InterRAI-HC (iHC) Assessment Guide:

This guide is intended to assist Supports Coordinators in completing the InterRAI-HC assessment (iHC) within COMPASS and ensuring a consistent interpretation of items. The majority of the following information is taken directly from the iHC Assessment Manual. Those items not included in the iHC Assessment Manual were discussed by the NCQA Team, the Internal Quality Committee, and the Supports Coordinator Review Team and a determination for the process and standardizing responses was made.

This assessment serves as a way to assess and monitor the ongoing status of a participant and their needs for care and services. When completing the assessment, the goal of the Supports Coordinator is to gather as much information as needed to assist in providing appropriate supports and determining the best participant-centered plan of care.

Not all questions within the COMPASS iHC Assessment are required by the Michigan Department of Health and Human Services (MDHHS) or Mi Choice Waiver contract. However, all questions within the assessment must be asked and items marked with the corresponding participant answer. There are also sections within the assessment where more information from the participant is necessary, yet the questions are not currently included in the electronic version of the assessment. Those sections will be denoted within this guide and direction for additional follow-up questions will be provided. The answers must be included in the corresponding "Description of Conditions Noted Above" box or "Comments" box within the assessment section.

It is important that the Supports Coordinator carry over vital information from one assessment to the other. Although the COMPASS assessment carries over the answer selections made from previous completed assessments, the information provided in the "Description of Conditions Noted Above" box does not populate into the future assessments. Therefore, the Supports Coordinator is responsible for summarizing or copying and pasting the vital information into this section at each new assessment.

COMPASS User Guides:

The COMPASS database system supports the HCBS waiver and other local aging programs. COMPASS currently tracks the status of program participants, billing, claims, and participant information including the comprehensive iHC Assessment and PCSP.

For technical assistance with accessing and utilizing the COMPASS database, multiple COMPASS guides are available through the Help function. These guides should be used when questions arise regarding how to login, navigate through the databases' functions and menu items, general operations, entering progress notes, and creating and finalizing assessments.

COMPASS also has multiple reporting and script functions that allow for the tracking of timeliness and completion of assessments, as well as the date of the next assessment due. These reports will be run monthly by the Waiver Director and the LTC Quality Improvement Manager to ensure that all assessments are being completed properly and in a timely manner.

Assessment of Participant's Health, Functioning, Communication Needs, and Available Resources:

As mentioned previously, the assessment serves as a way to assess and monitor the status of a participant and their needs for care and services. There are multiple categories of information and areas of importance gathered by the assessment:

- Health Status, including condition-specific issues
- Clinical History, including medications
- Activities of daily living, including use of supports
- Instrumental activities of daily living, including use of supports
- Behavioral Health status
- Cognitive functioning
- Social determinants of health
- Social functioning
- Health beliefs and behaviors
- Cultural and linguistic needs, preferences or limitations
- Visual and hearing needs, preferences or limitations
- Physical environment of risk
- Paid and unpaid caregiver resources, involvement, and needs
- Available benefits within the organization
- Community resources

Key Points Regarding Completion of the InterRAI-HC Assessment:

The assessment process requires communication with the participant, observation of the participant in their home environment, and review of secondary documents when available. Whereas the participant and/or legal representative should be the primary sources of information when completing the assessment, it may be appropriate to get additional insight into the participant's medical status and support needs by gathering information from the participant's informal supports, family members, and/or caregivers, with the participant's authorization. The participant is informed of their right to include the individuals of their choice to participate in the assessment process. When information is gathered from a source other than the participant, it should be clearly noted in the assessment.

Items on the InterRAI HC are designed to flow in a reasonable sequence and can be completed in the order in which they appear on the assessment form. However, the assessor is not bound by this sequence of items. Items may be reviewed in any sequence that works for the assessor and the participant.

Sometimes the assessor must reconcile multiple sources of information yielding seemingly inconsistent results (e.g., the person may report something that is very different from the daughter's response). In this case, the assessor must use his or her clinical judgment to determine the most appropriate response for the particular item(s) and make note within the assessment regarding the inconsistent or conflicting information.

The assessment should be performed in the person's home whenever possible. Parts of the assessment can be completed in settings other than the person's home (e.g., a hospital, day care center, outpatient clinic) with no loss in information quality. However, certain critical items (e.g., environmental factors) can best be assessed in the home.

Item-by-Item Guide:

The following types of information is presented:

Definition:

- Explanation of key terms.

Process:

- Sources of information and methods for determining the correct response for an item. Sources include:
    - Interview and observation of the participant
    - Discussion with the participant's family, other caregivers, and the participant's physician.
    - Review of any clinical records and other administrative documentation.

Coding:

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

Participant (Case File):

- This section contains personal identifiers necessary to identify the participant and link sequential assessments in an electronic database.
- The Supports Coordinator records the participant's preferences with regards to their name, pronouns, gender identity, method of communication, emergency contacts, and any cultural or linguistic needs that may impact their participation in the Mi Choice Waiver program and overall care.
- Information regarding life planning and end of life wishes is addressed within the section. It is vital that the Supports Coordinator discusses the importance of end-of-life planning and provides the participant with any information or forms that may be needed or requested.

Participant's Name:

Definition:

- Participant's legal name and pronouns

Process:

- Ask the participant their full legal name. Ensure proper spelling
- Ask the participant how they would like to be addressed and if they have preferred pronouns.

Coding:

- Use printed letters.
- Enter in the following order:
    - Last Name, Jr./Sr., First name, Middle initial
    - If the participant has no middle initial, leave blank.
    - Select Title from drop-down menu
    - Type/Enter the name the participant prefers to be called or addressed in conversation, on UPCAP documents, or on official correspondence.
    - Type/Enter the participant's preferred pronouns

Date of Birth:

Definition:

- The date on which the participant was born

Process:

- Ask the participant for their date of birth. Confirm the information using proof of identification, including birth certificate, driver's license or state ID.

Coding:

- For the month and day of date of birth, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: November 1, 1942. 11/01/1942

Sex Assigned at Birth:

Definition:

- The sex assigned to the participant at birth, most often based on their external anatomy.

Process:

- Ask the participant the sex they were assigned at birth

Coding:

- Select from the following options:
    - **Male**
    - **Female**

Gender Identity:

Definition:

- The participant's personal sense of having a particular gender. It may be different from their sex assigned at birth.

Process:

- Ask the participant if they identify with a gender other than their sex assigned at birth.

Coding:

- Select from the following options:
    - **Male**
    - **Female**
    - **Transgender**
    - **Gender non-binary**
    - **Not listed, please specify**
    - **Declined/not stated**
- If the participant's gender identity is not listed, please type/enter their answer in the open box provided.

Sexual Orientation:

Definition:

- The participant's identity in relation to the gender or genders to which they are sexually attracted.

Process:

- Ask the participant their sexual orientation

Coding:

- Select from the following options:
  - **Straight/Heterosexual**
  - **Bisexual**
  - **Gay/Lesbian/Same-Gender Loving**
  - **Questioning/Unsure**
  - **Not listed, please specify**
  - **Declined/not stated**
- If the participant's sexual orientation is not listed, please type/enter their answer in the open box provided.

Marital Status:

Definition:

- The participant's state of being married or not married

Process:

- Ask the participant their marital status.

Coding:

- Choose the answer that describes the current marital status of the participant. If the participant is in a common-law relationship, code as married. If the participant is in a same-sex relationship that is legally recognized as a marriage, code as married. If the participant is in a long-term same-sex relationship that is not legally recognized as a marriage, code as partner/significant other.
- Select from the following options:
  - **Never Married**
  - **Married**
  - **Widowed**
  - **Separated**
  - **Divorced**
  - **Partner/Significant Other**

Ethnicity/Race:

Process:

- Ask the participant or family member which of the categories below best describes their race and ethnic background. The participant may identify more than one category.

Coding:

- Check all that apply
  - **Yes**
  - **No**

- Ethnicity
  - **Is Participant Hispanic or Latino**

- Race
  - **American Indian or Alaskan Native**
  - **Asian**
  - **Black or African American**
  - **Native Hawaiian or other Pacific Islander**
  - **White**

Phone Number:

Definition:

- The number assigned to a telephone line or specific phone

Process:

- Ask the participant for their preferred phone number. Ensure that the number provided is reliable for contact. Remind them that UPCAP will be contacting them regularly to monitor their services and satisfaction in addition to preferred providers needing to contact them

Coding:

- Use Numbers only
- Area Code
  - Type/Enter the three-digit number that identifies the participant's telephone service region
- Phone
  - Type/Enter the seven-digit number that identifies the participant's individual personal calling code.
- If the participant does not have a phone number, leave blank and note this in the "Comments" box

Preferred Method of Communication:

Definition:

- The type/method of communication the participant prefers.

Process:

- Ask the participant how they would prefer to be contacted by UPCAP.

Coding:

- Select type of communication from drop-down menu
    - **Phone**
    - **Email**
    - **Text**
    - **Other**
- If the participant selects "Other", enter the contact information in the spaces provided
    - If other, please specify
    - **Name**
    - **Phone**
    - **Email**
- If the participant selects text or email, make sure to complete the corresponding consent form for text and email and communication.

Primary Language:

Definition:

- Preferred language for day-to-day communication

Process:

- Observe and interview the participant and family to determine the language the participant primarily speaks or understands. Review any clinical records.

Coding:

- Select from the following options:
    - **English**
    - **Spanish**
    - **French**
    - **Other**

Communication Support Needs:

Definition:

- Support that may be needed to support the participant with understanding, expressing themselves, or interacting with others.

Process:

- Ask the participant if they require any additional support with communication or if they have any specific cultural or linguistic needs. This could include needs like an interpreter, sign language, assistive devices, etc.

Coding:

- Use printed letters.
- List all needs communication, cultural or linguistic support needs reported by the participant.
- If no additional support needs are required, type "None" in the text box.

Education:

Definition:

- Refers to the years of formal instruction received and successfully completed.

Process:

- Ask the participant the highest level of formal education completed.

Coding:

- Select from the following options:
  - **None**
  - **8th Grade/Less**
  - **9-11 Grade**
  - **High School**
  - **Tech or Trade School**
  - **Some College**
  - **Bachelor's degree**
  - **Graduate degree**
- If the participant refuses to answer, mark No Selection

Religious Affiliation:

Definition:

- The self-identified association of a participant with a religion, denomination, or sub-denominational religious group.

Process:

- Ask the participant their religious affiliation. Ask if the participant has any religious beliefs that may impact their access to health care. Ask if the participant has any objections to specific procedures, treatments, medications, etc. due to their religious affiliation or beliefs.

Coding:

- Use printed letters
- Type/submit exactly what the participant says. If no religious affiliation reported, type "None" in the corresponding text box
- If the participant requires or reports any specific care needs related to religious affiliation, type/enter the information in the "Comments" box.

Family Contact Information:

Definition:

- An adult individual the participant has designated to receive information concerning the participant's services.

Process:

- Ask the participant for their emergency contact/family contact information. Inform them that if the participant is unable to contact, this elected family contact would potentially be contacted in an effort to make contact with the participant.

Coding:

- Use printed letters
- Enter the First and Last Name
- Select from the following options:
    - **Child or child-in-law**
    - **Spouse**
    - **Partner/Significant Other**
    - **Parent/Guardian**
    - **Sibling**
    - **Other relative**
    - **Friend**
    - **Neighbor**
    - **No Informal Helper**
- Enter area code and phone number in corresponding text fields
- Enter any additional information in the comments box – i.e. secondary phone number, hours available, etc.

Nursing Facility Admission Date:

Definition:

- The first day of the participant's most recent nursing facility stay.

Process:

- Confirm admission date with the participant or the nursing facility.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

Hospital Admission Date:

Definition:

- The first day of the participant's most recent hospital stay

Process:

- Confirm admission date with the participant or the hospital

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

Advance Medical Directives:

Definition:

- A legal document that states the participant's wishes about receiving medical care and/or end of life decisions, if they are no longer able to make decisions themselves.

Process:

- Ask the participant if they have an Advance Medical Directive.
    - If the participant has a completed Advance Medical Directive, ask for the name of the primary elected decision maker, their phone number, and the location of the document (if applicable)
    - If the participant has not completed an Advance Medical Directive, provide the participant with a blank Advance Medical Directive booklet and make a recommendation for completing one. Supports Coordinators may assist the participant with any questions that they may have regarding end of life decisions, however, the Supports Coordinator CAN NOT be the primary elected decision maker OR a witness.

Coding:

- Select from the following options:
    - **No**
        - Participant does not have any paperwork
    - **Yes**
        - Participant has paperwork and it completed.
    - **Pending**
        - Participant has paperwork but has not been completed yet.
- If "No" is selected:
    - Document in the Comments Box that the participant was given a blank copy of an Advanced Medical Directive booklet. Note that the Supports Coordinator offered to assist if needed.
    - If the participant is NOT interested in completing an Advance Medical Directive, document in the Comments Box and note why the participant declined.
- If "Yes" is selected:
    - Document the type of Advanced Medical Directive completed in the Comments Box – i.e. Living Will; Do Not Resuscitate Order; Durable Power of Attorney (DPOA); Patient Advocate.
    - If DPOA or Patient Advocate has been selected, complete the Name, Area Code, Phone, and Location of Advance Medical Directives boxes using printed letters.
    - Request a copy of the Advance Medical Directive for the participant's file.
- If "Pending" is selected:
    - Document in the Comments Box that the Supports Coordinator offered to assist, if needed.

Medicaid ID:

Definition:

- A 10-digit identification number provided by the Michigan Department of Health and Human Services (MDHHS) for Medicaid beneficiaries.

Process:

- Ask the participant if the currently have Medicaid or have applied for Medicaid in Michigan. Request to review a copy of their MiHealth card or correspondence from MDHHS to confirm the number provided.
- If they do not have the number available, the Supports Coordinator can confirm through CHAMPS.

Coding:

- Use numerical digits.

Medicaid Application:

Definition:

- A request to review participant information for Michigan Medicaid coverage sent to the Michigan Department of Health and Human Services

Process:

- If the participant does not currently have active Medicaid, the Supports Coordinator can/should assist with completing the application, gathering the needed verifications, and submitting the application to MDHHS. Once submitted, the Supports Coordinator will document the date the application was submitted.
- If the participant has already applied for Medicaid prior to the initial visit, request a copy of the application and verifications submitted to MDHHS.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

SSI:

Definition:

- Supplemental Security Income.
- Monthly benefits provided by the Social Security Administration to those who are disabled, blind or age 65 and older with limited income and resources.

Process:

- Ask the participant if they are currently receiving Supplemental Security Income.
- If the participant is unsure, request to review their financial information, including any correspondence from the Social Security Administration.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

QMB:

Definition:

- Qualified Medicare Beneficiary
- Program that provides Medicare coverage of Part A and Part B premiums and cost sharing to low-income Medicare Beneficiaries.

Process:

- Ask the participant if they are receiving any assistance or cost sharing for their Medicare premiums.
- If the participant is unsure, the Supports Coordinator can confirm through CHAMPS under "Benefit Plan".

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Medicaid Re/Certification Due Date:

Definition:

- The date that the participant is required to renew or recertify their Medicaid coverage. This is determined by MDHHS and is most commonly 1 year after the filing their initial Medicaid application and each subsequent year thereafter.

Process:

- Ask the participant if they have received any correspondence from MDHHS requesting a review of their finances for a Medicaid redetermination. Supports Coordinators should be inquiring at every assessment to prevent a potential lapse in coverage.

Coding:

- The CHAMPS Redetermination Date box is automatically populated through CHAMPS if available.

Level of Care (LOC) Entry Date to DCH Website:

Definition:

- The date the NFLOCD was entered into CHAMPS.

Process:

- Once the NFLOCD has been entered into CHAMPS, the appropriate staff person will enter the date.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

LOCD Renewal Due Date:

Definition:

- The date that the participant is required to recertify their functional eligibility through the completion of another NFLOCD. This is determined by the CHAMPS system and is most commonly 1 year after the previous NFLOCD was entered.

Process:

- Once the NFLOCD has been entered into CHAMPS, an end date will be populated by the CHAMPS system. The staff person entering the NFLOCD will enter the end date provided.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

Application ID:

Definition:

- The application identification number populated by CHAMPS when an NFLOCD is entered.

Process:

- The staff person entering the NFLOCD will enter the application ID assigned to the NFLOCD in CHAMPS.

Coding:

- Use numbers

Annual Release of Information Due Date:

Definition:

- The date UPCAP's Consent and Authorization is due.

Process:

- The Supports Coordinator will enter the due date based on the most recent UPCAP Consent and Authorization. The due date is 364 days from the date the most recent UPCAP Consent and Authorization was signed and completed.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022

Liquid Nutrition Supplement Due Date:

Definition:

- A liquid supplement that provides essential nutrients and calories as part of a therapeutic regimen. This is a MI Choice Waiver Service that can be provided to participants who meet the standards as outlined by MDHHS and requires a physician's order.

Process:

- If the participant receives nutritional supplements as a Mi Choice Waiver service, the Supports Coordinator is required to have a physician's order on file. The physician's order must be renewed every 6 months.
- The Supports Coordinator will enter the due date based on the most recent physician's order received. The due date is 179 days from the last physician's order received.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not receive liquid nutritional supplements, leave blank.

Oxygen Renewal Due Date:

Definition:

- A treatment that provides the participant with supplemental oxygen.

Process:

- If the participant receives supplemental oxygen **AND** the participant scores under Door 4 for daily oxygen use, the Supports Coordinator is required to have a physician's order on file documenting oxygen dependency. This physician's order must be renewed annually.
- The Supports Coordinator will enter the due date based on the most recent physician's order received. The due date is 364 days from the last physician's order received.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not utilize oxygen, leave blank.

Annual SD Budget Due Date:

Definition:

- The annual budget for self-determination services through the Mi Choice Waiver program.

Process:

- The self-determination budget for Mi Choice Services is required to be reviewed annually.
- The Supports Coordinator will enter the due date based on the most recent self-determination budget. The due date is 364 days after the most recent budget is completed.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not utilize self-determination for services, leave blank.

PDN Renewal Due Date:

Definition:

- Based on UPCAP internal policy, use this section to document the due date for both Private Duty Nursing or Nursing Services.
- Private Duty Nursing and Nursing Services are skilled nursing or respiratory care interventions for participant's with significant medical needs. This is a MI Choice Waiver Service that can be provided to participants who meet the standards as outlined by MDHHS and requires a physician's order.

Process:

- If the participant receives private duty nursing or Nursing Services through the Mi Choice Waiver, the Supports Coordinator is required to have a physician's order on file documenting the participant's need for service. The physician's order for Nursing Services must be renewed every 6 months. The physician order for Private Duty Nursing/Respiratory Care must be renewed every 12 months
- The Supports Coordinator will enter the due date based on the most recent physician's order received. The due date is 179 days or 364 days, depending on the MI Choice Service, from the last physician's order received.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not receive private duty nursing or nursing services, leave blank.

Counseling Renewal Due Date:

Definition:

- Mi Choice Waiver service that seek to improve the participant's emotional and social wellbeing through the resolution of personal problems or though changes in a participant's social situation.

Process:

- The Supports Coordinator is responsible for contacting and completing a care conference with the therapist/counselor providing the counseling service through MI Choice every 6 weeks.
- The Supports Coordinator will enter the due date 6 weeks out from the last documented contact with the therapist/counselor.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not receive counselling services, leave blank.

Section 8 Housing Voucher Renewal Due Date:

Definition:

- The federal program for assisting low-income families, the disabled, and the elderly with finding affordable housing.

Process:

- As the participant if they receive Section 8 housing assistance. If they do utilize Section 8 housing assistance, then inquire regarding the date of their renewal for their voucher.

Coding:

- For the month and day, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: December 1, 2022. 12/01/2022
- If the participant does not utilize Section 8 housing assistance or is unsure of their renewal date, leave blank.

Patient Pay Amount:

Definition:

- The amount of money that the participant is required to spend over the course of a month to meet Medicaid income eligibility. Participant's with the MA-Spenddown benefit plan are assigned this deductible amount by MDHHS.
- The amount of money that a patient is required to pay toward the cost of their nursing home care.
- This is an optional question and does not have to be filled out as it is not required for the Mi Choice Waiver program.

Process:

- If a participant has MA-Spenddown as a benefit plan, ask their monthly deductible amount.
- If possible, refer to their benefit statement from MDHHS. This can also be confirmed by contacting the participant's MDHHS Eligibility Specialist.

Coding:

- Use numerical digits

Medicare Number (or comparable railroad insurance number):

Definition:

- An 11-character identification number provided by Medicare beneficiaries.

Process:

- Ask the participant for their Medicare Card (the red, white, and blue card) and any other insurance cards that they may use. Confirm the type of Medicare coverage as well as the effective dates for each part of their coverage. Make copies of the cards if able.
- If the participant has Medicaid as well Medicare, this information can also be confirmed through CHAMPS.

Coding:

- Enter the participant's Medicare number using a combination of numerical digits and printed letters.
- Effective Dates of Coverage: For the month and day of date of birth, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
    - Part A Effective Date
    - Part B Effective Date
    - Part C Effective Date
    - Part D Effective Date
- Medicare Part C:
    - If the participant has Part C coverage through an insurance company, list the company name, company area code, company phone number, and the card number.
- Medicare Part D:
    - If the participant has Part D coverage through an insurance company, list the company name, company area code, company phone number, and the card number.
- If the participant does not have a Medicare number and only utilizes Medicaid for their healthcare coverage, leave this section blank. Document that the participant does not have Medicare coverage in the Comments box.
- If the participant does not have a particular "Part" of Medicare coverage, leave the item blank.

MA Spend Down:

Definition:

- The amount a married participant is required to spend to meet Medicaid asset eligibility. This spenddown amount is determined by MDHHS once an Initial Asset Assessment is filed

Process:

- Ask the participant for their spenddown mount as determined by MDHHS.
- Refer to their official correspondence from MDHHS. If the participant does not have this available, this can be confirmed by contacting their MDHHS Eligibility Specialist.

Coding:

- Use numerical digits.

Compass ID:

Definition:

- Auto-generated unique identification number assigned to individual participants within COMPASS.

Process:

- This identification number is auto-generated to be used as replacement for the participant's SSN. This may not be changed and is assigned when a participant is added to COMPASS.

Coding:

- No data entry needed – number auto-generated by program.

Veterans ID:

Definition:

- An identification card issued by the US Department of Veteran's Affairs (VA) to former military participant.

Process:

- Ask the participant if they are a Veteran. If yes, ask the participant for their Veteran's ID card. Make a copy of the card, if able.

Coding:

- Use numerical digits

Veteran:

Definition:

- A participant who has served in the military.

Process:

- Ask the participant if they are a Veteran. If they are not, inquire if their spouse, child, or other family relationship was a Veteran.

Coding:

- Select from the following options:
  - **Participant**
  - **Spouse**
  - **Child**
  - **Other**
  - **Not a Veteran**

Benefits Received:

Definition:

- Any benefit received from the VA based on military service, including medical coverage or financial compensation.

Process:

- As the participant if they receive any benefits from the VA for their military service or the service of a family member.

Coding:

- Select from the following options:
  - **Yes**
  - **No**
- If Yes, provide an explanation of the kinds of benefits received in the Comments box.

Social Security Number

Definition:

- A unique 9-digit number, in the format 000-00-000, provided to each individual at birth or date of citizenship and is used to track Social Security benefits and serve as a form of identification.

Process:

- Ask the participant for their social security number. Review the participant's social security card, if available. Make a copy of the card, if able.
- If the participant was assigned a "dummy" social security number at the time of referral, complete an administrative database change form to request the number be changed.

Coding:

- Enter the participant's Social Security number using numerical digits.
- If the participant does not have a Social Security number (e.g., if the participant is a recent immigrant or a child), enter the standard "no information" code, "NA."

Comments:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions.

Process:

- Document all pertinent information related to the participant's identifying information.
- Provide further explanation related to any selections made as specified above.

Coding:

- Using printed letters and text

SW Assessment:

Reminder:

- This section provides an opportunity for the Supports Coordinator to enter any specific issues or items of which they would like to be reminded at the next assessment.
- It is not required to enter anything into this section but serves as an open field to add notes, reminders, or important info.

Next Reminder:

Definition:

- Important information that the Supports Coordinator would like to be noted or recalled

Process:

- Enter any reminders related to the next assessment with this participant.

Coding:

- Use printed letters and text.

SW Assessment – FS: Benefits & Insurance

- In this section, the Supports Coordinator will gather information regarding the participant's current health insurance and benefits.
- This information can be used to identify other resources and/or sources of payment for services as the MI Choice Waiver is the payor of last resort. It also provides the opportunity to determine whether or not the participant's needs can be met through their current coverage or benefits.
- The Supports Coordinator will also record the participant's Medicaid status and identify if assistance with filing a Medicaid application is necessary for participation in the Mi Choice Waiver Program.

Medicaid Status:

Definition:

- The status of the participant's Medicaid.

Process:

- Ask the participant if they currently have Medicaid or have recently filed a Medicaid application.
- Utilize the CHAMPS Eligibility Report to confirm the participant's Medicaid status.

Coding:

- Select from the following options:
    - **Non-MA:** No Medicaid and no pending Medicaid application
    - **MA Active:** Active Medicaid with benefit plan
    - **MA Pending:** Medicaid application has been filed and being processed by MDHHS
    - **MA Spenddown:** Medicaid application filed and processed. Participant did not meet either financial criteria and was issued a spenddown or deductible amount.
    - **Medicaid Inactive**: No Medicaid in place at this time. Participant had a previous active MA case or had applied for Medicaid in the past.

Current Payment Sources:

Definition:

- All sources or methods of payment for the participant's medical care.

Process:

- Ask the participant for the type of insurance(s) that covers their medical care.
- If they are unsure, you may need to consult with their primary physician's office or pharmacy to confirm.
- This information can also be found on a CHAMPS report if the participant is currently enrolled in an active Medicaid benefit plan.

Coding:

- Select from the following options for each one below:
    - **No**
    - **Yes**
- **Medicaid** - Pays for nursing care and other necessary therapies or services
- **Medicare** - Pays for nursing care and other necessary therapies or services
- **Self or family pays for full cost** - The participant or family pays the full cost of care and services
- **Medicare with Medicaid co-payment** - The State is responsible for the Medicare co-payment
- **Private Insurance** - The participant's private insurance company (e.g., LTC insurance) covers all
- or part of the cost of care and services.
- **Other, specify** - Another entity covers all or part of the cost of care and services

Health Insurance:

Definition:

- A formal agreement in which an insurance company pays for some or all of your medical expenses.

Process:

- Ask the participant for information regarding their health insurance providers.
- Ask to see health insurance cards to confirm information and make copies, if able.

Coding:

- List all the important information associated the participant's and spouse's supplemental health insurance plans.
    - **Company Name**
    - **Area Code and Phone Number**
    - **Address**
    - **Contract Number**
    - **Plan Code**
    - **Group Number**
    - **Service Code**
- If the participant does not have additional health insurance, leave blank
- Do not enter Medicare Part C or Part D plans here as they are listed under the Participant's case file.

Life Insurance:

Definition:

- Insurance that pays out a sum of money either upon the death of the insured participant or after a set period of time.

Process:

- Ask the participant for information regarding their life insurance coverage.
- Ask to see the life insurance policy or statement to confirm information and make copies if able.
- If the participant does not have up to date life insurance information, the Supports Coordinator can assist the participant in contacting the life insurance company and requesting an updated benefit statement.
- If the participant has a cash-surrender value to their life insurance, this value should be reviewed at each annual assessment to ensure financial eligibility.

