) only, or with child(ren) and other individual(s), but not with spouse or partner.
- With parent(s) or guardian(s) – Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s), but not with spouse or partner, or child(ren).
- With sibling(s) – Lives with sibling(s) only, or with sibling(s) and other individual(s), but not with spouse or partner, child(ren), or parent(s) or guardian(s).
- With other relative(s) – Lives with a relative (such as aunt or uncle) other than spouse or partner, child(ren), parent(s), or sibling(s).

- With non-relative(s) – Lives in a group setting (e.g., a boarding home, long-term care facility, group home, or jail) or in shared accommodation with non-relative(s) (e.g., roommate). Excludes single overnight stays, such as in a homeless shelter.

Residential History During Last Five (5) Years

Intent	To determine the individual's five-year history and involvement with residential, clinical care.
Process	Ask the person and caregivers. Review any available documentation.
Definitions	Refer to definitions presented for "Residential/Living Status at time of assessment."
Coding	Select **all** settings the person lived in during the five **(5) years** prior to the date the case was opened.

Education - Highest Level Completed

Intent	To determine the individual's level of education at time of entry.
Process	Ask the person and caregivers. Review any available documentation.

Definitions No schooling – Individual did not attend or participate in any formal education.

Eighth grade or less – Individual was enrolled in a formal education program and completed no more than eighth grade, junior high school, or middle school.

Some high school– Individual was enrolled in high school (ninth grade or higher), but did not earn a high school diploma or its equivalent.

Completed high school – Individual earned a high school diploma or its equivalent.

Technical/trade school – Individual completed or earned a certification from an accredited vocational school.

Some college/university – Individual attended a post-secondary institution but did not earn a degree.

Diploma/bachelor's degree –Individual attended a post-secondary institution and earned a bachelor's degree.

Graduate degree – Individual attended a post-secondary institution and earned a master's degree or higher.

Unknown

Coding Select the one most appropriate response.

History of Attendance at a Special Education Program or Setting

Intent To determine if the individual has attended a special education program.

Process Ask the person and caregivers. Review any available documentation.

Definitions Special Education Program or Setting – the educational program is designed to focus on and address the specific educational needs of individuals with developmental disabilities.

Coding Select the one most appropriate response.

Employment Status

Intent To determine the person's present employment status, as it may have an impact on support planning, specifically around vocational issues.

Definitions Employed – Individual receives payment for full- or part-time work.

Unemployed, seeking employment – Individual is not employed and is actively seeking full- or part-time work.

Unemployed, not seeking employment – Individuals that are unemployed and not actively seeking employment. This includes a student who is not looking for employment while attending school, a retiree, or a parent who has chosen to stay at home to care for the family.

Process Ask the person or family members about the person's employment status.

Coding Select the appropriate code for present employment status. If the individual is employed, enter the name of the employer.

Employment Arrangements – Excluding Volunteering

Intent To document the person's employment arrangement.

Definitions Competitive employment – The person works in a workplace where he/she receives adequate pay for work (i.e., minimum wage or better) and does not receive any special support or supervision.

Supported employment – The person receives special support, monitoring or supervision while at work (e.g., a job coach).

Vocational Rehabilitation – The person works in a protected work environment that often provides a stipend for work performed (e.g., sheltered workshop).

Other - When "Other" is selected, please specify.

Not Applicable

Process Ask the person, family, or others about the person's present employment arrangement.

Coding Select the present employment arrangement. If other is selected, specify the employment arrangement.

Involvement in structured activities

Intent To document the person's involvement in structured activities

Definitions Formal education program – Includes enrollment in any formally recognized education program (e.g., elementary or high school, college, university, private vocational/technology/business school, retraining program).

Volunteerism (e.g., for community services) – The person currently provides services without compensation (e.g., with a community service, program, or group). Note: the person may be employed *and* serve as a volunteer. "Currently provides" implies holding an ongoing volunteer position, regardless of whether the person actively fulfilled his/her duties as a volunteer in the last 3 days.

Day program – Any program (outside the home) where the person receives social, recreational, medial, or functional support (e.g., teaching of self-care, instrumental activities of daily living [IADL] or social skills).

Other – If other, please specify.

Process Ask the person, family, or others about the person's involvement in any structured activities.

Coding Select the most appropriate response to indicate the person's involvement in structured activities. If other is selected, specify as appropriate.

Section B. Cognition

It is important to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These items are crucial factors in many care-planning decisions, in part because of their impact upon the person's ability to follow instructions and treatment regimens, and to make independent decisions in the community. Documentation should be entered in the comments section to support response options. For example, when there is difficulty only with new tasks or situations.

Cognitive Skills for Daily Decision Making

Intent

To record the person's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a person's abilities and his or her current level of performance, as the family may inadvertently be fostering the person's dependence.

Definition

Here are some examples of decision-making tasks:

- Choosing items of clothing
- Knowing when to eat meals
- Knowing and using space in the home appropriately
- Using environmental cues (e.g., clocks or calendars) to organize and plan the day
- In the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from family in order to plan the day
- Using awareness of one's own strengths and limitations in regulating the day's events (e.g., asking for help when necessary)
- Making prudent decisions concerning how and when to go out of the house; where applicable, acknowledging the need to use a walker or other assistive device and using it faithfully

Process

Interview and observe the person, then consult with a family member or other caregiver. Review the events of each day. **The inquiry should focus on whether the person is actively making decisions about how to manage tasks of daily living, not whether the caregiver believes the person might be capable of doing so. Remember that the intent of this item is to record what the person is doing (actual performance).** When a family member takes decision-making responsibility away from the person regarding tasks of everyday living, or when the person chooses not to participate in decision making (whatever his or her level of capability may be), the person should be considered as having impaired performance in decision making.

Coding

Select the one most appropriate response.

- Independent – The person's decisions in organizing daily routines and making decisions were consistent, reasonable, and safe (reflecting lifestyle, culture, values).

- Modified independence – The person organized daily routines and made safe decisions in familiar situations but experienced some difficulty in decision making when faced with new tasks or situations.
- Minimally impaired – In specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
- Moderately impaired – The person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
- Severely impaired – The person never (or rarely) made decisions.
- No discernible consciousness, coma – The person is nonresponsive.

Memory/Recall Ability

Intent — To determine a person's ability to remember past events (short-term memory) and to perform sequential activities (procedural memory).

Process — Short-term Memory – Conduct a structured test of short-term memory. If this is not possible, ask the person to describe a recent event that you should both have knowledge of (e.g., the election of a new political leader, a major holiday) or that you can validate with a family member (e.g., what the person had for breakfast). **If there is no positive indication of memory ability, code the item "Memory problem."**

Procedural memory OK –This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such an activity, as multiple steps are required to complete the task. The person must be able to perform or remember to perform all or most of the steps in order to be coded "Yes, memory OK." If the person demonstrates difficulty in two or more steps, code as "Memory problem." Remember that persons in need of care in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

Coding — Code for recall of what was learned or known.

Change in Decision Making as Compared to 90 Days Ago (or Since Last Assessment)

Intent — To compare the person's current decision-making ability to that of 90 days ago, or since the last assessment if that was less than 90 days ago. The changes may be permanent or temporary, and the cause may be known (e.g., psychotropic medication or new pain) or unknown. If the person is newly admitted to the program, include changes since admission **and** changes during the period prior to admission.

Process — Talk to the person and family members. Ask them to compare the person's decision-making status now versus 90 days ago (or since the last assessment if less than 90 days ago). To help identify the 90-day time period, ask the person or others to pinpoint an event that occurred 3 months ago, and then to relate the person's functioning to that event. For example, if the person visited a family

member 3 months ago, ask how able he or she was in making decisions during that trip.

Section C. Communication and Vision

Making Self Understood (Expression)

Intent — To document the person's ability to express or communicate requests, needs, opinions, and urgent problems, and to engage in social conversation. Such communication may take the form of speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

Process — Interact with the person. Observe and listen to the person's efforts to communicate with you. If possible, observe his/her interactions with family. If he/she has communication devices, encourage their use during the assessment. Observe the person's interactions with others in different settings (e.g., one-on-one, in groups, with family members) and different circumstances (e.g., when calm, when agitated). Note that this item is not intended to address differences in language understanding, such as only speaking in a language not familiar to the assessor.

Coding — Select the most appropriate response:

- Understood – The person expresses ideas clearly without difficulty.
- Usually understood – The person has difficulty finding the right words or finishing thoughts (resulting in delayed responses), **but** if given time, requires little or no prompting.
- Often understood – The person has difficulty finding words or finishing thoughts, **and** prompting is usually required.
- Sometimes understood – The person has limited ability, but is able to express **concrete** requests regarding at least basic needs, such as food, drink, sleep, and toilet.
- Rarely or never understood **–** At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language. For example, caregiver has learned to interpret person signaling the presence of pain or need to toilet.

Ability to Understand Others (Comprehension)

Intent — To describe the person's ability to comprehend verbal information, whether communicated to the person orally, in writing, or through sign language or Braille. This item measures the person's ability not only to hear messages but also to process and understand language.

Process — Interact with the person. Consult with family.

Coding — Select the most appropriate response.

- Understands – Clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

- Usually understands – With little or no prompting, person misses some part or intent of the message but comprehends most of it. The person may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- Often understands – The person misses some part or intent of the message. However, with prompting (repetition or more detailed explanation), the person often comprehends the conversation.
- Sometimes understands – The person demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions. When the message is rephrased or simplified, or gestures are used, the person's comprehension is enhanced.
- Rarely or never understands – The person demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the person can hear sounds but does not understand messages.

