

# Michigan Nursing Facility Transition Initiative

## Project Evaluation Report

### Transition Component

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Prepared for:

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# Executive Summary

## Michigan Nursing Facility Transition Initiative

### Project Evaluation Report

People with a disability or long term illness want the option of living and participating in their communities instead of extended Nursing Facility stays. The Nursing Facility Transition Initiative (NFTI) promoted the design and delivery of home and community-based services that made that option a reality. This report is a qualitative analysis of the NFTI project; details various demographic, clinical and cost aspects of the participants in Michigan's Nursing Facility Initiative project. The Michigan Department of Community Health (MDCH), funded by Centers for Medicare and Medicaid, 2001 Real Choice Systems Change Grant program, administered the project through a contract with DYNs Services, Inc.

Participants came from two avenues: nursing facility transition, and nursing facility diversion. The project, comprised of four components, included two additional ones; an evaluation component to analyze outcomes and cost benefit of transition services and, an education program to disseminate the methodology developed under the grant.

The Transition component used an innovative design, merging transition services with the MI CHOICE waiver in two Michigan Counties. Two MI Choice waiver agents, the Area Agency on Aging of Western Michigan (AAAWM) and the Detroit Area Agency on Aging (DAAA) delivered transition services to Kent and Wayne Counties. The goal was to develop methods and procedures to be used by agencies to transition individuals already in a nursing facility into the community. The tools used to place participants in the community include the Medicaid Home and Community Based Waiver (MI Choice) and integration of housing resources into the system. Funding was provided to cover costs for a transition supports coordinator, transition costs (deposits, furniture, transportation and so forth) and supports coordination.

A total of 112 people participated in the NFTI program during the study period from December 1, 2003 through April 30, 2005. Transition participants are evaluated by the waiver program using the MDS for home care (MDS-HC). The following scales and measures were used to group the participants: The Cognitive Performance Scale (CPS), Activity of Daily Living (ADL) Hierarchy, and RUG (Resource Utilization Group). Occurrence of these measures in the NFTI participants are compared to their occurrence in the general nursing facility population.

Cost data was obtained from actual cost data in the State of Michigan Data Warehouse (Medicaid Paid Claims data) and the MI Choice Information System, Center for Information Management, Inc. Analytical assistance was also provided by the University of Michigan, Institute of Gerontology.

The outcomes resulting from the program are of special note. Of the 112 people that participated in the NFTI project, 102 were able to transition to the community. Of these, only 56 (50%) participated in post-transition state-supported programs. Another 46 (41%) required no further state-supported services. Of those who received waiver services post transition, significant cost reduction was realized compared to costs of a nursing facility. The report gives a total of 308 participant months, for an average cost per participant month of \$917. This compares to a cost of approximately \$3450 per month in a nursing facility (\$115 per day).

The evaluation also shows very similar characteristics across the transition population compared to the nursing facility population. This is significant in that level of acuity had very little effect on determination of which individuals could successfully transition.

Significant recommendations include: need for expanded transition services, increased housing options and supports coordination and expanded study of the long term care population and at risk populations to develop a clear picture of those most likely to return to the community.

Based on preliminary evaluation findings, the NFTI project was expanded statewide in May of 2005. This project represents a significant milestone in the transformation of Michigan's long term care system.

# Nursing Facility Transition Initiative

## Transition Component Evaluation

The Nursing Facility Transition Initiative (NFTI) became reality under a 2001 Real Choice Systems Change Grant funded by the Centers for Medicare and Medicaid. These systems change grants represented a major new initiative to promote the design and delivery of home and community-based services that support people with a disability or long term illness to live and participate in their communities. Congress and the Administration have made \$50 million available for this initiative. Funding for the Michigan NFTI grant was \$770,000. The project was extended for an additional year to complete education and evaluation components.

The project had four major goals: nursing facility diversion, nursing facility transition, project evaluation, and education. The purpose of this section is to present the findings from the evaluation of the nursing facility transition component of the grant.

It is directed at the state level by the Michigan Department of Community Health, Division of Community Living. DYNS Services, Inc. was retained as a contractor to manage the evaluation process and the transition component.

As of March 2005, transition services developed by NFTI, became part of the regular Medicaid state plan services funded under the MI Choice waiver.

### **Brief description of models in use by NFTI:**

- 1) **Transition Model:** Michigan's transition model uses existing service agencies to provide housing and service plan development and implementation for relocation of individuals from nursing facilities to community living. Eligibility for the program was based solely on a person's expressed desire to return to community living. The goal has been to promote changes within the existing home and community based service delivery network, and in particular, the MI CHOICE Medicaid Waiver program.<sup>i</sup> By the third year of the grant, this evolved into a new model described in point 4 below.
- 2) **Diversion Model:** Michigan's diversion model detects and follows persons at risk of nursing facility placement in the acute care setting of the University of Michigan Medical Center. These people are at risk of nursing facility placement based on information collected as part of the inpatient assessment process. People are either diverted directly to the community from the hospital, or followed to the nursing facility and diverted before becoming permanently institutionalized. The model is based on a hospital-community liaison person at the

University of Michigan Hospital, Turner Geriatric program. They assist in the diversion from or reduction in potential nursing facility placement consistent with the individual's choice.

- 3) **Model for reduced NF stays:** This model is a sub-component of the Diversion process. Early detection and monitoring in the acute care setting allows Diversion staff to follow people released to the nursing facility (for rehabilitative services for example) and develop community care plans. The focus is on maintaining the person's community based support network so that they can return to the community sooner.
- 4) **Linkage with Medicaid Home and Community Based Waiver:** The Transition component was merged with the MI CHOICE waiver in two Michigan counties. The waiver program already has a robust service planning ability, transition funds were used to develop and integrate the housing planning function into the services planning process. This resulted in a new model of care planning that includes housing services to create a successful transition plan. Specifically, the housing services added to the Waiver program are:

<b><u>Housing Service Category:</u></b>	<b><u>Includes:</u></b>
Housing	Rent, security deposit, section 8 voucher
Household supplies	Cleaning products, linens, towels, blanket, pillow, laundry basket, waste basket, vacuum, paper products, soap toothbrush, toothpaste, etc
Kitchen Supplies	Utensils, cookware, dishes, glasses, containers, small appliances, microwave, plastic wrap/foil
Utilities	Telephone, past due utility fees, electric, gas
Furniture	Dining table and chairs, sofa, chair, end table, TV stand, bed, mattress, lamp
Groceries	
Pharmacy Transfer	Medication management, collection of NF medications, transfer of prescriptions to community drug store

- 5) **Supportive Housing Demonstration Projects:** This model is a subcomponent of the waiver model. Housing specialists at each waiver program are responsible to develop linkages and a

resource guide listing housing resources. This model supports the housing transition plan development.

- 6) **Information and Referral in two counties:** The MI CHOICE Waiver programs operate an information and referral system. Nursing facility transition information was added to that system as a referral type at pre-screening using the MICIS facesheet. Attachment 1 describes the modifications made to the MI Choice Information System to accommodate data collection for this project.
- 7) **Evaluation using MDS RAI and HC:** Service and outcomes are evaluated using the existing assessment protocols used for Nursing facilities and the MI CHOICE waiver. Transition participants are evaluated by the waiver program using the MDS for home care (MDS-HC). Diversion participants are evaluated by the University of Michigan Medical Center using the MDS Resident Assessment Instrument. The model looks primarily at personal care (ADLs and IADLs) and nursing care needs as well as mental health issues. Examples of the MI Choice face sheet and assessment are in attachment.

### **Evaluation Model:**

To meet the grant's requirements, DYNs Services, Inc. developed an evaluation model which considered demographic and clinical aspects of the transition population in comparison to the long term care population as a whole. The second major aspect is a cost benefit analysis based on pre and post long term care costs for long term care services for grant participants. This particular aspect of the evaluation, although very important, also delayed analysis given the lag time involved in the processing of Medicaid claims.

The total universe included in the analysis is 112 people who transitioned between December 1, 2003 and April 30, 2005. There are additional participants as the project continues to operate as a regular component of the state's Medicaid state plan services. However, complete cost data for later transitionees is not yet available. The methods used in this report can be used to analyze their data as necessary.

### **Data Sources:**

The data in this report come from three major sources:

- 1) MDCH/Medical Services Administration: Data Warehouse and the Medicaid Management Information System of Approved Paid Claims. This data set provides a rich source of information on eligibility and paid claims for all Medicaid beneficiaries. The system was used to verify participant's dates of departure from the nursing facility to the community. It also provides detailed data on all claims submitted to Michigan Medicaid for payment.

- 2) MI Choice Information System (MICIS): system used by all Michigan Waiver Agents to gather, store, and analyze data about participants, services, bills, and Medicaid claims.
  - a. Because the MICIS system was in use at both pilot NFTI sites, and because it could be used to gather information about both participants and the community services they receive, the MICIS system was established as the system to use in gathering NFTI pilot program information.
  - b. A wealth of information is available to review participant characteristics and service utilization patterns. The data presented in this report is only a small portion of information that is available in MICIS about long term care participants and services in the state.
  - c. MICIS is operated by the Center for Information Management, Inc. in Ann Arbor, Michigan. The Center for Information Management, Inc. specializes in automation tools for home and community based waivers. Based on the interRAI MDS-HC, these include comprehensive, integrated tools including client assessment, Client Assessment Protocols (CAPs) and Triggers, RUGS-III/HC Individual and Agency Profile reports, Individual and Agency Quality Indicator reports.
- 3) University of Michigan, Institute for Gerontology: The Institute maintains a Long Term Care Data Archive which has data from Michigan, other states and nations. For the purposes of this report, they assisted by providing information from the repository of Minimum Data Set Resident Assessment Instrument (MDS-RAI) for nursing facility residents and Minimum Data Set for Home Care (MDS-HC) in the Archive. The Institute is funded by the Michigan Department of Community Health for this purpose

### **Limitations of the data set:**

This report is a qualitative analysis<sup>ii</sup> of the NFTI project; details various demographic, clinical and cost aspects of the participants in Michigan's Nursing Facility Initiative project. The instruments used to collect data, the MDS-HC and the MDS-RAI are scientifically proven as are the scales and hierarchy used in analyzing the data. All of the systems used to collect and analyze the data; the University of Michigan Long Term Care Archive, Mi Choice Information System, CMS MDS-RAI repository and the DCH Data Warehouse have a long, proven record in processing long term care data. They provided a powerful resource when linked together. This is a compelling reason for devoting resources to the creation of a Long Term Care data warehouse. The sum of the linked and interrelated systems will be greater than the sum of the systems operating independently.

The report findings can be used to formulate hypothesis for a larger research project by providing interesting indicators. For example, it could be possible to track costs by Activity of Daily Living Hierarchy sub group or to look at clinical aspects for long staying residents vs. shorter stay residents. Indeed, that is one of the reports major recommendations is that the study be expanded to include a randomized sample of the Michigan nursing facility population to develop a clear picture of those most likely to return to the community.

### **Program model:**

The transition component operated in Kent and Wayne counties by two MI Choice waiver agents, the Area Agency on Aging of Western Michigan (AAAWM) and the Detroit Area Agency on Aging (DAAA), respectively. Both sites received grant funds to pay for transition costs and for supports coordination. Additional MI Choice waiver funds were allocated by the Michigan Department of Community Health to fund additional services for waiver eligible transitionees. Both sites were given some discretion in how they setup and organized their projects, under the oversight of the project director.

The AAAWM scenario: The agency hired a supports coordinator who had previously worked for the Grand Rapids Center for Independent Living as a team member on the previous transition grant. She brought years of experience in working with people with disabilities to the MI Choice waiver agent. This included a working relationship with nursing facilities in Kent County. The coordinator took charge of all aspects of transition plan development and implementation. Coordination with the MI Choice waiver program resources was included for people who were eligible for the program.

The DAAA scenario: The agency assigned an existing staff person to form a transition program within the agency structure. Subcontracts were



developed with Citizens for Better Care to find participants in facilities and with a housing consultant to connect residents to community housing. As part of this, the coordinator formed a collaborative of community resources, including legal aid, home and community based service providers, volunteers and other agency staff necessary to develop and implement transition plans.

Both approaches proved successful over the course of the project.

### **Characteristics of Participants**

There were a total of 112 people who participated in the NFTI program during the study period from December 1, 2003 through April 30, 2005.

Of the 112 participants in the NFTI program from December 1, 2003 through April 30, 2005, 66 were female, and 46 were male.

The average age of all participants was 64 years of age, with a range from 31 to 97 years of age. The average age of the Area Agency of Western Michigan participants (62 years) was 4 years less than the participants in the Detroit Area Agency on Aging program (66 years).

**Table 1**

<b>Gender and Age Categories</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>	<b>Percent</b>
Age 44 and under	6	5	11	10%
Age 45 to 54	11	11	22	20%
Age 55 to 64	14	10	24	21%
Age 65 and over	15	40	55	49%
Totals	46	66	112	100%

As Table 1 indicates, participants were more highly represented in the older age groups, but there were 11 participants under 44 years of age, and more participants 64 and under (57) than there were participants 65 and older (55).

This shows a larger representation of younger age groups at 51% than in the State's general waiver population at 24% as a whole. Some of this could be explained by the fact that NFTI Section 8 housing opportunities were limited to people under the age of 62, making it easier to transition those population groups. It is also possible that this is due to a lower level of long term care needs in the younger age groups, thereby making transition easier. It is particularly interesting given that the waiver agents have a longer history in working with elderly people, yet were very successful in working with younger transition candidates.

The group was clearly different from the general statewide nursing facility population, where only 11% for the residents are under the age of 65.

The number of males and females participating who were under 65 years of age was about the same, but there were over two and a half times as many females aged 65 or over (40) as males in that category (15). Again, this is significantly different from the MI Choice Waiver and nursing facility populations where 73% of the participants are female and 26% male.

**Table 2**

<b>Race</b>	<b>Number</b>	<b>Percent</b>
Caucasian	52	46%
African-American	56	50%
Asian/Pacific Islander	1	1%
Amer. Indian/Eskimo/Aleut	3	3%
Totals	112	100%

As table 2 above shows, there was an almost even split of Caucasian (52) and African American (56) participants, with four additional people in other race categories (see Table 2). The high number of people of African American race compared to the general long term care population (23% for MI Choice and 15% for nursing facility) is the likely result of the Detroit location for the project. From the 2000 US Census, approximately 42% of Wayne County including the city of Detroit is African American compared to 14.2% for the state as a whole.