Coding:

- Use printed letters/text and numerical digits as applicable
- If the participant does not have a life insurance policy, leave blank
- List all the important information regarding the participant's and spouse's life insurance policies
    - **Company Name**
    - **Area Code and Phone Number**
    - **Address**
    - **Contract Number**
    - **Face Value**
    - **Cash Value**
- Select type of policy
    - **Term** – Cash benefit is paid to beneficiary after death of insured participant.
    - **Whole Life** – Cash benefit is paid to beneficiary after death of insured participant. Policy also accumulates a cash value which can be borrowed or cashed out prior to death. This is viewed as an asset by MDHHS when determining Medicaid eligibility.
    - **Endowment** – A monetary fund with set up to provide long-term support
        - No
        - Yes

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

SW Assessment - FS: Financial Info:

- This section serves as a "snapshot" of the participant's finances and provides the Supports Coordinator with information regarding the participant's potential financial eligibility for the MI Choice Waiver Program.

- Information within this section must be reviewed annually and any discrepancies or potential issues that may affect Medicaid eligibility must be documented.

- Information gathered within this section can be used to determine potential barriers related to Social Determinates of Health (SoDH) that may affect the participant's ability to be successful in meeting their goals.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Gross Monthly Income: Participant

Definition:

- The participant's total monthly earnings before taxes or other deductions. This includes income from all sources.

Process:

- Ask the participant for their income information. Request to review verifications of income information and make a copy for the participant file.

Coding:

- Enter numerical amounts in the corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- Check the applicable box if the income is direct deposited into a bank account.
- If the participant does not receive income from the source listed, leave blank.
- **Social Security**
- **Railroad Retirement**
- **VA Benefits**
- **Pensions**
    - If a pension is received, enter sources of pensions in the text box
- **Alimony**
- **Estate or Trust Fund**
- **Interest Income**
- **Dividends**
- **Employment**
- **SSI**
- **Other Income 1**
    - If income comes from a source not listed below, enter here and provide a description of source in the text box.
- **Other Income 2**
    - If income comes from a source not listed below, enter here and provide a description of source in the text box.
- **Gross Monthly: Subtotal for Participant**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Gross Monthly Income: Spouse

Definition:

- The participant's total monthly earnings before taxes or other deductions. This includes income from all sources.

Process:

- Ask the participant's spouse for their income information. Request to review verifications of income information and make a copy for the participant file.

Coding:

- If the participant does not have a spouse, leave boxes blank.
- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- Check the applicable box if the income is direct deposited into a bank account.
- **Social Security**
- **Railroad Retirement**
- **VA Benefits**
- **Pensions**
    - If a pension is received, enter sources of pensions in the text box
- **Alimony**
- **Estate or Trust Fund**
- **Interest Income**
- **Dividends**
- **Employment**
- **SSI**
- **Other Income 1**
    - If income comes from a source not listed below, enter here and provide a description of source in the text box.
- **Other Income 2**
    - If income comes from a source not listed below, enter here and provide a description of source in the text box.
- **Gross Monthly: Subtotal for Participant**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Total Monthly Gross Household Income:

Definition:

- Combined total gross monthly income for the participant's household.

Process:

- This automatically calculated within COMPASS, based on adding the amounts listed for "gross monthly subtotal: participant" and "gross monthly subtotal: spouse".

Coding:

- N/A

Participant is at or less than the special income limit

Definition:

- The special income limit is 300% of the current supplemental security income (SSI) payment standard. This is also the income limit for the MI Choice Waiver Program. Yearly amounts change as the federal levels change.

Process:

- Review the participant's gross income amount and compare against Mi Choice Waiver income limits.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Participant or representative is effectively managing financial affairs

Definition:

- How the participant manages their personal finances. Are their bills paid on time, are they facing eviction due to non-payment, are they able to purchase medications, etc.

Process:

- Review the participants income vs expenses. Ask the participant if they are having any difficulties with financial management.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- If "No" is selected, the Supports Coordinator must address the issue in the "Description of Conditions Noted Above"

DHS Irrevocable PPD Burial Accounts

Definition:

- An irrevocable contract, approved by MDHHS, allowing a participant to pay for their funeral and burial costs in advance of their death.

Process:

- Ask the participant if they or their spouse have any irrevocable burial accounts through MDHHS.
- If they have an account, request to review the documentation and make a copy of the participant's file.

Coding:

- Enter numerical amounts in the corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- Check the applicable box if the income is direct deposited into a bank account.

Assets: Participant

Definition:

- An asset is anything owned that adds financial value. Examples include: cash, banking accounts, property, cash surrender values to life insurance, retirement accounts, etc.

Process:

- Ask the participant for information regarding their assets. Request to review verifications (bank account statements, life insurance policies, benefit statements, etc).

Coding:

- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- **Savings**
- **Checking**
- **Equity Value/Real Estate**
- **Stock/Securities**
- **CD/IRA/Money Market**
- **Cash Value Life Insurance**
- **Trade-In Value of Second Car**
- **Other Asset 1**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 2**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 3**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Assets: Subtotal for Participant:**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Assets: Spouse

Definition:

- An asset is anything owned that adds financial value. Examples include: cash, banking accounts, property, cash surrender values to life insurance, retirement accounts, etc.

Process:

- Ask the participant's spouse for information regarding their assets. Request to review verifications (bank account statements, life insurance policies, benefit statements, etc).

Coding:

- If the participant does not have a spouse, leave boxes blank.
- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- **Savings**
- **Checking**
- **Equity Value/Real Estate**
- **Stock/Securities**
- **CD/IRA/Money Market**
- **Cash Value Life Insurance**
- **Trade-In Value of Second Car**
- **Other Asset 1**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 2**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 3**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Assets: Subtotal for Spouse:**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Assets: Joint

Definition:

- An asset is anything owned that adds financial value. Examples include: cash, banking accounts, property, cash surrender values to life insurance, retirement accounts, etc.

Process:

- Ask the participant for information regarding their joint assets. Request to review verifications (bank account statements, life insurance policies, benefit statements, etc).

Coding:

- If the participant does not have a spouse or a joint asset, leave boxes blank.
- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- **Savings**
- **Checking**
- **Equity Value/Real Estate**
- **Stock/Securities**
- **CD/IRA/Money Market**
- **Cash Value Life Insurance**
- **Trade-In Value of Second Car**
- **Other Asset 1**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 2**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Other Asset 3**
    - If the type of asset is not listed below, enter here and provide a description of source in the text box.
- **Assets: Subtotal for Joint:**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Total Countable Assets:

Definition:

- Combined total assets for the participant's household.

Process:

- This automatically calculated within COMPASS, based on adding the amounts listed for "assets subtotal for participant", "assets subtotal for spouse", and "assets subtotal for joint".

Coding:

- N/A
- **Name on joint account:**
    - If there are joint assets, type the name listed on the joint accounts.

Total assets are at or below the limit for an individual or for a participant with a community spouse:

Definition:

- The asset limit used by MDHHS for determining asset eligibility for married couples applying for the MI Choice Waiver program.

Process:

- Review asset information and compare against Mi Choice Waiver program asset limits.

Coding:

- Select from the following options:
    - **No**
    - **Yes**

Current Monthly Household Expenses:

Definition:

- A breakdown of the general living expenses on a monthly basis. This includes recurring expenses, such as rent/mortgage payment and utilities, as well as variable expenses like groceries, clothes, haircuts, etc.

Process:

- Ask the participant about all of their monthly expenses.

Coding:

- Enter numerical amounts in the corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- If the participant does not have an expense in a listed area, leave it blank.
- **Rent/House**
- **Heat**
- **Electricity**
- **Telephone**
- **Cell Phone**
- **Food**
- **Car Payment**
- **Home Insurance**
- **Car Insurance**
- **Life Insurance**
- **Property Tax**
- **Charge Cards**
- **Water/Sewer**
- **Cable TV**
- **Internet Access**
- **Transportation Expenses**
- **Installation Payments**
- **Other Expense 1**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Other Expense 2**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Other Expense 3**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.

Total Monthly Household Expenses

Definition:

- Combined total expenses for the participant's household.

Process:

- This automatically calculated within COMPASS, based on adding the amounts for all types of expenses listed.

Coding:

- N/A

Comments on Household Expenses:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information related to the participant's monthly household expenses.

Process:

- Document all pertinent information related to the participant's monthly expenses.
- Provide further explanation related to any selections made as specified above, if needed.

Coding:

- Using printed letters and text

Monthly Medical Expenses: Participant

Definition:

- A breakdown of the participant's monthly medical expenses.

Process:

- Ask the participant about all of their monthly expenses related to their medical care.

Coding:

- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- If the participant does not have an expense in a listed area, leave it blank.
- **Prescriptions**
- **Health Insurance**
- **Medical Transport**
- **Dr. Office**
- **Personal Care**
- **Over the Counter Medications**
- **Durable Medical Equipment (DME)**
- **Medical Bills**
- **Medicare Premium**
- **Medicare Part D Premium**
- **Other Medical Expense 1**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Other Medical Expense 2**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Monthly Medical Expenses: Subtotal for Participant**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Monthly Medical Expenses: Spouse

Definition:

- A breakdown of the participant's spouse's monthly medical expenses.

Process:

- Ask the participant about all of their spouse's monthly expenses related to their medical care.

Coding:

- Enter numerical amounts in corresponding boxes; whole numbers only. For numbers with decimals, round to nearest dollar.
- If the participant does not have a spouse, leave blank
- If the participant does not have an expense in a listed area, leave it blank.
- **Prescriptions**
- **Health Insurance**
- **Medical Transport**
- **Dr. Office**
- **Personal Care**
- **Over the Counter Medications**
- **Durable Medical Equipment (DME)**
- **Medical Bills**
- **Medicare Premium**
- **Medicare Part D Premium**
- **Other Medical Expense 1**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Other Medical Expense 2**
    - If the participant has an ongoing expense not listed below, enter here and provide a description of source in the text box.
- **Monthly Medical Expenses: Subtotal for Spouse**
    - Automatically calculated by COMPASS based on numerical amounts entered in above boxes.

Total Monthly Medical Expenses

Definition:

- Combined total medical expenses for the participant's household.

Process:

- This automatically calculated within COMPASS, based on adding the amounts for "monthly medical expenses: subtotal for participant" and "monthly medical expenses: subtotal for spouse".

Coding:

- N/A

Total Monthly Expenses:

Definition:

- Participant's total monthly expenses.

Process:

- This automatically calculated within COMPASS, based on adding the amounts for all types of expenses listed.

Coding:

- N/A

Variance:

Definition:

- The difference between the participant's total income and the participants total expenses.

Process:

- This automatically calculated within COMPASS, based on subtracting the participant's total monthly expenses from the participant's total household income.
- If the participant has a negative variance, this should be addressed through further discussion as it is a "social determinant of health" and then documented in the "Description of Conditions Noted Above" and/or "Comments on Expenses".

Coding:

- N/A

Comments on Expenses

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information related to the participant's total monthly expenses.

Process:

- Document all pertinent information related to the participant's total monthly expenses.
- Provide further explanation related to any selections made as specified above, if needed.

Coding:

- Use printed letters/text

Income is adequate to meet expenses and needed purchases

Definition:

- Participant's monthly income, from all sources, is enough to cover the cost of their total monthly expenses.

Process:

- Review the total variance. If it is negative number, then the participant's income is not adequate. If it is a positive number, then the participant's income is adequate.
- Again, if the participant's income is not adequate to meet their expenses, this should be addressed through further discussion as it is a "social determinant of health" and then documented in the "Description of Conditions Noted Above".

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Participant has excessive expenses

Definition:

- The participant's monthly expenses exceed their available income and assets on an ongoing basis.

Process:

- Review the total variance and if the income is adequate to meet expenses. If expenses exceed what the participant can afford, the participant would have excessive expenses.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- If Yes, explain why in the comment box provided. Be sure to include information regarding the expenses.

Participant has unaddressed debt

Definition:

- The participant has debt that they are not paying or attempting to pay.

Process:

- As the participant if they have any outstanding debts that they are not currently paying or attempting to pay. If they do, ask if they have plans to contact the companies/entities to negotiate a payment plan.
- This refers to debt that the participant is aware of but isn't paying and has no intention to pay.

Coding:

- Select from the following options
  - **No**
  - **Yes**
- If yes, explain why in the comment box provided. Be sure to include detailed information regarding the source and amounts of the unaddressed debt.
- If they have contacted the company/entity regarding the debt and are working to set up a payment plan, then the participant is addressing the debt and you would mark "No".

Participant who handles participant's finances

Definition:

- The participant responsible for paying monthly bills, budgeting, and managing the household finances.

Process:

- Ask the participant who manages the household finances.

Coding:

- Use printed letters/text
- Enter the First and Last Name
- Enter the Area code and Phone Number.
- If the participant manages their own finances, enter "Self" into the name box.

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.
- All the participant's financial information must be reviewed annually. Enter the date of the most recent annual financial review in the box.
- If opening to the Mi Choice Waiver, SC must ensure that the amounts listed within this section of the assessment are in line with the income and asset limits as determined by MDHHS.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

SW Section A - Identifying Information

- This purpose of this section is to document important details regarding the assessment being completed (the type, location, and those present), as well as gathering more of the participant's detailed identifying information.

- Information gathered in this section will be vital to developing an appropriate Person-Centered Service Plan as the participant is prompted to express their goals of participant in the program as well as gathering information regarding the participant's strengths, characteristics, goals, etc.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Others Present:

Definition:

- All individuals present at the assessment, excluding the participant.

Process:

- List each individual present at the time of assessment, their relation to the participant, as well as how they are participating – i.e. in participant's home, by phone, virtually by video, etc.

Coding:

- Use printed letters/text

Place of Assessment:

Definition:

- The location where the assessment is being completed.

Process:

- Select the location that best fits where the assessment is being completed.

Coding:

- Select from the following options:
    - **Home** – Participant's primary residence
    - **Hospital** – Inpatient or Emergency Medical Facility
    - **NH/Institution** – Nursing Facility or Long-Term Care Facility
    - **Adult Foster Care/Home for the Aged –** Licensed Residential Setting
    - **Other** – any other reason not listed
        - If "Other" is selected, you must document the type of location in the "Description of Conditions Noted Above".

Assessment Reason:

Definition:

- Purpose or reason for the assessment.

Process:

- Select the type or purpose for the assessment that best fits the situation.

Coding:

- Select from the following options:
    - **First assessment** — An assessment that is done at the time of entry into the home care system, or when initially determining eligibility for home care/home health services.
    - **Routine reassessment** — A regularly scheduled follow-up assessment to ensure that the care plan is appropriate and current.
    - **Return assessment** —An assessment conducted when the participant returns from the hospital or reenters the home care system after a planned absence.
    - **Significant change in status reassessment** — A comprehensive reassessment conducted at any time during the uninterrupted course of care because the participant's status or condition has significantly changed. Code "return assessment" if the change in status is accompanied by a hospital stay.
    - **Other (e.g. research)—** Any assessment conducted outside of the established assessment schedule for reasons such as quality assurance, clinical research, confirmation of the appropriateness of the current plan (not the routine "follow-up" assessment), development of acuity scale, community needs assessment, etc.
        - If "Other" is selected, you must document the type of assessment and why in the "Description of Conditions Noted Above".

Reason for Late Assessment:

Definition:

- An assessment is considered "late" when it is completed AFTER the due date. The due date is based on the frequency outlined in program requirements or as requested by the participant (i.e. 90 days, 365 days, etc.)

Process:

- Confirm the assessment due date within the COMPASS file or on the COMPASS dashboard.

Coding:

- Select from the following options:
    - **No Selection** – All Initial Assessments and any subsequent reassessments that are completed by the due date
    - **Participant institutionalization** – The Supports Coordinator was unable to complete the assessment on time due to the participant currently residing in a facility or institution.
    - **Agency Scheduling Issue** – The Supports Coordinator was unable to complete the assessment on time due to the Supports Coordinator's availability
    - **Participant Choice/Scheduling Issue** – The Supports Coordinator was unable to complete the assessment on time due to the Participant's availability or request/choice.
    - **Inclement Weather** – The Supports Coordinator was unable to complete the assessment on time due to unsafe driving or weather conditions.
    - **Other** – any other reason not listed
        - If "Other" is selected, you must document the reason why in the "Description of Conditions Noted Above".

Marital Status at this Assessment:

Definition:

- The marital status of the participant at the time of the assessment.

Process:

- Ask the participant their current marital status

Coding:

- Choose the answer that describes the current marital status of the participant. If the participant is in a common-law relationship, code as married. If the participant is in a same-sex relationship that is legally recognized as a marriage, code as married. If the participant is in a long-term same-sex relationship that is not legally recognized as a marriage, code as partner/significant other.
- Select from the following options:
    - **Never married** – The participant was never legally married
    - **Married** – The participant is currently married
    - **Widowed** – The participant's spouse is deceased
    - **Separated** – The participant is legally separated from their spouse
    - **Divorced** – The participant is legally divorced
    - **Other** – Any other status not listed
        - If "Other" is selected, you must document the details in the "Description of Conditions Noted Above".
    - **Partner/Significant Other** – The participant has a significant other or partner but is not legally married.

Residential/Living Status at Time of Assessment:

Definition:

- The participant's residence at the time of the current assessment. This could be different from the location of the assessment and may be long-standing or temporary.

Process:

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

Coding:

- Select from the following options:
    - **Private home/apartment/rented room** — Any house, condominium, apartment, or room in the community, whether owned or rented by the participant or another party. Also included in this category are retirement communities or independent housing for older adults or the disabled.
    - **Board and care** — A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
    - **Assisted living or semi-independent living —** A second type of non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
    - **Mental health residence – e.g., psychiatric group home** — A residential setting for adults with mental health problems who need supervision and limited services (meals, housekeeping).
    - **Group home for participants with physical disability —** A setting that provides services to participants with physical disabilities. Typically, people live in group settings with 24-hour staff presence. Individuals are encouraged to be as independent and active as possible.
    - **Setting for participants with intellectual disability** — A setting that provides services to participants with intellectual disabilities. Typically, people live in group settings with 24-hour staff presence, but are encouraged to be as independent and active as possible.
    - **Psychiatric hospital or unit —**A psychiatric hospital that focuses on the diagnosis and treatment of psychiatric disorders and which is separate from other inpatient facilities, such as an acute, rehabilitation or chronic hospital. A psychiatric unit is a dedicated care unit located in a general hospital that is dedicated to the diagnosis and treatment of psychiatric disorders. This category also includes state and federal psychiatric hospitals.
    - **Homeless (with or without shelter)** — A homeless participant does not have a fixed residence (e.g., a house, apartment, room, or place to stay on a regular basis). The participant may live on the streets, or outside in wooded or open areas. The participant may sleep in cars, abandoned buildings, under bridges, etc. People who are homeless may or may not take advantage of existing homeless shelters.
    - **Long-term care facility (nursing home) —** A licensed health care facility that provides 24-hour skilled or intermediate-level nursing care.

- **Rehabilitation hospital/unit** — A licensed rehabilitation hospital that focuses on the physical and occupational rehabilitation of individuals who have experienced disease or injury with subsequent decline in physical function. A rehabilitation unit is located within an acute care hospital and focuses on the acute rehabilitation of individuals who have experienced disease or injury with a subsequent decline in physical function.
- **Hospice facility/palliative care unit** — A hospice facility (or unit within a facility providing more general care) provides care to participants who have a terminal illness with a prognosis of less than 6 months to live as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the participant and family. Palliative care is the care of participants whose diseases are not responsive to curative treatments. It targets pain and symptom relief without precluding use of life-prolonging treatments. Palliative care is often provided from the time a participant is diagnosed with a life-threatening illness.
- **Acute care hospital —** A facility licensed as an acute care hospital that focuses primarily on the diagnosis and treatment of acute medical disorders.
- **Correctional facility** — Any jail, penitentiary, or halfway house operated by a local, state, or federal government to care for and house people who have been sentenced to incarceration by a criminal court.
- **Other** –Any other type of setting not listed above.
    - If "Other" is selected, you must document the type of residence in the "Description of Conditions Noted Above"

Who participant lived with at time of referral (assessment) or currently lives with (reassessment):

Definition:

- Who the participant lives with and the duration of this arrangement. These items will help the home care staff determine the need for more, less, or different services.

Process:

- Ask the participant or family member who the participant lives with and whether this living arrangement has changed in the last 90 days.

Coding:

- Record the code that reflects who the participant is living with presently. Note that this excludes any temporary arrangements in living made while home care services are being set up.
- Select from the following options:
    - **Alone** — includes participant who lives only with a pet, lives on the streets or is homeless (whether or not uses shelters).
    - **With spouse/partner only** — includes spouse/partner, girlfriend or boy-friend, common-law marriage, or long-term, same-sex relationship.
    - **With spouse/partner and other(s)** — lives with spouse or partner and any other individuals, whether family or unrelated.
    - **With child (not spouse/partner) —** lives with child(ren) only, or with child(ren) and other individuals, but NOT with spouse or partner.
    - **With parents(s) or guardian(s)** — lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individuals, but NOT with spouse or partner or child(ren).
    - **With sibling(s)** — lives with sibling(s) only, or with sibling(s) and other individuals, but NOT with spouse or partner, child(ren), or parent(s) or guardian(s).
    - **With other relative(s)** — lives with a relative (such as aunt or uncle) other than spouse or partner, child(ren), parent(s), or sibling(s).
    - **With non-relative(s)** — lives in a group setting (e.g., boarding home, long-term care facility, group home, jail) or in shared accommodation with non-relative(s) (e.g., roommate). Excludes single overnight stays, such as in a homeless shelter.

Residential History Over Last 5 Years:

Definition:

- The settings in which the participant resided during the 5 years prior to the initial assessment.

Process:

- Ask the participant and caregivers to list any residences where the participant has lived in the 5 years previous to the assessment. Review any available documentation.

Coding:

- Select from the following options for each setting listed:
  - **No**
  - **Yes**
- **Long term care facility (e.g., nursing home) —** A licensed health care facility that provides 24-hour skilled or intermediate-level nursing care.
- **Mental health residence (e.g., psychiatric group home)** — A residential setting for adults with mental health problems who need supervision and limited services (meals, housekeeping).
- **Psychiatric hospital or unit** — A hospital that focuses on the diagnosis and treatment of psychiatric disorders and which is separate from other in-patient facilities, such as an acute, rehabilitation or chronic hospital. A psychiatric unit is a dedicated care unit located in a general hospital that is dedicated to the diagnosis and treatment of psychiatric disorders. This category also includes state and federal psychiatric hospitals.
- **Board and care home, assisted living** — A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, meal service, transportation, etc.
- **Setting for participants with intellectual disability —** A setting that provides services to participants with intellectual disabilities. Typically, such participants live in group settings with 24-hour presence of staff. Participants are encouraged to be as independent and active as possible.

About Me:

Definition:

- The participant's reported strengths, abilities, desires, choices, interests, likes, dislikes, etc.

Process:

- Ask the participant how they would described themselves. You can also ask follow up questions regarding their interests, strengths, unique characteristics, etc.
- Make sure to make note of exactly what the participant says as this should be recorded verbatim.

Coding:

- Use printed letters/text in the corresponding text box
- Record the participant's answers verbatim using "I" language.
- If the participant is unable to respond due to a cognitive or communication issue, this can be answered by a family member or caregiver. There must be supporting documentation of the issue preventing the participant from providing an answer in this section, i.e. Door 2 eligibility, dementia diagnosis, etc.

Participant's Expressed Goals of Care:

Definition:

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

Process:

- Talk to the participant and phrase your questions about goals of care in the most general way possible. For example, ask: How can we help you? Why are you getting (or applying for) services? What benefits do you expect to get? What changes in yourself do you hope will occur? Encourage the participant to express personal goals in his/her own words.
- Use this box to document outcomes that the participant hopes to achieve as a result of receiving services. These outcomes may relate to almost anything, including improved functional performance, a return to health, increased independence, an ability to maintain community residence, improved social relations, etc.
- Some participants will be unable to articulate a goal, expected outcome, or even a reason for seeking services. They may say they do not know or that they are getting service at the request of a relative. All of these are reasonable responses. Do not make inferences about what you or other clinicians believe should be goals of care. Follow your usual agency policy if the participant asks you for clarification on what they might expect from services.

Coding:

- Use printed letters/text in the corresponding text box
- Record the participant's verbatim response using "I" language.
- If the participant is unable to respond due to a cognitive or communication issue, this can be answered by a family member or caregiver. There must be supporting documentation of the issue preventing the participant from providing an answer in this section, i.e. Door 2 eligibility, dementia diagnosis, etc.

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section B - SW Social Functioning

Social Relationships:

- The purpose of this section is to document and describe the participant's interaction patterns and adaptation to his or her social environment, and to assess the degree to which the participant is involved in social activities, meaningful roles, and daily pursuits.

- Information gathered within this section can be used to determine potential barriers related to Social Determinates of Health (SoDH), as well as potential concerns with abuse and/or neglect. The section also addresses aspects of the participant's social functioning that may affect their mental and physical health.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Participation in social activities of long-standing interest:

Definition:

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

Process:

- Talk with the participant and ask for their point of view.
- Ask the participant what activities does she or he enjoy participating in? When was the last time she or he was able to participate?
- Ask if there have been any changes has occurred and gather information to determine the participant's subjective response to those changes.
- If possible, speak with the family, caregivers, or other informal contacts (e.g., neighbors) to get their opinions or additional insight.

Coding:

- Select from the following options:
    - **Never**
    - **More than 30 days ago**
    - **8 to 30 days ago**
    - **4 to 7 days ago**
    - **In last 3 days**
    - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relationships.

Visit by a long-standing social relation or family member:

Definition:

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

Process:

- Talk with the participant and ask for their point of view.
- Who tends to come to visit, and when was the last time that individual visited?
- Ask if there have been any changes has occurred and gather information to determine the participant's subjective response to those changes.
- If possible, speak with the family, caregivers, or other informal contacts (e.g., neighbors) to get their opinions or additional insight

Coding:

- Select from the following options:
    - **Never**
    - **More than 30 days ago**
    - **8 to 30 days ago**
    - **4 to 7 days ago**
    - **In last 3 days**
    - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relationships.

Other interaction with long-standing social relation or family member:

Definition:

- The participant interacted through a means other than a face-to-face visit with a family member, friend or social acquaintance with a long-standing relationship with the participant (e.g., neighbor, fellow member of community organization or religious group).
- As above, the focus is on well-established, informal ties rather than contacts by paid staff, volunteers or new acquaintances.
- Examples: Telephone call; Email; Facetime

Process:

- Talk with the participant and ask for their point of view.
- Are there other ways the participant contacts family or friends (e.g., telephone, e-mail)?
- Ask if there have been any changes has occurred and gather information to determine the participant's subjective response to those changes.
- If possible, speak with the family, caregivers, or other informal contacts (e.g., neighbors) to get their opinions or additional insight

Coding:

- Select from the following options:
    - **Never**
    - **More than 30 days ago**
    - **8 to 30 days ago**
    - **4 to 7 days ago**
    - **In last 3 days**
    - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relationships.

Conflict or anger with family or friends:

Definition:

- The participant expresses feelings such as abandonment, ingratitude on part of the family, lack of under-standing by close friends, or hostility regarding relationships with family or friends.

Process:

- Talk with the participant and ask for their point of view.
- Is the participant generally content or unhappy in relationships with family and friends? If the participant is unhappy, what specifically is he or she unhappy about?
- Ask if there have been any changes has occurred and gather information to determine the participant's subjective response to those changes.
- If possible, speak with the family, caregivers, or other informal contacts (e.g., neighbors) to get their opinions or additional insight

Coding:

- Select from the following options:
    - **Never**
    - **More than 30 days ago**
    - **8 to 30 days ago**
    - **4 to 7 days ago**
    - **In last 3 days**
    - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relation-ships.
    - **Example:** Mr. H. tells the assessor he has to do what his daughter says or "she gets mad with me." He said that he sees her every weekend and she "bosses" him around. When the assessor talks to his daughter, she reports no conflict
    - Code as "4-7 days ago" as the participant openly expresses conflict in last week

Fearful of a family member or close acquaintance:

Definition:

- The participant expresses (verbally or through behavior) fear of a family member or close acquaintance.