Hearing

Intent — To evaluate the person's ability to hear with environmental adjustments, if necessary.

Process — Evaluate hearing ability after the person has a hearing appliance in place (if the person uses an appliance). Be sure to ask if the battery works and if the hearing aid is turned on. Interview and observe the person, and ask about hearing function. Consult the person's family. Test the accuracy of your findings by observing the person during your verbal interactions.

Ask the person about hearing function, and observe hearing function during your verbal interactions. Use a variety of observations to make your assessment (e.g., one-on-one vs. in group situations). If possible, observe the person interacting with others, such as family members. Always be mindful of environmental factors (nearby conversations, outside noises, etc.) that could influence your assessment. If necessary, consult with the family, primary support people, or speech or hearing specialists to clarify the person's exact hearing level.

Be alert to what you have to do to communicate with the person. Clues that there is a hearing problem include having to speak more clearly or slowly, or use a louder tone or more gestures. Persons with hearing problems may also need to see your face to know what you are saying, or you may have to take the person to a more quiet area to conduct the interview.

Coding — Select the most appropriate response.

- Adequate – No difficulty in normal conversation, social interaction, listening to TV.
- Minimal difficulty – Difficulty in some environments (e.g., when the other person speaks softly or is more than 6 feet [2 meters] away).
- Moderate difficulty – Problem hearing normal conversation, requires quiet setting to hear well.

- Severe difficulty – Difficulty in all situations (e.g., speaker has to talk loudly or very slowly, or person reports that all speech is mumbled).
- No hearing.

Vision

Intent — To evaluate the person's ability to see close objects in adequate light, using the person's customary visual appliances for close vision (such as glasses or a magnifying glass).

Definition — Adequate light – Light that is sufficient or comfortable for a person with normal vision.

Process — Ask person, family member, or staff if the person has manifested any change in usual vision patterns – for example, is the person still able to read newsprint, greeting cards, and the like?

Ask the person about his or her visual abilities. Test the accuracy of your findings by asking the person to look at regular-sized print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (such as glasses or a magnifying glass). Then ask the person to read aloud, starting with larger headlines and ending with the finest, smallest print.

Be sensitive to the fact that some persons are not literate or are unable to read English. In such cases, ask the person to read aloud individual letters or numbers (such as dates or page numbers), or to name items in small pictures.

If the person is unable to communicate or follow your directions for testing vision, observe the person's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the person has any visual ability.

Coding — Select the most appropriate response.

- Adequate – The person sees fine detail, including regular print in newspapers/books.
- Minimal difficulty – The person sees large print, but not regular print in newspapers/books.
- Moderate difficulty – The person has limited vision; is not able to see newspaper headlines, but can identify objects in his or her environment.
- Severe difficulty – The person's ability to identify objects in his or her environment is in question, but the person's eye movements appear to be following objects (especially people walking by). Also includes the ability to see only light, colors, or shapes.
- No vision – The person has no vision; eyes do not appear to be following objects (especially people walking by).

NOTE: Many persons with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such persons appear to "track" or follow moving objects in their environment

with their eyes. For persons who appear to do this, select "Severe difficulty." This is often the best assessment you can do with the limited technology available.

Section D. Mood and Behavior

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to one's living situation, functional impairment, resistance to daily care, inability to participate in activities, social isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress, because they are treatable.

It would be very unusual for family members to have received specific training in how to evaluate persons who have distressed mood. Therefore, although family may sense that something is wrong, mood distress is often underdiagnosed and undertreated in community settings. Thus, this assessment may serve as a crucial first opportunity to identify whether such problems are present.

Indicators of Possible Depressed, Anxious, or Sad Mood

Intent — To record the presence of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator/behavior.

Definitions — The mental state indicators may be expressed verbally through direct statements or through nonverbal indicators or behaviors that can be monitored by observing the person during usual daily routines.

Made negative statements – For example, "Nothing matters;" "Would rather be dead than live this way;" "What's the use;" "Regret having lived so long;" "Let me die."

Persistent anger with self or others – For example, easily annoyed, anger at care received.

Expressions, including nonverbal, of what appear to be unrealistic fears – For example, fear of being abandoned, being left alone, or being with others; intense fear of specific objects or situations.

Repetitive health complaints – For example, persistently seeks medical attention, incessant concern with body functions.

Repetitive anxious complaints/concerns (non-health-related) – For example, persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationships.

Sad, pained, or worried facial expressions – For example, furrowed brows, constant frowning.

Crying, tearfulness – Distress may also be expressed through such nonverbal indications.

Withdrawal from activities of interest – Including long-standing activities, being with family/friends.

Reduced social interactions – Avoids social interactions; lack of responsiveness to others.

Process

Feelings of psychic distress may be expressed directly by the person who is depressed, anxious, or sad. Distress can also be expressed through nonverbal indicators. Initiate a conversation with the person, being cognizant of earlier statements by (or observations of) the person. Some persons are more verbal about their feelings than others and will either tell someone about their distress, or will at least tell someone when asked directly how they feel. For persons who verbalize their feelings, ask how long these conditions have been present. Other persons may be unable to articulate their feelings (perhaps because they cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3 days covered by this assessment. Consult with family members who have direct knowledge of the person's typical and current behavior, and any other clinicians working with the person (such as the primary care provider, if available).

Remember to be aware of cultural differences in how these indicators may be manifested. Some persons may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about the person's cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing a person whose culture may make him or her more stoic in his/her expressions.

Coding

Based on your interaction with and observation of the person, select the appropriate response based on the person's behavior over the last 3 days.

- Not present
- Present but not exhibited in last 3 days – indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days
- Exhibited on 1–2 of last 3 days
- Exhibited daily in last 3 days

Remember, select the response for each item based on what you see or what is reported to you, regardless of what you believe the cause to be. Whenever possible, ask the person.

Behavior Symptoms

Intent

To identify the frequency, during the last 3 days, of behavioral symptoms that cause distress to the person, or are distressing or disruptive to others with whom the person lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. These items are designed to pick up problem behaviors exhibited by the person that may be considered as "combative or agitated" by some health professionals.

Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care toward ameliorating the behavioral symptoms.

Definitions

Wandering – Moved with no rational purpose, seemingly oblivious to needs or safety.

Verbal abuse – For example, others were threatened, screamed at, cursed at.

Physical abuse – For example, others were hit, shoved, scratched, sexually abused. This item identifies physically aggressive behavior without making the distinction between intentional and unintentional behaviors.

Socially inappropriate or disruptive behavior – For example, made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings.

Inappropriate public sexual behavior or public disrobing – Sexual behavior should only be considered inappropriate when it contravenes usual social norms (e.g., deliberately exposing self, masturbating in public or in a room while others are present, and unacceptable sexual gestures, touching, pinching). Sexual activity in private (either alone or between consenting adults) is not considered here. Public disrobing refers to behavior that contravenes local laws. In the case of disrobing, remember to code for the absence or presence of the behavior but not the intent. For example, select "Present but not exhibited in last 3 days," or higher if a person reports undressing in public because there were no private places available.

Resists care – For example, taking medications/injections, activities of daily living (ADL) assistance, eating.

Process

Ask the family member or caregiver if each specified problem behavior occurred. Take an objective view of the person's behavioral symptoms, and focus on the person's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. The fact that some family members have become used to the behavior or minimize the person's presumed intent ("He doesn't really mean to hurt anyone — he's just frightened") should not be considered in coding items. Rather, code each item based on whether the person manifested the behavioral symptom.

Observe the person and the way he or she responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the person is not in the room. Recognize that responses given with the person present may need to be validated later and that the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.

A review of information in the record may also be helpful.

Coding

Select the appropriate response for the presence of each behavior symptom over the last 3 days, regardless of what you believe to be the underlying cause of the behavior. Remember to select the response for both the presence of the behavior

and the number of days in which it was exhibited, no matter how often it was exhibited per day.

Select one of the following options:

- Not present
- Present but not exhibited in last 3 days – indicates that while the assessor knows the condition is **present** and **active**, it was not physically manifested over the last 3 days
- Exhibited on 1–2 of last 3 days
- Exhibited daily in last 3 days

Self-Reported Mood

Intent — To record the person's self-reported mood over the last 3 days. In some cases, the person may deny feeling a particular way in the last 3 days but reports that the issue continues to be "present" and active.

Definitions — These items involve verbal reports of the person's subjective evaluation of three dimensions of mood state (anhedonia, anxiety, dysphoria) over the last 3 days.

Process — Once you have completed your own rating of the person's mood state using the other items in the Mood section of the assessment, ask the person the following questions directly:

"In the last 3 days, how often have you felt…?

- Little interest or pleasure in things you normally enjoy?
- Anxious, restless, or uneasy?
- Sad, depressed, or hopeless?"

Only the person's responses should be used to determine the appropriate selection response. Do not select a response based on your own inferences about the person's mood state and do not select ratings given by family, friends, or other informants. These items should be treated strictly as self-report measures. Do not dwell on these items and do not input responses for the person. Select "Person could not (would not) respond if the person is unable (due to cognitive impairment, for example) or refuses to respond.

Coding — For each item, use the **person's response as to whether/how often he or she experienced the feelings referenced in the items** over the last 3 days, regardless of what the person believes to be the underlying cause of those feelings. Remember to select the response for both the presence of the indicator and the number of days in which it was felt, no matter how often it was felt per day. Select "Person could not (would not) respond" for persons unable or unwilling to respond.

