

Working with Offline MEAs

About This Page

When you're offline, if you have downloaded MEAs on your local machine, this screen will allow you to see a list of them. From here, you can complete an assessment by clicking on the individual's name and completing each section, as you would if you were completing the assessment online.

Note: You will not be able to attach documents or submit the assessment while it is offline. You will need to access NH EASY Gateway to Services when connected to the Internet and using the same browser the MEA was completed with, in order to synchronize your offline information with the online assessment. Only then will you be able to attach the needed documents and submit the assessment to the LTSS Unit.

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Instructions for Interacting with Offline MEAs

When an MEA is downloaded onto your local machine, so you may work on it without having an internet connection, please remember the following things:

1. Make sure that you are using the same browser through which you downloaded the MEA when you were connected to the Internet.
2. You will use the same URL to access the offline MEA that you use for accessing the NH EASY Gateway to Services online. Make sure to login with the same user credentials that you use online.
3. The MEA that remains available online will be in read-only mode and cannot be edited by anyone.
4. Anyone in your organization will have the ability to cancel the downloaded MEA through the LTSS Search screen. This provides flexibility, in the event the MEA must be completed by someone else, in your place. If this happens unexpectedly, you will not be able to upload the offline MEA. In this instance:
 - a. Do not use the 'Delete' icon on the Offline MEAs page until you complete step b below.
 - b. When online and from the Offline MEAs page, click on the 'View' icon to access the information that you entered offline and manually enter it into the online MEA by opening NH EASY Gateway to Services in a different browser. This way you will not lose any information that you captured offline.
5. Make sure that you are not deleting any temporary files through your browser or on your local machine.

Introduction: Philosophy and Intent of NH MEA Instrument

The New Hampshire Medical Eligibility Determination (MEA) form is set up in sections. The MEA is designed to be an objective tool that is easily coded. Each section's page help includes the "how to complete" instructions and the timeframes in which to measure the person's abilities.

Assessor Responsibilities

Your general responsibilities as an assessor include:

- Reading all training materials
- Following the definitions and parameters specified in the page help for this assessment
- Completing the assessments in a thorough, efficient, and timely manner
- Maintaining confidentiality

Confidentiality Requirements

It is crucial that all information gathered from any source is treated as confidential: NO INFORMATION CAN BE DIVULGED BY AN ASSESSOR IN ANY WAY THAT WOULD SERVE TO IDENTIFY AN INDIVIDUAL PERSON.

How to Complete the MEA

This assessment contains several sections and the questions in those sections may include many parts. Some questions may not be required. You are only required to answer those questions which are marked with a red asterisk. Also, selecting certain answers may require you to answer additional questions. When this is true, you will see additional fields appear or fields that were disabled will become enabled.

After completing each section, select **Next** to continue to the next section. You can also select **Previous** to go back to the last section, or **Save and Finish Later** to close the individual's MEA and finish it at a later time.

Note: While you are offline, since you cannot complete the Attach and Submit section, you will have to click 'Save and Finish Later' at the end of the Identified Needs section to store all of the information that you entered.

Individual Information

This section appears at the top of every page in the assessment and displays the following information:

- **Individuals Located by SSN or MID:** Name, Gender, Date of Birth, SSN (masked to only show the last 4 numbers) and MID
- **Individuals Where SSN or MID was Unknown or Who Couldn't be Located by SSN or MID:** Name entered, Gender selected, Date of Birth entered, SSN entered, if any
 - **Note:** The MID field is not collected or displayed in this section for "Unknown" individuals

Activity Log

The purpose of this section is to log activities relevant to this assessment. Some of these activities will be done by the system, while others will be manually entered by someone within the provider organization. This log is a helpful way to track when an assessor is assigned to complete the assessment, when attempts are made to contact the individual, when the assessment appointment is made, etc. Once the assessment is submitted, this log is visible, but may not be edited.

You will not be able to add an activity while you're offline, but you will be able to view activities that occurred prior to the download. These appear in a grid with the following columns:

- **Date:** The date the activity was entered; this is automatically recorded by the system.

- **Activity:** The type of activity.
- **Worker:** The name of the worker who manually selected the activity, 'LTSS Unit' if the assessment was assigned, or 'SYSTEM' if the action was taken by the system.
- **Comments:** The text that is entered in the Comments field when manually entering an activity. System-generated comments provide useful information about the automated activity (e.g., "Created by: [Provider Name]", "Submitted by: [Provider Name]", or "MEA Assigned from LTSS Unit")

Section A: Professional Nursing Services

Definitions for Section A:

- **New/Recent** - within 30 days of assessment date.
- **Unstable** - a medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the individual's ability to function independently. These changes must require medical treatment and professional nursing observation, assessment and management at least once every 8 hours. The change or decline in physical health requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medications. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included is the loss of function resulting from a temporary disability from which full recovery is expected.

