Section A

Identification Information

Intent

This section contains personal identifiers necessary to identify the person and link sequential assessments in an electronic medical-record system.

A1. Name

Definition

Person's legal name.

Coding

Use printed letters. Enter in the following order:

A1a. Given name

A1b. Middle initial

A1c. Family name

A1d. Jr./Sr.

If the person has no middle initial, leave Item A1b blank. Likewise, leave Item A1d blank if appropriate.

A2. Gender

Definition

Person's gender identity. For most persons, this will be their biological sex that was identified at the time of their birth. For some persons, it will be based on a gender identity arrived at later in life.

Process

A person's biological sex plays an important role in treating certain health conditions and is a potential protective/risk factor. It can be used to predict health-related issues and outcomes. The same can be said for the person's self-representation of their gender. Ask the person, "What is your sex?" Code based on self-report. If the person cannot communicate, ask the family.

Coding

Use the code **"3"** for "Other gender identity" for persons who do not identify themselves solely as male or female. This includes persons who consider themselves to be non-binary.

1 Male

2 Female

3 Other gender identity

A3. Birthdate

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.

1	9	4	2		1	1		0	1
Year					**Month**			**Day**	

A4. Marital Status

Intent

To record the person's current marital status based on the country's legal framework.

Definitions

"Married" includes persons of the same or opposite sex who are legally married through either a religious ceremony or civil union. The prevailing country law can impact on designating a person as married. For example, in a few U.S. states, "married" includes people in a common-law marriage as part of a couple of the same or opposite sex who have lived together in a conjugal relationship for a designated number of years. Thus, in those states "Never married" refers to persons who have never been married or in a common-law marriage throughout their entire life course. If the person is in a long-term same-sex or opposite-sex relationship that is not legally recognized as a marriage or common-law marriage, code the item **"3"** for "Partner/significant other".

Coding

Choose the answer that describes the current marital status of the person.

1 Never married

2 Married

3 Partner/significant other

4 Widowed

5 Separated

6 Divorced

A5. Departmental Client Number (DCN)

Intent

To record the Medicaid identification number.

Process

This number will auto populate from the case record. Ensure the number is accurate.

Coding

Confirm the auto populated number is accurate.

A6. Disregard—this item not utilized in Missouri

A7. Disregard—this item not utilized in Missouri

A8. Reason for Assessment

Intent

To document the key reason for completing the assessment.

Coding

Enter the number corresponding to the reason for assessment.

1 **Initial assessment** — An assessment that is done at the time of enrollment, or when initially determining eligibility for home care services.

2 **Reassessment** — A regularly scheduled follow-up assessment to ensure that the care plan is appropriate and current.

A9. Assessment Reference Date

Intent

To establish a common temporal reference point for the assessment being completed.

Definition

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

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

Coding

For the month and day of the assessment, enter two digits each. Use a leading zero ("0") as a filler if a single digit. Use four digits for the year. Example: May 8, 2022. The period of observation for 3-day items includes May 6–8.

2	0	2	2		0	5		0	8
Year					**Month**			**Day**	

A10. Person's Expectations (Goals) of Care

Intent

It is essential to ask the person being assessed to identify what his or her goals of care might be. By doing so, the assessor encourages the person to be an active member of the health care team. This can also be a starting point to develop a person-centered plan of care or services. It opens a channel of communication to help the assessor better understand what the person expects or hopes to experience as a home care client. Because the person's view may change over time, this item is included both in the initial and in subsequent reassessments.

Process

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

Talk to the person and phrase your inquiry in the most general way possible. For example, ask: "I'd like to know why you are applying for services," "What benefits do you expect to get from this program?" "Tell me about changes in yourself you hope will occur." Encourage the person to express personal goals in his or her own words. On follow-up reassessments, ask: "Are you satisfied with your care experience, or would you like changes in how you live or are cared for?"

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

Coding

Use the large ("open text") box to record the person's verbatim response. Code the person's primary goal of care in the single line of boxes at the bottom, entering one letter in each box. Abbreviate if necessary. Enter "NONE" if the person is unable to articulate a goal of care.

B	E	S	U	R	E	I	T	A	K	E	M	E	D	S

A11. Postal/Zip Code of Usual Living Arrangement [Country Specific]

Definition

The postal or zip code for the community address where the person usually resides. For those persons being evaluated while in an acute care hospital, rehabilitation hospital or unit, post-acute unit, or nursing home, this would be the community address of the person's usual living arrangement prior to his or her transitory stay in the current setting.

