**MINIMUM DATA SET - HOME CARE (MDS-HC)**

**Unless otherwise noted, score for last 3 days**
**Examples of exceptions include IADLs / Continence / Services / Treatments where status scored over last 7 days**

**RUG SCORES**

RUG Category | ADL | RUG III Scoring

## SECTION AA. NAME AND IDENTIFICATION NUMBERS

| | | |
|---|---|---|
| 1. | Name of Client | a. (Last/Family Name) b. (First Name) c. (Middle Name) |
| 2. | Case Record No. | |
| 3. | Government Pension And Health Insurance Numbers | a. Pension (Social Security) Number<br>b. Health insurance number (other comparable insurance number) |

## SECTION BB. PERSONAL ITEMS (Complete at Intake Only)

| | | |
|---|---|---|
| 1. | Gender | 1. Male 2. Female |
| 2. | Birthdate | Month Day Year |
| 3. | Race / Ethnicity | 0. No 1. Yes **( Answer All )**<br>***Race:***<br>a. American Indian/ Alaskan Native<br>b. Asian<br>c. Black / African Amer<br>d. Native Hawaiian or other Pacific Islander<br>e. White<br>***Ethnicity:***<br>f. Hispanic or Latino |
| 4. | Marital Status | 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other |
| 5. | Language | Primary Language<br>0. English 1. Spanish 2. French 3. Other |
| 6. | Education *(Highest Level Completed)* | 1. No Schooling 2. 8th grade or less 3. 9 - 11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree |
| 7. | Responsibility / Advanced Directives | (Code for responsibility/advanced directives)<br>0. No 1. Yes<br>a. Client has a legal guardian<br>b. Client has advanced medical directives in place. (for example, a do not hospitalize order) |

## SECTION CC. REFERRAL ITEMS (Complete at Intake Only)

| | | |
|---|---|---|
| 1. | Date Case Opened/ Reopened | Month Day Year |
| 2. | Reason For Referral | 1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day Care 6. Other |
| 3. | Goals Of Care | (Code for client/family understanding of goals of care)<br>0. No 1. Yes **( Answer All )**<br>a. Skilled nursing treatments<br>b. Monitoring to avoid complications<br>c. Rehabilitation<br>d. Client/family education<br>e. Family respite<br>f. Palliative care |
| 4. | Time since Last Hospital Stay | Time since discharge from last in-patient setting ***(Code for most recent instance in LAST 180 DAYS)***<br>0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago |
| 5. | Where Lived At Time Of Referral | 1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other |
| 6. | Who Lived With At Referral | 1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (Not spouse or children) 6. Lived in group setting with non-relative(s) |
| 7. | Prior NH Placement | Resided in a nursing home at anytime during **5 YEARS** prior to case opening<br>0. No 1. Yes |
| 8. | Residential History | Moved to current residence within last two years<br>0. No 1. Yes |

## SECTION A. ASSESSMENT INFORMATION

| | | |
|---|---|---|
| 1. | Assessment Reference Date | **Date of assessment**<br>Month Day Year |
| 2. | Reasons For Assessment | **Type of assessment**<br>1. Initial Assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from program 5. Review at return from hospital 6. Change in status 7. Other |
| 3. | Time To Next Assessment | **Number of days or months until next assessment is due**<br>0. Follow up assessment not required 1. 30 days 2. 60 days 3. 90 days 4. 4 months 5. 5 months 6. 6 months 7. 9 months 8. 1 year |

## SECTION B. COGNITIVE PATTERNS

| | | |
|---|---|---|
| 1. | Memory Recall Ability | ***( Code for recall of what was learned or known )***<br>0. Memory OK 1. Memory problem |
| | Ability | a. Short-term memory OK -- seems/appears to recall after 5 min.<br>b. Procedural memory OK -- Can perform all or almost all steps in a multitask sequence without cues for initiation |
| 2. | Cognitive Skills For Daily Decision Making | a. How well client made decisions about organizing the day ( e.g., when to get up or have meals, which clothes to wear or activities to do )<br>0. *INDEPENDENT* -- Decisions consistent/reasonable/safe<br>1. *MODIFIED INDEPENDENCE* -- Some difficulty in new situations only<br>2. *MINIMALLY IMPAIRED* -- In specific situations, decisions are poor / unsafe and cues/supervision needed at those times<br>3. *MODERATELY IMPAIRED* -- Decision consistently poor or unsafe, cues/supervision required at all times<br>4. *SEVERELY IMPAIRED* -- Never/rarely made decisions<br>b. Worsening of decision making as compared to status **90 DAYS AGO** ( or since last assessment if less than 90 days )<br>0. No 1. Yes |
| 3. | Indicators Of Delirium | a. Sudden or new change in mental function in **LAST 7 DAYS** ( including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day )<br>0. No 1. Yes<br>b. **LAST 90 DAYS** ( or since last assessment if less than 90 days ), client has become agitated or disoriented such that their safety is endangered or they require protection by others<br>0. No 1. Yes |