How to Complete Section A

Please enter the date the assessment was completed and answer some basic questions about the individual's current situation.

For questions 1 through 10, make selections for each condition/treatment for which the individual will need care that is or otherwise would be provided by or under the supervision of a registered professional nurse. If the individual does not require some of the nursing services listed in this section, a response is not required; it may be left blank.

Note: If a treatment or procedure is self-administered and the individual is independent in the task, do not score as a nursing need.

The following options are available for questions 1 through 10:

1. Monthly
2. Several times per month
3. One time per week
4. Several times per week
5. Daily
6. Multiple hours per day

Guidance for the questions in this section:

1. **Injections and IV Feeding:** This includes intra-arterial, intravenous, intramuscular or subcutaneous injections or IV feeding for the treatment of an unstable condition requiring medical

or professional nursing intervention, excluding daily insulin injections for an individual whose diabetes is under control. A diabetic's condition is considered controlled, when his/her blood sugar is maintained at a level that is considered within normal limits for that individual and requires no adjustment of the maintenance dose of insulin.

2. **Feeding Tube:** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system (nasogastric, gastrostomy or jejunostomy tube, percutaneous endoscopic gastrostomy (PEG)) for a new/recent (within 30 days) or unstable condition. Please note the date of tube insertion in the field provided.
3. **Suctioning and Tracheostomy Care:** This includes deep nasopharyngeal suctioning or tracheostomy care for a new/recent (within 30 days) or unstable condition. Please note the date of insertion and specify the condition and whether it is new or unstable.
4. **Treatments/Dressings:** Treatment and/or application of dressings for which the physician has prescribed irrigation, application of prescribed medication(s), or sterile dressings that require the skills of an RN. Please specify the wound type and location and provide more details in Section Q.
5. **Oxygen:** Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) or unstable condition. Please note the start date in the field provided.
6. **Assessment/Management:** Professional nursing assessment, observation and management is required for unstable medical conditions. Observation is needed at least once every 8 hours (once per shift), throughout a 24-hour period. Please specify the condition for the applicant's need in the field provided.
7. **Catheter:** The insertion and maintenance of a urethral or supra-pubic catheter as an adjunct to the active treatment of a disease or medical condition. The need for the catheter must be documented and justified in the medical record. Examples include, but are not limited to, installation for the treatment of cancer of the bladder or as adjunctive treatment for wound or pressure ulcer healing.
 - a. **Note:** Catheters, as a method of managing incontinence, are considered in Section D – Physical/ Functioning/Structural Problems (e.g., Toilet Use)
8. **Comatose:** An individual is considered comatose when in a state of unconsciousness from which he or she cannot be aroused (i.e., persistent vegetative state or has a neurological diagnosis of coma).
9. **Ventilator/Respirator:** A registered nurse or other qualified staff is needed to manage the ventilator/respirator equipment.
10. **Uncontrolled Seizure Disorder:** Direct assistance from others is required for the safe management of an uncontrolled seizure disorder (e.g., grand mal). An "uncontrolled seizure disorder" is defined as a "diagnosed seizure disorder that cannot be managed by medications."
 - a. **Note:** Check the box provided, if none of the above professional nursing activities are required.
11. **Therapy/Therapies Provided by a Qualified Therapist:** Enter the number of days per week required for physical therapy, speech/language therapy, occupational therapy, and/or respiratory therapy provided or directed by a qualified therapist. This item pertains only to therapies prescribed by a physician and designed to achieve specific goals within a given timeframe.
 - a. **Note:** Record the number of days each therapy occurred for at least 15 minutes per day. Palliative or maintenance therapy should be included. Enter zero if therapy occurred less than 15 minutes per day.

Section B: Special Treatments and Therapies

For questions 1 and 2, make selections for each condition/treatment for which the individual will need care that is or otherwise would be provided by or under the supervision of a registered professional nurse. If the individual does not require some of the nursing services listed in this section, a response is not required; it may be left blank.

Note: If a treatment or procedure is self-administered and the individual is independent in the task, do not score as a nursing need.