Process

Talk to the person or family member. Review the person's admission or transmittal records as necessary.

Coding

Enter one digit per box, beginning with the leftmost box. If the four-digit code extension is unavailable, leave the extra four digits blank. For example, Roslindale, MA 02131 should be entered as follows:

0	2	1	3	1	–				

A12. Residential/Living Status at Time of Assessment

Intent

To document the person's community living arrangement at the time of the current assessment. The person's living arrangement may be long-standing or relatively new or even transitional in character (for example, maybe one of the agency goals is to find a better location).

Process

Ask the person or family if you are unsure of where the person is currently living, or consult the person's records, driver's license, or other documentation.

Coding

Choose only one answer and enter the appropriate code in the box provided. If the code is a single digit, leave the first box empty.

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

2 **Assisted living/semi-independent living/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, and so on.

3 **Mental health residence**— A community residential setting for adults with mental health problems who need supervision and limited services (meals, housekeeping). For example, psychiatric group home.

4 **Group home for persons with physical disability**— A setting that provides services to persons with physical disabilities. Typically, persons live in group settings with 24-hour staff presence. Individuals are encouraged to be as independent and active as possible.

5 **Setting for persons with intellectual disability**— A setting that provides services to persons with intellectual disabilities. Typically, persons live in group settings with 24-hour staff presence but individuals are encouraged to be as independent and active as possible.

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

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

8 **Long-term care facility (nursing home)**— A licensed health care facility that provides 24-hour skilled or intermediate nursing care. For example, you may use this code for someone who resides in a long-term care facility at the time of the assessment (no matter how long the stay), but for whom the continued stay is expected to be temporary and there is an expectation of an imminent transfer to a community setting.

9 **Continuing care hospital/unit**— A type of longer stay recuperative/rehabilitative hospital or unit.

10 **Rehabilitation hospital/unit**— A licensed rehabilitation hospital that focuses on the physical and occupational rehabilitation of persons 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 persons who have experienced disease or injury with subsequent decline in physical function.

11 **Hospice facility/palliative care unit**— A hospice facility (or unit within a facility providing more general care) provides care to persons who have a terminal illness with a prognosis of less than 6 months to live as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief, without precluding use of life-prolonging treatments. Palliative care is often provided from the time a person is diagnosed with a life-threatening illness.

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12 **Acute care hospital/unit**— A facility licensed as an acute care hospital that focuses primarily on the diagnosis and treatment of acute medical disorders.

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

14 **Other** — Any other type of setting not listed above.

A13. Living Arrangement

Intent

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

Process

Ask the person or family member.

A13a. Lives with

Coding

Record the code that reflects whom the person is living with presently. Exclude any temporary living arrangements made while home care services are being set up. Choose only one answer and enter the appropriate code in the box provided.

1 **Alone**— Includes person who lives only with a pet, lives on the streets, or is homeless (whether or not the person uses shelters).

2 **With spouse/partner only**— Includes spouse/partner, girlfriend or boyfriend, common-law marriage, or long-term same-sex relationship.

3 **With spouse/partner and other(s)**— Lives with spouse or partner and any other individual(s), whether family or unrelated.

4 **With child (not spouse/partner)** — Lives with child(ren) only, or with child(ren) and other individual(s), but **not** with spouse or partner.

5 **With parent(s) or guardian(s)**— Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s), but **not** with spouse or partner or child(ren).

6 **With sibling(s)**— Lives with sibling(s) only, or with sibling(s) and other individual(s), but **not** with spouse or partner, child(ren), or parent(s) or guardian(s).

7 **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).

8 **With nonrelative(s)** — Lives in a group setting (for example, a boarding home, long-term care facility, group home, or jail) or in shared accommodation with nonrelative(s) (for example, roommate). Excludes single overnight stays, such as in a homeless shelter.

A13b. Person or relative feels that the person would be better off living elsewhere

Process

Ask the person and family member/caregiver separately whether either believes there should be a change in living arrangements. Be sensitive to how the question is raised. Variants on the question "Do you believe the person would be better off

living elsewhere?" might include asking whether the person would be happier/less isolated living elsewhere, would have his or her needs met better, would be safer, or would have access to more nutritious meals.

Coding

Code for the most appropriate response. If either the family member or the person respond that it would be better to move, code **"1"** or **"2"** as appropriate.

0 No

1 Yes, other community residence

2 Yes, in non-community living setting (long-term care facility)

Intake and Initial History

NOTE: This section is completed only when the first interRAI HC Assessment is completed. It provides basic information about the person that is not expected to change during the person's involvement with the agency.