## SECTION C. COMMUNICATION/HEARING PATTERNS

| | | |
|---|---|---|
| 1. | Hearing | *( With hearing appliance if used )*<br>0. *HEARS ADEQUATELY* -- Normal talk, TV, phone, doorbell<br>1. *MINIMAL DIFFICULTY* -- When not in quiet setting<br>2. *HEARS IN SPECIAL SITUATIONS ONLY* -- Speaker has to adjust tonal quality and speak distinctly<br>3. *HIGHLY IMPAIRED* -- Absence of useful hearing |
| 2. | Making Self Understood (Expression) | *( Expressing information content -- however able )*<br>0. *UNDERSTOOD* -- Expresses ideas without difficulty<br>1. *USUALLY UNDERSTOOD* -- Difficulty finding words or finishing thoughts, BUT, if given time, little or no prompting required<br>2. *OFTEN UNDERSTOOD* -- Difficulty finding words or finishing thoughts, prompting usually required<br>3. *SOMETIMES UNDERSTOOD* -- Ability is limited to making concrete requests<br>4. *RARELY / NEVER UNDERSTOOD* |
| 3. | Ability To Understand Others (Comprehension) | *( Understands verbal information -- however able )*<br>0. *UNDERSTANDS* -- Clear comprehension<br>1. *USUALLY UNDERSTANDS* -- Misses part/intent of message, BUT, comprehends most conversation with little/no prompting<br>2. *OFTEN UNDERSTANDS* -- Misses some part/intent of message; with prompting can often comprehend conversation<br>3. *SOMETIMES UNDERSTANDS* -- Responds adequately to simple, direct communication<br>4. *RARELY / NEVER UNDERSTANDS* |
| 4. | Communication Decline | Worsening in communication ( making self understood or understanding others ) as compared to status of **90 DAYS AGO** ( or since last assessment if less than 90 days )<br>0. No 1. Yes |

## SECTION D. VISION PATTERNS

| | | |
|---|---|---|
| 1. | Vision | *(Ability to see in adequate light and with glasses if used)*<br>0. *ADEQUATE* -- Sees fine detail, including regular print in newspapers / books<br>1. *IMPAIRED* -- Sees large print, but not regular print in newspapers / books<br>2. *MODERATELY IMPAIRED* -- Limited vision; not able to see newspaper headlines, but can identify objects<br>3. *HIGHLY IMPAIRED* -- Object identification in question, but eyes appear to follow objects<br>4. *SEVERELY IMPAIRED* -- No vision or sees only light, colors, or shapes; eyes do not appear to follow objects |
| 2. | Visual Limitation/ Difficulties | Saw halos or rings around lights, curtains over eyes, or flashes of lights<br>0. No 1. Yes |
| 3. | Vision Decline | Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days)<br>0. No 1. Yes |

## SECTION E. MOOD AND BEHAVIOR PATTERNS

| | | |
|---|---|---|
| 1. | Indicators Of Depression, Anxiety, Sad Mood | *( Code for observed indicators irrespective of assumed cause )*<br>0. Indicator not exhibited in last 3 days<br>1. Exhibited 1-2 of last 3 days<br>2. Exhibited on each of last 3 days<br>a. A Feeling Of Sadness Or Being Depressed life is not worth living, nothing matters, that he or she is of no use to anyone or would rather be dead.<br>b. Persistent Anger With Self Or Others -- e.g., easily annoyed, anger at care received<br>c. Expressions of What Appear To Be Unrealistic Fears -- e.g., fear of being abandoned, left alone, being with others<br>d. Repetitive Health Complaints -- e.g., persistently seeks medical attention, obsessive concern with body functions<br>e. Repetitive Anxious Complaints, Concerns -- e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues<br>f. Sad, Pained, Worried Facial Expressions -- e.g., Furrowed brows<br>g. Recurrent Crying, Tearfulness<br>h. Withdrawal From Activities Of Interest -- e.g., no interest in long standing activities or being with family / friends<br>i. Reduced Social Interaction |
| 2. | Mood Decline | Mood indicators have become worse as compared to status of **90 DAYS AGO** ( or since last assessment if less than 90 days )<br>0. No 1. Yes |
| 3. | Behavioral Symptoms | Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred<br>0. Did not occur in last 3 days<br>1. Occurred, easily altered<br>2. Occurred, not easily altered<br>a. WANDERING -- Moved without rational purpose, seemingly oblivious to needs or safety<br>b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS -- Threatened screamed at, cursed at others<br>c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS -- Hit, shoved, scratched, sexually abused others<br>d. SOCIALLY INAPPROPRIATE / DISRUPTIVE BEHAVIORAL SYMPTOMS -- Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption<br>e. RESISTS CARE -- Resisted taking medications / injections, ADL assistance, eating, or changes in position |