The following options are available for questions 1 and 2:

1. Monthly
2. Several times per month
3. One time per week
4. Several times per week
5. Daily
6. Multiple hours per day

Guidance for the questions in this section:

1. **Treatments/Chronic Conditions:** Indicate the frequency care would be required by or under the supervision of a registered professional nurse for monitoring of treatments, procedures, dressings and/or medications.
 - a. **Medications via tube:** Any medication ordered by a physician that can only be administered via a gastrostomy, jejunostomy or naso-gastric tube.
 - b. **Tracheostomy care-chronic stable:** Includes cannula care, trach dressing changes and suctioning related to routine daily tracheostomy care.
 - c. **Urinary catheter change:** Removal and reinsertion of a new urinary catheter.
 - d. **Urinary catheter irrigation:** This includes the “flushing” of a urinary catheter to prevent or remove a deposit that prevents the free drainage of urine.
 - e. **Venous puncture for disease and/or medication management:** Drawing of blood to monitor the individual’s condition or response to treatment or for disease management.
 - f. **Injections:** The administration of a medication for disease management.
 - g. **Wound treatments:** When dressings are used to treat and/or debride, the assessment skills of a licensed nurse are required to monitor the effects of the treatment and to adjust or change the treatment plan in consultation with a physician.
 - h. **Chest PT:** This is chest physical therapy for a chronic condition to provide preventative/maintenance airway clearance.
 - i. **O2 therapy for chronic and/or unstable condition**
 - j. **Other:** Specify ‘other’ condition for which treatment is done by professional or caregiver.
 - k. **Teach/train:** Select the number of days training is required and the purpose for training/teaching.
 - l. **Disease management for diabetes:** This includes, but is not limited to, monitoring of glucose blood levels by device, foot care, and eye care, and any adverse symptoms from the disease that the individual is unable to independently manage.

2. **Treatments/Procedures:** Select the number of days that are required for Chemotherapy, Radiation Therapy, Hemodialysis, Peritoneal Dialysis and IV Therapy (excluding heparin and saline flushes).
3. **Pain/Pain Management Over the Past 7 Days:**
 - a. Select the frequency of the individual's pain and indicate its intensity. Frequency options include:
 - i. 0 - No pain
 - ii. 1 - Less often than daily
 - iii. 2 - Daily, but not constant
 - iv. 3 - All of the time

Intensity (1-10): Request that the individual describe his/her pain on a scale of 1 to 10 (1 is minimal discomfort and 10 is excruciating).
 - b. **Limitations:** Interferes with activity or movement: Indicate whether the pain interferes with activity or movement by selecting the appropriate option.
 - c. **Location:** Identify the specific site of the pain, for example "right shoulder" or "left leg".
 - d. **Type:** Select whether the pain is acute or chronic.
 - e. **Description:** Select the word the individual uses to describe the pain that is being experienced.
 - f. **Is there something that provides relief?** Indicate whether or not the individual has a medication or a modality that provides relief for the pain. If so, please specify what it is.

Section C: Cognition/Orientation

Be sure to interview the individual in a private, quiet area without distractions. It is important to keep in mind that any other person present should be there at the invitation of or with the consent of the individual, and that the capable individual should be providing answers to the questions, rather than a family member or a caregiver. Using a non-judgmental approach to questioning will help create a needed sense of trust with the individual.

- Engage the individual in general conversation to help establish rapport.
- Actively listen. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the individual.
- The information-gathering process does not need to be completed in one sitting, but may be ongoing during the entire assessment period.

Guidance for the questions in this section:

1. **Mini-Cog Screen for Cognitive Impairment:** The mini-cognitive screen is designed to test for cognitive impairment and involves the individual's ability to remember both new and well-established information. The individual is asked to recall three objects. The nurse assessor will use the designated clock drawing that is provided and ask the individual to put the numbers on the face of the clock and then to put the hands of the clock to indicate the time of 11:20. It is important that the test be carried out in the following sequence:

- a. Explain to the individual that you are going to name three unrelated objects that you would like the individual to try and remember. Have the individual repeat the names of the objects to make sure he/she has heard them correctly.
 - b. Use the designated clock drawing form (Form 3730 – Clock Drawing) and ask the individual to put numbers on the face of the clock and then to draw the hands of the clock to indicate the time of 11:20. If the individual is able to complete the clock showing the correct time, select “Yes” for the ‘Drew hands of the clock successfully?’ question. If the individual is unable to complete the clock exercise accurately, select “No”.
 - i. If individual is unable to perform the clock drawing test due to being unable to see, or lacks the ability to use his/her upper extremities (e.g., due to paralysis), then ask the individual to describe where they would place the numbers on the face of a clock represented by a circle (e.g., 12 at the top, 6 at the bottom) and where they would place the hands to indicate 11:20 (e.g., hour or short hand on 11, minute or long hand on 4). Include a comment in the Summary field on Section Q to document the above.
 - c. When the individual has completed the clock exercise, ask the individual to repeat the names of the three objects. For each of the objects the person is able to recall, select “Yes” under the appropriate object recall question (e.g., ‘First object recalled?’). If the individual is able to recall two of the objects, two recall questions will be marked “Yes”.
2. **Cognitive Skills for Daily Decision Making:** These questions are to demonstrate the individual’s current level of alertness, orientation, comprehension, concentration and immediate memory for simple commands at the time of the assessment. The assessor will have a conversation with the individual about a familiar real life scenario. For example: A snowstorm is predicted. The individual needs to go to the grocery store to purchase some food. Ask about the type of clothing that will be worn to the store. The individual has purchased ice cream. Ask where the ice cream would be stored upon returning home.