B1. Date Case Opened (This Agency)

Intent

To document the date the person's case was initiated by the agency.

Process

Enter the date when the person was first referred to the agency. If the care agency did not receive a referral, enter the date when the person first became known to the agency as needing an assessment. If the person was transferred from another agency, the date would be the date of transfer. The record is likely to be the most reliable source of this information.

Coding

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". For example, if the care agency received a referral from the primary care provider on March 14, 2022, the date should be entered as:

2	0	2	2		0	3		1	4
Year					**Month**			**Day**	

B2. Ethnicity and Race [Country Specific]

Intent

To document the person's race and ethnicity per established standards.

Process

Ask the person or family member which of the categories below best describes the person's race and ethnic background. The person may identify more than one category.

Coding

For each option that applies, enter **"1"** for "Yes". For options that do not apply, enter **"0"** for "No".

Ethnicity — Hispanic, Latino, or Spanish Origin

B2a. Mexican, Mexican American, Chicano

B2b. Puerto Rican

B2c. Cuban

B2d. Other — e.g., Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.

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Racial Group Identification(s)

B2e. American Indian or Alaska Native

B2f. Asian

B2g. Black or African American

B2h. Native Hawaiian or other Pacific Islander

B2i. White

B3. Primary Language [Country Specific]

Intent

To record the person's preferred language for day-to-day communication. Caregivers must be able to communicate with the person in a language he or she understands. Information about the person's language may indicate the need to consider interpretation services.

Definition

Preferred language for day-to-day communication.

Process

Observe and discuss with the person and family to determine the primary language the person speaks or understands.

Coding

Code for the most appropriate category.

1 English

2 Spanish

3 French

4 Other

B4. Interpreter Needed

Intent

To document whether the person requires the assistance of an interpreter to communicate with others.

Process

Observe and listen to the person. If still unsure, first review clinical records (if available). If necessary, check with family or referral source to determine the need for an interpreter. Item B3 ("Primary Language") indicates the person's primary language and thus the language required for an interpreter, if needed.

Coding

0 No

1 Yes

B5. Residential History over the last 5 years [Missouri Item]

Intent

This item is one indication of personal vulnerability. For example, persons with a prior long-term care facility stay have a higher likelihood of a subsequent stay.

Definition

a. **Long term care facility (e.g., nursing home)** — A licensed health care facility that provides 24-hour skilled or intermediate-level nursing care.

b. **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.

c. **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).

d. **Psychiatric hospital or unit** — A 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.

e. **Setting for persons with intellectual disability** — A setting that provides services to persons with intellectual disabilities. Typically, such persons live in group settings with 24-hour presence of staff. Persons are encouraged to be as independent and active as possible

Process

Ask the person and caregivers. Review any available documentation.

Coding

Code for all settings the person lived in during the 5 years prior to the date the case was opened [item B1]

0 No

1 Yes

Section C

Cognition

It is essential to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These are crucial factors in many care planning decisions, in part because of their impact upon the person's ability to follow instructions and treatment regimens, and to make independent decisions in the community.

A recommended approach for assessing cognitive items is to:

- Engage the person in general conversation to help establish rapport— for example, ask the person to tell you about him- or herself.
- Actively listen and observe for clues to help you structure your assessment. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with, but provide important information about the person's cognitive function.
- Be open, supportive, and reassuring during your conversation with the person (for example, "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you.").
- If the person becomes agitated, reassure him or her and stop discussing issues related to cognitive function. Because cognitive function and memory can be sensitive issues, the person may become defensive, agitated, or very emotional. Say to the agitated person, "Let's talk about something else now" or "We don't need to talk about that now." Observe the person's cognitive performance over the course of the assessment.

After eliciting the person's response, it may be necessary to follow up with the person's family or paid caregivers to clarify or validate information regarding the person's cognitive function over the last 3 days. Consultation with others is especially important for people with limited communication skills or with language barriers.

C1. Cognitive Skills for Daily Decision Making

Intent

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

Definition

Here are some examples of decision-making tasks:

- Choosing items of clothing;
- Knowing when to eat meals;
- Knowing and using space in the home appropriately;
- Using environmental cues (such as clocks or calendars) to organize and plan the day;

- In the absence of environmental cues, seeking information appropriately (that is, not repetitively) from others in order to plan the day;
- Using awareness of one's own strengths and limitations in regulating the day's events (for example, asking for help when necessary); and
- Making prudent decisions concerning how and when to go out of the house; where applicable, acknowledging the need to use a walker or other assistive device and using it routinely.