Use the following selection options:

- Not in last 3 days

- Not in last 3 days, but often feels that way – use only if the person indicates the feeling is frequently **present** and **active**, but was not experienced in the last 3 days
- In 1–2 of last 3 days
- Daily in the last 3 days
- Person could not (would not) respond

Section E. Psychosocial Well-Being

Social Relationships

Intent — To document and describe the person's interaction patterns and adaptation to his or her social environment. To assess the degree to which the person is involved in social activities, meaningful roles, and daily pursuits.

Definitions — Participation in social activities of long-standing interest — The person engaged in social activities that have been of long-standing interest to him or her. The activities may be quite varied and should be counted as long as they involve interaction with at least one other person. Examples include attending meetings of informal clubs or religious services, playing bridge or bingo, volunteering at the local clothing bank, or gossiping with the neighbors on their front porches in the evening.

Visit with a long-standing social relation or family member – The person was visited by (or made a visit to) any family member, friend, or social acquaintance with a long-standing relationship with the person (e.g., a neighbor or fellow member of a community organization or religious group). The focus here is on well-established, informal ties rather than visits with paid staff, volunteers, or new acquaintances.

Other interaction with long-standing social relation or family member – For example, telephone or e-mail. The person interacted through a means other than a face-to-face visit with a family member, friend, or social acquaintance with a long-standing relationship with the person (e.g., a neighbor or fellow member of a community organization or religious group). The focus is on well-established, informal ties rather than contacts by paid staff, volunteers, or new acquaintances.

Openly expressing conflict or anger with family or friends – The person expresses feelings such as abandonment, ingratitude on part of the family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

Fearful of a family member or close acquaintance – The person expresses (verbally or through behavior) fear of a family member or close acquaintance. Such fear can be expressed in many ways. A person may state that he or she is afraid of a caregiver or may appear to withdraw whenever the caregiver is around. This may include fear of physical or emotional abuse or mistreatment. It is not necessary to establish the reason for the fear, only to determine whether it is present.

Neglected, abused, or mistreated – The person experienced a serious or life-threatening situation or condition that went untreated or was not appropriately acknowledged. The situation may have put the person at risk of death or of complications that impinge on physical or mental health.

Process — Ask the person for his or her point of view. In what activities does he or she enjoy participating? When was the last time he or she was able to participate? Who tends to come visit, and when was the last time that individual visited? Are there other ways the person contacts family or friends (e.g., by telephone or e-mail)? Is the person generally content or unhappy in relationships with family and friends? If the person is unhappy, about what specifically is he or she unhappy?

If possible, also talk with family members and friends who visit or have frequent telephone contact with the person. The primary caregiver may have a good sense of who visits or contacts the person. He or she can also describe the most common social activities the person was involved in recently.

Coding — Select the most appropriate response:

- Never
- More than 30 days ago
- 8 to 30 days ago
- 4 to 7 days ago
- In last 3 days
- Unable to determine

Lonely

Definition — The person states or otherwise indicates that he or she feels lonely. The person may feel that others do not visit enough or desires more social interaction, even if visited regularly. Others may also report that the person sometimes comments on feeling lonely.

Process — Talk with the person to determine whether he or she feels lonely. If possible, speak with the person's family or other informal contacts, such as neighbors, to get their perception of the person's feelings of loneliness.

Change in Social Activities in Last 90 Days (Or Since Last Assessment if Less Than 90 Days Ago)

Intent — To identify a recent change (as compared to 90 days ago — or since the last assessment if fewer than 90 days have passed) in the person's level of participation in social, religious, occupational, or other preferred activities. If the level of participation has declined, determine whether the person is distressed by it.

Definition — The level of participation refers to the quantity (how many) of different types of social activities; the intensity (how frequently contact occurs); and the quality of the activity (how deeply the person is involved). Remote participation is equally important and significant for the person's role fulfillment and self-esteem (e.g., a person who cannot move outside his or her home may still participate or be

associated with some kind of religious, political, or social activity). Distress occurs when the person's mood is adversely affected by a recent change in the level of participation (e.g., as evidenced by sadness, loss of motivation or self-esteem, anxiety, or depression).

Process — Talk with the person to determine whether a change has occurred and to determine his or her subjective response to any changes. If possible, speak with the family or other informal contacts (such as neighbors) to get their opinions on whether the person's activity levels have changed and, if so, how he or she responded to those changes.

Coding — Select the most appropriate response:

- No decline – There was no change, or there was an increase in the person's level of participation in social activities.
- Decline, not distressed – The person experienced a decline in his or her level of participation in social activities, without a corresponding increase in his or her distress.
- Decline, distressed – Both decline and distress are observed or reported.

Length of Time Alone during the Day (Morning and Afternoon)

Intent — To identify the actual amount of time the person is alone in the morning and afternoon.

Definition — The amount of time the person is literally alone, without any other person in the home. If the person is residing in a board-and-care facility, adult-care facility, or other situation where there are other persons in their own rooms, count the amount of time the person spends by him- or herself in the person's own room as time alone.

Process — First ask the person how much time he or she spends alone. Be clear about how "being alone" is defined. Confirm with caregivers the amount of time the person spends alone.

Coding — Select the most appropriate response:

- Less than 1 hour
- 1–2 hours
- More than 2 hours but less than 8 hours
- 8 hours or more

Major Life Stressors in Last 90 Days

Intent — To identify any life events that the person considers to have had a major impact on his or her life in the last 90 days.

Definition — Life stressors – Experiences that either disrupted or threatened to disrupt the person's daily routine and that imposed some degree of readjustment.

Process — Ask the person if any stressful events have occurred in the last 90 days. Examples may include an episode of severe personal illness, the death or severe illness of a close family member or friend, the loss of the person's home, a major loss of

income or assets, being the victim of a crime such as robbery or assault, the loss of the person's driving license or car.

Section F. Functional Status

IADL Self-Performance and Capacity

Intent — To examine the areas of function that are most commonly associated with independent living (instrumental activities of daily living, or IADLs).

Definitions — Meal preparation – How meals are prepared (planning meals, assembling ingredients, cooking, setting out food and utensils). This item should be assessed in terms of the person's ability to put meals together, regardless of the quality or nutritional value of the meal. For example, if the person is able to make cold cereal for breakfast, or put together a cold sandwich and drink coffee at lunch, or make toast for dinner without assistance, the person would be scored as independent in meal preparation capacity.

Ordinary housework – How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

Managing finances – How bills are paid, checkbook is balanced, household expenses are budgeted, and credit card account is monitored.

Managing medications – How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).

Phone use – How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

Stairs – How a **full** flight of stairs is managed (i.e., 12–14 stairs). If the person is able to go up and down only a half flight (2–6 stairs), do not score as independent.

Shopping – How shopping is performed for food and household items (selecting items, paying money). **This item does not include transportation.**

Transportation – How person travels by public transportation (navigating system, paying fare) or drives self (including getting out of the house, into and out of vehicles).

Equipment Management (includes only oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies) – The **ability** (NOT compliance or willingness) to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. Note: If person is in nursing home at time of assessment, this should not be answered. **Answer for all other settings if the listed equipment is being used by the person.**

Process — Question the person about his or her performance of normal activities around the home or in the community in the last 3 days. You may also talk to family

members if they are available. Use your own observations as you are gathering information for other Community Health Assessment items.

Coding

For each item, select the most appropriate response in the following two categories:

Performance – Measures what the person actually did within each IADL category in the last 3 days. Do not base your selection on what the person might be capable of doing (see the Capacity category).

Capacity – Select the response based on the person's presumed ability to carry out the activity. This requires speculation by the assessor.

Because of a lack of skills or experience, a person may not perform some activities but would be capable of doing so with the proper training or opportunity. Therefore, it is important to distinguish between nonperformance that is due to impairment of capability (caused by health problems) and nonperformance that is due to other factors (not related to the person's health). For example, some males may never have learned to cook, and some females may never have handled financial matters. For some activities, the person may perform the activity independently at times but receive/require assistance at other times. First, determine whether the person actually performed the activity. If not, evaluate whether the person is capable of performing the activity.

- Independent – No help, setup, or supervision needed.
- Setup help only – Article or device provided or placed within reach, no physical assistance or supervision in any episode.
- Supervision – Oversight/cuing required.
- Limited assistance – Help required on some occasions.
- Extensive assistance – Help required throughout task, but performs 50% or more of task on own.
- Maximal assistance – Help required throughout task, but performs less than 50% of task on own.
- Total dependence – Full performance of activity during entire period by others.
- Activity did not occur – During entire period. **NOTE: You may select this response for the Performance category, but do not select it to for the Capacity category.**

ADL Performance

Intent

To record what the person did for him- or herself and how others assisted in the performance of self-care activities of daily living (ADLs) during the last 3 days.

Definitions

ADL self-performance – Measures based on all episodes of the activity over the last 3 days.

Bathing – How the person takes a full-body bath or shower. Includes how person transfers in and out of tub or shower **and** how each part of body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area. **Exclude washing of back and hair.**

Personal hygiene – How the person manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands. **Exclude baths and showers.**

Dressing upper body – How the person dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.

Dressing lower body – How the person dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirt, shoes, fasteners, etc.

Walking – How the person walks between locations on the same floor indoors.

Locomotion – How the person moves between locations on the same floor (walking or wheeling). If the person uses a wheelchair, this measures self-sufficiency once he or she is in the chair.