Conversations about familiar real life scenarios and actions to be taken by the individual will demonstrate the individual’s decision-making ability. Indicate what they’ve demonstrated by selecting one of the following:

0. **Independent** - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
 1. **Modified Independence** - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
 2. **Moderately Impaired** - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
 3. **Totally Dependent** due to disturbances such as constant disorientation, delirium and inability to make daily decisions
3. **Assessment/Management:** The assessor will determine if monitoring and supervision by professional staff, family members or caregivers is needed to manage the identified cognitive issues. Select one of the following:
- 0 – No
 - 1 – Once per month
 - 2 – Twice per month
 - 3 – Weekly
 - 4 – 3-5x week

- 5 – Daily
- 6 – Other (Specify the timeframe in the field provided)

Section D: Physical/Functioning/Structural Problems

Many elderly individuals have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency, particularly for individuals with chronic mental illness or others who may be taking psychotropic medications.

For questions a through g, consider the following:

- **Activities of Daily Living (ADL) Self-Performance:** Select the appropriate response in column 1 that describes the individual's self-care performance in activities of daily living. Information is identified as being reported to the assessor, being observed by the assessor, or being read by the assessor in an existing medical record. An individual's ADL self-performance may vary from day to day and within the day (e.g., from morning to night). The responsibility of the assessor, therefore, is to capture the total picture of the individual's ADL self-performance over the 7-day period, 24 hours a day.
 - Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.
 - The responses in the ADL items are used to record the individual's actual level of involvement in self-care and the type and amount of support actually received during the last 7 days.
 - Using the MDS definition for coding ADL performance, it is referred to as the "Rule of 3". When an activity occurs three times at any one given level in a 5-7 day time period, select that level. When an activity occurs three times at multiple levels, select the most dependent. For example: three times extensive assistance and three times limited assistance, select extensive assistance. When neither full staff performance, weight bearing assistance, nor non-weight-bearing assistance is indicated, then select supervision.
 - **Column 1, ADL Self-Performance** – select the option that best describes the individual's self-performance over a 24-hour period during the last 5-7 days.
 - Note: View each activity separately; do not blend activities together.
 - Self-performance options include:
 - **0. Independent** - no help or oversight or help/oversight provided only 1 or 2 times during the last 5-7 days. This includes set-up help.
 - **1. Supervision** - oversight, encouragement or cueing provided 3+ times OR supervision (3+ times) plus physical assistance provided, but only 1 or 2 times during the last 5-7 days.
 - **2. Limited assistance** - individual highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight-bearing assistance 3+ times OR limited assistance (3+ times) plus weight-bearing support 1 or 2 times during the last 7 days.

- **3. Extensive assistance** - while individual performed part of activity, help of the following type(s) provided 3 or more times during the last 7 days: Weight-bearing provided 3+ times AND full staff performance during part (but not all) of the activity.
 - **4. Total dependence** - full staff performance of the activity.
- **Activities of Daily Living (ADL) Support Provided:** Select the appropriate response in column 2 that measures the most support provided by staff over the last 5-7 days, even if that level of support only occurred once.
 - Support options include:
 - **0. No setup or physical help from staff**
 - **1. Setup help only** - individual is provided with materials or devices necessary to perform the activity of daily living independently. Examples of 'setup help only' include:
 - Dressing - retrieving clothes from closet and laying out on individual's bed
 - Eating - cutting meat and opening containers at meals
 - Personal hygiene - providing washbasin or grooming articles
 - Bathing - placing bathing articles at tub side within individual's reach.
 - **2. One-person physical assist**
 - **3. Two+ person physical assist**

Bladder and/or Bowel Continence: For questions h and i, select from the following options:

Note: If the client has an indwelling catheter, select continent.