Process:

- Talk with the participant and ask for their point of view.
- Fear can be expressed in many ways. Ask if the participant is afraid of fearful of any family member or close acquaintance.
- Look for non-verbal cues. A participant may appear to withdraw whenever the caregiver is around.
- Ask if there have been any changes has occurred and gather information to determine the participant's subjective response to those changes.
- If possible, speak with the family, caregivers, or other informal contacts (e.g., neighbors) to get their opinions or additional insight

Coding:

- Select from the following options:
  - **Never**
  - **More than 30 days ago**
  - **8 to 30 days ago**
  - **4 to 7 days ago**
  - **In last 3 days**
  - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relationships.
- If non-verbal cues lead the Supports Coordinator to believe that the participant may be fearful of a family member or close acquaintance, code based on the participant and/or representative's answer. Document concerns and observations in the Description of Conditions Noted Above box.

Neglected, abused, or mistreated:

Definition:

- The participant experienced a serious or life-threatening situation or condition that went untreated or appropriately acknowledged. The situation may have put the participant at risk of death, or other complications that impinge on physical and mental health.

Process:

- Talk with the participant and ask for their point of view.
- Ask the participant if they have been neglected, abused, or mistreated. Based on their response, you may need to gather more details regarding the specifics of their experience.
- If it is a recent or ongoing concern, as mandated a reporter, you will need to report this concern or allegation MDHHS Adult Protective Services.

Coding:

- Select from the following options:
  - **Never**
  - **More than 30 days ago**
  - **8 to 30 days ago**
  - **4 to 7 days ago**
  - **In last 3 days**
  - **Unable to determine**
- Note: Use "Unable to Determine" if no information is available from the participant or other informants about the participant's social relationships.
- If non-verbal cues lead the Supports Coordinator to believe that the participant may be abused, neglected, or mistreated code based on the participant and/or representative's answer. Document concerns and observations in the Description of Conditions Noted Above box.

Change in Social Activities in the LAST 90 DAYS (or since last assessment):

Definition:

- Identify a recent change (as compared to 90 days ago — or since the last assessment if less than 90 days) in the participant's level of participation in social, religious, occupational or other preferred activities. If the level of participation has declined, determine if the participant is distressed by it.

Process:

- Ask the participant if they have experienced a recent change in their level of participation in activities of interest. The level of participation refers to the quantity (how many) of different types of social activities; the intensity (e.g., how frequently contact occurs); and the quality of the activity (e.g., how deeply the participant is involved). Remote participation is equally important and significant for the participant's role fulfillment and self-esteem (e.g., a participant who cannot move outside her or his home may still participate or be associated with some kind of religious, political, or social activity).
- If a decline occurred, ask how the participant feels about this decline. Are they distressed? Distress occurs when the participant's mood is adversely affected by a recent change in the level of participation (e.g., as evidenced by sadness, loss of motivation or self-esteem, anxiety, depression, etc.).

Coding:

- Select from the following options:
    - **No Decline** (e.g., there was no change or there was an increase in the participant's level of participation in social activities)
    - **Decline, not distressed** – if the participant experienced a decline in his or her level of participation in social activities without a corresponding increase in the participant's distress
    - **Decline, distressed** -- if both decline and distress are observed or reported

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

Definition:

- The amount of time the participant is literally alone without any other participant in the home.

Process:

- Ask the participant how much time they spend "alone". Be clear about what is defined as "being alone".
- Confirm with caregivers the amount of time the participant spends "alone".
- Take note of the length of time they are alone during the day (morning and afternoon) -- If the participant is residing in a board and care facility, congregate housing, or other situation where there are other participants in their own rooms, count the amount of time the participant spends alone in his or her room by him/herself as time alone.

Coding:

- Select from the following options:
  - **Less than 1 hour**
  - **1 - 2 hours**
  - **More than 2 hours but less than 8 hours**
  - **8 hours or more**

Participant Says or Indicates that They Feel Lonely:

Definition:

- The participant makes statements that indicate a sense of loneliness. The participant may feel that others do not visit enough or desire more social interaction even if visited regularly. Others may also report that the participant sometimes comments on feeling lonely.

Process:

- Talk with the participant to determine whether or not he/she feels lonely. If possible, speak with the participant's family or other informal contacts (e.g., neighbor) to get their perception of the participant's feelings of loneliness.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Major Life Stressors in Last 90 Days:

Definition:

- Life stressors are experiences that either disrupted or threatened to disrupt a participant's daily routine and that imposed a degree of readjustment.

Process:

- Ask the participant if any stressful events have occurred in the last 90 days. Examples may include a severe episode of personal illness; the death or severe illness of a close family member or friend; the loss of the participant's home; a major loss of in-come or assets; being the victim of a crime such as robbery or assault; the loss of the participant's driving license or car, etc.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section C - SW Informal Support Services:

- The purpose of this section is to determine, document and describe the participant's informal support system or caregiver network. This section pertains to the participant's informal relationships, not those with individuals performing a formal service through an agency. It is also designed to assess the reserves of the informal caregiver support system and identify any need for resources or additional support.

- Information gathered within this section can be used to determine potential barriers related to Social Determinates of Health (SoDH), as well as potential concerns with caregiver's access to resources, caregiver burnout, and limitations within the participant's informal network.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the names of the caregivers, tasks that they perform, important information, any concerns, barriers, or potential issues, must be documented. Make sure to include the resources in place, whether they are sufficient to meet the participant's needs, and note any gaps to address. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

- ALL individuals identified in this section as informal supports or caregivers and anyone who will be listed in the participant's PCSP, must be listed in the "Caregiver" tab within the Next Assessment.

Informal helper(s) is unable to continue in care activities:

Definition:

- Informal helper(s) is unable to continue in caring activities (e.g., decline in health of caregiver makes it difficult to continue). —The caregiver, participant, or assessor believes 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.

Process:

- Ask the informal caregiver and participant separately about the caregiver's ability to continue providing care.
- For these items, you need to consider the current situation and also project future needs. The caregiver may be willing and able to continue, but the participant may feel like he or she is a burden and state that the caregiver cannot continue. Take this information into consideration and use your clinical judgment to make the assessment. This is a sensitive issue and should be handled carefully. Listen carefully to what is being said.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Primary informal helper expresses feelings of distress, anger, or depression

Definition:

- Primary caregiver expresses, by any means, that he/she is distressed, angry, depressed or in conflict because of caring for the participant.

Process:

- Ask the informal caregiver(s) and the participant separately about the caregiver's feelings of distress, anger, or depression or expression of such feelings.
- Be mindful that this might be a difficult subject to discuss in front of the participant and be sensitive to the current situation. Listen carefully to what is being said and use your clinical judgment to make the assessment.
- Depending on the caregiver(s) answers or responses, you may want to gather further information about "why" they feel that way. Is it a lack of caregiver resources? Is it a lack of caregiver support? Discuss and provide potential resources available through the MI Choice Waiver and/or external community resources that may be available to them. Document any and all interventions or resources discussed and/or provided.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Family or close friends report feeling overwhelmed by participant's illness:

Definition:

- Family members or close friends of the participant indicate that they are having trouble handling the illness. They may vocalize their feelings of being "overwhelmed" or "stressed out".

Process:

- Ask the informal caregiver(s) and the participant separately about the caregiver's feelings of being overwhelmed or expression of those feeling.
- Be mindful that this might be a difficult subject to discuss in front of the participant and be sensitive to the current situation. Listen carefully to what is being said and use your clinical judgment to make the assessment.
- Depending on the caregiver(s) answers or responses, you may want to gather further information about "why" they feel that way. Is it a lack of caregiver resources? Is it a lack of information regarding the participant's illness? Discuss and provide potential resources available through the MI Choice Waiver and/or external community resources that may be available to them. Document any and all interventions or resources discussed and/or provided.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Hours of Informal Care and Active Monitoring:

Definition:

- The number of hours informal helpers spent assisting the participant in instrumental and personal activities of daily living, including active monitoring, over the last 3 days.
- Include all people that provide assistance to the participant (e.g., family, friends, and neighbors). They may or may not be the primary caregiver. Instrumental activities of daily living include: meal preparation, housework, managing finance. Personal activities of daily living include: mobility in bed, dressing, toilet use.

Process:

- Consult with the participant about hours of care over the last 3 days. Confirm information with the primary caregiver.
- Make note if the last three days is not indicative of normal care trends.

Coding:

- Use numbers only
- Record the total amount of help the participant received from family, friends or neighbors, over last 3 days.
    - For example, if family members, friends and neighbors provided 120 minutes (2 hours) each day, the total number of hours for help received during the last 3 days is 6.
    - Round minutes to the nearest hour. For example, 12 hours and 45 minutes should be coded as 13 hours

Strong and Supportive Relationship with Family:

Definition:

- The participant indicates he or she has a supportive relationship with family members

Process:

- Ask the participant if they feel as though they have a strong and supportive relationship with their family.
- Make sure to code based on the participant's response. The participant may feel they can "rely on" family members. Family members may be actively involved in the participant's physical care, emotional support, maintaining the household, managing finances, or in helping the participant make medical decisions.

Coding:

- Select from the following options:
    - **No**
    - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section D: SW Environmental Home Environment

- The purpose of this section is to determine if the participant's physical home environment is hazardous or uninhabitable. It is also used to determine if the participant has environmental barriers or safety risks within their home that will impact their ability to meet their goals. Information gathered within this section can be used to determine potential barriers related to Social Determinates of Health (SoDH).

- By completing a thorough home assessment, the Supports Coordinator has the opportunity to discuss any safety risks, fall/trip hazards, and/or accessibility issues observed or discussed, and provide recommendations for environmental or accessibility adaptations or equipment that may improve the participant's independence and safety.

- Ask the participant (or family member) for permission to walk through the home. Look for evidence of the problem areas noted in this section. Talk to the participant (and family member if necessary) about any areas that you cannot assess yourself through visual inspection.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Disrepair of the home:

Definition:

- Any hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors, holes in floor, leaking pipes.

Process:

- Take note of any observations during the home walk-through.
- Ask the participant if they have any repair issues with the home or safety concerns.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Squalid condition:

Definition:

- Home would be considered extremely dirty. There may be dried urine, feces, or dried food on the floor, or infestation by insects or vermin (e.g., mice, rats). For an environment to be coded as "squalid," the condition is much more deteriorated than "usual" clutter and household dust and dirt accumulated over a week or so.

Process:

- Take note of any observations during the home walk-through.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Inadequate heating or cooling:

Definition:

- Heating and cooling systems may be inadequate (e.g., too hot in summer or cold in winter) or inappropriate (e.g., too cold in summer or hot in winter and not controllable by the participant or caregiver).

Process:

- Ask the participant if they have any issues heating or cooling their home

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Lack of personal safety:

Definition:

- The participant has a fear of violence in their home environment, including feeling at risk for violence within or immediately outside of his or her home. This can include a real or perceived risk of someone breaking into the home, or of being attacked while getting mail, visiting neighbors, or when leaving and returning home.

Process:

- Ask the participant if they feel safe in their current home environment and neighborhood.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Limited access to home or rooms in home:

Definition:

- The participant has difficulty entering or leaving the home; unable to climb stairs; difficulty maneuvering within rooms; no railings although needed. There are physical problems with the building that limit access, for example, a participant lives on the second floor and must enter or leave on unstable outside stairs; the participant lives in a multi-story building in which the elevator is often broken, or no stair rails are available.

Process:

- Ask the participant if they have any difficulty moving throughout their home. Are there areas they are unable to access within their home?
- Document any observations of how the participant moves through their home while on the walkthrough.

Coding:

- Select from the following options:
  - **Yes**
  - **No**

Living Arrangement. As compared to 90 days ago, person now lives with someone new:

Definition:

- The participant has moved to live with a new person or has had other people move in with them in the last 90 days, or since the last assessment.

Process:

- Ask the participant if they have recently moved or if anyone has recently moved in with them.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- If the participant had a spouse or other individual with whom they lived and that individual has passed away in the last 90 days, code as "Yes".

Participant or relative feels the participant would be better off living elsewhere:

Definition:

- The participant and family member/caregiver believe that the participant would be better off living somewhere other than their current residence.

Process:

- Ask the participant and family member/caregiver separately whether either believes there should be a change in living arrangements.
- Be sensitive to how the question is raised. For example, do you believe the participant would be better off living elsewhere (e.g., would be happier/less isolated, would have their needs met better, would be safer, would have access to more nutritious meals, etc.)?

Coding:

- Select from the following options:
  - **No**
  - **Yes, other community residence**
  - **Yes, institution**

Person Chooses to Live:

Definition:

- Where the participant prefers to live.

Process:

- Ask the participant where they would like to live and document their response.
- If this is different from their current home environment, document why and determine if the participant would like to pursue a change of residence. The Supports Coordinator may need to assist with this process, if requested by the participant.

Coding:

- Use printed letters/text

Housing Assessment - Person Lives in:

Definition:

- The type of residence/home environment the participant resides in at the time of the assessment.

Process:

- Use your observations about the home environment to make the best assessment of the type of residence. If needed, ask the participant for clarification.

Coding:

- Select from the following options:
    - **House**
    - **Apartment**
    - **Residential Group Home**
    - **Other**
        - If "Other" is selected, use printed text to specify the type of residence, if applicable, in the line provided.

Person:

Definition:

- How the participant finances their living environment/residence.

Process:

- Ask the participant if they own, rent, or have a different arrangement for financing their current living environment.

Coding:

- Select from the following options:
  - **Owns**
  - **Rents**
  - **Other**
    - If "Other" is selected, use printed text to specify how the residence is financed, if applicable, in the line provided.

Lives in Apartment or House Re-Engineered:

Definition:

- The residence has been modified in some way to be more accessible for participants with disabilities. This includes the completed installation of equipment or modifications made to the home/residence (i.e. ramp; grab bars; widened doorways; bathroom modification, etc).

Process:

- Take note of any observations during the walkthrough.
- Ask the participant if they have made any modifications to the home environment or equipment in the home that has been installed to make it more accessible for them.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Outside Environment:

Availability of emergency assistance:

Definition:

- The participant has access to emergency assistance. This could be by means of a telephone, or speed dialing option on the telephone, or an emergency response system.

Process:

- Ask the participant how they would notify emergency services.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- Note the type of access to emergency assistance in the "Description of Conditions Noted Above"

Accessibility to grocery store without assistance:

Definition:

- The participant is able to go to the grocery store and make purchases without assistance. The participant may travel to the grocery store by walking, driving or riding a car, or riding in a bus, trolley, subway or cab.

Process:

- Ask the participant how they get their groceries.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Availability of home delivery of groceries:

Definition:

- The participant has the option/availability of having groceries delivered to their home.

Process:

- Ask the participant if they have the ability to have groceries delivered to their home.
- Code regardless of whether or not the participant is using such a service at the present time. If there are delivery services available in the area, code accordingly.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Finances:

Definition:

- The participant's limited funds have prevented the participant from receiving required medical and environmental support.

Process:

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

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Cooking facilities and refrigerator on premises:

Definition:

- The participant has a refrigerator and the ability to cook a meal in their current residence.

Process:

- Ask the participant if they have a refrigerator and the ability to cook at their home.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Microwave on premises:

Definition:

- The participant owns or has access to a microwave in the home.

Process:

- Ask the participant if they have access to a microwave.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Telephone accessible and usable:

Definition:

- The participant has access to a working phone in the home. It can be a landline or cell phone.

Process:

- Ask the participant if they have access to a phone and working/up-to-date phone service.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Tub/Shower/Hot Water Accessible:

Definition:

- The participant has access to hot water to be used for bathing or personal care.

Process:

- Ask the participant if they are able to bathe in their current home environment.
- Ask if they can access their tub or shower.
- Ask if they have hot water available.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Pets:

Definition:

- The participant, or any other person in the home, owns a pet or domesticated animal.

Process:

- Ask the participant if there are any pets in the home.
- Take note of any observations or interactions with the pet.
- Notify the participant that there may be situations where they may have to put their pet up or out of the way while receiving in-home services. Ask if this will be an issue.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- If the participant does have a pet, make sure to note in the "Description of Conditions Noted Above" the amount, type, and temperament of the pet. Make sure to note if there are any safety concerns associated with the pet.

Smoke Detector:

Definition:

- The participant has working smoke detectors in the home.

Process:

- Ask the participant if there are working smoke detectors in the home.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Washer/Dryer Accessible:

Definition:

- The participant has access to a washer and dryer at their residence. It also counts if they live in an apartment and there are washers & dryers available to residents.

Process:

- Ask the participant how they complete their washing. Do they have access to a washer and dryer at the home or residence?

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Emergency Plan in Place:

Definition:

- The participant has a defined emergency plan that has been written out and can be reviewed with the Supports Coordinator.

Process:

- Ask the participant if they have a formal emergency plan in place and ask to make a copy of the emergency plan, if available.
- If they do not have one in place, let them know that you will be working with them to develop a contingency and back-up plan that will be part of their overall care plan.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Person is Homebound:

Definition:

- The participant is unable to leave the confines of their home due to their physical or medical limitations.

Process:

- Ask the participant if they are able to leave them home for any reason other than medical appointments?

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Will the Person need assistance to evacuate in case of emergency?:

Definition:

- The participant will need physical assistance or prompting to evacuate the home in case of an emergency. Without the assistance from an additional person, the participant would not be able to exit the home.

Process:

- Ask the participant if they would need any physical assistance to evacuate or leave the home in case of an emergency. Would they require any level of assistance?

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Are there other family members living in your home?:

Definition:

- There are other family members and/or individuals living in the home with the participant.

Process:

- Ask if there are family members or others living in the home. If there are, they should be listed in the "Description of Conditions Noted Above"

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If yes, will any other family member in home need assistance to evacuate in case of emergency?:

Definition:

- The participant's family member or any other individual living in the home will need physical assistance or prompting to evacuate the home in case of an emergency. Without the assistance from an additional person, this person would not be able to exit the home.

Process:

- Ask the participant, or the other family members/individuals if present at the assessment, if they will need any assistance to evacuate or exit the home in case of an emergency.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
- If the participant does not have other family members in the home, select "No Selection"

My Evacuation Plan is:

Definition:

- A formal plan for how the participant will evacuate their home in case of an emergency. This will be part of the formal back-up plan provided to the participant.

Process:

- Develop an evacuation plan with the participant. The evacuation plan should include:
  - What constitutes an emergency requiring evacuation?
  - Who in the home will need physical assistance to evacuate?
  - Who is able to provide the physical assistance?
  - All possible exits to be used during evacuation, specifically the exit(s) the participant will need to use to evacuate safely.
  - How the participant will contact emergency services/assistance – i.e. PERS, phone, 911.
  - Any equipment and/or medications that will need to be taken during evacuation, including details and location of a "go-bag' or other pre-packed emergency bag and who is responsible for grabbing it.
  - Where the participant could stay for a short-term period if the they could not return home.
- If the participant resides in an apartment complex, Adult Foster Care, Home for the Aged, or other residential facility and an evacuation plan is already established, make note within the section and make a copy of the evacuation plan, if available.

Coding:

- Use printed letters/text

Is there safe entry/exit to the home?

Definition:

- Any safety concerns or barriers for the participant to safely enter and exit the home.

Process:

- Ask the participant if they have any difficulty entering or exiting the home.
- Take note of any safety risks you observe as you are entering and exiting the home

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Are there safe pathways in the home clear of obstruction?

Definition:

- The participant has clear pathways within the home that allows them access to all necessary areas of the home. The areas are clear of trip hazards, fall risks, or safety concerns.

Process:

- Take note of any trip hazards, safety or fall risks during the walk through.
- Ask the participant if they are able to get to all necessary areas of the house safely.
- If there are fall or trip hazards in the home, educate the participant on fall risks and provide them with recommendations to remediate the concern.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Are there any stairs or steps in the house that the participant cannot safely negotiate?:

Definition:

- The participant's home contains steps or stairs that the participant is unable to use safely.

Process:

- Take note of any stairs and/or steps within the participant's home.
- Ask the participant if there are any stairs and/or steps that they have to use regularly in their home? Are they able to use them safely?

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Is there safe access to the bathroom?:

Definition:

- The participant is able to safely access and use the bathroom or designated toileting area.

Process:

- Take not of any barriers or safety issues related to the bathroom or the participant's designated toileting area.
- Ask the participant if they have any safety concerns or accessibility issues with using the bathroom or designated toileting area.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Are there grab bars around the tub and toilet?:

Definition:

- There are safety bars or grab bars installed in around the participant's tub and toilet.

Process:

- Take note of any observations of the tub and toileting areas. Do they have appropriate safety or grab bars. Towel bars used as grab bars should not be considered.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Is the participant able to use the stove safely?:

Definition:

- The stove in the home is in working order and the participant is able to access and use the stove safely.

Process:

- Take note of any observations regarding the cooking area, specifically the stove.
- Ask the participant if they are able to use their stove safely.
- Does the participant have any cognitive concerns that make using the stove unsafe?

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If not, what are the safeguards present?:

Definition:

- There are safeguards in place or adaptations made for safe stove use.

Process:

- If the participant is not able to use the stove safely, what safety plans or safeguards are in place to make sure that the participant does not experience injury or incident?

Coding:

- Use printed letters/text

Does the participant, or anyone in the household, smoke?

Definition:

- The participant and/or any other individuals living in the home smokes tobacco or other substance.

Process:

- Ask the participant if they smoke? Does anyone else in the home smoke?
- Is there medical Oxygen in use in the home? If so, provide education regarding the safety risks of smoking and using Oxygen.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Educated participant on identified safety risks:

Definition:

- The Supports Coordinator provided the participant with education and/or recommendations regarding any safety risks observed or discussed.

Process:

- If any safety risks were identified or observed during the home walkthrough or environmental assessment, provide the participant with recommendations and/or education to minimize any of those safety risks.
- Make sure to provide options for resources or interventions provided by the MI Choice Waiver or external agencies/organizations.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Home Safety Notes:

Definition:

- Any additional notes or information regarding the overall safety of the home environment.

Process:

- Add any additional information that is pertinent to the safety of the participant in their home. Add follow up or clarification to any of the answers provided for the above questions.

Coding:

- Use printed letters/text

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section E: SW Cognitive Patterns

- The purpose of this section is to record and assess the participant's cognitive functioning, ability to communicate and understand instructions, and the ability to process information about their care and medical needs. In addition to gathering information on the participant's regular cognitive functioning, this section gathers information related to the behavioral signs that may indicate that the participant is experiencing delirium (an acute, confused state). If identified and treated in a timely fashion, delirium can often be reversed.

- This section also provides insight into the participant's health literacy and the participant's ability to understand aspects of their medical condition or needs, understand potential treatments or medical interventions prescribed, and the ability to understand risks associated with behaviors or decision-making. A supplemental questionnaire and script regarding Health Literacy will need to be completed during this section as well. A summary of their responses and score will need to be added to the "Description of Conditions Noted Above" to confirm that the tool was utilized and provide insight into the participant's ability to comprehend information related to their medical needs and care. The hard copy of the questionnaire must be placed in the participant's hard chart.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- If the participant was found eligible for the MI Choice Waiver through Door 2 (Cognition) on the Nursing Facility Level of Care Determination (NFLOCD), Supports Coordinators will need to ensure that the selections within the section match the selections on the NFLCOD. Additionally, the narrative should contain additional information to support the determination of eligibility based on the participant's level of cognitive functioning.

- A summary of the participant's answers, including the Supports Coordinator's observations and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Cognitive Skills for Daily Decision Making/Making Decisions Regarding Tasks of Daily Life:

Definition:

- The level of independence exhibited by the participant for making safe decisions regarding their daily routine and tasks of daily life.

Process:

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

- Examples of Decision-making Tasks:
  - Choosing items of clothing;
  - Knowing when to eat meals;
  - Knowing and using space in the home appropriately;
  - Using environmental cues 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 and when to go out of the house; and acknowledging the need to use a walker or other assistive device and using it faithfully.

Coding:

- Select from the following options:
  - **Independent** — The participant's decisions in organizing daily routines and making decisions were consistent, reasonable, and safe (reflecting lifestyle, culture, values).
  - **Modified independence** — The participant organized daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations only.
  - **Minimally impaired** — In specific situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
  - **Moderately impaired** — The participant's decisions were consistently poor or unsafe; the participant required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
  - **Severely impaired** — The participant never (or rarely) made decisions.
  - **No discernable consciousness, coma** – the participant is non-responsive

Memory/Recall Ability:

Short-term Memory OK:

Definition:

- The participant seems/appears to recall after 5 minutes.

Process:

- Conduct a structured test of short-term memory (preferred approach--see example below). If this is not possible, ask the participant to describe a recent event that you should both have knowledge of (e.g., election of a new political leader, a major holiday) or that you can validate with a family member (e.g., what the participant had for breakfast). If there is no positive indication of memory ability, code "1", Memory problem.
- Example of a Structured Approach for Assessing Short Term Memory
    - Ask the participant to remember three unrelated items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the participant to repeat them to you (to verify that you were heard and understood by the participant). Then proceed to talk about something else, such as going on to another part of the assessment. Do not be silent; do not leave the room. In five minutes, ask the participant to repeat the name of each item.

Coding:

- Select from the following options:
    - **Memory OK** - if there are no indications of memory problems.s
    - **Memory Problem** - if the participant demonstrates difficulty during the exercise.
    - For participants with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked to point to items that are to be recalled, he or she can do so). If the participant is unable to recall all three items, code "Memory problem".

Procedural Memory OK:

Definition:

- The participant can perform all or almost all steps in a multitask sequence.

Process:

- Ask the participant or caregiver if the participant experiences any difficulty completing tasks throughout the day. Take note of their response and any details they provide.
- Give an example of a standard, multi-step daily task – getting ready/dressed in the morning; making a cup of coffee; preparing a sandwich. Ask the participant to walk you through the steps of completing the task.

Coding:

- Select from the following options:
    - **Memory OK** - if the participant is able to perform or remember to perform all or most of the steps in a multi-step task.
    - **Memory Problem** - if the participant demonstrates difficulty in two or more steps in a multi-step task.
    - NOTE: People in need of care in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities

Situational Memory OK:

Definition:

- The participant both recognizes caregivers' names/faces frequently encountered AND knows location of places regularly visited, both in and outside of the home.

Process:

- Ask the participant and the caregiver if there are any concerns with recognizing familiar family members or caregivers
- Ask the participant and the caregiver if there are any concerns with knowing how to get to and from places regularly visited – i.e. the bathroom, the kitchen, etc.

Coding:

- Select from the following options:
    - **Memory OK** - if the participant demonstrates the ability to recognize BOTH the names/faces of frequently encountered family members or caregivers AND know the location of places regularly visited.
    - **Memory Problem** - if the participant demonstrates difficulty in one or both areas.

Periodic Disordered Thinking or Awareness:

Easily Distracted:

Definition:

- The participant is exhibiting distracted behavior – e.g. episodes of difficulty paying attention; gets sidetracked

Process:

- Ask the participant or others who know the participant they noticed the participant was easily distracted over the last 3 days. If the response is yes, determine if the behavior is different from the participant's normal functioning.

Coding:

- Code for the participant's behavior in the last three days regardless of what you believe the cause to be, focusing on when the manifested behavior first occurred and whether it is different than the participant's usual pattern.
- Select from the following options:
    - **Behavior not present**
    - **Behavior present, consistent with usual functioning**
    - **Behavior present, appears different from usual functioning** (e.g., new onset or worsening, different from a few weeks ago)

Episodes of Disorganized Speech:

Definition:

- The participant has exhibited episodes of disorganized speech - e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought.

Process:

- Ask the participant, or others who know the participant, if they have observed any episodes of disorganized speech over the last 3 days. If the response is yes, determine if the behavior is different from the participant's normal functioning.

Coding:

- Code for the participant's behavior in the last three days regardless of what you believe the cause to be, focusing on when the manifested behavior first occurred and whether it is different than the participant's usual pattern.
- Select from the following options:
    - **Behavior not present**
    - **Behavior present, consistent with usual functioning**
    - **Behavior present, appears different from usual functioning** (e.g., new onset or worsening, different from a few weeks ago)

Mental Function Varies Over the Course of the Day:

Definition:

- The participant has exhibited changes in mental functioning over the course of the day - e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

Process:

- Ask the participant or others who know the participant if they have observed any issues with the participant's mental functioning the course of a day. If the response is yes, determine if the behavior is different from the participant's normal functioning.