Transfer toilet – How the person moves onto and off of the toilet or commode.

Toilet use – How the person uses the toilet room (or commode, bedpan, urinal), cleanses him- or herself after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes. **This item does not include transfer on and off the toilet.**

Bed mobility – How the person moves to and from a lying position, turns from side to side, and positions his or her body while in bed.

Eating – How the person eats and drinks (regardless of skill). Includes intake of nourishment by other means (such as tube feeding or total parenteral nutrition).

Setup help – Assistance characterized by the provision of articles, devices, or preparation necessary for the person's self-performance of an activity. This includes giving or holding out an item the person takes from the helper, if the helper then leaves the person alone to complete the activity. If someone remains nearby to watch over the person, the person is receiving oversight, thus the response would be "Supervision." Following are a few examples of setup help. For the "Personal hygiene" item, setup help might mean providing a washbasin or grooming articles. For "Walking," it might take the form of handing the person a walker or cane.

Weight bearing – Persons require varying degrees of physical assistance to complete ADL tasks. A key concept in scoring the degree of assistance is the degree of weight-bearing support provided. When relating to non-upright positions, such support might take the form of a helper holding the full weight of an arm while assisting the person with putting on a shirt. When relating to standing or walking, such support might mean taking the person's weight by holding him or her under the armpit, or allowing the person to lean on the helper's arm. Guiding movements with minimal physical contact and contact guarding with intermittent physical assistance are **not** considered weight bearing.

Process

To describe functioning, the assessor should first get a sense of the episodes in each ADL area over the last 3 days. Determine what the person does for him- or herself and the nature of assistance provided (if any).

When ADL self-performance in an area varies over the last 3 days, identify the 3 most dependent episodes — that is, the episodes when the person received the greatest care or assistance from others. The summarization that is done to develop the ADL scores (as described below) focuses on the most dependent episodes, providing a picture of the person's need for help from others in managing the ADLs.

In order to summarize ADL self-performance, gather information as noted below.

- Gather information from multiple sources. For example, talk with the person, family, staff, and others.
- Ask questions pertaining to all aspects of the ADL definitions. For example, when discussing "Personal hygiene," inquire how the person manages washing in the morning, combing hair, brushing teeth, and shaving. A person can be independent in one aspect of personal hygiene yet require extensive assistance in another aspect.
- Observe how the person is performing the physical tasks.
- Talk with the person to ascertain what he or she does for him- or herself in each ADL, as well as the type and level of assistance provided by others.
- If possible, talk with immediate caregivers or family members.
- Finally, weigh all responses to come up with a consistent picture of the person's ADL performance for each episode assessed in each area.

Coding

The following are the ADL Self-Performance scoring rules.

If **all** episodes in the last 3 days were performed at the same support level, score the ADL at that level.

- Note that regarding the scores "Independent", "Total dependence", and "Activity did not occur", this is the only situation in which such a score would apply. In other words, to receive one of these scores, all performance episodes must be at the same level.
- Also note that this rule applies when there was only one performance episode during the 3-day period. For example, if over the course of the 3 days the person moved once between locations on the same floor but was bed-bound for the remainder of the time, then the score for "Locomotion" should be based on the single episode when the person moved.

If **any** episodes were at level "Total dependence" and other episodes were less dependent, the item should be scored "Maximal assistance".

Otherwise, focus on the three most dependent episodes (or the two most dependent episodes if the ADL was only performed twice). If the most dependent of these episodes would be scored "Independent, setup help only", score the item "Independent, setup help only". If the most dependent of these episodes would receive a higher score, however, the item should receive the score to match the

least dependent of those episodes in the range between "Supervision" and "Maximal Assistance".

In accordance with these rules and the guidelines, select the most appropriate response.

- Independent – No physical assistance, setup, or supervision in any episode.
- Independent, setup help only – Article or device provided or placed within reach, no physical assistance or supervision in any episode.
- Supervision – Oversight/cuing.
- Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight.
- Extensive assistance – Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.
- Maximal assistance – Weight-bearing support (including lifting limbs) by two or more helpers; **or**, weight-bearing support for more than 50% of subtasks.
- Total dependence – Full performance by others during all episodes.
- Activity did not occur during entire period – Do not confuse a person's total dependence in an ADL activity with nonoccurrence of the activity itself. For example, even a person who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment) and must be evaluated under the eating category for his or her level of assistance in the process. A person who is highly involved in giving him- or herself a tube feeding should not be assessed as "Totally Dependent." Instead, the person should be assessed at an appropriate level based on the nature of the help received from others.

Here are general guidelines for recording accurate ADL Self-Performance:

- The coding scale for ADLs records the person's actual level of involvement in self-care and the type and amount of support actually received during the last 3 days.
- Do not base your assessment on the person's capacity for involvement in self-care — that is, what you believe the person **could** do for him- or herself.
- Do not record the type and level of assistance you think the person "should" be receiving (e.g., based on a written plan of care or expectations the family may have). The type and level of assistance actually provided might be quite different from what is indicated in a care plan. Record what is actually happening.
- Engage family (or, when possible, staff who have helped the person over the last 3 days) in discussions regarding the person's ADL functions. Remind these persons that the focus is on the last 3 days only. To clarify your own understanding and observations about each ADL activity (bed mobility, walking, transfer to toilet, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Primary Mode of Locomotion Indoors

Intent — To record the primary mode of locomotion and type of appliances, aids, or assistive devices the person used indoors over the last 3 days.

Definitions — Cane – A slender stick held in the hand and used for support when walking.

Crutch – A device for aiding a person with walking. Usually it is a long staff with a padded crescent-shaped portion at the top that is placed under the armpit.

Scooter – Motorized vehicle operated by a person for use in getting from one location to another.

Walker – A mobile device used to assist a person with walking. Usually consists of a stable platform made of metal tubing that the person grasps while taking a step. The person then moves the walker forward and takes another step.

Coding — Select the appropriate response for the primary mode of locomotion used by the person indoors within the last 3 days. For persons who walk by pushing a wheelchair in front of them for support, or by using a walker-type device such as a Merry Walker, select "Walking, uses assistive device."

- Walking, no assistive device
- Walking, uses assistive device – For example, a cane, walker, crutch, or pushing wheelchair
- Wheelchair, scooter
- Bed-bound

Activity Level

Intent — Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep persons fit in many ways. Below a certain threshold of activity, functional decline may be accelerated.

It is necessary to understand whether the person is motivated to undertake physical activity, what the person's needs may be, what barriers need to be overcome, and whether health education is needed.

Many persons are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own lifestyle is for health maintenance. For example, the person may understand the general importance of exercise and good nutrition, but may not be willing or readily able to make changes in his or her lifestyle without some type of support or assistance.

Definition — Exercise or physical activity – Any exercise that involves at least moderate physical activity, such as walking outdoors, swimming, yoga, class, exercise with machines.

Went out of the house or building – This means the person went outdoors, no matter how short the period of time he or she spent outdoors. This could mean going into the yard, standing on an open porch, or walking down the street.

Process For "Exercise of physical activity," ask the person and family to describe the person's involvement in physical activity in the last 3 days (e.g., walking).

For "Went out of the house or building," ask the person or family if the person went outside in the last 3 days.

Coding For "Exercise of physical activity," if the accumulated time is between 2 hours and 3 hours, select "1–2 Hours.**"** Hours of exercise do not have to occur all at once on a given day; they may be accumulated over the course of several instances.

For "Went out of the house or building," if illness or weather did not permit (e.g., if it snowed or there was a "tropical" downpour) and the person did not leave the house but normally would have during a 3-day period, select "Did not go out in last 3 days, but usually goes out over a 3-day period."

Change in ADL Status as Compared to 90 Days Ago (Or Since Last Assessment if Less Than 90 Days Ago)

Intent To determine whether the person's current ADL status differs from the status of 90 days ago (or since the last assessment, if that was less than 90 days ago).

Process Talk to the person. Ask the person to think about how well he or she was able to perform ADLs 90 days ago. How does the person's current ADL status compare to 90 days ago? If indicated, talk to a family member or caregiver.

Coding If there is a change in multiple domains, select the response for the overall direction of change. Select the most appropriate response:

- Improved
- Declined
- No Change
- Uncertain

Overall Self-Sufficiency Has Changed Significantly as Compared to Status of 90 Days Ago (Or Since Last Assessment if Less Than 90 Days Ago)

Intent To monitor the person's overall self-sufficiency in the community over time. If this is the person's first assessment, include changes during the period prior to admission to the service agency.

Definition Overall self-sufficiency – Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process Discuss with the person. If available, review clinical records, transmittal records (if new admission or readmission), previous assessments (if this is a reassessment), and any care plan notes if available. If necessary, discuss with a family member or caregiver.

Coding — Select the most appropriate response:

- Improved
- No Change
- Deteriorated

Driving

Intent — To evaluate one aspect of community independence and determine whether the person's driving is a concern.

Definitions — Drove car (vehicle) in the LAST 90 DAYS – For example, the person drove to a store, to visit, to a medical appointment.

If drove in LAST 90 DAYS, assessor is aware of whether someone has suggested that person limits OR stops driving.

Process — Ask the person about his or her driving and whether the person plans to continue driving. Be aware that driving may be a sensitive issue. Certain conditions may impair driving ability temporarily or on a more permanent basis. Ask whether the person thinks he or she is able to drive currently. If the person is unsure, recommend that before returning to driving, he or she talk to a physician, take a practice-driving test, or consult an occupational therapist or other appropriate professional(s) to assess driving capacity.

