Standardizing LTSS Assessments for State Initiatives

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Today's emphasis on person-centered systems is changing the way we think about addressing individuals' needs for both health care and long term service and supports (LTSS). A person-centered approach focuses holistically on a persons' needs, arranging services and settings that can meet those needs, rather than focusing on the various silo-ed service delivery systems and cobbling together services from across these systems. The person-centered approach assumes that organizing services and supports for the range of a person's health care and LTSS needs will improve their health outcomes and quality of life; contribute to better population health; and reduce aggregate care costs by reducing the potential for expensive adverse medical events. The capacity to communicate and share information across settings and service delivery systems is essential for care planning, care coordination, and accountability for outcomes. At the core of a person-centered approach are communication tools that provide a common language, allow information to be transferred easily, and eliminate duplication of effort and redundancy of information, while protecting individual privacy. The effort to standardize assessment approaches is aimed at collecting the information needed for multiple programs to determine eligibility, consider level of need, and identify appropriate services without duplication of assessment interviews and redundancy of data collection.

The Long-Term Quality Alliance (LTQA), with the support of The SCAN Foundation, is pursuing:

1) expert consensus around a core set of standardized items that could be broadly adopted to enable data sharing, care planning, and quality measurement across settings, and
2) an action plan for gaining broad adoption of these items in assessment instruments.

This paper is the second of two papers[1] intended to provide background information for a roundtable discussion among a selected group of organizations and experts addressing person-centered care initiatives. The roundtable is intended to share information, discuss the current state of standardized assessment, and develop recommendations for steps needed to advance progress toward common core assessment domains, concepts, and items that could form the basis for person-centered assessment, care planning, and care coordination.

This paper is based on an analysis of existing assessment instruments.[2] The paper reviews state and federal activity in standardizing assessment tools, identifies common domains, and

[1] The first paper is: G.L. Atkins and B. Gage. The Need to Standardize Assessment Items for Persons in Need of LTSS. Long-Term Quality Alliance. April 29, 2014.

[2] LTQA collected 66 assessment instruments from 48 states using state websites and other sources. LTQA compared instruments and conducted a detailed review of items, reviewed secondary documents, and interviewed experts.

discusses considerations and implications for state standardization of items that would contribute significantly to better integration.

New Initiatives from the Affordable Care Act

A number of provisions of the Affordable Care Act (ACA) have given new momentum to the nation's wide-ranging efforts to develop more person-centered systems. ACA provisions aimed at improving coordination of health care and social support services to better meet individual needs and preferences in the Medicaid and Medicare programs include:

- A new office at the Centers for Medicare & Medicaid Services (CMS) focused on integrating Medicare and Medicaid services for dually-eligible beneficiaries (the Medicare-Medicaid Coordination Office or MMCO);
- A broader definition of LTSS that includes a range of services from home health and rehabilitation to more traditional social support services, including those provided under state plans and under the various waivers.
- New programs to help states build the systems needed to rebalance LTSS, such as the Balancing Incentives Program (BIP) which provides Federal funds to states that still have a high reliance on institutional services for their LTSS populations. The BIP provides funding to help states establish stronger community-based programs with "no wrong door" approaches, standardized assessment systems to support them, and conflict-free case management to improve coordination.
- An expanded Medicaid Managed LTSS program to move more dually-eligible Medicare/Medicaid populations into integrated managed LTSS programs.
- Transition Grants from the Administration for Community Living (ACL) to improve service coordination across the health and social spectrum for aged and disabled populations.

Central to all these initiatives is the ability to coordinate resources and information to better meet the needs of the individual receiving services. As part of this effort, the Office of the National Coordinator (ONC) offered grants to support the development of data exchangeability across different systems of care. These grants have funded the establishment of interoperability standards within the health information technology (HIT) community that will allow the transfer of content as determined by the program communities. ONC grants have also been funding the establishment and diffusion of ways to exchange data across entities in states with and without health information exchanges, or IT superhighways. In addition, ONC has been working with the long term and post-acute care communities to develop interoperability standards for the mandated assessment items currently used in nursing facilities and home health agencies (e.g., the MDS 3.0 and the OASIS-C, respectively).

Medicare Standardization Efforts

The traditional, fee-for-service Medicare program also has been moving towards greater data and measurement standardization. The Deficit Reduction Act of 2005 directed CMS to standardize assessment items across the three federally mandated, public domain assessment tools: the Minimum Data Set (MDS) required on all Medicare and Medicaid populations in nursing facilities (NF), the OASIS required for all Medicare and Medicaid populations receiving Home Health Agency (HHA) services, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) required for all Medicare admissions to inpatient rehabilitation facilities (IRFs). CMS has been working across program offices to standardize items in the medical, functional, cognitive, and social support domains and to develop e-specifications to allow exchangeability options in the public domain.

This standardization initiative included extensive stakeholder input from the professional communities working with these populations in the acute hospitals, SNFs, HHAs, IRFs, and long term care hospitals (LTCHs). The standardization began with a review of the existing Federal and commercial assessment tools, and with input from the communities working with these populations, a set of the "best in class" items were identified to be tested across populations. This effort resulted in the Continuity Assessment Record and Evaluation (CARE) tool. The CARE tool was used to collect standardized items in each type of setting and test them for reliability with each type of population and across different types of caregivers. From this, the best performing items across different levels of patient complexity were selected to use in subsequent quality reporting programs.

These standardized items were selected based on their ability to explain differences in individual resource needs, minimize provider burden, and be reliable within and across settings. Cross-population, cross-discipline analyses then identified a subset of the medical, functional, and cognitive items that could be substituted in the existing forms to allow standardization across the MDS, the OASIS, and the IRF-PAI as well as to develop an assessment tool for use in long-term care hospitals. The items were reliable when used by a range of professionals including nurses, therapists, and social workers. A subset of these items is currently being used in the Bundled Payment Initiatives to allow cross-setting measurement of medical, functional, cognitive, and social support factors.

Currently, CMS is developing an assessment item library that contains the "best in class" assessment items, including those from the MDS, OASIS, IRF-PAI, and standardized CARE item set for cross-walking the common medical, functional, cognitive, and social support domains and identifying the electronic specifications to allow data exchangeability. A driving goal in the CMS item library is to make available to providers, vendors, states, and others a repository of electronically exchangeable items that have proven reliability across populations, can be used

to develop reliable quality measures independent of settings, and can be used to set equitable payment rates for similar service components.[3] Current work at CMS is beginning to examine the types of additional items needed in the standardized item library to assess LTSS populations for determining eligibility and service needs.[4]

These standardized items in the CARE item set serve as the core of several initiatives to expand the Federal standardized items beyond the medical, functional, cognitive, and social support domains. CMS has funded subsequent work to test the items with healthier populations receiving therapy services in the community and more impaired populations in a nursing facility. These items were tested in the community version of the CARE item set (CARE-C) and the nursing facility version (CARE-F). These item sets included the same core items from the medical, functional, and cognitive domains but dropped items that were not relevant to community-based residents. These item sets also added items to test for reliability, including self-report function items from the short form of the Activity Measures for Post-Acute Care (AM-PAC). These items were developed to measure the person's perspective on their abilities and are consistent with the additional domains of social participation that the World Health Organization put forth for persons with disabilities. These items were tested in addition to the professional assessment in the basic CARE items.

