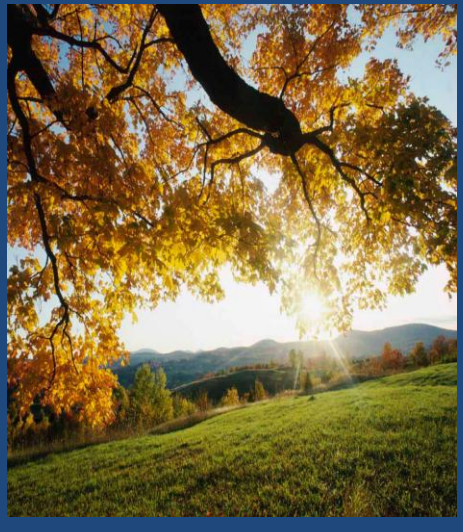
Ensuring Accuracy and Consistency in Assessment of Care Needs:

Minimum Data Set-Home Care Assessors Certification Training

Presented by:
The Office of Aging and Adult Services (OAAS)

01/25/10 1



Welcome

to the
Office of Aging and Adult Services

MDS-HC Assessor Training Workshop

01/25/10 2

Workshop Rules

- Morning & After Lunch Sign-In
- Turn off all mobile phones, or set them to vibrate
- Restrooms/Breaks/Smoking Areas
- Must stay for full training to receive MDS-HC Certificate and Assessor Registration Number
- Use index cards to jot down questions
- Complete and return Evaluation Form at conclusion of training
- Enjoy The Workshop

01/25/10 3

TRAINING OBJECTIVES

Upon completion of this training, participants will be able to:

- Provide an overview of the RAI-MDS/HC, & explain its various components, uses, & benefits
- Demonstrate familiarity with the *RAI-Home Care (RAI-HC) Assessment Manual for Version 2.0* ©, MDS-HC forms, terminology, and coding guidelines

01/25/10 4

TRAINING OBJECTIVES (continued)

- Demonstrate ability to accurately code sections of the MDS-HC utilizing classroom Case Studies
- List common coding errors and ways to avoid them
- Describe ways to improve proficiency in completion of MDS-HC assessments
- List State Agency contact information for on-going technical assistance and support

01/25/10 5

BURDEN or BENEFIT?

"Information is a source of learning. But unless it is organized, processed, and available to the right people in a format for decision making, it is a burden, not a benefit."

William Pollard - Business Leader, Author, Ethicist

01/25/10 6

Resident Assessment Instrument (RAI) Assessment/ Minimum Data Set-Home Care (MDS-HC)

01/25/10 7

RAI/MDS-HC

- Structured approach for applying a problem identification process in Long Term Care
- Provides a comprehensive, accurate, standardized, reproducible assessment of a client's functional status, strengths, & weaknesses,

01/25/10 8

RAI/MDS-HC:

- Validity & Reliability Tested
- MDS Target groups include older adults and people with disabilities or chronic diseases

01/25/10 9

InterRAI

- International group of 40+ researchers and clinicians
- Registered as not-for-profit corporation; owns international copyright on RAI instruments
- Conducts multinational collaborative research to develop, implement and evaluate the instruments and their related applications

01/25/10 10

Components of the MDS System

- Minimum Data Set assessment form
- Client Assessment protocols (CAPs trigger issues to review in developing client's care plan)

01/25/10 11

Components of the MDS System

- Resource Utilization Groups (RUGs): case mix system of groups with homogeneous resource requirements

01/25/10 12

Key Outcome Scales

- Cognitive Performance Scale (CPS)
- Depression Rating Scale (DRS)
- Activities of Daily Living (ADL) Performance Scales
- Instrumental Activities of Daily Living (IADL)

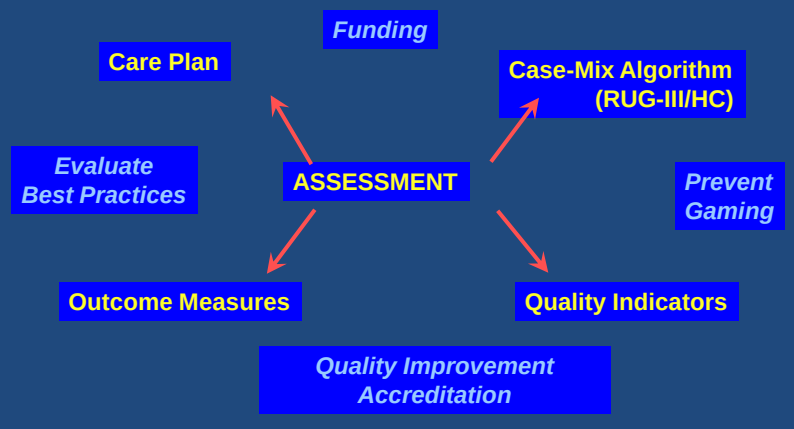
01/25/10 13

MDS-HC

- Uses all possible sources of information such as client, formal/informal caregivers, physician, medical record, etc.
- Trained assessors decide when sources are inconsistent, and when more information is needed to code each item appropriately (use best clinical judgment)

01/25/10 14

Applications of MDS-HC



01/25/10 15

MDS-HC Benefits

- For the Person:
  - ✓ Total assessment that focuses on needs and capabilities (e.g., what can the person do for him/herself)
  - ✓ Flags potential problems and benefits
  - ✓ Monitors existing risk factors

01/25/10 16

MDS-HC Benefits

- For care Providers:
  - ✓ Provides common language
  - ✓ Provides evidence-based knowledge
  - ✓ Guides the care planning process
  - ✓ Provides baselines that can be used to monitor progress

01/25/10 17

MDS-HC Benefits

- For Mangers/Supervisors
  - ✓ Provides consistent information that can be used for identification of problem areas, things that are working
  - ✓ Identifies training needs,
  - ✓ Focuses planning, and resource allocation efforts

01/25/10 18

Why do the MDS-HC?

- Official assessment tool in Louisiana for individuals elderly and disabled adults seeking HCBS Long Term Care Services
- Mandatory requirement

01/25/10 19

When is a MDS-HC Assessment Completed?

- Upon initial assessment
- When there is a Significant Change in the person's status (Status Change)
- Annual Reassessment

01/25/10 20

Who may Complete an MDS-HC Assessment?

- Only individuals who have been trained by DHH/OAAS on the MDS-HC assessment process may complete MDS-HC assessments. MDS-HC assessments completed by untrained staff will be considered invalid. On-going assessor proficiency will be continually monitored by the OAAS in order to assure assessment accuracy, quality care planning, and appropriate resource allocation.

01/25/10 21

Review of MDS-HC Manual

01/25/10 22

MDS-HC Manual – Chapter 3

- Chapter 3 *Item-by-Item Review* provides the authoritative instructions for completing each MDS-HC item
- MDS-HC Assessors are responsible for reading, studying, and familiarizing themselves with all sections of the MDS-HC Manual, & other reference materials as indicated by the OAAS

01/25/10 23

Standard Format for MDS-HC Items

- Facilitates completion of MDS-HC assessment and ensures consistent interpretation of items

01/25/10 24

Intent

- ***Reason(s) for including the item (or set of items) in the MDS-HC, including discussions of how the information will be used by clinical staff to identify problems and develop a plan of care.***

(Find & read an example of "Intent" item in MDS-HC Manual)

01/25/10 25

Definition

- ***Explanation of key terms***

(Find & read an example of "Definition" item in MDS-HC Manual)

01/25/10 26

Process

- ***Sources of information and methods for determining the correct response for an item. Sources include:***
-
  - Client interview and observation
  - Discussion with the client's family

(Find & read an example of "Process" in MDS-HC Manual)

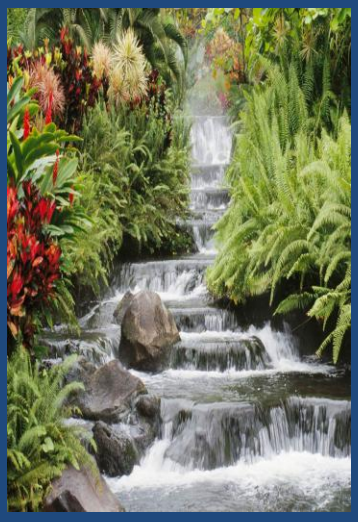
01/25/10 27

Coding

- ***Proper method of recording each response, with explanations of individual response categories.***

(Find & read an example of "Coding" item in MDS-HC Manual)

01/25/10 28



Basic Principles of MDS-HC

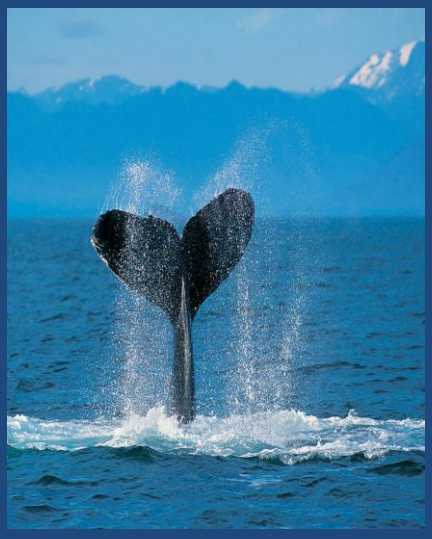
(See page 17 of MDS-HC Manual)

01/25/10 29

Ordering the MDS-HC Assessment

- consider the order in which the items in the assessment will be addressed
- consider client's cognitive status and communication skills
- no one "right order" in which the MDS-HC sections should be addressed

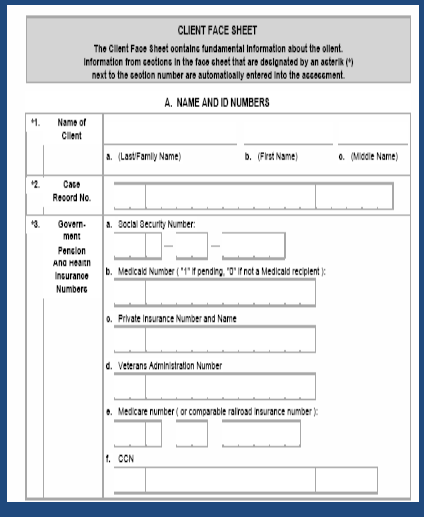
01/25/10 30



MDS-HC Forms Review & Sample Completion Activity

01/25/10 31

MDS-HC Face Sheet Overview



CLIENT FACE SHEET

The Client Face Sheet contains fundamental information about the client. Information from sections in the face sheet that are designated by an asterik (*) next to the section number are automatically entered into the assessment.

A. NAME AND ID 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. Social Security Number: b. Medicaid Number ("1" if pending, "0" if not a Medicaid recipient): c. Private Insurance Number and Name d. Veterans Administration Number e. Medicare number (or comparable railroad insurance number): f. CCN

The Face Sheet is used to "create" the client record in TeleSys and is established one time only at the point of the client's initial contact. The Face Sheet should be routinely reviewed to assure all demographic info. is current. If updates are made to Face Sheet, enter a note in the automated, TeleSys "Notes Box" indicating change(s) made.

01/25/10 32

MDS-HC Face Sheet - Section A.

*1. If client has no middle initial, leave 1c. Blank

*2. Case Record No. – Leave blank

*3 Government Pension & Health Insurance #s:

a. SSN

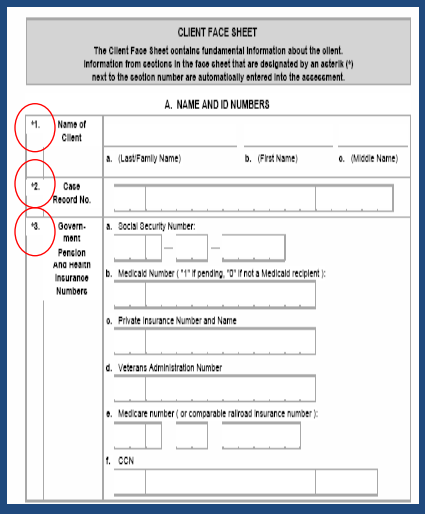
b. Medicaid # (leave blank if no #)

c. Private Insurance #

d. Veterans Admin. #

e. Medicare #

f. Card Control Number



CLIENT FACE SHEET

The Client Face Sheet contains fundamental information about the client. Information from sections in the face sheet that are designated by an asterik (*) next to the section number are automatically entered into the assessment.

A. NAME AND ID NUMBERS

*1. Name of Client — a. (Last/Family Name) b. (First Name) c. (Middle Name)

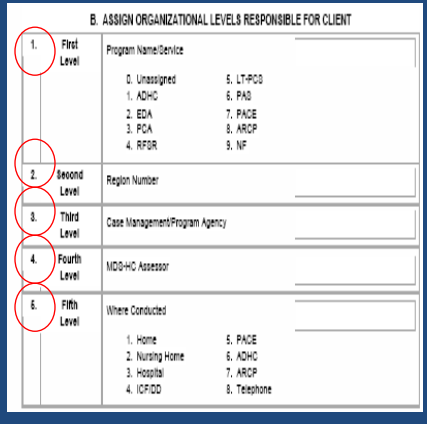
*2. Case Record No.

*3. Government Pension And Health Insurance Numbers — a. Social Security Number: b. Medicaid Number ("1" if pending, "0" if not a Medicaid recipient): c. Private Insurance Number and Name d. Veterans Administration Number e. Medicare number (or comparable railroad insurance number): f. CCN

01/25/10 33

MDS-HC Face Sheet - Section B.

