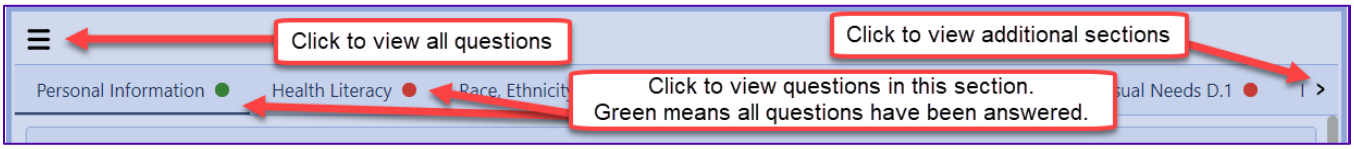
This assessment is created in CaseTrakker using tabs to separate questions by Sections. To view the questions in a Section, click the Section Title. Sections marked with ● have required questions that are incomplete, and Sections marked with ● have had all questions answered. Click the > to scroll and see additional Sections. To view all questions in the assessment, click ☰.

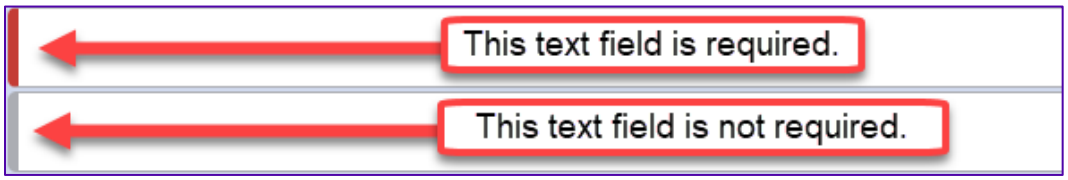


Some questions in the assessment may have icons next to them, which provide additional information when you hover your cursor over them:

Will show answers for this question from past assessments, if they exist.

Will give additional information or instructions for this question. Text in these popups will be listed next to each question in this document.

In this assessment, every question includes a free text field to allow the Care Manager to provide additional information, which may assist other members of the Interdisciplinary Care Team (ICT) to get a full picture of this member. In most cases, the Required marker on the text field will change when the question above is answered.



Comprehensive Assessment Header

Assessment Taken Date: *(Enter date or use calendar selection)*

Who Answered/Assisted:

- Enrollee
- Caregiver
- Other
  - *If Other selected: (Free text field to enter individual who answered/assisted)*

Relationship of Assistor: *(Free text field for relationship; Not required)*

Date Status Saved in Complete: *(Will auto-populate when assessment is saved in Complete status)*

Assessment Sections

Personal Information

Marital Status:

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced
6. Other

Education:

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

Health Literacy

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Care Manager Note: Scores greater than 2 are considered positive, indicating some difficulty with reading printed health related material.

Race, Ethnicity, Language, and Disability

What is your race? *(Check all that apply)*

- Caucasian/White
- African American/Black
- American Indian or Alaska Native
- Hispanic/Latino
- Asian
- Native Hawaiian or other Pacific Islander
- Unknown
- Declined to answer

What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Declined to answer

How well do you speak English?

- Very well
- Well
- Not well
- Not at all
- Declined to answer

What is the primary language you speak?

- Arabic
- Burmese
- Cape Verdean Creole
- Chinese (Cantonese)
- Chinese (Mandarin)
- Croatian
- English
- French
- German
- Gujarati
- Haitian Creole
- Hmong
- Italian
- Japanese
- Khmer (Cambodian)
- Korean
- Laotian; Lao
- Portuguese
- Russian
- Serbian
- Sign Language
- Spanish
- Tagalong
- Thai
- Vietnamese
- Other
- Declined to answer

Member's identified communication preference? *(Check all that apply; Not required, so skip if not applicable)*

- Language Line
- Interpreter
- None
- Other (please describe)
    - *If Other:* **Please Describe:** *(Free text field)*

Do you have any special circumstances or disability? *(Check all that apply)*

- Low Vision
- Blind
- Deaf
- Developmentally Disabled
- Intellectually Disabled
- Physically Disabled
- Hard of Hearing
- Other (please describe)
    - *If Other:* **Please Describe:** *(Free text field)*
- None