Process

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

Coding

Enter the single number that corresponds to the most correct response. If the person receives a score of **"5"**, do not complete the rest of Section C or any of Sections D, E, or F; instead, skip directly to Section G.

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

1 Modified independence — The person made reasonable and safe decisions in familiar situations, but experienced some difficulty in decision making when faced with **new** tasks or situations **only**.

2 Minimally impaired — In specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.

3 Moderately impaired — The person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.

4 Severely impaired — The person never (or rarely) made decisions.

5 No discernible consciousness, coma — The person is nonresponsive. (Skip to Section G.)

C2. Memory/Recall Ability

NOTE: If the person received a score of "5" ("No discernible consciousness, coma") on Item C1, do not complete Items C3–C7 or any of the items in Sections D, E, or F. Instead, proceed directly to Section G.

Intent

To determine a person's ability to remember recent and past events (short-term and situational memory).

C2a. Short-term memory OK

Definition Seems, appears to recall after 5 minutes.

Process Conduct a structured test of short-term memory (for the preferred approach, see the following "Example"). If this is not possible, ask the person to describe a recent event that you should both have knowledge of (for example, the election of a new political leader, a major holiday) or that you can validate with a family member (for example, what the person had for breakfast). **If there is no positive indication of memory ability, score this item "1" for "Memory problem".**

Coding Code for recall of what was learned or known.

0 Yes, memory OK

1 Memory problem

Example of a Structured Approach for Assessing Short-Term Memory

Ask the person to remember three unrelated items (such as book, watch, and table) for a few minutes. After you have stated all three items, ask the person to repeat them to you (to verify that you were heard and understood by the person). Then proceed to talk about something else, perhaps by going on to another part of the assessment. Do not be silent; do not leave the room. In 5 minutes, ask the person to repeat the name of each item. For persons with verbal communication deficits, nonverbal responses are acceptable (for example, when asked to point to items that are to be recalled, he or she can do so). **If the person is unable to recall all three items,**

Code: C3a = "1" = "Memory problem".

C2b. Procedural memory OK

Definition Can perform all or almost all steps in a multitask sequence without cues.

Process This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such an activity, as multiple steps are required to complete the entire task. The person must be able to perform or remember to perform all or most of the steps in order to be scored **"0"** for "Memory OK". If the person demonstrates difficulty in two or more steps, code as **"1"** for "Memory problem". Remember that persons in need of care in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

Coding Code for recall of what was learned or known.

0 Yes, memory OK

1 Memory problem

C2c. Situational memory OK

Definitions

Both recognizes caregivers' names/faces frequently encountered (includes formal and informal caregiver) AND knows the location of places regularly visited (bedroom, dining room, activity room, therapy room). Note: Activity rooms and therapy rooms can be present in senior housing or other congregate living environments.

Recognizes caregiver names and faces — The person distinguishes caregivers (informal and formal) from others (for example, other family members, strangers, visitors, and friends). It is not necessary that the person remember all the names of all caregivers, but rather that the person can recognize them as caregivers (for example, home health aide, nurse, therapist, the daughter who helps three days a week) versus others.

Remembers the location of places regularly visited — The person is able to locate or recognize key areas to which he or she regularly goes (for example, find the way to his or her room, recognize the purposes of particular rooms such as the kitchen or family room). It is not necessary for the person to know the street number of the house or apartment, but he or she should be able to find the way to his or her room, recognize the purposes of particular rooms, etc.

Process

This two-part measure of orientation assesses the person's cognitive ability to recognize both people and places. To be coded as OK, the person must **both** recognize the names/faces of frequently encountered family members or caregivers **AND** know the location of places regularly visited (bedroom, dining room, places visited outside the home).

Coding

Code for recall of what was learned or known.

0 Yes, memory OK

1 Memory problem

Examples of How to Code Memory/Recall Ability

Mrs. L is a 90-year-old former librarian who became a home care client 2 days ago, after being discharged from a rehabilitation hospital for continued occupational and physical therapy following surgical repair of a hip fracture. During the assessment, Mrs. L was articulate about her recent health history (including the names of the acute and rehabilitation hospitals, orthopedic surgeon, and primary nurses). She enumerated her current medication list and when the medications were to be taken and reported that she did this activity without help. She introduced her two visiting daughters to the assessor by name. She also provided a brief social history. This information was validated as accurate via a conversation with her daughters, a review of the hospital discharge summary, and a review of the labels on the medication bottles.