1. First Level: Select appropriate response
2. Second Level: Region Client resides in
3. Third Level: *Agency Specific Code
4. Fifth Level: Where MDS-HC Assessment was conducted
5. Fourth Level: Assessor Initials



B. ASSIGN ORGANIZATIONAL LEVELS RESPONSIBLE FOR CLIENT

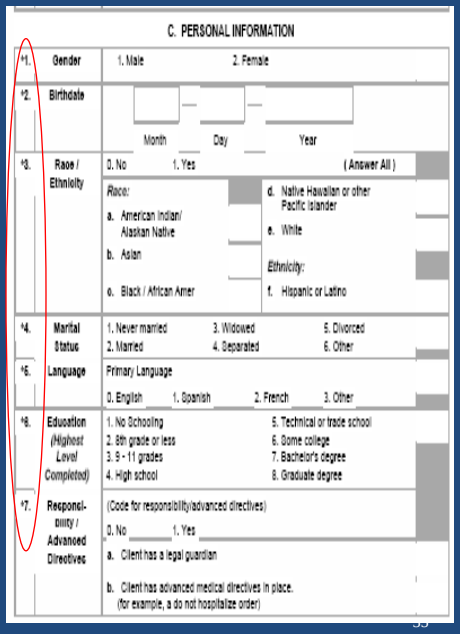
1. First Level — Program Name/Service
   0. Unassigned
   1. ADHC
   2. EDA
   3. PCA
   4. RFSR
   5. LT-PCS
   6. PAS
   7. PACE
   8. ARCP
   9. NF
2. Second Level — Region Number
3. Third Level — Case Management/Program Agency
4. Fourth Level — MDS-HC Assessor
5. Fifth Level — Where Conducted
   1. Home
   2. Nursing Home
   3. Hospital
   4. ICF/DD
   5. PACE
   6. ADHC
   7. ARCP
   8. Telephone

*Agency Specific Code is assigned by OAAS at the point of "linkage" to a Support Coordination Agency/Contractors DO NOT CHANGE/DELETE THIS CODE!

01/25/10 34

MDS-HC Face Sheet - Section C.

- *1. Gender:
  1. Male, 2. Female
- *2 Birthdate: Take special care to record & enter correct birthdate
- *3 Race/Ethnicity:
  0. No, 1. Yes
- *4 Marital Status:
- *5 Language: Primary Language
- *6 Education: If completed "Special Ed", code 2. 8th grade or less
- *7 Responsibility/Advanced Directives: 0. No, 1. Yes –
  a. Client has a legal guardian
  b. Client has advanced directives in place



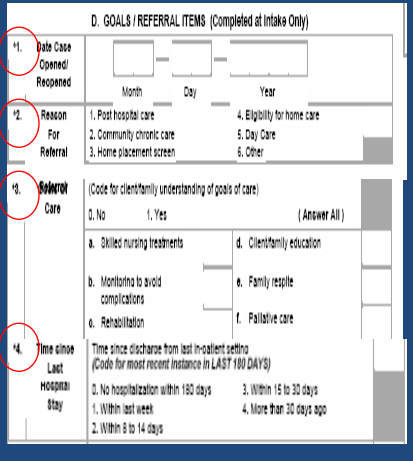
C. PERSONAL INFORMATION

*1.	Gender	1. Male 2. Female
*2.	Birthdate	Month Day Year
*3.	Race / Ethnicity	0. No 1. Yes (Answer All) Race: a. American Indian/ Alaskan Native b. Asian c. Black / African Amer d. Native Hawaiian or other Pacific Islander e. White Ethnicity: f. Hispanic or Latino
*4.	Marital Status	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other
*5.	Language	Primary Language 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) 0. No 1. Yes a. Client has a legal guardian b. Client has advanced medical directives in place. (for example, a do not hospitalize order)

01/25/10

MDS-HC Face Sheet
Section D. (Complete at Intake Only)

- *1 Date Case Opened/Reopened
  If this date is filled in at time of your assessment – Leave date as is.
- *2 Reason for Referral:
  *Choose from the following codes only:
  4. Eligibility for home care
  5. Day Care (ADHC)
  6. Other (PACE)
- *3 *Goals of Care: 0. No., 1. Yes
  (Code the client/family understanding of goals of care)
- *4 Time since Last Hospital Stay
  (Code for most recent instance in Last 180 days)



D. GOALS / REFERRAL ITEMS (Completed 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) 0. No 1. Yes (Answer All) a. Skilled nursing treatments b. Monitoring to avoid complications c. Rehabilitation d. Client/family education e. Family respite 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) 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

*Louisiana does not use other codes noted in MDS-HC Manual for this section!

01/25/10 36

MDS-HC Face Sheet
Section D. (Complete at Intake Only)

*5 Where Lived At Time of Referral (code appropriately)

*6 Who Lived With At Referral (code appropriately)

7 Prior NH Placement (Resided in a nursing home at anytime during 5 year period)
0. No, 1. Yes

*8 Residential History: Moved to current residence within last two years:
0. No, 1. Yes

*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 / ICF/DD 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 durin 5 YEARS prior to case opening 0. No 1. Yes
*8.	Residential History	Moved to current residence within last two years 0. No 1. Yes

01/25/10 37

MDS-HC Face Sheet - Section D.

9. Denial Date (Used by OAAS Nursing Facility Admissions Unit only. Not currently used by HCBS programs)

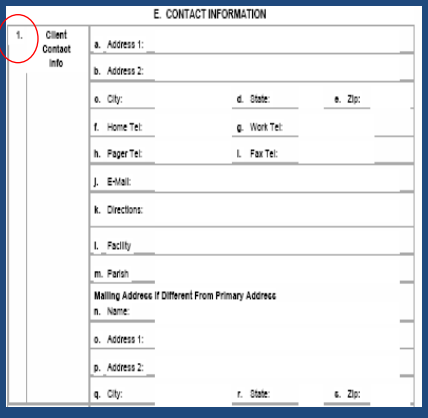
10. Denial Reason (Used by OAAS Nursing Facility Admissions Unit only. Not currently used by HCBS programs)

9.	Denial Date	Month Day Year
10.	Denial Reason	Reasons for denial: 1. Level of Care not met 2. Imminent Risk criteria not met 3. Timely and complete packet not submitted by Nursing Facility

01/25/10 38

MDS-HC Face Sheet - Section E.

1. Client Contact Info. (Complete as Indicated). Check this section to assure all contact information is current. If update/correction is warranted, the SC/Assessor makes correction, and places a note in the Face Sheet "Note Box" in TeleSys indicating corrections /changes made.

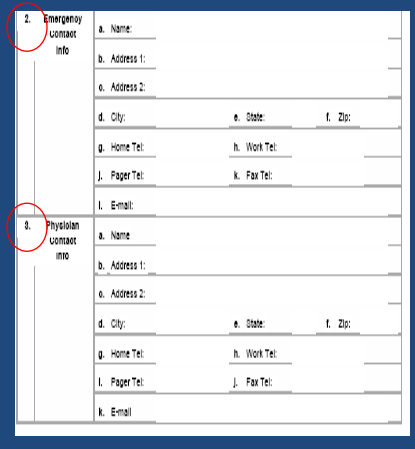

E. CONTACT INFORMATION

1. Client Contact Info
a. Address 1:
b. Address 2:
c. City: d. State: e. Zip:
f. Home Tel: g. Work Tel:
h. Pager Tel: i. Fax Tel:
j. E-Mail:
k. Directions:
l. Facility
m. Parish
Mailing Address if Different From Primary Address
n. Name:
o. Address 1:
p. Address 2:
q. City: r. State: s. Zip:

01/25/10 39

MDS-HC Face Sheet - Section E.

2. Emergency Contact Info. (Complete as Indicated). Check this section to assure all contact information is current. If update/correction is warranted, the SC/Assessor makes correction, and place a note in the Face Sheet "Note Box" in TeleSys indicating corrections /changes made.

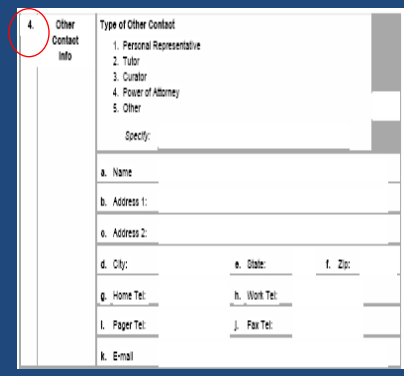

2. Emergency Contact Info
a. Name:
b. Address 1:
c. Address 2:
d. City: e. State: f. Zip:
g. Home Tel: h. Work Tel:
j. Pager Tel: k. Fax Tel:
l. E-mail:
3. Physician Contact Info
a. Name
b. Address 1:
c. Address 2:
d. City: e. State: f. Zip:
g. Home Tel: h. Work Tel:
i. Pager Tel: j. Fax Tel:
k. E-mail

3. Physician Contact Info. (Same as above)

01/25/10 40

MDS-HC Face Sheet - Section E.

4. Contact Info. (Complete as Indicated). Check this section to assure all contact information is current. If update/correction is warranted, SC/Assessor makes correction, and place a note in the Face Sheet "Note Box" in TeleSys indicating corrections/changes made.


4. Other Contact Info

Type of Other Contact
1. Personal Representative
2. Tutor
3. Curator
4. Power of Attorney
5. Other

Specify:

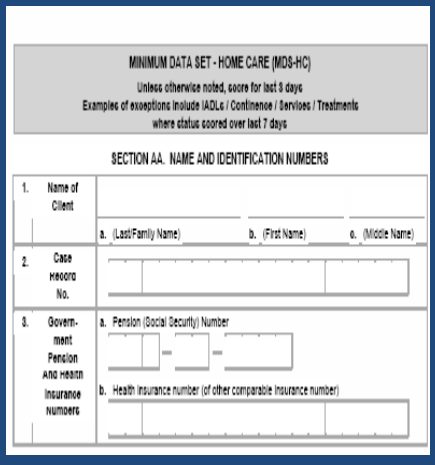
a. Name
b. Address 1:
c. Address 2:
d. City: e. State: f. Zip:
g. Home Tel: h. Work Tel:
i. Pager Tel: j. Fax Tel:
k. E-mail

01/25/10 41

MDS-HC Form Section Review

01/25/10 42

MDS-HC Form (6 pages)


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

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 b. Health insurance number (of other comparable insurance number)

The MDS-HC assessment form is used to collect information for items in Section AA – R. and is completed by the trained SC/Assessor upon Initial, Annual, enrollment/re-enrollment, And when a Significant Change in the client's physical functioning occurs.

01/25/10 43

Section AA. Name & Identification Number

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

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 b. Health insurance number (of other comparable insurance number)

Items on Client Face Sheet that are designated with and asterisk (*) next to the Section number Are automatically populated into this section of MDS-HC Assessment form. If this section of MDS-HC is blank – DO NOT LEAVE items that should be populated BLANK – Go to Face Sheet and enter information for the very first ever MDS-HC assessment in TeleSys. This will ensure that information designated with an asterisk have only been collected at INTAKE ONLY. Check all information in this section for accuracy (e.g., name spelled correctly, SSN # correct, etc.)

01/25/10 44

Section BB. Name & Identification Number (Complete at Intake Only)

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

Items on Client Face Sheet that are designated with and asterisk (*) next to the section number are Automatically populated into this section of MDS-HC Assessment form. Check information for accuracy.

01/25/10 45

Section CC. Name & Identification Number (Complete at Intake Only)

SECTION CC. REFERRAL ITEMS (Completed at Intake Only)

1.	Date Case Opened/ Reopened	Month Day Year
2.	Reason For Referral	1. Post hospital care 4. Eligibility for home care 2. Community chronic care 5. Day Care 3. Home placement screen 6. Other
3.	Goals Of Care	(Code for client/family understanding of goals of care) 0. No 1. Yes (Answer All) a. Skilled nursing treatments b. Monitoring to avoid complications c. Rehabilitation d. Client/family education e. Family respite 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)* 0. No hospitalization within 180 days 3. Within 15 to 30 days 1. Within last week 4. More than 30 days ago 2. Within 8 to 14 days
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 6 YEARS prior to case opening 0. No 1. Yes
8.	Residential History	Moved to current residence within last two years 0. No 1. Yes

Items on Client Face Sheet that are designated with and asterisk (*) next to the Section number Are automatically populated into this section of MDS-HC Assessment form. If this section of MDS-HC is blank – DO NOT LEAVE items that should be populated BLANK – Go to Face Sheet and enter information for the very first ever MDS-HC assessment in TeleSys. This will ensure that information designated with an asterisk have only been collected at INTAKE ONLY. Check all information in this section for accuracy (e.g., name spelled correctly, SSN # correct, etc.)

01/25/10 46

Section A. Assessment Information

1. Assessment Reference Date	Date of assessment Month — Day — Year
2. Reasons For Assessment	Type of assessment 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 0. Follow up assessment not required 1. 30 days — 5. 5 months 2. 60 days — 6. 6 months 3. 90 days — 7. 9 months 4. 4 months — 8. 1 year

1. Assessment Reference Date

Intent: Usually, assessments are completed based on information gathered at a single visit. Item 1 is the date of this visit. When an assessment requires a second visit, this item still records the initial visit. Although the assessor may visit on different dates, the coding for all items for this assessment refers to the fixed initial visit date, thereby ensuring the commonality of the assessment period.

.

01/25/10 47

Section A. Assessment Information

2. Reasons For Assessment	Type of assessment 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

2. Reasons for Assessment

Intent: To document the reason for completing the assessment. Each assessment requires completion of the MDS-HC (Functional Assessment), review of triggered CAPs, and development or revision of a comprehensive care plan.

The following Definitions describe the only codes currently used in Louisiana:

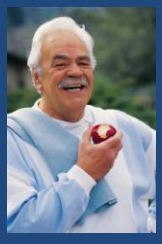
1. Initial assessment. Assessment should be completed within program guidelines

3. Routine assessment at fixed intervals — A comprehensive reassessment at specified intervals during the course of care (e.g., at the 12th-month anniversary of the initial assessment).

6. Change in status (Significant Change): A comprehensive reassessment prompted by a "major change" that is not self-limited, that affects the client's health status, and that requires review or revision of the care plan to ensure that appropriate care is given.