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**4. Changes In Behavior Symptoms**

Behavioral symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** ( or since last assessment if less than 90 days )

0. No, or no change 1. Yes

## SECTION F. SOCIAL FUNCTIONING

**1. Involvement**

**a.** At ease interacting with others (e.g., enjoys time with others)

0. At ease 1. Not at ease

**b.** Openly expresses conflict or anger with family / friends

0. No 1. Yes

**2. Change In Social Activities**

As compared to **90 DAYS AGO** ( or since last assessment if less than 90 days ago ), decline in the client's level of participation in social, religious, occupational or other preferred activities.
IF THERE WAS A DECLINE, client distressed by this fact

0. No decline
1. Decline, not distressed
2. Decline, distressed

**3. Isolation**

**a.** Length of time client is alone during day (morning, afternoon)

0. Never or hardly ever
1. About one hour
2. Long periods of time -- e.g., all morning
3. All of the time

**b.** Client says or indicates that he / she feels lonely

0. No 1. Yes

## SECTION G. INFORMAL SUPPORT SERVICES

**1. Two Key Informal Helpers**

**Primary (A) and Secondary (B)**

NAME OF PRIMARY AND SECONDARY HELPERS

**a.** ( Last / Family Name ) **b.** ( First )

**c.** ( Last / Family Name ) **d.** ( First )

| | (A) Prim | (B) Secn |
|---|---|---|
| **e.** Lives with client<br>0. Yes 1. No 2. No such helper [skip other items in the appropriate column] | | |
| **f.** Relationship to client<br>0. Child or child-in-law 2. Other Relative 4. None<br>1. Spouse 3. Friend / neighbor | | |
| 0. Yes 1. No | | |
| **g.** Advice or emotional support | | |
| **h.** IADL care | | |
| **i.** ADL care | | |
| If needed, willingness ( with ability ) to increase help:<br>0. More than 2 hours 1. 1-2 hours per day 2. No | | |
| **j.** Advice or emotional support | | |
| **k.** IADL care | | |
| **l.** ADL care | | |
| **m.** Disabled<br>0. No 1. Yes | | |
| **n.** Date of Birth<br>**( A )** Month Day Year | | |
| **( B )** Month Day Year | | |

**2. Caregiver Status**

0. No 1. Yes

**a.** A caregiver is unable to continue in caring activities--e.g., decline in the health of the caregiver makes it difficult to continue

**b.** Primary caregiver is not satisfied with support received from family and friends ( .e.g., other children of client )

**c.** Primary caregiver expresses distress, anger or depression

**3. Extent Of Informal Help ( Hours Of Care, Rounded )**

For instrumental and personal activities of daily living received over the **LAST 7 DAYS,** indicate extent of help from family, friends, and neighbors

| | HOURS |
|---|---|
| **a.** Sum of time across five weekdays | |
| **b.** Sum of time across two weekend days | |

## SECTION H. PHYSICAL FUNCTIONING

**. IADL PERFORMANCE IN 7 DAYS**

**. ADL PERFOMANCE IN 3 DAYS**

**1. IADL Self Performance**

Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**

**(A)** IADL SELF PERFORMANCE CODE
*( Code for client's performance during LAST 7 DAYS)*
0. *INDEPENDENT* - did on own
1. *SOME HELP* - help some of the time
2. *FULL HELP* - performed with help all of the time
3. *BY OTHERS* - performed by others
8. *ACTIVITY DID NOT OCCUR*