Coding:

- Code for the participant's behavior in the last three days regardless of what you believe the cause to be, focusing on when the manifested behavior first occurred and whether it is different than the participant's usual pattern.
- Select from the following options:
    - **Behavior not present**
    - **Behavior present, consistent with usual functioning**
    - **Behavior present, appears different from usual functioning** (e.g., new onset or worsening, different from a few weeks ago)

Acute Change in Mental Status

Definition:

- The participant has experienced an acute change in mental status, which is different from participant's usual functioning. (e.g. restlessness, difficulty to arouse, altered environmental perception)

Process:

- Ask the participant, or others who know the participant, if they have observed any recent, marked changes in the participant's mental status.

Coding:

- Select from the following options:
    - **No**
    - **Yes**

Change in Decision Making (as compared to 90 days ago or since last assessment)

Definition:

- The participant has experienced a change in their decision-making ability in the last 90 days or since the last assessment, if less than 90 days ago. The changes may be permanent or temporary and the cause may be known (e.g., due to new pain or psychotropic medication) or unknown.

Process:

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

Coding:

- Select from the following options:
  - **Improved**
  - **No change**
  - **Declined**
  - **Uncertain**

Making Self Understood (Expression):

Definition:

- The participant's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or key board).

Process:

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

Coding:

- Select the most correct response based on feedback from the participant, their family, and your observations.
- Select from the following options:
    - **Understood** — The participant expresses ideas clearly without difficulty.
    - **Usually Understood** — The participant has difficulty finding the right words or finishing thoughts (resulting in delayed responses), BUT if given time, little or no prompting is required.
    - **Often Understood** — The participant has difficulty finding words or finishing thoughts, AND prompting is usually required.
    - **Sometimes Understood** — The participant has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
    - **Rarely or Never Understood** — At best, understanding is limited to interpretation of highly individual, participant-specific sounds or body language (e.g., caregiver has learned to interpret participant signaling the presence of pain or need to toilet).

Ability to Understand Others (Comprehension):

Definition:

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

Process:

- Interact with the participant. Observe the participant's ability to comprehend the questions asked throughout the assessment. Consult with family or caregivers for input regarding the participant's ability to understand verbal and/or written information.

Coding:

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

BRIEF Health Literacy Screening Tool:

- Utilize the supplemental BRIEF Health Literacy Screening Tool at this time to assess and document the participant's potential for comprehending information regarding their health and medical needs.
- Follow the instructions for administering the questions and scoring the participant's answers provided on the supplemental tool form.
- Provide a brief summary of the participant's answers and score in the "Description of Conditions Noted Above" section.
- Scan the completed BRIEF Health Literacy Screening Tool and upload to the COMPASS Case File; place hard-copy of tool in the participant's chart.

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.
- If the participant scored eligible for Mi Choice Waiver services on the NFLOCD through Door 2, ensure that this section is comprehensive and matches the information documented on the NFLOCD.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section G: SW Mood and Behavior Patterns

- The purpose of this section is to record and assess the participant's mood, mental health conditions, and behavioral patterns that may affect the participant's care and ongoing medical needs. This section also serves to record and assess any substance abuse issues.

- Information gathered within this section can be used to determine potential barriers related to the participant's health beliefs and behaviors that may impact the participant's decision-making related to their services, medical care, and overall care.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- If the participant was found eligible for the MI Choice Waiver through Door 6 (Behaviors) on the Nursing Facility Level of Care Determination (NFLOCD), Supports Coordinators will need to ensure that the selections within the section match the selections on the NFLCOD. Additionally, the narrative should contain additional information to support the determination of eligibility based on the participant's mental health concerns and/or behavioral patterns.

- A summary of the participant's answers, including the Supports Coordinator's observations and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Indicators of Possible Depressed, Anxious or Sad Mood:

- All questions within this section refer to observations and/or reported experiences in the last 3 days, irrespective of the assumed cause of the behavior.

- The mental state indicators may be expressed verbally through direct statements or through non-verbal indicators or behaviors that can be monitored by observing the participant during usual daily routines.

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

Made Negative Statements

Definitions:

- In the last 3 days, the participant has made negative statements like "Nothing matters; Would rather be dead than live this way; What's the use; Regret having lived so long; Let me die."

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Persistent anger with self or others:

Definitions:

- The participant has experienced persistent anger with themselves or others in the last 3 days. They might experience anger at the care received or feel easily annoyed by those around them.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Expressions, including non-verbal, or what appear to be unrealistic fears:

Definitions:

- The participant has exhibited or expressed what appears to be unrealistic fears like fear of being abandoned, fear of being left along, fear of being with others, or an intense fear of specific objects or situations in the last 3 days.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Repetitive health complaints:

Definitions:

- The participant has expressed repetitive health complaints in the last three days. The participant may persistently seek medical attention or have incessant concern with bodily functions.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Repetitive anxious complaints/concerns (non-health related):

Definitions:

- The participant has expressed repetitive anxious complaints and/or concerns in the last 3 days. The participant may persistently seek attention and reassurance regarding schedules, meals, laundry, clothing relationships, etc.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Sad, pained, or worried facial expressions:

Definitions:

- The participant has exhibited sad, pained, or worried facial expressions in the last 3 days. Non-verbal signs may include a furrowed brown or constant frowning.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Crying, tearfulness:

Definitions:

- The participant has experienced crying or tearfulness in the last 3 days.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Recurrent statements that something terrible is about to happen:

Definitions:

- The participant has expressed or made recurrent statements that something terrible is about to happen, in the last three days. The participant may have made comments that they believe they are about to die, have a heart attack, etc.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Withdrawal from activities of interest:

Definitions:

- The participant has experienced withdrawal from activities of interest in the last three days. The participant may have stopped participating in activities of long-standing interest or spending times with family/friends.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Reduced social interactions:

Definitions:

- The participant has experienced reduced social interactions in the last 3 days.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is re-ported to you, regardless of what you believe the cause to be.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Expressions, including non-verbal, or a lack of pleasure in life:

Definitions:

- In the last 3 days, the participant has expressed a lack of pleasure in life or stated that they don't enjoy anything anymore.

Process:

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

Coding:

- Based on your interaction with and observation of the participant, code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on what you see or is reported to you, regardless of what you believe the cause to be.
- Select form the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
        - Note: Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Self-Reported Mood:

- All questions in this section are focused on documenting verbal reports of the participant's subjective evaluation of three dimensions of mood state (i.e., dysphoria, anxiety, anhedonia) over the last 3 days.
- In some cases, the participant may deny feeling a particular way in the last 3 days, but reports that the issue continues to be "present" and active.
- Only the participant's responses should be used to rate each item. Do not code the items based on your own inferences about the participant's mood state and do not record ratings given by family, friends or other informants. These items should be treated strictly as self-report measures. If the participant is unable (e.g., due to cognitive impairment) or refuses to respond, do not dwell on these items and do not impute responses for the participant.

Little Interest or Pleasure in Things you Normally Enjoy?:

Definition:

- The participant has experienced little interest or pleasure in doing things that they normally enjoy doing in the last 3 days.

Process:

- Ask the participant directly and record their answer.

Coding:

- Code each item using the participant's response as to whether/how often they experienced the feelings referenced in the items over the last 3 days, regardless of what the participant believes to be the underlying cause of these feelings.
- Remember to code for both the presence of the indicator and the number of days in which it was felt no matter how often it was felt per day. Participants unable or unwilling to respond should be coded as "Participant could not (would not) respond."
- Select from the following options:
    - **Not in last 3 days**
    - **Not in last 3 days, but often feels that way** (Note: use this code only if the participant indicates the feeling is present and active, but was not experienced in the last 3 days.)
    - **In 1-2 of last 3 days**
    - **Daily in last 3 days**
    - **Participant could not (would not) respond**

Anxious, Restless, or Uneasy?:

Definition:

- The participant has experienced feelings of anxiousness, restlessness, or uneasiness in the last 3 days.

Process:

- Ask the participant directly and record their answer.

Coding:

- Code each item using the participant's response as to whether/how often they experienced the feelings referenced in the items over the last 3 days, regardless of what the participant believes to be the underlying cause of these feelings.
- Remember to code for both the presence of the indicator and the number of days in which it was felt no matter how often it was felt per day. Participants unable or unwilling to respond should be coded as "Participant could not (would not) respond."
- Select from the following options:
    - **Not in last 3 days**
    - **Not in last 3 days, but often feels that way** (Note: use this code only if the participant indicates the feeling is present and active, but was not experienced in the last 3 days.)
    - **In 1-2 of last 3 days**
    - **Daily in last 3 days**
    - **Participant could not (would not) respond**

Sad, Depressed, or Hopeless?:

Definition:

- The participant has experienced feelings of sadness, depression, or hopelessness in the last 3 days.

Process:

- Ask the participant directly and record their answer.

Coding:

- Code each item using the participant's response as to whether/how often they experienced the feelings referenced in the items over the last 3 days, regardless of what the participant believes to be the underlying cause of these feelings.
- Remember to code for both the presence of the indicator and the number of days in which it was felt no matter how often it was felt per day. Participants unable or unwilling to respond should be coded as "Participant could not (would not) respond."
- Select from the following codes:
    - **Not in last 3 days**
    - **Not in last 3 days, but often feels that way** (Note: use this code only if the participant indicates the feeling is present and active, but was not experienced in the last 3 days.)
    - **In 1-2 of last 3 days**
    - **Daily in last 3 days**
    - **Participant could not (would not) respond**

Behavioral Symptoms:

- All questions in this section are focused on identifying the frequency of behavioral symptoms during the last three days that cause distress to the participant, or are distressing or disruptive to others with whom the participant lives.
- Such behaviors include those that are potentially harmful to the participant or disruptive to others. These items are designed to pick up problem behaviors exhibited by the participant that may be considered as "combative or agitated" by some health professionals. Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms.

Wandering:

Definition:

- In the last 3 days, the participant has exhibited wandering behaviors – i.e. moved about with no discernible, rational purpose, seemingly oblivious to needs or safety.
- A wandering participant may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry participant moving about the apartment in search of food). Wandering may be by walking or by wheelchair. Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering.

Process:

- Observe the participant and how the participant responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the participant is not in the room. Recognize that responses given with the participant present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.
- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Verbal Abuse:

Definition:

- In the last 3 days, the participant was verbally abusive towards others - e.g., others were threatened, screamed at, or cursed at.

Process:

- Observe the participant and how the participant responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the participant is not in the room. Recognize that responses given with the participant present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.
- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Physical Abuse:

Definition:

- In the last 3 days, the participant was physically abusive towards others - e.g., others were hit, shoved, scratched, sexually abused.

Process:

- Observe the participant and how the participant responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the participant is not in the room. Recognize that responses given with the participant present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.
- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Socially Inappropriate or Disruptive Behavior:

Definition:

- In the last three days, the participant has exhibited socially inappropriate or disruptive behaviors — e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings.

Process:

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

- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Inappropriate Public Sexual Behavior or Public Disrobing:

Definition:

- In the last 3 days, the participant exhibited inappropriate public sexual behavior or public disrobing.

Process:

- Observe the participant and how the participant responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the participant is not in the room. Recognize that responses given with the participant present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.
- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant's behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Resists Care:

Definition:

- In the last three days, the participant has resisted care. Resisting care includes refusing to take medications/injections, pushing/physically resisting caregiver while assisting with ADLs, eating or changing position. This category does not include instances where the participant has made an informed choice not to follow a course of care (e.g., the participant has exercised his or her right to re-fuse treatment, and reacts negatively as others try to reinstitute treatment.)
- Signs of resistance may be verbal or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the participant's responses to interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify the care being provided).

Process:

- Observe the participant and how the participant responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the participant is not in the room. Recognize that responses given with the participant present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.
- Ask the family member, or caregiver if each specified problem behavior occurred. Take an objective view of the participant's behavioral symptoms, and focus on the participant's actions, not intent.

Coding:

- Code each indicator based on the participant’s behavior over the last three days using one of the following codes. Remember, code each item based on whether the participant manifested the behavioral symptom, regardless of what you believe the cause to be or the participant’s intention.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days** (Note: this code indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days.)
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Changes in Behavioral Symptoms:

Definition:

- The participant's behavioral symptoms have become worse or are less well tolerated by family as compared to 30 days ago.

Process:

- Ask the family member, or caregiver, if any of the specified problem behaviors have worsened or become more difficult to deal with over the last 30 days. Take an objective view of the caregiver/family member's perception and experience.

Coding:

- Code based on the participant's behavior over the last thirty days as reported by family and/or caregivers, regardless of what you believe the cause to be or the participant's intention.
- Select from the following options:
    - **No**
    - **Yes**

Mental Health

Delusions:

Definition:

- In the 3 days, the participant has experienced delusions. Delusions are fixed, false beliefs not shared by others that the participant holds even when there is obvious proof or evidence to the contrary.
- For example, the participant may believe that he or she is terminally ill; believe that her spouse is having an affair; or believe that food served at a restaurant or congregate dining room is poisoned.

Process:

- Ask the participant if they have experienced any delusions in the last 3 days or if they have a history of delusional beliefs.
- Depending upon the participant's behavioral status, it may not be appropriate to ask the participant. Ask family members/caregivers if they have observed verbal or non-verbal evidence of delusional thought processes.

Coding:

- Code based on the participant's behaviors in the last 3 days.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Hallucinations:

Definition:

- In the last 3 days, the participant has experienced hallucinations. Hallucinations are false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g. hearing voices), visual (e.g. seeing people, animals), tactile (e.g. feeling bugs crawling over skin), olfactory (e.g. smelling poisonous fumes), or gustatory (e.g. having strange tastes).

Process:

- Ask the participant if they have experienced any hallucinations in the last 3 days or if they have any history of hallucinations.
- Depending upon the participant's behavioral status, it may not be appropriate to ask the participant. Ask family members/caregivers if they have observed verbal or non-verbal evidence of hallucinations.

Coding:

- Code based on the participant's behaviors in the last 3 days.
- Select from the following options:
    - **Not Present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Number of Prior Lifetime Mental Health Admissions:

Definition:

- The total number of times the participant has been admitted to a hospital or mental health facility for the primary purpose or treatment of a mental health disorder by a specialist mental health service.

Process:

- Ask the participant and/or family/caregivers if the participant has every been admitted to a hospital or facility for mental health services. This may need to be confirmed through medical records or contact with their physician, if needed.

Coding:

- Code for the total number of times reported or confirmed.
- Select from the following options:
    - **None**
    - **1 to 3**
    - **4 to 6**
    - **7 or more**

Self-Injury:

- This section is designed to record any history of self-injurious behavior, include suicidal attempts, ideation, or planning.
- Self-injury or self-harm is defined as attempts by the participant in hurt themselves on purpose. Types of self-hard include: cutting; scratching; burning; hitting or punching oneself; piercing skin with sharp objects; pulling out hair; picking at existing wounds.
- Appropriate follow-up questions may be asked in this section at the discretion of the Supports Coordinator. If the participant is open to discussing their self-injurious behavior(s), it may be appropriate to document details regarding their history, experiences, treatments, etc. Any additional information received through follow-up questions should be documented in the "Description of Conditions Noted Above" in narrative form.

Self-Injurious Attempt:

Definition:

- The participant has attempted or succeeded in injuring or harming themselves.

Process:

- Ask the participant if they have any history of purposely hurting or injuring themselves. Be mindful that this subject matter is delicate in nature and the participant may be hesitant to discuss.
- If appropriate, it may be necessary to confirm with input from caregivers and/or the participant's primary physician, but this approach should be taken cautiously and only if the Supports Coordinator feels that the participant may not be providing accurate information or is a potential risk to themselves.

Coding:

- Code based on the provided information.
- Select from the following options
    - **None**
        - If the participant reports none, skip to question "Considered self-injurious behavior in the last 30 days".
    - **Attempt(s) more than 12 months ago**
    - **Attempt(s) in the last 12 months**

Intent of any Self-Injurious Attempt was to Kill Themselves:

Definition:

- If the participant has made any attempt or succeeded to self-injure or self-harm, was their intent to kill themselves.

Process:

- Ask the participant for more information regarding their history of self-injury and self-harm. Inquire regarding the intent to their self-injurious behavior and ask if they harmed themselves with the intent to commit suicide/kill themselves.

Coding:

- Code based on the reported information.
- Select from the following options
    - **No Selection**
        - Utilize this if the participant does not report any history of self-harm or self-injury
    - **No**
    - **Yes**

Considered Self-Injurious Behavior in the last 30 days:

Definition:

- The participant has considered, but not attempted, to hurt or injure themselves in the last 30 days.

Process:

- Ask the participant if they have considered hurting or injuring themselves in the last 30 days.

Coding:

- Code based on the participant's response.
- Select from the following options:
    - **No**
    - **Yes**

Family/Caregiver/Friend/Staff Express Concern that Patient is at Risk for Self-Injury:

Definition:

- Family, caregivers, close friends, or staff express concern that the participant is at risk for self-injury.

Process:

- Ask the participant's family, caregivers, close friends, or appropriate staff if they are concerned that the participant may be at risk of self-injury or self-harm. It may not be appropriate to ask this question while the participant is present and may require follow up from the Supports Coordinator.
- If concern is expressed, the Supports Coordinator should ask follow up questions as to "why" the person feels this way and document those concerns or observations in the "Description of Conditions Noted Above" section.

Coding:

- Code based on the response
- Select from the following options:
    - **No Selection**
        - Use this if the participant does not have any family, caregiver, friend, or staff to ask. Make note of this in the
    - **No**
    - **Yes**

Tobacco and Alcohol

- This section is intended to record the participant's alcohol and tobacco use. It also provides an opportunity to assess any of the participant's existing health beliefs and behaviors that may affect the participant's ability to adhere to the case management plan.

Smokes or Chews Tobacco Daily:

Definition:

- The participant smokes tobacco daily — refers to cigar, cigarette, or any other tobacco product that is inhaled.

Process:

- Ask the participant directly. This information may be sensitive to the participant or create feelings within the assessor. Care must be taken to acknowledge these feelings.
- Begin asking the participant about tobacco usage, with a simple non-judgmental statement, "Do you smoke?" If yes, determine the frequency. Address this issue with the participant in a gentle way to avoid her or him feeling judged or that they are doing something wrong. For example, you might say "Like the other questions I asked, I am just trying to find out about you...it doesn't mean that what you are doing is wrong." Validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the participant.
- If the participant does smoke, determine whether or not the participant is interested in smoking cessation. Document the participant's answer and add as a goal to the care plan if requested.

Coding:

- Code for reported smoking.
- Select from the following options:
    - **No**
    - **Not in last 3 days, but is usually a daily smoker**
    - **Yes**

Has more than 3 Drinks of Beer/Liquor/Wine Almost Every Day:

Definition:

- The participant drinks beer, liquor, wine or a combination of these alcoholic beverages on a daily basis. Daily consumption meets exceeds 3 drinks a day.

Process:

- Ask the participant directly about whether he or she consumes alcohol. Consult with a family member, if necessary. Sometimes it is prudent to talk to the participant and family separately.
- Start by asking the participant "Do you drink alcoholic drinks?" If they say yes, then ask "Do you drink daily, or almost every day?". If they report that they drink daily, then follow up with asking how many drinks, on average, they consume on a daily basis.

Coding:

- Code based on the participant's report. If the family or caregiver reports differently from the participant, make sure to note in the "Description of Conditions Noted Above".
- Select from the following options:
    - **No**
    - **Yes**

Alcohol:

Definition:

- The total number of drinks that a participant has had in a single sitting within the last 14 days. Drinks include beer, wine, mixed drinks, liquor, and liqueurs. A single sitting refers to any given point in time (e.g., at dinner, after work, while out at a social event, watching television).

Process:

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

Coding:

- Code for the highest number of drinks ingested by the participant at one sitting over the last 14 days.
- Select from the following options:
    - **None**
    - **1**
    - **2-4**
    - **5 or more**

In the last 90 days, person felt the need or was told by others to cut down on drinking or others were concerned with person's drinking:

Definition:

- The participant has felt or told by others close to them, that they need to decrease the frequency or amount of drinking over the last 90 days. Friend or family may have expressed concern about the participant's drinking habits or the participant themselves may feel as though they need to decrease their consumption.

Process:

- Ask the participant directly whether or not they have concerns about their drinking – either frequency or consumption levels. Ask the participant if anyone has expressed concern about their drinking.
- Consult with a family member or caregiver, if needed or necessary. You may need to talk to them separately from the participant. Ask them if they have concerns about the participant's drinking.

Coding:

- Code based on reported answers.
- Select from the following options:
    - **No**
    - **Yes**

In the last 90 days, person had to have a drink first thing in the morning to steady nerves or has been in trouble because of drinking:

Definition:

- The participant needs to start the day with a drink to feel better or "steady nerves" or has been in trouble because of drinking in the last 90 days. Trouble is defined as anything that the participant perceives as trouble or causing distress.

Process:

- Ask the participant if they have needed to have a drink of alcohol first thing in the morning. If they respond yes, ask them if this has happened in the last 90 days.
- Ask the participant if they have ever been in trouble because of drinking. If yes, ask the participant for more information on the trouble that they experienced and if this has happened in the last 90 days.

Coding:

- Code based on reported answers.
- Select from the following options:
    - **No**
    - **Yes**

Violence:

- This section is intended to record any dangerous or potentially violent behaviors by the participant, currently or historically.
- The questions and subject matter within this section are sensitive in nature and it is important to proceed cautiously and without judgement. The participant may not feel comfortable disclosing details or information. It is important that the Supports Coordinator acknowledge and confirm that the participant's answers will not prevent them from participation in the Mi Choice Waiver or Care Management programs.

History of Violence to Others

Definition:

- The participant exhibits, or has exhibited, violence toward others. Violence is defined as an act of physical force that causes or is intended to cause harm. The damage inflicted by violence may be physical, psychological, or both

Process:

- Ask the participant directly. If yes, ask the participant if any issues related to violence have occurred in the last 7 days.

Coding:

- Code based on participant response for the most recent instance of violent behavior.
- Select from the following options:
    - **Never**
    - **Any history more than 7 days ago**
    - **In the last 7 days**

Intimidation of others or threatened violence

Definition:

- The participant has threatened violence or attempted to compel another individual through intimidation.

Process:

- Ask the participant directly. If yes, ask the participant if any issues related to violence have occurred in the last 7 days.

Coding:

- Code based on participant response for the most recent instance of violent behavior.
- Select from the following options:
    - **Never**
    - **Any history more than 7 days ago**
    - **In the last 7 days**

Violent Ideation

Definition:

- The participant has experience violent ideations. Violent ideations can be defined as thoughts, daydreams or fantasies of inflicting harm on. another.
- Violent ideations should be distinguished from plans or threats to commit an aggressive act, from aggressive delusions and from ideations of self-directed and sexual.

Process:

- Ask the participant directly. If yes, ask the participant if any issues related to violence have occurred in the last 7 days.

Coding:

- Code based on participant response for the most recent instance of violent behavior.
- Select from the following options:
    - **Never**
    - **Any history more than 7 days ago**
    - **In the last 7 days**

Police Intervention for Violent Behavior

Definition:

- The participant has a history of violent behavior that has resulted in police intervention. Policy intervention does require that the participant was arrested or has a criminal background.

Process:

- Ask the participant directly. If yes, ask the participant if any issues related to violence have occurred in the last 7 days.

Coding:

- Code based on participant response for the most recent instance of violent behavior.
- Select from the following options:
    - **Never**
    - **Any history more than 7 days ago**
    - **In the last 7 days**

Sexual Violence

Definition:

- The participant has a history of sexual violence toward others. Sexual violence defines a broad category of actions in which a person exerts their power and control over another person through unwanted or harmful sexual actions.

Process:

- Ask the participant directly. If yes, ask the participant if any issues related to violence have occurred in the last 7 days.

Coding:

- Code based on participant response for the most recent instance of violent behavior.
- Select from the following options:
    - **Never**
    - **Any history more than 7 days ago**
    - **In the last 7 days**

Mental Health Interventions, specify

Definition:

- The participant's current mental health interventions, if applicable. Interventions in this case can be preventative or therapeutic – therapy, pharmaceutical, etc.

Process:

- Ask the participant if they are currently receiving any interventions for their mood, behaviors, or mental health concerns.
- If they are currently taking any medications, you may need to consult with their primary health physician or mental health professional.
- If they are currently receiving mental health services, including therapy or supplemental community mental health services, you may need to consult with their case manager or mental health professional.

Coding:

- Use printed letters/text and enter into the text box
- Include the reason and medication name, if applicable
- Include the type of mental health services, frequency of services, and provider, if applicable.

Developmental Disability

Definition:

- The participant has been diagnosed with a developmental disability. Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas.
- Examples of a developmental disability include: Attention-Deficit/Hyperactivity Disorder (ADHD); Autism Spectrum Disorder; Cerebal Palsy; Intellectual Disabilities; Language Disorders; Learning Disorders; Tourette Syndrome.

Process:

- Ask the participant if they have a developmental disability.. If the participant is unclear as to what constitutes a developmental disability, you can provide examples.

Coding:

- Code based on reported answers.
- Select from the following options:
    - **No**
    - **Yes**

If Developmental Disability, Diagnosis

Definition:

- Confirmation of the participant's diagnosis by a physician.

Process:

- Ask the participant if they received their diagnosis from a physician.
- You may need to confirm with the participant's primary physician, if appropriate.
- If the participant has been "self-diagnosed", make sure to note in the "Description of Conditions Noted Above."

Coding:

- Code based on reported answers.
- Select from the following options:
    - **No Selection**
        - Use this coding if the participant answered "No" to the previous question regarding a diagnosis of a developmental disability.
    - **No**
    - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.
- If the participant scored eligible for Mi Choice Waiver services on the NFLOCD through Door 6, ensure that this section is comprehensive and matches the information documented on the NFLOCD.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section H: SW Summary:

- This section is intended to capture the signature of the Supports Coordinator, certify, and confirm completion of the SW Assessment.

- It also provides an opportunity for the Supports Coordinator to document any other pertinent information to the participant's case that was not documented in any of the previous sections within the SW Assessment.

SC Certification Agree:

Definition:

- Supports Coordinator certifies that based on the information obtained, observations made, and belief formed after reasonable inquiry, the statements and information contained in this document are true, accurate and complete.

Process:

- Once all answers are completed within all sections of the SW Assessment, confirm completion and certify accuracy of the answers and information documented.

Coding:

- Check the "Agree" box to indicate agreement with the certification statement.

Supports Coordinator Name:

Definition:

- The name and credentials of the Supports Coordinator that completed the SW Assessment.

Process:

- Type your name and professional credentials into the text box.

Coding:

- Use printed letters/text

SW Summary:

Definition:

- Any additional comments not documented elsewhere in the assessment.

Process:

- Use the provided text box to document any important information pertinent to the participant's case that was not documented in any of the other sections of the SW Assessment.
- The text box may remain blank if there is no additional documentation needed.

Coding:

- Use printed letters/text

Prior Additional Comments not Documented elsewhere in the Assessment:

Definition:

- Automatically populated by COMPASS based on the text entered in the "SW Summary: Additional Comments not Documented elsewhere in Assessment" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Additional comments not Documented elsewhere in Assessment" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Caregiver – Basic

- Each informal support or caregiver that plays an integral part in the participant's care and/or will be listed on the person-centered service plan, must be added as a caregiver in this section.

- Each individual that the participant designated as emergency or alternative contacts must be added to this section. Information in this section will be populated and added to the Back-Up Plan so it is important to ensure that the information is correct and documented.

- There are three sections associated within each individual caregiver– Basic; Primary Only; and Self-Determination Only. Even those these sections are available, the only section that must be completed is BASIC.

- These questions may be asked of the participant and/or the identified caregiver, if they are present at the assessment. If there is no caregiver to add to the participant's file, this section of the assessment may be left blank.