Transportation

Intent — To determine whether individual can physically tolerate, without substantial discomfort, transportation to access community-based programs and medical services outside the home.

Definition — Transportation includes automobile, taxi, van, etc. used to transport persons with disabilities. Inability to tolerate transportation, including the amount of time spent in transport, may necessitate that all services be provided in the home. Medical appointments may require special medical transportation.

Process — Ask the individual or family members, if they are available.

Section G. Continence

Bladder Continence

Intent — To determine and record the person's pattern of bladder continence (control) over the last 3 days.

Definition — This item describes the person's bladder continence pattern, taking into account any control plans or devices, such as scheduled toileting plans, continence training programs, or urinary appliances. It does not refer to the person's ability to toilet him- or herself — for example, a person may require extensive assistance in toileting and still be continent. Bladder incontinence includes any level of dribbling or wetting of urine.

Process

Review the person's urinary elimination pattern with him or her. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for persons who are struggling to maintain control. Many persons with poor control will try to hide their problems out of embarrassment or fear of retribution or institutionalization. Others will not report problems because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many persons are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

Validate continence patterns with people who know the person well (such as family caregivers).

Remember to consider continence patterns over the last 3-day period, 24 hours a day, including weekends.

Coding

A six-level scale is used to describe continence patterns. Select the one response to indicate the person's level of urinary continence over the last 3 days.

- Continent – Complete control, including control achieved by cuing or supervision that involves prompted voiding, habit training, reminders, etc. The person **does not use** any type of catheter or other urinary collection device.
- Control with any catheter or ostomy – Control with use of any type of catheter or urinary collection device.
- Infrequently incontinent – Not incontinent over last 3 days, but does have incontinent episodes (i.e., a recent history of incontinence).
- Occasionally incontinent – Less than daily episodes of bladder incontinence (incontinent on 1–2 of the last 3 days).
- Frequently incontinent – Incontinent daily, but some control present (the person is not incontinent during each episode of urination). Example: During the day, the person remains dry and is continent of urine. At night, the person wets his or her bed.
- Incontinent – No control of bladder; multiple daily episodes all or almost all of the time.
- Did not occur – No urine output from bladder in last 3 days.

Select the response for the actual bladder continence pattern, with urinary device if used. This pattern is the frequency with which the person is wet during the 3-day assessment period. Do not record the level of control that the person **might** have had under optimal circumstances (e.g., had a caregiver been available 24 hours/day to help the person with toileting).

If you are uncertain whether to select "Frequently incontinent" or "Incontinent," decide based on the presence ("Frequently incontinent") or absence (**"**Incontinent**"**) of any bladder control.

Bowel Continence

Intent — To determine and record the person's pattern of bowel continence (control) over the last 3 days.

Definition — The term "bowel continence" refers to control of the person's bowel movements. This item describes the person's bowel continence pattern with any scheduled toileting plans, continence training programs, or appliances in use. It does not refer to the person's ability to toilet him- or herself — for example, a person can require extensive assistance in toileting and still be continent of stool.

Process — The assessment for bowel continence should be completed concurrently with the bladder continence review. Control of bowel function is also a sensitive issue. Be sure to ask about the matter in a sensitive, straightforward manner. If necessary, validate continence patterns with others who know the person (e.g., a family member). Remember to consider continence patterns over the **last 3 days, 24 hours a day.**

Coding — Select the most appropriate code.

- Continent – Complete control; the person **does not use** any type of ostomy device.
- Complete control with ostomy – Control with ostomy device over last 3 days.
- Infrequently incontinent – Not incontinent over last 3 days, but does have incontinent episodes.
- Occasionally incontinent – Incontinent less than daily.
- Frequently incontinent – Incontinent daily, but person has some control.
- Incontinent – No control present.
- Did not occur – No bowel movement in the last 3 days.

Section H. Disease Diagnoses

Diseases

Intent — To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs.

Definitions — ***Musculoskeletal***

Hip fracture during last 30 days (or since last assessment if less than 30 days ago) – Includes any hip fracture that that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

Other fracture during last 30 days (or since last assessment if less than 30 days ago) – Any fracture other than hip bone (e.g., wrist) due to any condition, such as falls or weakening of the bone as a result of cancer.

Neurological

Alzheimer's disease – A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

Dementia other than Alzheimer's disease – Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological diseases other than Alzheimer's (e.g., Pick's, Creutzfeldt-Jakob, Huntington's disease).

Stroke/CVA – A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction.

Cardiac or Pulmonary

Coronary heart disease – A chronic condition marked by the thickening and loss of elasticity of the coronary artery, and caused by deposits of plaque containing cholesterol, lipoid material, and lipophages.

Chronic obstructive pulmonary disease – Any long-standing condition that impairs airflow in and out of the lungs.

Congestive heart failure – A condition in which the heart cannot pump out all the blood that enters it, which leads to an accumulation of blood in the vessels, fluid in the body tissues, and lung congestion.

Psychiatric

Anxiety – A nonpsychotic mental disorder. There are five types, which include:

- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Panic disorder
- Phobias
- Post-traumatic stress disorder

Bipolar disorder – Includes documentation of a clinical diagnosis of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

Depression – A mood disorder often characterized by a depressed mood (e.g., the person feels sad or empty, appears tearful); decreased ability to think or concentrate; loss of interest or pleasure in usual activities; insomnia or hypersomnia; loss of energy; change in appetite; or feelings of hopelessness, worthlessness, or guilt. May also include thoughts of death or suicide.

Schizophrenia – A disturbance characterized by delusions, hallucinations, disorganized speech, grossly disorganized behavior, disordered thinking, or flat

affect. This category includes schizophrenia subtypes (i.e., paranoid, disorganized, catatonic, undifferentiated, residual).

Other

Cancer – Any malignant growth or tumor caused by abnormal and uncontrolled cell division. The malignant growth or tumor may spread to other parts of the body through the lymphatic system or the bloodstream.

Diabetes mellitus – Any of several metabolic disorders marked by persistent thirst and excessive discharge of urine.

Process — Talk to the person and review any available clinical records. Consult with the person's primary physician or nurse practitioner. Talk with family members.

Coding — Select the most appropriate response for all diseases present.

- Primary diagnosis/diagnoses for current stay – One or more diagnoses that are the main reason(s) used to support and justify services being provided.
- Diagnosis present, receiving active treatment – Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
- Diagnosis present, monitored but no active treatment – Person has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Section I. Health Conditions

Falls

Intent — To determine whether the person has a history of falling, which is an important factor in assessing the person's risk of future falls or injuries. Persons who have sustained at least one fall are at risk of future falls. Falls are a common cause of morbidity and mortality among persons in the home. Serious injury results from 6% to 10% of falls, with hip fractures accounting for approximately one-half of all serious injuries.

Definition — Fall – Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.

Coding — Select the most appropriate response:

- No fall in last 90 days
- No fall in last 30 days, but fell 31-90 days ago
- One fall in last 30 days
- Two or more falls in last 30 days

Number of Falls

Intent — To record the number of falls in the last 90 days that resulted in major, minor, or no injury.

Definition — Major injury – refers to injuries such as bone fracture, joint dislocation, closed head injuries with altered consciousness, and subdural hematoma.

Minor injury – refers to injuries such as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the person to complain of pain.

No injury – refers to no evidence of any injury is noted; no complaints of pain or injury by the member; no change in member's behavior is noted after the fall.

Coding — For each type of injury (major, minor, no injury), enter the number of falls that occurred in the last 90 days. If the number is greater than 99, enter 99.

Problem Frequency

Definition — ***Balance***

Dizziness – The person experiences a sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

Unsteady gait – A gait that places the person at risk of falling. Unsteady gaits take many forms. The person may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

Cardiac

Chest pain – The person experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc.

Psychiatric

Abnormal thought process – When the person is observed, there are apparent abnormalities in the form or way in which the person is expressing thoughts. Examples of indicators for this item include:

- Loose associations – Person jumps from one topic to another without an apparent connection between the topics.
- Thought blocking – Person suddenly stops in the middle of a sentence and is unable to recover what he or she intended to say or to complete other thoughts.
- Flight of ideas – Person's thoughts are expressed so quickly that the listener has difficulty keeping up.
- Tangentiality – Person digresses from the subject under discussion and introduces thoughts that seem unrelated, oblique, or irrelevant.

- Circumstantiality – Person exhibits lack of goal-directedness, incorporates unnecessary details, and has difficulty getting to an end point in the conversation.
- Clang association – Connection between the person's thoughts is tenuous. The person may use rhyming and punning in his or her speech.
- Incoherence – Person's speech is unclear or confused. The communication does not make sense to the intended listener.
- Neologism – Person makes up a word, which may be condensed from several words. Neologisms are unintelligible to the listener.
- Punning – Person uses words that are similar in sound but different in meaning.

Delusions – Fixed, false beliefs not shared by others that the person holds even when there is obvious proof or evidence to the contrary. For example, the person may believe that he or she is terminally ill, that his or her spouse is having an affair, or that food served at a restaurant or congregate dining room is poisoned.

Hallucinations – The person has false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people or animals), tactile (e.g., feeling bugs crawling over the skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., experiencing strange tastes).

GI Status

Acid reflux – The regurgitation of small amounts of acid from the stomach to the throat.

Constipation – No bowel movement in 3 days, or difficult passage of hard stool.