Additional modules are also being developed for the LTSS populations under the Testing Experience and Functional Tools (TEFT) grants program sponsored by CMS. The grants are designed to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (LTSS). The CARE item set is being modified to to identify additional domains, such as social and environmental factors that are important for LTSS population information but were not included in the earlier standardization efforts. This work includes a review of existing state Medicaid assessment instruments and input from the stakeholders.

Federal quality reporting programs are also pursuing item standardization to allow comparison of outcomes associated with different types of services, such as those in nursing facilities relative to those provided by a home health agency. For example, the items underlying "changes in pressure ulcers" have been standardized across the Federal assessment tools so that everyone tracking pressure ulcers is using the same language and standards. CMS currently has work underway to develop standardized measures of function. This standardized

[3] B. Gage and S. Mandl. Standardized Assessment Data: Continuity Assessment Record and Evaluation (CARE) Item Set. Presented to Long Term Care Discussion Group. Wednesday, November 6, 2013.
[4] See TEFT program announcements, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html

measurement is key to allowing comparability across settings and creating electronic information transfers across people and organizations.

State Activity in Standardized Assessments

States are also undertaking standardized assessment initiatives. Several provisions of the Affordable Care Act (ACA) allow for Medicaid funding for initiatives to standardize assessments for LTSS populations. The legislation broadly defined LTSS services to include home and community-based services (HCBS) under 1915 (c or d) or 1115 waivers; state plan services for home health, personal care, and optional rehabilitation services, PACE, home and community care under section 1929(a), self-directed personal assistance services under 1915(j), services under 1915(i), community-based, private duty nursing under section 1905 (a)(8), state options for health homes for enrollees with chronic conditions, and Community First Choice Option as defined under ACA section 2401, 1915(k).[5]

Standardized assessment efforts are in different stages of development. Some states have older systems that were put in place to meet the OBRA '87 requirements to improve quality. Many of these states rely on MDS-related tools such as the InterRAI-Home Care instrument. Other states, like Minnesota, have developed their own approaches for coordinating assessments across multiple state programs to increase their programs' efficiency or are considering testing the LTSS CARE items developed under the TEFT program tool to improve their ability to report to CMS and their Medicaid agencies.

Managed Long Term Services and Supports (MLTSS) - More recently, with the establishment of the Managed LTSS demonstrations under CMS' MMCO, managed care plans are trying to establish more standardized approaches for assessing their enrolled populations across states that meet state-specific assessment requirements in those states that have them.

As of April 2014, 19 states had moved to integrate LTSS and medical care in either their Medicaid-only or dual-eligible programs[6] . These efforts are designed to improve outcomes, enhance experience, reduce costs, and streamline program administration. They typically have a care coordinator who assesses the consumer's need and preferences, works with the primary care physician (PCP) and others to plan, authorize, and coordinate services, monitors the service plan, follows the consumer across services and through transitions, and facilitates information transfers across multiple parties, including the consumer, family, social worker,

[5] Mission Analytics Group. The Balancing Incentives Program Implementation Manual. February 2013. Pp. 22-24.
[6] Saucier, Paul, State Approaches to Integrating Care, LTQA/NCHC Capital Hill Forum, April 2014

PCP, specialists, pharmacy consultants, state/county social services, community-based organizations, and others. The focus is on person-centered planning although the details vary across these programs.

Balancing Incentives Program (BIP) - BIP is one of the largest ACA initiatives for LTSS populations. It provides additional Federal Matches to states with low proportions of their LTSS spending in non-institutional settings as incentive payments to rebalance their LTSS systems. In exchange for the increased federal matches, BIP participants must ensure their state systems have three components:

- **No Wrong Door/Single Entry Point (SEP)** to all LTSS programs that includes functional and financial assessment eligibility determination
- **Conflict-Free Case Management** where case management, eligibility, and funding level decisions are not provided by the entity providing direct services. Further, assessments and plans of care cannot be conducted by family members of the individual or their caregivers.
- **Core Standardized Assessment Instruments** for determining eligibility for LTSS; need for support services, support training, medical care, transportation, and other services; and to develop an individual service plan to address these needs. Five core domains are required, including activities of daily living (ADL), instrumental activities of daily living (IADL), medical diagnoses/conditions, information.

Currently, 19 states are participating in the BIP including Arkansas, Connecticut, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Ohio, Maine, Massachusetts, Missouri, Mississippi, Maryland, New York, New Jersey, Nevada, New Hampshire, and Texas. These participants must establish core uniform assessments similar to those in the Federal tools for measuring medical conditions, functional status (ADLs/IADLs), cognitive status (including functioning and learning), behavioral concerns, and financial and employment information. These data will be used in "no wrong door" eligibility determination for LTSS, as well as to develop care plans. The BIPs technical assistance team also recommended using the information to predict expected level of care needs for setting individual budgets.

Aging Disability Resource Centers (ADRCs) - Resources, such as the Aging Disability Resource Centers (ADRCs) found in each state, are excellent sources of information on the various state initiatives. However, this information is dispersed across different venues and is difficult to compile. A better understanding of what different states are doing on assessment is needed as the level and diversity of state activity on uniform assessment increases with growth in the

number of states receiving funding requiring uniform assessment or participating in managed Duals programs.

Common Domains in State LTSS Assessment Tools

To better understand the current variability of state assessment tools and the potential for developing a common core of standardized items, the team collected and reviewed a wide array of state assessment tools for LTSS populations to identify the common concepts currently included in state program assessments.[7] The assessment forms all supported state programs but varied in whether they were tied to specific Medicaid waivers or other state programs for LTSS. Many of them include the same domains as in the federally-mandated assessment forms, such as the MDS and the OASIS. These domains include items measuring medical conditions and complications, functional status, cognitive status, and social support factors but they vary in the items used.

Few states currently have comprehensive assessment approaches that meet all six domains identified in the BIP definition of core assessment requirements. Components may be found in different assessment tools used by parts of the LTSS system but most are not exchangeable across systems to allow caregivers to see the complete information that may affect determination of person's overall support needs. Where concepts may be common within a state across programs, the items may still differ. The most commonly collected concepts are Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), which are frequently used for determining eligibility in nursing home transition programs. Payment amounts are often set relative to impairment thresholds, but these payments are typically for purchasing support services. With the expansion of the LTSS definition to also include rehabilitation and home health services, more specific information may be needed to predict expected level of need for these populations. For example, if the state programs are each using the standard assessment items, the programs covering therapy services may need more information on level of impairment than number of ADL limitations.

The assessment tools varied in the number and types of ADL items collected in their state programs. The RAI tool provides a set of items consistent with the Federal MDS tool but inconsistent with the OASIS assessment required by participating home health agencies. The therapy community varies even more in terms of the items they use to estimate service need based on their measures of ambulation and self-care (ADLs). IADL items used in each tool varied by state.