Caregiver

Definition:

- Caregiver's legal name -First and Last

Process:

- Ask the participant who currently provides regular assistance with their ADLs and IADLS. Are there family members, friends, etc that provide help on a regular basis? Who do they depend on to assist with completing their daily routine?
- Ask the participant for each caregiver's full legal name. Ensure proper spelling

Coding:

- Use printed letters.
- Enter in the following order:
    - Last Name, First name

Date of Birth

Definition:

- The date on which the caregiver was born

Process:

- Ask the participant or caregiver for their date of birth. Coding:

Coding:

- For the month and day of date of birth, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year.
- Example: November 1, 1942. 11/01/1942

Status

Definition:

- An active caregiver is currently providing assistance to the participant. An in-active caregiver is one that may have provided assistance in the past, but is no longer providing regular or consistent help.

Process:

- Ask the participant if the caregiver listed is currently providing assistance and/or care.

Coding:

- Select from the following:
    - **Active**
    - **Not Active**

Helper Type

Definition:

-

Process:

- For each caregiver identified, rank them based on the participant's account of their type of care, frequency, and level of responsibility.

Coding:

- Select from the following:
  - **Primary helper** The caregiver/helper that provides the majority of the ADL or IADL assistance to the participant on a consistent/daily basis.
  - **Secondary helper –** The caregiver/helper that provides the second-most amount of ADL or IADL assistance to the participant and may act as the back-up caregiver.
  - **Other helper –** The caregiver/helper that provides assistance to the participant but may be intermittent in nature.

Relationship to Person

Definition:

- The caregiver/helper's relationship to the participant.

Process:

- Ask the participant and/or the caregiver the nature of their relationship with the participant.

Coding:

- Select from the following:
  - **Child or Child-in-law**
  - **Spouse**
  - **Partner/Significant Other**
  - **Parent/Guardian**
  - **Sibling**
  - **Other relative**
  - **Friend**
  - **Neighbor**
- **If the caregiver is a** non-relative or "Other" was selected, specify the type of relationship in the box provided, using printed text.

Lives with Person

Definition:

- Does the participant live with anyone who is responsible for providing primary, secondary or "other" care.

Process:

- Ask the participant if they are currently living with any of their caregivers.

Coding:

- Select from the following:
  - **No**
  - **Yes, 6 months or less**
  - **Yes, more than 6 months**

Address

Definition:

- The caregiver's physical address.

Process:

- As the participant and/or caregiver for the caregiver's current address.

Coding:

- Use printed letters and text to complete the boxes available:
  - **Line 1 –** Street Address
  - **Line 2 –** Apt/Lot/Unit Number or Other Identifying Info
  - **City**
  - **State**
  - **Zip**
  - **County**
  - **Township Code**
  - **Email Address**
- If the participant does not have the caregiver's address, this can be gathered and confirmed at another time and completed

Phone Numbers

Definition:

- The number assigned to a telephone line or specific phone.

Process:

- Ask the participant and/or caregiver for their preferred phone number for contact.
- Ask the participant and/or caregiver for any other phone numbers that may be used to contact the caregiver

Coding:

- Use numbers only for each of the phone number types
    - **Main Phone**
        - **Area Code**
        - **Number**
    - **Mobile Phone**
        - **Area Code**
        - **Number**
    - **Work Phone**
        - **Area Code**
        - **Number**

Contacts:

Emergency Contact

Definition:

- The first person, elected by the participant, to be contacted in case of an emergency, medical, or mental health crisis. This individual is also the first person contacted by UPCAP staff if there have been issues with contacting the participant.

Process:

- Ask the participant if they would like to designate the caregiver as an emergency contact.

Coding:

- Select from the following:
    - **No**
    - **Yes**

Family Contact

Definition:

- The family member that the participant would like to receive information regarding the participant's services and plan of care.

Process:

- Ask the participant if they would like to designate the caregiver as a family contact.

Coding:

- Select from the following:
  - **No**
  - **Yes**

Billing Contact

Definition:

- The person identified by the participant to assist with the participant's finances and receive copies of the participant's financial information ss it relates to the Mi Choice Waiver (MDHHS/Medicaid)

Process:

- Ask the participant if they would like to designate the caregiver as a billing contact.

Coding:

- Select from the following:
  - **No**
  - **Yes**

Legal Relationship with Person

Guardian

Definition:

- A person who is a court-appointed representative and legally responsible for the participant.

Process:

- Ask the caregiver and/or participant if the caregiver is the legal guardian.
- Guardianship must be confirmed via legal, official documentation. If the participant has a guardian, make a copy of the documentation and add it to the participant's file.

Coding:

- Select from the following:
  - **No**
  - **Yes**
  - **Pending**

Durable Power of Attorney (DPOA)

Definition:

- A person, designated by the participant, to handle important matters and decisions like health care and finances when they have been deemed unable to make their own decisions.

Process:

- Ask the caregiver and/or participant if the caregiver is the Durable Power of Attorney
- Durable Power of Attorney is not activated unless it has been determined, through the signatures of two separate health care professionals ,that the participant is unable to make their own decisions.
- The existence of DPOA paperwork, without the necessary signatures, does not designate the caregiver as the decision maker. They would be considered "pending".

Coding:

- Select from the following:
  - **No**
  - **Yes**
  - **Pending**

Areas of informal help during last 3 days

IADL Help

Definition:

- IADLs are Instrumental Activities of Daily Living. IADLs include tasks that must be completed every day to take care the participant and their home. IADLs often require more complex planning and thinking – Using the telephone, shopping for groceries, meal preparation, managing medications, homemaking, transportation, financial management, etc.

Process:

- Ask the participant and/or caregiver if they have assisted the participant with IADLs in the last 3 days.

Coding:

- Select from the following:
  - **No**
  - **Yes**

ADL Help

Definition:

- ADLs are Activities of Daily Living. ADLs include the fundamental skills required for the participant to care for themselves independently. ADLs include ambulation, bed mobility, feeding, dressing, bathing, and toileting.

Process:

- Ask the participant and/or caregiver if they have assisted the participant with ADLs in the last 3 days.

Coding:

- Select from the following:
  - **No**
  - **Yes**

Advice or Emotional Support

Definition:

- Emotional Support is defined as the verbal and nonverbal processes by which one communicates care and concern for another, offering reassurance, empathy, comfort and acceptance.
- Advice is defined as guidance or recommendations offered with regard to future action.

Process:

- Ask the participant and/or caregiver if they have provided advice or emotional support to the participant in the last 3 days.

Coding:

- Select from the following:
  - **No**
  - **Yes**

If needed, willingness (with ability) to increase help

IADL Help

Definition:

- The caregiver has the willingness and ability to increase the amount of assistance they are currently providing.

Process:

- Ask the caregiver if they have the willingness and ability to increase the amount of IADL assistance that they are currently providing to the participant.

Coding:

- Select from the following:
  - **No**
  - **1-2 hours/day**
  - **More than 2 hours/day**

ADL Help

Definition:

- The caregiver has the willingness and ability to increase the amount of assistance they are currently providing.

Process:

- As the caregiver if they have the willingness and ability to increase the amount of ADL assistance that they are currently providing to the participant.

Coding:

- Select from the following:
  - **No**
  - **1-2 hours/day**
  - **More than 2 hours/day**

Advice or emotional support

Definition:

- The caregiver has the willingness and ability to increase the amount of assistance they are currently providing.

Process:

- As the caregiver if they have the willingness and ability to increase the amount of emotional support or advice that they are currently providing to the participant.

Coding:

- Select from the following:
  - **No**
  - **1-2 hours/day**
  - **More than 2 hours/day**

Tasks

Definition:

- The types of jobs or duties that the caregiver performs for the participant, including the frequency and duration.

Process:

- Ask the caregiver and the participant what type of tasks the caregiver provides on a regular basis, the frequency, the amount, and the duration of the assistance provided.

Coding:

- Use printed letters/text.
- If the caregiver is going to be added to the PCSP, make sure that this section includes the type, frequency, and amount of the tasks provided informally.

Do you want this person to receive a copy of the back-up plan and person-centered service plan?

Definition:

- The participant is able to designate which individuals will and will not receive a copy of their back-up plan and person-centered service plan.

Process:

- Ask the participant if they would like the caregiver to receive a copy of their back-up plan and person-centered service plan, initially and each time a change is made.

Coding:

- Select from the following:
  - **No**
  - **Yes**

Comments:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions.

Process:

- Add any additional information in this section that pertains to the caregiver.
- If the caregiver will be providing ongoing informal support to the participant, the Supports Coordinator must confirm and document in this section that the caregiver agrees to provide unpaid care to the participant.

Coding:

- Use printed letters/text

Community Supports:

- Individuals who offer support to the participant on an intermittent basis are considered community supports. Ex: neighbor, religious clergy, etc.

- Each community support individual that the participant would like to be listed on the person-centered service plan or back-up plan, must be added as a community support in this section.

Name:

Definition:

- Community Support's name -First and Last

Process:

- Ask if the participant receives any assistance from any specific community members on a intermittent but ongoing basis.
- Ask the participant for each community support's full legal name. Ensure proper spelling

Coding:

- Use printed letters.
- Enter in the following order:
    - Last Name, First name

Phone:

Definition:

- The number assigned to a telephone line or specific phone.

Process:

- Ask the participant for the community support's phone number.

Coding:

- Use numbers only

Description:

Definition:

- A statement or account giving the characteristics or someone or something.

Process:

- Ask the participant for more information and/or descriptors about the "type" of community support.

Coding:

- Use letters/text

Tasks:

Definition:

- The types of jobs or duties that the community support performs for the participant, including the frequency and duration.

Process:

- Ask the caregiver and the participant what type of tasks the caregiver provides on a regular basis, the frequency, the amount, and the duration of the assistance provided.

Coding:

- Use printed letters/text.
- If the caregiver is going to be added to the PCSP, make sure that this section includes the type, frequency, and amount of the tasks provided informally.

Do you want this person to receive a copy of the back-up plan and person-centered service plan?

Definition:

- The participant is able to designate which individuals will and will not receive a copy of their back-up plan and person-centered service plan.

Process:

- Ask the participant if they would like the caregiver to receive a copy of their back-up plan and person-centered service plan, initially and each time a change is made.

Coding:

- Select from the following:
  - **No**
  - **Yes**

Is this person part of the back-up plan?

Definition:

- The participant is able to designate which individuals will and will not receive a copy of their back-up plan and person-centered service plan.

Process:

- Ask the participant if they would like to include this person on the back-up plan.

Coding:

- Select from the following:
  - **No**
  - **Yes**

RN Assessment:

Reminder:

- This section provides an opportunity for the Supports Coordinator to enter any specific issues or items of which they would like to be reminded at the next assessment.
- It is not required to enter anything into this section but serves as an open field to add notes, reminders, or important info.

Next Reminder:

Definition:

- Important information that the Supports Coordinator would like to be noted or recalled

Process:

- Enter any reminders related to the next assessment with this participant.

Coding:

- Use printed letters and text.

Section I: RN - Disease Diagnosis, Disabilities

- This section is intended to gather information regarding the participant's current health conditions, including active diagnosis and potential plans for treatment. The participant's current health conditions/diagnosis should be documented as well as any other significant past illnesses, treatments, medications, and surgical history that may have an impact on the participant's current health conditions and/or status.

- A formal diagnosis by a physician or medical professional must be present in order to code as a diagnosis in this section. A participant's self-diagnosis is not sufficient.

- Any major hospitalizations, procedures, past medications/treatments, and/or surgical history should be documented and include all important details, including dates, if available.

- To confirm the information provided in the section, Supports Coordinators may want to request a copy of the participant's most recent discharge paperwork and medical records. A Medical Release Form will be completed at the initial visit and will be sent to the participant's primary physician for more information regarding the participant's primary and secondary diagnosis, current medications, treatments, prognosis, most recent surgical date, and physician certification of the participant's need for assistance.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Most Recent Hospitalization:

Definition:

- The name of the hospital where the participant was most recently admitted/hospitalized.

Process:

- Ask the participant for more information regarding their most recent hospitalization. Make sure to make note of the hospital's name.

Coding:

- Use printed letters/text

Hospital Use, Emergency Room Use, Physician Visit

Inpatient acute hospital with overnight stay

Definition:

- The participant was formally admitted as an inpatient, by physician's order, and stayed over one or more nights in the last 90 days (or since last assessment). It does not include admissions for day surgery, out-patient services, etc.

Process:

- Ask the participant if they have been admitted to the hospital in the last 90 days.
- Review prior hospitalizations with the participant. If available, review the clinical record.

Coding:

- Use numbers. Enter the number of hospital admissions in the box. Enter "0" if no hospital admissions occurred in the last 90 days.
- Code for the number of events during the last 90 days (or since last assessment if less than 90 days)
- If the participant has been hospitalized, be sure to note the details regarding the hospitalization in the "Description of Conditions Noted Above".

Emergency room visit (not counting overnight stay):

Definition:

- The participant visited an emergency room, not accompanied by an overnight hospital stay, in the past 90 days (or since last assessment).

Process:

- Ask the participant if they have visited the emergency room in the last 90 days.
- Review prior hospitalizations with the participant and family. If available, review the clinical record.

Coding:

- Use numbers. Enter the number of ER visits in the last 90 days (or since last assessment). Enter "0" if no ER visits occurred.
- Do not include instances in which the participant was admitted to the hospital for an overnight stay after being seen in the ER.
- If the participant has visited the ER, be sure to note the details regarding the ER visit(s) in the "Description of Conditions Noted Above".

Physician visit (or authorized assistant or practitioner):

Definition:

- A visit to a physician's office or clinic by the participant, a physician's visit to the participant's home, or a telehealth/virtual appointment with a physician, in the last 90 days (or since last assessment).
- This item includes a very broad spectrum of medical providers or specialists (e.g., MD or osteopaths, who is either the primary physician or consultant). Also include, for example, an authorized physician assistant or nurse practitioner.

Process:

- Ask the participant how many visits they have had to their physician or other medical providers/specialists in the last 90 days.

Coding:

- Use numbers. Enter the number of visits with a physician or authorized professional in the last 90 days (or since last assessment). Enter "0" if no physician visits occurred.
- Make note of the physicians, medical providers, and/or specialists discussed. All of the participant's medical providers should be listed in the Medical Providers section within the COMPASS Assessment.

Time Since Last Hospital Stay:

Definition:

- The time of the most recent instance of hospitalization during the last 90 days. This information can assist assessing the stability of the participant's condition(s) and whether post-acute care is needed.

Process:

- Ask the participant how long it has been since he/she was last discharged from an in-patient hospital setting.
- Calculate the period counting back from the Assessment Reference Date.

Coding:

- Code for most recent instance in last 90 days
- Select from the following options:
    - **No hospitalization within 90 days**
    - **31 to 90 days ago**
    - **15 to 30 days ago**
    - **8 to 14 days ago**
    - **In the last 7 days**
    - **Now in hospital**

Diseases - Disease Diagnoses

- Document the presence of diseases or infections relevant to the participant's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
- In general, these types of conditions are associated with the type and level of care needed by the participant.
- Ask the participant about their clinical, surgical, and diagnostic history. Make note of the participant's surgical history and the circumstances surrounding the procedure. If there are significant illnesses, surgeries, or treatments in the participant's past that may affect their current health status, make sure to document all important information in the "Description of Conditions Noted Above".
- Ask the participant if a medical professional has diagnosed them with any of the following diseases.
    - If the participant answers, yes, make sure to document whether or not the participant is currently receiving any treatment for the diagnosis.
    - Do not include conditions that have been resolved or no longer affect the participant's functioning or care needs.
- Ask the participant to list any other diagnosis not listed within this section and document in the "Description of Conditions Noted Above".
- Any diseases or diagnosis listed or reported in this section should also be added to the "Other or Primary Diseases" section, with a corresponding ICD-10 code.

Cardiac or Pulmonary

Congestive heart failure:

Definition:

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

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Coronary heart disease:

Definition:

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

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Chronic Obstructive Pulmonary Disease (COPD):

Definition:

- Any long-standing condition that impairs air flow in and out of the lungs.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Hypertension:

Definition:

- A condition in which the force of the blood flow through your arteries is at a higher-than-normal pressure. Also referred to as "high blood pressure".

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Peripheral Vascular Disease:

Definition:

- A slow and progressive circulation disorder, often caused by the narrowing, blockage, or spasms in a blood vessel.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Musculoskeletal:

Arthritis:

Definition:

- The swelling, inflammation, and tenderness of one or more joints.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Hip Fracture during the last 30 days (or since last assessment if less than 30 days):

Definition:

- A break of the femur where it meets the pelvic bone that occurred during the past 30 days (or since the last assessment) that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Osteoporosis:

Definition:

- A condition or disease in which the bones become brittle and fragile from loss of bone tissue.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Other fracture during the last 30 days (or since last assessment if less than 30 days):

Definition:

- Any break of a bone, other than hip bone (e.g. wrist), due to any condition – e.g. falls, weakening of the bone as a result of cancer, etc.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
  - **Not present**
  - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
  - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Neurological:

Alzheimer's disease:

Definition:

- A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
  - **Not present**
  - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
  - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Dementia other than Alzheimer's disease

Definition:

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

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Cerebral Palsy

Definition:

- A group of neurological disorders that affect a person's ability to move and maintain balance and posture. These disorders appear in infancy or early childhood and permanently affect body movement and muscle coordination.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Hemiplegia

Definition:

- Paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Multiple sclerosis:

Definition:

- A disease in which there is demyelination through-out the central nervous system. Typical symptoms are weakness, un-coordination, paresthesia, speech disturbances and visual complaints.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Paraplegia:

Definition:

- Paralysis (i.e., a temporary or permanent impairment of active motion) of the lower part of the body, including both legs.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Parkinson's disease:

Definition:

- A disorder of the brain characterized by tremor and difficulty with walking, movement and coordination.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Quadriplegia:

Definition:

- Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs and trunk.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Stroke/CVA:

Definition:

- A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Transient Ischemic Attack (TIA)

Definition:

- Transient or brief episode of neurologic dysfunction resulting from an interruption in the blood supply to the brain or eye – sometimes referred to as a "mini stroke"

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Traumatic Brain Injury

Definition:

- A nondegenerative, non-congenital injury to the brain from an external force, leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Psychiatric/Mood

Anxiety:

Definition:

- A group of non-psychotic mental disorders – Generalized Anxiety Disorder; Obsessive-Compulsive Disorder; Panic Disorder; Phobias; Post-Traumatic Stress Disorder – that often cause constant feeling of fear, worry, or nervousness.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Depression:

Definition:

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

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Bipolar disorder:

Definition:

- "Bipolar disorder" is a mental condition marked by alternating periods of elation and depression, formerly referred to as "manic depression". Includes documentation of clinical diagnoses of either manic depression or bipolar disorder

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Schizophrenia:

Definition:

- A mental disorder in which people interpret reality abnormality and is characterized by delusions, hallucinations, disorganized speech, grossly disorganized behavior, disordered thinking, or flat affect. This category includes schizophrenia subtypes (e.g. paranoid, disorganized, catatonic, undifferentiated, residual).

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Other:

Renal Failure:

Definition:

- A condition in which a the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Cancer:

Definition:

- Any malignant growth or tumor caused by abnormal and un-controlled cell division. The malignant growth or tumor may spread to other parts of the body through the lymphatic system or the blood stream.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Diabetes mellitus:

Definition:

- Any of several metabolic disorders marked by inappropriately elevated blood glucose levels. Includes Type 1, Type 2, Maturity-onset, gestational diabetes, and neonatal diabetes.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Infections:

Antibiotic Resistant Infection:

Definition:

- An infection that occurs when bacteria evolve to evade the effect of antibiotics through multiple different mechanisms. e.g. Methicillin resistant staph infection

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Pneumonia:

Definition:

- Inflammation of the lungs, most commonly of bacterial or viral origin.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Urinary tract infection in last 30 days:

Definition:

- Includes chronic and acute symptomatic infection(s) in the last 30 days. Code only if there is current supporting documentation and significant laboratory findings in the clinical record.

Process:

- Talk to the participant and review any available clinical/medical records. If necessary, consult with the participant's primary physician or nurse practitioner. Talk with family members.

Coding:

- For all diseases present, select from the following options:
    - **Not present**
    - **Diagnosis present, receiving active** treatment - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section J: RN - Health Conditions and Preventative Health Measure

- The intent of this section is to gather information regarding the participant's health beliefs and behaviors, specifically the participant's perspective on preventative health. The participant's beliefs related to prevention and treatment may significantly impact the participant's involvement in the care planning process and self-interventions needed to meet the participant's goals.

- This section also gathers additional information regarding the participant's current health status and their self-reported health. More information regarding how the participant's diagnosis impacts their life and daily living, as well as potential risks that may exist due to various problems/issues.

- The section provides an opportunity to conduct an informal pain assessment in order to gain a clearer picture of the participant's pain and pain therapeutic treatment regimen.

- To confirm the information provided in the section, Supports Coordinators may want to request a copy of the participant's medical records.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Prevention:

- This section helps home care workers to identify whether the participant has unmet needs for health counseling and preventative care.
- If the participant answers "No" to the questions in this section, the Supports Coordinator should ask follow-up questions to determine the participant's reasoning for declining the preventative health measures and document the participant's answers in the "Description of Conditions Noted Above" section. Understanding the participant's perspective on preventative health and treatment could have a direct impact on the care planning process.
- If appropriate, the Supports Coordinator can provide more education and information to the participant regarding the importance of preventative care.
- The Supports Coordinator may also assist the participant with scheduling and/or receiving preventative measures if the participant is agreeable.

Blood Pressure Measured in the Last Year:

Definition:

- The participant's blood pressure was measured by a clinician during the last year.

Process:

- Ask the participant if they have had their blood pressure measured in the last year.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Colonoscopy Test in Last 5 Years:

Definition:

- The entire colon (from anus to cecum) was viewed by means of a fiber-optic colonoscopy.

Process:

- Ask the participant if they have had a colonoscopy test in the last 5 years.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Pneumovax Vaccine in last 5 Years or After Age 65:

Definition:

- The participant received the vaccine for prevention of pneumonia within the last 5 years or after age 65.

Process:

- Ask the participant if they have had a pneumonia vaccine in the last 5 years.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Influenza Vaccine in Last Year:

Definition:

- The participant has received vaccination for influenza prevention during the past year.

Process:

- Ask the participant if they have received the influenza vaccine.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Have you had a Fully Completed Covid-19 Vaccine:

Definition:

- The participant has received the initial two-dose vaccination for Covid-19.

Process:

- Ask the participant if they received the two-dose Covid-19 vaccination.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If Yes, have you had a Covid-19 Vaccine Booster:

Definition:

- The participant has received Covid-19 vaccine booster.

Process:

- If the participant answered "Yes" to receiving the initial two-dose Covid-19 vaccination, ask if they received the Covid-19 vaccine booster. If they answer "Yes", document if the participant has received more than 1.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If Male, Prostate Exam:

Definition:

- The participant has received a screening for prostrate cancer through a blood test and rectal exam.

Process:

- Ask the participant if they have had a prostrate exam.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If Male, Testicular Exam (self or health provider):

Definition:

- The participant has had their testicles inspected, both the appearance and feel.

Process:

- Ask the participant if they have had a testicular exam.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

If Female, Mammogram or Breast Exam in Last 2 Years:

Definition:

- The participant had either a mammogram or a breast examination by a clinician during the last 2 years.

Process:

- Ask the participant if they have had a mammogram or breast exam in the last two years.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Falls:

Definition:

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

Process:

- Ask the participant if they have fallen recently.
- If they answer "Yes" ask for more information regarding the fall.
    - How many times have they fallen?
    - Have they fallen in the last 30 days? If so, how many times?
    - Have they fallen in the last 90 days? If so, how many times?
    - Did the fall(s) result in injury?
    - What was the cause or reason for the fall(s)?
- To determine if the participant is a fall risk due to frequent falls and is at risk of injury, it may be appropriate to ask additional follow up questions at this time to determine if there are certain circumstances or contributors to the participant's falls. The Supports Coordinator may need to provide education or recommend resources/classes available to the participant. Document additional information in the "Description of Conditions Noted Above" section.

Coding:

- Select from the following options:
    - **No fall in last 90 days**
    - **No fall in last 30 days, but fell 31-90 days ago**
    - **One fall in last 30 days**
    - **Two or more falls in last 30 day**

Recent Falls:

Definition:

- Any unintentional change in position where the participant ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others in less than 30 days.

Process:

- Asked at follow-up assessment only, and then only if there is less than 30 days since last assessment.
- This question is not asked at the initial assessment or if the last assessment was more than 30 days ago.

Coding:

- Select from the following options:
    - **Not applicable (first assessment, or more than 30 days since last assessment)**
    - **No fall in last 30 days**
    - **Yes, fall in last 30 days**

Problem Frequency:

- For questions related to problem frequency, if the participant answers "Yes", it may be appropriate to ask follow up questions to gain more insight into the circumstances surrounding the issue/problem. It is important to determine the frequency at which an issue occurs, but it is also vital to determine if there are potential interventions and/or education that could be discussed or implemented to mitigate the participant's risk.
- All additional information regarding problems specified in this section should be documented in further detail in the "Descriptions of Conditions Noted Above".

Balance:

Difficult or unable to move to a standing position unassisted:

Definition:

- The participant needs physical assistance or has difficulty moving from a seated position to a standing position.

Process:

- Ask the participant about their balance. Have they had any difficulty moving to a standing position unassisted in the last 3 days?

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Difficult or unable to turn self around and face the opposite direction when standing

Definition:

- The participant has difficulty or is unable to independently turn themselves around, while standing, to face the opposite direction.

Process:

- Ask the participant about their balance. Have they had any difficulty turning themselves around, while standing, in the last 3 days?

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Dizziness:

Definition:

- The participant experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

Process:

- As the participant if they have experienced any dizziness in the last 3 days.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Unsteady gait:

Definition:

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

Process:

- Ask the participant about their balance while walking in the last 3 days. Ask if they have ever had someone express concern about their balance while walking. Ask if their physician has ever recommended using a cane or walker while ambulating.
- Observe the participant's gait as they move through the home during the assessment and make note of any concerns.
- Ask a family member/caregiver, if applicable.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Cardiac or Pulmonary:

Chest pain

Definition:

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

Process:

- Ask the participant if they have experienced any chest pains in the last 3 days.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Difficulty clearing airway secretions:

Definition:

- The participant re-ports or has been observed to be unable to cough effectively to expel respiratory secretions (e.g. secondary to weakness or pain) or is unable to mobilize secretions or sputum from mouth (e.g. secondary to dysphagia or pain) or tracheostomy (e.g. secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples include a participant with pneumonia who is too weak to cough and expel sputum or someone with ALS who requires suctioning to manage secretions.

Process:

- Ask the participant if they have had any issues clearing their airway secretions in the last 3 days.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Psychiatric:

Abnormal thought process (e.g. loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality):

Definition:

- There are abnormalities in the form or way in which the participant is expressing thoughts. Included are indicators such as loosening of associations, thought blocking, flight of ideas, tangentiality, circumstantiality, clang association, incoherence, neologisms, punning, etc.
    - Loose associations: The participant jumps from one topic to another without an apparent connection between the topics.
    - Thought blocking: The participant suddenly stops in the middle of a sentence, and is unable to recover what he or she said or complete other thoughts.
    - Flight of ideas: The participant's thoughts are expressed so quickly that the listener has difficulty keeping up.
    - Tangentiality: A thought process whereby the participant digresses from the subject under discussion and introduces thoughts that seem unrelated, oblique, or irrelevant.
    - Circumstantiality: The participant exhibits lack of goal directedness, incorporates unnecessary details, and has difficulty getting to an end point in the conversation.
    - Clang Association: The connection between the participant's thoughts is tenuous. The participant may use rhyming and punning in their speech.

    - Incoherence: The participant's speech is unclear or confused. The communication does not make sense to the intended listener.
    - Neologism: A word made up by the participant that is often condensed from several words. Neologisms are unintelligible to the listener.
    - Punning: The participant uses words that are similar in sound, but different in meaning.