- **0. Continent** - complete control
- **1. Usually continent** - incontinent episodes once a week or less
- **2. Occasionally incontinent** - 2 or more times a week, but not daily
- **3. Frequently incontinent** - tends to be incontinent daily, but some control present
- **4. Incontinent** - Bladder incontinent all (or almost all) of the time

Appliances/Programs: For question j, check off each appliance or program the client has, then select the level of "Support" for each, based on the following options:

- **0. Independent**
- 1. Hands on person assist

The appliances or programs in this question are:

- a. **External (condom) catheter**
- b. **Indwelling catheter** - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine; includes catheters inserted through the urethra or by supra-pubic incision.
- c. **Intermittent catheterization** - A program where the catheter is not indwelling, but is inserted at least once a day or more frequently for the purpose of emptying the bladder; includes catheters inserted through the urethra or by supra-pubic incision.

- d. **Pads/briefs used**
- e. **Ostomy present** - Any type of ostomy of the gastrointestinal or genitourinary tract.
- f. **Scheduled toileting or other program** - Timed/scheduled toileting of the individual or any other program, such as bladder retraining or bowel evacuation.

Section E: Medication List

Please list all medications currently used. Include medications used regularly less than weekly as part of the individual's treatment regimen.

To enter a medication, select the **+ Add Medication** button and enter the following required fields:

1. **Medication Name and Dosage**
2. **RA:** Route of Administration - enter the appropriate route, such as "po", "IM", or "IV"
3. **Frequency:** enter the frequency ordered, such as "qd", "bid" or "q8h"
4. **Prescribed by:** Enter the prescriber's name

Select **Save** to add the medication to the list or **Cancel** to close the pop up, without adding the medication. Selecting **Clear** will delete all information entered in the fields described above.

To change information related to a medication already entered, select **Edit** to re-open the pop up and make changes. Select **Delete** to remove a medication from the list.

To attach the individual's Medication Administration Record, rather than enter each medication separately, select the checkbox next to **Attach Medication Administration Record**. Checking this box will cause the Medication Administration Record to appear as a required attachment on the Attach and Submit page.

In some cases, it may be appropriate to use a combination of both options. For example: the medication record contains all prescribed medications, but the individual also takes vitamins, herbal supplements, or over-the-counter cold or pain medication, as needed. In this case, check the box to indicate the record will be uploaded and enter each additional item using the **+ Add Medication** button.

Section F: Medication

For question 1a, determine the patient's current ability to prepare and take all medications reliably and safely, including administration of the correct dosage, at the appropriate times/intervals.

Assess the patient's ability to obtain medication from where it is routinely stored, the ability to read the label or otherwise identify the medication correctly, open the container, select the correct amount of tablets/pills or liquid, and orally ingest at the correct times. Place a checkmark next to each of the following that apply:

0. Able to independently take the correct medication(s) and proper dosage at the correct time
1. Able to take medications at the correct times if:
 - (a) Individual dosages are prepared in advance by another person; OR

- (b) Alternative medication dispensing system is used
 - If this is checked, please specify the dispensing system in use
2. Able to take medication(s) at the correct times if given reminders by another person and/or device at the appropriate times
 - If this is checked, please specify if reminders come from another person or a device. If reminders come from a device, please specify the device in use.
 3. Unable to take medications unless administered by another person due to physical and /or mental disability
 4. Individual had no medications in the last 7 days

Note: If the patient's ability to manage medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

For question 1b, check all medications or treatments that the patient self-administers.

Section G: Communication/Hearing Patterns

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

Be alert to what you have to do to communicate with the individual. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use gestures - all of these are indications that there is a hearing problem.

Observe and listen to the individual's efforts to communicate with you. Observe the individual's interactions with others in different settings.

Once the observation is complete, indicate if the patient has any hearing problems by answering the first question in this section "Yes" or "No". If you select "Yes", at least one of the questions 1 through 3 must be completed to proceed to the next section. If you select "No", simply select **Next** to move on.

When answering questions 1 through 3, consider the following:

1. **Hearing:** Select one of the following options to indicate how well the patient hears. If a hearing appliance is used, select an option based on the individual's ability to hear with the hearing appliance.
 - **Hears adequately** - The individual hears all normal conversational speech, including when using the telephone, watching television, and engaged in-group activities.
 - **Minimal difficulty** - The individual hears speech at conversational levels but has difficulty hearing when not in a quiet setting or when not in one-to-one situations.
 - **Hears in special situations only** - Although hearing-deficient, the individual compensates when the speaker adjusts tonal quality and speaks distinctly, or the individual can hear only when the speaker's face is clearly visible.

