1993

Development of the Functional Classification System for the Rehabilitation Unit of St. Alexius Medical Center

Janice L. Devine-Ruggles
University of North Dakota

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DEVELOPMENT OF THE FUNCTIONAL CLASSIFICATION SYSTEM FOR
THE REHABILITATION UNIT OF ST. ALEXIUS MEDICAL CENTER

by

Janice L. Devine-Ruggles
Bachelor of Science in Physical Therapy
University of North Dakota, 1978

An Independent Study
Submitted to the Graduate Faculty of the
Department of Physical Therapy
School of Medicine
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master of Physical Therapy

Grand Forks, North Dakota
May
1993
This Independent Study, submitted by Janice L. Devine-Ruggles in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

(Chairperson, Physical Therapy)
Title

Development of the Functional Classification System for the Rehabilitation Unit of St. Alexius Medical Center

Department

Physical Therapy

Degree

Master of Physical Therapy

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Signature

Janine L. Devine-Ruggles

Date

March 26, 1993
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ACKNOWLEDGMENTS

I would like to acknowledge the assistance of Ms. Christine Eixenberger in the work that was done to revise the Functional Classification System. We have worked together throughout this project and her assistance has been invaluable. I have appreciated her positive outlook and hard work during hours of element revision for the Functional Classification System. Our work together has produced a final result of which I am proud and it has also produced a valuable friendship.

I would also like to thank my family for their patience and love during my graduate work.
ABSTRACT

Medical rehabilitation is being influenced by a changing health care system that is putting pressure on care providers to increase emphasis on monitoring and documenting the functional outcomes of their clients. Rehabilitation needs tools that will assist in documentation of patient progress and attainment of goals and give an overview of the facility for program review. The Functional Classification System (FCS) is the tool used at the Rehabilitation Unit at St. Alexius. This paper documents the revision of the system.

A literature review was done to develop an understanding of the history of rehabilitation and functional assessment, to look at other functional assessment measures and their strengths and weaknesses, and to research the necessary characteristics of a functional assessment tool. The individuals who were using the original system (FCS:ver. 2) were then asked to rate the system and give suggestions for possible improvement through a questionnaire. After this groundwork was completed, a thorough review of the individual elements was performed. When the system had been in place for approximately four months, professionals using it were given the same questionnaire and asked to rate their satisfaction with the scale and the changes made. Results of this survey show improved rater satisfaction with all areas reviewed. Continued validity studies will be necessary but the new
version of the FCS has improved in all necessary characteristics of a functional classification tool.
CHAPTER I
INTRODUCTION

"Rehabilitation is a holistic and integrated program of medical, physical, psychosocial, and vocational interventions that empower a disabled person to achieve a personally fulfilling, socially meaningful, and functionally effective interaction with world."\(^1\)

This definition of rehabilitation, written by Dr. John Banja, highlights the multifaceted job facing inpatient rehabilitation units. Professionals from diverse disciplines must work together to maximize many areas of a client's function. Because of rehabilitation's unique emphasis on human performance within the context of medical care, along with an accompanying emphasis on comprehensiveness, medical rehabilitation has a need to develop means of measuring changes in performance which are more elaborate than those generally found in other human service programs.\(^2\)

The field of inpatient rehabilitation began in the late 1940s and early 1950s with an unquestionable need to assist disabled veterans and individuals with neuromuscular diseases to improve the wholeness of their lives. But now, the influence of certification processes and third party payers is causing rehab units to put increased emphasis on monitoring and documenting the functional outcomes of their clients. Facilities must keep sight of the original mission of rehabilitation as reflected in the above quote, yet meet the changing demands of the health care market. Therefore, facilities need tools that effectively and
efficiently evaluate the abilities of clients and aid in treatment planning, discharge planning, and program review.

History of the Functional Classification System

Since its inception in March, 1990, the Rehabilitation Unit of St. Alexius Medical Center, Bismarck, North Dakota, has used an assessment tool called the Functional Classification System (FCS) as an objective means of assessing function and progress during a client's rehab stay. A rough form of this scale was used when the unit first opened, and gradual additions and alterations were made to the FCS until Fall, 1990, when "FCS:ver.2" was assembled. Changes in the structure of the Unit and in the caseload made team members increasingly aware that FCS:ver.2 needed further alterations to make it perform its expected assessment tasks.

Purpose of This Project

The goal of this project has been the revision and expansion of the Functional Classification System into a tool that is easy to use, adequately summarizes a patient's functional status, and is valid. Emphasis has been placed on producing an assessment tool that looks at the person broadly, and that gives an accurate picture of present ability, helps set goals, and predicts readiness for discharge. The changes have been aimed at making the system more productive, less time consuming, and more "user-friendly." An attempt has also been made to produce a tool that will easily adapt to computer utilization. The revised tool is now in use at the Rehabilitation Unit of St.
Alexius Medical Center. Once validity and reliability are established, the FCS may be made available to other rehab facilities. The Functional Classification System, version 3.0, of the St. Alexius Medical Center Rehabilitation Unit is protected by copyright.
CHAPTER II

LITERATURE REVIEW

Usefulness of Functional Assessment Tools

A good functional assessment tool can serve many duties. One use is ongoing clinical monitoring of patients which aids decision-making during case management. It gives staff an objective way to monitor patient progress by following a patient's improvement and, in a quantitative manner, conveying that improvement to third party payers. This is an important task of the assessment tool. The consistent use of an assessment tool can also provide valuable information that can be used in program review. This review may be done by the facility or by other agencies or review bodies that must deliberate over quality of care, utilization of services, and accreditation. Large amounts of useful information are produced by these tools, and because of its numerical format, this quantified information can then be compared and analyzed in a statistical fashion.