Process:

- Due to the nature of this question, the participant may not be able to identify abnormalities in their own thought processes
- Supports Coordinators should note objective observations in the form or way in which the participant is expressing their thoughts.
- If able, the Supports Coordinator should gather input from family and/or caregivers.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Neurological:

Aphasia:

Definition:

- A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing), or understanding spoken or written language.

Process:

- Due to the nature of this question, the participant may not be able to communicate this answer effectively.
- Supports Coordinators should note objective observations in the way in which the participant is expressing themselves verbally.
- If able, the Supports Coordinator should gather input from family and/or caregivers.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

GI Status:

Acid Reflux:

Definition:

- The regurgitation of small amounts of acid from the stomach to the throat.

Process:

- Ask the participant if they have experienced acid reflux in the last 3 days.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Constipation:

Definition:

- No bowel movement in 3 days or difficult passage of hard stool.

Process:

- Ask the participant if they have had any constipation or any difficulty passing their stool in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Diarrhea:

Definition:

- The frequent elimination of watery stools caused by any etiology.

Process:

- Ask the participant if they have had any diarrhea in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Vomiting:

Definition:

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

Process:

- Ask the participant if they have vomited in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Difficulty Urinating or Urinating 3 or more times at night:

Definition:

- Difficulty starting the stream of urine, keeping it flowing, or the flow of urine stops before the bladder is empty. The participant may also exhibit frequent urination of 3 or more times during the night.

Process:

- Ask the participant if they have had any difficulty with urination or have experienced frequent urination at night, in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Sleep Problems:

Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep:

Definition:

- The participant experiences an extended time gap between the point at which he/she attempted to fall asleep and the time at which sleep was actually initiated; wakes up well before the desired time due to some factor inherent to him/her (exclude situations in which the participant is awakened by some external source); Experiences sleep that is accompanied by repeated tossing and turning, or dreaming that causes motion or wakefulness, etc. such that the participant does not feel relaxed when sleeping or rested when awake; Is easily awakened during sleep by sounds or movements and experiences one or more periods of awakening after sleep is initiated.

Process:

- Ask the participant if experience any difficulty with sleep in the last 3 days.
- If the participant answers, "Yes", ask them for more information regarding their experiences with sleep. Ask them if they have difficulty falling or staying asleep, waking up early, non-restful sleep, etc.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Too much sleep:

Definition:

- An excessive amount of sleep that interferes with the participant's normal functioning.

Process:

- Ask the participant if they experience getting an excessive amount of sleep in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Other:

Aspiration:

Definition:

- The inhalation of food or fluid into the participant's lungs.

Process:

- Ask the participant if they have experienced aspiration in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Fever:

Definition:

- A rise in the participant's body temperature, frequently as a result of infection.

Process:

- Ask the participant if they have had a fever in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Gastrointestinal (GI) Bleeding or Genitourinary (GU) Bleeding:

Definition:

- GI bleeding is any documented bleeding as diagnosed by a gastrointestinal evaluation or any evidence of current bleeding through rectal exam or guaiac testing. Bleeding may be frank (such as bright red blood) or occult (such as black, guaiac-positive stools). GU bleeding that occurs anywhere along the genitourinary tract. Urine that is dark or cloudy should be tested for the presence of blood. There may also be visible blood in the participant's urine, or frank (bright red blood) coming from the urethral opening.

Process:

- Ask the participant if they have experienced any GI or GU bleeding in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Peripheral edema:

Definition:

- The participant has an abnormal buildup of fluid in foot/ankle/leg tissues.

Process:

- Ask the participant if they have had any swelling in their foot/ankles/legs in the last 3 days.

Coding:

- Select from the following options:
  - **Not present**
  - **Present but not exhibited in last 3 days**
  - **Exhibited on 1 of last 3 days**
  - **Exhibited on 2 of last 3 days**
  - **Exhibited daily in last 3 days**

Dyspnea (Shortness of Breath):

Definition:

- The participant has reported or been observed to be breathless or "short of breath."

Process:

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

Coding:

- Code for the most severe occurrence during the last 3 days. If the symptom was absent over the last 3 days, but would have been present had the participant undertaken activity, code according to the activity level (day-to-day or moderate) that would normally have caused the participant to experience shortness of breath.
- Select from the following options:
    - **Absence of symptom**
    - **Absent at rest, but present when performed moderate activities –** moderate activities are defined as activities that include some type of physical exercise, such as walking a long distance, climbing 2 flights of stairs, or gardening.
    - **Absent at rest, but present when performed normal day-to-day activities** – normal day to day activities include all ADLs (bathing, transferring, etc.) and IADLs (e.g., meal preparation, shopping, etc.).
    - **Present at rest**

Fatigue:

Definition:

- An overwhelming or sustained sense of exhaustion resulting in de-creased capacity for physical or mental work. Normal day-to-day activities include all ADLs (bathing, transferring, etc.) and IADLs (e.g., meal preparation, shopping, etc.).

Process:

- Ask the participant if they experience exhaustion or fatigue when completing their normal daily routine.

Coding:

- If fatigue was absent over the last 3 days, but would have been present had the participant undertaken activity, code according to the activity level that would normally have caused the person to experience fatigue.
- Select from the following options:
    - **None –** No diminished energy
    - **Minimal** — Diminished energy but completes normal day-to-day activities
    - **Moderate** — Due to diminished energy, unable to finish normal day-to-day activities
    - **Severe** — Due to diminished energy, unable to start some normal day-to-day activities
    - **Unable to commence any normal day-to-day activities** — Due to diminished energy, unable to start any normal day-to-day activities

Self-Reported Health:

Definition:

- The participant's account of how they would rate their own health.

Process:

- Ask the participant, "In general, how would you rate your health?" based on the coding options provided below.

Coding:

- Do not code based on your own inferences about the participant's physical health and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the participant is unable (e.g., due to cognitive impairment) or refuses to respond, do not presume responses for the participant; instead, code that the participant could not/would not respond.
- Select from the following options:
    - **Excellent**
    - **Good**
    - **Fair**
    - **Poor**
    - **Could not (would not) respond**

Instability of Conditions:

Conditions/diseases make cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating):

Definition:

- The participant may have a condition such as ulcerative colitis, rheumatoid arthritis, or multiple sclerosis that causes pain or impairs mobility or sensation, resulting in increased dependence on others and depression.

Process:

- Consult with the participant and participant's family.
- Review any clinical records, if needed.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Experiencing an acute episode or a flare-up of a recurrent or chronic problem:

Definition:

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

Process:

- Consult with the participant and participant's family.
- Review any clinical records, if needed.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

End stage disease, 6 or fewer months to live:

Definition:

- The participant or family has been told that in the best clinical judgment of the physician, the participant has end-stage disease with approximately six or fewer months to live.

Process:

- Consult with the participant and participant's family.
- Review any clinical records.
- Use your clinical judgment to determine whether it is appropriate to ask the participant about whether they have an "end stage disease".

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Pain:

Definition:

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

Process:

- Ask the participant if they have any pain. If the participant answers, "Yes", ask them to rate their pain on a scale from 0 to 10, with 0 being no pain and 10 being unbearable pain.
- If the participant reports any of level of pain, the Supports Coordinator should ask follow up questions to determine the participant's location of pain, how they manage the pain, the "type" of pain that they feel, the frequency of the pain, and any treatment that they use to manage the pain. Make note of the participant's answers in the box provided.

Coding:

- Code using numbers between 0-10 in the small open box provided.
- Code using letters to document the participant's answers in the "Notes about pain" text box provided.

Pain Symptoms:

- Note: Always ask the participant about frequency, intensity, and control of the pain. Observe the participant and ask others who are in contact with the participant.
- This item can be used to identify indicators of pain, as well as to monitor the participant's response to pain management interventions. A substantial number of people with pain receive inadequate or no treatment. In particular, people with chronic, non-cancer related pain are often overlooked and not treated. One of the biggest reasons for this is that many people mistakenly believe that pain is to be expected as one ages, or that nothing can be done to relieve their pain.
- Pain is highly subjective. It is what the participant says it is. There are no objective markers or tests to indicate when someone is having pain, or to measure its severity. What a participant experiences may not be proportional to the type or extent of the underlying tissue damage. Sometimes a specific cause for chronic pain cannot be identified. Regardless, unless the participant refuses, pain must always be treated, even if its cause is unknown.
- The most accurate and reliable evidence of the existence of pain and its intensity is what the participant tells you. Even in cognitively impaired participants, self-reports of pain should be considered reliable.
- However, you may not get an accurate answer if you simply ask "Are you in pain?" A participant may think of "pain" as a more intense experience after an acute event -- such as what they may have experienced after surgery or spraining an ankle. For example, a woman may have a sore foot that "acts up" when she pivots to transfer to her wheelchair or the toilet but it does not bother her most of the time. So, she might deny being "in pain." People often use different words in describing pain, referring to what they're feeling as "discomfort", "burning", "hurting", "aching", "tightness", "heaviness", "soreness", or a "twinge" or "pang."
- If the participant states he or she has pain, ask about the degree of control. If the participant is unable to tell you if he or she is experiencing some type of painful sensation, observe the participant for indicators of pain such as moaning, wincing, or guarding. In some people, the presence of pain can be hard to discern. For example, participants with dementia may not be able to verbalize that they are feeling pain, although they may manifest pain by particular behaviors such as calling out. Although such behaviors may not be indicative solely of pain, the assessor needs to make a determination (through assessment) if the behaviors are secondary to pain. If necessary, ask those who have had frequent contact with the participant if he or she complained or showed evidence of pain in the last three days.

Frequency:

Definition:

- How often the participant complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched or other non-verbal signs suggesting pain)

Process:

- Ask the participant how frequently, in the last 3 days, they have complained of pain or others have noticed evidence of pain through the participants behavior or non-verbal signs.

Coding:

- Select from the following options:
    - **No pain**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1-2 of last 3 days**
    - **Exhibited daily in last 3 days**

Intensity of highest level of pain present:

Definition:

- The level of pain reported by or observed in the participant.

Process:

- Ask the participant their highest level of pain experienced in the last 3 days. If needed, prompt the participant with the coding options listed below.

Coding:

- Select from the following options:
    - **No pain**
    - **Mild**
    - **Moderate**
    - **Severe**
    - **Times when pain is horrible or excruciating**

Consistency of pain:

Definition:

- Measures the frequency (i.e., ebb and flow) of pain from the participant's perspective.

Process:

- Ask the participant the consistency or frequency of their pain in the last 3 days.

Coding:

- Select from the following options:
  - **No pain**
  - **Single episode during last 3 days**
  - **Intermittent** – not continuous or steady; occurring at irregular intervals
  - **Constant** – occurring continuously over a period of time

Breakthrough pain:

Definition:

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

Process:

- Ask the participant if they have experienced any sudden, acute, flare-ups of pain in the last 3 days.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Pain Control:

Definition:

- The ability of the current therapeutic regime to control the participant's pain adequately (from the participant's point of view). This item describes the adequacy or inadequacy of pain control measures (e.g., medications, massage, TENS, or other therapeutic regime) instituted by the participant, caregiver, or clinical staff caring for the participant.

Process:

- Ask the participant how they manage their pain.
- Ask the participant if they follow a therapeutic pain control regimen. Are satisfied with their current pain control regimen? Do they experience pain relief?

Coding:

- Select from the following options:
    - **No issue of pain**
    - **Pain intensity acceptable to participant, no treatment regimen or change in regimen required**
    - **Controlled adequately by therapeutic regimen**
    - **Controlled when therapeutic regimen followed, but not always followed as ordered**
    - **Therapeutic regimen followed, but pain control not adequate**
    - **No therapeutic regimen being followed for pain, pain not adequately controlled**

Other Status Indicators

Hygiene:

Definition

- Unusually poor hygiene, unkempt, disheveled. The participant is observed to have unusually poor hygiene well beyond what is considered culturally appropriate.

Process:

- Due to the nature of this question, it may be most appropriate to ask for input from family and/or caregivers.
- Supports Coordinators may also code based on their own observations of the participant's hygiene.

Coding:

- Select from the following options:
    - **Not present**
    - **Present but not exhibited in last 3 days**
    - **Exhibited on 1 of last 3 days**
    - **Exhibited on 2 of last 3 days**
    - **Exhibited daily in last 3 days**

Physically Restrained:

Definition:

- The participant is physically restrained on a regular basis - limbs restrained, use of bed rails, restrained to chair when sitting.

Process:

- Supports Coordinators should observe and make note of any noticeable restraints.
- Ask the participant and/or caregivers if restraints are used at any time. If so, determine and make note of the types of restraints used in the "Description of Conditions Noted Above".
- Depending upon the type of restraints, the Supports Coordinator may need to provide additional education. Please refer to the Participant Management of Risk policy regarding the use of restraints for more information on agency policy.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section K: RN - Nutritional/Hydration Status:

- This section is intended to gain insight into the participants nutritional status as well as any issues that may be present due to dehydration, lack of access to meals or appropriate nutrition, unexpected weight loss or weight gain, and any specific dietary needs or restrictions.

- This section also relates to the potential Social Determinants of Health that may impact the participant's access to nutrition, whether it be the type of foods available or access to groceries or prepared meals.

- If the participant is in need of home delivered meals, assistance with meal preparation, or nutritional supplements, the documentation in this section should reflect the need and the minimum requirements as set for in the MI Choice service standards.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Weight loss of 5% or more in last 30 days, or 10% or more in last 180 days

Definition:

- Weight loss of 5% or more in last 30 days, or 10% or more in last 180 days. 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 or social factors.

Process:

- Ask the participant or family about weight changes over the last 30 and 180 days.
- Measurement: Use actual records of weight if available. A subjective estimate of weight change from the participant or caretaker can be used if no written records are available. Identifying a particular time approximately 6 months previous (such as "compared to last New Year's") may help the participant remember their approximate weight 180 days ago.
- You may be able to help the respondent answer the question by asking "How much weight do you think you have lost?" and mentally compare this with the reported or your estimated current weight of the participant. You can also ask "Have you lost a lot of weight? Do you feel much thinner or weaker?" or "Your clothes seem very loose on you. Were you much heavier six months ago?"

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Weight Change – pounds:

Unintended weight loss of 10 pounds in last 6 months:

Definition:

- The participant has lost 10 pounds or more in the last 6 months without trying to lose weight.

Process:

- Ask the participant or family about weight changes over the last 180 days.
- Measurement: Use actual records of weight if available. A subjective estimate of weight change from the participant or caretaker can be used if no written records are available.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Unintended weight gain of 10 pounds in last 6 months:

Definition:

- The participant has gained 10 pounds or more in the last 6 months without trying to gain weight.

Process:

- Ask the participant or family about weight changes over the last 180 days.
- Measurement: Use actual records of weight if available. A subjective estimate of weight change from the participant or caretaker can be used if no written records are available.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Consumption:

In at least 4 of the last 7 days, person ate one or fewer meals a day

Definition:

- A meal is defined as an act or the time of eating a portion of food to satisfy appetite. The participant ate a "meal" one or fewer times a day in at least 4 of the last 7 days.

Process:

- Ask the participant about their regular food/meal intake. Ask the participant if they eat a meal or more every day. If not, determine whether or not they ate a meal once or less in the last 4-7 days.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Eats less than 2 meals per day

Definition:

- A meal is defined as an act or the time of eating a portion of food to satisfy appetite. The participant eats less than 2 meals a day on a consistent basis.

Process:

- Ask the participant about their regular food/meal intake. Ask the participant if they eat at least 2 meals or more every day. If not, determine if they eat less than 2 meals per day consistently.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Eats few fruits/vegetables/milk products:

Definition:

- The participant eats a small number of fruits, vegetables, and/or milk products daily. The CDC recommends 1 ½ to 2 cups of fruits, 2 to 3 cups of vegetables, and 3 cups of milk daily for the average American adult (based on a normal diet).

Process:

- Ask the participant about their daily intake of fruit, vegetables, and milk products. Ask the participant to estimate the amount of each category they consume.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Has illness/condition that changes the kind or amount of food eaten:

Definition:

- The participant has been diagnosed with an illness or condition that has impacted the amount of food or the kind of food that the participant can consume.

Process:

- Ask the participant if they have had any changes to their diet recently. If so, ask if this was a result of an illness or condition that was diagnosis.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Able to chew, swallow foods prepared or presented:

Definition:

- The participant is able to chew and swallow the foods prepared or presented to them. The foods may already be manipulated or modified in some way prior to being presented to them. This is a measure of whether or not they are able to consume the food served to them on a regular basis.

Process:

- Ask the participant if they are able to chew and swallow foods as prepared or presented to them on a regular basis.
- If not, ask the participant what they experience – difficulty swallowing or difficulty chewing – and if this is a new issue. Make note of any other additional and/or important information in the "Description of Conditions Noted Above".

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Dietary supplement between meals (in the last 7 days):

Definition:

- The participant consumed a dietary supplement between their regular meals in the last 7 days. These may be supplemental meal bars or liquid supplements intended to add to the participant's nutritional intake.

Process:

- Ask the participant if they have consumed any dietary supplements in the last 7 days.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Dehydrated:

Definition:

- A condition that occurs when the body loses too much water and other fluids that it needs to work normally.

Process:

- Ask the participant if they have any issues with dehydration. Symptoms may include feeling thirsty or lightheaded, tiredness, dark-colored or strong-smelling urine, and having limited urine output.
- Identifying dehydration can be difficult. Record your clinical judgment based upon signs and symptoms (e.g., severe vomiting over a period of time). Alternatively, a laboratory results indicating dehydration may be available (i.e., BUN/creatinine ratio of >25) (Note – the standard for the latter ratio value can be country specific).

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Fluid intake less than 1,000 cc per day:

Definition:

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

Process:

- Ask the participant how much fluid/liquid they consume on a daily basis.
- Ask the participant the type of fluid they normally consume (water, coffee, soda pop, etc) and make note in the "Description of Conditions Noted Above".

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Mode of Nutritional Intake

Definition:

- How the participant receives the majority of their daily nutrition.

Process:

- If the participant reported having difficulty swallowing in the previous question, ask the participant if there are any dietary modifications needed to the consistency of their food to address their swallowing difficulties.
- Note if these issues are a result of a disease process or functional decline.
- If available, review the participant's clinical record, including MD, dietitian and Speech Language Pathology notes if applicable.

Coding:

- Select from the following options to indicate which item best describes the dietary prescription used to accommodate swallowing difficulties:
  - **Normal** — Swallows all types of foods
  - **Modified independent** — e.g. liquid is sipped, takes limited solid food; need for modification may be unknown
  - **Requires diet modification to swallow solid food** — e.g., mechanical diet (e.g. puree, minced, etc.) or only able to ingest specific foods
  - **Requires modification to swallow liquids (e.g., thickened liquids)**
  - **Can swallow only pureed solids AND thickened liquids**
  - **Combined oral and parental or tube feeding**
  - **Nasogastric tube feeding only**
  - **Abdominal feeding tube** (e.g. PEG tube)
  - **Parenteral feeding only —** includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
  - **Activity did not occur** — Did not eat or receive any form of nutritional supplementation during entire period

Type of Diet:

Definition:

- The kind of food that a person consumes on a regular basis. It may be a special course of food to which the participant restricts themselves for medical reasons.

Process:

- Ask the participant if they follow a special diet or if their physician has recommended a special diet due to medical reasons.

Coding:

- Select and check the box for the following options:
  - **Regular –** Diet with no specific restrictions.
  - **Sodium Restricted –** Diet that consists of foods naturally low in sodium and prepared without salt.
  - **Fat Controlled** - Diet often limits fat to 50 grams per day; often recommended for cardiac patients and those with certain gastrointestinal disorders.
  - **Diabetic –** Diet for those with diabetes or high blood sugar; often low in fat and calories
  - **Mechanical Soft –** Diet designed for people who have trouble chewing and swallowing; foods are chopped, ground and/or pureed.
  - **Bland Low Residue –** Diet that limits dietary fiber to less that 10-15 grabs per day with restrictions for foods that could stimulate bowel activity.
  - **Calorie Restricted –** Diet that reduces average daily caloric intake.

Diet Comments:

Definition:

- Additional details about the participant's regular diet and nutritional habits.

Process:

- Ask the participant if there are any other specific details or information about their diet and nutritional habits.

Coding:

- Use letters
- Enter in the open text box provided.

Physically capable to purchase or attain ample food/fluids to meet dietary needs:

Definition:

- Participant is physically able to purchase or secure appropriate amounts of food and fluids to meet their dietary needs. This may be through access to the grocery store, food pantries, food distribution or delivery, etc.

Process:

- Ask the participant if they have any difficulty getting the food and fluids that they need. Do they have access to a grocery store, home-delivered groceries, home-delivered meals, food distribution, etc.
- If they answer, "Yes", ask the participant the cause of the issue – i.e. issues of transportation, distance to the store, mobility, finances, etc.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Always has enough money to buy food:

Definition:

- The participant is able to purchase food on a regular basis without issue. The participant does not restrict purchasing food in order to buy or pay for something else.

Process:

- Ask the participant if they have any difficulty purchasing/buying food on a regular basis.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Eats alone most of the time:

Definition:

- The participant eats alone, by themselves, for the majority of their meals.

Process:

- Ask the participant if they eat alone for most of their meals.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section L: RN - Dental or Oral

- This section is intended to gain insight into the participant's overall oral health and dental status.

- In discussing dental status and oral health, the Supports Coordinator may gain insight into aspects of Social Determinants of Health, as well as the participants health beliefs regarding preventative exams and treatment.

- If the participant is in need of dental care or lacks access to care, the Supports Coordinator may be able to provide resources and assist with linking the participant with a potential dentist or dental clinic.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Dental or Oral

Dental Exam:

Definition:

- The participant underwent a dental examination by a dentist, oral surgeon or dental hygienist during the past year.

Process:

- Ask the participant if they have had a dental exam in the LAST YEAR. If the participant does not have intact teeth or wears dentures, ask if their primary physician checks their mouth or gums.
- If the participant answers "No", the Supports Coordinator should ask follow-up questions to determine the participant's reasoning for not having a dental exam and document the participant's answers in the "Description of Conditions Noted Above" section.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Reports difficulty chewing:

Definition:

- The participant is unable to chew food easily and without pain or difficulties, regardless of cause (e.g., the participant uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, temporomandibular joint pain, or a painful tooth).

Process:

- Ask the participant if they have any difficulties chewing.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Reports having dry mouth:

Definition:

- The participant reports having a dry mouth or difficulty in moving a food bolus in his or her mouth.

Process:

- As the participant if they regularly experience dry mouth.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Has broken, fragmented, loose, or otherwise non-intact natural teeth:

Definition:

- The participant has natural teeth that are broken, fragmented (i.e., piece of tooth may be missing), or loose (i.e., tooth is moveable when touched).

Process:

- Ask the participant if they have any broken, fragments, loose, or otherwise non-intact natural teeth.
- If the participant answers, "Yes", ask the participant if they currently have any mouth or dental pain associated with these teeth.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Person needs dental care

Definition:

- The participant needs dental care or a dental examination by a dentist, oral surgeon or dental hygienist.

Process:

- Ask the participant if they are need of dental care.
- If the participant answers, "Yes", ask the participant if they currently have a dentist or if they are in need of assistance in finding a dental clinic of dentist.
- If the participant is agreeable to assistance, the Supports Coordinator may help by providing information regarding available dentist or clinics in the participant's area.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Wears a denture (removable prosthesis) —

Definition:

- The participant wears a device that may replace all or some of the teeth of the upper or lower jaw. A denture is removable by the participant or a helper.

Process:

- Ask the participant if they wear a full or partial denture.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section M: RN - Hearing and Vision

- This section is intended to gain insight into the participant's visual and hearing needs, including documentation of the participant's potential visual impairment and need for, or use of, visual aids (e.g., talking clocks, large-font prescription labels), and documentation of the participant's potential hearing impairment and need for, or use of, hearing aids or other supports or devices (e.g., sign language interpreters, bed shakers).

- The Supports Coordinator should document any barriers to communication and their potential impact on the care planning process.

- In discussing the participant's hearing and visual needs, the Supports Coordinator may gain insight into aspects of Social Determinants of Health, as well as the participants health beliefs regarding preventative exams and treatment.

- If the participant is in need of a visual or hearing exam, and lacks access to care, the Supports Coordinator may be able to provide resources and assist with linking the participant with a potential physician or clinic.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Hearing:

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

Ability to Hear (with hearing appliance normally used)

Definition:

- The participants ability to hear based on their normal day-to-day routine and functioning. If the participant uses a hearing on a daily basis, then assess the participant's ability to hear verbal information using the hearing appliance.

Process:

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

Coding:

- Select from the following options:
  - **Adequate** — No difficulty in normal conversation, social interaction, listening to TV
  - **Minimal difficulty** — Difficulty in some environments (e.g., when participant speaks softly or is more than 6 feet [2 meters] away)
  - **Moderate difficulty** — Problem hearing normal conversation, requires quiet setting to hear well
  - **Severe difficulty** — Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly or participant reports that all speech is mumbled)
  - **No hearing**

Hearing Aid:

Definition:

- A small device that fits in or on the wear to amplify sound.

Process:

- Ask the participant if they use a hearing aid or assistive device.

Coding:

- Select from the following options:
    - **Uses reliably**
    - **Does not use reliably**
    - **Needed, but not available**
    - **Does not need/want**

Hearing Exam in the Last 2 Years:

Definition:

- The participant underwent a hearing examination by an audiologist, or other clinician within the past two years.

Process:

- Ask the participant if they have had a hearing examination within the last 2 years.
- If the participant answers "No", the Supports Coordinator should ask follow-up questions to determine the participant's reasoning for declining the hearing exam and document the participant's answers in the "Description of Conditions Noted Above" section.

Coding:

- Select from the following options:
    - **No**
    - **Yes**

Vision:

- Be sensitive to the fact that some participants are not literate or are unable to read English. In such cases, ask the participant to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

Ability to See in Adequate Light:

Definition:

- The participant's ability to see close objects in adequate light (sufficient or comfortable for a participant with normal vision) using the participant's customary visual appliances for close vision (e.g., glasses, magnifying glass).

Process:

- Ask participant about their ability to see in adequate light.
- Ask the participant about his or her visual abilities. Test the accuracy of your findings by asking the participant to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the participant to read aloud, starting with larger headlines and ending with the finest, smallest print.
- If the participant is unable to communicate or follow your directions for testing vision, observe the participant's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the participant has any visual ability.

Coding:

- Select from the following options:
    - **Adequate** — The participant sees fine detail, including regular print in news-papers/books.
    - **Minimal difficulty** — The participant sees large print, but not regular print in newspapers/books.
    - **Moderate difficulty**— The participant has limited vision; is not able to see newspaper headlines, but can identify objects in his or her environment.
    - **Severe difficulty** — The participant's ability to identify objects in his or her environment is in question, but the participant's eye movements appear to be following objects (especially people walking by). Also includes the ability to see only light, colors, or shapes.
        - **Note**: Many participants with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such participants appear to "track" or follow moving objects in their environment with their eyes. For participants who appear to do this, use code "3", Severe difficulty. This is the best assessment you can often do with the limited technology avail-able in the home care environment.
    - **No vision** — The participant has no vision; eyes do not appear to be following objects (especially people walking by).

Eye exam in last year:

Definition:

- The participant underwent an eye examination by an ophthalmologist, optometrist, physician, nurse, or other clinician within the past year.

Process:

- Ask the participant if they have had a visual examination in the last year.
- If the participant answers "No", the Supports Coordinator should ask follow-up questions to determine the participant's reasoning for declining a vision exam and document the participant's answers in the "Description of Conditions Noted Above" section.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section N: RN - Skin Condition

- This section is intended to gain insight into the participant's skin integrity and current skin issues. If the participant has current skin or foot problems, the Supports Coordinator may be able to provide education and interventions to mitigate risk to the participant's health and well-being.