- **Highly impaired** - There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.
2. **Communication Devices/Techniques:** Check all that apply.
- **Hearing aid, present and used** - A hearing aid or other assistive device is available to the individual and is used regularly.
 - **Hearing aid, present and not used regularly** - The hearing aid is used only occasionally or is broken.
 - **Adaptive phones** - A specialized phone is available to allow the individual to communicate with others (e.g., TTY).
 - **Lifeline** - A personal emergency response system is available for the individual to utilize in case of emergency.
 - **None of the above** - Individual is without any specialized hearing assistive devices.
3. **Ability to Understand Others:** Select one of the following options to indicate how well the patient understands information content:
- **Understands** - The individual clearly understands the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.
 - **Usually understands** -The individual may miss some part or intent of the message, but comprehends most of it.
 - **Sometimes understands** -The individual demonstrates frequent difficulties integrating information and responds adequately only to short, simple and direct questions or directions.
 - **Rarely/Never understands** - The individual demonstrates very limited ability to understand communication.

Section H: Vision Patterns (Use of Standard Vision Card)

Indicate if the patient has any vision problems by answering the first question in this section "Yes" or "No". If you select "Yes", at least one of the questions 1 or 2 must be completed to proceed to the next section. If you select "No", simply select **Next** to move on.

When answering questions 1 and 2, consider the following:

1. **Vision:** Select one of the following options to indicate how well the patient sees in adequate light. If glasses are used, select an option based on the individual's ability to see with their glasses.
- **0. Adequate** - Sees fine detail, including regular print in newspapers/books
 - **1. Impaired** - Sees large print, but not regular print in newspapers/books
 - **2. Moderately impaired** - Limited vision; not able to see newspaper headlines, but can identify objects
 - **3. Highly impaired** - Object identification is in question, but eyes appear to follow objects
 - **4. Severely impaired** - Has no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

Note: Many people with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such people appear to “track” or follow moving objects in their environment with their eyes. For people who do this, select “3. Highly impaired”.

2. **Visual Appliances: Select all that apply.**
 - a. **Glasses, contact lenses**
 - b. **False eye**
 - c. **Implant**
 - d. **Other**
 - i. If this is selected, please specify the appliance used

Section I: Mood

Mood distress is a serious condition and is associated with declines in health and functional status. Associated factors include poor adjustment to living environment or new location, functional impairment, resistance to daily care, inability to participate in or withdrawal from activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain.

This section seeks information for all applicants over the past 7 days by asking two initial questions:

1. **Have you been bothered by little or no pleasure in doing things?** A “Yes” or “No” response is required.
2. **Have you been bothered by feeling down, depressed, or hopeless?** A “Yes” or “No” response is required.

If non-verbal, use any visible evidence or report of depression. Is there evidence of crying, sad expressions, little or no interest in eating, getting out of bed, refusal to take part in activities, taking medications as prescribed, etc. Information provided by others who have frequent contact may be beneficial.

If the answer to both questions is “No”, skip to Section J Problem Behavior.

If either question is answered “Yes”, please administer the Patient Health Questionnaire, based on the person’s mood over the last 14 days.

Patient Health Questionnaire - use the following scale:

- **0. Not at all**
 - **1. Several Days** - Feelings exhibited within the past 1-3 days
 - **2. More than half of the days** - Feelings exhibited within the past 3-5 days
 - **3. Nearly every day** - Feelings exhibited more than 5 days
1. Little or no pleasure in doing things
 2. Feeling down, depressed, or hopeless
 3. Trouble falling or staying asleep, or sleeping too much
 4. Feeling tired or having little energy

5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.
9. Thoughts that you would be better off dead or of hurting yourself in some way

The system will calculate the score by totaling the selections made for each question. All questions with 0 selected are valued at 0 points, with 1 selected are 1 point, with 2 selected are 2 points, and 3 selected are 3 points each. For example: 2 identified 1 responses with 4 identified 2 responses and 3 identified 3 responses would be a total score of 19.

If depression is identified as a problem (scores 5 and above), it should be listed in the Identified Needs Section.

Section J: Problem Behavior

Problem behaviors are those that cause distress to the individual, or are distressing or disruptive to family members, caregivers, other residents, or staff. Such behaviors include those that are potentially harmful to the individual or disruptive in the environment, even if staff and other residents, or family and caregivers appear to have adjusted to them.

Indicate if the patient exhibits any problematic behaviors by answering the first question in this section "Yes" or "No". If you select "Yes", indicate what types of behaviors (a through e) were exhibited within the last 7 days and how frequently they occur. If they occur more often than three times per week, you must complete the Supplement J.S. questions to proceed to the next section. If you select "No", simply select **Next** to move on.

NOTE: Question f. - Major Physical Abuse is not limited to the last 7 days; please check if this behavior was exhibited in the last 6 months.