[7] Assessment forms were collected from state websites, review of secondary documents, and based on discussions with individuals working in this area.

Other commonly collected concepts include memory and cognition. Almost all assessment tools that measure memory and cognition collect information on short term memory, such as the items used in the MDS and included in CMS' standardized item set.

Other concepts that are highly common include communication impairments, home environments and environmental safety, behavioral symptoms and medical and mental health symptoms, medications management, adherence, and types. Many also collect information on transportation needs, social networks, and economic status. A longer comparison of the differences in individual items used in each assessment will be provided at the meeting.
Few of the assessment tools collected focused specifically on subpopulation factors, with the exception of the preadmission screening and resident review (PASRR) screening tools for developmentally-disabled eligibility determinations.

Many of the Medicaid waivers for HCBS apply to specific subpopulations, such as those with traumatic brain injuries or HIV/AIDs. These programs may require additional information unique to the subpopulation or the waiver, and may incorporate domains and items that have been traditionally used to measure complexity of needs and document service provision. For specific cognitively and physically disabled subpopulations, it may be both clinically necessary and cost-effective to use the "best in class" traditionally-used measures to determine appropriate service levels and measure outcomes and effectiveness of services consistently across state and federal funding. These measures could be supplemental to a common core of items used for all populations. The communities serving the developmentally disabled populations have been working on these issues and can contribute items they find useful for these purposes.

Considerations for Standardizing Assessment Tools

These directives to create more standardized assessment approaches raise many issues. First, most state assessment processes have been designed to meet their respective needs. Many have been in use for a long time and their state information systems have incorporated these items as they were developed and refined. Changes to these systems can be costly. However, many of these systems prohibit coordination across state programs as needed by the "no wrong door" initiatives and supported by many states legislatures attempting to improve the efficiency and effectiveness of their state-funded programs.

Second, items that will be used across different programs to determine eligibility, level of service needs, and manage the person's needs in a holistic manner must be scientifically valid

and reliable. Meeting these types of scientific standards is important for ensuring the items perform consistently across different users, especially in programs where users may have different types of backgrounds. Although CMS has shown that training can improve inter-rater reliability as with the on-going MDS and OASIS training they provide, the items themselves must be reliable to ensure fair and equitable application. For example, an item may have been in use for years but its wording may be so broad that it measures more than one concept, and therefore, its application inadvertently covers more people than intended, or when used to estimate cost allocation, could result in very different service estimations. For example, toileting items that include transferring abilities may identify someone who has difficulty toileting or difficulty transferring to the toilet. One task can be accomplished with the assistance of a lower cost aide while the other suggests the need for higher cost skilled therapy to either strengthen or train the person in mobility functions.

Response scales are also important to consider. The possible answers to an item must be mutually exclusive so only one answer is correct. And they should use language that is simple enough to be clear without requiring extensive, detailed training. For example, some of the ADL scales use response codes that ask the assessor to rate the person's abilities in terms of the percent of their independence – 25 percent, 50 percent, 75 percent or total independence or dependence. Determining which quartile a person belongs in can be difficult and misleading – giving a sense of specificity despite the subjectivity of the rating and the potential for inaccuracy. Where scales are used, the specificity should be granular enough to determine expected service needs. For example, the standardized function items in the CARE set distinguish between whether someone needs assistance with more than half or less than half an activity. If the person needs assistance with less than half the activity, can materials be set up and the person be safely left alone to complete the task or does someone need to remain for cueing or supervising purposes? If the person cannot do half the task themselves, does the caregiver perform the entire task or is the person able to do part of the task?

A third consideration in thinking about standardization is determining which items would be beneficial to standardize. While one could argue that using the same method for recording any item would be beneficial to data exchangeability across program systems, these efforts can be costly for states that have already invested in their current disparate systems. Prioritizing the types of items that need to be standardized will allow those states to incrementally move to standardization. Identifying those items that are key to determining eligibility in multiple state programs would be an early consideration. One of the key reasons to standardize is to meet the "no wrong door" goal which provides opportunity to collect the data once to identify the range of benefits for which the person may qualify. Common elements are activities of daily living, instrumental activities of daily living, mobility status, medical conditions that require

nursing services, such as skin conditions, caregiver ability, and social support networks. In addition, one of the key areas under the person-centered approach is incorporating information on the person's and family's goals. State nursing home transition programs may offer a standardized item which may be important for building person-centered systems.

A fourth consideration may be to determine how widely standardized your items should be. Across what range of programs and activities is it necessary to develop consistency? There are several possible levels:

- State-funded programs to allow "no wrong door" eligibility determination and comparative reporting for people qualifying for more than one benefit. This could allow comparability of outcomes for people who qualify for nursing home use but receive home and community-based services under one of the LTSS benefits.
- State and federal services to compare medical or functional status for people receiving home health benefits who transfer to Medicaid-covered benefits at the end of an episode and who may ping-pong between benefits due to chronic illness or impairments. This would also apply to people moving between Medicare and Medicaid covered nursing facility benefits.
- Regional or cross-state comparisons to determine whether there are systematic differences in outcomes across state lines for similar types of populations or services.

A fifth consideration may be the level of IT sophistication among your LTSS community participants. Are your community-based service providers or intermediaries or other key players already using a technology that allows them to transfer information across transitions? If so, are these systems program-specific or are they using interoperable data standards that would allow exchange with other types of IT systems? Some systems are designed as a suite of forms and the data can be shared across system users while other systems may use "electronic envelopes" allowing transfer of commonly defined items across systems.

Implications for State Standardization

As we move forward with discussions about the needs of LTSS *populations*, instead of the issues around LTSS service management, it may be useful to think about how to capitalize on existing resources to create state-wide efficiencies in building person-centered systems. The move toward person-centered care and accountability to increase efficiency is increasing the number and types of resources available to build these systems and create efficiencies.

Some states are leading the way to developing uniform assessments across their programs. Their ability to electronically transfer the data varies but they are addressing issues of identifying the concepts important to them for payment, quality, or coordination. Other states are just beginning this process.

One opportunity for the less advanced states may be to decide which concepts they feel are important to their stakeholders and then use the assessment data standardization efforts occurring at the Federal level to pull in items that have been identified as valid and reliable measures of a specific concept. Using the Federal items would also have the benefit of the data exchangeability standards to all allow data transfers among programs without a large investment on the state's part. This would be consistent with state goals in allowing the data to be collected once at the "no wrong door" assessment and be transferred around the state. Alternatively, commercial products have been developed to address the needs of the LTSS providers. These systems often offer exchangeability within their commercial system but not necessarily with the other systems used by the state or federal programs.

Conclusions

Standardizing the assessment items improves program efficiencies as data can be collected once but used multiple times, improves transitions of care because of better communications, and allows data to be transferred electronically across services, allowing comparisons of outcomes associated with each type of service. Collecting the data once and using it across programs reduces both the provider burden for data collection and the individual and family burden in repeating information previously given to their team. While data need to be updated as individual status changes, information on prior functioning, utilization, and social supports can be readily transferred across users. This may also improve the accuracy of the information as it changes over time.