Do you need support services/reasonable accommodations to communicate? *(Check all that apply)*

- Text telephone (TTY)
- Large print publications
- American Sign Language interpreter
- Video Relay Services (VRS)
- Communication Access Real Time Translations (CART)
- Publications in Braille
- Assistive Listening Device
- Publications in electronic format
- Other (please describe)
  - *If Other:* **Please Describe:** *(Free text field)*
- None

Communication Needs *(No free text fields in this section)*

Hearing (With hearing appliance if used) C.1

0. HEARS ADEQUATELY - Normal talk, TV, phone, doorbell
1. MINIMAL DIFFICULTY - When not in quiet setting.
2. HEARS IN SPECIAL SITUATIONS ONLY - Speaker has to adjust tonal quality and speak distinctly
3. HIGHLY IMPAIRED - Absence of useful hearing

Making Self Understood (Expression) C.2

0. UNDERSTOOD - Expresses ideas without difficulty
1. USUALLY UNDERSTOOD - Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2. OFTEN UNDERSTOOD - Difficulty finding words or finishing thoughts, prompting usually required
3. SOMETIMES UNDERSTOOD - Ability is limited to making concrete requests
4. RARELY/NEVER UNDERSTOOD

Ability to Understand Others (Comprehension) C.3

0. UNDERSTANDS - Clear comprehension
1. USUALLY UNDERSTANDS - Misses some part/intent of message, BUT comprehends most conversation with little or no prompting
2. OFTEN UNDERSTANDS - Misses some part/intent of message, with prompting can often comprehend conversation
3. SOMETIMES UNDERSTANDS - Responds adequately to simple, direct communication
4. RARELY/NEVER UNDERSTANDS

Visual Needs D.1 *(No free text fields in this section)*

Vision - Ability to see in adequate light and with glasses if used?

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 in question, but eyes appear to follow objects
4. SEVERELY IMPAIRED - No vision or sees only light, colors, or shapes; eyes do not appear to follow objects

Living Arrangements

I have your Home Address as:

[auto-populates from member information]

Is this your Correct Physical Address?

- Yes
- No

What is your current living arrangement?

- Alone or in a private home or apartment
- Alone in a senior housing building
- With a family member
- With a paid caregiver
- Assisted living facility
- Homeless
- Other

Home Environment - [Check any of the following that make home environment hazadarous or uninhabitable (if none apply, check NONE OF ABOVE; if temporarily in institution, base assessment on home visit)] ***(Check all that apply)***

a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)
b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)
c. Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)
d. Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)
e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)
f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)
g. Access to home (e.g. difficulty entering/leaving home)
h. Access to rooms in house (e.g., unable to climb stairs)
i. NONE OF ABOVE

Do you have someone to help you if you became ill?

- Yes
- No

Who would help you if you became ill?

- Spouse/significant other
- Child
- Friend
- Paid caregiver
- Family member
- Other

PCP Contact Info

Do you have a primary care physician?

- Yes
- No

If No - **Care Manager Note: Assist member in contacting Customer Service to select an in-network PCP**

When was the last time you saw your PCP? *(Question is not required)*

- Within the past year
- Greater than 1 year ago

Support Services

Do you attend or participate in any of the following support services? *(Check all that apply)*

- Personal Care Attendant Program
- Adult Day Health
- Adult Foster Care
- N/A

Are you currently receiving any of the following services from an agency? *(Check all that apply)*

- Visiting nurse
- Social worker
- Physical therapy
- Occupational therapy
- Speech therapy
- Home health aid
- Homemaker or chore service
- Transportation services
- Home delivered meals
- Personal Emergency Response System
- N/A

Validate Services

Member validates the above services (e.g., homemaker, PCA, etc.) are being received?

- Yes
  - *If Yes* - **Care Manager Note: See OP Events on member's Auth Summary**
- No
- N/A

IADL Function

Physical Functioning (IADL) - Do you need some assistance with any of the following activities?