Necessary Characteristics of a Functional Assessment Tool

The tasks expected of any assessment tool are multifaceted. Using the work of Harvey and Jellinek, the following factors are proposed as the necessary qualities of such a tool:

1. A sensitive gain scale to track small changes in a patient's functional performance during the inpatient stay.
2. A broad functional performance inventory to include items from all the disciplines working with the patient.

3. A system in which a common scale value shows changes from dependent to independent status in a parallel fashion in each functional performance item.

4. A system which can be easily understood by the team, peer reviewers, and outside agencies.

5. An ability to assist the reviewing bodies and agencies in their deliberations over quality of care, utilization of service, third-party reimbursement, and accreditation.

Reviewing Other Functional Assessment Tools

A functional approach is essential to inpatient rehabilitation's emphasis on systematic and comprehensive care that addresses the frequently overlooked consequences of long-term illness that eludes traditional approaches. Many systems have been developed to assess and classify functional abilities, but they often lack the broad evaluation of function that was desired in a system.

The Barthel Index includes ten activities of daily living (ADL) and has been widely documented for reliability. However, the Barthel Index fails to look at psychosocial areas important in assessing a patient's readiness to return to independent living. The Kinney Self-Care Evaluation includes 17 areas of assessment in ADLs rated on a 0 to 4 scale. The Katz Index of ADL looks at six basic ADL areas but does not include assessment of ambulation. These
two scales limit their scope to ADL evaluation, and fail to assess additional facets of patient ability that have a strong influence on independent living, such as cognition. The Functional Independence Measure (FIM)\textsuperscript{5} assesses 19 different areas of function, including cognition and communication, that are not consistently reviewed by other assessment tools. But this tool lacks review of homemaking skills and pain control, areas that can have a major impact on the ability to live independently. The Patient Evaluation Conference System (PECS)\textsuperscript{4} was found to be the most similar to the FCS in that it has a broad ranking scale of 0 to 7. However, its 76 functional performance areas make it effective but too cumbersome to be efficient. The FCS reduces this number of performance areas by averaging scores from disciplines that overlap in ability assessment.
CHAPTER III

METHODOLOGY

Preliminary Work

Revision work on the FCS:ver.2 was based on the works of Harvey et al.\textsuperscript{4} and Granger et al.\textsuperscript{5} The initial step was to analyze the FCS:ver.2 to determine its strengths and weaknesses, and then to proceed with necessary changes in the assessment elements.

The analysis of FCS:ver.2 was done through a questionnaire (Appendix A) filled out by the professionals who regularly used the FCS. This provided information on rater satisfaction and perceptions of how well different disabilities were assessed. Suggestions were also received for additional elements in the system. Ongoing input was received from staff members at monthly Unit meetings where updates of the revision process were discussed. This input helped clarify the changes needed in the FCS:ver.2.

Element Revision

As the next step, a steering committee was formed with representatives from each of the principle disciplines using the FCS. They served as primary writers or resource persons for the FCS elements used in their individual disciplines. The committee worked together to develop the score definitions listed in Table 1. By working together, each discipline became more
Table 1.--Definitions of Ratings Scores
Within FCS Elements

9 - Within normal limits on admission
8 - Independent or within functional limits, may have some small residual impairment
7 - Within functional limits with some type of assistive intervention
6 - Standby assistance
5 - Minimum assistance
4 - Moderate assistance
3 - Maximum assistance but with strong patient participation
2 - Dependent but patient aware and trying to participate
1 - Dependent and not participating
0 - Area not assessed

knowledgeable in the specifics of the system as well as more compliant in following the guidelines established as they composed their respective elements.

Each discipline was asked to review all elements they used and to make any correction they felt necessary. For some departments, this meant deleting certain elements while adding others. Other departments simply revised the elements they had already been using to make them more relevant. Once the revisions were made, the elements were reviewed by the author and Ms. Eixenberger to assure they conformed to the overall score definitions, to correct grammar, and to clarify meanings within the element. This process was repeated until the department and the revision team were in agreement on each element. When all elements had been reviewed, a draft version was given to Dr. Alan Ward, the Unit Medical Director, and with him, further revisions were
made. The Functional Classification System:ver.3 (Appendix B) was put into use in the St. Alexius Rehab Unit September 14, 1992.

Description of the System

The FCS:ver.2 had 33 areas of assessment. During the review process, elements were deleted and added with a net result of 33 elements still making up the system. Each area is rated on a 0 to 9 scale. The definitions of scoring levels within the system are listed in Table 1. An important goal was to establish parallel definitions throughout the system so, for example, a score of 5 always means the client needs minimum assistance with a task in any given element.

The 33 areas of function reviewed include ADL functions such as bathing, dressing, ambulation, communication, transfers, and stair climbing; but also continues on into areas less commonly reviewed by other scales, such as economic situation, family understanding, and social interaction. A complete list of FCS:ver.3 elements can be found in Table 2.

Rehab patients are evaluated and given a rating score for each element upon admission, then again for each weekly staffing meeting, and upon discharge. Goals to be achieved by discharge are set and given a point level at admission. The higher the total score on any given review, the higher the patient’s functional level. The disciplines contributing to the scoring are physical therapy, occupational therapy, speech therapy, nursing service, social services, Actual Community Training, and the attending physiatrist or physician’s
Table 2.--Functional Classification System Elements