This paper provides background information to allow the beginning of a national discussion on LTSS item standardization. The benefits have been widely noted.[8] The question is: how far can we go and how far do we need to go in developing a common core of assessment domains, concepts, and items needed to support person-centered health care and LTSS? Where do the benefits of a uniform assessment, single care plan, care coordination and quality measurement tool outweigh the costs and complexity of developing and implementing a common core assessment? How broadly should the common core apply – within the state and across states?

[8] P. Black and K. Leitch. Analysis of State Approaches to Implementing Standardized Assessments. C.E. Reed and Associates. April 2012

What are the steps necessary to take the very significant progress that has been made with standardized assessment in Medicare, BIP, CMS's Item Library, and within several states and apply the results of this progress or develop it further for other programs and in other states?

Appendix A:
Item Comparison Tables

Table 1: ADLs

	Arizona HCBS Member Needs Assessment	California MSSP Assessment	Colorado Uniform Assessment Tool	Illinois Statewide Comprehensive Needs Assessment	Michigan Medicaid Nursing Facility Level of Care Determin-ation	MnCHOICES	New York COMPASS
Bathing	BATHING Sponge bath: Independent: No assistance needed As needed per week. In general not to exceed 45 transfers including in bath time. Minimum: Some supervision, cueing, or set-up. Assist with getting in & out of tub. Help with back or lower body. Moderate: Step-by-step cueing or supervision. Hands-on assist with 50- 75% of the bathing process. Moderate: Step-by-step cueing or supervision. Hands-on assist with 50- 75% of the bath process. Maximum: 75%+ with bathing process. One or more assist. Hoyer needed / bed-baths.	Bathing 1. Independent 2. Verbal Assistance 3. Some Human Help 4. Lots of Human Help 5. Dependent	The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. ADL SCORING CRITERIA 0=The client is independent in completing the activity safely. 1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone. 2=The client requires hands on help or standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity. 3=The client is dependent on others to provide a complete bath.	Bathing Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3		Do you have any difficulties with bathing or require support or assistance during bathing? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Bathing 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent checking and observing/minimal assistance at times. 3. Requires continual help 4. Person does not participate, is bathed by another.

Table 1: ADLs

	Arizona HCBS Member Needs Assessment	California MSSP Assessment	Colorado Uniform Assessment	Illinois Statewide Comprehen-sive Needs Assessment	Michigan Medicaid Nursing Facility Level of Care Determination	MnCHOICES	New York COMPASS
Eating	EATING & FEEDING Enter number of meals eaten per day requiring assistance, then enter the time per meal Independent: No assistance needed Minimum: Meal set up, cutting food, or cueing /reminders. Moderate: As above plus hands-on assist, cueing, or supervision for 50- 75% of meal. Maximum: Hands-on assist with 75%+ of meal, bringing food to mouth or totally feeding member. Constant supervision and cueing.	Eating 1. Independent 2. Verbal Assistance 3. Some Human Help 4. Lots of Human Help 5. Dependent 6. Paramedical	EATING Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist. ADL SCORE CRITERIA 0=The client is independent in completing activity safely 1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment. 2=The client can feed self but needs standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person. 3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.	Eating Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3	Eating How the applicant eats and drinks (regardless of skill). Includes intake of nourishment by other means (i.e., tube feeding, total parenteral nutrition). Independent No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days. Supervision Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days. Limited Assistance Applicant received physical help in guided maneuvering of limbs or other assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days. Extensive Assistance While the applicant performed part of activity over last 7-day period, help of the following type provided 3 or more times: Total Dependence Full performance by another during part, but not all, of last 7 days Activity did not occur during entire 7 days (regardless of ability).	Does the person have any difficulties with eating or require support or assistance with eating? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Eating 1. Requires no supervision or assistance. 2. Requires intermittent checking and observing/minimal assistance at times. 3. Requires continual help and/or physical assistance 4. Person does not participate. Totally fed by hand, or tube or parental feeding for primary intake of food.

Table 1: ADLs

	Arizona HCBS Member Needs Assessment	California MSSP Assessment	Colorado Uniform Assessment Tool	Illinois Statewide Comprehen-sive Needs Assessment	Michigan Medicaid Nursing Facility Level of Care Determination	MnCHOICES	New York COMPASS
Toilet Use	Toileting Independent: No assistance needed Minimum: Stand-by assist, supervision, reminders Moderate: 50-70% assist with clothing, diapers, post-toilet hygiene or equipment Maximum: Total assist with clothing, briefs, entire toileting process. Includes episodes of incontinence. Catheter: Pouring out bag and cleaning bag or other supplies. Ostomy: Pouring out and cleaning bag	Toileting 1. Independent 2. Verbal Assistance 3. Some Human Help 4. Lots of Human Help 5. Dependent 6. Paramedical	The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing. 0=The client is independent in completing activity safely. 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing. 2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean. 3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aware of own needs.	Continence Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3	Toilet Use: How the applicant uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Independent No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days. Supervision Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days. Limited Assistance Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days. Extensive Assistance While the applicant performed part of activity over last 7-day period, help of following types(s) provided 3 or more times: • Weight-bearing support • Full performance by another during part, but not all, of last 7 days Total Dependence Full performance of activity by another during entire 7 days.	Does the person need assistance or support with toileting? Note to assessor: Self-managed incontinence does not constitute needing assistance or help with toileting. No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Toileting 1. Requires no supervision or assistance. 2. Requires intermittent checking and observing/minimal assistance . 3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance 4. Incontinent of bowel and bladder.

Table 1: ADLs

	Arizona HCBS Member Needs Assessment	California MSSP Assessment	Colorado Uniform Assessment Tool	Illinois Statewide Comprehen-sive Needs Assessment	Michigan Medicaid Nursing Facility Level of Care Determination	MnCHOICES	New York COMPASS
Transferring	Transfers: Includes bathing and toileting transfers Independent: No assistance needed with/without assistive devices Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices or restraints. Moderate: Needs hands-on assist. One-person assist with/without assistive devices. Maximum: One or more person assist, totally dependent. Bed Bound: Frequent turning & repositioning in the bed. Hoyer: If Hoyer time assessed no transfer time in other areas.	Transferring 1. Independent 2. Verbal Assistance 3. Some Human Help 4. Lots of Human Help 5. Dependent	TRANSFERRING Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices for transfers. Note: Score client's mobility without regard to use of equipment. ADL SCORE CRITERIA 0=The client is independent in completing activity safely. 1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed. 2=The client transfer requires standby or hands on assistance for safety; client may bear some weight. 3=The client requires total assistance for transfers and/or positioning with or without equipment.	Transferring Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3	Transfers: How the applicant moves between surfaces, to/from bed (sleeping surface), chair, wheelchair, standing position (exclude to/from bath/toilet). Independent No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days. Supervision Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days. Limited Assistance Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days. Extensive Assistance While the applicant performed part of activity over last 7-day period, help of following types(s) provided 3 or more times: • Weight-bearing support • Full performance by another during part, but not all, of last 7 days Total Dependence Full performance of activity by another during entire 7 days. Activity did not occur during entire 7 days	Does the person have any difficulties with transfers or require support or assistance when making transfers? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Transfer 1. Requires no supervision or assistance. May use adaptive equipment 2. Requires intermittent observation. May require human assistance at times. 3. Requires constant supervision or physical assistance 4. Requires lifting equipment and at least one person to provide constant supervision and/or physically life, or cannot and is not taken out of bed.