**(B)** IADL DIFFICULTY CODE
*(How difficult it is, or would it be, for client to do activity on own)*
0. *NO DIFFICULTY*
1. *SOME DIFFICULTY* - e.g., needs some help, is very slow, or fatigues
2. *GREAT DIFFICULTY* - e.g., little or no involvement in the activity is possible

| | (A) | (B) |
|---|---|---|
| **a.** MEAL PREPARATION - How meals are prepared (e.g., planning meals cooking, assembling ingredients, setting out food, utensils ) | | |
| **b.** ORDINARY HOUSE WORK - How ordinary work around the the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry) | | |
| **c.** MANAGING FINANCE - How bills are paid, checkbook is balanced household expenses are balanced | | |
| **d.** MANAGING MEDICATIONS - How medications are managed (e.g., remembering to take medicines, opening bottles taking correct drug dosages, giving injections, applying ointments | | |
| **e.** PHONE USE - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification) | | |
| **f.** SHOPPING - How shopping is performed for food and household items (e.g., selecting items, managing money) | | |
| **g.** TRANSPORTATION - How client travels by vehicle (e.g., gets to places beyond walking distance) | | |

**2. ADL Self Performance**

The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS considering all episodes of these activities.**
For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.
*( NOTE - For bathing, code for most dependent single episode in **LAST 7 DAYS** )*

0. *INDEPENDENT* -- No help, setup, or oversight -- OR -- Help, setup, oversight provided only 1 or 2 times ( with any task or subtask )
1. *SETUP HELP ONLY* -- Article or device provided within reach of client 3 or more times
2. *SUPERVISION* -- Oversight, encouragement or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANCE* -- Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period ( for a total of 3 or more episodes of physical help )
4. *EXTENSIVE ASSISTANCE* -- Client performed part of activity on own ( 50% or more of subtasks ), but help of following type(s) were provided 3 or more times:
-- Weight-bearing support -- OR --
-- Full performance by another during part ( but not all ) of last 3 days
5. *MAXIMAL ASSISTANCE* -- Client involved and completed less than 50% of subtasks on own ( includes 2+ person assist ), received weight bearing help or full performance of certain subtasks 3 or more times
6. *TOTAL DEPENDENCE* -- Full performance of activity by another
8. *ACTIVITY DID NOT OCCUR* ( regardless of ability )

**a.** MOBILITY IN BED -- Including moving to and from lying position, turning side to side, and positioning body while in bed

**b.** TRANSFER -- Including moving to and between surfaces - to / from bed, chair, wheelchair, standing position [ Note--Excludes to / from bath / toilet ]

**c.** LOCOMOTION IN HOME
[ Note--If in wheelchair, self-sufficiency once in chair ]

**d.** LOCOMOTION OUTSIDE OF HOME
[ Note--If in wheelchair, self-sufficiency once in chair ]

**e.** DRESSING UPPER BODY -- How client dresses / undresses **( street clothes, underwear )** above waist, includes prostheses, orthotics, fasteners, pullovers, etc.

**f.** DRESSING LOWER BODY -- How client dresses / undresses **( street clothes, underwear )** from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners

**g.** EATING -- Including taking in food by any method, including tube feedings

**h.** TOILET USE -- Including using the toilet or commode, bedpan urinal, transferring on / off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required ( ostomy or catheter ), and adjusting clothes.

**i.** PERSONAL HYGIENE -- Including combing hair, brushing teeth, shaving applying makeup, washing / drying face and hands ( exclude baths and showers )

**j.** BATHING -- How client takes full-body bath / shower or sponge bath. ( **EXCLUDE** washing of back and hair ). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.
**Code for most dependent episode in LAST 7 DAYS**

**3. ADL Decline**

ADL status has become worse (I.e., now more impaired in self performance ) as compared to status **90 DAYS AGO** ( or since last assessment if less than 90 days )

0. No 1. Yes

**4. Primary Modes Of Locomotion**

0. No assistive device 3. Scooter ( e.g., Amigo )
1. Cane 4. Wheelchair
2. Walker / Crutch 8. ACTIVITY DID NOT OCCUR

**a.** Indoors

**b.** Outdoors

**5. Stair Climbing**

In the **LAST 3 DAYS,** how client went up and down stairs ( e.g., single or multiple steps, using handrail as needed )

0. Up and down stairs without help
1. Up and down stairs with help
2. Not go up and down stairs

**6. Stamina**

**a.** In a typical week, during the **LAST 30 DAYS** ( or since last assessment ) code the number of days client usually went out of the house or building in which client lives. ( no matter how short a time period )