<table>
<thead>
<tr>
<th>Elements</th>
<th>Disciplines Evaluating Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Management</td>
<td>Nursing</td>
</tr>
<tr>
<td>Bladder Management</td>
<td>Nursing</td>
</tr>
<tr>
<td>Skin Management</td>
<td>Nursing</td>
</tr>
<tr>
<td>Pain</td>
<td>Nursing</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Nursing</td>
</tr>
<tr>
<td>Safety</td>
<td>Nursing, Occ. Therapy, Phys. Therapy, Speech Therapy, Psychologist*</td>
</tr>
<tr>
<td>Orientation/Memory</td>
<td>Speech Therapy, Psychologist*</td>
</tr>
<tr>
<td>Auditory and/or Reading Comprehension</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Intelligibility</td>
<td>Speech Therapy, Occupational Therapy</td>
</tr>
<tr>
<td>Swallowing</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Eating</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Upper Limb Usage</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Bathing</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Grooming</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Dressing</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Transfers</td>
<td>Phys. Therapy, Occ. Therapy, Nursing</td>
</tr>
<tr>
<td>Lower Extremity Function</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Lower Extremity Sensation/Proprioception</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Bed Mobility</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Wheelchair Activities</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Ambulation</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Stairs</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Community Reintegration</td>
<td>Actual Community Training Program (ACT)</td>
</tr>
<tr>
<td>Leisure Activity Skills</td>
<td>ACT</td>
</tr>
<tr>
<td>Communication/Social Interaction</td>
<td>ACT</td>
</tr>
<tr>
<td>Activity Tolerance</td>
<td>ACT</td>
</tr>
<tr>
<td>Patient Understanding of Disability</td>
<td>Social Services</td>
</tr>
<tr>
<td>Family Understanding of Disability</td>
<td>Social Services</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>Social Services</td>
</tr>
<tr>
<td>Economic Situation</td>
<td>Social Services</td>
</tr>
<tr>
<td>Psychological Adjustment</td>
<td>Physician’s Services, Psychologist*</td>
</tr>
</tbody>
</table>

*Psychologist input occurs only on patients actively followed by the unit psychologist.
assistant. Table 2 shows which disciplines are involved in evaluating each element. If more than one discipline scores an element, the multiple scores are averaged to reach a final rating in that area.

Rater Satisfaction Questionnaire

A questionnaire was distributed to professional staff in February/March, 1992, to obtain some perspective on how they perceived the FCS:ver.2 before any revisions were begun. As a follow-up, the first half of that questionnaire was given to professional staff again in January, 1993, approximately four months after FCS:ver.3 was put into use, to look at changes in rater satisfaction with the system. The results of these surveys can be found in Table 3. It should be noted that the original questionnaire had five questions and only the results from four of these questions are reported. The set-up of the rating scale for question #4 was different than for the rating scales of the other questions making the results suspect. These results are preliminary in nature but beneficial in revealing an apparent improvement in rater satisfaction with FCS:ver.3 compared to FCS:ver.2. Eixenberger\textsuperscript{11} has more thoroughly worked on the statistical analysis of this information and other validity studies on the FCS:ver.3
Table 3.--Rater Satisfaction Questionnaire Results

1. Does the Functional Classification System currently being used give a good representation of the patient’s status?

(agree) 1.........2.........3.........4.........5 (disagree)

<table>
<thead>
<tr>
<th>Date</th>
<th>FCS:ver.2:</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/92</td>
<td>0 5 6 5 0</td>
<td>31.25% 37.5% 31.25%</td>
</tr>
<tr>
<td>1/93</td>
<td>3 12 1 0 0</td>
<td>18.75% 75.0% 6.25%</td>
</tr>
</tbody>
</table>

2. Does the Functional Classification System take a reasonable amount of time for the information it gives?

(agree) 1.........2.........3.........4.........5 (disagree)

<table>
<thead>
<tr>
<th>Date</th>
<th>FCS:ver.2:</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/92</td>
<td>1 8 6 1 9</td>
<td>6.25% 50.0% 37.5% 6.25%</td>
</tr>
<tr>
<td>1/93</td>
<td>2 12 2 0 0</td>
<td>12.5% 75.0% 12.5%</td>
</tr>
</tbody>
</table>

3. Is the Functional Classification System sensitive enough to reflect change in a patient’s status?

(agree) 1.........2.........3.........4.........5 (disagree)

<table>
<thead>
<tr>
<th>Date</th>
<th>FCS:ver.2:</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/92</td>
<td>2 6 3 5 0</td>
<td>12.5% 37.5% 18.75% 31.25%</td>
</tr>
<tr>
<td>1/93</td>
<td>4 9 3 0 0</td>
<td>25.0% 56.25% 18.75%</td>
</tr>
</tbody>
</table>

5. Does the Functional Classification System give a good representation of ability for all types of disabilities seen in our Rehab Unit?

(agree) 1.........2.........3.........4.........5 (disagree)

<table>
<thead>
<tr>
<th>Date</th>
<th>FCS:ver.2:</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/92</td>
<td>0 2 3 9 2</td>
<td>12.5% 18.75% 56.25% 12.5%</td>
</tr>
<tr>
<td>1/93</td>
<td>1 4 7 4 0</td>
<td>6.25% 25.0% 43.75% 25.0%</td>
</tr>
</tbody>
</table>
The goal of this project was to make the Functional Classification System a better functioning assessment tool. The preliminary results of the rater satisfaction questionnaire are positive and point to the attainment of this goal. It is suggested that the necessary characteristics of an assessment tool proposed in Chapter II be reviewed as another measure of success. The first characteristics dealt with sensitivity of the scale and question #3 of the rater survey shows an improvement in the professional staff's perception of sensitivity to change in functional status. Comprehensiveness in assessment of clients has also improved as shown in question #1 results to meet the second characteristics, a broad inventory of function. The third proposed characteristic, the use of a common scale in evaluating patients, was a major objective during rewriting of elements. It is now possible for a person with only basic knowledge of the rating definitions (see Table 1) to review a patient's scores and understand his/her general functioning level. This parallel nature of elements also increases ease of rating a person. A clinician need not read through every definition during scoring of a patient, but can go straight to a score of 5, for instance, if they know the patient is able to walk with minimum assistance. The parallel construction of elements, along with the rewriting of elements for better clarity, helps achieve characteristic number four—an easily understood system.
The fifth characteristic, use of the system in progress review, has not been extensively pursued because of the recent implementation of the FCS:ver.3.