Table 1: ADLs

	Arizona HCBS Member Needs Assessment	California MSSP Assessment	Colorado Uniform Assessment Tool	Illinois Statewide Comprehensive Needs Assessment	Michigan Medicaid Nursing Facility Level of Care Determination	MnCHOICES	New York COMPASS
Dressing	Dressing and Grooming AM Independent: No assistance needed Minimum: Some supervision, reminding, selecting clothes. Moderate: Supervision or hands- on with 50-75% of dressing activity. Regular asst. with buttons, shoes & socks, fixing hair or brushing teeth. Maximum: Hands-on with 75%+ of dressing and grooming tasks. Complete assist with dressing includes transfer if needed. Dressing and Grooming PM Independent: No assistance needed Minimum: Some supervision, reminding, selecting clothes. Moderate: Supervision or hands- on with 50-75% of dressing activity. Regular asst. with buttons, shoes & socks, or brushing teeth. Maximum: Hands-on with 75% of dressing and grooming tasks. Complete assist with dressing includes transfer if needed.	Dressing 1. Independent 2. Verbal Assistance 3. Some Human Help 4. Lots of Human Help 5.Dependent	The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. ADL SCORE CRITERIA 0= The client is independent in completing activity safely. 1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days. 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time. 3= The client is totally dependent on others for dressing and undressing	Dressing Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3		Does the person have any difficulties with dressing or require support or assistance during dressing? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Does the person have any difficulties with dressing or require support or assistance during dressing? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence

Table 1: ADLs							
	Arizona HCBS Member Needs Assessment	**California MSSP Assess-ment**	**Colorado Uniform Assessment Tool**	**Illinois Statewide Comprehensive Needs Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**MnCHOICES**	**New York COMPASS**
Hygiene	See above	Grooming 1. Independent 3. Some Human Help 4. Lots of Human Help 5. Dependent	The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. ADL SCORE CRITERIA 0= The client is independent in completing activity safely. 1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days. 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time. 3= The client is totally dependent on others for dressing and undressing	Grooming Level of Impairment 0;1;2;3 Unmet Need for Care 0;1;2;3		Does the person have any difficulty with or require support or assistance to take care of their grooming and hygiene needs? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Personal Hygiene 1. Requires no supervision or assistance. 2. Requires intermittent checking and observing/minimal assistance at times. 3. Requires continual help 4. Person does not participate; another person performs all aspects of personal hygiene.

Table 1: ADLs							
	Arizona HCBS Member Needs Assessment	**California MSSP Assessment**	**Colorado Uniform Assessment Tool**	**Illinois Statewide Comprehensive Needs Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**MnCHOICES**	**New York COMPASS**
Mobility	Mobility Independent: No assistance needed with/without assistive devices Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices or restraints Moderate: Needs hands-on assist. One-person assist with/without assistive devices Maximum: One or more person assist, totally dependent.	Mobility indoor Mobility outdoor Independent Verbal Assistance Some Human Help Lots of Human Help Dependent Mobility Fully ambulatory Ambulatory with assistance Cane/walker Occasional Wheelchair use Prosthesis/Appliance Bed Bound If bed bound describe ROM	MOBILITY Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment. ADL SCORE CRITERIA 0=The client is independent in completing activity safely. 1=The client is mobile in their own home but may need assistance outside the home. 2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home. 3=The client is dependent on others for all mobility.			Does the person have any difficulty with mobility or require support or assistance to get around? No Yes Sometimes Chose not to answer Cuing/Supervision None To initiate the task Intermittently during the task Constantly throughout the task Physical Assistance None Setup/Prep Limited Extensive/Total Dependence	Mobility 1. Requires no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Assessment Instrument**	**MnCHOICES**	**New York COMPASS**	**Ohio Functional Assessment**	**Virginia Uniform Assessment Instrument**
Money Management	MONEY MANAGEMENT: Definition: The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e. to do financial management for basic necessities (food, clothing, shelter). Do not check if limitation is only cultural (e.g., recent immigrant who has not learned U.S. currency and/or English language). IADL SCORE CRITERIA 0=The client is independent in completing activity. 1=The client requires cueing and/or supervision. May need minimal physical assistance. 2=The client requires assistance in budgeting, paying bills, planning, writing checks or money orders and related paperwork. Client has the ability to manage small amounts of discretionary money without assistance. 3=The client is totally dependent on others for all financial transactions and money handling.	How much assistance do you need with the following tasks? Manage Money No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Do you need assistance with finances? No Yes Sometimes Chose not to answer When handling personal finances, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance	Handle personal business/finances Totally Able (with or without equipment) Limited, participates but does not complete task fully (needs some assistance) Unable to participate at all (needs maximum assistance) Unwilling to perform	Pay bills Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Pay bills Yes No Manage money Access insurance and/or public benefits Yes No	Money Management Needs help? Yes No

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Assessment Instrument**	**MnCHOICES**	**New York COMPASS**	**Ohio Functional Assessment**	**Virginia Uniform Assess-ment Instrument**
Managing Medi-cation	MEDICATION MANAGEMENT: Definition: The ability to follow prescribed medication regime. IADL SCORE CRITERIA 0=The client is Independent in completing activity safely. 1=The client is physically able to take medications but requires another person to (a) remind, monitor or observe the taking of medications less than daily; or (b) open a container, lay out or organize medications less than daily. 2=The client can physically take medications, but requires another person to either remind, monitor, or observe the taking of medications daily, or the client can physically take medications if another person daily opens containers, lays out, organizes medications. 3=The client cannot physically take medications and requires another person to assist and administer medication	How much assistance do you need with the following tasks? Managing Medication No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Does the person need assistance with medication management? No Yes Sometimes Chose not to answer In regard to the ability to manage and take medications, this person: Needs no help or supervision Doesn't take medications Needs medication setup only Needs visual or verbal reminders only Needs medication setups and reminders Needs medication setups and administration		Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Self-administer medications as defined in Chapter 47 of the Revised Code. Yes No	Do you have any problems with medicine(s) : Taking them as instructed/ prescribed