MEAL PREPARATION (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils). H.1a

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
8. Activity did not occur

ORDINARY HOUSEWORK (e.g., doing dishes, dusting, making bed, tidying up, laundry). H.1b

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
8. Activity did not occur

MANAGING FINANCES (e.g., how bills are paid, checkbook is balanced, household expenses managed.) H.1c

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
8. Activity did not occur

MANAGING MEDICATIONS (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments). H.1d

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
8. Activity did not occur

PHONE USE (e.g., how telephone calls are made or received, e.g. with assistive devices such as large numbers on telephone, amplification as needed). H.1e

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
8. Activity did not occur

SHOPPING (e.g., how shopping is performed for food and household items, e.g. selecting items, managing money). H.1f

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
8. Activity did not occur

TRANSPORTATION (e.g., how member travels by vehicle, e.g. gets to places beyond walking-distance). H.1g

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
8. Activity did not occur

ADL Function

All questions in this section use the rating scale below, which is the same as the one used in the Minimum Data Set for Home Care (MDS-HC). To save space in this document, it will only be written out in full once, though each question in CaseTrakker includes the full text on each question. For more information on using this scale in assessments, see the computer-based training ***MDS-HC: Tips and Reminders***.

0. INDEPENDENT - No help, setup, or oversight -OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask)

1. SETUP HELP ONLY - Article or device provided within reach of client 3 or more times

2. SUPERVISION - Oversight, encouragement, or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision.

3. LIMITED ASSISTANCE - Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)

4. EXTENSIVE ASSISTANCE - Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support -OR- Full performance by another during part (but not all) of last 3 days

5. MAXIMAL ASSISTANCE - Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times

6. TOTAL DEPENDENCE - Full performance of activity by another

8. ACTIVITY DID NOT OCCUR (regardless of ability)

Physical Functioning (ADL) - Do you need some assistance with any of the following activities?

For members who performed the activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.

MOBILITY IN BED - (Including moving to and from lying position, turning side to side, and positioning body while in bed) H.2a

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

TRANSFER (Including to/from bed, chair, wheelchair, standing; excludes to/from bath/toilet) H.2b

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

LOCOMOTION IN HOME (If in wheelchair, self-sufficiency once in chair) H.2c

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

LOCOMOTION OUTSIDE OF HOME (If in wheelchair, self-sufficiency once in chair) H.2d

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

DRESSING UPPER BODY (How member dresses and undresses - street clothes, underwear - above the waist; includes prostheses, orthotics, fasteners, pullovers, etc.) H.2e

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

DRESSING LOWER BODY (How member dresses and undresses - street clothes, underwear - from the waist down; includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners) H.2f

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

EATING (Including taking in food by any method, including tube feeding) H.2g

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

TOILET USE (Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required - ostomy or catheter - and adjusting clothes) H.2h

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

PERSONAL HYGIENE (Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands - EXCLUDE baths/showers) H.2i

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

BATHING (How member takes full-body bath/shower or sponge bath - EXCLUDE washing of back and hair. Include how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area) H.2j

0. INDEPENDENT
1. SETUP HELP ONLY
2. SUPERVISION
3. LIMITED ASSISTANCE
4. EXTENSIVE ASSISTANCE
5. MAXIMAL ASSISTANCE
6. TOTAL DEPENDENCE
8. ACTIVITY DID NOT OCCUR

Medical Conditions & Treatments

Has your doctor told you that you have any of the following health conditions? *(Check all that apply)*

- Diabetes
- Heart Failure (CHF)
- Heart condition/Chest pain
- High blood pressure
- Emphysema or asthma
- Stroke
- Cancer (other than skin cancer)
- Hip fracture (within the past 12 months)
- Parkinson's Disease
- End stage renal (kidney) disease
- N/A

Do you receive any of the following special treatments? (May select multiple)

- Tube feeding
- Tracheostomy care
- Ostomy care
- Wound care
- Chemotherapy
- Oxygen
- None

Nebulizer

- Yes
- No

Do you use any of the following equipment? (May select multiple)

- Hospital bed
- Hoyer lift
- Grab bars
- Bedside commode
- Wheelchair
- Walker
- Cane
- Other
- N/A

How would you best describe your current activities? (Select one)

- Confined to bed most of the time
- Confined to the house most of the time
- Need assistance by someone to get outside the house
- Need the help of special equipment outside the house
- No limitations in my activities

In general, how do you rate your health? (Select only one)

- Very good
- Good
- Fair
- Poor

Is this a recent change? (Select one)

- Yes
- No

Falls

How many times have you fallen all the way to the ground or floor in the past 6 months?