01/25/10 48

Section B. Cognitive Patterns (MDS-HC Manual page 31)



01/25/10 49

Section B. Cognitive Patterns (MDS-HC page 31)

SECTION B. COGNITIVE PATTERNS

1.	Memory Recall Ability	*(Code for recall of what was learned or known)* 0. Memory OK 1. Memory problem
		a. Short-term memory OK – seems/appears to recall after 5 min.
		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) 0. *INDEPENDENT* – Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE* – Some difficulty in new situations only 2. *MINIMALLY IMPAIRED* – In specific situations, decisions are poor / unsafe and cues/supervision needed at those times 3. *MODERATELY IMPAIRED* – Decision consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED* – Never/rarely made decisions
		b. Worsening of decision making as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 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) 0. No 1. Yes
		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 0. No 1. Yes

1. Memory /Recall Ability

Intent:
To determine the client's functional capacity to remember recent events (i.e., short-term memory).

a. Short Term Memory
Process: Ask client to tell you what he/she had for breakfast, when last pain medication was taken (validate with information from family/friends, use observation skills). Use structured 3 item recollection question (see example on page 31 of MDS-HC Manual)

01/25/10 50

Section B. Cognitive Patterns

1. a. short-term memory (see page 31 MDS-HC Manual)

Examples

Ask the client to describe the breakfast meal or an activity just completed.

Ask the client to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the client to repeat them (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the client to repeat the name of each item. If the client is unable to recall all three items, code "1."

Coding: Record the number corresponding to the most correct response.

Coding Exercise:
Mrs. A was able to recall only 2 of 3 items after 5 minutes. How would you code B. 1. A Short Term Memory?

0 = Memory Ok
1= Memory Problem
CODE: _____

01/25/10 51

Section B. Cognitive Patterns

1. Memory/Recall Ability
b. Procedural Memory

2. This item refers to the cognitive ability to perform sequential activities. For example dressing, fixing a cup or coffee, etc. Client must remember to perform all or most all of the steps in order to score a "0" Memory Okay.

Coding Exercise:
Mr. B indicated that he fixes a cup of coffee every morning for breakfast, but he was unable to recall any of the steps past putting water in the coffee pot. How would you code this section B. 1. b. Procedural Memory?

0 = Memory Ok
1= Memory Problem
Code: _____

01/25/10 52

Section B. Cognitive Patterns

2. Cognitive Skills for Daily Decision-Making

Intent:

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

01/25/10 53

Section B. Cognitive Patterns

2. Cognitive Skills for Daily Decision-Making
(see page 33 MDS-HC Manual)
a. How well client made decisions about organizing the day.

Examples

Choosing items of clothing; knowing when to go to meals; knowing and using space in home appropriately; using environmental cues to organize and plan the day (e.g., clocks, calendars); 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., asks for help when necessary); making the correct decision concerning how to go out of house; acknowledging need to use a walker, and using it faithfully.

01/25/10 54

Section B. Cognitive Patterns (see page 33 & 34 MDS-HC Manual)

2. Cognitive Skills for Daily Decision-Making: a. How well client made decisions about organizing the day

Coding: Enter the single number that corresponds to the most correct response.

0. Independent — The client's decisions were consistent, reasonable, and safe (reflecting lifestyle, culture, values); the client organized daily routine and made decisions in a consistent, reasonable, and organized fashion.
1. Modified Independence — The client organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.
2. Minimally Impaired — In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times.
3. Moderately Impaired - The client's decisions were consistently poor or unsafe; the client required reminders, cues, and supervision in planning, organizing, and correcting daily routines at all times.
4. Severely Impaired — The client's decision-making was severely impaired; the client never (or rarely) made decisions.

01/25/10 55

Section B. Cognitive Patterns

2. Cognitive Skills for Daily Decision-Making: **a. How well client made decisions about organizing the day.**

Coding Exercise:
Mrs. C. manages her daily routine well if she is in her own home, but her daughter reports that she becomes very flustered and forgetful when she is out of her home. Mrs. C's daughter reported that Ms. C forgets to use her walker when she goes to the doctor's office, or when she goes to grocery store. As a result, Mrs. C has almost fallen during those times. Mrs. C's daughter has to provide cues alerting her mother to use her walker, as well as supervision to prevent her mother from falling during visits to doctor's office, or when they are at the grocery store.

How would you code this item for Mrs. C?

B. . 2 a._____

01/25/10 56

Section B. Cognitive Patterns

2. Cognitive Skills for Daily Decision-Making:

b. Worsening of decision making as compared to status of 90 days ago (or since last assessment if less than 90 days)

Coding Exercise:
Mrs. C.'s family reports that her decision making has become worse as compared to 90 days ago. When asked to explain, Mrs. C's daughter stated that her mother always made sure to use her walker, especially when going out of doors, but has not done so since being released from the hospital for treatment of pneumonia 2 months ago.

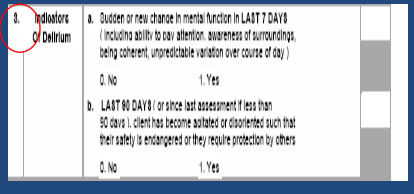
How would you code Section 2.b. for Mrs. C?

0. No
1. Yes
CODE:_____

01/25/10 57

Section B. Cognitive Patterns

3. Indicators of Delirium


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)

0. No 1. Yes

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

0. No 1. Yes

3. Indicators of Delirium
a. Sudden or new onset/change in mental function over last 7 days

***Intent:* Mental function can vary over the course of the day (e.g., sometimes better, sometimes worse; the behavior manifestation will be present** **while at other times they will not be present).**
Many treatable illnesses are manifested as an acute confused state, and when present this can be an important clinical marker that should be evaluated.

***Process:* You will depend largely on statements by the family, formal caregivers,** or the referring agency.
In asking questions, refer to changes observed over the past **7 days**, or subsequent to a recent hospitalization. Ask about sudden or new onset or change in ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over the course of the day.

***Coding:* Code for client's behavior in the last seven days regardless of what you believe the cause to be.**
Code:
0 = N0
1= Yes

01/25/10 58

Section B. Cognitive Patterns

3. Indicators of Delirium

3. Indicators of Delirium
b. Become agitated or disoriented
***Intent:* Changes in client behavior such that his or her safety is endangered.**
***Process:* You will need to ask family or the referring agency to think about client's behavior over the past 90 days (or since last assessment if less than 90 days).**
***Coding:* Code for client's behavior over the *past 90 days* (or since last assessment if less than 90 days) (regardless of cause).**

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) 0. No 1. Yes
		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 0. No 1. Yes

(See page 35 in MDS-HC Manual)

Case Example 1

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her family has reported that during the last two days, since her return from the hospital, Mrs. K has "not been herself." She has been napping more frequently and for longer periods during the day. She is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually did, she picks at her food as if she doesn't know what to do with a fork, then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling, demanding to be taken to see her husband (although he is deceased) — she never did this before. **For item 3a Code 1, Yes; For item 3b Code 1 Yes.**

01/25/10 59

Section B. Definition of Delirium

Delirium or acute confusional state is a transient global disorder of cognition. The condition is a medical emergency associated with increased morbidity and mortality rates. Early diagnosis and resolution of symptoms are correlated with the most favorable outcomes. Therefore, it must be treated as a medical emergency. Delirium is not a disease but a syndrome with multiple causes that result in a similar constellation of symptoms. Delirium is defined as a transient, usually reversible, cause of cerebral dysfunction and manifests clinically with a wide range of neuropsychiatric abnormalities. The clinical hallmarks are decreased attention span and a waxing and waning type of confusion.

01/25/10 60

Section C. Communication Patterns (pg. 35)

SECTION C. COMMUNICATION/HEARING PATTERNS

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

1. Hearing

Intent: ***To evaluate the client's ability to hear (with environmental adjustments, if necessary) during the past three-day period.***

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

01/25/10 61

Section C. Communication Patterns

(Refer to MDS-HC Manual pages 36-38 for Hearing coding options)

C. 1. Hearing Coding Exercise:

Mr. D.'s family reports that they often have to slow down their speech, lower their voice, and face Mr. D. in order for him to hear what they are saying. How would you code Mr. D for this item?

C. 1. Hearing: _____

(What types of information might you include in the MDS-HC Note Book?)

01/25/10 62

Section C. Communication Patterns (pg. 36)

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

C. 2. Making Self Understood (Expression)

Intent: To document the client's ability to express or communicate request, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or combination of these (includes use of word board or key board).

01/25/10 63

Section C. Communication Patterns

(Refer to MDS-HC Manual pages 36-38 for Hearing coding options)

C. 2. Making Self Understood (Expression)

The assessor noted that Mr. D. sometimes had trouble finding the right word during normal conversation, but if given time, he was eventually able to communicate his needs with little or no prompting. How would you code Mr. D. for this item?

C. 2. Making Self Understood: _____

(What types of information might you include in the MDS-HC Note Book?)

01/25/10 64

Section C. Communication Patterns (pg. 37)

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

3. Ability to Understand Others (Comprehension)

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

01/25/10 65

Section C. Communication Patterns

(Refer to MDS-HC Manual pages 36-38 for Hearing coding options)

C. 3. Ability to Understand Others

Mr. D. often misses part or intent of message, but with prompting, he often comprehends the conversation. How you code this item for Mr. D.?

C. 3. Ability to Understand Others:

_____

(What types of information might you include in the MDS-HC Note Book?)

01/25/10

Section C. Communication Patterns (pg. 38)

SECTION C. COMMUNICATION/HEARING PATTERNS

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

4. Communication Decline

Intent: To compare client's current abilities to make him or herself understood or to understand others to status of 90 days ago.

01/25/10 67

Section C. Communication Patterns

(Refer to MDS-HC Manual pages 36-38 for Hearing coding options)

C. 4. Communication Decline Coding Exercise:

Mr. D's family indicated that his ability to communicate diminished greatly after he experienced a stroke 9 months ago, but otherwise, his ability to make himself understood or to understand others, has been pretty consistent since that time. How would you code Mr. D. in this area?

C 4. Communication Decline: _____

(What types of information might you include in the MDS-HC Note Book?)

01/25/10 68

Section D. Vision Patterns (pg. 38)

SECTION D. VISION PATTERNS

1.	Vision	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE – Sees fine detail, including regular print in newspapers / books 1. IMPAIRED – Sees large print, but not regular print in newspapers / books 2. MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects 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 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) 0. No 1. Yes

***Intent:* To record the client's visual abilities and limitations over the past three days, assuming adequate lighting and assistance of visual appliances, if used.**

1. Vision

***Intent:* To evaluate the client's ability to see close objects in adequate lighting, using the client's customary visual appliances for close vision (e.g., glasses, magnifying glass).**

***Definition:* "Adequate" lighting — What is sufficient or comfortable for a person with normal vision.**

01/25/10 69

Section D. Vision Patterns (Refer to MDS-HC Manual page 39 – 41 for Vision coding options)

D. 1. Vision Coding Exercise:

Mrs. E reports that she wears glasses, but that she accidently stepped on them a few weeks ago and has not been able to get to the eye doctor to have them replaced. She was unable to read written materials when presented to her, but could identify objects in her environment such as her bed, chair, slippers, etc. Mrs. E reports sometimes seeing flashes of light and rings around lights. Mrs. E's son reported that recently (within last 2 months) he has noticed that his mother has had trouble seeing dark colored objects. When asked, Mrs. E denies any such problems. Assessor notices that Mrs. E is wearing one black and one brown shoe. How would you code the following items in Section D. for Mrs. E?

D 1. Vision_____

D 2. Visual Limitations/Difficulties: 0. No, 1. Yes

D 3. Vision Decline: 0. No, 1. Yes

01/25/10 70

Section D. Vision Patterns (pg. 38 - 40)

SECTION D. VISION PATTERNS

1.	Vision	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE – Sees fine detail, including regular print in newspapers / books 1. IMPAIRED – Sees large print, but not regular print in newspapers / books 2. MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects 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 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) 0. No 1. Yes

2. Visual Limitations/ Difficulties

Intent:
To document whether the client experiences limitations or difficulties related to diseases common in aged persons (e.g., glaucoma, cataracts, macular degeneration, diabetic retinopathy, neurologic diseases).

01/25/10 71

Section D. Vision Patterns (Refer to MDS-HC Manual page 39 – 41 for Vision coding options)

D. 2. Visual Limitation/Difficulty Coding Exercise:

Mrs. E reports sometimes seeing flashes of light and rings around lights. How would you code this item?

Code: 0. No
1. Yes

01/25/10 72

Section D. Vision Patterns (pg. 41)

SECTION D. VISION PATTERNS		
1.	Vision	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE – Sees fine detail, including regular print in newspapers / books 1. IMPAIRED – Sees large print, but not regular print in newspapers / books 2. MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects 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 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) 0. No 1. Yes

3. Vision Decline

Intent:
To document change in client's ability to see objects in adequate lighting using customary visual appliances, as compared to 90 days ago (or since last assessment if less than 90 days ago).

01/25/10 73

Section D. Vision Patterns (Refer to MDS-HC Manual page 39 – 41 for Vision coding options)

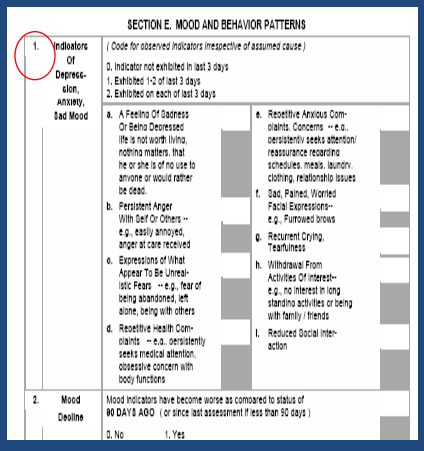
D. 3. Vision Decline Coding Exercise:

Mrs. E's son reported that recently (within last 2 months) he has noticed that his mother has had trouble seeing dark colored objects. When asked, Mrs. E. denies any such problems. Assessor notices that Mrs. E is wearing one black and one brown shoe. How would you code this item for Mrs. E?