Code: C2a (Short-term memory OK) = "0" = "Yes, memory OK".

Code: C2b (Procedural memory OK) = "0" = "Yes, memory OK".

Code: C2c (Situational memory OK) = "0" = "Yes, memory OK".

Mr. I is a 63-year-old divorced man with a 30-year history of alcohol abuse. Three weeks prior to intake into the home care program, Mr. I passed out while smoking in bed in his rented room, sustaining second-degree burns on his left ear, neck, and chest. He was

admitted to an acute care hospital for treatment of burns, smoke inhalation, and delirium tremens. He was transferred to a nursing facility 13 days ago and spent 10 days in a recuperative state.

During the admission assessment to the home care program, which occurred 2 days after his discharge from the nursing home, Mr. I was able to recall the fire but was sketchy on the details of his hospitalization and treatment. He was unable to recall any of the three items posed to him during a test of his short-term memory. Mr. I did relay information about his early life, including his 10-year marriage, the names of his three sons from whom he is now estranged, and his prior work as an accountant (information validated as accurate from his medical record). Mr. I has been able to recognize the faces of those providing care to him in the home and knows their roles (the nurse and the "therapist"). He also can find his way around his home, can remember his rehabilitation schedule, and prepares and eats lunch with no help from others.

Code: C2a (Short-term memory OK) = "1" = "Memory problem".

Code: C2b (Procedural memory OK) = "0" = "Yes, memory OK".

Code: C2c (Situational memory OK) = "0" = "Yes, memory OK".

C3. Periodic Disordered Thinking or Awareness

Intent

To record behavioral signs that may indicate that delirium is present.

Definitions

Frequently, delirium (an acute confusional state) is caused by a treatable illness such as an infection or a reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may result in rambling, irrelevant, or incoherent speech.

A recent and perhaps rapid deterioration in cognitive function is likely indicative of delirium, which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. When a person has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium by being attuned to recent changes in the person's usual functioning. For example, a person who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive (hypo-active delirium). Conversely, one who is normally quiet and content may suddenly become restless and noisy (hyperactive delirium). Many affected persons may fluctuate and exhibit both forms of delirium over time. Or, a person who is usually able to find his or her way around the house may begin to get "lost."

C3a. Easily distracted— For example, episodes of difficulty paying attention; person gets sidetracked.

C3b. Episodes of disorganized speech— For example, speech is nonsensical, irrelevant, or rambling from subject to subject; person loses train of thought.

C3c. Mental function varies over the course of the day— Sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

Process

Ask the person or others who know the person if any of the behaviors have been noticed over the last 3 days. If the response is yes, determine whether the behavior is different from the person's usual functioning.

Coding

Code for the person's behavior in the last **3** days regardless of what you believe the cause to be, focusing on when the manifested behavior first occurred and whether it is different from the person's usual pattern.

0 Behavior not present

1 Behavior present, consistent with usual functioning

2 Behavior present, appears different from usual functioning— For example, new onset or worsening; different from a few weeks ago.

Examples of How to Code Periodic Disordered Thinking or Awareness

Tom was observed to have episodes of rambling speech on 2 of the last 3 days. This behavior has been present for some time, and its frequency has not changed. It occurs during the day and evening; Tom generally sleeps through the night. He is able to attend to conversations with his caregiver, however.

Code: C3a (Easily distracted) = "0" = "Behavior not present".

Code: C3b (Episodes of disorganized speech) = "1" = "Behavior present, consistent with usual functioning".

Code: C3c (Mental function varies over the course of the day) = "0" = "Behavior not present".

Mr. Smith has been observed to be picking at his clothing when he is spoken to and rambles incoherently whenever he is awake. These are new behaviors, according to his family.

Code: C3a (Easily distracted) = "2" = "Behavior present, appears different from usual functioning".

Code: C3b (Episodes of disorganized speech) = "2" = "Behavior present, appears different from usual functioning".

Code: C3c (Mental function varies over the course of the day) = "0" = "Behavior not present".

C4. Acute Change in Mental Status from Person's Usual Functioning

Intent

To determine if a person has experienced a rapid, unexpected deterioration of his or her mental status, because this can be an indication of possible delirium.

Definition

Any sudden or recent change in the person's usual level of functioning; such changes may include restlessness, lethargy, being difficult to arouse, or altered environmental perception.