Diarrhea – The frequent elimination of watery stools, regardless of cause.

Vomiting – Regurgitation of stomach contents, regardless of etiology (e.g., drug toxicity, influenza, psychogenic).

Sleep Problems

Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep – For example, the person:

- Experiences an extended time gap between the point at which he or she attempted to fall asleep and the time at which sleep was actually initiated;
- Wakes up well before the desired time due to some factor inherent to him or her (exclude situations in which the person is awakened by some external source)
- Experiences sleep that is accompanied by repeated tossing and turning, or dreaming that causes motion or wakefulness, etc., such that the person does not feel relaxed when sleeping and rested when awake
- Suffers from sleep apnea

- Is easily awakened during sleep by sounds or movements, and experiences one or more periods of awakening after sleep is initiated

Too much sleep – An excessive amount of sleep that interferes with the person's normal functioning.

Process — Ask the person – he or she may not have told others of his or her symptoms. Ask family members or caregivers. Review any available clinical records.

Coding — Select the most appropriate response:

- Not present
- Present but not exhibited in last 3 days
- Exhibited on 1 of last 3 days
- Exhibited on 2 of last 3 days
- Exhibited daily in last 3 days

Dyspnea (Shortness of Breath)

Definition — The person has reported being, or has been observed to be, breathless or "short of breath."

Process — Ask the person if he or she has experienced shortness of breath. If the answer is affirmative, determine if the symptom occurred with strenuous activity, during normal day-to-day activity, or when resting. If the person is unable to respond, review the clinical record and consult with other clinicians and the person's family.

Coding — Select the appropriate response:

- Absence of symptom
- Absent at rest, but present when performed moderate activities
- Absent at rest, but present when performed normal day-to-day activities
- Present at rest

Responses should be for the most severe occurrence during the last 3 days. If the symptom was absent during the last 3 days, but would have been present had the person undertaken activity, select the response according to the activity level (day-to-day or moderate) that would normally have caused the person to experience shortness of breath.

"Moderate activities" include some type of physical exercise, such as walking a long distance, climbing two flights of stairs, or gardening. "Normal day-to-day activities" include all ADLs (bathing, transferring, etc.) and IADLs (meal preparation, shopping, etc.).

Fatigue

Intent — To describe gradations of fatigue or impaired stamina. Fatigue is associated with some chronic diseases and end-stage conditions.

Definitions

Fatigue – An overwhelming or sustained sense of exhaustion resulting in decreased capacity for physical or mental work.

Normal day-to-day activities – These include all ADLs (bathing, transferring, etc.) and IADLs (meal preparation, shopping, etc.).

Coding

Select the appropriate response. If fatigue was absent over the last 3 days, but would have been present had the person undertaken activity, select the response according to the activity level that would normally have caused the person to experience fatigue.

- None
- Minimal – Diminished energy but completes normal day-to-day activities.
- Moderate – Due to diminished energy, **unable to finish** normal day-to-day activities.
- Severe – Due to diminished energy, **unable to start some** normal day-to-day activities.
- Unable to commence any normal day-to-day activities – Due to diminished energy.

Pain Symptoms

NOTE: Always ask the person about frequency, intensity, and control of the pain. Observe the person and ask others who are in contact with the person.

Intent

To record the frequency and intensity of any pain the person may be experiencing. This item can be used to identify indicators of pain, as well as to monitor the person's response to pain management interventions. A substantial number of persons with pain receive inadequate or no treatment. In particular, persons with chronic, non-cancer-related pain are often overlooked and not treated. One of the biggest reasons for this is that many persons mistakenly believe that pain is to be expected as one ages, or that nothing can be done to relieve their pain.

Definition

Pain – "An unpleasant sensory and emotional experience" that is generally associated with actual or potential tissue damage.

Process

Pain is highly subjective. It is what the person says it is. There are no objective markers or tests to indicate when someone is having pain, or to measure its severity. What a person experiences may not be proportional to the type or extent of the underlying tissue damage. Sometimes, a specific cause for chronic pain cannot be identified. Regardless, unless the person refuses, pain must always be treated, even if its cause is unknown.

The most accurate and reliable evidence of the existence of pain and its intensity is what the person tells you. Even in cognitively impaired persons, self-reports of pain should be considered reliable.

You may not get an accurate answer if you simply ask "Are you in pain?" A person may think of "pain" as a more intense experience after an acute event — such as what may be experienced after surgery or spraining an ankle. For example, a woman may have a sore foot that "acts up" when she pivots to transfer

to her wheelchair or the toilet but does not bother her most of the time. So she might deny being "in pain." Persons often use different words in describing pain, referring to what they're feeling as "discomfort," " burning," "hurting," "aching," "tightness," "heaviness," "soreness," or a "twinge" or "pang."

If the person states he or she has pain, ask about the degree of control. If the person is unable to tell you if he or she is experiencing some type of painful sensation, observe the person for indicators of pain such as moaning, wincing, or guarding. In some persons, the presence of pain can be hard to discern. For example, persons with dementia may not be able to verbalize that they are feeling pain, although they may manifest pain by particular behaviors such as calling out. Although such behaviors may not be indicative solely of pain, the assessor needs to make a determination (through assessment) if the behaviors are secondary to pain. If necessary, ask those who have had frequent contact with the person whether he or she complained or showed evidence of pain in the last 3 days. All pain items except "Frequency With Which Person Complains or Shows Evidence of Pain" have a 3 day look back period. However, the person must **first** be asked directly about frequency and intensity.

Frequency With Which Person Complains or Shows Evidence of Pain

Definition Measures how often the person experiences pain (reports or shows evidence of pain); includes grimacing, teeth clenching, moaning, withdrawal when touched, and other nonverbal signs suggesting pain.

Coding Select the appropriate response:

- No pain
- Present but not exhibited in last 3 days
- Exhibited on 1-2 of last 3 days
- Exhibited daily in last 3 days

Intensity of Highest Level of Pain Present

Definition Measures the level of pain reported by or observed in the person.

Coding Select the appropriate response:

- No pain
- Mild
- Moderate
- Severe
- Times when pain is horrible or excruciating

Consistency of Pain

Definition Measures the frequency (ebb and flow) of pain from the person's perspective.

Coding Select the appropriate response:

- No pain
- Single episode during last 3 days

- Intermittent
- Constant

Breakthrough Pain

Definition The person experienced a sudden, acute flare-up of pain one or more times in the last 3 days. Breakthrough pain might appear as a dramatic increase in the level of pain above that addressed by ongoing analgesics, or the recurrence of pain associated with end-of-dose failure.

Pain Control

Definition The ability of the current therapeutic regimen to control the person's pain adequately (from the person's point of view). This item describes the adequacy or inadequacy of pain control measures (such as medications, massage, TENS, or other therapeutic regimen) instituted by the person, caregiver, or clinical staff caring for the person.

Coding Select the appropriate response:

- No issue of pain
- Pain intensity acceptable to person; no treatment regimen or change in regimen required
- Controlled adequately by therapeutic regimen
- Controlled when therapeutic regimen followed, but not always followed as ordered
- Therapeutic regimen followed, but pain control not adequate
- No therapeutic regimen being followed for pain; pain not adequately controlled

Instability of Conditions

Definitions Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating) – For example, the person may have a condition such as ulcerative colitis, rheumatoid arthritis, or multiple sclerosis that causes pain or impairs mobility or sensation, resulting in increased dependence on others and depression.

Experiencing an acute episode or a flare-up of a recurrent or chronic problem – The person is symptomatic for an acute health condition (such as new myocardial infarction, adverse drug reaction, or influenza) or recurrent acute condition (such as aspiration pneumonia or urinary tract infection). Also included are persons who are experiencing an exacerbation or flare-up of a chronic condition (e.g., new-onset shortness of breath in someone with a history of asthma, or increased pedal edema in a person with congestive heart failure). This type of acute episode usually is of sudden onset, has a time-limited course, and requires evaluation by a physician.

Process Consult with the person and the person's family. Review any clinical records.

Self-Reported Health

Process — Ask the person: "In general, how would you rate your health?" Record the person's response according to one of the categories below. Do not code based on your own inferences about the person's physical health and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the person is unable (e.g., due to cognitive impairment) or refuses to respond, do not dwell on the item and do not presume responses for the person; instead, code that the person could not/would not respond.

Coding — Select the appropriate response:

- Excellent
- Good
- Fair
- Poor
- Could not (would not) respond

Tobacco, Alcohol and Substance Abuse

Smokes Tobacco Daily

Intent — To determine whether the person smokes tobacco.

Definition — Tobacco – Refers to cigar, cigarette, or any other tobacco product that is inhaled.

Process — Ask the person directly. This information may be sensitive to the person or create feelings within the assessor. Care must be taken to acknowledge these feelings. Begin asking the person about tobacco usage, with a simple nonjudgmental question, "Do you smoke?" If yes, determine the frequency. Address this issue in a gentle way to avoid the person feeling judged or as though he or she is doing something wrong. For example, you might say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the person.

Coding — Select the appropriate response:

- No
- Not in last 3 days, but usually a daily smoker
- Yes

Smokes Safely

Intent — To determine whether the person's smoking is a safety risk to self or others.

Definition — The person has reported or been observed smoking tobacco products such as cigarettes, cigars, or a pipe in an unsafe manner. Smoking marijuana or other substances may pose a similar risk.