**Table 3**

<b>Marital Status</b>	<b>Number</b>	<b>Percent</b>
Single / Never married	30	27%
Married	14	12%
Widowed	31	28%
Separated	3	3%
Divorced	21	19%
Not Available	13	11%
Totals	112	100%

Table 3 displays the marital status of participants. Of the reporting participants, only 14 were married, supporting the claim that people who are not married (and thus have no spousal support) are more likely to be in a nursing facility

**Table 4**

<b>Education Level</b>	<b>Number</b>	<b>Percent</b>
8th grade or less	9	8%
Grades 9 - 11	19	17%
High School	30	27%
Tech or Trade School	1	1%
Some College	17	15%
Bachelor's Degree	4	3%
Graduate Degree	2	2%
Not Available	30	27%
Totals	112	100%

As Table 4 indicates, the majority of reporting participants had an education level of high school or less. However, education level was not available for a significant number, 30 out of 112.

**Table 5**

<b>Residential Setting/Svcs Rec'd Prior to NF</b>	<b>Number</b>	<b>Percent</b>
Nursing facility (NF)	47	42%
NF & Rehabilitative Services	7	6%
NF & Home Care (HC)	9	8%
NF, HC, and Rehab	9	8%
NF, HC, Rehab & MH or DD Facility	1	1%
NF & Assisted Living	1	1%
Home Care	4	4%
Home Care & Rehab	12	10%
None of the Above	3	3%
Not Available	19	17%
Totals	112	100%

At initial assessment, the residential history of participants in the five years prior to assessment included 78 people who had been in a nursing facility (some with other living settings as well), and 15 people who had home care. Of these home care recipients, 11 had rehabilitation services prior to the nursing facility. These numbers show the bulk of the participants had established nursing facility care histories, not just transitory in nature.

Table 6 presents the number and percent of the 86 participants with diseases recorded who were being treated for the indicated diseases:

**Table 6**

<b>Diagnosis Description</b>	<b>Number of Participants</b>	<b>Percent of Assessed Participants</b>
Hypertension	33	38%
Depression	28	33%
Diabetes Mellitus	24	28%
Arthritis	22	26%
Anxiety	20	23%
Congestive Heart Failure	16	19%
Cerebral Vascular Accident (stroke)	15	17%
Hypothyroidism	15	17%
Coronary Artery Disease	14	16%
Allergies	14	16%
Anemia	11	13%
Cataracts	10	12%
Other fractures	9	10%
Emphysema	9	10%
Renal Failure	8	9%
Hemiplegia/ Hemiparesis	8	9%
Peripheral Vascular Disease	8	9%
Arteriosclerotic Heart Disease (ASHD)	7	8%
Missing Limb	6	7%
Osteoporosis	6	7%
Cardiac Dysrhythmia	5	6%
Other Cardiovascular Disease	5	6%
Aphasia	5	6%
Traumatic Brain Injury	5	6%
Manic Depression (Bipolar disease)	5	6%
Other Psychiatric Diagnoses	5	6%
Asthma	5	6%
Diabetic Retinopathy	5	6%
Total Participants Assessed	86	

Of the 86 participants who were assessed with the MDS-HC, all of the 88 diseases in the assessment were present and subject to treatment in at least one participant, with the exception of Parkinson's disease, cerebral palsy and schizophrenia. One participant had only one diagnosis noted (quadriplegia), while all others had multiple diseases that were being treated. One participant who successfully transitioned to the community had eighteen different diseases that were being treated. Twenty six participants (112-86) were not assessed with the MDS-HC for several

reasons. Some residents moved out of the nursing facility shortly after contact with the NFTI case coordinator and before a full assessment could be conducted. Coordination of assessment staff schedules (one nurse and one social worker with the NFTI case coordinator) were a major contributing factor to this.

Other diseases being treated in fewer than five participants included hyperthyroidism, hypotension, deep vein thrombosis, hip fracture, pathological bone fracture, Alzheimer's disease, dementia, multiple sclerosis, paraplegia, quadriplegia, seizure disorder, transient ischemic attack, cancer, and glaucoma.

Over 60% of the 80 participants for whom this information is available took 9 or more medications when first assessed.

**Table 7**

<b>Number of Medications at Assessment</b>	<b>Number of Participants</b>	<b>Percent</b>
2	2	3%
3	0	0%
4	4	5%
5	5	6%
6	6	8%
7	3	4%
8	9	11%
9+	51	63%
Totals	80	100%

### **MDS-HC Assessment Tools**

The State of Michigan Home and Community Based Elderly and Disabled Waiver uses the MDS-HC (Minimum Data Set for Home Care) to assess all Waiver participants. This assessment tool was chosen because of the wealth of research information and measurements available from interRAI, Inc. the developers of the MDS family of assessment tools.

Because the MDS assessment instrument is used to assess all residents of nursing facilities, and therefore is available in both the nursing facility and home care settings, it is possible to review a participant both in the nursing facility and once they had returned to the community using different scales developed by interRAI.

### **RUG III Case Mix Groups:**

An important measure of acuity in long term care participants is derived from the MDS assessment. Called RUG (Resource Utilization Group), this acuity measure is calculated using information from the MDS-RAI or MDS-HC assessments. Developed by interRAI researchers, the RUG score derived by algorithms from the MDS-RAI for nursing facility residents and MDS-HC for home care, groups participants into seven different categories of service utilization and thus presents a way to look at participant acuity. The RUG categories in order from highest to lowest acuity are: special rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical functions. Table 8 shows this distribution for the NFTI population as well as a comparison to the statewide nursing facility population.

The reduced physical function is of particular interest as a method of targeting residents with one or less ADL deficiencies and no nursing needs. The lowest two RUGs groups, Reduced Physical Functioning A1 and A2 represented or about 8% of Michigan's nursing facility residents fall in this group or about 5,000 people statewide. However, the distribution of NFTI participants shows that a person's RUGs group may not bear a direct relation to a person's ability to live successfully in the community. Almost an equal number of the NFTI project participants fell into higher RUGs categories, such as special care, clinically complex and impaired cognition as they did the lowest level, reduced physical functioning. This could mean that successful transitioning is due more to other community factors, such as availability of services and supports or a supports coordinator as provided by NFTI, than a person's level of acuity.

(The remainder of this page has been left intentionally blank to accommodate table 8 in its entirety on the page 9)

**Table 8**

<b>Resource Utilization Group (RUG)</b>	<b>NFTI Number of Participants</b>	<b>NFTI Percent of Participants</b>	<b>Nursing Facility*</b>
Special Rehabilitation	18	1%	4%
Extensive Services	3	13%	3%
Special Care	10	33%	9%
Clinically Complex	11	27%	24%
Impaired Cognition	11	14%	18%
Behavior Problems	7	8%	1%
Reduced Physical Functions	44	48%	41%
Reduced Physical Functions - E			9%
Reduced Physical Functions - D			19%
Reduced Physical Functions - C			2%
Reduced Physical Functions - B			3%
Reduced Physical Functions – A2			8%
Reduced Physical Functions – A1			
Total RUG assessments	79	100%	100%
Unavailable*	33		
Total Participants	112		

\*The RUGs grouper relies on elements in the MDS-HC assessment to calculate a score. If the MDS-HC assessment is not completely filled out or not completed (as was the case for twenty-six, previously mentioned) a RUGs score will be unavailable.

### **ADL Hierarchy**

The Activity of Daily Living (ADL) Hierarchy is a measure developed by interRAI researchers to determine different levels of physical functioning using the MDS-HC data. The ADL hierarchy was derived from assessment items that conceptually measure early ADL loss (dressing, hygiene), intermediate ADL loss (transfer, locomotion, and toileting), and late ADL loss (bed mobility, eating). The Hierarchy combines these ADLs into a comprehensive scale based on the degree of losses and performance level coding.

The NFTI participants for whom this measure could be calculated at initial assessment were arrayed across the categories, with most participants falling in the Limited or Extensive 1 categories. Only one

participant was independent, while three were classified in the total dependence category.

**Table 9**  
**NFTI ADL Scores compared to Nursing Facility - Michigan**

<b>ADL Hierarchy</b>	<b>NFTI Number of Participants</b>	<b>NFTI Percent of Participants</b>	<b>Nursing Facility*</b>
Independent	1	1%	7%
Supervision	10	13%	8%
Limited	26	33%	16%
Extensive 1	21	27%	26%
Extensive 2	11	14%	12%
Dependent	7	8%	18%
Total Dependence	3	4%	14%
Total	79	100%	100%
Unavailable*	33		
Total Participants	112		

\*see discussion in table 8.

This table shows difference in the ADL scores for NFTI transitionees and nursing facility residents. While significant differences appear in ADL scores for the two groups, NFTI was able to find and transition people who were medically needy. This profoundly underscores the desire and hopes that residents with physical disabilities have to return to the community. Recently, in 2004 data, when asked to respond to MDS-RAI question Q1a, “Do you wish to return to the community?” 64% of the residents in Michigan’s Kent and Wayne Counties responded affirmatively.<sup>iii</sup>

### **Cognitive Performance Scale**

The Cognitive Performance Scale (CPS) is a measure developed by InterRAI researchers to determine different levels of cognitive performance using the MDS-HC data, from intact to very severe impairment. The CPS is a hierarchical index used to rate cognitive status. The CPS has been validated against the Mini Mental State Examination. The nursing facility CPS scales uses comatose to identify the most impaired group. Because these types of persons are rarely seen in home care settings, a modified CPS for waiver participants based on four assessment items: memory, cognitive skills for daily decision making, expressive communication, and eating.



Using the first assessment conducted for NFTI participants, the highest numbers of participants were in the intact category, with fewer participants in each category as the impairment increases.

**Table 10**  
**NFTI CPS Scores compared to Nursing Facility - Michigan**

<b>Cognitive Performance Scale</b>	<b>NFTI Number of Participants</b>	<b>NFTI Percent of Participants</b>	<b>Nursing Facility*</b>
Intact	32	38%	11%
Borderline Intact	20	24%	9%
Mild Impairment	14	17%	14%
Moderate Impairment	11	13%	33%
Moderately Severe Impairment	4	5%	12%
Severe Impairment	2	2%	10%
Very Severe Impairment	1	1%	11%
Total	84	100%	100%
CPS unavailable	28		
Total Participants	112		

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## Transition Outcomes

Of the 112 people that participated in the NFTI project from December 1, 2003 through April 30, 2004, 102 were able to transition to the community. Of these, only 56 (50%) participated in post-transition state-supported programs. Another 46 (41%) required no further state-supported services.

**Table 11**

<b>NFTI Participant Transition Status</b>				
<b>Category</b>	<b>Program/Status</b>		<b>Total Participants</b>	<b>Percent of Total</b>
<b>Post Transition Community Programs</b>				
	HCBE/ED Waiver		43	38%
	OSA Care Management		8	7%
	OSA Targeted Care Management		2	2%
	Transferred to DHS Program		2	2%
	Local Agency Funds		1	1%
		<b>Total:</b>	<b>56</b>	<b>50%</b>
<b>Transition Only</b>				
	NFTI Program Only; No Further Services		32	29%
	No Further Contact		14	13%
		<b>Total:</b>	<b>46</b>	<b>41%</b>
<b>Still in Nursing Facility</b>	Stayed in Nursing Facility; Closed NFTI		5	4%
	Still in Nursing Facility; may transition		5	4%
		<b>Total:</b>	<b>10</b>	<b>8%</b>
<b>Total Participants</b>			<b>112</b>	

## **Current Status of Participants in Community Programs (as of September 13, 2005)**

Of the 56 participants who transitioned to community programs, 38 are still open in those programs.

**Table 12**

<b>NFTI Community Programs Post Transition Status</b>			
<b>Post Transition Program</b>	<b>Total Participants</b>	<b>Still Open as of 9/13/2005</b>	<b>Percent Still Open</b>
HCBE/ED Waiver	43	33	77%
OSA Care Management	8	4	50%
OSA Targeted Care Management	2	1	50%
Transferred to FIA Program	2	unknown	unknown
Local Agency Funds	1	0	0%
<b>Total</b>	<b>56</b>	<b>38</b>	

### **Waiver Services Provided to NFTI Participants After Transition**

The HCBS/ED Waiver provides a core set of services for people in the program that allow them to remain in the community. These services include personal care, private duty nursing, Homemaker services, home delivered meals, personal emergency response systems, respite care, chore services (e.g. snowplowing), home modifications, medical equipment and supplies, and adaptive items to assist with necessary activities. These services were provided as needed to waiver participants who had transitioned from nursing facilities. Table 13 indicates the number of NFTI participants who received waiver services post-transition.

**Table 13**  
**Distribution of Post Transition**  
**Waiver Services for 51 participants**

<b>Service</b>	<b>Number of Participants Receiving each Service</b>	<b>Percent of Participants</b>
Personal Care	41	80%
Homemaker	37	73%
Emergency Response Systems	24	47%
Home Delivered Meals	20	39%
Special Waiver Service*	11	22%
Private Duty Nursing	10	20%
Specialized Medical Equipment	9	18%
Personal Care Item	8	16%
Tub Stool or Bench	8	16%
Home Modifications	7	14%
Respite Care	7	14%
Chore Services	6	12%
Enteral Formulae	6	12%
Raised Toilet Seat	6	12%

\* Includes security deposit, initial rent payment, appliances, furniture, etc.

In the Home Modifications category, one NFTI participant required to have a ramp installed, and three needed specialized door locks. In the Special Waiver Service category, four participants needed to have a security deposit or initial rent paid, and a few need appliances and furniture. One participant required an over tub sliding bath system, the most expensive item was purchased for these NFTI participants. Since the start of the program through May, 2005, the total cost of HCBS/Ed Waiver services for all participants was \$282,479. This total covers 308 participant months, for an average cost per participant month of \$917. This compares to a cost of approximately \$3450 per month in a nursing facility (\$115 per day).