- In discussing the participant's skin issues or needs, the Supports Coordinator may gain insight into aspects of Social Determinants of Health, as well as the participants health beliefs regarding preventative treatments and physical ability or mobility.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Major Skin Problems:

Definition:

- The participant has current burns or other major skin issues - items include lesions, 2nd or 3rd degree burns, and healing surgical wounds.

Process:

- Ask the participant if they have any major skin issues – refer to the types of skin problems listed above.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Most Severe Pressure Ulcer

Definition:

- Any lesion caused by unrelieved pressure. Pressure ulcers usually occur over bony prominences and are staged to classify the degree of tissue damage observed.

Process:

- Consult with the participant and family about the presence of an ulcer.
- Ask if the participant has been examined for the presence of pressure ulcers or other skin conditions. It may be necessary to consult with the participant's physician or wound care RN to determine the stage of the current pressure ulcer.

Coding:

- Select from the following options:
    - **No pressure ulcer**
    - **Any area of persistent skin redness**- An area of skin that appears continually reddened and does not disappear when pressure is relieved. There is no break in the skin. Also known as Stage 1.
    - **Partial loss of skin layers**- A partial thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater. Also known as Stage 2.
    - **Deep craters in the skin**- A full thickness of skin is lost exposing the subcutaneous tissues. Presents as a deep crater with or without undermining of adjacent tissue. Also known as Stage 3.
    - **Breaks in skin exposing muscle or bone** - A full thickness of skin and subcutaneous tissue is lost exposing muscle or bone. Also known as Stage 4.
    - **Not code able, e.g., necrotic eschar predominant –** Presence of necrotic (dead) tissue.

Prior Pressure Ulcer:

Definition:

- The participant's history of pressure ulcers.

Process:

- Ask the participant if he or she has ever had a pressure ulcer that is now healed. A review of old records (including discharge summaries), clinical progress notes, flow sheets, or care plans may also yield this information.
- If necessary, check with a family member or care provider who has prior knowledge of the participant's skin condition.

Coding:

- Select from the following options:
    - **No**
    - **Yes**

Presence of Skin Ulcer Other than Pressure Ulcer:

Definition:

- An open lesion caused by poor circulation in the lower limbs. (e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer)

Process:

- Ask the participant if they have any current skin ulcers not as a result of a pressure wound.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Skin Tears or Cuts (other than surgery):

Definition:

- Any traumatic break in the skin penetrating to the subcutaneous tissue. Does not include surgical incisions.

Process:

- Ask the participant if they have any skin tears or cuts not as a result from surgery.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Other Skin Conditions or Changes in Skin Conditions:

Definition:

- The presences of any other of skin conditions - e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema,

Process:

- Ask the participant if they have any other skin conditions or changes in skin conditions other than the problems noted previously.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Foot Problems:

Definition:

- Includes bunions, hammertoes, overlapping toes, structural problems, infections and ulcers.

Process:

- Ask the participant if they have any current foot problems that impact their ability walk.

Coding:

- Select from the following options
  - **No foot problems**
  - **Foot problems, no limitation in walking**
  - **Foot problems limit walking**
  - **Foot problems prevent walking**
  - **Foot problems, does not walk for other reasons**

Who Performs Foot Care:

Definition:

- The individual responsible for performing the participant's foot care.

Process:

- Ask the participant if they get regular foot care.
- If the participant receives regular foot care, ask them who is responsible for performing it.
- If the participant is in need of regular foot care, the Supports Coordinator must ensure that documentation is thorough in this section and represents the participant's inability to receive foot care though other sources (podiatrist, foot clinic, etc).

Coding:

- Use letters.
- Enter the name of the individual in the empty text box provided.
    - If the participant completes their own foot care, type "Self"
    - If the participant does not have anyone who assists, type "None"

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.

- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section O: RN – Continence:

- This section is intended to gain insight into the participant's potential issues with continence and the medical issues associated with their incontinence. If the participant has current urinary or bowel incontinence, the Supports Coordinator may be able to provide education and interventions to mitigate risk to the participant's health and well-being.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Bladder Continence:

Definition:

- Bladder incontinence includes any level of dribbling or wetting of urine in the last 3 days.
- This item describes the participant's pattern of bladder control considering any control plans or devices, such as scheduled toileting plans, continence training programs, or urinary appliances. It does not refer to the participant's ability to toilet him - or herself - e.g., a participant can receive extensive assistance in toileting and be continent.

Process:

- Ask the participant about their urinary elimination pattern over the last 3-day period, 24 hours a day, including weekends.
- Control of bladder function is a sensitive subject, particularly for participants who are struggling to maintain control.
- If possible, validate continence patterns with people who know the participant well (e.g., family caregivers).

Coding:

- Select from the following options:
  - **Continent** — Complete control, including control achieved by cuing or supervision that involves prompted voiding, habit training, reminders, etc. The participant DOES NOT USE any type of catheter or other urinary collection device.
  - **Complete control with any catheter or ostomy** — Control with use of any type of catheter or urinary collection device.
  - **Infrequently incontinent** — Not incontinent over last 3 days, but does have incontinent episodes (i.e., a recent history of incontinence).
  - **Occasionally incontinent** — Less than daily episodes of bladder incontinence (e.g., incontinent on 1-2 of the last 3 days).
  - **Frequently incontinent** — Incontinent daily, but some control present (e.g., the participant is not incontinent during each episode of urination) Example: During the day, the participant remains dry and is continent of urine. At night, the participant wets his or her bed.
  - **Incontinent** — No control of bladder; multiple daily episodes all or almost all of time.
  - **Did not occur** — No urine output from bladder in last 3 days.
- Code for the actual bladder continence pattern with urinary device if used. This pattern is the frequency with which the participant is wet during the 3-day assessment period. Do not record the level of control that the participant might have had under optimal circumstances (e.g., had a caregiver been available 24 hours/day to help the participant with toileting).

Urinary Collection Device (Excludes pads and briefs)

Definition:

- A device that allows the collection of urine, not pads or briefs.

Process:

- Ask the participant if they utilize any urinary collection devices, other than pads or briefs.
- If necessary, ask the caregiver and check any clinical documentation. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (e.g., a ureterostomy collection bag).

Coding:

- Select from the following options:
    - **None** – No device used.
    - **External (condom) catheter** — A urinary collection device worn over the penis.
    - **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.
    - **Cystostomy, Nephrostomy, Ureterostomy**
        - **Cystostomy** — A urinary collection appliance (urostomy bag) covers an opening to the bladder made by a surgical incision.
        - **Nephrostomy** — A tube, stent or catheter that is used to provide urinary drainage when a ureter is obstructed. In some cases, the catheter drains urine out of a participant's body into a drainage bag. In other cases, the catheter drains urine directly into the bladder.
        - **Ureterostomy** — A urinary collection device placed over a surgical urinary diversion, where the ureter(s) is detached from the bladder and brought to the surface of the abdomen.

Bowel Continence

Definition:

- The control of the participant's bowel movements over the last 3 days.
- This item describes the participant's bowel continence pattern with any scheduled toileting plans, continence training programs, or appliances in use. It does not refer to the participant's ability to toilet him or herself — e.g., a participant can receive extensive assistance in toileting and be continent of stool.

Process:

- Ask the participant about their bowel movement patterns over the last 3-day period, 24 hours a day, including weekends.
- Control of bowel movements is a sensitive subject, particularly for participants who are struggling to maintain control.
- If possible, validate continence patterns with people who know the participant well (e.g., family caregivers).

Coding:

- Select from the following options:
  - **Continent** — Complete control; DOES NOT USE any type of ostomy device
  - **Control with ostomy** — Control with ostomy device over last 3 days
  - **Infrequently incontinent** — Not incontinent over last 3 days, but does have incontinent episode(s)
  - **Occasionally incontinent** — Less than daily
  - **Frequently incontinent** — Daily, but some control present
  - **Incontinent** — No control present
  - **Did Not occur** — No bowel movement in the last 3 days

Pads or Briefs Worn

Definition:

- Any type of absorbent, disposable or reusable undergarment or item, whether worn by the participant (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 the participant is never or rarely incontinent.

Process:

- Ask the participant if they use any type or disposable or reusable undergarment on a regular basis.
- The Supports Coordinator should inquire regarding the type worn or needed and offer to arrange the participant shipment and delivery of regular supplies.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Ostomy Care:

Definition:

- An ostomy is a prosthetic medical device that provides a means for the collection of bowel waste.

Process:

- Ask the participant if they utilize an ostomy device.
- If the participant uses an ostomy, ask the participant if they manage their own ostomy or if someone else, like a caregiver or informal support, manages it for them.

Coding:

- Select from the following options:
    - **Ostomy (self-care)**
    - **Ostomy (not self-care)**
    - **No ostomy**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section P: RN - Physical Functioning

- The intent of this section is to assess the participant's ability and capacity for completing their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). In this section it is important to document which ADL or IADL with which the participant needs assistance as well as the type of assistance needed.

- It is critical to get a "picture" of the participant's day to day routine and functioning and capacity to meet their daily needs in order to effectively approach the care planning process.

- If the participant has Community Living Supports as a Waiver Service, this section (Physical Functioning) should be added as an issue in their Person-Centered Service Plan.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

IADL Self Performance and Capacity:

- In each of the following categories, the participant's actual performance as well as their capacity for completing the listed tasks.
- To measure performance, ask the participant what they actually did in each category within the last three days. Assess the level of assistance that they may have received to complete the task.
- To measure capacity, score based on the participant's presumed ability to carry out the activity. This requires speculation by the Supports Coordinator. It is also important to note that some participant may lack skills or experience in performing some activities but would be capable with proper training or opportunity.
- It is important to distinguish between physical capability and non-performance for reasons not related to health problems affecting capacity.

Meal Preparation- Performance:

Definition:

- How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils.)

Process:

- Ask the participant if they have prepared a meal in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Meal Preparation – Capacity:

Definition:

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

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for preparing a meal.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Ordinary Housework – Performance:

Definition:

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

Process:

- Ask the participant if they have completed any basic household tasks in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Ordinary Housework -Capacity:

Definition:

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

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity completing basic housework tasks.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Managing Finances – **Performance:**

Definition:

- How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored.

Process:

- Ask the participant if they have managed their finances in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Managing Finances – Capacity:

Definition:

- How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored.

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for managing their finances.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Managing Medications – **Performance**:

Definition:

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

Process:

- Ask the participant if they have prepared a managed their medications the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Managing Medications – Capacity:

Definition:

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

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for managing their medications.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Phone use – Performance:

Definition:

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

Process:

- Ask the participant if they have prepared used the phone in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Phone Use – Capacity:

Definition:

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

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for using the telephone.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Stairs – Performance:

Definition:

- How a full flight of stairs is managed (i.e., 12-14 stairs). [Note – if the participant is able to go up and down only a half flight (2-6 stairs), do not score as independent.]

Process:

- Ask the participant if they have climbed a flight of stairs in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Stairs – Capacity:

Definition:

- How a full flight of stairs is managed (i.e., 12-14 stairs). [Note – if the participant is able to go up and down only a half flight (2-6 stairs), do not score as independent.]

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for managing a flight of stairs.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Shopping – Performance:

Definition:

- How shopping is performed for food and household items (e.g., selecting items, paying money) – EXCLUDE TRANSPORTATION.

Process:

- Ask the participant if they have gone shopping in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Shopping – Capacity:

Definition:

- How shopping is performed for food and household items (e.g., selecting items, paying money) – EXCLUDE TRANSPORTATION.

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for shopping.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.
-

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Transportation – Performance:

Definition:

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

Process:

- Ask the participant if they have driven or utilized public transportation in the last 3 days.
- You may also talk to family members if they are available.

Coding:

- Measures what the participant actually did within each IADL category in the last 3 days. Do not base your coding on what the participant might be capable of doing (see IADL CAPACITY item).
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Transportation – Capacity:

Definition:

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

Process:

- Based on your observations, input from the participant, and conversation regarding the participant's self-performance, determine the participant's level of capacity for transportation.
- You may also talk to family members if they are available. Use your own observations as you are gathering information.

Coding:

- Code based on the participant's presumed ability to carry out the activity. This requires speculation by the assessor.
- Select from the following options:
    - **Independent** — No help, set up, or supervision
    - **Setup help only**
    - **Supervision** — Oversight/cuing
    - **Limited Assistance** — Help on some occasions
    - **Extensive assistance** — Help throughout task, but performs 50% or more of tasks on own
    - **Maximal assistance** — Help throughout task, but performs less than 50% of task on own
    - **Total dependence** — Full performance of activity during entire period by others
    - **Activity did not occur** — During entire period [Do not use this code in scoring capacity].

Activities of Daily Living (ADL) Self Performance:

- In each of the following categories, record the participant's actual level of involvement in self-care and the type and amount of support actually received during the last 3 days.
- Do not base your assessment on the participant's capacity for involvement in self-care or the level of assistance you think that the participant "should" be receiving. Record what is actually happening.
- To determine what the participant does for him/herself and the nature of assistance provided (if any), gather information from multiple sources (e.g., discussion with the participant, family, staff and others). Engage the family, caregivers, or formal home care staff, if possible, in discussions regarding the participant's ADL functions.
- When ADL self-performance in an area varies over the last 3 days, identify the three most-dependent episodes — i.e., the episodes when the participant received the greatest care or assistance from others. The summarization that is done to develop the ADL scores (as described below) focus on the most de-pendent episodes, providing a picture of the participant's need for input by others in managing this ADL.
    - **Note:** For Independent, Total Dependence, and Activity Did Not Occur, this is the only way a participant can be scored into these levels – **ALL** performance episodes over the last 3 days, must be at these levels
    - **Note:** This rule also applies even when where there was only one performance episode during the 3-day period (e.g., if the participant only moved once during the three days between locations on same floor but was bed-bound for the remainder of the time, then score Locomotion based on the single episode when they moved).

Bed mobility:

Definition:

- How moves to and from lying position, turns from side to side, and positions body while in bed.

Process:

- Ask the participant if they received any assistance with bed mobility in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Transfer toilet:

Definition:

- How moves on and off toilet or commode.

Process:

- Ask the participant if they received any assistance with transferring on and off the toilet in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Locomotion:

Definition:

- How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair.

Process:

- Ask the participant if they received any assistance with locomotion in the last 3 days and if so, how much.

Coding:

- Select from the following options:
  - **Independent** — No physical assistance, setup, or supervision in any episode
  - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
  - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
  - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
  - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
  - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
  - **Total dependence** — Full performance by others during all episodes
  - **Activity did not occur during entire period**

Dressing lower body:

Definition:

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

Process:

- Ask the participant if they received any assistance with dressing their lower body in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Dressing upper body:

Definition:

- How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pull-overs, etc.

Process:

- Ask the participant if they received any assistance with dressing their upper body in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Eating:

Definition:

- How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

Process:

- Ask the participant if they received any assistance with eating in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Toilet use:

Definition:

- How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET.

Process:

- Ask the participant if they received any assistance with using the toilet in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Personal hygiene:

Definition:

- How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands – EXCLUDE BATHS AND SHOWERS.

Process:

- Ask the participant if they received any assistance with personal hygiene in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Bathing:

Definition:

- How takes a full-body bath/shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen and perineal area – EXCLUDE WASHING OF BACK AND HAIR

Process:

- Ask the participant if they received any assistance with bathing in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Walking:

Definition:

- How walks between locations on same floor indoors.

Process:

- Ask the participant if they received any assistance with walking in the last 3 days and if so, how much.

Coding:

- Select from the following options:
    - **Independent** — No physical assistance, setup, or supervision in any episode
    - **Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode
    - **Supervision**-Oversight/cuing – someone remains nearby to watch over the participant.
    - **Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight
    - **Extensive assistance** — Weight-bearing support (including lifting limbs) by 1 helper where participant still performs 50% or more of subtasks
    - **Maximal assistance** — Weight-bearing support (including lifting limbs) by 2+ helpers -OR- Weight-bearing support for more than 50% of sub-tasks
    - **Total dependence** — Full performance by others during all episodes
    - **Activity did not occur during entire period**

Locomotion/Walking:

Primary Mode of Locomotion:

Definition:

- How the participant moves from one place to another, with or without appliances, aides or assistive devices over the last 3 days.

Process:

- Ask the participant how they have moved from one place to another, inside, within the last 3 days.
- Ask the participant if they utilize an appliances, aides, or assistive devices in order to support their ability to move safely.

Coding:

- Select from the following options:
  - **Walking, no assistive device**
  - **Walking, uses assistive device** (e.g., cane, walker, crutch, pushing wheelchair)
  - **Wheelchair, scooter**
  - **Bedbound**

Timed Walk - 4 meter (13 foot) walk

Definition:

- This is a performance test to provide a measure of the participant's stamina. It is designed to establish an objective benchmark for comparison of the participant's performance upon subsequent reassessments.

Process:

- Lay out a straight, unobstructed course, if possible. You could use a tape measure to measure off the 4 meters or create a comparable course that can be used at each subsequent reassessment.
- Have the participant walk at a normal pace and utilizing any assistive devices that they would normally use for ambulation. Use a stopwatch or watch to time how long it takes the participant to navigate the course from start to finish.
- Note that this is not an appropriate test to be done with participants who require any type of physical weight-bearing assistance to walk.

Coding:

- Select from the following options:
  - **Unable to create 13-foot course**
  - **Stopped before test complete**
  - **Refused to do the test**
  - **Not tested – e.g. does not walk on own**
  - **Test completed**
- Note all observations and the results of the test in the "Description of Conditions Noted Above"

Distance Walked

Definition:

- Farthest distance walked at one time without sitting down in the last 3 days, with support as needed.

Process:

- Ask the participant and family member about the participant's walking in the home or community during the last 3 days.
- Record the farthest distance walked without sitting down.

Coding:

- Select from the following options:
  - **Did not walk**
  - **Less than 15 feet (under 5 meters)**
  - **15-149 feet (under 5 - 49 meters)**
  - **150-299 feet (50 - 99 meters)**
  - **300+ feet (100+ meters)**
  - **½ mile or more (1+ kilometer)**

Distance Wheeled Self:

Definition:

- Farthest distance wheeled self at one time in the last 3 days (includes independent use of motorized wheelchair).

Process:

- Ask the participant and family member about the participant's movement in the home or community during the last 3 days. Record the farthest distance traveled without a prolonged stop.

Coding:

- Select from the following options:
  - **Wheeled by others**
  - **Used motorized wheelchair/scooter**
  - **Less than 15 feet (under 5 meters)**
  - **15-149 feet (5 - 49 meters)**
  - **150-299 feet (50 - 99 meters)**
  - **300+ feet (100+ meters)**
  - **Did not use wheelchair**

Change in ADL Status As compared with 90 days ago (or since last assessment if less than 90 days ago):

Definition:

- The participant's ability to complete their Activities of Daily Living have changed or remained the same within the last 90 days, or since the last assessment if less than 90 days ago.

Process:

- Talk to the participant. Ask them to think about how well they were able to do ADLs 90 days ago. How does the participant's current ADL status compare to 90 days ago?
- If indicated, talk to a family member or caregiver.

Coding:

- Select from the following options:
  - **Improved**
  - **No change**
  - **Declined**
  - **Uncertain**

Overall Self-Sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days ago)

Definition:

- The participant's overall self-sufficiency (including self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.) has changed or remained in the same over the last 90 days, or since the last assessment if less than 90 days.

Process:

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

Coding:

- Select from the following options:
  - **Improved**
  - **No change**
  - **Deteriorated**

Driving:

Drove Car (vehicle) in the last 90 Days:

Definition:

- The participant has operated and controlled the directions and speed of a motor vehicle.

Process:

- Ask the participant if they have driven a motor vehicle in the last 90 days.

Coding:

- Select from the following options
  - **No**
  - **Yes**

If drove in the last 90 days, assessor is aware that someone has suggested that person limits OR stops driving

Definitions:

- If the participant drove in LAST 90 DAYS, assessor is aware that someone has suggested that participant limits OR stops driving

Process:

- Ask participant about their driving and whether the participant plans to continue driving. Be aware that driving may be a sensitive issue. Certain conditions may impair driving ability temporarily or on a more permanent basis.
- Ask whether participant thinks they are able to drive currently.
- Ask the participant has ever had anyone express concern regarding their driving or if anyone has ever instructed them to limit or stop driving.

Coding:

- Select from the following options:
  - **No, or does not drive**
  - **Yes**

Activity Level:

In the last 3 days, number of days went out of the house or building in which the participant resides:

Definition:

- In the last 3 days, the participant went out of the house or building in which they reside - this means the participant went outdoors. This could be going into the yard, standing on an open porch, or walking down the street each day.

Process:

- Ask the participant if they went outside in the last 3 days.

Coding:

- Select from the following options:
  - **No days out**
  - **Did not go out in last 3 days, but usually goes out over a 3-day period**
  - **1-2 days**
  - **3 days**
- If illness or weather did not permit (e.g., if it snowed or there was a "tropical" downpour), use code "Did not go out in last 3 days, but usually goes out over 3-day period" if the participant did not leave the house, but normally would have during a 3-day period.

Total hours of exercise or physical activity in the LAST 3 DAYS (e.g., walking)

Definition:

- The total amount of the participant's exercise or physical activity in the last 3 days – any exercise that involves at least moderate physical activity, e.g., walking outdoors, swimming, yoga, class, exercise with machines.

Process:

- Ask the participant to describe their involvement in physical activity in the last 3 days (e.g., walking).

Coding:

- Select from the following options:
  - **None**
  - **Less than 1 hour**
  - **1 - 2 hours**
  - **3 - 4 hours**
  - **More than 4 hours**
- If the accumulated time is more than two hours but less than three then use "1 - 2 hours". Hours of exercise may be accumulated over several instances per day or all at once.

Physical Function Improvement Potential:

Person believes they are capable of improved performance in physical function:

Definition:

- The participant, in their opinion, believes that they are capable of improving their physical functioning.

Process:

- Ask the participant if they believe that they are capable of improving their current physical functioning. Record the participant's opinion only.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Care professional believes person is capable of improved performance in physical function:

Definition:

- The Supports Coordinator believes that the participant is capable of improved physical functioning.

Process:

- Based on all the information provided during the assessment and medical information gathered from physicians and other health records, make a determination of whether or not you believe that the participant is capable of improved performance in physical function.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section Q: RN - Service Utilization/Formal Care

- The intent of this section is to capture the number of minutes spent by formal caregiving agencies in providing care or care management in the last 7 days (or since last assessment if less than 7 days).

- There are many situations in which capturing the minutes of formal care over the last 7 days is not indicative of the participant's care plan. Authorized services versus received services could be different based on multiple factors – direct worker shortage; provider availability; participant hospitalization; aide illness; etc. In the event that the minutes reported in this section to do not represent the participant's authorized services as reflected in the Person-Centered Service Plan, you must note why in the "Description of Conditions Noted Above" text box. There should also be follow up noted in the Progress Notes.

- Be sure to document the different payor sources if the total amount of minutes reported include providers other than those provided through the Mi Choice Waiver – i.e. Medicare/Home Health; Tribal Services; etc.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Formal Care: Extent of Care in the Last 7 days

- Care or care management includes direct services provided to the participant (both ADL and IADL support), the management of care received (e.g., making medication schedules, planning for future needs), and the provision of therapeutic care by any formal agency or service provider.

Personal Assistants/Aides:

Definition:

- Home health aides or formal agency aides that provide "hands-on" ADL support and simple monitoring (taking blood pressure)

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Home Nurse:

Definition:

- Licensed or registered nurses providing assessment and complex or invasive interventions (skilled treatments), education and referral.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Homemaking Services:

Definition:

- Formal agency aides providing IADL support, usually in the form of housekeeping services, shopping, and meal preparation.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Meals:

Definition:

- Prepared meals delivered to the participant for immediate or later consumption, e.g. "Meals on Wheels."

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Physical Therapy:

Definition:

- Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others giving therapy.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Occupational Therapy:

Definition:

- Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupation therapy assistant may provide therapy but not supervise others giving therapy.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Speech-Language Pathology and Audiology Services:

Definition:

- Services provided by a qualified speech-language pathologist. Services may involve assessment of swallowing ability or hearing ability, swallowing therapy, speech therapy, communication therapy, providing hearing appliances and education.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Day Care or Day Hospital:

Definition:

- Adult day programs are planned programs of activities in a professional care setting designed for older adults who require supervised care during the day, or those who are isolated and lonely.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Social Worker in home:

Definition:

- Social workers provide support and act as advocates for patients who are working through psychological, health, family, and financial struggles.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

Psychological Therapy:

Definition:

- Therapy given by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

Process:

- Ask the participant or helper(s) about the agencies involved with care, about the nature of the relationship, and the amount of time spent in providing care or care management.
- If possible, contact the agencies providing services or care management to confirm responses. Consult log books that the participant may have in the home, and review agency documentation if available.

Coding:

- Select the best category for the type of support provided
- Code the number of total days in column A (maximum = 7)
- Code the number of total minutes in column B.
- Do not double code.

I want an alternate caregiver to provide services if my regularly scheduled person is not available:

Definition:

- An alternate caregiver or back up worker would provide assistance if the participant's regularly scheduled aide/caregiver was not available.

Process:

- Ask the participant if they would be agreeable to alternative caregiver providing assistance if their regularly scheduled aid/caregiver was not available.
- If the participant has chosen self-determination, ask if they have a back-up worker they would like to enroll as an alternate caregiver.

Coding:

- Select the following options:
  - **No**
  - **Yes**

My Back-Up Plan for Care:

Definition:

- The participant's contingency plan for services or care.

Process:

- Discuss the participant's wishes for care if their regularly-scheduled caregiver/aide is unable to provide assistance.
- Discuss and document any informal supports or caregivers that would be able to provide care in the event that contracted providers are unable to provide care.
- In situations where services are limited or not available due to participant location and/or provider agency staffing, discuss the potential risks with the participant.
- If there are no informal supports able to supplement paid providers or the participant has specified that they do NOT want alternate caregivers, note all unaddressed needs in this section. Provide a brief summary stating specifically which services will not be provided and that the participant is aware of the risks.

Coding:

- Use letters/text in the open text box provided

Back-Up Plan Reviewed:

Definition:

- The Back-Up Plan is reviewed with the participant at each assessment, no less than annually.

Process:

- Review the participant's plan for alternative services and make any changes as needed.
- Review the COMPASS-populated Back-Up Plan with the participant and note any changes needed. Ensure that the participant receives a copy of this plan annually.

Coding:

- Select the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section Q: Service Utilization/Treatments and Programs Received or Scheduled

- The intent of this section is to review prescribed treatments and determine the extent of the participant's adherence to the prescription. This section includes special treatment, therapies and programs received or scheduled during the last 3 days (or since the last assessment if less than 3 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.

- Be sure to document treatments that are regularly received but may not have been administered in the last 3 days or treatments that are not included in the following assessment questions.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Treatments and Programs Received or Scheduled in the Last 3 Days (or Since Last Assessment if Less than 3 Days):

Transfusion:

Definition:

- A procedure in which blood are put into a participant's bloodstream through a vein. Includes transfusion of blood (whole blood) or any type of blood products.

Process:

- Ask the participant if they received a transfusion in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Chemotherapy:

Definition:

- A treatment that uses chemical substances to stop the growth of cancer cells. Includes any type of chemotherapy (anticancer drug) given by any route.

Process:

- Ask the participant if they received any chemotherapy in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Dialysis:

Definition:

- A treatment that purifies blood by removing extra fluid and waste products when the kidneys are unable to. Includes peritoneal or renal dialysis that occurs at home or at a facility

Process:

- Ask the participant if they received dialysis in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

IV Medication:

Definition:

- IV (Intravenous) medications that are solutions administered directly into a vein via a syringe or intravenous catheter (tube). Includes any drug or biological (e.g. contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

Process:

- Ask the participant if they received an IV in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Oxygen Therapy:

Definition:

- Treatment that provides supplemental oxygen. Includes continuous or intermittent oxygen via mask, cannula, etc.

Process:

- Ask the participant if they received oxygen therapy in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Radiation:

Definition:

- The use of high-energy radiation from x-rays, gamma rays, neutrons, protons, and other sources to kill cancer cells and shrink tumors. Includes radiation therapy or having a radiation implant.