- None
- 1 to 3
- 4 or more
    - *If 1 or more:* **If you have fallen, describe the nature of the fall.**
        - *(Required free text field)*

Are you unsteady on your feet? (Danger of fall - unsteady gait) K.6a

0. No
1. Yes

Do you limit going outdoors because you are afraid of falling? (e.g., stopped using bus, goes out only with others) K.6b

0. No
1. Yes

Timed Get Up and Go Test *(This section is optional)*

Ask the member to perform the following series of maneuvers, wearing regular footwear and using a walking aid if needed. Time the effort:

1. Sit comfortably in a straight-backed chair.
2. Rise from the chair
3. Stand still momentarily
4. Walk a short distance (approx. 10 feet)
5. Turn around
6. Walk back to the chair
7. Turn around
8. Sit down in the chair

Timed Get Up and Go Test

- Unable to perform
- Seconds to perform *(use narrative field to record seconds to perform)*

Timed Get Up and Go Results

- Normal
- Abnormal
    - *If Abnormal:* **Educated about fall risk. Consider fall reduction program.**
        - Yes
        - No
        - Not applicable

Care Manager Note: Greater than or equal to 12 seconds to complete indicates high risk for falling.

Pain

How often do you have pain? (Frequency with which client complains or shows evidence of pain). K.4a

- No pain
- Less than daily
- Daily - one period
- Daily - multiple periods (e.g., morning and evening)

How intense is your pain? K.4b

- No pain
- Mild
- Moderate
- Severe
- Times when pain is horrible or excruciating

Does the pain disrupt your usual activities? (From the member's point of view.) K.4c

- Yes
- No

Is the pain in one location or multiple sites? (Character of pain) K.4d

- No pain
- Localized - single site
- Multiple sites

Do medications adequately control your pain? (From member's point of view) K.4e

- Yes or no pain
- Medications do not adequately control pain
- Pain present, medication not taken

Mental Health Conditions

Has your doctor told you that you have any of the following mental health conditions?

- Depression
- Anxiety
- Bipolar
- Schizophrenia
- Alzheimer's Disease
- Dementia
- Psychosis

Have you recently suffered the loss of a loved one?

- Yes
- No

Depression PHQ2

This section is the two questions asked in the PHQ-2, which is used to determine the likelihood an individual may have depression. By default, this section consists only of the two questions and Click here to create a PHQ-9 Assessment. Do not use this button, as the PHQ-9 should be delivered by a behavioral health specialist.

Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

- Not at all – 0
- Several days – 1
- More than half the days – 2
- Nearly every day – 3

Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?

- Not at all – 0
- Several days – 1
- More than half the days – 2
- Nearly every day – 3

If the member scores 3 or more on the two questions below, an additional tab will be added to the Comprehensive Assessment.

PHQ2 POC – Appears with positive PHQ

PHQ2 Score is greater than or equal to 3. Would you like to add "PHQ2 - Positive screen for depression" as a problem to the Member's Plan of Care?

- Yes
- No

Care Manager Note: Refer to PCP and consider BH consult.

If you select **Yes** here, the member's **Plan of Care** screen will populate with the **Problem** "**PHQ2 - Positive screen for depression**." The **Plan of Care** will not populate with any **Goals** or **Interventions**, and the Care Manager will be responsible for populating these.

Health Care Utilization

In the past year, have you been admitted to a nursing home?

- Yes
- No

If Yes: **Have you lived in a nursing home at any time during the past 5 years? CC.7**

0. No
1. Yes

How many times have you visited an emergency room in the past 6 months? (Select one)

- None
- 1
- 2
- 3 or more

How many times have you stayed overnight in the hospital in the past 6 months? (Select one)

- None
- 1
- 2 or more

How long has it been since your last hospital stay? (Time since discharge from last inpatient setting) CC.4

0. No hospitalization within 180 days
1. Within last week
2. Within 8 to 14 days
3. Within 15 to 30 days
4. More than 30 days ago

How many times have you visited a doctor or other healthcare provider in the past 6 months?

- None
- 1 to 3
- 4 to 6
- 6 or more

Do you currently see 3 or more doctors on a regular basis?