Coding

0 No

1 Yes

C5. Change in Decision Making as Compared to 90 Days Ago (or Since Last Assessment If Less Than 90 Days Ago)

Intent

To compare the person's current decision-making ability to that of 90 days ago (or since the last assessment, if less than 90 days ago). The changes may be permanent or temporary, and the cause may be known (for example, psychotropic medication or new pain) or unknown. If the person is newly admitted to the program, include changes since admission **and** changes during the period prior to admission. Note: Some persons may have experienced an intermittent change in status but this should not be considered in the assessment. Consider only their current status as contrasted with their status 90 days ago.

Process

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

Coding

0 Improved

1 No change

2 Declined

8 Uncertain

C6. Self-Reported Activity Interests/Preferences and Involvement

Intent

To document the person's engagement (or interest/preference in engaging) in cognitively supportive activities.

Definitions

The activities listed have been shown to play a role in slowing cognitive decline on the Cognitive Performance Scale.

C6a. Playing games with others— For example, Mahjong, bridge, chess, multiplayer video games.

C6b. Using computer, smartphone, tablet, or other similar activities

C6c. Doing puzzles— For example, crosswords, Sudoku, jigsaw.

C6d. Participating in program to improve memory— For example, formal programs (online or in person) to improve reasoning, speed-of-processing, or memory.

Process

These are self-report items. If possible ask the person: "Are you interested in the following activities, and if so, do you participate in the activity?" List each activity and assess the response. **Only the person's responses** should be used to rate each item. If the person is unable (due to cognitive impairment, for example) or refuses to respond, do not dwell on these items and do not impute responses to the person. Instead, use code **"8"** for "Person could not (would not) respond".

Coding

Consider both the person's preference (interest) in the activity and whether the person is currently involved in the activity. Persons unable or unwilling to respond should be scored "8" for "Person could not (would not) respond". Use the following codes:

0 No preference, not involved in last 3 days

1 No preference, involved in last 3 days

2 Preferred, not involved

3 Preferred, regularly involved but not in last 3 days

4 Preferred, involved in last 3 days

8 Person could not (would not) respond

Section D

Communication and Vision

There are many possible causes for deteriorating communication. Some can be attributed to the aging process; others are associated with progressive physical, neurological, or psychiatric disorders. As persons age, a communication problem often is caused by more than one factor. For example, an individual might have aphasia as well as long-standing hearing loss; or he or she might have dementia and word-finding difficulties and a hearing loss. The individual's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or an isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in one's ability to make him- or herself understood (expressive communication deficits) can include reduced voice volume; difficulty in producing sounds; or difficulty in finding the right word, constructing sentences, writing, or gesturing.

D1. Making Self Understood (Expression)

Intent

To document the person's ability to express or communicate requests, needs, opinions, and urgent problems and to engage in social conversation.

Definition

This item includes the person'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 the use of word board or keyboard). This item is not intended to address differences in language understanding, such as a Russian speaker in an English-language facility, or difficulties with speech, such as slurring words that may make expression unclear.

Process

Observe and listen to the person's efforts to communicate with you. If possible, observe his or her interactions with family. If he or she has communication devices, encourage their use during the assessment. If possible, observe the person's interactions with others in different settings (for example, one-on-one, in groups, with family members) and different circumstances (for example, when calm, when agitated). If available, and needed, additional clarification can be secured by talking with the individual's family or speech-language pathologist. 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

Enter the code that most closely corresponds to the person's ability to make himself or herself understood over the last 3 days.

0 **Understood**— The person expresses ideas clearly without difficulty.

1 **Usually understood**— The person has difficulty finding the right words or finishing thoughts (resulting in delayed responses), BUT if given time, requires little or no prompting.

(continued)

(continued)

2 **Often understood** — The person has difficulty finding words or finishing thoughts, AND prompting is usually required.

3 **Sometimes understood** — The person has limited ability, but is able to express concrete requests regarding at least basic needs (such as food, drink, sleep, toilet, pain).

4 **Rarely or never understood** — At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language (for example, caregiver has learned to interpret person signaling the presence of pain or need to toilet).

D2. Ability to Understand Others (Comprehension)

Intent

To describe the person's ability to comprehend information, whether communicated to the person by speaking, reading, or gesture, as well as sign language or Braille.

Definition

This item involves the person's ability to understand others in whatever manner. It includes the use of a hearing appliance, if needed. However, this item does not test whether the problem is in understanding a particular language, such as when the individual's native language is different than that normally used by others.