0. Every day 2. 1 day a week
1. 2-6 days a week 3. No days

**b.** Hours of physical activities in the **LAST 3 DAYS** ( e.g., walking, cleaning house, exercise )

0. Two or more hours 1. Less than two hours

**7. Functional Potential**

0. No 1. Yes **( Answer all )**

**a.** Client believes he / she capable of increased functional independence ( ADL, IADL, mobility )

**b.** Caregivers believe client is capable of increased functional independence ( ADL, IADL, mobility )

**c.** Good prospects of recovery from current disease or conditions, improved health status expected

## SECTION I. CONTINENCE IN LAST 7 DAYS

**1. Bladder Continence**

**a. In LAST 7 DAYS** control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note-if dribbles, volume insufficient to soak thru underpants]

0. *CONTINENT* -- Complete control; DOES NOT USE any type of catheter or other urinary collection device that
1. *CONTINENT WITH CATHETER* -- Complete control with use of any type of catheter or urinary collection device does not leak urine
2. *USUALLY CONTINENT* -- Incontinent episodes once a week or less
3. *OCCASIONALLY INCONTINENT* -- Incontinent episodes 2 or more times a week but not daily
4. *FREQUENTLY INCONTINENT* -- Tends to be incontinent daily, but some control present
5. *INCONTINENT* -- Inadequate control, multiple daily episodes
8. *DID NOT OCCUR* -- No urine output from bladder

**b.** Worsening of bladder incontinence as compared to status **90 DAYS AGO** ( or since last assessment if less that 90 days )

0. No 1. Yes

**2. Bladder Devices**

0. No 1. Yes **( During Last 7 Days )**

**a.** Used pads or briefs to protect against wetness

**b.** Used an indwelling urinary catheter

**3. Bowel Continence**

In **LAST 7 DAYS,** control of bowel movement ( with appliance or bowel continence program if employed )

0. *CONTINENT* -- Complete control; DOES NOT USE ostomy device
1. *CONTINENT WITH OSTOMY* -- Complete control with use of ostomy device that does not leak stool
2. *USUALLY CONTINENT* -- Bowel incontinent episodes less than weekly
3. *OCCASIONALLY INCONTINENT* -- Bowel incontinent episodes once a week
4. *FREQUENTLY INCONTINENT* -- Bowel incontinent episodes 2 - 3 times a week
5. *INCONTINENT* -- Bowel incontinent all (or almost all) of time
8. *DID NOT OCCUR* -- No bowel movement during entire 7 day assessment period

## SECTION J. DISEASE DIAGNOSES

Disease / infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in **LAST 90 DAYS** ( or since last assessment if less than 90 days )

0. Not present
1. Present -- not subject to focused treatment or monitoring by home care professional
2. Present -- monitored or treated by home care professional

**1. Diseases**

**Heart / Circulation**
- **a.** Cerebrovascular accident *( stroke )*
- **b.** Congestive heart failure
- **c.** Coronary artery disease
- **d.** Hypertension
- **e.** Irregularly irregular pulse
- **f.** Periph. vascular disease

**Neurological**
- **g.** Alzheimer's
- **h.** Dementia other than Alzheimer's disease
- **i.** Head trauma
- **j.** Hemiplegia / hemiparesis
- **k.** Multiple sclerosis
- **l.** Parkinsonism

**Musculo / Skeletal**
- **m.** Arthritis
- **n.** Hip fracture
- **o.** Other fractures *(e.g., wrist, vertebral )*
- **p.** Osteoporosis

**Senses**
- **q.** Cataract
- **r.** Glaucoma

**Psychiatric / Mood**
- **s.** Any psychiatric diagnosis

**Infections**
- **t.** HIV infection
- **u.** Pneumonia
- **v.** Tuberculosis
- **w.** Urinary tract infection *( in LAST 30 DAYS )*

**Other Diseases**
- **x.** Cancer--(in past 5 years) *(not including skin cancer)*
- **y.** Diabetes
- **z.** Emphysema/COPD/asthma
- **aa.** Renal failure
- **ab.** Thyroid disease *( Hyper or hypo )*

**2. Other Current Or More Detailed Diagnosis and ICD-9 Codes**

**a.** . . . .
**b.** . . . .
**c.** . . . .
**d.** . . . .

## SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

**1. Preventive Health ( Past Two Years )**

0. No 1. Yes ( During past 2 years ) **( Answer all )**

- **a.** Blood pressure measured
- **b.** Received influenza vaccination
- **c.** Test for blood in stool or screening endoscopy
- **d.** IF FEMALE: Received breast examination or mammography