- Yes
- No

Medications

How many medications do you take on a regular basis (prescription and over the counter)?

- None
- 1 to 3
- 4 to 6
- 7 or more

Do you take injectable insulin (May select one)

- Yes
- No

Do you have any drug or other allergies?

- Yes
- No

If yes: **Care Manager Note: Enter on Member File**

If yes: **What are they?**

[free text field – not required to submit assessment]

Nutritional Info

Do you have any special dietary needs?

- Yes
- No

If yes: **Care Manager Note: Enter on Member File**

Have you lost 10 lbs. or more in the past 6 months without trying to do so? (select one)

- Yes
- No

What is your height? (Inches):

[Free text field for height in inches]

What is your weight? (Pounds):

[Free text field for weight in pounds]

BMI

[BMI is auto-calculated when height and weight are entered; Press Enter or click  *if this is not done automatically]*

Is the BMI > 30?

- Yes
- No

Is the BMI < 18.5?

- Yes
- No

Cognition/Behavior

Cognitive Skills - How well does the member make decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do)? B.2a

0. INDEPENDENT - Decisions consistent/reasonable/safe
1. MODIFIED INDEPENDENCE - Some difficulty in new situations only
2. MINIMALLY IMPAIRED - In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times
3. MODERATELY IMPAIRED - Decisions consistently poor or unsafe, cues/supervision required at all time
4. SEVERELY IMPAIRED - Never/rarely made decisions

BEHAVIORAL SYMPTOMS - How often does the member experience the following behavioral symptoms? If experienced, how easy was it to alter the symptom when it occurred? *[No free text fields with these questions]*

Wandering (moved with no rational purpose, seemingly oblivious to needs or safety) E.3a

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

Verbally abusing (threatened, screamed at, cursed at others) E.3b

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

Physically abusive (hit, shoved, scratched, sexually abused others) E.3c

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

Socially inappropriate/Disruptive (disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviors or disrobing in public) E.3d

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

Resists care (resisted taking medications, ADL assistance, eating, or changes in position) E.3e

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

[Section continues on next page]

Mini-Cog Assessment *[This section is optional]*

1) **I'd like you to remember these three words: Banana, Sunrise, Chair**
   - Pass
   - Fail

Care Manager Note *(step 1)*:
- Ask member to repeat the words to ensure the learning was correct.
- Allow the member 3 tries, then go to the next item.

2) **Ask member to draw the face of a clock. After numbers are on the face, ask member to draw hands on the clock to read 10 minutes after 11:00 (or 20 minutes after 8:00).**
   - Pass
   - Fail

3) **Ask the patient to recall the three words from Step 1.**
   - Pass
   - Fail

Care Manager Note *(step 2)*:
- Either a blank piece of paper or a preprinted circle (other side) may be used.
- A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 12 (or the 4 and 8).
- These two specific times are more sensitive than others.
- A clock should not be visible to the patient during this task.
- Refusal to draw a clock is scored abnormal.
- Move to next step if clock not complete within three minutes.

Add Cognitive to POC - This section is optional

This section is referring to the member's score on the Mini-Cog Assessment in the previous tab.
- If the member can recall 1 or more words in **Step 3**, and passes the Clock Drawing Test (CDT) in **Step 2**, answer **Yes** in the first question (**Negative for cognitive impairment**).
- If the member can recall 1 or 2 words in **Step 3**, but cannot pass the CDT in **Step 2**, answer **Yes** in the second question (**Positive for cognitive impairment**).
- If the member cannot recall any words in **Step 3**, answer **Yes** in the third question (**Positive for cognitive impairment**), regardless of the CDT results in **Step 2**.

1-2 recalled words + normal CDT: Negative for cognitive impairment
- Yes
- No

1-2 recalled words + abnormal CDT: Positive for cognitive impairment

Note: Refer to PCP and consider BH consult
- Yes
- No

0 recalled words: Positive for cognitive impairment

Note: Refer to PCP and consider BH consult
- Yes
- No

Substance Use

Do you use alcohol?

- Yes
- No

Do you currently use any street drugs or take prescription medications that were not prescribed for you or take prescription medications in larger amounts than were prescribed?