As part of the follow-up questionnaire, clinicians were asked what disabilities were well assessed and which were not. Strokes were listed by 75% of the respondents as being well assessed by the scale. This is an encouraging result as 24% of the patients of St. Alexius’ Rehab Unit from 7/1/91 to 6/30/92 suffered strokes, our largest diagnostic group. Spinal cord injury was the disability most mentioned as poorly assessed (by 50% of the respondents). This was one of the Rehab Unit’s smallest diagnostic groups with 4% of the admissions during the same reference period as above.

There is great satisfaction in the results of this project. There has been a noticed improvement in the FCS which enhances the work done by St. Alexius’ Rehab Unit. There is further work to be done in establishing validity but with this groundwork completed, the ongoing validity studies will blend in well with current quality assurance and program review analyses. Another facet of the FCS that needs more work is an instruction section that would give clinicians unfamiliar with it a thorough overview of the system and how it is used within the context of St. Alexius Rehab Unit.
APPENDIX A
RATER SATISFACTION QUESTIONNAIRE

The following questionnaire is an attempt to ask you, the people who routinely use the FCS, what you think of the system. Please rate the following questions on a 1 to 5 scale with 1 being strongly agreeing and 5 being strongly disagreeing to the question asked.

1. Does the Functional Classification System currently being used give a good representation of the patient's status?
   (agree) 1 ........ 2 ........ 3 ........ 4 ........ 5 (disagree)

2. Does the Functional Classification System take a reasonable amount of time for the information it gives?
   (agree) 1 ........ 2 ........ 3 ........ 4 ........ 5 (disagree)

3. Is the Functional Classification System sensitive enough to reflect change in a patient's status?
   (agree) 1 ........ 2 ........ 3 ........ 4 ........ 5 (disagree)

4. Are each of the disciplines giving an equal input for the total score of the Functional Classification System?
   (lowest) 1 ........ 2 ........ 3 ........ 4 ........ 5 (highest)

5. Does the Functional Classification System give a good representation of ability for all types of disabilities seen in our Rehab Unit?
   (agree) 1 ........ 2 ........ 3 ........ 4 ........ 5 (disagree)

Please answer the following yes/no questions and give additional comments to clarify your answer.

1. Are there additional areas of assessment that should be added to the Functional Classification System? yes no
   If yes, state what areas need better representation:

2. Are there Functional Classification System assessment areas that should be removed from the scale? yes no
   If yes, tell us what you think should be removed:

3. Is there too much overlapping between disciplines in rating different areas of function? yes no
   If yes, tell us the areas where this could be eliminated:

4. What disabilities are best assessed by the Functional Classification System?

   What disabilities are not well assessed by the Functional Classification System?

5. Do you think that any rating definitions for your discipline need to be reworded? yes no
   If yes, please attach suggested revisions:
APPENDIX B
**BOWEL MANAGEMENT**

This includes not only continence but the ability to transfer and adequately clean oneself after a bowel movement.

**LEVEL**

9  **NO PROBLEM NOTED/NOT APPLICABLE:** This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  **MINIMAL (INDEPENDENT):** The person assessed has regular continent bowel movements and is also independent in transfers and hygiene.

7  **MILD (MOSTLY INDEPENDENT):** The person assessed has regular continent bowel movements using medications or treatments as needed, and is independent with transfers and/or hygiene with assistive devices.

   - If person assessed has colostomy, is able to do care of the colostomy independently.

6  **MILD-TO-MODERATE (MINIMUM ASSISTANCE):** The person assessed is aware of bowel movements but needs standby-by to minimum assistance with transfers and hygiene.

   - The person assessed needs set-up for colostomy cares.

5  **MODERATE (MINIMUM ASSISTANCE):** The person assessed is aware of bowel movements but may occasionally depend on nursing intervention for defecation or bowel continence is maintained by an established bowel program. Minimum assistance is needed for transfers and/or hygiene. Continence is maintained 75 to 90% of the time.

   - The person assessed needs verbal cueing for colostomy cares or bowel management program.

4  **MODERATE-TO-SEVERE (MODERATE ASSISTANCE):** The person assessed is inconsistent in awareness of bowel movement or in communication of awareness. Continence may be maintained by a toileting schedule. Moderate assistance may be needed for transfers and/or hygiene. The person assessed is continent 50-75% of the time.

   - Instruction in colostomy care or bowel management program has begun and person assessed needs constant assistance during cares but takes an active part in the process.

3  **SEVERE (MAXIMUM ASSISTANCE):** The person assessed is dependent upon nursing measures for bowel management but incontinence is becoming less frequent. The person assessed may occasionally communicate need to be toileted. Maximum assistance of one person is needed for transfers and/or hygiene. Continence is maintained 25-50% of the time. The use of continence garments is necessary.

2  **SEVERE-TO-PROFOUND (DEPENDENT):** The person assessed is totally dependent upon nursing measures for bowel management and/or frequent incontinence is experienced. When toileting, maximum assistance of two people or more people is needed for transfers and/or hygiene. Continence is maintained 5-25% of the time. The use of continence garments is necessary.

   - The person assessed is dependent on nursing staff for colostomy cares.

1  **PROFOUND (DEPENDENT):** The person assessed has complete bowel incontinence. Continence is maintained 0-5% of the time.

0  **UNABLE TO ASSESS:** To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
**BLADDER MANAGEMENT**

When scoring this element keep in mind that an individual need not meet all the criteria listed at a level. Because of the many different bladder management techniques possible, several different descriptions are given, find the section of a particular level that best describes the client being evaluated.