Coding: 0. No
1. Yes

01/25/10 74

Section E. Mood and Behavior Patterns (Refer to MDS-HC Manual, page 42)



SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	Indicators Of Depression, Anxiety, Sad Mood	(Code for observed indicators irrespective of assumed cause) 0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days
	a. A Feeling Of Sadness Or Being Depressed b. Persistent Anger With Self Or Others -- e.g., easily annoyed, anger at care received c. Expressions of What Appear To Be Unrealistic Fears --e.g., fear of being abandoned, left alone, being with others d. Repetitive Health Complaints --e.g., persistently seeks medical attention, obsessive concern with body functions e. Repetitive Anxious Complaints, Concerns --e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues f. Sad, Pained, Worried Facial Expressions-- e.g., Furrowed brows g. Recurrent Crying, Tearfulness h. Withdrawal From Activities Of interest-- e.g., no interest in long standing activities or being with family / friends 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) 0. No 1. Yes

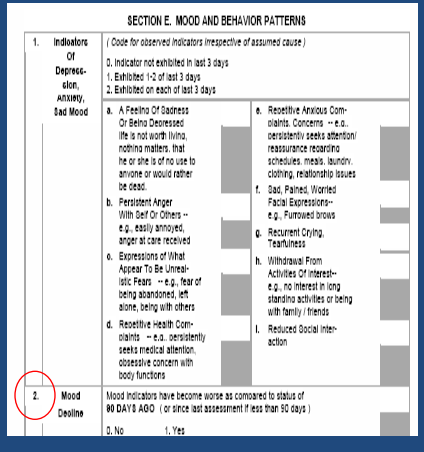
1. Indicators of Depression, Anxiety, Sad Mood

Intent: To record the presence of indicators observed in the **last 3 days**, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychic distress may be expressed directly by the client who is depressed, anxious, or sad. Distress can also be expressed by non-verbal indicators.

01/25/10 75

Section E. Mood and Behavior Patterns (page 43)



SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	Indicators Of Depression, Anxiety, Sad Mood	(Code for observed indicators irrespective of assumed cause) 0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days
	a. A Feeling Of Sadness Or Being Depressed b. Persistent Anger With Self Or Others -- e.g., easily annoyed, anger at care received c. Expressions of What Appear To Be Unrealistic Fears --e.g., fear of being abandoned, left alone, being with others d. Repetitive Health Complaints --e.g., persistently seeks medical attention, obsessive concern with body functions e. Repetitive Anxious Complaints, Concerns --e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues f. Sad, Pained, Worried Facial Expressions-- e.g., Furrowed brows g. Recurrent Crying, Tearfulness h. Withdrawal From Activities Of interest-- e.g., no interest in long standing activities or being with family / friends 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) 0. No 1. Yes

2. Mood Decline

Intent: To compare status of mood indicators to status 90 days ago.

01/25/10 76

Section E. Mood and Behavior Patterns (page 44)

3. Behavioral Symptoms

3. Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
	a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others 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 e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

Intent: To identify a.) symptom frequency and b.) The family's view of the alterability of the behavioral symptoms **(in the last three days)** that cause distress to the client, or are distressing or disruptive to others with whom the client lives. Such behaviors include those that are potentially harmful to the client or disruptive to others. This item is designed to pick up problem behaviors exhibited by the elder at home. In this item we ask the caregiver to tell us if a specified problem behavior occurred or not. Then we also determine if this behavior was easily controlled or could be easily altered by actions of the family.

01/25/10 77

Section E. Mood and Behavior Patterns (page 44)

3. Behavioral Symptoms

3. Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
	a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others 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 e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

Definitions:

Wandering: Moved about with no discernible, rational purpose, seeming oblivious to needs or safety. Differentiated from purposeful movement (e.g., a hungry person moving about the apartment searching for food). Wandering may be by walking or by wheelchair. Do not include pacing as wandering behavior.

01/25/10 78

Section E. Mood and Behavior Patterns (page 44)

3.	Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
		a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others
		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
		e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

3. Behavioral Symptoms

Definitions:

Verbally Abusive Behavioral Symptoms : **Others were threatened, screamed at, or cursed at.**

Physically Abusive Behavioral Symptoms: **Others were hit, shoved, scratched, or sexually abused.**

01/25/10 79

Section E. Mood and Behavior Patterns (page 44)

3.	Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
		a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others
		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
		e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

3. Behavioral Symptoms

Definitions:

Socially Inappropriate/ Disruptive Behavioral Symptoms: **Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings, repetitive behaviors, rising early and causing distress to others.**

01/25/10 80

Section E. Mood and Behavior Patterns (page 44)

3.	Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
		a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS– Threatened screamed at, cursed at others c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS– Hit, shoved, scratched, sexually abused others 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 e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

3. Behavioral Symptoms

Definitions:

Resists Care — Resists taking medications/injections, pushed caregiver during ADL assistance. This category does not include instances where client has made an informed choice not to follow a course of care (e.g., client has exercised his right to refuse treatment, and reacts negatively as others try to reinstitute treatment).

Coding:

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

01/25/10 81

Section E. Mood and Behavior Patterns

(Refer to MDS-HC Manual page 46)

E. 3. Behavioral Symptoms Coding Exercise:

Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the apartment throughout the day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still when anyone visits. Numerous attempts in the past to redirect his wandering have been met with hitting and pushing family. Over time, family members have found him to be most content while he is wandering within the structured setting of the apartment. How would you code the following items?

CODE:
Wandering :_____
Verbally abusive: _____
Physically abusive :_____
Socially inappropriate :_____
Resists Care :_____

01/25/10 82

Section E. Mood and Behavior Patterns

(Refer to MDS-HC Manual page 46)

Section E. 3. Behavioral Symptoms Coding Exercise:

The elder's daughter states she has found her mother up and going through her daughter's closet in the middle of the night. This has happened several nights over the past three days. When she tried to get her mother to return to her own room and bed, the mother became angry and shouted at her daughter. She accused the daughter of stealing her things. How would you code the following items?

CODE:

Wandering: _____

Verbally abusive: _____

Physically abusive:_____

Socially inappropriate: _____

Resists care: _____

01/25/10

Section E. Mood and Behavior Patterns (pg. 46)

3.	Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered
		a. WANDERING – Moved without rational purpose, seemingly oblivious to needs or safety b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others 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 e. RESISTS CARE – Resisted taking medications / injections, ADL assistance, eating, or changes in position
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

4. Changes in Behavior Symptoms:

Intent: To document whether the behavioral symptoms or resistance to care exhibited by the client has increased in frequency of occurrence or alterability, or in acceptance by family as compared to his or her status of 90 days ago (or since last assessment if less than 90 days).

Code:

0. No, or no change

1. Yes

01/25/10 84

Section F. Social Functioning (pg. 47)

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

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

1. Involvement

a. Client At Ease
Code:
0. At ease
1. Not at ease

b. Openly Expresses Conflict
Code:
0. No
1. Yes

01/25/10 85

Section F. Social Functioning (Refer to MDS-HC Manual, page 48)

Example: Mr. H. Tells assessor he has to do what his daughter says or "she gets mad with me." When assessor talks to daughter, she reports no conflict.

Code as "1" (Yes, openly expresses conflict).

01/25/10 86

Section F. Social Functioning (pg. 48)

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

2. Change in Social Activities

Intent:
Identify a recent change (as compared to 90 days ago – or since last assessment if less than 90 days) in the level of participation in activities or relationships.

Definition: • The level of participation refers to:
a. The quantity (how many) of different types of social activities
b. The intensity (how frequently) of the relationship
c. The quality (how deep the client's involvement is in the activity) of the relationship

01/25/10 87

Section F. Social Functioning (pg. 49)

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

3. Isolation

Intent: To identify the actual amount of time that the client is alone, and his/her perception of loneliness.

Definition: Length of time alone during the day (morning and afternoon) means literally left alone without any other person. If the client is residing in a board and care facility, congregate housing, or other situation where there are other clients in their own rooms, count the amount of time alone in room by him/herself as time alone.

01/25/10 88

Section F. Social Functioning (pg. 49)

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

Process: **First ask the client how much time he/she spends "alone". Be clear about what is defined as "being alone". Then ask questions about loneliness. For example: "Do you feel alone or as if you are by yourself?" "Do you feel alone, even when you have visitors or other people are near?" Does the client wish their were more visitors, or pets to interact with?**

Coding:

Code the most appropriate category.

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

01/25/10 89

Section F. Social Functioning (pg. 50)

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

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

Coding: Code if client says or indicates he/she feels lonely.

0. No
1. Yes

01/25/10 90

Section G. Informal Support Services (pg. 50-54)

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
0. Yes 1. No 2. No such helper [skip other items in the appropriate column]

f. Relationship to client
0. Child or child-in-law 2. Other Relative 4. None
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:
0. More than 2 hours 1. 1-2 hours per day 2. No

1. Two Key Informal Helpers

Intent: To assess the informal caregiver support system. This is different from a formal relationship that the client may have with a health care agency.

01/25/10 91

Section G. Informal Support Services (pg. 50-54)

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
0. Yes 1. No 2. No such helper [skip other items in the appropriate column]

f. Relationship to client
0. Child or child-in-law 2. Other Relative 4. None
1. Spouse 3. Friend / neighbor

0. Yes 1. No

g. Advice or emotional support

h. IADL care

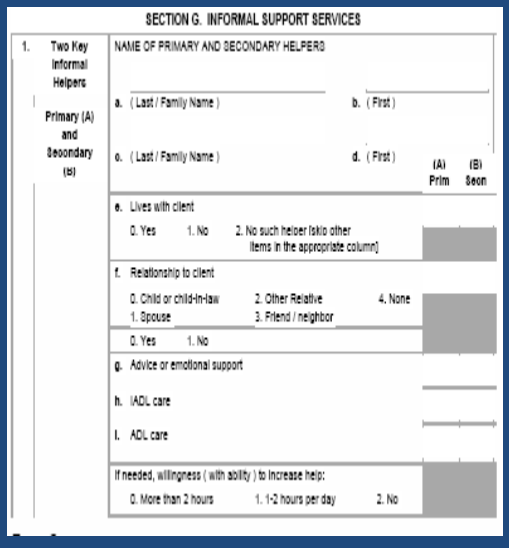
i. ADL care

If needed, willingness (with ability) to increase help:
0. More than 2 hours 1. 1-2 hours per day 2. No

Definition: Primary informal caregiver. Primary caregiver may be a family member, friend or neighbor (but not a paid provider). It is not required that the caregiver actually live with the client, rather that he/she visits regularly, or would respond to needs that the client may have. This is the person who is most helpful to the client, who he could most rely upon.

01/25/10 92

Section G. Informal Support Services (pg. 50-54)



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
0. Yes 1. No 2. No such helper [skip other items in the appropriate column]

f. Relationship to client
0. Child or child-in-law 1. Spouse 2. Other Relative 3. Friend / neighbor 4. None

0. Yes 1. No

g. Advice or emotional support

h. IADL care

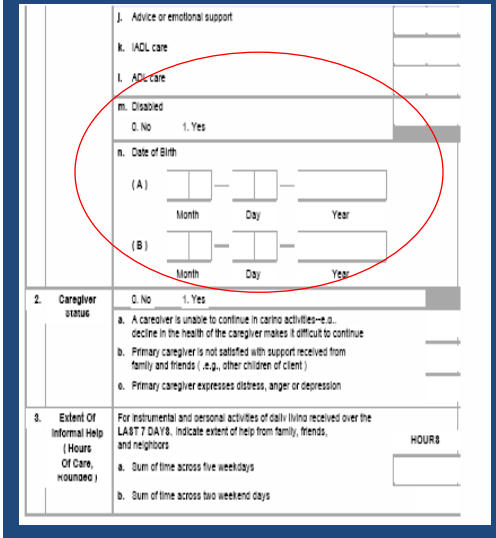
i. ADL care

If needed, willingness (with ability) to increase help:
0. More than 2 hours 1. 1-2 hours per day 2. No

Definition

Secondary informal caregiver. The second most important informal provider of care, or the person who, after the primary caregiver, could be most relied on to help or give advice and counsel if needed.

Section G. Informal Support Services (pg. 50-54)



j. Advice or emotional support

k. IADL care

l. ADL care

m. Disabled
0. No 1. Yes

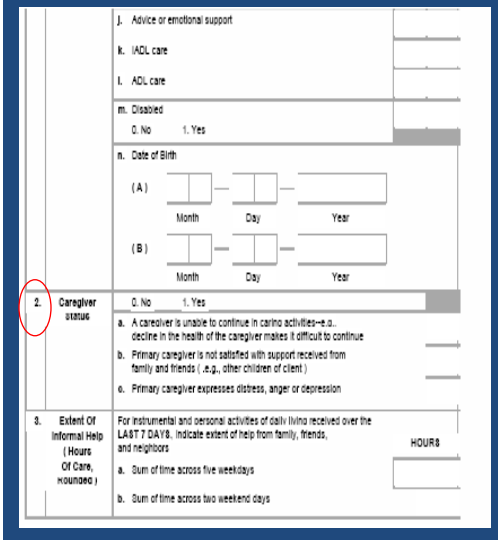
n. Date of Birth
(A) Month Day Year
(B) Month Day Year

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

Caregiver G. 1. m & n questions are unique to Louisiana MDS-HC. Ask if the primary care giver is disabled. Collect the date of birth for both primary and secondary caregivers if any identified in this section.

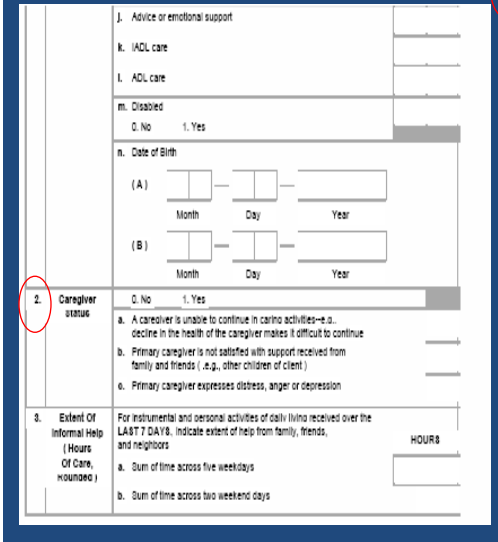
Section G. Informal Support Services (pg. 50-54)


j. Advice or emotional support
k. IADL care
l. ADL care
m. Disabled
0. No 1. Yes
n. Date of Birth
(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

2. Caregiver Status

Intent: To assess the reserve of the informal caregiver support system.