Process:

- Ask the participant if they received radiation in the last 3 days.

Coding:

- Select from the following options:
    - **Not ordered AND did not occur**
    - **Ordered, not implemented**
    - **1 - 2 of last 3 days**
    - **Daily in last 3 days**

Tracheostomy Care:

Definition:

- A tracheostomy is a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing. Care includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions.

Process:

- Ask the participant if they received any tracheostomy care in the last 3 days.

Coding:

- Select from the following options:
    - **Not ordered AND did not occur**
    - **Ordered, not implemented**
    - **1 - 2 of last 3 days**
    - **Daily in last 3 days**

Ventilator or Respirator:

Definition:

- Mechanical device designed to provide adequate ventilation in participants who are, or may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Includes any participant who was in the process of being weaned off of the ventilator or respirator in the last 3 days.

Process:

- Ask the participant if they have utilized a ventilator or respirator in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Infection Control (e.g. isolation; quarantine):

Definition:

- Enforced isolation or restriction of free movement imposed to prevent the spread of a contagious disease.

Process:

- Ask the participant if they have been in isolation or quarantine in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Suctioning:

Definition:

- Suctioning is the mechanical aspiration of pulmonary secretions from a patient with an artificial airway in place. Includes oropharyngeal, nasopharyngeal, or tracheal aspiration.

Process:

- Ask the participant if they required suctioning in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Wound Care:

Definition:

- Includes the application of bandages (e.g. dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles); wound irrigation; application of ointments and topical medications to treat skin conditions (e.g. cortisone, antifungal preparations, chemotherapeutic agents, etc.); debridement (chemical or surgical) to remove dirt or dead tissue from a wound; suture removal.

Process:

- Ask the participant if they received any wound care in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Palliative Care Program:

Definition:

- A formal program in which care is focused on the relief of pain and other uncomfortable symptoms (e.g., dyspnea). Participants receiving palliative care generally have end-stage disease, but may not necessarily have a life prognosis of 6 months or less to live (e.g., the participant may live for many months or years).

Process:

- Ask the participant if they received palliative care in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Scheduled Toileting Program:

Definition:

- The participant is taken to the toilet room, or given a urinal, or reminded to go to the toilet on a regular and ongoing basis. In the home, this may be done by family members or paid help. Includes any habit training or prompted voiding program.

Process:

- Ask the participant if they have been on a scheduled toileting program in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Turning/Repositioning Program:

Definition:

- The participant is periodically turned from side to side and onto his or her back while in bed. Once the participant has been turned to the new side, staff ensures that the head, torso and limbs are positioned to minimize pain, promote function, and minimize pressure on bony prominences.

Process:

- Ask the participant if they received any turning or repositioning in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Medical Alert Bracelet or Electronic Security Alert:

Definition:

- Medical alert bracelet is jewelry that contains unique medical information that includes conditions, allergies, medication and more to provide first response personnel with important information regarding your health.
- An Electronic Security Alert is a system that provides an alert when there is a medical emergency or other necessary event requiring attention. This includes a wander guard or other safety alert device within a residential setting.

Process:

- Ask the participant if they used a medical alert bracelet or electronic security alert unit in the last 3 days.

Coding:

- Select from the following options:
  - **Not ordered AND did not occur**
  - **Ordered, not implemented**
  - **1 - 2 of last 3 days**
  - **Daily in last 3 days**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section Q: RN -Service Utilization/Equipment:

- The intent of this section is to review the participant's medical equipment and record how the equipment is managed and by whom in the last 14 days.

- Many of the answers within this section directly relate to the COMPASS Back-Up Plan that is provided to the participant. Ensure that this section is completed entirely. Make note of any additional information regarding the management and use of equipment.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Management of Equipment (in last 14 days):

Oxygen:

Definition:

- The participant utilizes oxygen and oxygen equipment is present and utilized in the last 14 days.

Process:

- Ask the participant how their oxygen is managed, if used, specifically over the last 14 days.
- If they receive any assistance, inquire regarding how much assistance was needed and who provided the assistance. If the assistance is provided informally, make sure that it is reflected in the PCSP.

Coding:

- Select from the following options:
  - **Not Used**
  - **Managed on own**
  - **Managed on own if laid out or with verbal reminders**
  - **Partially performed by others**
  - **Fully performed by others**

IV:

Definition:

- The participant utilizes an IV and equipment is present and utilized in the last 14 days

Process:

- Ask the participant how their IV is managed, if used, specifically over the last 14 days.
- If they receive any assistance, inquire regarding how much assistance was needed and who provided the assistance. If the assistance is provided informally, make sure that it is reflected in the PCSP.

Coding:

- Select from the following options:
  - **Not Used**
  - **Managed on own**
  - **Managed on own if laid out or with verbal reminders**
  - **Partially performed by others**
  - **Fully performed by others**

Catheter:

Definition:

- The participant utilizes a catheter and catheter equipment is present and utilized in the last 14 days.

Process:

- Ask the participant how their catheter is managed, if used, specifically over the last 14 days.
- If they receive any assistance, inquire regarding how much assistance was needed and who provided the assistance. If the assistance is provided informally, make sure that it is reflected in the PCSP.

Coding:

- Select from the following options:
  - **Not Used**
  - **Managed on own**
  - **Managed on own if laid out or with verbal reminders**
  - **Partially performed by others**
  - **Fully performed by others**

Other:

Definition:

- The participant utilizes medically necessary equipment in the last 14 days.

Process:

- Ask the participant if there is any other equipment utilized in the last 14 days. Document the type of equipment discussed and how much assistance was required to manage it.
- If they receive any assistance, inquire regarding how much assistance was needed and who provided the assistance. If the assistance is provided informally, make sure that it is reflected in the PCSP.

Coding:

- Select from the following options:
  - **Not Used**
  - **Managed on own**
  - **Managed on own if laid out or with verbal reminders**
  - **Partially performed by others**
  - **Fully performed by others**

Does person use medical equipment that relies on power?:

Definition:

- The equipment used by the participant relies on electrical power to operate properly.

Process:

- Ask the participant if they have medical equipment that relies on power.

Coding:

- Select from the following options:
  - **No**
  - **Yes**
  - **Not Applicable**

If yes, is there a back-up system in case of power failure?:

Definition:

- In the case of electrical or power failure, the participant has a back-up system so that the participant can continue to properly utilize the medical equipment.

Process:

- If the participant has medical equipment that relies on power, ask if they have a back-up system for their equipment in the event of power failure.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

What is the back-up system?"

Definition:

- In the case of electrical or power failure, the participant has a back-up system so that the participant can continue to properly utilize the medical equipment.

Process:

- Ask the participant what they use as a back-up system for their equipment in the event of power failure.

Coding:

- Select from the following options:
  - **Battery**
  - **Generator**
  - **Participant chooses not to have back-up system**

How many hours will the back-up system operate?:

Definition:

- The length of time the back-up system will support the medical equipment needed by the participant.

Process:

- Ask the participant how many hours the current back-up system will operate in the event of power failure.

Coding:

- Use numbers

If participant uses oxygen, are there back-up oxygen tanks present?:

Definition:

- Back-up tanks are metal cylinders containing oxygen under pressure and used for oxygen therapy.

Process:

- Ask the participant if they have oxygen tanks for back-up.
- Make sure to document the medical equipment company providing the back-up tanks as well as the amount normally on hand.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section R: RN - Medication Use

- The intent of this section is to determine if the participant is receiving medications as prescribed by a physician, nurse practitioner, or physician's assistant and assess the participant's medication use, adherence, and need for assistance.

- These questions also provide the Supports Coordinator an opportunity to assess the participant's health beliefs associated with medication use. The participant's health beliefs and behaviors associated with medication use can directly impact the participant's overall health status and potential success of the participant's goals and interventions in the PCSP.

- To determine if the individual has any known allergies to either prescription or over-the-counter medications and document the participant's reactions to documented allergies.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

My Medication List is located:

Definition:

- The participant's personal list of their current up-to-date medications.

Process:

- Ask the participant if they have a list of their current medications.
    - If the participant answers, Yes, ask where they keep their list and document the location.
    - If the participant answers, No, ask them if they would like you to provide a copy of their medications.

Coding:

- Use letters/text
- If the participant does not have a medication list, enter No List Available.

Adherent with Medication Prescribed by Physician:

Definition:

- The participant is taking medications as prescribed.

Process:

- Ask the participant if they take their medications as prescribed. If appropriate, ask the caregiver or informal support. Score based on what is actually happening, not the participant's intention to take the medication as prescribed.
- Remember, this item is not intended to evaluate the appropriateness of the medication prescribed.

Coding:

- Select from the following options:
  - **Always adherent**
  - **Adherent 80% of time or more** — Over the last 3 days, 24 hours a day, participant deviated from prescribed mediation regime 20%, or less, of the time.
  - **Adherent less than 80% of the time, including failure to purchase prescribed medications** — Over the last 3 days, 24 hours a day, participant deviated from prescribed mediation regime more than 20% of the time.
  - **No medications prescribed** — Participant is not receiving any prescribed medication.

Person Needs Reminding Several Times a day to Take Medications:

Definition:

- In order to be adherent, the participant requires multiple reminders to take medications as prescribed.

Process:

- Ask the participant how they ensure that they take their medications on time and as prescribed. Do they set alarms or require reminders from caregivers, family members, or informal supports? Do they use a medication machine?
- If they require reminders, how many times do they usually need to be reminded before taking their medications.
- If appropriate, ask caregivers for input.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Preparation of Medications Needed:

Definition:

- The participant requires assistance with setting up or preparing their medications on a daily basis.

Process:

- Ask the participant if anyone assists them with setting up or preparing their medications.
- If the participant requires assistance, document who assists the participant and what type of assistance they provide.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Medications Must be Administered to Person:

Definition:

- The participant requires the direct application of a prescribed medication – whether by injection, inhalation, ingestion, or other means.

Process:

- Ask the participant if anyone assists them with administering their medications. Are they able to apply their own topical ointments/creams? Are they able to administer their own injections or inhaled medications? Are they able to take their own oral medications without assistance?
- If the participant requires any assistance, document who assists the participant and what type of assistance they provide.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Allergy to Any Drug:

Definition:

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

Process:

- Ask the participant whether they are allergic or have ever had a reaction to a drug(s). Include reactions to both prescription and over the counter drugs administered by any route.

Coding:

- Select from the following options:
  - **No known drug allergies**
  - **Yes**

Allergies/Sensitivities, Specify – include reaction:

Pharmaceutical:

Definition:

- Pharmaceutical allergies involve an immune system response to a prescribed or over-the-counter medication.

Process:

- Ask the participant whether they are allergic or have ever had a reaction to a drug(s), including prescription and over-the-counter drugs.
- If the participant has had an allergic reaction, ask the participant what symptoms or reaction they experienced. Document all important details/information.

Coding:

- Use letters/text

Environmental:

Definition:

- Environmental allergies involve an immune system response to things that exist in our everyday surroundings – i.e. pollen, dust, mold, pets, etc.

Process:

- Ask the participant whether they are allergic or have ever had a reaction to any environmental triggers.
- If the participant has had an allergic reaction, ask the participant what symptoms or reaction they experienced. Document all important details/information.

Coding:

- Use letters/text

Food:

Definition:

- Food allergies involve an immune system response that occurs after eating or being exposed to a certain food.

Process:

- Ask the participant whether they are allergic or have ever had a reaction to any food.
- If the participant has had an allergic reaction, ask the participant what symptoms or reaction they experienced. Document all important details/information.

Coding:

- Use letters/text

Prior Description of Conditions Noted Above:

Definition:

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Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

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- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
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- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section S: RN – Vital Signs and Systems:

- The intent of this section is to record the participant's current height and weight in order to monitor nutrition, hydration status, and weight stability over time. For example, a participant who has had edema may experience an expected weight loss as a result of taking a diuretic. Weight loss can also be the intended result of limiting caloric intake and participating in an exercise program, or the unintended consequence of poor intake and malnutrition.

- Be sure to provide documentation in narrative form within the "Description of Conditions Noted Above" text box to summarize the information gathered in this section. Based on the participant's response to any of the questions, you may need to ask follow-up questions to gain more information that may be applicable to the participant's care and service planning. All pertinent information should be documented.

- A summary of the participant's answers, including the Supports Coordinator's observations of the home environment and any concerns, barriers, or potential issues, must be documented. **"No issues" or "No changes" are NOT sufficient.**

- If any concern, barrier, or potential issue is discussed and documented during the assessment, please make sure that any follow up contacts, updates, or interventions implemented to address the issue are documented in the Progress Notes, Participant-Centered Service Plan, if appropriate, and the Next Assessment.

Height

Definition:

- The measurement from head to foot of a standing person.

Process:

- Ask the participant for an estimate of their height. If needed, ask the participant's caregivers, family, or informal supports.

Coding:

- Use numbers
- Enter Feet
- Enter Inches
- Base height on estimate of most recent height measured. Round height up to nearest whole inch.

Weight

Definition:

- The measurement of the body's relative mass.

Process:

- Ask the participant for an estimate of their weight. If needed, ask the participant's caregivers, family or informal supports.

Coding:

- Use numbers
- Base weight on estimate of most recent weight measured. Round the participant's weight upward to the nearest whole pound.

Prior Description of Conditions Noted Above:

Definition:

- Automatically populated by COMPASS based on the text entered in the "Description of Conditions Noted Above" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Description of Conditions Noted Above" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's answers or anything else pertinent to the participant's needs.

Coding:

- Use printed letters/text.

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section T: RN – Nursing Notes:

- This section is intended to capture the signature of the Supports Coordinator, certify, and confirm completion of the RN Assessment.
- It also provides an opportunity for the Supports Coordinator to document any other pertinent information to the participant's case that was not documented in any of the previous sections within the RN Assessment.

RN Certification Agree:

Definition:

- Supports Coordinator certifies that based on the information obtained, observations made, and belief formed after reasonable inquiry, the statements and information contained in this document are true, accurate and complete.

Process:

- Once all answers are completed within all sections of the RN Assessment, confirm completion and certify accuracy of the answers and information documented.

Coding:

- Check the "Agree" box to indicate agreement with the certification statement.

Supports Coordinator Name:

Definition:

- The name and credentials of the Supports Coordinator that completed the RN Assessment.

Process:

- Type your name and professional credentials into the text box.

Coding:

- Use printed letters/text

Service Need Level:

Definition:

- Supports Coordinators must categorize each Mi Choice Participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports.

Process:

- Based on the information provided within the assessment, make a determination of the participant's service need level.
- This service level must be reflected on service orders and direct service providers must be aware of the participant's classification. It must also be updated as needed.

Coding:

- Select from the following options:
    - **1A** - This means you cannot be left alone. If your services are not delivered as planned, your backup plan needs to start immediately.
    - **1B** - This means you cannot be left alone. If your services are not delivered as planned, your family/friends need to be contacted immediately.
    - **1C** - This means you cannot be left alone. Staff at your place of residence must be available to you as planned or follow established emergency procedures.
    - **2A** - This means you can be left alone for a short time. If your services are not delivered as planned, your backup plan needs to start within 12 hours.
    - **2B** - This means you can be left alone for a short time. If your services are not delivered as planned, your family/friends need to be contacted within 12 hours.
    - **2C** - This means you can be left alone for a short time. Staff at your place of residence must be available to you periodically each day. Follow established emergency procedures if no staff are available.
    - **3A** - This means you can be left alone for a day or two. If your services are not delivered as planned, your backup plan needs to start within a couple days.
    - **3B** - This means you can be left alone for a day or two. If your services are not delivered as planned, your family/friends need to be contacted within a couple days.

Discussed the internal grievance and external appeals process:

Definition:

- The Supports Coordinator provided and discussed UPCAP's internal grievance and external appeals process with the participant at the initial assessment and annually thereafter.

Process:

- Discuss UPCAP's internal grievance and external appeals process. Refer the participant to the Participant Handbook provided to the participant at the initial assessment.
- If the participant no longer has the Participant Handbook at an annual assessment, provide the participant with a new copy.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Person rights and responsibilities explained:

Definition:

- The Supports Coordinator has explained the Participant's Rights and Responsibilities with the participant at the initial assessment and annually thereafter.

Process:

- Review the Participant's Rights and Responsibilities. Refer the participant to the Participant Handbook provided to the participant at the initial assessment (should be in the Agency folder).
- If the participant no longer has the Participant Handbook at an annual assessment, provide the participant with a new copy.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Agency folder was provided and reviewed with participant:

Definition:

- The Supports Coordinator provided and reviewed the UPCAP Agency Folder with the participant at the initial assessment and annually thereafter.

Process:

- Review the Agency folder with the participant. Explain to the participant that it is important for them to keep their copy as it will be reviewed annually.
- If the participant no longer has the Agency folder at an annual assessment, provide the participant with a new copy.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Person is/remains medically eligible under Door:

Definition:

- Based on the Michigan Nursing Facility Level of Care Determination, the participant is or remains medically eligible.

Process:

- Record the Door under which the participant scored on the NFLOCD completed at the initial assessment or at the annual reassessment.
- This must match what is entered into CHAMPS.

Coding:

- Select from the following options:
  - **Not Medically Eligible**
  - **1** – Activities of Daily Living
  - **2** – Cognitive Performance
  - **3** – Physician Involvement
  - **4** – Treatments and Conditions
  - **5** – Skilled Rehabilitation Therapies
  - **6** - Behavior
  - **7 –** Service Dependency
  - **8 –** Frailty Exception
  - **MPRO Exception** – Based on participant-requested or MPRO-initiated secondary review.

RN Summary:

Definition:

- Any additional comments not documented elsewhere in the assessment.

Process:

- Use the provided text box to document any important information pertinent to the participant's case that was not documented in any of the other sections of the RN Assessment.
- The text box may remain blank if there is no additional documentation needed.

Coding:

- Use printed letters/text

Prior Additional Comments not Documented elsewhere in the Assessment:

Definition:

- Automatically populated by COMPASS based on the text entered in the "RN Summary: Additional Comments not Documented elsewhere in Assessment" section of the previous assessment.

Process:

- Review previous issues or information documented.
- Ensure that follow up and/or resolution to any issues or information reported here is documented.
- At reassessments, Supports Coordinators need to ensure that vital information is copied and pasted from here to the "Additional comments not Documented elsewhere in Assessment" box order to carry over to the next assessment

Coding:

- None – automatically carried over from previous assessment
- If there is no previous assessment, it will be blank

Include in PCSP?

Definition:

- PCSP – Participant-Centered Service Plan

Process:

- Identify any issues the participant has related to the questions in that section.
- Supports Coordinators will determine if there are issues that should be included in the PCSP based on the participant's answers. However, the participant will ultimately determine if the issues should be added to the PCSP.

Coding:

- Select from the following options:
  - **Yes** – Participant would like issues added to PCSP
  - **No** – Participant would not like issues added to PCSP
  - **No Issues Identified** – No issues were identified in this section of the assessment.
- If any responses to questions in the section are considered 'not normal', COMPASS will not allow the Supports Coordinator to select "No Issues Identified"
- If "No" is selected, the Supports Coordinator will be required to document the reason in the comment box below.
- If "Yes" is selected, the issues must be listed in the comment box and will automatically appear in the PCSP interventions and goal.
- Issues addressed should not be duplicated across multiple assessment sections. If the issue is to be addressed in a different section, select "No", then document the reason and corresponding assessment section in the comment box.
  - Ex: "Issue not added as it will be addressed in Section P: Physical Functioning"

Section U: RN – Person Location/Status

Confirms Person Medically Eligible for MI-Choice:

Definition:

- The participant is medically eligible for MI Choice.

Process:

- Confirm the participant's medical eligibility for MI Choice.

Coding:

- Select from the following options:
  - **No**
  - **Yes**

Description of Conditions Noted Above:

Definition:

- An open, multi-line text box for the Supports Coordinator to provide a written account of the information gathered from the assessment questions and any additional information pertinent to the participant's record.

Process:

- Document any additional information related to the participant's medical eligibility.

Coding:

- Use printed letters/text.

List of All Primary and Other Diseases:

- List all Primary and Other diseases present and select the most appropriate code. This list should include **ALL diseases** previously noted in Section I, as well as any additional diagnosis reported in that section.
- Make sure to select a Primary Diagnosis. You may need to consult medical records or with their primary physician in order to determine the primary diagnosis and the appropriate ICD-CM code. To process claims and encounters, a primary disease diagnosis and ICD code will need to be present in this section.
- For step by step instructions or technical questions/issues, refer to the COMPASS Assessment & PCSP User Guide found in COMPASS.

Definition:

- A Primary disease is viewed as the "root cause" of the participant's need for services. Secondary and/or Other diseases are those conditions that are present that directly affect the care needed or developed as a result of the primary diagnosis.
- ICD stands for International Classification of Diseases and are codes assigned to medical diagnosis for the purposes of collection, processing, classification, and presentation of mortality statistics

Process:

- Completed the following for each diagnosis listed in **RN Assessment: Section I – Disease/Disabilities:**
    - Record the disease diagnosis, the ICD-CM code, and the associated disease code.
    - Select whether the disease is the primary diagnosis, a current diagnosis in which the participant is receiving active treatment, or a current diagnosis in which the participant is not receiving treatment but is being monitored.
- There is no need to list diagnosis that are no longer active.

Coding:

- For all diseases present, select the most appropriate code from those listed below.
    - **Not present**
    - **Primary diagnosis/diagnoses** - One or more diagnoses that are the main reason(s) used to support and justify services being provided.
    - **Diagnosis present, receiving active treatment** - Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
    - **Diagnosis present, monitored but no active treatment** - Participant has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Medications:

- List all prescribed and non-prescribed medications taken by the participant.
- This section will assist Supports Coordinators in identifying any potential problems related to the participant's consumption of, or failure to take, medications.
- The medication list MUST be updated with every change to a participant's prescriptions and include short-term prescriptions – i.e. antibiotics, etc.
- For step by step instructions or technical questions/issues, refer to the COMPASS Assessment & PCSP User Guide found within COMPASS.
- For specific policy and process questions, refer to *UPCAP Policy 2022-19: Participant Medications*

Definition:

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

Process:

- Obtain a complete list of the medications the participant is currently taking, including all prescriptions, herbal supplements, vitamins, homeopathic, and over the counter medications.
- Ask the participant, and family members when appropriate, to list all medications actually taken in the last 3 days. Ask the participant to see all of the medication bottles or containers to confirm all information, as well as any medications kept in other areas of the home, such as a bedroom or bathroom, kitchen fridge, or in a bag/purse. Be certain that you specify that this is not just prescription medication, but any medication consumed regardless of how it was obtained.
- Use the actual drug container to confirm the prescription information. Complete all COMPASS fields for each medication including, strength, frequency, route, purpose, and prescribing physician. All herbal, homeopathic, and over the counter medications should be listed and noted as such. Supports Coordinators must note all important medication information, including the dosage, how the medication is taken (route/administration), number of puffs for inhalers, number of drops, where a medicated cream is used on the body, etc.

Coding:

- Use letters/text and numbers.
- Complete all COMPASS fields for each medication:
    - **Medication/Prescription Name**
    - **Strength/Dosage**
    - **Route of Administration**
    - **Frequency**
    - **PRN, if applicable**
    - **Purpose**
    - **Prescribing Physician**
    - **Start Date**
    - **Stop Date**
    - **Notes or Special Instruction, if applicable**
- Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose EXACTLY as it appears on the medication container. For example, if the medication label indicates Acetaminophen 650 mg, do not write Acetaminophen 325 mg. 2 tabs — even if two 325 mg. tables were actually taken by the participant.
- Occasionally, dosages of medication may have changed during the 3-day assessment period. In this case, each dosage of the medication should be recorded separately

Medical Providers

- List all of the participant's current medical providers, being sure to denote the participant's primary care physician.
- If a provider is listed as a prescribing physician on the participant's medication list, the provider MUST be listed in this section. The only exception are those providers that prescribed a medication in a one-time only situation – i.e emergency room physician, attending physician, etc.
- If the participant's physician is part of a medical group or clinic, it is not appropriate to list the clinic as the provider. Ensure that the individual provider is listed.
- If you attempt to add a provider and they are not in the COMPASS data base, utilize the "Add Provider to COMPASS" request form to add any physicians or providers.
- For step by step instructions or technical questions/issues, refer to the COMPASS Assessment & PCSP User Guide found in COMPASS

Definition:

- A medical provider is any person determined to be capable of providing health care services and is performing within the scope of their practice as defined under State law– includes doctor of medicine or osteopathy; podiatrist, dentists, clinical psychologists, optometrists, chiropractors, nurse practitioners, clinical social workers, physician assistants, etc.
- A current provider is a provider that the participant has seen within the last year.

Process:

- Ask the participant for a list of their current medical providers, including any specialists. Make note of the frequency in which the participant has appointments with each medical provider and the date the provider was last seen.
- Make sure to confirm the participant's primary physician

Coding:

- Select a provider from the drop-down list.
- If the provider is not listed, complete the "Add Provider to COMPASS" request form and submit to a case tech for entry.
    - Make sure to include the following information for each provider:
        - **Medical Provider Name**
        - **Address**
        - **City**
        - **Zip**
        - **Phone Number**
        - **Fax Number**
        - **Provider Type**
        - **Specialty**
        - **Counties Served**
        - **Services Provided**
- Once a provider is selected, make sure to add the following information:
    - **Additional Descriptor** – type of provider or specific care provided (e.g. foot care)
    - **Primary Care Physician**
    - **Provider Last Seen**
    - **Special Notes Related to the case**, if applicable

Pharmacies

- List all pharmacies utilized by the participant.
- If you attempt to add a pharmacy and they are not in the COMPASS data base, utilize the "Add Provider to COMPASS" request form to add the pharmacy.
- For step by step instructions or technical questions/issues, refer to the COMPASS Assessment & PCSP User Guide found in COMPASS

Definition:

- Pharmacies are where the participant goes to fill a prescription for medicine, including online services.

Process:

- Ask the participant what pharmacy or pharmacies they use to fill their prescription medications. They participant may utilize more than one – make note of all pharmacies and any special notes related to specific medications or refills.

Coding:

- Select a provider from the drop-down list.
- If the provider is not listed, complete the "Add Provider to COMPASS" request form and submit to a case tech for entry.
    - Make sure to include the following information for each provider:
        - **Medical Provider Name**
        - **Address**
        - **City**
        - **Zip**
        - **Phone Number**
        - **Fax Number**
        - **Provider Type**
        - **Specialty**
        - **Counties Served**
        - **Services Provided**
- Once a provider is selected and added, make sure to add the following information:
    - **Special Notes Related to the case**, if applicable

Durable Medical Equipment

- List all DME utilized by the participant, regardless of the purchaser.
- For step by step instructions or technical questions/issues, refer to the COMPASS Assessment & PCSP User Guide found in COMPASS

Definition:

- Durable Medical Equipment is defined as equipment and supplies ordered by a health care provider for everyday or extended use.

Process:

- Ask the participant what equipment or supplies that they have and/or use on a regular basis. Make note of when the participant received each piece of equipment and the company that provided it.

Coding:

- Select the Durable Medical Equipment Item from the drop-down menu.
- If the item is not listed, select **Other** and enter the description of the type of item in the **Additional Description/Details** section.
- Once the item is selected and added, make sure to add the following information:
    - **Durable Medical Equipment Provider**
        - If you attempt to add a DME provider and they are not in the COMPASS data base, utilize the "Add Provider to COMPASS" request form.
    - **Additional Description/Details, if applicable**
    - **When acquired**
    - **Payor Source**
    - **Comments, if applicable**
- If the participant does not recall or have the requested information regarding a piece of equipment, leave blank.

Effective Date:

- 07/17/2023

Document History:

- 09/21/2023 – Internal Quality Team
    - Reviewed and updated guidance re: BRIEF Literacy Tool
- 10/03/2023 – LTC Quality Improvement Manager (EB)
    - Updated guidance re: due dates for O2 script and Nursing Services/PDN to align with updated policies.