**2. Problem Conditions Present On 2 Or More Days**

0. No 1. Yes ( During 2 of last 3 days ) **( Answer all )**

- **a.** Diarrhea
- **b.** Difficulty urinating or urinating 3 or more times a night.
- **c.** Fever
- **d.** Loss of appetite
- **e.** Vomiting

**3. Problem Conditions**

0. No 1. Yes ( Any time during last 3 days ) **( Answer all )**

***Physical Health***
- **a.** Chest pain / pressure at rest or on exertion
- **b.** No bowel movement in 3 days
- **c.** Dizziness or lightheadedness
- **d.** Edema
- **e.** Shortness of breath

***Mental Health***
- **f.** Delusions
- **g.** Hallucinations

**4. Pain**

**a.** Frequency that client complains or shows evidence of pain
0. No pain ( score b-e as 0 )
1. Less than daily
2. Daily - one period
3. Daily - multiple periods ( e.g., morning and evening )

**b.** Intensity of pain
0. No pain
1. Mild
2. Moderate
3. Severe
4. Times when pain is horrible or excruciating

**c.** From client's viewpoint, pain intensity disrupts usual activities
0. No 1. Yes

**d.** Character of pain
0. No pain 1. Localized - single site 2. Multiple sites

**e.** From client's viewpoint, medications adequately control pain
0. Yes or no pain
1. Medications do not adequately control pain
2. Pain present, medication not taken

**5. Falls Frequency**

Number of times fell in **LAST 90 DAYS** ( or since last assessment if less than 90 days ) If none, code "0"; if more than 9, code "9"

**6. Danger Of Fall**

0. No 1. Yes

- **a.** Unsteady gait
- **b.** Client limits going outdoors due to fear of falling ( e.g., stopped using bus, goes out only with others )

**7. Life Style ( Drinking / Smoking )**

0. No 1. Yes

- **a. In the LAST 90 DAYS** ( or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or other were concerned with client's drinking
- **b. In the LAST 90 DAYS** ( or since last assessment if less than 90 days), client had to have a drink in the morning to steady nerves (i.e., "eye opener" ) or been in trouble due to drinking
- **c.** Smoked or chewed tobacco daily

**8. Health Status Indicators**

0. No 1. Yes **( Answer all )**

- **a.** Client feels he / she has poor health ( when asked )
- **b.** Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, deteriorating)
- **c.** Experiencing a flare-up of a recurrent or chronic problem
- **d.** Treatments changed in **LAST 30 DAYS** ( or since last assessment if less than 30 days ) because of new acute episode or condition
- **e.** Prognosis of less than six months to live--e.g., physician has told client or client's family that client has end-stage disease

**9. Other Status Indicators**

0. No 1. Yes **( Answer all )**

- **a.** Fearful of a family member or caregiver
- **b.** Unusually poor hygiene
- **c.** Unexplained injuries, broken bones, or burns
- **d.** Neglected, abused, or mistreated
- **e.** Physically restrained ( e.g., limbs restrained, used bed rails, constrained to chair when sitting )

## SECTION L. NUTRITION/HYDRATION STATUS

**1. Weight**

0. No 1. Yes

- **a.** Unintended weight loss of 5% or more in the **LAST 30 DAYS** [ or 10% or more in the **LAST 180 DAYS** ]
- **b.** Severe malnutrition ( Cachexia )
- **c.** Morbid Obesity

**2. Consumption**

0. No 1. Yes

- **a. In at least 2 of the last 3 days,** ate one or fewer meals a day
- **b. In last 3 days,** noticeable decrease in the amount of food client usually eats or fluids usually consumes
- **c.** Insufficient fluid--did not consume all / almost all fluids during last 3 days
- **d.** Enteral tube feeding

**3. Swallowing**

0. *NORMAL* -- Safe and efficient swallowing of all diet consistencies
1. *REQUIRES DIET CHANGE TO SWALLOW SOLID FOODS* ( mechanical diet or able to ingest specific foods only )
2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* ( puree, thickened liquids )
3. *COMBINED ORAL AND TUBE FEEDING*
4. *NO ORAL INTAKE ( NPO )*

## SECTION M. DENTAL STATUS (ORAL HEALTH)

**1. Oral Status**

0. No 1. Yes

- **a.** Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)
- **b.** Mouth is "dry" when eating a meal
- **c.** Problem brushing teeth or dentures

## SECTION N. SKIN CONDITION

**1. Skin Problems**

Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies )

0. No 1. Yes

**2. Ulcers (Pressure/ Stasis)**

Presence of an ulcer anywhere on the body. Ulcers include:

0. No Ulcer
1. Any area of persistent skin redness
2. Partial loss of skin layers
3. Deep craters in the skin
4. Breaks in skin exposing muscle or bone

**a. Pressure ulcer** -- any lesion caused by pressure, shear forces, resulting in damage of underlying tissues

**b. Stasis ulcer** -- open lesion caused by poor circulation in the lower extremities

**3. Other Skin Problems Requiring Treatment**

0. No 1. Yes **( Answer All )**

- **a.** Burns (Second/third degree)
- **b.** Open lesions other than ulcers, rashes, cuts ( e.g., cancer )
- **c.** Skin tears or cuts
- **d.** Surgical wound
- **e.** Corns, calluses, structural problems, infections, fungi

**4. History Of Resolved Pressure Ulcers**

Client previously had (at any time ) or has an ulcer anywhere on the body

0. No 1. Yes

**5. Wound/ Ulcer Care**

Have the following treatments been completed in the last 7 days ?

0. No 1. Yes **( Answer All )**

- **a.** Antibiotics, systemic or topical
- **b.** Dressings
- **c.** Surgical wound care
- **d.** Other wound / ulcer care ( e.g., pressure relieving device, nutrition, turning, debridement )

## SECTION O. ENVIRONMENTAL ASSESSMENT

**1. Home Environ-Ment**

0. No 1. Yes **( Answer all )**

- **a.** Lighting in evening ( including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors )
- **b.** Flooring and carpeting ( e.g., holes in floor, electric wires where client walks, scatter rugs )
- **c.** Bathroom and toiletroom ( e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet )
- **d.** Kitchen (e.g., dangerous stove, operative refrigerator, infestation by rats or bugs )
- **e.** Heating and cooling ( e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic )
- **f.** Personal safety ( e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street )
- **g.** Access to home ( e.g., difficulty entering / leaving home )
- **h.** Access to rooms in house ( e.g., unable to climb stairs )

**2. Living Arrange-ment**

**a.** As compared to **90 DAYS AGO** ( or since last assessment ), client now lives with other person -- e.g., moved in with another person, other person moved in with client.
0. No 1. Yes

**b.** Client or primary caregiver feels that client would be better off in another living environment
0. No
1. Client only
2. Caregiver only
3. Client and caregiver

## SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

**1. Formal Care** ( Minutes rounded to even 10 minutes )

Extent of care or care management in assessment if less than 7 days ) involving **LAST 7 DAYS** ( or since last

| | (A) # of Days | (B) Hours | (C) Mins |
|---|---|---|---|
| **a.** Home health aides | | | |
| **b.** Visiting nurses | | | |
| **c.** Homemaking services | | | |
| **d.** Meals | | | |
| **e.** Volunteer services | | | |
| **f.** Physical therapy | | | |
| **g.** Occupational therapy | | | |
| **h.** Speech therapy | | | |
| **i.** Day care or day hospital | | | |
| **j.** Social worker in home | | | |

**2. Special Treatments Therapies, Programs**

Special treatments, therapies, programs received or scheduled during **LAST 7 DAYS** ( or since last assessment if less than 7 days ) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.

0. Not Applicable
1. Scheduled, full adherence as prescribed
2. Scheduled, partial adherence
3. Scheduled, not received

**Respiratory Treatments**
- **a.** Oxygen
- **b.** Respirator for assistive breathing
- **c.** All other respiratory treatments

**Other Treatments**
- **d.** Alcohol / drug treatment program
- **e.** Blood transfusion(s)
- **f.** Chemotherapy
- **g.** Dialysis
- **h.** IV infusion - central
- **i.** IV infusion - peripheral
- **j.** Medication by injection
- **k.** Ostomy care
- **l.** Radiation
- **m.** Tracheostomy care

**Therapies**
- **n.** Exercise therapy
- **o.** Occupational therapy
- **p.** Physical therapy

**Programs**
- **q.** Day center
- **r.** Day hospital
- **s.** Hospice care
- **t.** Physician or clinic visit
- **u.** Respite care

**Special Procedures Done In Home**
- **v.** Daily nurse monitoring (e.g., EKG, urinary output )
- **w.** Nurse monitoring less than daily
- **x.** Medical alert bracelet or electronic security alert
- **y.** Skin treatment
- **z.** Special diet