**LEVEL**

9 **NO PROBLEM NOTED/NOT APPLICABLE**: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 **MINIMAL (INDEPENDENT)**: The person assessed has consistent bladder continence without interventions. The person assessed is able to transfer, void and clean self after voiding without assistance, and is able to manage menstrual care independently.

7 **MILD (MOSTLY INDEPENDENT)**: Continence is maintained by a self-bladder management program (intermittent catheterization, crede, indwelling catheter or urinary diversion), and the person assessed is able to use equipment needed for bladder control independently, this includes set-up, application, removal and clean-up.

6 **MILD-TO-MODERATE (MINIMUM ASSISTANCE)**: The person assessed communicates need to void but needs minimum assistance with transfer and/or hygiene after voiding. The person assessed may need assistance with application of feminine hygiene materials. Continence is maintained 95% of the time.

5 **MODERATE (MINIMUM ASSISTANCE)**: The person assessed communicates need to void but may experience urgency, frequency or stress incontinence. Minimum assistance is needed for transfers and/or hygiene. Minimum assistance is also needed for feminine hygiene. Continence is maintained 75-90% of the time.

- The person assessed has good understanding of techniques needed for self-bladder care but still may need some verbal cueing.

4 **MODERATE-TO-SEVERE (MODERATE ASSISTANCE)**: The person assessed is inconsistent in awareness of need to void or in communicating need to void. Continence may be maintained by a toileting schedule. Moderate assistance may be needed for transfers and/or hygiene. The person assessed is continent 50-75% of the time. -Instruction in self bladder care has begun and person assessed needs constant supervision and assistance.

3 **SEVERE (MAXIMUM ASSISTANCE)**: The person assessed is dependent upon nursing measures for bladder management but incontinence is becoming less frequent. The person assessed may occasionally communicate need to void. Maximum assistance of one person is needed for transfers and/or hygiene and for feminine hygiene. Continence is maintained 25-50% of the time. The use of continence garments is necessary.

2 **SEVERE-TO-PROFOUND (DEPENDENT)**: The person assessed is dependent upon nursing measures for bladder management and/or frequent incontinence is experienced. When toileted maximum assistance of two people or more people is needed for transfer and/or hygiene. Continence is maintained 5-25% of the time.

- The person assessed depends on staff for intermittent catheterization program.

1 **PROFOUND (DEPENDENT)**: The person assessed has complete bladder incontinence or catheter is in place. Continence is maintained 0-5% of the time.

0 **UNABLE TO ASSESS**: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
SKIN MANAGEMENT

LEVEL
9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): Skin is intact and not reddened at pressure points. Surgical site is dry and intact.

7 MILD (MOSTLY INDEPENDENT): Skin is intact. Slight redness is present at surgical site. Redness occurs on pressure points but disappears within 20 to 30 minutes after pressure is relieved.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): Skin is intact, but is reddened at pressure points. Skin has no blisters or small breaks but may have dryness that requires attention.

5 MODERATE (MINIMUM ASSISTANCE): Slight surgical drainage may be present and requires a surgical dressing. Staples or sutures are intact at surgical site. Reddened areas don't blanch.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Skin breakdown is present but has no subcutaneous involvement. Moderate rash may be present. Moderate surgical drainage is present that requires a dressing. Skin has blisters and breaks (includes: skin tears, bruises, abrasions, etc.)

3 SEVERE (MAXIMUM ASSISTANCE): Skin breakdown is present and has subcutaneous tissue involvement, but skin breakdown has no muscle involvement. Staples or sutures are intact at surgical site, however, large amounts of drainage are present at site. A severe raw rash may be present on any body area.

2 SEVERE-TO-PROFOUND (DEPENDENT): Skin breakdown has muscle involvement, but breakdown has no bone involvement. Copious drainage or dehiscence of surgical site is present.

1 PROFOUND (DEPENDENT): Skin breakdown has bone involvement.

0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
LEVEL
9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.
8 MINIMAL (INDEPENDENT): The person assessed has no functional limitation as a result of pain and displays no pain behavior.
7 MILD (MOSTLY INDEPENDENT): The person assessed has no functional limitations as a result of pain or displays no pain behavior, control techniques may be used.
6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): Pain is reported as a concern by the person assessed but control techniques are independently, routinely and appropriately applied. The person assessed is able to pursue activities with some adjustments relative to demands.
5 MODERATE (MINIMUM ASSISTANCE): Pain is reported as a concern by the person assessed but is using control techniques with cueing - pursues many activities with some adjustments relative to demands.
4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Pain and/or pain behavior do not limit activities of daily living (ADLs); however, social and vocational activities may be limited.
3 SEVERE (MAXIMUM ASSISTANCE): Pain and/or pain behaviors at times compromise ADL's and limit social and vocational activities.
2 SEVERE-TO-PROFOUND (DEPENDENT): Pain and/or pain behaviors are severely compromising personal, social, and economic adjustment on a daily basis; may include constant use of narcotic drugs to control pain.
1 PROFOUND (DEPENDENT): The person assessed demonstrates excessive pain behaviors and/or is pre-occupied with pain to the extent that they are unable to focus on other issues.
0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen or when a necessary evaluation process has not been completed prior to coding the person assessed.
PROGRAM EDUCATION

When scoring this element, refer to the Patient/Family Education Check List for the areas to consider.

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: The person assessed shows and demonstrates complete understanding of deficits and in the management of all self-care activities on admission.

8 MINIMAL (INDEPENDENT): The person assessed understands deficits fully and can perform self-care activities independently.

7 MILD (MOSTLY INDEPENDENT): The person assessed understands deficits and can manage self-cares but requires assistive equipment.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed understands deficits and performs self-care activities but requires verbal cues, and may require standby supervision and/or set-up of equipment.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed understands deficits and performs self-cares skills but requires minimal physical assistance to complete tasks.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed understands deficits and is performing self-care skills but requires moderate physical assistance to complete the tasks.