- a. **Wandering** - moved with no rational purpose, seemingly oblivious to needs or safety. Wandering may be by walking or by wheelchair.
 - **Note:** Do not include pacing as wandering behavior.
- b. **Verbally abusive** - others were threatened, screamed at, or cursed at.
- c. **Socially inappropriate / disruptive behavior** - made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/throw food/feces, hoarding, rummaged through others' belongings.
- d. **Resists care** - resisted taking medications/injections, ADL assistance or eating. Signs of resistance may be verbal and/or physical. This category does not include instances where individual has made an informed choice not to follow a course of care.
- e. **Minor Physical abuse** - others were shoved, scratched, or pinched, but did not result in physical injury.
- f. **Major Physical abuse** - others were hit, punched, sexually or otherwise abused, resulting in bodily injury at least once in the past six months.

The assessor needs to determine if monitoring and supervision by staff or caregivers are required to manage the identified behavioral issues. Select from the following options:

0. No
1. Once per month
2. Twice per month
3. Weekly
4. Three to Five times a week
5. Daily
6. Other (Specify the timeframe in the field provided)

Note: If 4, 5, or 6 are selected above, complete the supplemental questions that follow - Section J.S. Problem Behavior Supplement.

SECTION J.S. PROBLEM BEHAVIOR SUPPLEMENTAL SCREENING TOOL

Make the selection for each question that most accurately describes the individual's behavior within the last 7 days, except for J.S.4. Danger to Self and Others.

1. **Sleep patterns:** Select the option that best describes the individual's sleep patterns: 0, 1, 2, or 3.
2. **Wandering:** Select the option that best describes the individual's wandering behavior: 0, 1, 2, 3 or 4.
3. **Behavioral Demands on Others:** Select the option that best describes the effect of the individual's behavior on their living arrangement: 0, 1, 2, or 3.
4. **Danger to Self and Others:** Select the option that best describes the extent to which the individual has been dangerous to self or others. Note the specific timeframes while make a selection for this item: 0, 1, 2, 3, or 4 (reflects timeframe of the previous 6 months).
5. **Awareness of Needs/Judgment:** Select the option that best describes the individual's awareness of their needs and their level of cooperation in meeting those needs.

Section K: Environmental Assessment

Indicate if the person resides OUTSIDE of a facility such as a nursing facility, residential care facility or hospital by answering the first question in this section "Yes" or "No". If you select "Yes", at least one of the questions must be completed to proceed to the next section. If you select "No", simply select **Next** to move on.

When answering questions 1 and 2, check all that apply:

1. **Risk Factors:**
 - Feels threatened or unsafe?
 - Is able to make needs known?

- Because of limited finances has made trade-offs in purchases of heat, food or medication in the last month?
2. **Home Environment:** Check any of the following that makes the home hazardous or uninhabitable:
- a. Lighting (including inadequacy of lighting or exposed wiring)
 - b. Flooring or carpeting (holes in floor, scatter rugs)
 - c. Bathroom and toilet room environment (non-operating plumbing, leaking pipes)
 - d. Kitchen environment (dangerous stove, inoperative refrigerator, infestation of rodents)
 - e. Heating and cooling system issues
 - f. Personal safety (fear of violence, heavy traffic in street, fear of neighbors)
 - g. Access to home (entering and leaving home)

Section L: Instrumental Activities of Daily Living

This section is to assess the patient's physical, cognitive, and mental ability to safely perform daily tasks of meal preparation, homemaking, shopping/errands, telephone use and transportation needs. This ability can be temporarily or permanently limited by: physical impairments, emotional/cognitive/behavioral impairments, sensory impairments and environmental barriers. For each question, indicate if the patient completes the task independently, with assistance, or is dependent on others. Also indicate the average time spent per week to complete these tasks and include appropriate items in the Identified Needs section.

Section M: Social/Community Information

The AUDIT – C1 (Alcohol Use Disorders Identification Test – Consumption) is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). Each AUDIT – C question has 5 answer choices with associated points.

In men, a score of 4 or more is considered positive (optimal for identifying hazardous drinking or active alcohol use disorders). In women, a score of 3 or more is considered positive. However, when the points are all from Question #1 (Question #2 and Question #3 are zero), it can be assumed that the individual is drinking below recommended limits and it is suggested that the assessor review the individual's alcohol intake over the past few months to confirm accuracy. Generally, the higher the score; the more likely it is that the individual's drinking is affecting his or her safety.

1. **Alcohol Use Disorders Identification Test:** For questions 1-3 select the option that best describes the individual's behavior. When the section is completed, the system will total the score and display it.
2. **Substance Use:** Select "Yes" or "No". If "Yes", check all substances that apply. If "No", proceed to Section N.

Section N: Reported Conditions

Check only those existing known conditions that relate to the individual's current status. Do not include conditions that have been resolved or no longer affect the individual's functioning. Do not list inactive conditions.