Process — Interview the person and/or others living in or visiting the household. Observations of the individual smoking are also valuable in determining whether

the person can safely light, hold, and extinguish the substance. Such behaviors as dropping cigarettes on the floor, carpet, or clothing; failing to properly extinguish a cigarette; smoking while in bed or a recliner are examples of unsafe behaviors which would place the person at risk for burns or starting a fire.

Chews Tobacco Daily

Intent — To determine if the person chews tobacco placing him/her at risk for oral cancer.

Definition — The person has reported or been observed using chewing tobacco.

Process — Ask the person directly. This information may be sensitive to the person or create feelings within the assessor. Care must be taken to acknowledge these feelings. Begin asking the person about tobacco usage, with a simple nonjudgmental question, "Do you use chewing tobacco?" If yes, determine the frequency. Address this issue in a gentle way to avoid the person feeling judged or as though he or she is doing something wrong. For example, you might say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the person.

Coding — Select the appropriate response:

- No
- Not in last 3 days
- Yes

Alcohol

Intent — To determine if a person's consumption of alcohol is a potential problem by identifying the highest number of alcoholic drinks the person had in a "single sitting" during **the last 14 days.**

Definitions — Alcohol – Includes beer, wine, mixed drinks, liquor, and liqueurs.

Single sitting – Refers to any given point in time (e.g., at dinner, after work, while out at a social event, watching television).

Process — Ask the person directly about whether he or she consumes alcohol. Consult with a family member if necessary. Sometimes it is prudent to talk to the person and family separately. Start by asking the person, "Do you drink alcoholic drinks?" If yes, then ask, "When you look back over the last 14 days, what is the highest number of drinks you had in a single sitting?"

Coding — Select the appropriate response based on the highest number of drinks ingested by the person at one sitting over the last 14 days.

- None
- 1
- 2-4
- 5 or more

Presence of Behavioral Indicators of Potential Substance-Related Addiction in Last 90 Days

Intent

To identify behaviours that would indicate the person may have a problem with an alcohol or drug addiction. Note: These observations may be reported by the person him/herself ***or*** by others.

Definitions

Felt the need to or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use — others in his/her life or the person him/herself expresses concern regarding his/her alcohol consumption or use of substances. The concern may have various motivations. For example, a person may be concerned about the amount he/she is drinking since finding out about a friend who recently died from liver disease, or a spouse may express concern that the person has been drinking too much since losing a job. The person, family, or others may also report that there has been trouble because of substance use. For example, family or friends may have withdrawn because of the behavior of the person when drunk or high, or the person's driver's licence may have been taken away because of driving while under the influence of alcohol/drugs.

Has been bothered by criticism from others about drinking or drug use – the person, family members, or others indicate that the person becomes angry or agitated when others express disapproval of the substance use. The person may express that it is "no one else's business how much I drink," or that others are too critical and there is nothing wrong with having a few drinks or using a few drugs.

Has reported feelings of guilt about drinking or drug use – the person, family, or others report that the person has experienced feelings of guilt related to his/her substance use. This guilt could have several origins. For example, the person may feel guilty about the emotional and financial distress it has caused the family, the embarrassment it has caused loved ones, or the way he/she treats others when under the influence of alcohol/drugs.

Had to have a drink or use drugs first thing in the morning to steady nerves, e.g., an "eye opener" – the person, family, or significant others report that the person drinks/uses drugs or had been observed to do so early in the day. The person may use the expression "I need an eye opener."

Feels social environment encourages or facilitates abuse of drugs or alcohol – the person acknowledges (or the family or significant others report) that he/she maintains regular contact with individuals who drink alcohol or use drugs and that this contact makes it more likely that he/she will drink or use drugs when they interact.

Process

Engage the person in a conversation about his/her patterns of substance use. This information may be a sensitive issue for the person and may cause uneasy feelings for the assessor. Care must be taken to acknowledge these feelings. Begin asking about alcohol/drugs with a simple non-judgmental statement like "Do you drink?" or "Do you ever get high?" It is important that the person not feel judged as though he/she is doing something wrong. Address substance use in a gentle way.

For example, say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Ask how he/she feels about his/her drinking/drug use and whether others express disapproval of this behavior. If others express disapproval, ask how this criticism makes the person feel. Discuss the person's substance use with family members, but not with the person present.

Coding: Select the appropriate response based on the presence of indicators in last 90 days, regardless of the amount or number of days of drug/alcohol use, the number of people who were concerned, or the number of times the concerns were raised. Indicators can be reported by the person or by others who know him/her.

Section J. Nutritional Status

Nutritional Issues

Intent Marked, unintended declines in weight can indicate failure to thrive or be a sign of a potentially serious medical problem or poor nutritional intake due to physical, cognitive, or social factors.

Definitions

Process Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS – ask the person or family about weight changes over the course of the past 30 to 180 days. Use actual records of weight if available. A subjective estimate of weight change from the person or caretaker can be used if no written records are available. Identifying a particular time approximately 6 months earlier (such as "compared to last New Year's") may help the person remember his or her approximate weight 180 days ago. You may be able to help the person answer the question by asking "How much weight do you think you have lost?" then mentally compare this with the reported, or your estimated, current weight of the person. You can also ask, "Have you lost a lot of weight? Do you feel much thinner or weaker?" or "Your clothes seem very loose on you. Were you much heavier 6 months ago?"

Dehydrated or BUN/creatinine ratio > 25 – Identifying dehydration can be difficult. Record your clinical judgment based upon signs and symptoms (for example, severe vomiting over a period of time). Alternatively, laboratory results indicating dehydration may be available (that is, BUN/creatinine ratio of >25.

Fluid intake less than four 8 oz. cups per day (or less than 1,000 cc per day) – Person did not consume all/almost all fluids during the last 3 days.

Fluid output exceeds input – Fluid loss exceeds the amount of fluids the person takes in (e.g., loss from vomiting, fever, or diarrhea that exceeds fluid replacement).

Mode of Nutritional Intake

Intent — The ability to swallow safely can be affected by many disease processes and by functional decline. Alterations in one's ability to swallow could result in choking and aspiration, both of which can cause morbidity and mortality. Often, persons with swallowing difficulties require altered consistencies of food and fluids in order to ingest nutrition by mouth. This item details any dietary modifications necessary to address swallowing difficulties.

Process — Observe and talk with the person. If available, review the person's clinical record, including MD, dietitian, and speech-language pathology notes if applicable.

Coding — Select the response that best describes the dietary prescription used to accommodate swallowing difficulties.

- Normal – Person swallows all types of foods.
- Modified independent – For example, liquid is sipped, or person takes limited solid food; need for modification may be unknown.
- Requires diet modification to swallow solid food – For example, mechanical diet (pureed, minced, etc.) is required, or person is only able to ingest specific foods.
- Requires modification to swallow liquids – For example, liquids must be thickened.
- Can swallow only pureed solids AND thickened liquids.
- Combined oral and parenteral or tube feeding.
- Nasogastric tube feeding only.
- Abdominal feeding tube – For example, a percutaneous endoscopic gastrostomy (PEG) tube.
- Parenteral feeding only – Includes all types of parenteral feedings, such as total parenteral nutrition (TPN).
- Activity did not occur – Person did not eat or receive any form of nutritional supplementation during the last 3 days.

Section K. Medications and Allergies

Person Requires Either Prescription or Over-the-Counter medication?

Intent — To facilitate a medication evaluation by having a single listing of all prescribed and non-prescribed medications taken by the person. This section will help clinicians identify potential problems related to the consumption of, or failure to take, medications (such as any physical or emotional problems an individual may experience as the result of taking one or more medications). For example, identifying how frequently an individual uses a PRN (as needed) pain medication, sleeping medication, or laxative may lead the clinician to do further assessment of the underlying problems that prompted their use. It may also help the clinician identify medications that might cause specific problems, such as incontinence or delirium.

Definitions — Medications – These include all prescribed, non-prescribed, and over-the-counter medications that the person consumed in the last 3 days. Medications may be taken by mouth, placed on the skin or in the eyes, injected, given intravenously, etc. This includes prescriptions now discontinued but taken in the last 3 days and drugs prescribed PRN that were taken during this period. It also includes medications that are prescribed on a maintenance schedule, such as vitamin injections given once a month, even if they were not given in the last 3 days.

Process — Ask the person, and family members when appropriate, if any medications were taken in the last 3 days.

Record all prescription and over-the-counter medications in the "Medications" section.

Allergy to Any Drug

Intent — To determine if the individual has any known allergies to either prescription or over-the-counter medications.

Definition — The presence of an allergy would be determined by a history of a serious negative reaction to a particular drug or category of drugs.

Process — Ask the person whether he or she is allergic or has ever had a reaction to any drug(s). Include reactions to both prescription and over-the-counter drugs administered by any route.

Coding — Select the appropriate response:

- No known drug allergies
- Yes

Identify allergic drug or category of drugs

Coding

Enter the name of the drug or category of drugs to which the individual is allergic.

Use the text box to record other allergies of the individual.

Other Non-Drug Allergies

Intent — To identify any known allergies the person may have, other than drug allergies.

Definition — The presence of an allergy would be determined by a history of a serious negative reaction to such allergens as dust, pollen, foods, pets, insect bites, etc.

Process — Ask the person to describe any known allergies and determine if the allergy was reported to and diagnosed by a physician. Determine what remedies or actions were prescribed to treat the allergic reaction. List any allergies that the person appears to have.

Coding — Use the text box to record other non-drug allergies of the individual.

Section L. Treatments and Procedures

Prevention

Intent — This item helps to identify whether the person has unmet needs for health counseling and preventive care.