- Yes
- No

If Yes: **If yes, what drugs or medications?**

[Free text field]

CAGE-AID – Appears with *Yes* response to either question in *Substance Use* section

This section is the CAGE assessment, used to determine the likelihood of a substance use disorder. Each question is worth one point, and the Cage Score POC section will appear with a positive score of 2 or more.

Have you felt the need to cut down on your drinking or drug use?

- Yes
- No

Do you feel annoyed by people complaining about your drinking or drug use?

- Yes
- No

Do you ever feel guilty about drinking or drug use?

- Yes
- No

Do you ever drink an eye-opener or use drugs first thing in the morning to relieve shakes, steady your nerves, or to get rid of a hangover?

- Yes
- No

Cage Score POC – Appears if CAGE Score is greater than 2

Cage Score is greater than or equal to 2. Would you like to add to POC?

Note: Refer to PCP and consider BH consult

- Yes
- No

Counseling and Smoking

Has member been referred for counseling?

- Yes
- No

Have you ever smoked cigarettes or used other tobacco products?

- Yes
- No

If Yes: **Have you smoked/used any in the past 30 days?**

- Yes
- No

If Yes: **On average, how many cigarettes do you smoke (or times do you use) per day?**

[Free text field]

How long have you been smoking (using) at that rate?

[Free text field]

Preventive Care

Have you had the flu shot within the past year?

- Yes
- No
- Allergic
- Refused

If Yes: **Enter Date**

[Type or use calendar drop down]

Care Manager Note: Update Member File with Preventive Care information.

Have you ever had the pneumococcal vaccine?

- Yes
- No
- Allergic
- Refused

If Yes: **Enter Date**

[Type or use calendar drop down]

Care Manager Note: Update Member File with Preventive Care information.

Have you had an eye exam within the past 2 years?

- Yes
- No
- Refused

If Yes: **Which eye exam did you receive?**

- Dilated eye exam
- Glaucoma screening

Enter Date

[Type or use calendar drop down]

Care Manager Note: Update Member File with Preventive Care information.

Have you had a hearing exam within the past 2 years?

- Yes
- No
- Refused

Care Manager Note: Update Member File with Preventive Care information.

Have you had a colorectal cancer screening?

- Yes
- No
- Refused

If Yes: **Which colorectal cancer screening test did you receive?**

- Fecal Occult Blood Test
- Sigmoidoscopy
- Colonoscopy

Enter Date

[Type or use calendar drop down]

Care Manager Note: Update Member File with Preventive Care information.

For Women: Have you had a breast cancer screening during the past year?

- Yes
- No
- Refused
- Not applicable

If Yes: **Which breast cancer screening test did you receive?**

- Mammogram
- Ultrasound

Enter Date

[Type or use calendar drop down]

Care Manager Note: Update Member File with Preventive Care information.

Advanced Directives

Do you have a health care proxy or a durable power of attorney for healthcare decisions?

- Yes
- No
- I don't know

Care Manager Note: Try to identify if the member has someone who can make healthcare decisions if they were to become unable.

What are your goals of care?

- Longevity
- Function
- Comfort
- Member does not wish to answer

Have you spoken to your family or your doctor about your healthcare wishes? (Select one)

- Yes
- No
- I don't know

Are there any family traditions related to illness, death, or dying that we should be aware of?

- Yes
- No

Caregiver Status

Caregiver Status (Select all that apply) G.2

- A caregiver is unable to continue in caring activities - e.g., decline in the health of the caregiver makes it difficult to continue
- Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client)
- Primary caregiver expresses feelings of distress, anger, or depression
- NONE OF THE ABOVE

Safety

Has anybody hurt you?

- Yes
- No

Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.

Are you afraid of anybody?

- Yes
- No

Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.

If Yes is answered to either of the previous two questions (Has anybody hurt you? or Are you afraid of anybody?)

Are you being abused by your partner or someone important to you?

- Yes
- No

Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.

Within the past 12 months, have you been hit, slapped, pushed, or otherwise hurt by someone?

- Yes
- No

Care Manager Note: If yes, Protective Services referral and/or Social Worker consult.

Please note: After the Comprehensive Assessment is marked Complete, CaseTrakker will take you to the member's Care Plan screen and suggest a Care Level for the member in a pop-up.