## Waiver Service Costs for ADL Hierarchy Groups

The following table presents HCBS/ED Waiver costs for NFTI participants by ADL Hierarchy groupings. There were 51 participants who were scored on this scale who had service codes during the period from January 1, 2004 through May 31, 2005. The average cost per service month is highest for those in the Extensive 1 category, and range from \$493 to \$893 for the other groups.

**Table 14**

<b>Waiver Service Costs For NFTI Participants by ADL Hierarchy</b>	<b>Number of Participants</b>	<b>Number of Service Months</b>	<b>Average Cost per Service Month</b>
Independent	0	0	\$0
Supervision	2	18	\$493
Limited	17	98	\$775
Extensive 1	11	81	\$1,406
Extensive 2	5	41	\$716
Dependent	5	33	\$893
Total Dependence	1	4	\$821
No ADL, not classified	10	33	\$657
Total	51	308	\$917

## Waiver Service Costs for Cognitive Performance Scale Groups

The following table presents HCBS/ED Waiver costs for NFTI participants by CPS groupings. There were 51 participants who were scored on this scale who had service codes during the period from January 1, 2004 through May 31, 2005. The average cost per service month is highest for those in the “Intact” category, which is also the category with the most participants. The other monthly costs range from \$575 to \$821 for the other groups.

**Table 15**

<b>Service Costs For NFTI Participants by CPS</b>	<b>Number of Participants</b>	<b>Number of Service Months</b>	<b>Average Cost per Service Month</b>
Intact	17	131	\$1,231
Borderline Intact	8	56	\$ 763
Mild Impairment	10	53	\$ 642
Moderate Impairment	6	36	\$ 787
Moderately Severe Impairment	1	4	\$ 821
Severe Impairment	1	7	\$ 575
Very Severe Impairment	0	0	\$ 0
Not Classified	8	21	\$ 417
Total	51	308	\$ 917

## Comparison of Pre and Post Nursing Facility Costs

It was possible to compare Nursing Facility six month pre-transition costs and six month post-transition costs for six NFTI participants. Others had not been in either the Nursing Facility or the Waiver long enough for a six-month comparison. Overall, community services for participants cost about 25% of what was charged by the nursing facility in the six months before transitioning. For the largest group, who saw a 90% reduction in cost, include people who returned to the community with a minimum of Medicaid supports and who did not enroll in any ongoing long term care services and supports program. The other programs group includes people who chose a variety of programs for people with service and supports needs outside the Medicaid long term care programs such as the Department of Human Services Home Help program, Office of Services to the Aging Care Management Program and Targeted Care Management.

**Table 16**  
**Summary Costs by Population Group Served/Medicaid Paid Claims**  
**6 months pre transition vs. 6 months post transition**

Population	Number of Participants	Total Claims		Cost Shift	
		Pre	Post	Amount	Percent
All NFTI	112	\$1,797,258	\$441,918	\$1,355,340	-75.4
MI Choice Waiver	43	\$736,239	\$293,261	\$ 442,978	-60.1
Other Programs	19	\$331,927	\$79,852	\$252,075	-75.9
NFTI in Community	46	\$729,092	\$ 68,805	\$660,287	-90.5
Still in NF	4	\$103,421	-	0	0

Table 17 shows examples from the project of transition costs for individual participants. Waiver costs include all costs for the thirteen MI Choice waiver services: personal care, home maker, home delivered meals, medical supplies, home modifications, transportation, chore, respite, counseling, private duty nursing, personal emergency response, personal care supervision, and adult day care. Medicaid costs include other state plan services such as pharmacy, therapies, and hospital.

**Table 17**  
**Sample Pre and Post Transition Total Medicaid and Waiver Costs**  
**Sept. 15, 2005**

			Total Six Month Medicaid Costs for:			Cost	Community Costs	
	Six Mo. Cost			Other		Difference	as % of NF Costs	
	Nursing Facility		Waiver	Medicaid	Total			
Person A	\$18,788		\$3,444	\$2,072	\$5,516	\$13,272		29%
Person B	\$14,363		\$10,260	\$1,464	\$11,724	\$2,639		82%
Person C	\$25,547		\$8,944	\$863	\$9,807	\$15,740		38%
Person D	\$12,261		\$4,629	\$1,410	\$6,039	\$6,222		49%
Person E	\$27,869		\$7,682	\$3,066	\$10,748	\$17,121		39%
Person F	\$26,498		\$8,164	\$8,303	\$16,467	\$10,031		62%
Person G	\$24,170		\$21,369	\$12,028	\$33,397	-\$9,227	Hosp*	138%
Person H	\$10,050		\$2,905	\$847	\$3,752	\$6,298		37%
Total	\$159,546		\$67,397	\$30,053	\$97,450	\$62,096		61%

\* NFTI costs are inclusive of a hospital stay.

## **Transition Barriers:**

Comments from both sites have been combined in the list.

- 1) Lack of person centered community supports and community supports coordinator. Residents in facilities for more than a few weeks start to lose their connections to the community. Once these connections are lost, it becomes nearly impossible for a person to orchestrate their own transition. A surrogate or community supports coordinator is required to reconnect the individual to the community supports and services. Funds are required to pay for transition expenses. Availability of both these were reasons for NFTI's success. This barrier results from a set of false biases commonly held by the general population of citizens and health professionals:
  - a. Often people do not consider community living a "safe" or "appropriate" living arrangement for people with significant long term care health needs for services and supports. Because of this bias, people are not even offered the option of community living. Many NFTI participants were placed in nursing facilities with no discussion or explanation of other options for community living.
  - b. Person centered, consumer driven decisions are not the "norm" for providers in the long term care health area, more often decisions are driven by the medical professionals or family members, not the person.
- 2) Lack of an information source to receive information about long term care and community living options. Residents reported not being able to access a telephone, fax or internet to assist in this effort.
- 3) Lack of funds to pay for services and supports due to the state's budget crisis. During the first two years of the NFTI project the MI Choice Waiver was closed to new enrollments. This made it very difficult to transition people with significant health needs.
- 4) Housing Issues: This is the single most difficult barrier for residents to tackle once they have lost community supports.
  - a. More subsidized housing, for all ages. The limitation of vouchers to age 62 and younger was a barrier to placing older residents in the community.
  - b. Education for landlords on the special needs of the long term care population and how to accommodate them in a successful housing arrangement.
  - c. Lack of a directory of housing options and availability. When the need arises to locate housing that is acceptable to the participant, there is not a web site or housing resource directory containing information on publicly and privately funded housing including assisted living, apartments, condominiums, single family homes.



- d. MI Choice Medicaid waiver cannot pay for services in licensed assisted living.
  - e. Current Medicaid waivers for home and community based services cannot include housing costs (rent or purchase) while the nursing facility rate does.
- 5) Services and person centered planning and direction: Residents encounter a grinding mass of paperwork, forms, conflicting program instructions and assessments that often become barriers in themselves. People should be put first, with a focus on their hopes and desires for a better more productive life.
- 6) Financial assistance and financial planning: Many residents, particularly younger people with disabilities, may have not had the opportunity to manage their own finances and require assistance to take on this responsibility.
  - a. lack ability to save funds to transition: after nursing facility expenses, residents are left with about \$60 per month. This is not enough to save towards transitioning to the community.
  - b. Poor credit history: For a variety of reasons do to poor health, lack of planning, guardianship issues, and no job or income, most NFTI participants had serious credit problems. These had to be resolved before a landlord would consider renting an apartment.
- 7) Lack of support from corporate guardians
- 8) Nursing facilities do not keep resident data up to date. This makes transition planning difficult because key elements about the person's supports and care needs are missing and/or not current.
- 9) Residents are reluctant to share personal and financial information with supports coordinator.

### **NFTI Transition Accomplishments:**

- Established ability to provide independence to persons who previously had no hope of returning to the community
- Transitioned 112 people to the community
- Demonstrated ability of MI Choice Waiver program to be a strong partner in long term care services, supports and transition
- Demonstrated MI Choice waiver programs commitment to person centered planning for younger persons with disabilities and elderly persons
- Savings established in long term care costs
- Community outreach activities, i.e., permanently expanded number of contacts available to assist in relocation of nursing facility residents back to the community
- Outreach efforts have created a heightened awareness of housing challenges, especially for disabled participants under 55 years of age.
- Outreach activities have created new opportunities for long term care residents

- NFTI project informed MDCH, DAAA and AAAMW and participating agencies regarding barriers and cost savings.
- Helped define and develop statewide policies and procedures for transition expansion.

### **Future Actions to NFTI Challenges, Conclusions and Discussion:**

- 1) Many people residing Michigan nursing facilities can return to the community. In the NFTI group, 41% of the people transitioned with no further service needs. The remainder had moderate to high needs similar to all nursing facility residents but still chose to live in the community. This represents a significant expense to the state that should be reduced as soon as possible by expansion of transition and diversion models statewide using NFTI techniques, including:
  - a. Providing supports coordination to nursing facility residents who wish to develop transition plans to move back to the community
  - b. Funding for transition costs (rent deposits, household furnishings, transportation), including funding for non Medicaid and non medically eligible residents
- 2) People requiring long term care can live successfully in the community. Most of the people who did need long term care services were still living in the community at the end of the project.
- 3) The MI Choice Waiver agents can provide effective and less costly alternative to institutional care. Service costs were less than one third the cost of a month in an institution.
- 4) Build local collaborative whose focus is to assist people to move out of nursing facilities and wish to live in the community.
- 5) Encourage communities to develop local consortia that combine Centers for Independent Living, Mi Choice Waiver and other service/housing providers to develop and implement transition plans
  - a. Develop discussion groups to work out special issues that would aid in transition such as pain management, arranging transportation, substance abuse, and employment counseling.
  - b. Use consortia to mobilize local resources and create a climate of change to educate people on person centered planning, choice and control and the appropriateness of community home based care.
- 6) Develop an information and referral function to provide people with up to date information on alternatives to institutions.
  - a. Develop state level money follows the person model, as people shift from one care system to another the long term care funds would follow them.
  - b. Develop an ongoing transition and diversion program by redirecting funds previously used for people in institutions who now reside in the community.

- 7) Close nursing facility beds and/or waiver slots as people transition to community based care
- 8) Fund advanced research to refine NFTI findings
- 9) Annually rebase long term care funds to follow person directed care settings
- 10) Revise long term care quality management plan to include transition and diversion status and measurement indicators.
- 11) Include housing, in addition to home modification, as a core long term care service
- 12) Provide financial counseling services: poor credit history is one of major barriers to finding a place to live outside of the institution
- 13) Develop and education and training program to raise community awareness to the appropriateness of home and community based services for people with long term care needs.
- 14) Work with nursing facilities to develop new models of care that more closely resemble community living.

In closing, the NFTI transition program demonstrated that most people in nursing facilities who have long term care supports and services can live in the community successfully. Some need extensive services but an equal number really only need housing and supports. Nursing facility residents should be helped at all cost to regain community living in a setting that achieves their wishes and desires for a better life.