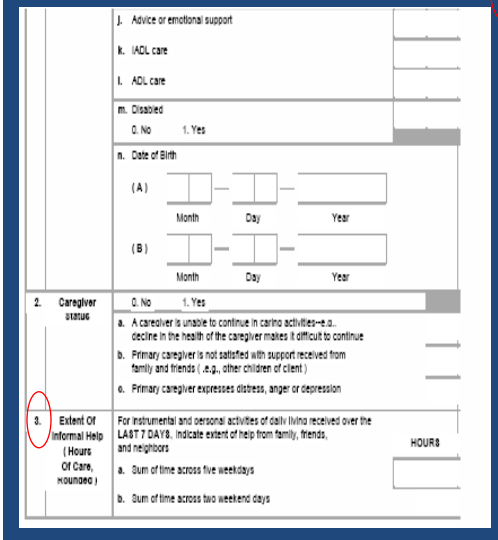
Section G. Informal Support Services (pg. 50-54)


j. Advice or emotional support
k. IADL care
l. ADL care
m. Disabled
0. No 1. Yes
n. Date of Birth
(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

2. Caregiver Status

Definition: A caregiver is unable to continue in caring activities - <u>The caregiver, client, or assessor believes</u> that a caregiver(s) is not able to continue in caring activities. This can be for any reason, for example: lack of desire to continue, geographically inaccessible, other competing requirements (child care, work requirements), personal health issues.

Section G. Informal Support Services (pg. 50-54)

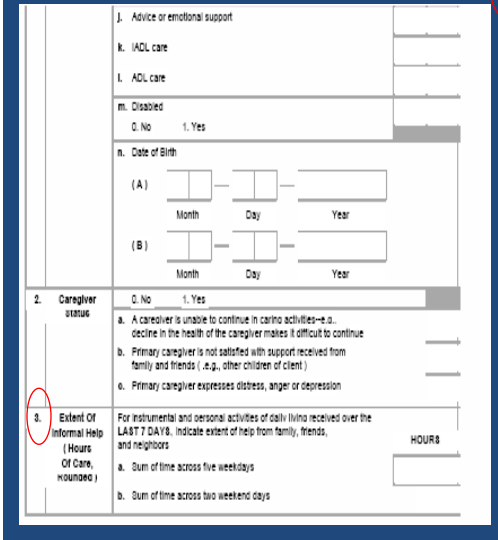

j. Advice or emotional support
k. IADL care
l. ADL care
m. Disabled
0. No 1. Yes
n. Date of Birth
(A) Month Day Year
(B) Month Day Year
2. Caregiver status
0. No 1. Yes
a. A caregiver is unable to continue in caring activities–e.g., decline in the health of the caregiver makes it difficult to continue
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

3. Extent of Informal Help

<u>Intent:</u> To capture the number of hours and minutes spent assisting the client in instrumental and personal activities of daily living, over the last 7 days.

01/25/10 97

Section G. Informal Support Services (pg. 50-54)


j. Advice or emotional support
k. IADL care
l. ADL care
m. Disabled
0. No 1. Yes
n. Date of Birth
(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

3. Extent of Informal Help

Definition: <u>Include all people that provide assistance to the client,</u> for example family, friends and neighbors. They may or may not be the primary caregiver. Instrumental activities of daily living include: meal preparation, house work, managing finance. Personal activities of daily living include: mobility in bed, dressing, toilet use.

01/25/10 98

Section H. 1. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)

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 MEDICATION - 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)		

1. IADL Self Performance

Intent: ***The intent of these items is to examine the areas of function that are most commonly associated with independent living.***

01/25/10 99

Section H. 1. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)

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

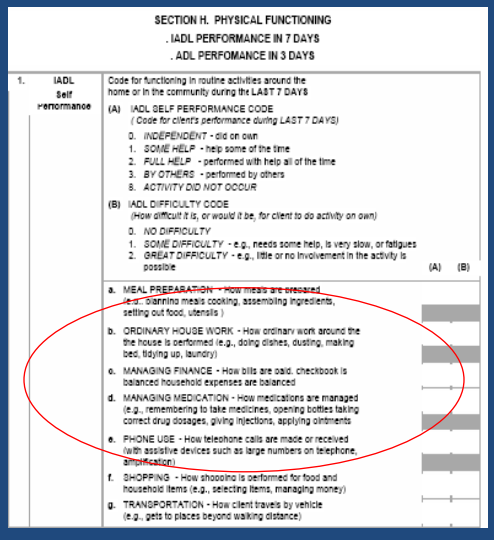
	(A)	(B)
a. MEAL PREPARATION - How meals are prepared (e.g., planning meals cooking, assembling ingredients, setting out food, utensils)		
b. ORDINARY HOUSE WORK - How ordinary work around the the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. MANAGING FINANCE - How bills are paid, checkbook is balanced household expenses are balanced		
d. MANAGING MEDICATION - 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)		

1. IADL Self Performance

Process: **The client is questioned directly about his or her performance of normal activities around the home or in the community in the last 7 days. You may also talk to family members if they are available. You also should use your own observations as you are gathering information for other MDS-HC items.**

01/25/10 100

Section H. 1. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)



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 MEDICATION - 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)

Definition:

a. Meal preparation — How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils.)

b. Ordinary housework — How ordinary work around the house is per-formed (e.g., doing dishes, dusting, making bed, tidying up.)

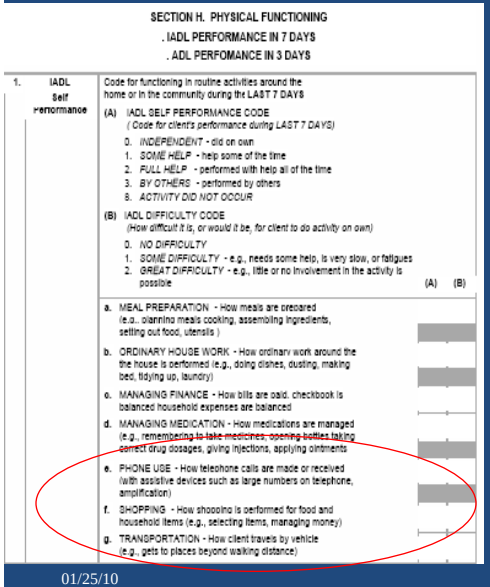
c. Managing finances — How bills are paid, checkbook is balanced, household expenses are balanced.

d. Managing medications — How medications are managed (e.g., remember to take medicines, open bottles, take correct dosage of pills, injections, ointments.)

01/25/10

101

Section H. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)



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 MEDICATION - 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)

Definition:

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

f. Shopping — How shopping is completed for food and household items (e.g., selecting items, managing money.)

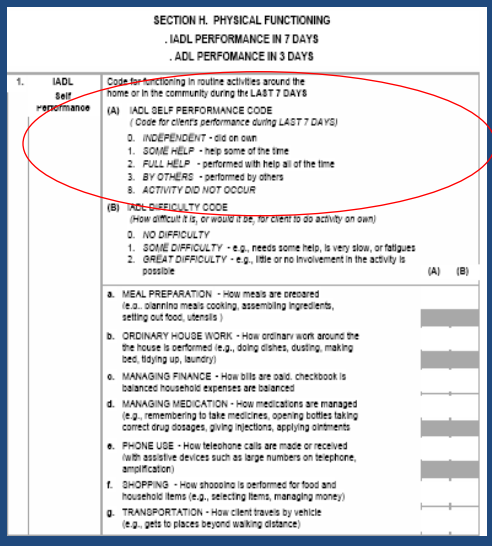
g. Transportation — How client travels by vehicle (e.g., gets to places beyond walking distance) — includes driving vehicle him/herself; travelling as a passenger in a car, bus or subway.

Coding: Note-each item has two codes Code A, and Code B.

01/25/10

102

Section H. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)



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 MEDICATION - 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)

CODE (A) IADL SELF-PERFORMANCE CODE — Code for the client's performance over the past 7 days.

0. Independent, did on own

1. Some help — client involved but received help from others some of the time.

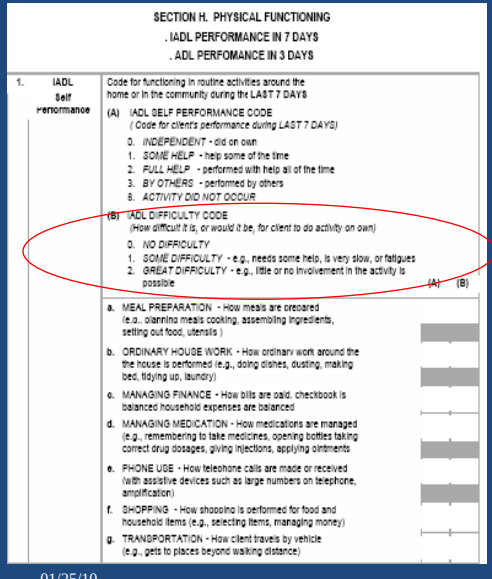
2. Full help — client involved but received help from others all of the time

3. By others — client totally dependent on others

8. ACTIVITY DID NOT OCCUR

01/25/10 103

Section H. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)



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 MEDICATION - 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)

CODE (B) IADL DIFFICULTY CODE — For those involved in activities, ask: How difficult is it (or would it be) for client to do activity on own. [Note: This may well be a judgment call by assessor for client may never have done this activity (e.g., never cooked a meal himself].

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)

Code for the most appropriate response.

01/25/10 104

H.1.a. - Meal Preparation

Code for functioning in routine activities around the home or in the community during the past 7 days: Meal preparation – How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils)

01/25/10 105

H.1.a. - Meal Preparation – Test Your Knowledge

- Ms. P fixes her meals when she is able to do so. During the 7 day look-back period, Ms. P's neighbor cooked for her on two days because Ms. P was feeling very weak.

- **CODE:**

01/25/10 106

H.1.b. – Ordinary Housework

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

01/25/10 107

H.1.b. – Ordinary Housework – Test Your Knowledge

• Ms. P was able to perform all task related to doing the laundry on Monday, of the past week (7 day look-back period), but was only able to assist with folding of the laundry on Wednesday of same 7 day look back period.

•**CODE:**

01/25/10 108

H.1.c. – Managing Finances

- How bills are paid, checkbook is balanced, household expenses are balanced.

01/25/10 109

H.1.c. – Managing Finances – Test Your Knowledge

- Ms. P's niece, Carla, helps her four times a month to balance her check book and to go over all of her bills to assure that they are paid timely. The last time Carla assisted Ms. P. with this task, was four days ago.

- **CODE:**

01/25/10 110

H.1.d. – Managing Medications

- How medications are managed (e.g., remembers to take medicines, open bottl3es, take correct dosage of pills, injections, ointments.)

01/25/10 111

H.1.d. – Managing Medications - Test Your Knowledge

Mr. N. takes Ibuprofen – Two, 800 mg. tablets every day for his arthritis. When Mr. N's arthritis is not flaring up he opens his pill bottle by himself . During the 7 day look-back period, Mr. N required help only two times from his daughter, Carol, in order to get his pill bottle opened.

•**CODE:**

01/25/10 112

H.1.d. – Managing Medications - Test Your Knowledge

Ms. O is blind and is unable to administer her own insulin dosages to manage her diabetes. During the 7 day look-back period, Mrs. O's insulin was administered by her sister at all times.

- **CODE**

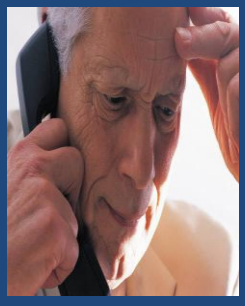
01/25/10 113

H.1.e. – Phone Use

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

01/25/10 114

H.1.e. – Phone Use - Test Your Knowledge



During the 7 day look-back period, Mr. N required help only two times from his daughter-in-law in order to make a telephone call. Mr. N. was able to answer the telephone without assistance during the entire 7 day look-back period.

- **CODE:**

01/25/10 115

H.1.f. – Shopping

- How shopping is performed for food and household items (e.g., selecting items, managing money.)

01/25/10 116

H.1. f. – Shopping – Test Your Knowledge

Before Ms. Q broke her hip, she shopped for her food and household items herself, but during the 7 day look- back period, her son shopped for all of her shopping needs.

•**CODE:**

01/25/10 117

H.1.g. – Transportation

- How client travels by vehicle (e.g., gets to places beyond walking distance)- Includes driving vehicle him/herself; traveling as a passenger in a car, bus or subway.

01/25/10 118

H.1. g. – Transportation – Test Your Knowledge

During the 7 day look-back period, Mr. R did not leave his home, other than to sit on his back porch for a few minutes each day.

•**CODE:**

01/25/10 119

Section H. 2. ADL Performance In Last 3 Days (pg. 55-68)

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)

Definition: ***ADL SELF-PERFORMANCE — Measures what the client actually did (not what he or she might be capable of doing) within each ADL category over the last three days according to the performance-based scale. (For bathing code for most dependent single episode in last 7 days)***

01/25/10 120

Section H. 2. Physical Functioning: ADL Coding Definitions

0. Independent : No help or oversight, OR help or oversight was provided only 1 or 2 times in the last 3 days (with any task or subtask).

01/25/10 121

Section H. 2. Physical Functioning: ADL Coding Definitions

1. Setup Help Only – Article of device provided or placed within reach of client 3 or more times. (Examples include: For hygiene- provides basin or grooming articles; For locomotion- handling walker or locking wheels on wheelchair; For eating cutting meat, opening containers; For dressing-retrieving clothes and lying out on bed; For bathing articles at tubside.)

01/25/10 122

Section H. 2. Physical Functioning: ADL Coding Definitions

2. Supervision – Oversight, encouragement, or cueing provided 3 or more times during period – OR Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for total of 3 or more episodes of help or supervision).

01/25/10 123

Section H. 2. Physical Functioning: ADL Coding Definitions

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 total of 3 or more episodes of physical help).

01/25/10 124

Section H. 2. Physical Functioning: ADL Coding Definitions

4. Extensive Assistance – Client performed part of activity on own (50% or more of subtasks) BUT help of the following type was provided 3 or more times:

- Weight-bearing support (e.g., holding weight of one or both lower limbs, trunk, or arms)
- Full staff performance of task (some of time) or discrete subtask.

01/25/10 125

Section H. 2. Physical Functioning: ADL Coding Definitions

5. Maximal Assistance – Client involved and completed less than 50% of subtasks on own, received weight bearing help or full performance of certain subtasks 3 or more times. Includes two person physical assist.