3 SEVERE (MAXIMUM ASSISTANCE): The person assessed is beginning to understand deficits and is willing to perform one task in self-care management of condition with maximum assistance.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is showing interest in management of self-care and in what is being taught.

1 PROFOUND (DEPENDENT): The person assessed does not perform any self-care tasks and shows no interest in learning or person assessed is not able to comprehend instruction at this time.

0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
SAFETY

An index of person assessed's ability to safely be alone.

LEVEL

9  NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  MINIMAL (INDEPENDENT): Some slight deficits in cognition/judgment may be noted, but person assessed is safe in home environment, including higher level skills (i.e. cooking). Minor errors in judgment and impulsivity have no social consequences or impact on safety.

7  MILD (MOSTLY INDEPENDENT): The person assessed is safe at home during basic ADL activities, but needs supervision for higher level skills (e.g. bathing, cooking, etc.), but person assessed has good understanding of limitations and will not attempt higher level skills without assist. At this level person assessed could be left unattended for long periods of time.

6  MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed at this level would need supervision for basic skills (e.g., toileting, dressing, mobility). The person assessed has enough awareness of situation to be left alone for short periods of time (up to one hour) if positioned comfortably in bed, chair, etc.

5  MODERATE (MINIMUM ASSISTANCE): The person assessed may need just occasional cueing for safety, but awareness of condition is such that person assessed cannot be left alone unsupervised.

4  MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed requires frequent supervision and redirection. The person assessed, at this level, however accepts supervision readily without much resistance.

3  SEVERE (MAXIMUM ASSISTANCE): The person assessed requires constant supervision and may need some physical redirection with resistance to supervision or limitations sometimes noted. Physical restraints may be needed for short periods.

2  SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is very impulsive, often needs physical redirection and may often be resistive to limitations. Thus, person assessed may have to be restrained at most times.

1  PROFOUND (DEPENDENT): At this level, alertness is decreased such that restraint is not needed. In future as alertness increases suspect that higher level of supervision may be needed.

0  UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
ORIENTATION/MEMORY

The ability to store, process and retrieve information, serving as an index of an individual's ability to effectively cope with his/her environment. Ascending order for measurement of orientation is person, location and time (day and date).

LEVEL

9  NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  MINIMAL (INDEPENDENT): The person assessed is oriented times three with environmental (calendar, clock, etc.) cueing. Their processing rate may remain somewhat slow. Shows carryover and does not require supervision.

7  MILD (MOSTLY INDEPENDENT): The person assessed is oriented times three with environmental cues or cueing. Their processing rate remains slow relative to length, complexity, and rate of presentation. Shows carryover but may periodically experience problems retrieving information. Does not require supervision.

6  MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed is oriented times three with maximum cueing. Their processing rate remains slow relative to length, complexity and rate of presentation. Shows carryover but requires supervision.

5  MODERATE (MINIMUM ASSISTANCE): The person assessed is oriented times two with cueing. Their processing rate is slow relative to length, complexity, and rate of presentation. Shows carryover but needs reminders. May require supervision.

4  MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is oriented times two with maximum cueing. Their processing rate is slow relative to length, complexity and rate of presentation. Fails to show carryover even with reminders. Requires supervision.

3  SEVERE (MAXIMUM ASSISTANCE): The person assessed is oriented times one with cueing. Processes information about self and immediate environment but fails to show carryover. Requires supervision.

2  SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is oriented times one with maximum cueing. Processes information about self but fails to show carryover. Requires supervision.

1  PROFOUND (DEPENDENT): Unable to assess because person assessed cannot respond.

0  UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
AUDITORY AND/OR READING COMPREHENSION

The ability to understand input either by listening to or reading the information.

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is to be used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): Person assessed comprehends abstract and complex paragraph length material with 80% accuracy, given the ability to examine the written material.

7 MILD (MOSTLY INDEPENDENT): The person assessed follows three-step verbal or written directions with 80% accuracy.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed follows two-step verbal or written directions with 80% accuracy given minimal cues.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed follows one-step verbal or written directions and responds to concrete "yes/no" questions with 50-80% accuracy given cues.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed follows one-step verbal or written directions and responds to concrete "yes/no" questions with <50% given maximum cues.

3 SEVERE (MAXIMUM ASSISTANCE): The person assessed follows whole body commands and responds to personally relevant "yes/no" questions in verbal or written form with 50-80% accuracy given cues.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed follows whole body commands and responds to personally relevant "yes/no" questions in verbal or written form with <50% accuracy given maximum cueing.

1 PROFOUND (DEPENDENT): Unable to follow whole body commands even with maximum cueing.

0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
VERBAL AND/OR WRITTEN EXPRESSION

The individual's ability to express themselves either in verbal or written form.

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that the person assessed is functioning with normal limits in this area.

8 MINIMAL (INDEPENDENT): Communicates at a conversation level in verbal or written form. Hesitation may be noted with abstract material. May require environmental cues.

7 MILD (MOSTLY INDEPENDENT): Imitates or produces sentences in verbal or written form. Hesitations may be noted. Aware of errors and able to self-correct given environmental cues.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): Imitates or produces phrases or short sentences in verbal or written form. Hesitations may be noted. Aware of errors and able to self-correct given minimal cues.

5 MODERATE (MINIMUM ASSISTANCE): Imitates or produces phrases in verbal or written form. Word finding difficulty noted. Responds to concrete tasks. Aware of errors but unable to self-correct even given cues.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Imitates or produces word-to-phrase length material in verbal or written form. Word finding difficulty. Aware of errors, but unable to self-correct even given maximum cues.

3 SEVERE (MAXIMUM ASSISTANCE): Imitates or produces words in verbal or written form. Jargon may be prevalent. Unaware of errors and unable to self-correct even with cues.