# Nursing Facility Transition Project Data Collection: MI Choice Face Sheet

<b>MI CHOICE Participant Information</b>			
SSN <span style="border: 1px solid black; padding: 0 5px;">  </span> - <span style="border: 1px solid black; padding: 0 5px;">  </span> - <span style="border: 1px solid black; padding: 0 5px;">  </span>		Screening Date <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span>	Page 1
Agent <span style="border: 1px solid black; padding: 0 5px;">  </span>		Facsheet Date <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span>	
<b>Section A: Identifying Information</b>			
<b>1. Client Name</b>		<b>6. Spouse Date of Birth</b>	
Last <span style="border: 1px solid black; padding: 0 5px;">  </span>	First <span style="border: 1px solid black; padding: 0 5px;">  </span>	Middle <span style="border: 1px solid black; padding: 0 5px;">  </span>	Initial <span style="border: 1px solid black; padding: 0 5px;">  </span>
<b>2. Date of Birth</b> <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span>		<b>3. Gender</b>	
		<input type="radio"/> Male <input type="radio"/> Female	
<b>5. Spouse Last Name</b> <span style="border: 1px solid black; padding: 0 5px;">  </span>		<b>4. Marital Status</b>	
First Name <span style="border: 1px solid black; padding: 0 5px;">  </span>		<input type="radio"/> Single/NM <input type="radio"/> Separated <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Other	
Middle <span style="border: 1px solid black; padding: 0 5px;">  </span>		Date of Birth <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span>	
<b>7a. Race</b> (Fill only one)		<b>b. Is Client Hispanic?</b>	
<input type="radio"/> White <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Black <input type="radio"/> American Indian/Eskimo/Aleut		<input type="radio"/> No <input type="radio"/> Yes	
<b>c. Is Client Multiracial?</b>		<b>d. If Client Multiracial</b> (Check all that apply)	
<input type="radio"/> No <input type="radio"/> Yes		<input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Eskimo/Aleut	
<b>8. Client Address</b> <span style="border: 1px solid black; padding: 0 5px;">  </span>			
County <span style="border: 1px solid black; padding: 0 5px;">  </span> Township <span style="border: 1px solid black; padding: 0 5px;">  </span>			
<b>9. City</b> <span style="border: 1px solid black; padding: 0 5px;">  </span>			
State <span style="border: 1px solid black; padding: 0 5px;">  </span> Zip <span style="border: 1px solid black; padding: 0 5px;">  </span> - <span style="border: 1px solid black; padding: 0 5px;">  </span>			
<b>10. Client Phone</b> ( <span style="border: 1px solid black; padding: 0 5px;">  </span> ) <span style="border: 1px solid black; padding: 0 5px;">  </span> - <span style="border: 1px solid black; padding: 0 5px;">  </span>		<b>11. Has SSN Been Verified?</b> <input type="radio"/> No <input type="radio"/> Yes	
<b>Directions to Home</b>		<b>12. Primary Language</b>	
<b>13. Education: Highest level completed</b>			
<input type="radio"/> None <input type="radio"/> 9-11 Grade <input type="radio"/> Tech or Trade School <input type="radio"/> Bachelor's degree <input type="radio"/> 8th Grade/Less <input type="radio"/> High School <input type="radio"/> Some College <input type="radio"/> Graduate degree			
<b>14. Religious affiliation</b>		<b>15. Cultural issues that pertain to care plan</b>	
Contact <span style="border: 1px solid black; padding: 0 5px;">  </span> Phone ( <span style="border: 1px solid black; padding: 0 5px;">  </span> )		<input type="radio"/> No <input type="radio"/> Yes If Yes, explain	
<b>16. Client Rights and responsibilities explained</b>		<b>17. Reason for Referral</b>	
No   Yes		<input type="radio"/> Post hospital care <input type="radio"/> Eligibility for home care <input type="radio"/> Community chronic care <input type="radio"/> Day care <input type="radio"/> Home placement <input type="radio"/> Other	
<b>18. Where Lived at time of referral</b>		<b>19. Who lived with at referral</b>	
Private home/appt w/no home care services   Nursing home Private home/appt.w/home care services   Other Board and care/assisted living/group home		<input type="radio"/> Alone <input type="radio"/> w/Child (not Spouse) <input type="radio"/> w/Spouse only <input type="radio"/> w/Other(s) (not Spouse/Child) <input type="radio"/> w/Spouse and other(s) <input type="radio"/> w/non-relatives in group setting	
<b>20. Referral Name</b>		<b>21. Referral Date</b>	
		<span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span> / <span style="border: 1px solid black; padding: 0 5px;">  </span>	
<b>22. Referral Agency Code</b>		<b>23. Referral Agency Name</b>	
<span style="border: 1px solid black; padding: 0 5px;">  </span>		<span style="border: 1px solid black; padding: 0 5px;">  </span>	
<b>24. Referral Type</b>			
<span style="border: 1px solid black; padding: 0 5px;">  </span>			
<b>25. Family Contact Name</b>		<b>26. Contact Phone</b>	
<span style="border: 1px solid black; padding: 0 5px;">  </span>		( <span style="border: 1px solid black; padding: 0 5px;">  </span> ) <span style="border: 1px solid black; padding: 0 5px;">  </span> - <span style="border: 1px solid black; padding: 0 5px;">  </span>	
<b>27. Residential History and Services 5 Years Prior to Referral</b> (Check all settings resident lived in or services received during 5 years prior to date case opened)			
<input type="checkbox"/> Lived in nursing home <input type="checkbox"/> Lived in assisted living or congregate apartment <input type="checkbox"/> Lived for a protracted period of time in hospital setting <input type="checkbox"/> Home care client prior to this episode <input type="checkbox"/> Lived in mental health/psychiatric setting <input type="checkbox"/> Recipient of rehabilitative services prior to this episode <input type="checkbox"/> Lived in mental retardation or development disability setting <input type="checkbox"/> None of the above			
<b>28. Surrogate Decision Maker</b>			
Client has legal Guardian <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending		Name <span style="border: 1px solid black; padding: 0 5px;">  </span> Telephone <span style="border: 1px solid black; padding: 0 5px;">  </span>	
DPOA <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending		<span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span>	
Conservator <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending		<span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span>	
Rep Payee <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending		<span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span>	
This form will be processed using a scanner. The best results in interpreting your handprinting will be achieved if you use a fine or medium black or dark blue ink pen and attempt to keep letters and numbers inside the boxes provided for entry. Use all uppercase letters when possible. Circles represent field responses where only one should be chosen, square boxes represent fields which may include multiple responses. Please fill in circles completely and use "X" instead of checkmarks in the squares.			

SSN				-			-			
-----	--	--	--	---	--	--	---	--	--	--

Section B: Benefits & Insurance									
1. Client has Advance Medical Directives in place (i.e., a do not resuscitate order) <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending					Name _____ Telephone _____				
2. Living Will <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Pending					( )				
3. Client has Medicare <input type="radio"/> No <input type="radio"/> Yes		Medicare ID _____			Part A Effective _____			Part B Effective _____	
4. Medicaid Status <input type="radio"/> Non MA <input type="radio"/> MA Active		MA Effective From _____		MA Effective To _____		MA Spend Down _____			
5. QMB <input type="radio"/> No <input type="radio"/> Yes		6. Medicaid ID _____			7a. MA Case Number _____			7b. Medicaid Re/Certification Date _____	
8. FIA Case Worker/Phone _____					9. Patient Pay Amt _____				
10. Veterans ID _____					Veteran <input type="radio"/> Client <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other				
Benefits Received <input type="radio"/> No <input type="radio"/> Yes					Military service Date of entry: ____/____/____ Date of discharge: ____/____/____				
11. Insurance Resource (Select most appropriate response. If client has more than one coverage, select the primary coverage.)									
<input type="radio"/> No other insurance <input type="radio"/> Private insurance <input type="radio"/> Blue Cross/Blue Shield <input type="radio"/> Other <input type="radio"/> Worker's disability compensation <input type="radio"/> Eligible for Medicare <input type="radio"/> Employer/Union									
12. Health Insurance (Client) Company Name _____ Phone _____									
Address _____									
Contract # _____					Plan Code _____				
Group # _____					Service Code _____				
13. Health Insurance (Spouse) Company Name _____ Phone _____									
Address _____									
Contract # _____					Plan Code _____				
Group # _____					Service Code _____				
14. Life Insurance (Client)									
Co. Name _____				Phone ( ) _____			Term <input type="radio"/> No <input type="radio"/> Yes		
Address _____				Face Value \$ _____			Whole Life <input type="radio"/> No <input type="radio"/> Yes		
Contract # _____				Cash Value \$ _____			Endowment <input type="radio"/> No <input type="radio"/> Yes		
15. Life Insurance (Client)									
Co. Name _____				Phone ( ) _____			Term <input type="radio"/> No <input type="radio"/> Yes		
Address _____				Face Value \$ _____			Whole Life <input type="radio"/> No <input type="radio"/> Yes		
Contract # _____				Cash Value \$ _____			Endowment <input type="radio"/> No <input type="radio"/> Yes		
16. Life Insurance (Spouse)									
Co. Name _____				Phone ( ) _____			Term <input type="radio"/> No <input type="radio"/> Yes		
Address _____				Face Value \$ _____			Whole Life <input type="radio"/> No <input type="radio"/> Yes		
Contract # _____				Cash Value \$ _____			Endowment <input type="radio"/> No <input type="radio"/> Yes		
17. Client or representative can describe health benefits correctly <input type="radio"/> No <input type="radio"/> Yes									
18. Client or representative can interpret explanation of benefits correctly <input type="radio"/> No <input type="radio"/> Yes									

45157



# MI CHOICE Participant Information

SSN [ ] [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]

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## Section C: Financial Information

### 1. Gross Monthly (check box if Direct Deposit)

	Client	Spouse
Social Security	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Railroad Retirement	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
VA Benefits	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Pensions*	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Alimony	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Estate or Trust Fund	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Interest Income	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Dividends	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Employment	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
SSI	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Other	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
<b>Subtotals</b>	<b>\$ [ ] [ ] [ ] [ ] [ ] [ ]</b>	<b>[ ] [ ] [ ] [ ] [ ] [ ]</b>

**Total Household Income \$** [ ] [ ] [ ] [ ] [ ] [ ]

\*Itemize source of pensions:

Client is at or less than the special income limit: ☐ No ☐ Yes  
 Client or representative is effectively managing financial affairs: ☐ No ☐ Yes

FIA Irrevocable PPD Burial Accounts \$ [ ] [ ] [ ] [ ] [ ] [ ] \$ [ ] [ ] [ ] [ ] [ ] [ ]

### 2. Assets

	Client	Spouse	Joint
Savings	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Checking	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Equity Value/Real Estate	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Stock/Securities	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
CD/IRA/Money Market	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Cash Value Life Insur.	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Trade-In Val Second Car	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
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	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]

**Subtotals** [ ]

**Total Countable Assets** [ ] [ ] [ ] [ ] [ ] [ ]

Total Assets are at or below the limit for an individual or for a client with a community spouse: ☐ No ☐ Yes

### 5. Protected Spousal Amount (Worksheet) ☐ Check here if not applicable.

A) Initial assessment amount divided by 2 [ ] [ ] [ ] [ ] [ ] [ ]

B) Enter the lowest amount: Line A or the maximum PSA (if A is lower than the minimum PSA, enter the minimum PSA) [ ] [ ] [ ] [ ] [ ] [ ]

C) Add individual asset limit to B: [ ] [ ] [ ] [ ] [ ] [ ]

### 3. Current Monthly Household Expenses

Rent / House	[ ] [ ] [ ] [ ] [ ] [ ]	Property Tax	[ ] [ ] [ ] [ ] [ ] [ ]
Heat	[ ] [ ] [ ] [ ] [ ] [ ]	Charge Cards	[ ] [ ] [ ] [ ] [ ] [ ]
Electricity	[ ] [ ] [ ] [ ] [ ] [ ]	Water / Sewer	[ ] [ ] [ ] [ ] [ ] [ ]
Telephone	[ ] [ ] [ ] [ ] [ ] [ ]	Cable TV	[ ] [ ] [ ] [ ] [ ] [ ]
Food	[ ] [ ] [ ] [ ] [ ] [ ]	Transp Expenses	[ ] [ ] [ ] [ ] [ ] [ ]
Car Payment	[ ] [ ] [ ] [ ] [ ] [ ]	Install Payments	[ ] [ ] [ ] [ ] [ ] [ ]
Home Insurance	[ ] [ ] [ ] [ ] [ ] [ ]	Other	[ ] [ ] [ ] [ ] [ ] [ ]
Car Insurance	[ ] [ ] [ ] [ ] [ ] [ ]	Other	[ ] [ ] [ ] [ ] [ ] [ ]
Life Insurance	[ ] [ ] [ ] [ ] [ ] [ ]	Other	[ ] [ ] [ ] [ ] [ ] [ ]

**Household Total** [ ] [ ] [ ] [ ] [ ] [ ]

### 4. Current Monthly Medical Expenses

	Client	Spouse
Prescriptions	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Health Insurance	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Medical Transport	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Dr. Office	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Personal Care	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Over Counter Meds	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
DME	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Medical Bills	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Medicare Premium	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Other	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
Other	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]
<b>Medical Subtotal</b>	<b>[ ] [ ] [ ] [ ] [ ] [ ]</b>	<b>[ ] [ ] [ ] [ ] [ ] [ ]</b>

**Total Monthly Expenses** [ ] [ ] [ ] [ ] [ ] [ ]

**Variance** [ ] [ ] [ ] [ ] [ ] [ ]

(Total Household Income - Total Monthly Expenses)

Income is adequate to meet expenses and needed purchases: ☐ No ☐ Yes

Client has excessive expenses: ☐ No ☐ Yes

If yes, explain

**Client has unaddressed debt:** ☐ No ☐ Yes

If yes, define:

**Note: C = the maximum amount of countable assets the couple can have for the client to be asset eligible.**

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## Attachments 2

### Nursing Facility Transition Project Data Collection: MI Choice Assessment

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# MI-CHOICE CARE MANAGEMENT ASSESSMENT

Page 1

Agent  Office  Participant SSN  -  -

Assessed by:  Others Present:

SECTION A: IDENTIFYING INFORMATION			
1. Screen Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>		5. Client Last Name <input type="text"/>	
2. Date of Assessment (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>		Client First Name <input type="text"/> Middle Initial <input type="text"/>	
3. Place of Assessment <input type="radio"/> Home <input type="radio"/> Hospital <input type="radio"/> NH/Institution <input type="radio"/> Other		6. Date of Birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
4. Assessment Reason <input type="radio"/> Initial assess/Appropriate placement <input type="radio"/> 45 day follow-up assess <input type="radio"/> 90 day follow-up assess <input type="radio"/> 180 day follow-up assess <input type="radio"/> Discharge assess (<45 days after initial assess) <input type="radio"/> Death assess (<45 days after initial assess) <input type="radio"/> Other		7. Date Case Opened / Reopened (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Comments, Section A		8. Has SSN Been Verified? <input type="radio"/> No <input type="radio"/> Yes	
SECTION B: SOCIAL FUNCTIONING			
1. Involvement a. Client is at ease interacting with others (e.g., likes to spend time with others): <input type="radio"/> Not at ease <input type="radio"/> At ease b. Openly expresses conflict or anger with family/friends: <input type="radio"/> No <input type="radio"/> Yes		3. Isolation a. Length of time client is alone during the day (morning/afternoon) <input type="radio"/> Never or hardly ever <input type="radio"/> About one hour <input type="radio"/> Long periods of time-e.g., all morning <input type="radio"/> All of the time b. Client says or indicates that he/she feels lonely <input type="radio"/> No <input type="radio"/> Yes	
2. Change in Social Activities As compared to 180 days ago, decline in the client's level of participation in social, religious, occupational or other preferred activities. If there was a decline, client distressed by this fact: <input type="radio"/> No decline <input type="radio"/> Decline, not distressed <input type="radio"/> Decline, distressed		Comments, Section B	
SECTION C: INFORMAL SUPPORT SERVICES			
Relationship Codes: 0. Child or child-in-law 1. Spouse 2. Other relative 3. Friend or neighbor Task Codes: 1. Shopping 2. Transportation 3. Meals 4. Housekeeping 5. Personal Care 6. Money Management 7. Medication Preparation 8. Other 9. Other			
1. Primary Helper Last Name <input type="text"/> First Name <input type="text"/>		Phone <input type="text"/>	Relationship <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Tasks (check all that apply) 1 2 3 4 5 6 7 8 9 Cont.--- <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Added-- <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Secondary Helper Last Name <input type="text"/> First Name <input type="text"/>		Phone <input type="text"/>	Relationship <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Tasks (check all that apply) 1 2 3 4 5 6 7 8 9 Cont.--- <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Added-- <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

This form will be processed using a scanner. The best results in interpreting your handprinting will be achieved if you use a medium black or dark blue ink pen and attempt to keep letters and numbers inside the boxes provided for entry. Use all uppercase letters when possible. Circles represent field responses where only one should be chosen, square boxes represent fields which may include multiple responses. Please fill in circles completely and use "X" instead of checkmarks in the squares.