(Difference between Maximal & Extensive is degree of client involvement in activity. If less than 50% involvement – use this code.)

01/25/10 126

Section H. 2. Physical Functioning: ADL Coding Definitions

6. Total Dependence – Full performance of the activity by another during entire period.

8. Activity Did Not Occur- During the last three days, the ADL activity was not performed by the client or other. In other words, the specific activity did not occur at all (regardless of ability)

01/25/10 127

Section H. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)

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

01/25/10 128

Section H. Physical Functioning: IADL In 7 Days – ADL Performance In 3 Days (pg. 55-68)

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 90 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

4. Primary Modes of Locomotion

Intent: ***To record the type(s) of appliance, devices, or personal assistance the client used for locomotion.***

Definition: ***Scooter (e.g. Amigo) - A motorized chair/cart that is controlled by the client. Do not code electric wheel chair in this category. Electric wheelchair should be coded as "4".***

Coding: ***Indicate device or appliance most often used indoors (A) and outdoors***

01/25/10 129

Section H. 2. Physical Functioning:

- Assessor must understand all IADL/ADL definitions
- Consider and assess all the aspects of ADLs
- Important to use various methods to collect necessary information (direct observation of client, ask family/friends, caregivers, record review, etc.)
- <u>Must consider 24 hour period of each day of the look-back/observation period</u>

01/25/10 130

Section H. 2. a. Bed Mobility

- How the client turns from side to side in bed
- How the client lays down and sits up when placed in bed
- How the client positions himself in bed, in a recliner or other type of furniture the client sleeps in, rather than a bed
- Include all movement until the client leaves the bed

01/25/10 131

H.2.a. - Bed Mobility- Test Your Knowledge

- Mr. D is slowly regaining his strength as a result of a recent surgery. Every day of the last 3 days, Mr. D's caregiver assisted him from a lying position to a sitting position by physically supporting his weight (weight-bearing) so he could sit up to eat all three of his daily meals (breakfast, lunch and dinner). Mr. D was able to perform less than 50% of subtask on his own.
- **CODE:**

132

Section H. 2. b. Transfer

- How the client moves between surfaces:
  - Bed to chair
  - Chair to bed
  - Bed to wheelchair
  - Standing position
  - Exclude movement to/from bath or toilet, which is covered under Toilet Use and Bathing

01/25/10 133

H.2.b. Transfer ADL – Test Your Knowledge:

Mrs. H was recently placed on total bed rest, and as a result, did not leave her bed during the entire 3 day look-back period.

- **CODE:**

134

Section H. 2. c. Locomotion

- **Locomotion in *(Walking or wheeling once in W/C)*.** How client gets around in the home environment. For example: How does she/he get from the bedroom to the bathroom, from kitchen to living room, etc? (excludes stairs)

01/25/10

135

H.2.c. Locomotion in Home – Test Your Knowledge:

During the 3 day look-back period, Mr. A ambulated independently around his home during the day. At night, Mr. A required his wife, Emily, to walk by his side to provide oversight and verbal encouragement as he walked to the bathroom at least 3 times during the 3 day look-back period.

- **CODE:**

136

Section H. 2. d. Locomotion Outside of Home

- **Locomotion Outside of Home *(Walking or wheeling once in W/C)*.** How client gets around outside of the home. How does she/he get around when visiting friends, neighbors, out in the community, etc?

01/25/10 137

H.2.c. Locomotion Outside of Home – Test Your Knowledge:

– During the 3 day look-back period, Mr. B visited his neighbor on 2 days of the 3 day look-back period by wheeling himself to and from his house to his neighbor's house in his wheelchair . On the third day of the look-back period, Mr. B's neighbor wheeled Mr. B back from his house to Mr. B's house.

- **CODE:**

138

Section H. 2. e. Dressing Upper Body

- **Dressing Upper Body –** How client dresses and undresses (street clothes, underwear) above the waist. How the client puts on, fastens and takes off all items of clothing, including donning /removing a prosthesis, pullovers, etc.

(Code an "8" if not dressed in street clothes)

01/25/10 139

H.2.e.- Dressing Upper Body – Test Your Knowledge:

- Ms. C's caregiver provided non-weight bearing assistance by guiding Ms. C's arms through the opening of her bra strap as she was getting dressed each morning during the 3 day look-back period.
- **CODE:**

140

Section H. 2. f. Dressing Lower Body

- **Dressing Lower Body –** How client dresses and undresses (street clothes, underwear) from the waist down. Includes prostheses, orthotics (e.g., antiembolic stockings) belts, pants, skirt, shoes, and fasteners. **(Code an "8" if not dressed in street clothes)**

01/25/10

141

H.2.f. Dressing Lower Body – Test Your Knowledge:

- Ms. C's caregiver provided weight-bearing assistance by lifting Ms. C's legs in to the legs of her pajama pants each morning after her bath. **Ms. C did not wear street clothes during the entire 3 day look-back period.**
- **CODE:**

142

Section H. 2. g. Eating

- How client eats and drinks, regardless of skill. The ability to get food into his/her body. Includes taking nourishment by other means (i.e., tube feeding, total parenteral nutrition, etc.). Do not consider food prep here. Looking at how client consumes /eats food.

01/25/10 143

H.2.g. Eating – Test Your Knowledge:

Mrs. D is fed by a feeding tube. No food or fluids are consumed through her mouth. Mrs. D's caregivers prepared and administered all feedings via her feeding tube during the 7 day look back period.

CODE:

144

Section H. 2. h. Toilet Use

- How the client uses bathroom, commode, bedpan or urinal? How does the client transfer on/off toilet? How much assistance is needed to clean themselves afterwards? How much assistance is needed when the client pulls down or pulls up clothing? How much assistance is needed when the client changes pads, manages ostomy or catheter?

Note: Do not limit assessment to bathroom use only - Elimination occurs in many settings and includes transferring on/off toilet, cleansing, changing pads, managing ostomy or catheter and adjusting clothing.

01/25/10 145

H.2.h. – Toilet Use – Test Your Knowledge:

- Mr. E's caregiver provided him with weight-bearing assistance getting on and off the toilet at least 5 times during the 3 day look-back period.
- **CODE:**

146

Section H. 2. i. Personal Hygiene

- Includes combing hair, brushing teeth, shaving, applying makeup, washing/ drying face and hands.

  Note: Excludes bath and showers.

01/25/10 147

H.2.i. Personal Hygiene – Test Your Knowledge

- Ms. F's caregiver provided verbal cueing 4 times during the 3 day look-back period to assist Ms. F in the completion of her daily morning hand and face washing, tooth brushing, and hair combing task.
- **CODE:**

148

Section H. 2. j. Bathing

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

01/25/10 149

H.2.j. - Bathing – Test Your Knowledge:

- Mr. G's caregiver provided weight-bearing assistance on one occasion during the 7 day look-back period in order to assist Mr. G with completing his shower. Mr. G. participated in less than 50 % of subtasks on his own.
- **CODE:**

150

Section I. Continence In Last 7 Days (pg. 69-72)

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	Bladder Conti-nence	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

1. Bladder Continence

Intent: To determine and record the client's pattern of bladder continence (control) over the last 7 days (or since last assessment if less than 7 days).

Definition: Bladder Continence — Refers to control of urinary bladder function. This item describes the bladder continence pattern with scheduled toileting plans, continence training programs, or appliances. It does not refer to the client's ability to toilet self — e.g., a client can receive extensive assistance in toileting and yet be continent, perhaps as a result of help by the family.

01/25/10 151

Section I. Continence In Last 7 Days (pg. 69-72)

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	Bladder Conti-nence	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

Coding:

0. Continent — Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.); does not use any type of catheter or urinary collection device.

1. Continent with Cather – Complete control achieved with use of any type of catheter or urinary collection device that does not leak.

2. Usually Continent — Incontinent episodes occur once a week or less;

3. Occasionally Incontinent — Incontinent episodes occur two or more times a week but not daily;

4. Frequently Incontinent — Incontinent episodes tend to occur daily, but some control is present (e.g., in the day time);

5. Incontinent — Has inadequate control. Incontinent episodes occur multiple times daily.

8. Did Not Occur – No urine output from bladder (e.g., hemo-dialysis).

Choose one response to code level of bladder continence over the last 7 days (or since last assessment if less than 7 days).

01/25/10 152

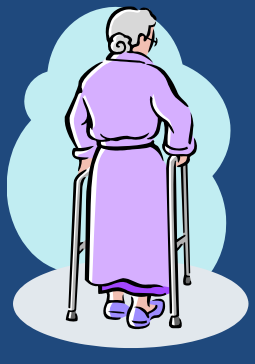
I.1. Bladder Continence – Test Your Knowledge

- Mr. I had an indwelling catheter in place during the entire 7 day look-back period. He was never found wet.
- **CODE:**

153

I.1. Bladder Continence – Test Your Knowledge

- Although she is generally continent of urine, Mrs. J did not make it to the bathroom in time during one episode last week causing her to wet on herself.
- **CODE:**



154

Section I. 2. Bladder Devices Used in last 7 Days (pg. 71)

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	Bladder Conti-nence	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 6. 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

Definition: Pads/brief used – Any type of absorbent, disposable or reusable undergarment or item, whether worn by the client (e.g., diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a client is never or rarely incontinent. .

Indwelling catheter – A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

01/25/10 155

Section I. Continence In Last 7 Days (pg. 69-72)

3.	Bowel Conti-nence	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 6. DID NOT OCCUR -- No bowel movement during entire 7 day assessment period

Bowel Continence

Intent: To determine and record the client's pattern of bowel continence (control) over the last 7 days (or since last assessment if less that 7 days).

Definition: Bowel Continence — Refers to control of bowel movements. This item describes the client's bowel continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the client's ability to toilet self — e.g., a client can receive extensive assistance in toileting and yet be continent, perhaps as a result of family help.

01/25/10 156

Section I. Continence In Last 7 Days (pg. 69-72)

8.	Bowel Conti-nence	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

Coding:

0. Continent — Complete control (including control achieved by care that involves prompted bowel evacuation, habit training, reminders, etc.). Does not use ostomy device.

1. Continent with Ostomy – Complete control with use of ostomy device that does not leak stool.

2. Usually Continent — Incontinent episodes occur less than once a week.

3. **Occasionally Incontinent — Incontinent episodes occur once a week.**

4. **Frequently Incontinent — Incontinent episodes occur two to three times per week.**

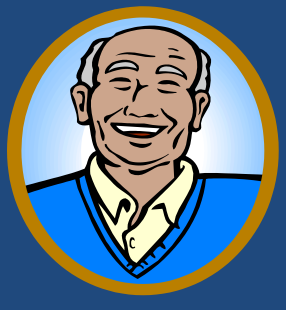
5. **Incontinent — Bowel incontinent all (or almost all) of the time.**

8. Did not Occur – No bowel movement during the entire 7 day assessment period.

01/25/10 157

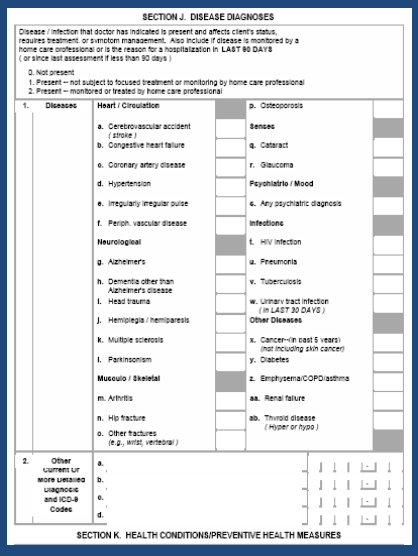
I.2. Bowel Continence – Test Your Knowledge

- Mr. K. requires insertion of a suppository every day in order to prompt bowel evacuation. During the 7 day look-back period Mr. K was never found soiled on himself.
- **CODE:**



158

Section J. Disease Diagnosis (pg. 72-75)



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		p. Osteoporosis
	a. Cerebrovascular accident (stroke)		**Senses**
	b. Congestive heart failure		q. Cataract
	c. Coronary artery disease		r. Glaucoma
	d. Hypertension		**Psychiatric / Mood**
	e. Irregularly irregular pulse		s. Any psychiatric diagnosis
	f. Periph. vascular disease		**Infections**
	Neurological		t. HIV infection
	g. Alzheimer's		u. Pneumonia
	h. Dementia other than Alzheimer's disease		v. Tuberculosis
	i. Head trauma		w. Urinary tract infection (in LAST 30 DAYS)
	j. Hemiplegia / hemiparesis		**Other Diseases**
	k. Multiple sclerosis		x. Cancer–(in past 5 years) (not including skin cancer)
	l. Parkinsonism		y. Diabetes
	Musculo / Skeletal		z. Emphysema/COPD/asthma
	m. Arthritis		aa. Renal failure
	n. Hip fracture		ab. Thyroid disease (Hyper or hypo)
	o. Other fractures (e.g., wrist, vertebral)		
2. Other current or more detailed diagnosis and ICD-9 Codes	a.		
	b.		
	c.		
	d.		

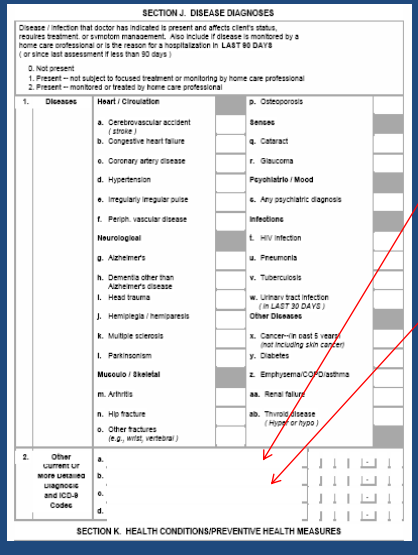
SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

Diseases

Intent: To document the presence of diseases/infections that have a relationship to the client's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. Also code if reason for hospitalization in last 90 days (or since last assessment if less than 90 days). In general, these are conditions that drive the current plan of care. Do not include conditions that have been resolved or no longer affect the client's functioning or care plan.