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Comprehensive Assessment**	**MnCHOICES**	**New York COMPASS**	**Ohio Functional Assessment**	**Virginia Uniform Assessment Instrument**
Meal Preparation	MEAL PREPARATION: Definition: The ability to obtain and prepare routine meals. This includes the ability to independently open containers and use kitchen appliances, with assistive devices if person uses them. If the person is fed via tube feedings or intravenously, treat preparation of the tube feeding as meal preparation and indicate level of help needed. IADL SCORE CRITERIA 0=The client is independent in completing activity. 1=The client requires some instruction or physical assistance to prepare meals. 2=The client can participate but needs substantial assistance to prepare meals. 3=The client cannot prepare or participate in preparation of meals.	How much assistance do you need with the following tasks? Preparing Meals No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Does the person have any difficulty preparing meals? No Yes Sometimes Chose not to answer When doing simple meal preparation, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance		Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Plan and prepare nutritious meals Yes No	Meal Preparation Needs help? Yes No

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Assessment Instrument**	**MnCHOICES**	**New York COMPASS**	**Ohio Functional Assessment**	**Virginia Uniform Assessment Instrument**
House-keeping	LAUNDRY: Definition: The ability to maintain cleanliness of personal clothing and linens. IADL SCORE CRITERIA 0=Independent in completing activity. 1=The client is physically capable of using laundry facilities, but requires cueing and/or supervision. 2=The client is not able to use laundry facilities without physical assistance. 3=The client is dependent upon others to do all laundry. HOUSEWORK: Definition: The ability to maintain cleanliness of the living environment. 0=The client is independent in completing activity. 1=The client is physically capable of performing essential housework tasks but requires minimal prompts/cues or supervision to complete essential housework tasks. 2=The client requires substantial prompts/cues or supervision and/or physical assistance to complete essential housework tasks. The client may be able to perform some housekeeping tasks but may require another person to complete heavier cleaning tasks. 3=The client is dependent upon others to do all housework in client use area.	How much assistance do you need with the following tasks? Light Housekeeping Heavy Chores No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Does the person need assistance with housework? No Yes Sometimes Chose not to answer When performing "light" housekeeping, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance When performing "heavy" housekeeping, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance When doing their own laundry, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance	Housework Cleaning Laundry 1. Totally able, with or without equipment 2.Limited, participates but does not complete task fully (needs some assistance) 3.Unable to participate at all (needs maximum assistance) 4.Unwilling to perform	Capacity for independent living (Circle yes or no for each task and the summary item) Housekeeping Clean house, make beds, sweep and mop floors, dust, wash dishes, pick up clutter, and take out trash Wash and dry clothing Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Y/N	Home Maintenance, Housekeeping, Laundry Needs help? Yes No

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Assessment Instrument**	**New York COMPASS**	**MnCHOICES**	**Ohio Functional Assessment**	**Virginia Uniform Assessment Instrument**
Using Telephone		How much assistance do you need with the following tasks? Using the Telephone No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Telephone 1. Totally able, with or without equipment 2.Limited, participates but does not complete task fully (needs some assistance) 3.Unable to participate at all (needs maximum assistance) 4.Unwilling to perform	Does the person need assistance to use the telephone? No Yes Sometimes Chose not to answer When "Answering" the phone, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance When "Calling" on the phone, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance	Capacity for independent living (Circle yes or no for each task and the summary item) Make and answer telephone calls Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Y/N	Using Phone Needs help? Yes No

Table 2: IADLs						
	Colorado Uniform Assessment Tool	**Florida Department of Elder Affairs Assessment Instrument**	**New York COMPASS**	**MnCHOICES**	**Ohio Functional Assessment**	**Virginia Uniform Assessment Instrument**
Shopping	SHOPPING: Definition: The ability to run errands and shop; select appropriate items, get around in a store, physically acquire, transport and put away items (money management not considered in this activity). 0=The client is independent in completing activity. 1=The client is physically able to shop but needs prompts/cueing to initiate task. 2=The client requires accompaniment and verbal cues, and/or physical assistance during the activity. 3=The client is totally dependent on others to do essential shopping.	How much assistance do you need with the following tasks? Shopping No Assistance Needed Uses assistive device Needs supervision or prompt Needs assistance (but not total help) Needs total assistance (cannot do at all)	Shopping 1. Totally able, with or without equipment 2.Limited, participates but does not complete task fully (needs some assistance) 3.Unable to participate at all (needs maximum assistance) 4.Unwilling to perform	Do you need assistance to shop? No Yes Sometimes Chose not to answer When managing shopping for food or other items, this person: Needs no help or supervision Sometimes needs assistance or occasional supervision Often needs assistance or constant supervision Always or nearly always needs assistance	Capacity for independent living (Circle yes or no for each task and the summary item) Purchase groceries, clothing and household items Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Y/N	Shopping Needs help? Yes No

Table 3: Skin Condition						
	California MSSP Assessment	**Florida Department of Elder Affairs Assessment Instrument**	**Illinois State Comprehensive Needs Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**New York COMPASS**	**Wisconsin Long-Term Care Functional Screen**
Skin/Pressure Ulcers	Review of Systems Instructions: Check each condition identified by client or observed during the assessment. Inquire about specific items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function. Skin Rash Dry skin Itching Growths Changes in wart or mole Wounds, lesions Sores that will not heal Skin characteristics: Warm Dry Moist Color	Have you been told by a physician that you have any of the following health conditions? Past Current Bed Sores (Decubitus) Location:	Skin Condition: Pressure Sores Open Lesions Skin Tears or Cuts Bruises/rashes Foot problems that interfere with gait	Treatments and Conditions (Has the applicant in the last 14 days received any of the following health treatments, or demonstrated any of the following health conditions?) Complete each item below, either Yes or No. Stage 3-4 pressure sores Yes No		Diagnoses Check diagnosis here if 1) it is provided by a health care provider, or 2) you see it written in a medical record (including hospital discharge forms, nursing home admission forms, etc.), or 3) if person or informant can state them EXACTLY— Other: Wound / Burn / Bedsore / Pressure Ulcer

Table 4: Cognition						
	California MSSP Assessment	**Illinois Statewide Comprehensive Needs Assessment form**	**Kentucky Medicaid Waiver Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**New York COMPASS**	**Virginia Uniform Assessment Instrument**
Orientation	Orientation: What is the...? Year Season Date Day Month Where are we? State Country Town Hospital Floor Psychological Functioning : Orientation Evidence of Problem? None; Some; Severe	Cognitive Observations of Client: Alert Confused Forgetful Disoriented	Is member oriented to person, place, time? Yes No (If no, check below all that apply and comment) Forgetful Confused Unresponsive Impaired judgment			Orientation (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.) Person: Please tell me your full name (so that I can make sure our record is correct). Place: Where are we now (state, county, town, street/route number, street name/box number)? Give the client 1 point for each correct Time: Would you tell me the date today (year, season, date, day, month)? response. Oriented Spheres affected: Disoriented – Some spheres, some of the time Disoriented – Some spheres, all the time Disoriented – All spheres, some of the time Disoriented – All spheres, all of the time Comatose
Memory	Psychological Functioning Memory Evidence of Problem? None; Some; Severe		Is the member experiencing any of the following (For each checked, explain the frequency and details in the comments section) Short-term memory loss Long-term memory loss	Cognitive Performance (Does the applicant have any problems with memory or making decisions?) A. Short-term memory okay (seems/appears to recall after 5 minutes) Memory Okay Memory Problem	Psycho-Condition Does the person appear, demonstrate, and/or report any of the following? Memory deficit	Short-Term: Ask the client to recall the 3 words he was to remember. Long-Term: When were you born (What is your date of birth)?