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# MI-CHOICE CARE MANAGEMENT ASSESSMENT

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Participant SSN [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ]

3. Other Helper	Phone	Relationship 0 1 2 3 ○ ○ ○ ○	Tasks (check all that apply) Cont.--- Added--	Days/Hours Avail.
4. Other Helper		0 1 2 3 ○ ○ ○ ○	Cont.--- Added--	
5. Other Helper		0 1 2 3 ○ ○ ○ ○	Cont.--- Added--	
<b>Primary and Secondary Helpers Only:</b>				
6. Lives with Client	0. No 1. Yes 2. No such helper (skip remaining items in this section)	Primary ○ 0 ○ 1 ○ 2		Secondary ○ 0 ○ 1 ○ 2
7. Areas of Help	a. Advice or emotional support	○ No ○ Yes		○ No ○ Yes
	b. IADL Care	○ No ○ Yes		○ No ○ Yes
	c. ADL Care	○ No ○ Yes		○ No ○ Yes
8. If Needed, Willingness (with ability) to Increase Help	0. No 1. 1-2 Hours/day 2. More than 2 hours			
	a. Advice or emotional support	○ 0 ○ 1 ○ 2		○ 0 ○ 1 ○ 2
	b. IADL Care	○ 0 ○ 1 ○ 2		○ 0 ○ 1 ○ 2
	c. ADL Care	○ 0 ○ 1 ○ 2		○ 0 ○ 1 ○ 2
9. Caregiver Status (check all that apply)		10. Extent of Help (Hours of care, rounded)		
<input type="checkbox"/> A caregiver is unable to continue in caring activities (e.g., decline in health or the caregiver makes it difficult to continue) <input type="checkbox"/> Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) <input type="checkbox"/> Primary caregiver expresses feelings of distress, anger, or depression <input type="checkbox"/> None of the above		For instrumental and personal activities of daily living received over the last 7 days, indicate extent of help from family, friends and neighbors: a. Sum of time across five weekdays [ ] [ ] hours b. Sum of time across two weekend days [ ] [ ] hours		
Comments, Section C				
<b>SECTION D: ENVIRONMENTAL ASSESSMENT</b>				
1. Home Environment (Check any of the following that make home environment hazardous or uninhabitable. If none apply, check None of above; if temporarily in institution, base assessment on home visit)		3. Housing Assessment		
<input type="checkbox"/> Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors) <input type="checkbox"/> Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs) <input type="checkbox"/> Bathroom and toilet room (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet) <input type="checkbox"/> Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs) <input type="checkbox"/> Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in home with asthmatic) <input type="checkbox"/> Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street) <input type="checkbox"/> Access to home (e.g., difficulty entering / leaving home) <input type="checkbox"/> Access to rooms in house (e.g., unable to climb stairs) <input type="checkbox"/> None of above		Client lives in: <input type="radio"/> House <input type="radio"/> Apartment <input type="radio"/> Residential Group Home <input type="radio"/> Other Client: <input type="radio"/> Owns <input type="radio"/> Rents <input type="radio"/> Other		
2. Living Arrangement		4. Neighborhood Unsafe (client report) Does the client refrain from going out because of safety issues in the neighborhood?		
a. As compared to 90 days ago, client now lives with other persons (e.g., moved in with another person, other moved in with client) <input type="radio"/> No <input type="radio"/> Yes b. Client or primary caregiver feels that client would be better off in another living environment <input type="radio"/> No <input type="radio"/> Caregiver only <input type="radio"/> Client only <input type="radio"/> Client and Caregiver		<input type="radio"/> No <input type="radio"/> Yes 5. Cooking facilities and refrigerator on premises <input type="radio"/> No <input type="radio"/> Yes 6. Microwave on premises <input type="radio"/> No <input type="radio"/> Yes 7. Telephone accessible and usable <input type="radio"/> No <input type="radio"/> Yes Private line <input type="radio"/> No <input type="radio"/> Yes Modular jack <input type="radio"/> No <input type="radio"/> Yes Touch tone service <input type="radio"/> No <input type="radio"/> Yes 8. Home requires modifications to remove barriers or home repairs are needed (roof leaks, unsafe flooring, other) <input type="radio"/> No <input type="radio"/> Yes 9. Tub/shower/hot water accessible <input type="radio"/> No <input type="radio"/> Yes 10. Pets <input type="radio"/> No <input type="radio"/> Yes 11. Smoke detector <input type="radio"/> No <input type="radio"/> Yes 12. Washer/dryer accessible <input type="radio"/> No <input type="radio"/> Yes 13. Emergency plan in place <input type="radio"/> No <input type="radio"/> Yes		

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Comments, Section D

## SECTION E: COGNITIVE PATTERNS

<b>1. Memory</b> a. Short-term memory OK - seems/appears to recall after 5 minutes <input type="radio"/> Memory OK <input type="radio"/> Memory Problem b. Long-term memory OK - seems/appears to recall long past <input type="radio"/> Memory OK <input type="radio"/> Memory Problem <b>2. Cognitive Skills for Daily Decision Making</b> How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) <input type="radio"/> Independent - decisions consistently reasonable <input type="radio"/> Modified independence - some difficulty in new situations <input type="radio"/> Moderately impaired - decisions poor; cues/supervision required <input type="radio"/> Severely impaired - never/rarely made decisions	<b>3. Indicators of Delirium</b> a. Sudden or new onset/change in mental function (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) <input type="radio"/> No <input type="radio"/> Yes  b. In the last 90 days, client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others <input type="radio"/> No <input type="radio"/> Yes
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Comments, Section E (Discuss orientation to surroundings, date, time, place, and reliability of information)

## SECTION F: COMMUNICATION / HEARING PATTERNS

<b>1. Hearing</b> (with hearing appliance if used) <input type="radio"/> Hears adequately - normal talk, TV, phone, doorbell <input type="radio"/> Minimal difficulty when not in quiet setting <input type="radio"/> Hears in special situations only - speaker has to adjust tonal quality and speak distinctly <input type="radio"/> Highly impaired - absence of useful hearing <b>2. Making self understood</b> (Expressing information content - however able) <input type="radio"/> Understood <input type="radio"/> Usually understood - difficulty finding words or finishing thoughts <input type="radio"/> Sometimes understood - ability limited to making concrete requests <input type="radio"/> Rarely/never understood	<b>3. Ability to understand others</b> (understands verbal information - however able) <input type="radio"/> Understands <input type="radio"/> Usually understands - may miss some part/intent of message <input type="radio"/> Sometimes understands - responds adequately to simple, direct communication <input type="radio"/> Rarely/never understands <b>4. Hearing aid</b> <input type="radio"/> Uses reliably <input type="radio"/> Does not use reliably <input type="radio"/> Needed, but not available <input type="radio"/> Does not need/want
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Comments, Section F

## SECTION G: MOOD AND BEHAVIOR PATTERNS

<b>1. Drinking / Smoking</b> a. In the last 90 days, client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking <input type="radio"/> No <input type="radio"/> Yes b. In the last 90 days, client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking <input type="radio"/> No <input type="radio"/> Yes c. Smoked or chewed tobacco daily <input type="radio"/> No <input type="radio"/> Yes d. Over a typical week in the last month, record the number of days (0-7) client had one or more drinks <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 </div> <div> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 </div> </div> e. On days client had a drink, record the number of drinks usually consumed per day (code 0 for no drinks, 9+ for 9 or more drinks) <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 </div> <div> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 </div> </div>	<b>2. Indicators of Depression, Anxiety, Sad Mood</b> (Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days/week 2. Indicator of this type exhibited daily or almost daily (6-7 days/week) a. A feeling of sadness or being depressed, that life is not worth living, that nothing matters that he or she is of no use to anyone or would rather be dead <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 b. Persistent anger with self or others (e.g., easily annoyed, anger at care received) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 c. Repetitive anxious complaints, concerns (e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 d. Sad, pained worried facial expressions (e.g., furrowed brows) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 e. Recurrent crying, tearfulness <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 f. Withdrawal from activities of interest (e.g., no interest in long standing activities or being with family/friends) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
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# MI-CHOICE CARE MANAGEMENT ASSESSMENT

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Participant SSN  -  -

<p><b>3. Behavioral Symptoms</b> (In the last 7 days, instances when the client exhibited following behavioral symptoms. If exhibited, ease of altering the symptom when it occurred)</p> <p>0. Did not occur in last 7 days  1. Occurred, easily altered  2. Occurred, not easily altered</p> <p>a. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>b. Verbally abusive behavioral symptoms (threatened, screamed at, cursed at others) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>c. Physically abusive behavioral symptoms (hit, shoved, scratched, sexually abused others) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>d. Socially inappropriate/disruptive behavioral symptoms (disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disturbing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>e. Aggressive resistance of care (e.g., threw medications, pushed caregiver) <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p>	<p><b>7. Self Injury</b></p> <p>a. Self injurious attempt (code for most recent instance)  <input type="radio"/> None (skip to item c.)  <input type="radio"/> Attempt(s) more than 12 months ago  <input type="radio"/> Attempt in last 12 months</p> <p>b. Intent of any self injurious attempt was to kill him/herself <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Considered self-injurious behavior in last 30 days <input type="radio"/> No <input type="radio"/> Yes</p> <p>d. Family/caregiver/friend/staff express concern that patient is at risk for self-injury <input type="radio"/> No <input type="radio"/> Yes</p> <p><b>8. Violence</b> (Code for most recent instance)</p> <p>0. Never      1. Any history prior to last 7 days      2. Last 7 days</p> <p>a. History of violence to others <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>b. Intimidation of others or threatened violence <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>c. Violent ideation <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>d. Police intervention for violent behavior <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p> <p>e. Sexual violence <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2</p>
<p><b>4. Changes in Behavioral Symptoms</b></p> <p>Behavioral symptoms have become worse or are less well tolerated by family as compared to 30 days ago</p> <p><input type="radio"/> No or no change in behavioral symptoms <input type="radio"/> Yes</p>	<p><b>9. Mental Health Interventions</b> (Specify)</p>
<p><b>5. Mental Health</b></p> <p>Problem conditions in last week (check all present at any point during last 7 days)</p> <p><input type="checkbox"/> Delusions  <input type="checkbox"/> Hallucinations  <input type="checkbox"/> None</p>	<p><b>10. Mental Retardation</b> <input type="radio"/> No <input type="radio"/> Yes  If yes, check all that apply <input type="checkbox"/> Diagnosis <input type="checkbox"/> History <input type="checkbox"/> Observed</p> <p><b>11. Developmental Disability</b> <input type="radio"/> No <input type="radio"/> Yes  If yes, check all that apply <input type="checkbox"/> Diagnosis <input type="checkbox"/> History <input type="checkbox"/> Observed</p>
<p><b>6. Number of prior lifetime mental health admissions</b></p> <p><input type="radio"/> None  <input type="radio"/> 1 to 3  <input type="radio"/> 4 to 6  <input type="radio"/> 7 or more</p>	<p><b>12. Significant Life Changes within the Last Six Months</b> (check all that apply)</p> <p><input type="checkbox"/> Death of a loved one  <input type="checkbox"/> Functional status change  <input type="checkbox"/> Divorce  <input type="checkbox"/> Other, explain  <input type="checkbox"/> None</p>

Comments, Section G (discuss history of mental health impairment)