01/25/10 159

Section J. Disease Diagnosis (pg. 72-75)



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		p. Osteoporosis
	a. Cerebrovascular accident (stroke)		**Senses**
	b. Congestive heart failure		q. Cataract
	c. Coronary artery disease		r. Glaucoma
	d. Hypertension		**Psychiatric / Mood**
	e. Irregularly irregular pulse		s. Any psychiatric diagnosis
	f. Periph. vascular disease		**Infections**
	Neurological		t. HIV infection
	g. Alzheimer's		u. Pneumonia
	h. Dementia other than Alzheimer's disease		v. Tuberculosis
	i. Head trauma		w. Urinary tract infection (in LAST 30 DAYS)
	j. Hemiplegia / hemiparesis		**Other Diseases**
	k. Multiple sclerosis		x. Cancer–(in past 5 years) (not including skin cancer)
	l. Parkinsonism		y. Diabetes
	Musculo / Skeletal		z. Emphysema/COPD/asthma
	m. Arthritis		aa. Renal failure
	n. Hip fracture		ab. Thyroid disease (Hyper or hypo)
	o. Other fractures (e.g., wrist, vertebral)		
2. Other current or more detailed diagnosis and ICD-9 Codes	a.		
	b.		
	c.		
	d.		

SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

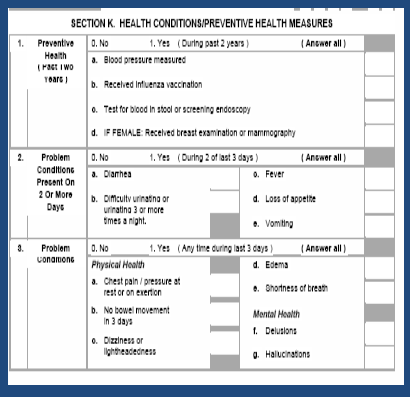
J. 2. Other Current or More Detailed Diagnosis and ICD-9 Codes:

- **Diagnosis of Quadriplegia must be listed in this section with ICD-9 Code of *344 if present**
- **Diagnosis of Cerebral Palsy with ICD-9 Code of *343 must be listed in this section if present**

***Do not add any other #s to these codes (e.g., 344.2, 343.9). Failure to include these diagnosis and related ICD-9 codes, exactly as described above, in Section J.2. of MDS-HC will result in an incorrect RUGs Score!**

01/25/10 160

Section K. Health Conditions/Preventive Health Measures (pg. 75)



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	c. Fever
		b. Difficulty urinating or urinating 3 or more times a night.	d. Loss of appetite
			e. Vomiting
3.	Problem Conditions	0. No 1. Yes (Any time during last 3 days) (Answer all)	
		Physical Health	d. Edema
		a. Chest pain / pressure at rest or on exertion	e. Shortness of breath
		b. No bowel movement in 3 days	*Mental Health*
		c. Dizziness or lightheadedness	f. Delusions
			g. Hallucinations

1. Preventative Health

Intent: This section helps home health care workers identify which clients have unmet needs for health counseling and preventive care.

Process: These screening activities are incorporated within the initial MDS-HC assessment. The elder needs to be asked if he has received specific health measures or discussed health prevention measures with a health professional in the past **two years.**

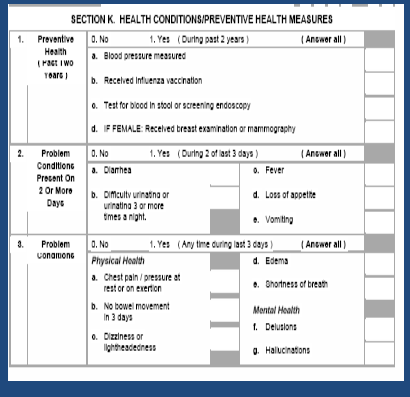
Coding:

0 = No

1 = Yes (During past 2 years)

01/25/10 161

Section K. Health Conditions/Preventive Health Measures (pg. 76 -77)



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	c. Fever
		b. Difficulty urinating or urinating 3 or more times a night.	d. Loss of appetite
			e. Vomiting
3.	Problem Conditions	0. No 1. Yes (Any time during last 3 days) (Answer all)	
		Physical Health	d. Edema
		a. Chest pain / pressure at rest or on exertion	e. Shortness of breath
		b. No bowel movement in 3 days	*Mental Health*
		c. Dizziness or lightheadedness	f. Delusions
			g. Hallucinations

2. Problem Conditions present on 2 or more days

Intent: To record specific reoccurring problems or symptoms that affect or could affect the client's health or functional status, and to identify risk factors for illness, accident, and functional decline.

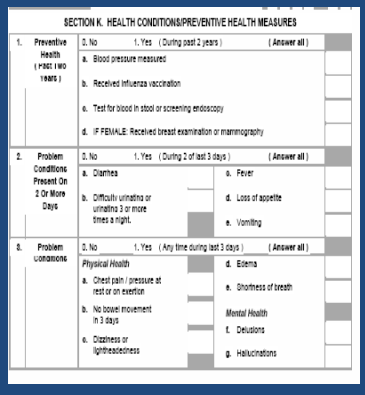
Coding:

0 = No

1 = Yes (During 2 of last 3 days)

01/25/10 162

Section K. Health Conditions/Preventive Health Measures (pg. 77)



SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

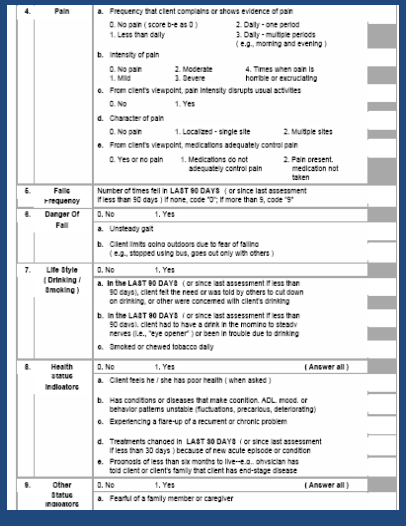
1.	Preventive Health (PAST TWO YEARS)	0. No 1. Yes (During past 2 years) (Answer all)	
		a. Blood pressure measured	
		b. Received Influenza vaccination	
		c. Test for blood in stool or screening endoscopy	
		d. IF FEMALE: Received breast examination or mammography	
2.	Problem Conditions Present On 2 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	

3. Problem Conditions
Mental Health
f. Delusions —Fixed, false beliefs not shared by others that the clients hold even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food is poisoned).

g. Hallucinations — False perceptions that occur in the absence of any real stimuli. An hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes

01/25/10 163

Section K. Health Conditions/Preventive Health Measures (pg. 77 - 80)

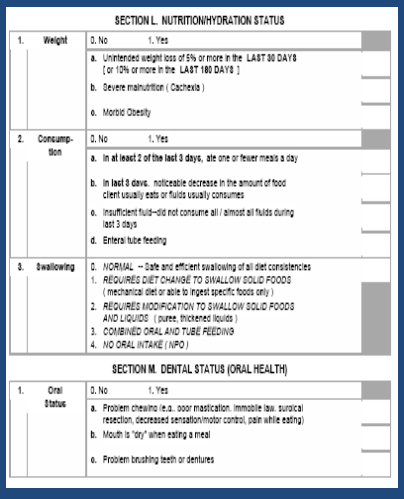


4.	Pain	a. Frequency that client complains or shows evidence of pain 0. No pain (score b-e as 0) 1. Less than daily 2. Daily - one period 3. Daily - multiple periods (e.g., morning and evening) b. Intensity of pain 0. No pain 1. Mild 2. Moderate 3. Severe 4. Times when pain is horrible or excruciating 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 seen 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

4. Pain
Intent : To record the frequency and intensity of the signs and symptoms of pain.
5. Falls Frequency
Intent: To determine the client's risk of future falls or injuries.
6. Danger of Falls
Definitions: Unsteady gait: A gait that places client at risk of falling. Examples include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps
Limits going outdoors due to fear of falling: Any restriction (self imposed or imposed by others) of going outdoors with the goal of preventing a fall.

01/25/10 164

Section L. Nutritional/Hydration Status (pg. 83-85)



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.	Consump-tion	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

1. Weight Change

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

Definition: Weight loss in percentages (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

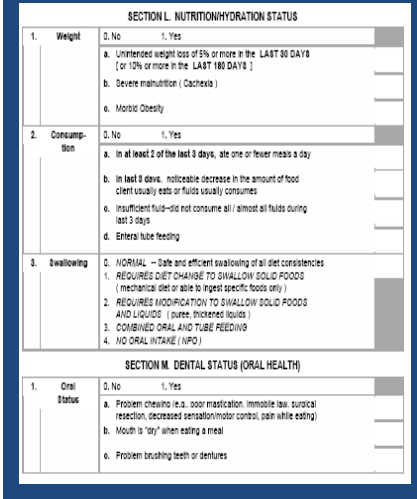
Coding:

0 = No

1 = Yes

01/25/10 165

Section L. Nutritional/Hydration Status (pg. 83-85)



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.	Consump-tion	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

2. Consumption

Intent: Regardless of size of the meal, persons eating only one or fewer meals a day are unlikely to be deriving sufficient nutrition. Any decrease in overall consumption should be considered noticeable.

Coding:

0 = No

1 = Yes

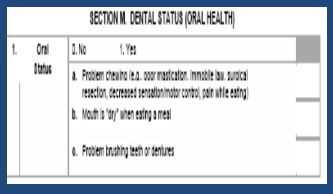
3. Swallowing:

Intent: This item details the diet consistencies & modifications in place to address swallowing difficulties

Coding: 0 = Normal, 1 = Requires diet modifications to swallow solid foods, 2 = Requires modification to swallow solid foods & liquids, 3 = Combined oral & tube feeding, 4 = No oral intake (NPO)

01/25/10 166

Section M. Dental Status (Oral Health) (pg 85)


SECTION M. DENTAL STATUS (ORAL HEALTH)

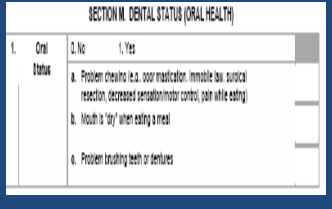
1. Oral Status	0. No 1. Yes
	a. Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)
	b. Mouth is "dry" when eating a meal
	c. Problem brushing teeth or dentures

Coding:
0 = No
1 = Yes

1. Oral Status
Intent: To record any oral problems present in the last three days.
Definition:
a. Chewing problem — Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., client uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint pain, or a painful tooth).

01/25/10 167

Section M. Dental Status (Oral Health) (pg 85)


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

Coding:
0 = No
1 = Yes

b. Mouth is "dry" when eating a meal - Client reports having a dry mouth, or observed difficulty in moving food bolus in mouth. Dry mouth can also be seen by inspection, or observed when client speaks and experiences difficulty, such as tongue sticking to roof of mouth.
C . Problem brushing teeth or dentures - Difficulty in cleaning teeth and/or dentures due to endurance, motivation or fine motor skill problems.
Process: Ask the client about difficulties in these areas. If possible, observe the client during a meal. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

01/25/10 168

Section N. Skin Conditions (pg 86-89)

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
6.	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)

1. Skin Problems
Intent: To document the presence of skin problems or changes.

2. Ulcers (Pressure/Stasis)
Intent: To record the highest stage of pressure and stasis ulcers on any part of the body, that was present in the last 3 days.

01/25/10 169

Section O. Environmental Assessment

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 toilet room (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 2. Caregiver only 1. Client only 3. Client and caregiver

1. **Home Environment** (Refer to MDS-HC Manual, pages 90-91 for definitions to the following items:
   a. Lighting
   b. Flooring and Carpeting
   c. Bathroom and toilet room
   d. Kitchen
   e. Heating and cooling
   f. Personal Safety
   g. Access to home
   h. Access to rooms in house

   Coding:
   0 = No
   1 = Yes

01/25/10 170

Section P. Service Utilization (pg 92-93)

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1. Formal Care (Minutes rounded to even 10 minutes)	Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving	(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			

1. Formal Care

Intent: To capture the number of hours and minutes spent by formal care giving agencies in providing care or care management in the last 7 days (or since last assessment if less than 7 days).

01/25/10 171

Section P. Service Utilization (pg 92-93)

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1. Formal Care (Minutes rounded to even 10 minutes)	Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving	(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			

1. **Formal Care** = Paid supports.
   - Be sure to include care provided by Home Health provider if present (Home Health Plan of Care must be submitted per program protocols as applicable)
   - Do not list if service(s) were not provided in 7 day look back period!

01/25/10 172

Section P. Service Utilization (pg 92-93)

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

			(A) # of Days	(B) Hours	(C) Mins
1.	Formal Care (Minutes rounded to even 10 minutes)	Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving			
		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			

Definition: Care or care management includes both the direct services provided to the client (both ADL and IADL support) and the management of care received (e.g., making medication schedules, planning for future needs). This includes care or care management provided by any formal agency.

01/25/10 173

Section P. 2. Special Treatments, Therapies, Programs (MDS-HC Manual pg 94-95)

Intent: To review prescribed treatments and determine extent of client adherence to the prescription. This section includes special treatments, therapies and programs received or scheduled during the last 7 days (or since last assessment if less than 7 days) and adherence to required schedule. Includes services received in the home or on an outpatient basis.

01/25/10 174

Section P. 2. Special Treatments, Therapies, Programs (MDS-HC Manual pg 94-95)

Treatments:

It is critical that you review the definitions on page 95-97 of MDS-HC Manual regarding treatments, therapies, Programs, and special procedures done in the home for this section of MDS-HC.

Important Note:

P2. c. All other respiratory therapy treatments includes only those listed that are provided by a qualified professional (e.g., Home Health Nurse). Do not code self administered, or family administered care here.

01/25/10 175

Section P. 2. Special Treatments, Therapies, Programs (MDS-HC Manual pg 94-95)

Important Note:

P2. c. All other respiratory therapy treatments includes only those listed that are provided by a qualified professional (e.g., Home Health Nurse). Do not code self administered, or family administered care here.

P2. m Tracheostomy care- Includes cleansing of tracheostomy and cannula (Include self-care, and/or care performed by family, others)

P2.z Special diet – Include all special diets (e.g., diabetic diet, low salt diet, etc.)not just "nutritionally supplemented or mechanically altered diet."