Table 4: Cognition						
	California MSSP Assessment	**Illinois Statewide Comprehensive Needs Assessment form**	**Kentucky Medicaid Waiver Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**New York COMPASS**	**Virginia Uniform Assessment**
Judgment/Decision-Making Capacity	Psychological Functioning Judgment Evidence of Problem? None; Some; Severe	Cognitive Skills for Daily Decision Making (Decisions regarding tasks of daily life, e.g. when to get up/have meals, what clothes to wear/activities to do) Independent (decisions consistent/reasonable /safe) Modified Independence (some difficulty in new situations only) Minimally impaired (in specific situations, decision become poor or unsafe; cues/supervision necessary at those times) Moderately Impaired (decisions consistently poor or unsafe, cues/supervision required at all times) Severely Impaired (never/rarely makes decisions)	Behaviors Demonstrated at Least Once a Week: Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions.	Cognitive Performance (Does the applicant have any problems with memory or making decisions? Cognitive skills for daily decision-making (made decisions regarding tasks of daily life for last 7 days). Independent The applicant's decisions were consistent and reasonable (reflecting lifestyle, culture, values); the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion. Modified Independent The applicant organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations. Moderately Impaired The applicant's decisions were poor; the applicant required reminders, cues, and supervision in planning, organizing, and correcting daily routines. Severely Impaired The applicant's decision-making was severely impaired, the applicant never (or rarely) made decisions.	Psycho-Condition Does the person appear, demonstrate, and/or report any of the following? Check all that apply Impaired decision making	Judgment: If you needed help at night, what would you do?

Table 5: Communication					
	Illinois Statewide Comprehensive Needs Assessment form	**Kentucky Department for Medicaid Services Medicaid Waiver Assessment**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**MnCHOICES**	**Ohio Functional Assessment**
Expressive Communication	Expression - Making self understood (check only one): Understood - client expresses ideas without difficulty Usually understood - client has difficulty finding words or finishing thoughts BUT if given time, little or no prompting required Often understood – client has difficulty finding words or finishing thoughts, prompting usually required Sometimes understood - ability is limited to concrete requests Rarely/never understood	Is member able to communicate needs? Yes No (If no, check below all that apply and comment) Speaks with difficulty but can be understood Uses sign language and/or gestures/communication device Inappropriate context Unable to communicate	Making self understood (expressing information content, however able). Understood The applicant expresses ideas clearly, without difficulty. Usually Understood The applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses. If given time, little or no prompting required. Sometimes Understood The applicant has limited ability, but is able to express concrete requests regarding at least basic needs (i.e., food, drink, sleep, toilet). Rarely/Never Understood At best, understanding is limited to interpretation of highly individual, applicant-specific sounds or body language (i.e., indicated presence of pain or need to toilet).	Does the person have difficulty communicating with and/or making their wants and needs known to others? No Yes Chose not to answer Expressive Communication Skills: No impairment Speech intelligible to familiar listeners Speech difficult to understand Combines signs and/or gestures to communicate Uses single signs or gestures to express wants and needs Uses augmentative communication aid Does not have functional expressive language	Communication (Circle yes or no for each task and the summary item) Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable amount of time? Yes/No Express needs and wants in a manner that is understandable to people who do not know the individual, using spoken, written, signed, electronic or mechanical means

Table 6: Sensory						
	California MSSP Assessment	**Florida Department of Elder Affairs Assessment Instrument**	**Illinois Statewide Comprehensive Needs Assessment form**	**MnCHOICES**	**New York COMPASS**	**Virginia Uniform Assessment Instrument**
Hearing	Review of Systems Instructions: Check each condition identified by client or observed during the assessment. Inquire about specific items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function. Ears Trouble with hearing Wears a hearing aid	Has a doctor told you that you currently have hearing problems? No Yes Deaf a. Have you had a hearing exam in the past year? No Yes b. Can you understand words clearly over the telephone? No Yes c. Is your hearing worse than it was last year? No In one ear Slightly worse Much worse	Health Conditions and Diseases Hearing Problems Current Medical History Treatment/Support Received at: Outcome/Comments /Details/types of surgery, etc. Unmet Needs	Does the person have any hearing loss? No Yes Chose not to answer Describe your hearing WITHOUT the use of an assistive device: ¢ Normal ¢ Difficulty in 1:1 conversations with some people and/or in noisy environments (Minimally Impaired) ¢ Some useful hearing; uses own speech to make needs and wants known (Moderately Impaired) ¢ May hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television) (Highly Impaired) ¢ No useful hearing (Severely Impaired) ¢ Unknown * Describe your hearing WITH the use of your assistive device(s): ¢ Normal ¢ Minimally Impaired – difficulty in 1:1 conversations with some people and/or in noisy environments ¢ Moderately Impaired – overall useful hearing; uses own speech to make needs and wants known ¢ Highly Impaired – may hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television) ¢ Severely Impaired – no useful hearing ¢ Unknown	Does the person have a self-declared chronic illness or disability? Check all that apply Hearing Impairment	How is your hearing? No impairment Impairment Complete loss Date of last exam

Table 6: Sensory						
	California MSSP Assessment	**Florida Department of Elder Affairs**	**Illinois Statewide Comprehensive Needs Assessment form**	**MnCHOICES**	**New York COMPASS**	**Virginia Uniform Assessment Instrument**
Vision	Review of Systems Instructions: Check each condition identified by client or observed during the assessment. Inquire about specific items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function. Eyes Glasses or contact lenses Change in vision last year Trouble with vision	Has a doctor told you that you currently have vision problems? No Yes Blind a. Have you had an eye exam in the past year? No Yes b. Do you bump into objects (people, doorways) because you don't see them? No Yes c. Is your vision getting worse than it was last year? No In one eye Slightly worse Much worse	Health Conditions and Diseases Visual Impairments Current Medical History Treatment/Support Received at: Outcome/Comments /Details/types of surgery, etc. Unmet Needs	Does the person have any problems with their vision? No Yes Chose not to answer Check all that apply: Cataracts Decreased Side Vision - Left Decreased Side Vision - Right Diabetic retinopathy Farsighted Glaucoma Halos or rings around light, curtains over eyes, or flashes of lights Legally Blind (even with the use of glasses or contacts) Macular degeneration Nearsighted Night Blindness (unable to functionally see in dark environments) Problems with Depth Perception Retinitis Pigmentosa Tunnel Vision Describe your vision WITHOUT the use of an assistive device: Can read regular print in books or newspapers (Adequate) Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print (Minimally Limited) Must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation (Moderately Limited) Sees primarily lights and shadows; has significantly restricted field of vision; or no useful vision (Severely Limited) Unknown Describe your vision WITH the use of your assistive device(s):* Adequate – can read regular print in books or newspapers Minimally limited – can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print Moderately limited – must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation Severely limited – sees primary lights and shadows; has significantly restricted field of vision; or no useful vision Not determined	Does the person have a self-declared chronic illness or disability? Check all that apply Visual Impairment	How is your vision? No impairment Impairment Complete loss Date of last exam