Process

Interact with the person. Consult with family. Ensure that issues are not based on language differences between the person and others. It is expected that as you interact with the person, you will be able to determine if he or she is able to understand you. If there is some difficulty, pay attention to the amount of clarification or repetition the person requires to process and understand what is being said, and ask the person if he or she sometimes has difficulty understanding or hearing what others are saying. If the information is being provided by someone other than the person (for example, a family member), ask the informant if the person in question has any difficulty with understanding information.

Coding

Enter the number corresponding to the most accurate response.

0 **Understands** — Clearly comprehends the speaker's message(s) and demonstrates comprehension by responding in words or actions/behaviors.

1 **Usually understands** — Person misses some part or intent of the message BUT with little or no prompting comprehends most of it. The person may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions/behaviors.

2 **Often understands** — The person misses some part or intent of the message. BUT, with prompting (repetition or more detailed explanation), the person often comprehends the conversation.

3 **Sometimes understands** — The person demonstrates frequent difficulties integrating information and responds only to simple and direct questions or directions. When the message is rephrased or simplified, or gestures are used, the person's comprehension is enhanced.

4 **Rarely or never understands** — At best, the person demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the person can hear sounds but does not understand messages.

D3. Hearing

Intent

To evaluate the person's ability to hear with assistive devices, if used, and environmental adjustments, if necessary, during the last 3-day period.

Process

Evaluate hearing ability after the person has a hearing device in place (if the person uses a device). Be sure to ask if the battery works and the hearing device is on. Interact with and observe the person and ask about hearing function. Consult the person's family. If possible, observe the person interacting with others (such as family members).

If possible, use a variety of observations to make your assessment (for example, one-on-one vs. in group situations). Always be mindful of environmental factors (nearby conversations, outside noises, etc.) that could influence your assessment. If necessary, consult with the family, primary support people, or speech or hearing specialists (if available) to clarify the person's exact hearing level.

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

Coding

Enter the number corresponding to the most correct response.

0 **Adequate** — No difficulty in normal conversation, social interaction, listening to TV, or using the telephone.

1 **Minimal difficulty** — Difficulty in some environments (for example, when the other person speaks softly or is more than 6 feet [2 meters] away).

2 **Moderate difficulty** — Problem hearing normal conversation, requires quiet setting to hear well.

3 **Severe difficulty** — Difficulty in all situations (for example, speaker has to talk loudly or speak very slowly, or person reports that all speech is mumbled).

4 **No hearing**

D4. Vision

Intent

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

Definition

Adequate light — What is sufficient or comfortable for a person with normal vision.

Process

Ask the person, and if necessary, family members or paid caregivers, if the person has manifested any change in usual vision patterns over the last 3 days — for example, is the person still able to read newsprint, email, and the like?

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

Be sensitive to the fact that some persons are not literate or are unable to read your language (for example, English). In such cases, ask the person to read aloud

individual letters or numbers (such as dates or page numbers), or to name items in small pictures.

If the person is unable to communicate or follow your directions, observe the person's eye movements to see if his or her eyes seem to follow movement and objects. For example, can the person see close objects in his or her environment, such as food on the plate or the location of a cup? Though these are gross measurements of visual acuity, they may assist you in assessing whether the person has any visual ability.

Coding

Enter the number corresponding to the most correct response.

0 Adequate— The person sees fine detail, including regular print in newspapers/books.

1 Minimal difficulty— The person sees large print but not regular print in newspapers/books.

2 Moderate difficulty— The person has limited vision; is not able to see newspaper headlines, but can identify objects in his or her environment.

3 Severe difficulty— The person's ability to identify objects in his or her environment is in question, but the person's eye movements appear to be following objects (especially people walking by). Also includes the ability to see only light, colors, or shapes.

NOTE: Many persons with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such persons appear to "track" or follow moving objects in their environment with their eyes. For persons who appear to do this, score the item **"3"** for "Severe difficulty". This is often the best assessment you can do with the limited technology available in the home environment.

4 No vision— The person has no vision; eyes do not appear to be following objects (especially people walking by).

Section E

Mood and Behavior

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

Most family members have not received specific training in how to evaluate persons who have distressed mood or behavioral symptoms. Therefore, although family may sense that something is wrong, mood distress is often underdiagnosed and undertreated in community settings. Thus, the assessment may serve as a crucial first opportunity to identify whether such problems are present.