Process — Ask the person if he or she received the following specific health measures.

Blood pressure measured in LAST YEAR – The person's blood pressure was measured by a clinician during the past year.

Colonoscopy test in LAST 5 YEARS – The entire colon (from anus to cecum) was viewed by means of a fiber-optic colonoscopy within the past 5 years.

Dental exam in LAST YEAR – The person underwent a dental examination by a dentist within the past year.

Eye exam in LAST YEAR – The person underwent an eye examination by an ophthalmologist, optometrist, physician, nurse, or other clinician within the past year.

Per NYS Medicaid Program Vision Care Manual Policy Guidelines, an optometric eye exam is comprised of, at a minimum, a case history, an internal and external eye examination, objective and subjective vision corrections/determination of refractive state, binocular coordination testing, gross visual field testing and tonometry for recipients age 35 and over or others where indicated, performed by licensed professionals within the field.

https://www.emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Policy_Guidelines.pdf

If the response is 'Yes' (per NYS Medicaid Program Vision Care Manual Policy Guidelines), document the following information in Section L Comment Box: the name and license number of the professional who conducted the eye exam (if known) and the approximate date the exam was conducted.

Hearing exam in LAST 2 YEARS – The person underwent a hearing examination by an audiologist or other clinician within the past 2 years.

Per NYS Medicaid Program Hearing Aid/Audiology Services Policy Guidelines, other clinician means (in addition to audiologist) hearing aid dispenser, certified clinic or speech and hearing center, with the appropriate specialty. Hearing screening and testing can be provided by any licensed practicing provider who may administer hearing services within their scope of practice using accepted standards and practices for screening, medical clearance, testing and evaluation.

https://www.emedny.org/ProviderManuals/HearingAid/PDFS/HearingAid_Policy_Guidelines.pdf

If the response is 'Yes' (per NYS Medicaid Program Hearing Aid/Audiology Services Policy Guidelines), document the following information in Section L Comment Box: the name of the license number of the professional who conducted the hearing exam (if known) and the approximate date the exam was conducted.

Influenza vaccine in LAST YEAR – The person received a vaccination for influenza prevention during the past year.

Mammogram or breast exam in LAST 2 YEARS (for women) – The person had either a mammogram or a breast examination by a clinician during the past 2 years.

Pneumococcal vaccine in LAST 5 YEARS or after age 65 – The person received the vaccine for prevention of pneumonia within the past 5 years or after age 65.

Hospital Use, Emergency Room Use, Nursing Facility Use, Physician Visit in Last 90 Days (Or Since Last Assessment if Less Than 90 Days Ago)

Inpatient Acute Hospital with Overnight Stay

Intent	To record how many times the person was admitted to the hospital with an overnight stay in the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).
Definition	The person was formally admitted as an inpatient (by physician's order), and stayed over one or more nights. It does not include admissions for day surgery, outpatient services, etc.
Process	Review prior hospitalizations with the person and family. If available, review the clinical record. Sometimes transmittal or billing records from recent hospital admissions are available.
Coding	Enter the number of hospital admissions in the box. Enter **"0"** in both boxes if no hospital admissions occurred in the last 90 days.

Emergency Room Visit (including overnight observation stay, but not accompanied by an overnight hospital admission.)

Intent	To record whether, during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago), the person visited a hospital emergency room (e.g., for treatment or evaluation).
Definition	A visit to an emergency room including overnight observation stay, but not accompanied by an overnight hospital admission.
Process	Ask the person and family and review transmittal records if available.
Coding	Enter the number of ER visits in the last 90 days (or since last assessment). Enter **"0"** in both boxes if no ER visits occurred. Do not include instances in which the person was admitted to the hospital for an overnight stay after being seen in the ER.

Physician Visit (Or Authorized Assistant or Practitioner)

Intent — To record the person's visits to (or from) doctors and authorized assistants or practitioners during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).

Definition — A visit to a medical provider's office or clinic by the person, or a medical provider's visit to the person's home. This item includes a very broad spectrum of medical providers and specialists — for example, MDs or osteopaths who may be either the primary physician or consultant(s); authorized physician's assistants; or nurse-practitioners.

Coding — Enter the number of visits with a physician or authorized assistant or practitioner during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago). Enter "0" in both boxes if no visits occurred.

Nursing Facility Use

Intent — To record the person's use of a nursing facility during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).

Definition — The person was in an approved nursing facility (nursing home) for rehabilitation, respite or long-term care services.

Coding — Enter the number of days the individual used a nursing facility during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago). Enter "0" in both boxes if no use occurred.

Clinical Reason(s) For Hospitalization

Coding — If the individual had an overnight hospital stay as an inpatient, record the clinical reason for the hospitalization using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Injury caused by fall or accident at home
- Respiratory problems (SOB, infection, obstruction, COPD, pneumonia)
- Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction
- Exacerbation of CHF, fluid overload, heart failure
- Myocardial infarction, stroke
- Chemotherapy or other cancer-related admission
- Scheduled surgical procedure
- Urinary tract infection
- IV catheter-related infection
- Deep vein thrombosis, pulmonary embolus
- Uncontrolled pain (including back pain)
- Psychotic episode or other change in mental status

- Other than above reasons
- Unknown

Clinical Reason(s) For Emergency Room Use

Coding If the individual visited a hospital ER for treatment or evaluation, not including any ER visits that were accompanied by an overnight hospital stay, record the clinical reason for the visit using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Nausea, dehydration, malnutrition, constipation, impaction
- Injury caused by fall or accident at home
- Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- Wound infection, deteriorating wound status, new lesion/ulcer
- Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction
- Other than above reasons
- Reason unknown

Reason(s) For Nursing Home Use

Coding If the individual used a nursing facility within the last 90 days (or since last assessment if less than 90 days), record the clinical reason for the use using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Therapy services
- Respite care
- End of life care
- Permanent placement
- Unsafe for care at home
- Other
- Unknown

Section M. Social Supports

Strong and Supportive Relationship with Family

Definition The person indicates he or she has a supportive relationship with family members. The person may feel able to “rely on” family members. Family members may be actively involved in the person’s physical care, maintaining the household, managing finances, or helping the person make medical decisions.

Strong and Supportive Relationship with Surrounding Community

Definition — The person indicates he or she has a supportive relationship with members of the surrounding community. The person may feel able to "rely on" members of the surrounding community. Members of the surrounding community may be actively involved in the person's physical care, maintaining the household, managing finances, or helping the person make medical decisions.

Section N. Environmental Assessment

Finances

Intent — To determine if limited funds prevented the person from receiving required medical and environmental support.

Definition — Limited funds – Because of insufficient funds during the last 30 days, the person made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care.

Process — Ask the person, or caregiver, if prescribed medications, sufficient home heat (electricity, gas), necessary medical care, or adequate food were not obtained due to insufficient funds. Asking financial questions can be a sensitive area. Questioning must be sensitive and respectful to the person.

SIGN/FINALIZE

This section is designed to record the RN Assessor signature and sign/finalize the assessment. Signing/Finalizing an assessment in the UAS-NY consists of an electronic signature (or e-signature) process; no paper is involved.

RN Assessor Signature: Only one RN Assessor may conduct and sign/finalize an assessment. The RN Assessor indicates they are the only contributor to the assessment (if true) and signs/finalizes the assessment. Once the RN Assessor signs/finalizes the assessment, it cannot be further edited without supervisor intervention. Only an RN Assessor Supervisor can unsign/unfinalize an assessment once it has been signed/finalized by an RN Assessor. The original RN Assessor must then re-sign/re-finalize the assessment before the system locks the assessment.

- **IMPORTANT:** The Community Health Assessment is a nursing assessment and, as such, New York State Education Department Law (NYS Education Law, Article 139, Nursing aka the Nurse Practice Act) requires the assessment be conducted and signed/finalized by a licensed Registered Nurse (RN). As the UAS-NY is a legal document, in order to maintain the integrity of their RN license, the RN cannot delegate any portion of the *Community Health Assessment*, including any triggered supplements, or any data entry of the assessment to other staff.

Process

The RN Assessor will complete and review the entire assessment. The RN Assessor will then record their name, license number, title, and any comments. The RN Assessor will click the box to "sign/finalize" the assessment. The UAS-NY will automatically populate the user id, user name as it appears in the HCS (this is separate from the signature), organization name, date, and time fields.

Once this process is complete, the UAS-NY Community Health Assessment may not be further edited without an RN Assessor Supervisor unsigning/unfinalizing the assessment.

[Deprecated as of version 1.13] Optional Social Assessor Signature **(Local Department of Social Services (LDSS) only)**: Social Assessor contribution is allowed but not required when conducted by an LDSS (UAS-NY Policy 18.1 *Change to LDSS Assessment Requirements*). A Social Assessor may conduct parts of the assessment, as appropriate to their education level and as directed by their organization, collaboratively with RN Assessor oversight. Under no circumstances can a Social Assessor conduct the majority of the assessment. Only one Social Assessor contribution and signature is permitted. *The RN Assessor will have final word on all assessment questions as they are responsible for reviewing and signing/finalizing the assessment under their RN license*. If a Social Assessor did not contribute to the assessment, then this signature is not required.

[Deprecated Process]

Once the Social Assessor, if applicable (LDSS Only), has completed his/her sections of the UAS-NY Community Health Assessment, the Social Assessor will enter his/her name, title, and any comments. The Social Assessor will then click the box to