Table 7: Demographic Information						
	Colorado Screening Tool	**Florida Department of Elder Affairs Assessment Instrument**	**Illinois Statewide Comprehensive Needs Assessment**	**MnCHOICES**	**New York COMPASS**	**Virginia Uniform Assessment Instrument**
Demographics	Marital Status: S M D W	Sex: Male, Female Race: (Mark all that apply) White Black/African American Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander Other Ethnicity: Hispanic/Latino Other Marital Status: Married Partnered Single Separated Divorced Widowed	Race Ethnicity Marital Status Gender	Person gender: F/M What is your race or ethnic background? You may choose more than one (Read all categories before taking answer): Would you say that you are: Asian Black or African American American Indian or Alaska Native Hispanic or Latino Pacific Islander or Native Hawaiian White Other (Specify) What is your marital status? (Read all before taking answer) Single, never married Divorced Widowed Married Legally separated Unknown	Sex: Female, Male Marital Status Married, Widowed, Divorced, Separated Race/Ethnicity American Indian/Native Alaskan Asian/Pacific Black Non-Hispanic White Non-Minority Hispanic	Marital Status Married Widowed Separated Divorced Single Unknown Race White Black/African American American Indian Oriental/Asian Alaskan Native Unknown Ethnic Origin:

Table 8: Continence					
	California MSSP Assessment	**Florida Department of Elder Affairs Assessment Instrument**	**Illinois Statewide Comprehensive Needs Assessment**	**MnCHOICES**	**New York COMPASS**
Continence/Genitourinary	Review of Systems Check each condition identified by client or observed during the assessment. Inquire about specific items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function. HX Bladder disease Catheter Incontinence Frequency at night Urgency Trouble starting/stopping urine Pain/burning with urination Testicular/Prostate Problems	Health Conditions Have you been told by a physician that you have any of the following health conditions? Incontinence, bladder Constant Frequent Occasional Rare Incontinence, bowel Constant Frequent Occasional Rare Kidney problems or renal disease End stage? No Yes	Health Conditions and Diseases Kidney/Bladder Problems Prostate/Incontinent problem	GENITOURINARY Does the person have problems with urination? No Yes Unsure Chose not to answer Check all that apply: Blood in urine Frequent urination Incontinence Kidney stones Pain on urination Renal failure Urinary Tract Infection	Does the person have a self-declared chronic illness or disability? (check all that apply) Renal Disease Urinary Tract Disease

Table 9: Behavioral Symptoms						
	California MSSP Assessment	**Florida Department of Elder Affairs Assessment Instrument**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**MnCHOICES**	**New York COMPASS**	**Virginia Uniform Assessment Instrument**
Harmful to others	Psychological Functioning Combative, Abusive, or Hostile Behavior Evidence of Problem? None Some Severe	Problem Behaviors: Threatens or is verbally hostile Physically aggressive or violent Not at all Once Several days More than half the days Nearly every day	Behavior (Has the applicant displayed any challenging behaviors in the last 7 days?) Behavioral Code: 0 = Behavior not exhibited in last 7 days 1 = Behavior of this type occurred 1 to 3 days in last 7 days 2 = Behavior of this type occurred 4 to 6 days, but less than daily 3 = Behavior of this type occurred daily Verbally Abusive-Others were threatened, screamed at, cursed at. Physically Abusive-Others were hit, shoved, scratched, sexually abused.	AGGRESSIVE TOWARDS OTHERS, PHYSICAL Person engages in, or would without an intervention, behavior that causes physical harm to other people or to animals. A person who causes physical harm due to involuntary movement is not considered to have physical aggression towards others. No Yes	Psycho-Condition Does the person appear, demonstrate, and/or report any of the following? Physical Aggression	Does the client ever become agitated and abusive? Abusive / Aggressive / Disruptive – Less than weekly Abusive / Aggressive / Disruptive – Weekly or more Comatose

Table 9: Behavioral Symptoms						
	California MSSP Assessment	**Florida Department of Elder Affairs Assessment Instrument**	**Michigan Medicaid Nursing Facility Level of Care Determination**	**MnCHOICES**	**New York COMPASS**	**Virginia Uniform Assessment**
Disruptive Behavior		Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Problem Behaviors: Easily agitated or disruptive Sexually inappropriate Not at all Once Several days More than half the days Nearly every day	Behavior (Has the applicant displayed any challenging behaviors in the last 7 days?) Behavioral Code: 0 = Behavior not exhibited in last 7 days 1 = Behavior of this type occurred 1 to 3 days in last 7 days 2 = Behavior of this type occurred 4 to 6 days, but less than daily 3 = Behavior of this type occurred daily Socially Inappropriate/Disruptive-Made disruptive sounds, noisiness, screaming, self-abusive acts, inappropriate sexual behavior or disrobing in public, smeared or threw food/feces, hoarded or rummaged through others' belongings.	Socially Unacceptable Behavior Person expresses themselves, or would without an intervention, in an inappropriate or unacceptable manner including sexual, offensive or injurious to self with others. Includes behavior that draws negative attention to themselves resulting in increased vulnerability. Behavior can be verbal or non-verbal. No Yes	Psycho-Condition Does the person appear, demonstrate, and/or report any of the following? Disruptive socially Verbally disruptive	Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive? Appropriate Wandering / Passive – Less than weekly Wandering / Passive – Weekly or more Abusive / Aggressive / Disruptive – Less than weekly Abusive / Aggressive / Disruptive – Weekly or more Comatose
Wandering	Check each condition identified by client or observed during the assessment. Inquire about specific items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function. Psychiatric Wanders Psychological Assessment Wandering Evidence of Problem None; Some; Severe	Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Problem Behaviors: Gets lost or wanders off Not at all Once Several days More than half the days Nearly every day	Behavior (Has the applicant displayed any challenging behaviors in the last 7 days?) Behavioral Code: 0 = Behavior not exhibited in last 7 days 1 = Behavior of this type occurred 1 to 3 days in last 7 days 2 = Behavior of this type occurred 4 to 6 days, but less than daily 3 = Behavior of this type occurred daily Wandering - Moved with no rational purpose, seemingly oblivious to needs and safety.	Wandering/elopement Person purposefully will, or would without an intervention, leave an area or group without telling others or depart from the supervision staff unexpectedly resulting in increased vulnerability. No Yes		Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive? Appropriate Wandering / Passive – Less than weekly Wandering / Passive – Weekly or more Abusive / Aggressive / Disruptive – Less than weekly Abusive / Aggressive / Disruptive – Weekly or more Comatose