2 SEVERE-TO-PROFOUND (DEPENDENT): Imitates or produces oral movements and words in verbal or written form. Automatic speech may be noted. Jargon prevalent. Unaware of errors and unable to self-correct even with maximum cues.

1 PROFOUND (DEPENDENT): Unable to imitate or produce oral movements. Jargon prevalent. No meaningful verbal output even with maximum cues.

0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
INTELLIGIBILITY

The level at which an individual's speech can be understood by a listener.

LEVEL

9  NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  MINIMAL (INDEPENDENT): The person assessed is 90-100% intelligible in conversation when the topic is unknown. Articulation is intelligible and production fluent.

7  MILD (MOSTLY INDEPENDENT): The person assessed is 80-90% intelligible with the topic unknown. Imitates or produces sentence length material. Articulation is intelligible and production primarily fluent.

6  MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed is 70-80% intelligible with the topic unknown. Imitates or produces phrase-to-short sentence length material. Articulation is intelligible and production primarily fluent.

5  MODERATE (MINIMUM ASSISTANCE): The person assessed is 60-70% intelligible with the topic known. Imitates or produces phrase length material. Articulation is intelligible and production primarily dysfluent but closely approximates the target.

4  MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is 45-60% intelligible with the topic known. Imitates or produces word-to-phrase length material. Articulation is unintelligible and production primarily dysfluent.

3  SEVERE (MAXIMUM ASSISTANCE): The person assessed is 30-45% intelligible with the topic known. Imitates or produces words. Articulation is unintelligible and production dysfluent but closely approximates the target.

2  SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is 15-30% intelligible with the topic known. Imitates or produces oral movements and words. Articulation is unintelligible and production dysfluent.

1  PROFOUND (DEPENDENT): The person assessed is 0-15% intelligible, and unable to imitate or produce oral movements. Articulation is unintelligible, production non-productive and rarely approximates the target.

0  UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
SWALLOWING

The ability to chew, manipulate and swallow different types of food consistencies. Results of swallow study, oral intake and dietary consistency might also be considered.

LEVEL

9  NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  MINIMAL (INDEPENDENT): Very slight deficits in chewing or swallowing, but person assessed able to drink and eat normal food consistencies with adequate oral intake.

7  MILD (MOSTLY INDEPENDENT): Mild deficit noted, requiring some dietary modification, but person assessed has good understanding of limitations and oral intake is adequate.

6  MILD-TO-MODERATE (STAND-BY ASSISTANCE): Person assessed has mild swallowing/feeding deficit and person assessed needs some prompting for safety in swallowing.

5  MODERATE (MINIMUM ASSISTANCE): The person assessed has mild to moderate swallowing problems and is learning swallowing techniques such that occasional supervision and cueing are needed.

4  MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed has mild to moderate swallowing problems, but needs frequent supervision to learn new techniques and for safety.

3  SEVERE (MAXIMUM ASSISTANCE): The person assessed has moderate to severe swallowing problems. The person assessed takes some food orally under direct supervision, may need supplemental feedings.

2  SEVERE-TO-PROFOUND (DEPENDENT): The person assessed has severe swallowing problems. The person assessed being tube fed, but some oral stimulation being started as part of therapy session only.

1  PROFOUND (DEPENDENT): The person assessed's alertness/swallowing is unsafe for oral feedings and is thus not to be fed orally (NPO) or tube fed.

0  UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
EATING

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): The person assessed is independent in all eating activities without adaptive devices.

7 MILD (MOSTLY INDEPENDENT): The person assessed is independent in eating with assistive devices and is independent in applying and using those devices.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed can complete all eating activities with cueing and/or set-up. This may include cues to use an assistive device, compensate for field cut, and/or neglects or pocketing.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed needs minimal physical assist (other than with cueing) to complete meal.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed can actively participate in eating, but requires moderate physical assistance which may include cueing. Increased assistance may be needed at end of meal due to fatigue.

3 SEVERE (MAXIMUM ASSISTANCE): The person assessed participates throughout the entire meal, but requires constant maximal physical assistance and/or constant cueing throughout the meal.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is able to initiate eating activities, but is unable to sustain more than three or four attempts due to physical or cognitive deficits.

1 PROFOUND (DEPENDENT): The person assessed is unable to perform any part of activity. At this level, person assessed is getting supplemental feedings.

0 UNABLE TO ASSESS: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
## Upper Limb Usage

Functional usage of the extremity is the primary consideration in assignment of a level. Use of an adaptive device is permissible to achieve these levels. In this scale, 50% of normal is considered a fair grade muscle. Score refers to most involved arm.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>No Problem Noted/Not Applicable: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.</td>
</tr>
<tr>
<td>8</td>
<td>Minimal (Independent): Extremity is utilized normally in all functional activities. Extremity has normal ROM, strength and coordination.</td>
</tr>
<tr>
<td>7</td>
<td>Mild (Mostly Independent): Full functional use is only slightly limited and/or slight deficits in strength, ROM or coordination are noted.</td>
</tr>
<tr>
<td>6</td>
<td>Mild-to-Moderate (Minimum Assistance): The person assessed utilizes the extremity for 50-75% of the task and/or extremity has 50-75% of normal strength, ROM or coordination, or arthritic/orthopedic involvement mildly affects function (e.g., person assessed has difficulty with dressing due to shoulder/hand involvement but can complete independently, although with difficulty.)</td>
</tr>
<tr>
<td>5</td>
<td>Moderate (Minimum Assistance): The person assessed utilizes the extremity in gross motor activities. The person assessed utilizes the extremity for 25-50% of the task and/or the extremity has 25-50% of normal strength, ROM or coordination, or arthritic/orthopedic involvement moderately affects function (e.g., involvement limits independence in some areas, although independence may be achieved with adaptive equipment.)</td>
</tr>
<tr>
<td>4</td>
<td>Moderate-to-Severe (Moderate Assistance): The person assessed utilizes the extremity for 25% or less of the task and/or extremity has 25% or less of normal strength, ROM or coordination, or arthritic/orthopedic involvement severely affects function (e.g., involvement limits independence in many areas.)</td>
</tr>
<tr>
<td>3</td>
<td>Severe (Maximum Assistance): The extremity is used as a stabilizer spontaneously.</td>
</tr>
<tr>
<td>2</td>
<td>Severe-to-Profound (Dependent): The extremity may be used as a stabilizer if prompted.</td>
</tr>
<tr>
<td>1</td>
<td>Profound (Dependent): The extremity is completely non-functional.</td>
</tr>
<tr>
<td>0</td>
<td>Unable to Assess: To be used when a person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.</td>
</tr>
</tbody>
</table>
**BATHING**