Note: If the condition is not listed, indicate the condition in the section entitled Other Conditions.

Section O: Balance

1. **Falls:** The purpose is to determine whether or not the individual has had a significant fall in the last 180 days resulting in an injury. Indicate when the fall occurred and if it resulted in an injury. If "Yes", identify the injury in the field provided.
2. **Fall Risk:** Check all that apply (a-g). Observe the following five (5) activities to complete the evaluation of risk:
 - a. Moving from seated to standing position
 - b. Walking (with device if used)
 - c. Turning around
 - d. Moving on and off the toilet
 - e. Surface to surface transfer

During the observation of activity, you should be assessing the following:

1. Steady at all times
2. Not steady, but able to stabilize without human assist
3. Not steady and can only stabilize with human assist and/or device.

Locomotion: Evaluate the person's current ability to walk safely once in a standing position, or use a wheelchair once in a seated position, on a variety of surfaces. A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this section. The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. Select the appropriate value:

- Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (without human assistance or assistive devices)
- With the use of a one-handed device, able to independently walk on even and uneven surfaces and negotiate stairs with or without hand railings
- Requires use of two-handed device to walk alone on level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
- Able to walk with the supervision of another person at all times
- Chair fast, unable to ambulate but able to wheel self independently
- Chair fast, unable to ambulate and unable to wheel self.

Primary Modes of Locomotion: Select the most used device(s) on a given day.

- No assistive devices
- Hoyer Lift
- Walker/Crutch

- Scooter or Power Wheelchair
- Wheelchair
- Activity does not occur

Section P: Nutritional Status

Indicate if the person has provided any information about their nutritional status by answering the first question in this section “Yes” or “No”. If you select “Yes”, at least one of the questions 1 through 3 must be completed to proceed to the next section. If you select “No”, simply select **Next** to move on.

When answering questions 1 through 3, consider the following:

1. **Weight and Height:** record weight in pounds and height.
2. **Weight change:** Determine if the individual’s weight has changed in the past 30 days and select “Yes” or “No”. If “Yes”, indicate if the change was a gain or loss, the number of pounds lost or gained, and whether this was intended or unintended.
3. **Nutritional problems or approaches:** Check all items that apply.
 - a. **Chewing or swallowing problem**
 - b. **Missing teeth or dentures** - Check only if this results in a problem of eating/chewing/swallowing.
 - c. **Special diet** - Specify what the special needs are for this individual in the field provided.
 - d. **Mechanically altered (or pureed) diet**
 - e. **Noncompliance with diet** - Individual consistently does not follow specific diet orders.
 - f. **Food allergies** - Specify any known food allergies that the individual has in the field provided.
 - g. **Poor appetite** - Fails to eat a normal amount of food on a regular basis.

Section Q: Skin Conditions

1. **Skin problems:** Indicate the presence of skin problems/conditions (other than ulcers) and/or that are risk factors for more serious problems. Check all that apply.
 - a. **Abrasions (scrapes) or cuts** - includes skin that has been scraped or rubbed away, such as skin tears.
 - b. **Burns** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing.
 - c. **Bruises**
 - d. **Rashes, itchiness, body lice, scabies** - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat and bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, dermatitis and Intertrigo).
 - e. **Skin changes, such as moles**
 - f. **Pressure ulcers, open sores or lesions** – If this is selected, additional fields will be displayed to collect additional details such as the type of wound, its stage, how many are present, where they are located and the treatment ordered

- g. **Skin cancer past/present** – Use the Summary field to indicate “past” if the cancer is resolved and “present” if this is a current known condition.
 - h. **Eczema**
 - i. **Cellulitis**
 - j. **None of the above**
2. **Foot Problems:** Select all that apply. If question b is answered selected, check what specific foot problems the individual is dealing with. For question c, indicate whether the identified foot problems interfere with standing and ambulation.

Summary

This space is provided for the assessor to add any additional information that needs further explanation (i.e., if the individual was not able to complete the clock drawing due to vision problems or physical problems). The assessor must also include their name and title at the end of the note.

Section: Identified Needs

Through the assessment process, the assessor will be able to identify the needs of the individual, and list them in this section. The assessor will review the identified needs obtained from the assessment with the individual or the individual's representative. The assessor will offer choice to the individual as to where the services can be provided, whether it is community or nursing facility.

To enter an identified need, select the **+ Identified Need** button and enter the specific need. Select **Save** to add the identified need to the list or **Cancel** to close the pop up, without adding the need. Selecting **Clear** will delete all information entered in the field.

To change information related to an identified need already entered, select **Edit** to re-open the pop up and make changes. Select **Delete** to remove the need from the list.