01/25/10 176

Section P. 3 Management of Equipment. (MDS-HC Manual pg 97)

Intent: To record the client's self-care performance (i.e., what the client actually did for himself or herself and/or how much help was required by others) with management of equipment (i.e., catheter, IV, Oxygen, ostomy) during the last 3 days.

It is critical that you review the definitions on page 97 of MDS-HC Manual regarding this section.

01/25/10 177

Section P. 4 Visits (MDS-HC Manual pg 99)

P. 4. a. Admitted to Hospital:
Intent: To record how many times the client was admitted to the hospital with an overnight stay in the last 90 days (or since last assessment).
Coding: Enter the number of hospital admissions in the box. Enter "0" if not hospital admissions.
P. 4. b. Visited Emergency Room:
Intent: To record if during the last 90 days (or since last assessment) the client visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for overnight stay at the time

01/25/10 178

Section P. 5. Treatment Goals (MDS-HC Manual pg 99)

P. 5. Treatment Goals

Intent: To identify if any client treatment goals, established by nurses, social workers, therapists, or medical doctors, have been achieved in the last 90 days (or since last assessment if less than 90 days).

01/25/10 179

Section P. 6. Overall Change in Care Needs (MDS-HC Manual pg 100 - 101)

Intent: To monitor the client's overall functional status over the past 90 days (or since last assessment if less than 90 days).

Definition: Functional Status – Includes self-care performance and support, continence patterns, use of treatments, etc.

01/25/10 180

Section P. 7. Trade Offs (MDS-HC Manual pg 101)

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

Definition: Because of limited funds during the last month, client made trade-offs among purchasing any of the following: Prescribed medications, sufficient home heat, necessary physician care, adequate food, home care.

01/25/10 181

Section Q. Medications (pg 101-105)

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

1. Number of Medications

Intent: To determine the number of different medications (over-the-counter and prescription) the client used in the past 7 days.

2. Receipt of Psychotropic Medications (Refer to Appendix A)

3. Medical Oversight

4. Compliance/Adherence with Medications

01/25/10 182

Section Q. Medications (pg 101-105)

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

1. Number of Medications

Intent:

To determine the number of different medications (over the counter and prescription) the client used in the past 7 days.

01/25/10 183

Section Q. Medications (pg 101-105)

Q. 1. Process: Ask to see all the client's medication bottles and containers. Tell the client you want to see everything they are taking or using, whether or not a physician prescribed it. Ask the client if he has been taking the medications as ordered. You may need to count medications in the containers. Count the number of different medications, (note the doses or different dosages) administered through all means. If the client takes both a generic and brand name of a single drug, count only one medication. This item includes topical, ointments, creams used in wound care (e.g., Elase), eye drops, and vitamins.

01/25/10 184

Section Q. Medications (pg 101-105)

Q. 2. Receipt of Psychotropic Medications:
Intent: To record the number of days that the client received any of the psychotropic medications listed (antipsychotic, antianxiety agents, antidepressants, hypnotics), in the past sever days. See appendix for list of drugs y category. Includes any of these medications given to the client by any route (p.o., IM, or IV) in any setting (e.g., home, in a hospital emergency room)

01/25/10 185

Section Q. Medications (pg 102-103)

Q. 3. Medical Oversight
Intent: This item helps to determine if the client has discussed all their medications (and therefore, medical problems) with a physician in the last 180 days (or since last assessment). It may be necessary for the physician and the health care staff to review all the client's current medications and make necessary changes r deletions.

01/25/10 186

Section Q. Medications (pg 103)

Q. 4. Compliance/Adherence

Intent: To determine if client is receiving medications as prescribed by physician/nurse practitioner.

Definition: Compliant with medication means that the client is actually taking the medication as prescribed.

01/25/10 187

Section Q. Medications (pg 103)

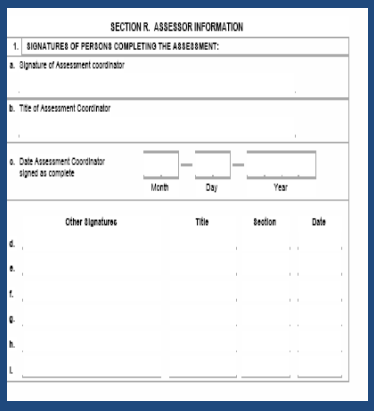
Q. 5. List of All Medications

Intent: To facilitate a mediation assessment by having a single listing of all medications taken by the client

Definition: Medications include all prescribed, nonprescribed and over the counter medications that the client used in the last 7 days. .

01/25/10 188

Section R. Assessment Information (pg 105)


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.			

1. Signature of Person Completing Assessment

Intent: Each individual (should there be more than one) who completes a portion of the assessment should sign and certify its accuracy. The Assessment Coordinator (who will usually be the sole assessor) signs and certifies that the assessment is complete.

This section is not for attendees of CPOC meeting.

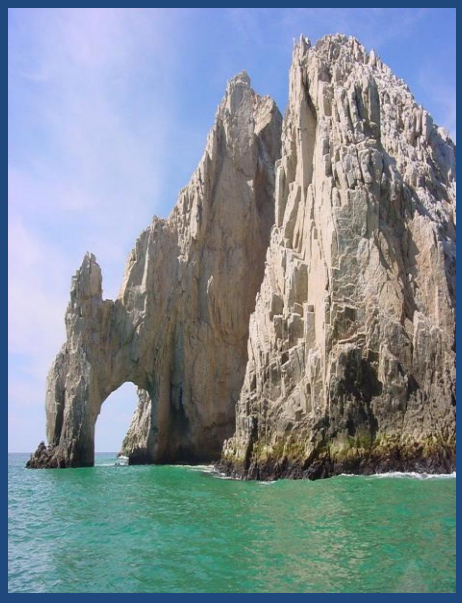
01/25/10 189

Section R. Assessment Information (pg 105)

IMPORTANT NOTES:

- **"Signing" Section R. 1. a. (i.e., entering the assessors name in this section of the MDS-HC) will automatically lock the MDS-HC assessment and will not allow data entry past that point in time.**
- **Do not enter an incomplete MDS-HC assessment in TeleSys for any reason.**
- **MDS-HC Assessments must be entered in to the TeleSys database within 10 business days from the date of MDS-HC assessment completion date in Section R. 1. c.**
- **Do not leave MDS-HC unsigned once you enter it in TeleSys!**

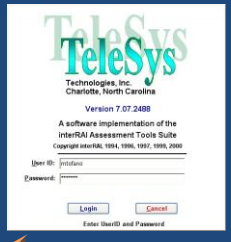
01/25/10 190



A Word about MDS-HC Data Input & the OAAS MDS-HC Systems Software (“TeleSys”)

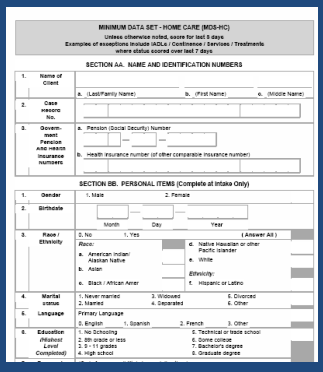
01/25/10 191

From Assessment to Data Input to Person Centered Care Planning



01/25/10 192

Data Quality Monitoring & Correction to Assure Assessment Quality & Timely Provision of Services


MINIMUM DATA SET - HOME CARE (MDS-HC)
Unless otherwise noted, score for last 5 days
Examples of exceptions include IADLs / Continence / Services / Treatments where status scored over last 7 days

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 medical insurance numbers	a. Pension (Social Security) Number b. Health insurance number (of 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) Race: a. American Indian/ Alaskan Native b. Asian c. Black / African Amer d. Native Hawaiian or other Pacific Islander e. White Ethnicity: f. Hispanic or Latino
4.	Marital status	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated 6. Other
5.	Language	Primary Language 0. English 1. Spanish 2. French 3. Other
6.	Education (Highest Level Completed)	1. No Schooling 5. Technical or trade school 2. 8th grade or less 6. Some college 3. 9 - 11 grades 7. Bachelor's degree 4. High school 8. Graduate degree

- All sections of MDS-HC Assessment Forms, Care Plans, SMS forms, etc., must be reviewed for accuracy and consistency , first, by the Support Coordinator/MDS-HC Assessor, and secondly, by his/her Supervisor PRIOR to submission to OAAS.

01/25/10 193

- MDS-HC Assessors are responsible for accurate, timely completion of all assigned assessments within applicable program guidelines
- MDS-HC Assessors & designated agency supervisors are responsible for reviewing each section of the MDS-HC to assure it has been coded accurately as reflected in POC & other supporting documentation, prior to submitted to OAAS Regional Office.

01/25/10 194

MDS-HC's Relationship to Care Planning

01/25/10 195

Purpose of the Assessment Process

- The main purpose of the assessment process is to generate a care plan. Information is collected for the purpose of making a series of decisions regarding the following areas:

- Is help needed?
- What help is needed?
- Is the person eligible for the help offered through OAAS programs/Other community resources?
- Is the help needed available thorough OAAS programs at a cost that does not exceed nursing home care (a precondition of HCBS waiver funding)?
- Will the individual accept the help OAAS programs can offer, and finally,
- What services need to be in place to assure the individual's needs and preferences are addressed.

01/25/10 196

Client Assessment Protocols (CAPs) Inform and Guide the Care Planning Process

- MDS-HC Assessors use “triggered CAP” information, along with other client-specific information, to prepare an agreed upon person centered Plan Of Care (POC)
- The POC, Triggered CAPs, specified supporting documentation (e.g., “Notes Page” from automated MDS-HC), and other required documentation are complete and accurate, and submitted/available in Telesys with in specified time lines, for OAAS Regional Office/Contractor for review & processing

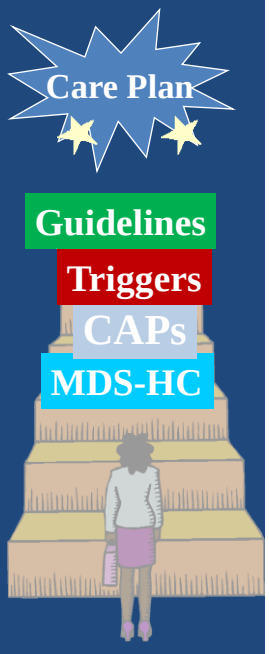
01/25/10 197

MDS –HC Manual - Chapter 4 Client Assessment Protocols (CAPs) Guidelines Overview

01/25/10 198

What are CAPs?

Client Assessment Protocols (CAPs) are a structured, problem-oriented framework for organizing information collected During the MDS-HC Assessment process



01/25/10 199

CAP Process

- CAPs are "Analyzed/Run" on all MDS-HC Assessments, regardless of type of assessment (e.g., Initial, Annual, Significant Change, etc.) once entered in TeleSys in order to generate triggered CAPS and RUGs Score for POC planning;
- Designated agency staff are responsible for assuring that MDS-HC data is entered in TeleSys within 10 working days of final completion date as noted on MDS-HC, Section R. c.

01/25/10 200

CAP Process

- All Triggered CAPs must be identified in the POC with clear documentation/evidence that the triggered CAPs were explained and discussed with the individual, and his/her support network, and that the person was provided with timely information necessary to make an informed choice regarding his/her supports and services preferences.

01/25/10 201

The Care Plan Meeting - Who Participates?

- Individual consumer Care Planning Team Members whom:
  - The individual wants present (Direct Service Providers do not participate in the initial planning meeting)
  - Have participated in the assessment process;
  - Have provided, or can provide direction, education, resources, etc. for identifying & care planning triggered CAPs

01/25/10 202

Documentation
Focus on KEY Issues

Your *rationale* for your decision to Care Plan or not to Care Plan:

- Client is at risk
- Improvement is possible
- Decline can be minimized
- Client could benefit from consultation, referral, etc.

01/25/10 203

"Working" the CAPs

01/25/10 204

CAP Focus Example

Falls

01/25/10 205

Falls – Background

- One third of elderly living in the community fall annually, with 50% falling more than once 10% of these falls result in serious injury. May be indicator of functional decline. Leading cause of morbidity and mortality in this population.

01/25/10 206

Falls – Objective

- To ascertain if falls occurred recently and if the client is at risk of falling, and to provide care planning guidance for minimizing the risk of falls and limiting the extent of possible injury

01/25/10 207

Falls – Definition

- *An unintentional change in position where the elder ends up on the floor or ground. A fall may result from intrinsic (internal) or extrinsic (external) causes or both*

01/25/10 208

Falls – Triggers

- What triggered the CAP?
- Identification of MDS-HC item(s) that "triggered" CAP *crucial link* in developing an individualized Care Plan

  Potential for additional falls or risk of initial fall suggested if one or more of the following is present (page 187):
- Falls in the last 90 days – K5 = 1 or more
- Sudden change of mental functioning B3a = 1
- Being treated fro dementia J1g = 2
- Being treated for Parkinsonism J1 l = 2
- Unsteady gait (K6a = 1) AND Does not limit going out (K6b = 0)

01/25/10 209

- Mrs. Jones triggered the Falls CAP. You explained to her and her family members that Mrs. Jones was at an increased risk for falling because of one fall she experienced in the last 90 days (K5 = 1), and a sudden change of her mental functioning (B3a = 1).
- What would be the next steps in care planning Mrs. Jones for Falls Prevention?
- How would you state the Outcome/Goal in Section P of the POC?
- What are some examples of strategies that would help accomplish this goal/outcome?
- How and when would you measure progress towards achieving the stated goal/outcome?
- How would you provide the necessary information Mrs. Jones and her family need to inform and facilitate her decision making regarding supports and services?

01/25/10 210

Who do I call if I have questions regarding MDS-HC?

- Contact your OAAS Regional Office (see enclosed Regional Office Contact List)
- Your Regional Office will contact OAAS State Office as needed

01/25/10 211

- **Timely and accurate completion of the MDS-HC assessment by <u>a DHH/OAAS trained assessor</u> is a critical first step in a person centered planning process that informs and guides the individual towards achieving or maintaining his or her highest practicable level of well-being.**

01/25/10 212