## SECTION H: SUMMARY - SOCIAL WORKER

SW Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## SECTION I: DISEASE DIAGNOSIS, DISABILITIES

<b>1. Primary Physician</b> _____ Address _____ Phone _____ Date last seen _____		<b>NEUROLOGICAL</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Alzheimer's disease <input type="radio"/> <input type="radio"/> <input type="radio"/> Multiple sclerosis <input type="radio"/> <input type="radio"/> <input type="radio"/> Aphasia <input type="radio"/> <input type="radio"/> <input type="radio"/> Paraplegia <input type="radio"/> <input type="radio"/> <input type="radio"/> Cerebral palsy <input type="radio"/> <input type="radio"/> <input type="radio"/> Parkinson's disease <input type="radio"/> <input type="radio"/> <input type="radio"/> Cerebrovascular accident (stroke) <input type="radio"/> <input type="radio"/> <input type="radio"/> Quadriplegia <input type="radio"/> <input type="radio"/> <input type="radio"/> Dementia (other than Alzheimer's disease) <input type="radio"/> <input type="radio"/> <input type="radio"/> Seizure disorder <input type="radio"/> <input type="radio"/> <input type="radio"/> Hemiplegia/Hemiparesis <input type="radio"/> <input type="radio"/> <input type="radio"/> Transient ischemic attack (TIA) <input type="radio"/> <input type="radio"/> <input type="radio"/> Traumatic brain injury	
<b>2. Specialist</b> _____ Address _____ Phone _____ Date last seen _____		<b>PSYCHIATRIC / MOOD</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Manic depression (bipolar disease) <input type="radio"/> <input type="radio"/> <input type="radio"/> Anxiety disorder <input type="radio"/> <input type="radio"/> <input type="radio"/> Schizophrenia <input type="radio"/> <input type="radio"/> <input type="radio"/> Depression <input type="radio"/> <input type="radio"/> <input type="radio"/> Other psychiatric diagnosis	
<b>3. Specialist</b> _____ Address _____ Phone _____ Date last seen _____		<b>PULMONARY</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Asthma <input type="radio"/> <input type="radio"/> <input type="radio"/> Emphysema/COPD	
<b>4. Specialist</b> _____ Address _____ Phone _____ Date last seen _____		<b>SENSORY</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Cataracts <input type="radio"/> <input type="radio"/> <input type="radio"/> Glaucoma <input type="radio"/> <input type="radio"/> <input type="radio"/> Diabetic retinopathy <input type="radio"/> <input type="radio"/> <input type="radio"/> Macular degeneration	
<b>5. Specialist</b> _____ Address _____ Phone _____ Date last seen _____		<b>OTHER</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Allergies <input type="radio"/> <input type="radio"/> <input type="radio"/> Renal failure <input type="radio"/> <input type="radio"/> <input type="radio"/> Anemia <input type="radio"/> <input type="radio"/> <input type="radio"/> Cancer (in past 5 years - not including skin cancer)	
<b>6. Most recent</b> (mm/dd/yyyy) a. Hospitalization Admission Date [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] Discharge Date [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] Hospital Name _____ b. Emergency Room date of visit [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]		<b>8. Infections</b> Disease/infection that doctor has indicated is present and affects client's status, requires treatments, or requires symptom management. Also include if disease is being monitored by a home care professional or is the reason for hospitalization in last 90 days <b>Codes:</b> 0. Not present 1. Present-not subject to focused treatment or monitoring by home care professional 2. Present-monitored or treated by home care professional 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Antibiotic resistant infection (e.g., Methicillin resistant staph) <input type="radio"/> <input type="radio"/> <input type="radio"/> Clostridium difficile (c. diff) <input type="radio"/> <input type="radio"/> <input type="radio"/> Conjunctivitis <input type="radio"/> <input type="radio"/> <input type="radio"/> Sexually transmitted diseases <input type="radio"/> <input type="radio"/> <input type="radio"/> HIV infection <input type="radio"/> <input type="radio"/> <input type="radio"/> Tuberculosis <input type="radio"/> <input type="radio"/> <input type="radio"/> Pneumonia <input type="radio"/> <input type="radio"/> <input type="radio"/> Urinary tract infection last 30 days <input type="radio"/> <input type="radio"/> <input type="radio"/> Respiratory infection <input type="radio"/> <input type="radio"/> <input type="radio"/> Viral hepatitis <input type="radio"/> <input type="radio"/> <input type="radio"/> Septicemia <input type="radio"/> <input type="radio"/> <input type="radio"/> Wound infection	
<b>7. Diseases</b> Disease/infection that doctor has indicated is present and affects client's status, requires treatments, or requires symptom management. Also include if disease is being monitored by a home care professional or is the reason for hospitalization in last 90 days <b>Codes:</b> 0. Not present 1. Present-not subject to focused treatment or monitoring by home care professional 2. Present-monitored or treated by home care professional		<b>9a. Other current or more detailed diagnosis and ICD-9 Codes</b> a. _____ [ ] [ ] [ ] [ ] [ ] [ ] b. _____ [ ] [ ] [ ] [ ] [ ] [ ] c. _____ [ ] [ ] [ ] [ ] [ ] [ ] d. _____ [ ] [ ] [ ] [ ] [ ] [ ]	
<b>ENDOCRINE/METABOLIC/NUTRITIONAL</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Diabetes mellitus <input type="radio"/> <input type="radio"/> <input type="radio"/> Hyperthyroidism <input type="radio"/> <input type="radio"/> <input type="radio"/> Hypothyroidism		<b>9b. Primary diagnosis code</b> [ ] [ ] [ ] [ ] [ ] [ ]	
<b>HEART / CIRCULATION</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Arteriosclerotic heart disease (ASHD) <input type="radio"/> <input type="radio"/> <input type="radio"/> Deep vein thrombosis <input type="radio"/> <input type="radio"/> <input type="radio"/> Hypertension <input type="radio"/> <input type="radio"/> <input type="radio"/> Hypotension <input type="radio"/> <input type="radio"/> <input type="radio"/> Cardiac dysrhythmia <input type="radio"/> <input type="radio"/> <input type="radio"/> Peripheral vascular disease <input type="radio"/> <input type="radio"/> <input type="radio"/> Congestive heart failure <input type="radio"/> <input type="radio"/> <input type="radio"/> Other cardiovascular disease <input type="radio"/> <input type="radio"/> <input type="radio"/> Coronary artery disease		<b>10. Source of medical information</b>	
<b>MUSCULOSKELETAL</b> 0 1 2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Arthritis <input type="radio"/> <input type="radio"/> <input type="radio"/> Osteoporosis <input type="radio"/> <input type="radio"/> <input type="radio"/> Hip fracture <input type="radio"/> <input type="radio"/> <input type="radio"/> Pathological bone fracture <input type="radio"/> <input type="radio"/> <input type="radio"/> Missing limb <input type="radio"/> <input type="radio"/> <input type="radio"/> Other fractures		<b>11. Aware of diagnosis</b> Client <input type="radio"/> No <input type="radio"/> Yes Family <input type="radio"/> No <input type="radio"/> Yes	
<b>Comments, Section I: (include Medical History)</b> _____ _____ _____			

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## SECTION J: HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

<p><b>1. Preventive Health</b> (check all that apply - in last 90 days)</p> <input type="checkbox"/> Blood pressure measured <input type="checkbox"/> Received influenza vaccination <input type="checkbox"/> Health assessment and physical exam by health care provider in the last 90 days	<p><b>7. Health Status Indicators</b> (check all that apply)</p> <input type="checkbox"/> Client feels he/she has poor health (when asked) <input type="checkbox"/> Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating) <input type="checkbox"/> Experiencing a flare-up of a recurrent or chronic problem <input type="checkbox"/> Treatments changed in last 30 days because of a new acute episode or condition <input type="checkbox"/> Prognosis of less than six months to live (e.g., physician has told client or client's family that client has end-stage) <input type="checkbox"/> None of the above
<p><b>a. If MALE</b></p> <input type="checkbox"/> Prostate exam <input type="checkbox"/> Testicular exam (self or health provider) <input type="checkbox"/> PSA blood test (Prostate-specific antigen) <p><b>b. If FEMALE</b></p> <input type="checkbox"/> Pap smear <input type="checkbox"/> Received breast examination or mammography	<p><b>8. Pain</b></p> <p>a. Frequently complains or shows evidence of pain (in last 7 days)</p> <input type="radio"/> No Pain (skip to item 8.e.) <input type="radio"/> Pain less than daily <input type="radio"/> Pain daily
<p><b>2. Client needs medication to control pain</b> <input type="radio"/> No <input type="radio"/> Yes</p> <p><b>3. Falls frequency</b> Number of times fell in last 180 days (or since last assessment) If none, code "0"; if more than 9, code "9+": 7 8 9+  <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9+         </p> <p><b>4. Danger of Fall</b></p> <p>Unsteady Gait <input type="radio"/> No <input type="radio"/> Yes          Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others) <input type="radio"/> No <input type="radio"/> Yes</p> <p><b>5. Problem Conditions Present on 2 or more days</b> (check all that were present on at least 2 of last 7 days)</p> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty urinating or urinating 3 or more times at night <input type="checkbox"/> Fever <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> None of the above	<p>b. Pain is unusually intense <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Pain intensity disrupts usual activities <input type="radio"/> No <input type="radio"/> Yes</p> <p>d. Character of pain</p> <input type="radio"/> No pain <input type="radio"/> Localized- single site <input type="radio"/> Multiple sites <p>e. Pain controlled by medication</p> <input type="radio"/> No pain <input type="radio"/> Medication offered no control <input type="radio"/> Pain is partially or fully controlled by medication
<p><b>6. Problem Conditions in last week</b> (Physical Health-check all present at any point in last 7 days)</p> <input type="checkbox"/> Change in sputum production <input type="checkbox"/> Chest pain at exertion or chest pain/pressure at rest <input type="checkbox"/> Constipation in 4 of last 7 days <input type="checkbox"/> Dizziness or light-headedness <input type="checkbox"/> Edema <input type="checkbox"/> Shortness of breath <input type="checkbox"/> None of the above	<p><b>9. Other Status Indicators</b> (check all that apply)</p> <input type="checkbox"/> Fearful of a family member or caregiver <input type="checkbox"/> Unusually poor hygiene <input type="checkbox"/> Unexplained injuries, broken bones, or burns <input type="checkbox"/> Neglected, abused, mistreated <input type="checkbox"/> Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting) <input type="checkbox"/> None of the Above

Comments, Section J

## SECTION K: NUTRITIONAL / HYDRATION STATUS

<p><b>1. Weight Change</b></p> <p>a. Unintended weight loss of 5% or more in last 30 days, or 10% or more in last 180 days <input type="radio"/> No <input type="radio"/> Yes</p> <p>b. Unintended weight gain of 5% or more in last 30 days, or 10% or more in last 180 days <input type="radio"/> No <input type="radio"/> Yes</p> <p><b>2. Consumption</b></p> <p>a. In at least 4 of the last 7 days, client ate one or fewer meals a day <input type="radio"/> No <input type="radio"/> Yes</p> <p>b. In the last 3 days, noticeable decrease in the amount of food client eats or fluids usually consumes <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Insufficient fluids - client did not consume all/almost all fluids during last 3 days <input type="radio"/> No <input type="radio"/> Yes</p> <p>d. Nutritional approaches (check all that apply in the last 7 days)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Parenteral IV  <input type="checkbox"/> Feeding Tube  <input type="checkbox"/> Mechanically altered diet  <input type="checkbox"/> Syringe oral feeding  <input type="checkbox"/> Therapeutic diet         </div> <div> <input type="checkbox"/> Dietary supplement between meals  <input type="checkbox"/> Plate guard, stabilized built-up utensils, etc.  <input type="checkbox"/> On a well planned weight change program  <input type="checkbox"/> None of the above         </div> </div> <p>e. Well-balanced meals per setting? <input type="radio"/> No <input type="radio"/> Yes</p>	<p><b>3. Type of Diet</b> (Check all that apply)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Regular  <input type="checkbox"/> Sodium Restricted  <input type="checkbox"/> Fat controlled  <input type="checkbox"/> Diabetic         </div> <div> <input type="checkbox"/> Mechanical soft  <input type="checkbox"/> Bland low residue  <input type="checkbox"/> Calorie restricted  <input type="checkbox"/> Other         </div> </div> <p><b>4. Nutritional Treatments</b></p> <p><b>A. Management Codes:</b>          0. Not used 1. On own 2. Partially performed by others 3. Fully performed by others</p> <p><b>B. Number of days</b> formal care received in last week (0-7)</p> <table border="1"> <thead> <tr> <th>Management</th> <th>0</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> <th>6</th> <th>7</th> </tr> </thead> <tbody> <tr> <td>a. Intravenous or infusion therapy-hydration (not including TPN)</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>b. Fluids by mouth</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>c. Parenteral nutrition (TPN or lipids)</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>d. Enteral - tube feeding</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>	Management	0	1	2	3	4	5	6	7	a. Intravenous or infusion therapy-hydration (not including TPN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	b. Fluids by mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	c. Parenteral nutrition (TPN or lipids)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	d. Enteral - tube feeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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# MI-CHOICE CARE MANAGEMENT ASSESSMENT

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Participant SSN    -    -

<p><b>5. Ability to Access Food/Drink</b></p> <p>a. Physically capable to purchase or attain ample food/fluids to meet dietary needs (e.g., issues of transportation, mobility, mental functioning, distance to store, etc.) <input type="radio"/> No <input type="radio"/> Yes</p> <p>b. Able to chew, swallow foods prepared or presented <input type="radio"/> No <input type="radio"/> Yes</p>	<p><b>7. Appetite problems</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>6. Describe what client actually consumed during last three meals. Include snacks between meals</b></p> <p>Breakfast: _____</p> <p>_____</p> <p>_____</p> <p>Lunch: _____</p> <p>_____</p> <p>_____</p> <p>Dinner: _____</p> <p>_____</p> <p>_____</p> <p>Snacks consumed during the last 24 hours: _____</p> <p>_____</p> <p>_____</p>	

**Comments, Section K**

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SECTION L: DENTAL STATUS (ORAL HEALTH)	
<p><b>1. Oral Status</b> Check all that apply</p> <p><input type="checkbox"/> Problem chewing or swallowing (e.g., pain while eating)</p> <p><input type="checkbox"/> Mouth is "dry" when eating a meal</p> <p><input type="checkbox"/> Problem brushing teeth or dentures</p> <p><input type="checkbox"/> None of the above</p>	<p><b>2. Dental Care</b></p> <p>a. Client needs dental care <input type="radio"/> No <input type="radio"/> Yes</p> <p>b. Client has dentures <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. If Yes, uses reliably <input type="radio"/> No <input type="radio"/> Yes</p>
<p><b>3. Describe condition of mouth</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	

**Comments, Section L**      Date dentist last seen      /      /

\_\_\_\_\_

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SECTION M: VISION PATTERNS	
<p><b>1. Vision</b> (ability to see in adequate light and with glasses if used)</p> <p><input type="radio"/> Adequate - sees fine detail, including regular print in newspapers/books</p> <p><input type="radio"/> Impaired - sees large print, but not regular print in newspapers/books</p> <p><input type="radio"/> Moderately impaired - limited vision; not able to see newspaper headlines, but can identify objects</p> <p><input type="radio"/> Highly impaired - object identification in question, but eyes appear to follow objects</p> <p><input type="radio"/> Severely impaired - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects</p>	<p><b>2. Visual Limitation/Difficulties</b></p> <p>Saw halos or rings around lights, curtains over eyes, or flashes of lights <input type="radio"/> No <input type="radio"/> Yes</p>
<p><b>3. Vision decline</b></p> <p>Worsening of vision as compared to status of 90 days ago <input type="radio"/> No <input type="radio"/> Yes</p>	

**Comments, Section M**

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## SECTION N: SKIN CONDITION

**1. Skin Problems** Any troubling skin conditions or changes in the last 30 days (e.g., bumps, bruises, rashes, itchiness, body lice, scabies) ☐ No ☐ Yes

**2. Ulcers (Pressure/Stasis)** Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (**Stage 1**)

Partial loss of skin layers (**Stage 2**)

Deep craters in the skin (**Stage 3**)

Breaks in skin exposing muscle or bone (**Stage 4**)

(Code "0" if no ulcer, otherwise record the highest ulcer stage (1-4))

a. Pressure ulcer - any lesion caused by pressure, shear forces, resulting in damage of underlying tissue ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

b. Stasis ulcer - open lesion caused by poor circulation in the lower extremities ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

**3. Other Skin Problems** Requiring Treatment (Check all that apply):

☐ Burns (second or third degree)

☐ Open lesions other than ulcers, rashes, cuts (e.g., cancer)

☐ Skin tears or cuts

☐ None of the above

**4. Surgical Wound Sites** (Check all that apply)

☐ Thorax

☐ Other

☐ Abdomen

☐ None of the above

☐ Extremities

**5. History of Resolved Pressure Ulcers:** Client previously had (at any time) or has an ulcer anywhere on the body: ☐ No ☐ Yes