**3. Management Of Equipment** ( in Last 3 Days )

**Management Codes:**
0. Not used
1. Managed on own
2. Managed on own if laid out or with verbal reminders
3. Partially performed by others
4. Fully performed by others

- **a.** Oxygen
- **b.** IV
- **c.** Catheter
- **d.** Ostomy

**4. Visits In Last 90 Days Or Since Last Assessment**

***Enter 0 if none, if more than 9, code "9"***

- **a.** Number of times ADMITTED TO HOSPITAL **with** overnight stay
- **b.** Number of times VISITED EMERGENCY ROOM **without** overnight stay
- **c.** EMERGENCY CARE -- Including unscheduled nursing, physician, or therapeutic visits to office or home

**5. Treatment Goals**

Any treatment goals that have been met in the **LAST 90 DAYS** ( or since last assessment if less than 90 days )

0. No 1. Yes

**6. Overall Change In Care Needs**

Overall self sufficiency changed significantly compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days)

0. No change 1. Improved-- receives fewer supports 2. Deteriorated-- receives more support

**7. Trade Offs**

Due to limited funds, during last month, client made trade-offs in purchasing any of the following: prescribed medications, sufficient home heat, physician care, adequate food, home care

0. No 1. Yes

## SECTION Q. MEDICATIONS

**1. Number of Medications**

Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** or since last assessment)
*[ If none, code "0", if more than 9, code "9" ]*

**2. Receipt of Psychotropic Medication**

Psychotropic medications taken in **LAST 7 DAYS** (or since last assessment) [Note-Review client's medications with list that applies to the following categories]

0. No 1. Yes

- **a.** Antipsychotic / neuroleptic
- **b.** Anxiolytic
- **c.** Antidepressant
- **d.** Hypnotic

**3. Medical Oversight**

Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment)

0. Discussed with at least one phys. (or no medication taken)
1. No single physician reviewed all medications

**4. Compliance / Adherence With Medications**

Compliant all or most of time with **medications** prescribed by a physician (during and between therapy visits) in **LAST 7 DAYS**

0. Always compliant
1. Compliant 80% of the time or more
2. Compliant less than 80% of the time, including failure to purchase prescribed medications
3. *NO MEDICATIONS PRESCRIBED*

**5. List Of All Medications**

List prescribed and nonprescribed medications taken in the **LAST 7 DAYS** ( or since last assessment )

**a. Name and Dose** -- Record name of the medication and dose ordered

**b. Form:** Code the route of administration using the following list:

| | | | |
|---|---|---|---|
| 1. By Mouth | ( PO ) | 6. Rectal | ( R ) |
| 2. Sublingual | ( SL ) | 7. Topical | |
| 3. Intramuscular | ( IM ) | 8. Inhalation | |
| 4. Intravenous | ( IV ) | 9. Enteral tube | |
| 5. Subcutaneous | ( SQ ) | 10. Other | |

**c. Number Taken** -- Record the number of units (pills, cc, tsp, etc) taken each time the medication is administered.

**d. Freq** -- Code the number of times per day, week, or month the medication is administered using the following list:

| | | | |
|---|---|---|---|
| PRN | As necessary | QW | Once each week |
| QH | Every hour | 2W | 2 times every week |
| Q2H | Every 2 hours | 3W | 3 times every week |
| Q3H | Every 3 hours | 4W | 4 times each week |
| Q4H | Every 4 hours | 5W | 5 times each week |
| Q6H | Every 6 hours | 6W | 6 times each week |
| Q8H | Every 8 hours | 1M | Once every month |
| QD | Once daily | 2M | Twice every month |
| BID | 2 times daily (Includes every 12 hours) | C | Continuous |
| | | O | Other |
| TID | 3 times daily | | |
| QID | 4 times daily | | |
| 5D | 5 times daily | | |
| QOD | Every other day | | |

| | a. Name and Dose | b. Form | c. Number Taken | d. Freq |
|---|---|---|---|---|
| a. | | | | |
| b. | | | | |
| c. | | | | |
| d. | | | | |
| e. | | | | |
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| x. | | | | |

## SECTION R. ASSESSOR INFORMATION

**1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:**

**a.** Signature of Assessment coordinator

**b.** Title of Assessment Coordinator

**c.** Date Assessment Coordinator signed as complete — Month — Day — Year

| Other Signatures | Title | Section | Date |
|---|---|---|---|
| **d.** | | | |
| **e.** | | | |
| **f.** | | | |
| **g.** | | | |
| **h.** | | | |
| **i.** | | | |