E1. Indicators of Possible Depressed, Anxious, or Sad Mood

Intent

To record the presence of mood indicators observed in the last 3 days, irrespective of the assumed cause. In some cases, an indicator may not have been observed in the last 3 days, but it continues to be "present" and active in a way that has a meaningful impact on the person's current care needs. When combined with other items in the assessment, these indicators can provide information about the severity of the person's condition.

Definitions

Indicators may be expressed verbally through direct statements or through behaviors that can be monitored by observing the person during usual daily routines.

- **E1a. Made negative statements**— For example, "Nothing matters"; "Would rather be dead than live this way"; "What's the use"; "Regret having lived so long"; "Let me die."
- **E1b. Repetitive anxious complaints/concerns (non-health-related)** — For example, persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationships.
- **E1c. Sad, pained, or worried facial expressions** — For example, furrowed brow, constant frowning.
- **E1d. Withdrawal from activities of interest**— Including long-standing activities, being with family/friends.
- **E1e. Reduced social interactions**
- **E1f. Expressions, including nonverbal, of a lack of pleasure in life (anhedonia)** — For example, saying "I don't enjoy anything anymore."

Process

Engage in conversation with the person and observe the person interacting with others. Keep in mind on a follow-up assessment any previous statements made by the person and observations that you have made.

Some persons may freely share their feelings, and in this instance feelings of psychic distress may be expressed directly by the person who is depressed, anxious, or

sad. Some persons are more verbal about their feelings than others and will either tell someone about their distress or will at least tell someone when asked directly how they feel. For persons who verbalize their feelings, ask how long these have been present. Other persons may be unable to articulate their feelings perhaps because they cannot find the words to describe how they feel or lack insight or cognitive capacity. Distress can also be expressed through nonverbal indicators.

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

Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3 days covered by this assessment. Consult with family members who have direct knowledge of the person's typical and current behavior, and any other clinicians working with the person (such as the primary care provider, if available).

In situations where there is a discrepancy between what is reported by the person, what you observe, and what is reported by others, use your clinical judgment to determine the best response.

Coding

Score each indicator based on the person's behavior over the last 3 days, regardless of what you believe to be the underlying cause of the indicator. Remember to code for both the presence of the indicator and the number of days in which it was exhibited. Use the following codes:

0 Not present

1 Present but not exhibited in last 3 days — Use this code if you know the indicator is present and active, even though it was not observed over the last 3 days.

2 Exhibited on 1–2 of last 3 days

3 Exhibited daily in last 3 days

E2. Self-Reported Mood

Intent

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

Definitions

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

Ask: "In the last 3 days, how often have you felt . . ."

E2a. Little interest or pleasure in things you normally enjoy?

E2b. Anxious, restless, or uneasy?

E2c. Sad, depressed, or hopeless?

E2d. Angry with yourself?

E2e. Angry with others?

Process

Ask the person the previous questions directly once you have completed your own ratings of the person's mood state using the other items in the Mood section of the assessment. **Only the person's responses** should be used to rate each item. If the person is unable (due to cognitive impairment, for example) or refuses to respond, do not dwell on these items and do not impute responses to the person. Instead, use code **"8"** for "Person could not (would not) respond".

Coding

Code each item using the **person's response**. 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. Persons unable or unwilling to respond should be scored **"8"** for "Person could not (would not) respond". Use the following codes:

0 Not in last 3 days

1 Not in last 3 days, but often feels that way — Use this code only if the person indicates the feeling is frequently **present** and **active**, but was not experienced in the last 3 days.

2 In 1–2 of last 3 days

3 Daily in last 3 days

8 Person could not (would not) respond

E3. Self-Reported Life Satisfaction

Intent

To record the person's current perception of his/her overall satisfaction with life.

Process

Ask the person the question using the exact words on the form — "At the current time, how satisfied are you with your life as a whole?" If the person asks for clarification, repeat the words as written. **Only the person's responses** should be used to rate each item. If the person is unable (due to cognitive impairment, for example) or refuses to respond, do not dwell on the item and do not impute a response; use code **"8"** for "Person could not (would not) respond".

Coding

Use the following codes:

0 Delighted

1 Pleased/content

2 Mostly satisfied, but it could be better

3 Less satisfied

4 Dissatisfied

8 Person could not (would not) respond

E4. Behavior Symptoms

Intent

To identify the frequency of behavioral symptoms during the last 3 days that cause distress to the person, or are distressing or disruptive to others with whom the person lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. Behavioral symptoms may reflect how a person experiences unmet needs, feelings of insecurity, fear or anxiety, or somatic symptoms such as pain or shortness of breath. Acknowledging and documenting behavioral