Comments, Section N

## 6. Wound/Ulcer Care

**A. Management codes** 0. Not used 1. On own 2. Partially performed by others 3. Fully performed by others

**B. Number of days** formal care received in the last week (0-7)

	Management				Number of days							
	0	1	2	3	0	1	2	3	4	5	6	7
Antibiotics, systemic or topical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hyperbaric oxygen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pressure reduction/relieving devices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nutrition or hydration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Turning/repositioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Debridement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgical wound care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 7. Foot Problems (check all that apply)

☐ Corns, calluses, structural problems, infections, fungi

☐ Open lesions on the foot

☐ Foot not inspected in the last 90 days by client or other

☐ None of the above

## 8. Who Performs Foot Care:

## SECTION O: CONTINENCE IN LAST 14 DAYS

**1. Bladder Contenance** In the last 14 days, control of urinary bladder function (with appliances such as catheters or incontinence program employed) (Note-if dribbles, volume insufficient to soak through underpants)

☐ Continent-Complete control

☐ Usually continent-incontinent episodes once a week or less

☐ Occasionally incontinent-episodes 2 or more times a week but not daily

☐ Frequently incontinent-Tends to be incontinent daily, but some control present

☐ Incontinent-Inadequate control, multiple daily episodes

## 2. Bladder Devices (in last 14 days)

☐ External device (self care)

☐ Indwelling urinary catheter (self care)

☐ Ostomy (self care)

☐ External device (not self care)

☐ Indwelling urinary catheter (not self care)

☐ Ostomy (not self care)

☐ Use of pads or briefs to protect against wetness

☐ None

## 3. Urgency, frequency or other problems

**4. Bowel Contenance** In last 14 days, control of bowel movement (with appliance or bowel continence program if employed)

☐ Continent - complete control

☐ Usually continent - bowel incontinent episodes less than weekly

☐ Occasionally incontinent - Bowel incontinent episode once a week

☐ Frequently incontinent - Bowel incontinent episodes 2-3 times a week

☐ Incontinent - Bowel incontinent all (or almost all) of the time

## 5. Bowel Function

☐ Ostomy (self care) ☐ Ostomy (not self care) ☐ None

## 6. Type of Ostomy

☐ Colostomy ☐ Ileostomy ☐ None

## 7. Define usual elimination pattern or problems

Comments, Section O

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## SECTION P: PHYSICAL FUNCTIONING (SELF PERFORMANCE OF INSTRUMENTAL (IADL) AND PERSONAL (ADL) ACTIVITIES OF DAILY LIVING)

<p><b>1. IADL Self Performance</b> Code for functioning in routine activities around the home or in the community during the last 7 days.</p> <p><b>(A) IADL Self Performance Code</b> (Code for client's performance during the last 7 days) 0. Independent- did on own 1. Some help- help some of the time 2. Full help- performed with help all of the time 3. By others-performed by others 4. Activity did not occur</p> <p><b>(B) IADL Difficulty Code</b> (How difficult is it (or would it be) for a client to do activity on own) 0. No difficulty 1. Some difficulty-e.g., needs some help, is very slow, or fatigued 2. Great difficulty - e.g., little or no involvement in the activity is possible</p> <table border="1"> <thead> <tr> <th></th> <th>Performance</th> <th>Difficulty</th> </tr> </thead> <tbody> <tr> <td>a. Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food &amp; utensils)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>b. Ordinary House Work: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>c. Managing Finances: how bills are paid, checkbook is balanced, household expenses are balanced</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>d. Managing Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>e. Phone Use: How telephone calls are made / or received (with assistive devices such as large numbers on phone, amplification as needed)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>f. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> <tr> <td>g. Transportation: How client travels by vehicle (e.g., gets to places beyond walking distance)</td> <td>0 1 2 3 4 5</td> <td>0 1 2</td> </tr> </tbody> </table>		Performance	Difficulty	a. Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food & utensils)	0 1 2 3 4 5	0 1 2	b. Ordinary House Work: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	0 1 2 3 4 5	0 1 2	c. Managing Finances: how bills are paid, checkbook is balanced, household expenses are balanced	0 1 2 3 4 5	0 1 2	d. Managing Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	0 1 2 3 4 5	0 1 2	e. Phone Use: How telephone calls are made / or received (with assistive devices such as large numbers on phone, amplification as needed)	0 1 2 3 4 5	0 1 2	f. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)	0 1 2 3 4 5	0 1 2	g. Transportation: How client travels by vehicle (e.g., gets to places beyond walking distance)	0 1 2 3 4 5	0 1 2	<p><b>b. Transferring</b> - including moving to and between surfaces - to/from bed, chair, wheelchair, standing position (Note - excludes to/from bath/toilet)</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH only <input type="radio"/> MH and HH <input type="radio"/> Is not transferred</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p> <p><b>c. Locomotion in home</b> - (Note - if in wheelchair, self sufficiency once in chair)</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH only <input type="radio"/> MH and HH <input type="radio"/> N/A</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p> <p><b>d. Dressing</b> - including laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH only <input type="radio"/> MH and HH <input type="radio"/> Is not dressed</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p> <p><b>e. Eating</b> - including taking in food by any method, including tube feedings</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH intermittent <input type="radio"/> MH and HH <input type="radio"/> HH Continuous</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p> <p><b>f. Toilet use</b> - including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes</p> <p>Requires:  <input type="radio"/> No help day &amp; night <input type="radio"/> MH only <input type="radio"/> HH intermittent <input type="radio"/> HH Continuous <input type="radio"/> MH and HH <input type="radio"/> Does not use toilet room</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p>
	Performance	Difficulty																							
a. Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food & utensils)	0 1 2 3 4 5	0 1 2																							
b. Ordinary House Work: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	0 1 2 3 4 5	0 1 2																							
c. Managing Finances: how bills are paid, checkbook is balanced, household expenses are balanced	0 1 2 3 4 5	0 1 2																							
d. Managing Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	0 1 2 3 4 5	0 1 2																							
e. Phone Use: How telephone calls are made / or received (with assistive devices such as large numbers on phone, amplification as needed)	0 1 2 3 4 5	0 1 2																							
f. Shopping: How shopping is performed for food and household items (e.g., selecting items, managing money)	0 1 2 3 4 5	0 1 2																							
g. Transportation: How client travels by vehicle (e.g., gets to places beyond walking distance)	0 1 2 3 4 5	0 1 2																							
<p><b>Note: Refer to the following codes when answering the ADL portion of this assessment.</b></p>																									
<p><b>2. ADL Self-Performance</b> The following address the client's physical functioning in routine personal activities of daily life, for example dressing, eating, etc., during the last 7 days, considering all episodes of these activities. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.</p> <p><b>0. Independent</b>- No help or oversight or help/oversight provided only 1 or 2 times during the last 7 days</p> <p><b>1. Supervision</b>- Oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days</p> <p><b>2. Limited Assistance</b>- Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times</p> <p><b>3. Extensive Assistance</b>- While client performed part of activity, over last 7-day period, help of the following type(s) were provided 3 or more times: -Weight-bearing support -OR- -Full performance by another during part (but not all) of the last 7 days</p> <p><b>4. Total Dependence</b>- Full performance of activity by another during the entire 7 days.</p> <p><b>5. Activity did not occur</b> during entire 7 days (regardless of ability.)</p>	<p><b>g. Personal hygiene</b> - including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum(exclude baths and showers)</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH intermittent <input type="radio"/> HH Continuous</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p> <p><b>3. Bathing</b>- in the last 7 days (include shower, full tub or sponge bath; exclude washing back or hair)</p> <p><input type="radio"/> Independent, did on own <input type="radio"/> Received assistance in part of bathing activity</p> <p><input type="radio"/> Supervision, oversight help only <input type="radio"/> Total dependence</p> <p><input type="radio"/> Received assistance in transfer only <input type="radio"/> Activity did not occur</p> <p><b>4. Primary modes of locomotion</b></p> <p>0. No assistive device 1. Cane 2. Walker/Crutch 3. Scooter (e.g., Amigo) 4. Wheelchair 5. Activity does not occur</p> <p>Indoors 0 1 2 3 4 5 Outdoors 0 1 2 3 4 5</p> <p>Describe: _____</p>																								
<p><b>Requires - Mark ONE Primary answer</b>          Note: MH=Mechanical Help HH=Human Help</p>																									
<p><b>a. Mobility in bed</b> - including moving to and from lying position, turning side to side, and positioning body while in bed</p> <p>Requires:  <input type="radio"/> No help <input type="radio"/> MH only <input type="radio"/> HH only <input type="radio"/> MH and HH</p> <p><input type="radio"/> Turn/Reposition</p> <p>Performance 0 1 2 3 4 5 Describe: _____</p>	<p><b>5. Wheeling</b></p> <p><input type="radio"/> Walks <input type="radio"/> Without help <input type="radio"/> MH Only (e.g., motorized) <input type="radio"/> MH and HH <input type="radio"/> N/A</p> <p>Describe: _____</p> <p><b>6. Walking</b></p> <p><input type="radio"/> Without help <input type="radio"/> MH only (e.g., walker/cane) <input type="radio"/> HH intermittent <input type="radio"/> HH continuous <input type="radio"/> MH and HH <input type="radio"/> Does not walk</p> <p>Describe: _____</p>																								

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Participant SSN  -  - 

**7. Stair Climbing** In the last 7 days, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed.) If client did not go up and down stairs, code client's capacity for stair climbing.

☐ Up and down stairs without help  
☐ Up and down stairs with help  
☐ Does not go up and down stairs-could do without help  
☐ Does not go up and down stairs-could do with help  
☐ Does not go up and down stairs-no capacity to do it  
☐ Unknown - did not climb stairs and assessor is unable to judge whether the capacity exists

**8. Stamina**

a. In a typical week, during the last 30 days, code the number of days client usually went out of the house or building in which client lives (no matter for how short a time period)  
☐ Every day ☐ 2-6 days a week ☐ 1 day a week ☐ No days

b. Hours of physical activities in the last 7 days (e.g., walking, cleaning house, exercise)  
☐ Two or more hours ☐ Less than two hours

**9. Functional Potential** (check all that apply)

☐ Client believes he/she capable of increased functional independence (ADL, IADL, mobility)  
☐ Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)  
☐ Good prospects of recovery from current disease or conditions, improved health status expected  
☐ None of the above

Comments, Section P

## SECTION Q: SERVICE UTILIZATION

**1. Recent/Impending Surgery** within last six months:  
 Nature of Surgery ☐ No ☐ Yes  
 Date / /

**2. Formal Care** (minutes rounded to even 10 minutes).  
 Extent of care or care management in last 14 days involving this or other agencies

	# Days	Hours	Minutes
a. Home Health aides			
b. Visiting nurses			
c. Homemaking services			
d. Meals			
e. Volunteer services			
f. Physical Therapy			
g. Occupational therapy			
h. Speech therapy			
i. Day care or day hospital			
j. Social Worker in home			

**3. Special Treatments, Therapies, Programs** - received or scheduled during the last 14 days (received in the home or on an outpatient basis) and adherence to the required schedule.

**Scheduled Adherence Code**  
 0. N/A 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received

**Location Code** - select predominant place of treatment location  
 0. N/A 1. Home 2. N.F. 3. Hospital 4. Outpatient 5. Other

**Treatments** (mark appropriate responses)

	Adherence 0 1 2 3	Location 0 1 2 3 4 5
a. Alcohol/drug treatment program	<input type="radio"/>	<input type="radio"/>
b. Blood transfusions	<input type="radio"/>	<input type="radio"/>
c. Chemotherapy	<input type="radio"/>	<input type="radio"/>
d. Cardiac rehabilitation	<input type="radio"/>	<input type="radio"/>

**Treatments (continued)**

	Adherence 0 1 2 3	Location 0 1 2 3 4 5
e. Continuous positive airway pressure (CPAP)	<input type="radio"/>	<input type="radio"/>
f. Dialysis-peritoneal (CAPD)	<input type="radio"/>	<input type="radio"/>
g. Dialysis-renal	<input type="radio"/>	<input type="radio"/>
h. Holter monitor	<input type="radio"/>	<input type="radio"/>
i. IV infusion-central	<input type="radio"/>	<input type="radio"/>
j. IV infusion-peripheral	<input type="radio"/>	<input type="radio"/>
k. Medication by injection	<input type="radio"/>	<input type="radio"/>
l. Ostomy care	<input type="radio"/>	<input type="radio"/>
m. Oxygen therapy - intermittent	<input type="radio"/>	<input type="radio"/>
n. Oxygen therapy - continuous (concentrator)	<input type="radio"/>	<input type="radio"/>
o. Oxygen therapy - continuous (other)	<input type="radio"/>	<input type="radio"/>
p. Radiation therapy	<input type="radio"/>	<input type="radio"/>
q. Tracheostomy care	<input type="radio"/>	<input type="radio"/>
r. Ventilator	<input type="radio"/>	<input type="radio"/>

**Therapies**

	Adherence 0 1 2 3	Location 0 1 2 3 4 5
s. Exercise therapy	<input type="radio"/>	<input type="radio"/>
t. Occupational therapy	<input type="radio"/>	<input type="radio"/>
u. Physical therapy	<input type="radio"/>	<input type="radio"/>
v. Respiratory therapy (including suctioning, IPPB)	<input type="radio"/>	<input type="radio"/>

**Programs**

	Adherence 0 1 2 3	Location 0 1 2 3 4 5
w. Day Care	<input type="radio"/>	<input type="radio"/>
x. Day hospital	<input type="radio"/>	<input type="radio"/>
y. Hospice care	<input type="radio"/>	<input type="radio"/>
z. Physician or clinic visit	<input type="radio"/>	<input type="radio"/>
aa. Respite care	<input type="radio"/>	<input type="radio"/>

**Special Procedures Done in Home**

	Adherence 0 1 2 3	Location 0 1 2 3 4 5
bb. Daily nurse monitoring (e.g., EKG, urinary output)	<input type="radio"/>	<input type="radio"/>
cc. Nurse monitoring less than daily	<input type="radio"/>	<input type="radio"/>
dd. Medical alert bracelet or electronic security alert	<input type="radio"/>	<input type="radio"/>
ee. Skin treatment	<input type="radio"/>	<input type="radio"/>
ff. Special diet	<input type="radio"/>	<input type="radio"/>
gg. Other	<input type="radio"/>	<input type="radio"/>

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Participant SSN    -    

Comments: (Define other treatments, therapies, etc.)

**4. Management of Equipment** (in last 14 days)

Select the appropriate response from the following:

0. Not Used 1. Managed on own 2. Managed on own if laid out or with verbal reminders 3. Partially performed by others 4. Fully performed by others

0 1 2 3 4

a. Oxygen

☐ ☐ ☐ ☐ ☐

b. IV

☐ ☐ ☐ ☐ ☐

c. Catheter

☐ ☐ ☐ ☐ ☐

d. Other

☐ ☐ ☐ ☐ ☐**5. Visits in last 90 days** or since last assessment:

Code "0" if none, if more than 9, code "9+".

0 1 2 3 4 5 6 7 8 9+

Number of times admitted to hospital with an overnight stay

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Emergent Care-including unscheduled nursing, physician, or therapeutic visits to office or home

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Number of times visited ER without an overnight stay

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐**6. Treatment Goals** Any treatment goals that have been met in the last 90 days☐ No ☐ Yes**7. Treatment Goal(s)** met in the last 90 days (define):**8. Overall change in care needs**

Overall self sufficiency has changed significantly as compared to status as of 90 days ago:

- ☐ No change  
☐ Improved, e.g., receives fewer supports  
☐ Deteriorated, e.g., receives more support

**9. Trade-Offs:**

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

☐ No ☐ Yes

Comments, Section Q

## SECTION R: MEDICATIONS

**1. Number of Medications:** Record the number of different medicines (prescriptions and over the counter, including eye drops), taken regularly or on an occasional basis in the last 7 days. (if none, code "0", if more than 9, code "9+")

0 1 2 3 4 5 6 7 8 9+

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐**2. Receipt of Psychotropic Medication:** Psychotropic medications taken in the last 7 days (Note-Review client's medications with the list that applies to the following categories)Antipsychotic ☐ No ☐ Yes Antidepressant ☐ No ☐ YesAnxiolytic ☐ No ☐ Yes Hypnotic ☐ No ☐ Yes**4. Compliance/Adherence with Medications:** Compliant all or most of time with medications prescribed by physician (both during and between therapy visits):

- ☐ Always compliant  
☐ Compliant 80% of time or more  
☐ Compliant less than 80% of time  
☐ No medications prescribed

**5. Client needs reminding several times a day to take medications:**☐ No ☐ Yes**6. Preparation of medications needed:**☐ No ☐ Yes**3. Medical Oversight:** Physician reviewed client's medications as a whole in the last 180 days:

- ☐ Discussed with at least one physician (or no medication taken)  
☐ No single physician reviewed all medications

**7. Medications must be administered to client:**☐ No ☐ Yes**8. Pharmacy used:**

Phone #:

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# MI-CHOICE CARE MANAGEMENT ASSESSMENT

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Participant SSN    -    -

**9. Current Medications (Rx & OTC)** \*For the Compliance category, please choose one of the following: **0.** Always compliant **1.** Compliant 80% of the time or more **2.** Compliant less than 80% of the time

	Name / Strength	Frequency (eg., BID, PRN)	Purpose	Prescribed By: Self or Dr.'s Name	*Compliance		
					0	1	2
1					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 10. Allergies/Sensitivities (specify-include reaction)

Pharmaceutical:

Environmental:

Comments, Section R

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Participant SSN [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ]

## SECTION S: VITAL SIGNS AND SYSTEMS

## 1. Vital Signs

BP (sitting) Left arm [ ] [ ] [ ] / [ ] [ ] [ ] BP (sitting) Right arm [ ] [ ] [ ] / [ ] [ ] [ ]

Temperature (F) [ ] [ ] [ ] BP (standing) Left arm [ ] [ ] [ ] / [ ] [ ] [ ] BP (standing) Right arm [ ] [ ] [ ] / [ ] [ ] [ ]

Respiration [ ] [ ] [ ] Pulse-Apical [ ] [ ] [ ] Pulse-Radial [ ] [ ] [ ]  
Lung sounds L [ ] [ ] [ ] R [ ] [ ] [ ]

2a. Height [ ] [ ] feet [ ] [ ] inches

2b. Weight [ ] [ ] [ ] lbs.

3. Grips (hands): ☐ Equal ☐ Unequal4. Cold hands/feet: ☐ No ☐ Yes5. Sleeping Problems that occurred within the last 7 days reported by client: ☐ No ☐ Yes6. Numbness/Tingling that occurred within the last 7 days reported by client: ☐ No ☐ Yes

7. Functional Limitation in Range of Motion--(Code for limitations during the last 7 days that interfered with daily functions or placed client at risk of injury.)

A. Range of Motion:

0. No Limitation 1. Limitation on one side 2. Limitation on both sides

B. Voluntary Movement:

0. No Loss 1. Partial Loss 2. Full Loss

	Range (0,1,2)			Voluntary (0,1,2)		
	0	1	2	0	1	2
a. Neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Arm - Including shoulder or elbow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Hand - Including wrist or fingers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Leg - Including hip or knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Foot - Including ankle or toes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Other limitation or loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments, Section S

## SECTION T: NURSING NOTES

List all issues identified during assessment requiring intervention:

RN Signature:

Date / /

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## SECTION U: CLIENT LOCATION RECOMMENDATION

### 1. a. CM recommends:

☐ Community based care ☐ Institutional care

### b. Client choice:

☐ Community based care ☐ Institutional care

2. Confirm client medically eligible for MI Choice. ☐ No ☐ Yes

Comments, Section U

Care Manager 1  
Initials

  

Care Manager 2  
Initials

  

## SECTION V. STATUS

### 1. Opened

#### Presumed Status

☐ CM-Aging ☐ WA-Pending ☐ WA ☐ Others

### 2. Not Opened

Check **EITHER** CM reason **OR** DCH reason:

Choose CM reason not opened: ☐ Death ☐ Moved ☐ Not eligible ☐ NH placement ☐ Refused Service  
☐ ICF/MR Institutional Placement ☐ Other:

**OR**

Choose DCH reason not opened: ☐ Hearing Decision ☐ For Cause

Comments, Section V

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## **MICIS Service Bureau Nursing Facility Transition Initiative (NFTI) Data Collection Guidelines August 19, 2004**

Nursing Facility Transition Initiative (NFTI) participants will be tracked using MICIS. This document outlines MICIS data collection requirements and options for NFTI participants.

### **I. NFTI Screen**

Potential NFTI participants are screened using the MICIS screen, which must be entered to MICIS as a first step in data collection.

Once the screen is entered, a facesheet and assessment are generated to use in conducting the assessment interview.

### **II. NFTI Facesheet and Assessment Data Collection**

#### **A. Participant Identification by Referral Type**

All participants served in the NFTI program must be entered using "NFTI" (Referral Type code 14) as the Referral Type in the MICIS Facesheet. This is the data item that will be used to identify NFTI participants across all agencies.

B. Other facesheet and assessment data collection for NFTI participants is handled as with all other participants.

C. All NFTI participants need to be entered to MICIS, whether or not they will receive ongoing services.

### **III. NFTI Status Data Collection**

#### **A. Waiver Status: Client Type**

During the time that a person is receiving transition services, including housing plan development, they will be designated as a NFTI participant (using the NFTI Client Type in the MICIS Waiver status table) as long as they are not being served in another program such as the Waiver or Care Management. If a NFTI participant comes directly into another program at the agency (e.g. the Waiver), they will be designated as a Waiver Client Type from the beginning. It is not necessary to assign the NFTI Client Type unless the participant is served in NFTI before becoming eligible for another program.

Some persons may remain in the NFTI program and not be

moved to a different program. These persons will remain in MICIS with the NFTI Client Type (and the mandatory NFTI Referral Type) until they are closed.

Persons can move to and from the NFTI Client Type as required within a given episode.

- B. MOU Status Agents can apply for MOU status for NFTI participants if appropriate.
- C. Movement from MICIS Program to Nursing Facility and Back to Program

A person who is in MICIS (in one of the existing programs) who then moves to a nursing facility would typically be kept open (in Care Management or Waiver Ineligible) in anticipation of the return. However, if the person is transitioned back to the agent using the NFTI program, the only way to appropriately track the NFTI participant is to create a new episode, using the NFTI Referral Type code.

#### IV. Care Plans: Housing Plan Development and Transition Services

- A. Tracking NFTI Services in Care Plans

NFTI services will be tracked during the time a housing plan is being developed and transition is occurring.

A special list of service codes (Attachment A) has been created to identify NFTI transition services. Care plans should be created for these services as required by the person's transition plan.

- B. NFTI Fund Sources

NFTI Housing Plan and Transition services should be entered using the fund source code 972, NFTI Transition Funds. This code should be used for all purchased NFTI services identified in Attachment A.

A donations fund source code (703) can be used for donated items.

- C. Movement from NFTI to Another Agency Program

When (and if) the person enters another program, such as the Waiver or Care Management, the services delivered in this program will be tracked as they are with any other



agency client. New care plans should be created with the appropriate fund sources for these services.

## V. Tracking Care Manager Time

- A. At the Agent discretion, Care Manager time spent in NFTI activities can be tracked in MICIS. Care Managers would need to keep track of time spent on behalf of each NFTI participant, including assessment time, housing negotiations, phone calls, shopping, client contacts, etc.
- B. The Care Manager service would be entered to MICIS Care Plans using service T1016 (Case Management), and fund source 972 (NFTI transition). An appropriate template can be created to use in posting bills.
- C. “Bills” can be posted using this care plan to indicate the number of 15-minute units spent on behalf of the client. These “bills” can be posted daily as they occur, or in aggregate weekly or monthly.
- D. As an option, more detailed services could be created to differentiate services (for example, housing work, shopping, phone calls, travel time, etc), using standard remarks. This means that separate care plans would need to be created for each of these services. If necessary, CIM will add standard remarks for these additional services.

## VI. NFTI Bills and Waiver Claims

- A. Bills will be posted against care plans for NFTI participants in the same way that bills are posted for regular MICIS participants.
- B. If a NFTI person is moved into the Waiver, the normal data collection rules are required (Waiver Client Type, Waiver-funded care plans and bills). The Medicaid claims for these services will be generated in the same way as all other Waiver participants.

## VII. NFTI Reporting

### A. NFTI Participants in Other Agency Programs

Once in another program like the Waiver, NFTI participants will be handled as any other Waiver participant. They will:

- 1. 1. Use Waiver days like any other Waiver participant
- 2. 2. Be included in the Waiver Enrollment report

## B. DCH Identification of NFTI Participants

DCH will identify NFTI participants and remove their costs from Cost Reconciliation processing. These costs will need to be monitored against the \$100,000 NFTI grant.

## C. NFTI Service Days and Service Costs

Service costs for NFTI participants who never move to another Agency program will need to be tracked by participant. The NFTI referral source will be used to identify all participants transitioned, and service costs for this referral source will be presented in a report by fund source and service.

Service costs for NFTI participants who do move to another Agency program (like the Waiver) will also need to be tracked by participant. Agents will need to be able to identify both days and service costs for NFTI participants; this will allow the calculation of administrative costs for each day, and service costs (both detail by participant and summary by service) to count against the \$100,000 grant. CIM will develop scripts to provide these reports.

## D. Individual RUG Reports for NFTI Participants

The RUG Reports are available by specifying a Client ID, so they could be run for NFTI participants. The current version of RUG cost reports can only be run by Client Type, and since NFTI participants may include different type of clients it is not currently possible to run them as a group for only NFTI participants.

## E. Individual Quality Indicator Reports

QI reports are available by Client Type, but since NFTI will be tracked using a referral source, the current version of QI reports cannot be run as a group for only NFTI participants. These reports can be run for individual NFTI participants.

**Attachment A MICIS Service Bureau NFTI Service Data Collection  
April 22, 2004**

The Nursing Facility Transition Initiative (NFTI) provides special services to participants who are establishing residence in the community after a nursing home stay. The NFTI programs need to be able to track both the traditional in-home services provided to participants, and the more specialized NFTI services. The following HCPCS codes and standard remarks will enable NFTI Agents to collect information about the specialized services in the MICIS Care Plan and Billing modules. Some of these codes have been added for the NFTI program, and others were already available for other programs.

<b>HCPCS Category</b>	<b>HCPCS Code</b>	<b>Standard Remark</b>	<b>Includes:</b>
Housing	99199	9908	Rent
		9909	Security deposit
		9910	Section 8 voucher
Household Supplies	99199	9009	Cleaning products, linens, towels, blanket, pillow, laundry basket, waste basket, vacuum, paper products, soap, toothbrush, toothpaste, etc.
Kitchen Supplies (same code as Household supplies)	99199	9009	Utensils, cookware, dishes, glasses, containers, small appliances, microwave, plastic wrap/foil
Utilities	99199	9013	Telephone, past due utility fees, electric, gas, cable
Furniture	99199	9014	Dining table and chairs, sofa, chair, end table, TV stand, bed, mattress, lamp
Groceries	99199	9015	
Pharmacy Transfer	H2010	2000	Medication management, collection of NF medications, transfer of prescriptions to community drug store

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<sup>i</sup> The MI Choice Waiver Program is a 1915c Medicaid Waiver Program funded under Title 19 of the Social Security Act. Through this program, eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes, but can stay in their own home or another residential setting. Each participant can receive the basic services Michigan Medicaid covers, and one or more of the following services unique to the waiver: Homemaker services, Respite services, Adult day care, Environmental modifications, Transportation, Medical supplies and equipment not covered under the Medicaid State Plan, Chore services, Personal emergency response systems, Private duty nursing, Counseling, Home delivered meals, Training in a variety of independent living skills, Nursing Facility Transition Services.

<sup>ii</sup> It is not intended to be generalized to the larger nursing facility population given the relatively small number of participants in the program. It is limited to people in a select number of nursing facilities who indicated a desire to return to community living in two Michigan counties, Wayne and Kent. An expanded sample size of at least 300 participants would be necessary to present qualitative comparison data for the entire state of Michigan.

<sup>iii</sup> Frequency of Q1a in CY 2004 for only Kent and Wayne counties, July 2005, Michigan MDS repository, special report from the University of Michigan. Note that this includes both Medicare and Medicaid residents of Michigan nursing facilities.