To include person assessed's ability to transfer in/out of shower/bath and ability to stand, stoop, etc. during activity. Also to include person assessed's ability to clean oneself during bath/shower.

### LEVEL

**9 NO PROBLEM NOTED/NOT APPLICABLE:** This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

**8 MINIMAL (INDEPENDENT):** Able to transfer and bathe independently. The person assessed able to set self up independently.

**7 MILD (MOSTLY INDEPENDENT):** The person assessed is independent with transfers and bathing using adaptive equipment.

**6 MILD-TO-MODERATE (MINIMUM ASSISTANCE):** The person assessed only needs standby assist for transfer and/or needs set-up or slight cueing to bathe safely or completely.

**5 MODERATE (MINIMUM ASSISTANCE):** The person assessed needs some minimal physical assist in transfer and/or minimal assist for bathing (e.g., may need assist to wash feet, back or uninvolved U/E). May need occasional cueing to maintain balance or wash completely.

**4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE):** The person assessed needs moderate assist for transfer and/or needs constant cueing, and/or frequent minimal assist to bathe safely and completely.

**3 SEVERE (MAXIMUM ASSISTANCE):** The person assessed needs maximal assist for transfer and/or needs some moderate assist to bathe safely and completely.

**2 SEVERE-TO-PROFOUND (DEPENDENT):** The person assessed must use wheeled shower chair due to safety concerns and needs maximum assist to transfer onto shower chair. Person assessed needs maximum assist throughout to bathe safely and completely and/or person assessed can assist some in bed bath.

**1 PROFOUND (DEPENDENT):** The person assessed appropriate only for bed bathing due to safety concerns. The person assessed does not assist with bed bathing.

**0 UNABLE TO ASSESS:** To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
GROOMING

To include the person assessed’s ability to wash face and hands, clean teeth, comb hair and shave.

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): The person assessed performs all grooming activities independently without assistive devices.

7 MILD (MOSTLY INDEPENDENT): The person assessed is able to complete all activities with assistive devices, but is able to use assistive devices independently.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed is able to complete all the activities with set-up and very minimal cueing to complete task. No physical assist needed.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed requires occasional verbal cueing and/or very minimal physical assist to complete.

4 MODERATE-TO-SEVERE (MEDIUM ASSISTANCE): Frequent verbal cueing and/or moderate physical assist needed to complete tasks.

3 SEVERE (MAXIMUM ASSISTANCE): Maximal physical assist needed to complete.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed attempts grooming tasks, but is unable to complete any of the activities. May need hand over hand guidance.

1 PROFOUND (DEPENDENT): The person assessed is dependent for all grooming activities.

0 UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
DRESSING

To include donning and doffing all the usual and customary articles of clothing (including braces, splints, etc. but excluding TEDS hose.)

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): The person assessed performs the dressing activity independently without assistive devices.

7 MILD (MOSTLY INDEPENDENT): The person assessed performs the dressing activity independently with assistive devices.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed can complete all dressing activities with occasional cues, set-up, and/or occasional physical assist. Assistance is primarily needed with fasteners or donning/doffing one item.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed can complete dressing activities, but minimal physical assistance is needed throughout the task.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is able to independently complete one-half of all dressing, including upper extremities, lower extremities, or a combination of both.

3 Severe (MAXIMUM ASSISTANCE): The person assessed is learning dressing skills and may be able to start an item but requires another person to complete the activity. The person assessed needs direct assist throughout to complete tasks.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed assists with dressing (rolling, lifting-limbs) but is unable to complete any part of the activity.

1 PROFOUND (DEPENDENT): The person assessed is unable to perform any part of the activity.

0 UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
MEAL PREPARATION

To include an estimate of the person assessed's ability to perform usual and customary duties of meal preparation (e.g., organization of cooking area, transport of items to table, actual cooking, and safe operation of appliances, clean-up and meal planning.)

LEVEL

9 NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8 MINIMAL (INDEPENDENT): The person assessed is independent with all customary roles and functions in light homemaking activities.

7 MILD (MOSTLY INDEPENDENT): The person assessed is independent in light cooking tasks but requires assistance with meal planning and/or may need assistive devices to achieve independence.

6 MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed performs preparation and clean-up of simple meal with set-up only. This includes persons receiving Meals-on-Wheels.

5 MODERATE (MINIMUM ASSISTANCE): The person assessed performs preparation and clean-up of simple meals and other light homemaking tasks with verbal/standby supervision.

4 MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed performs preparation and clean-up of simple meals with occasional physical assistance (e.g., due to deficits in balance, coordination, endurance.)

3 SEVERE (MAXIMUM ASSISTANCE): Person assessed is participating in light meal preparation tasks but requires direct, constant, physical assist to complete a task.

2 SEVERE-TO-PROFOUND (DEPENDENT): The person assessed has potential for participation in meal preparation tasks, however, it is not appropriate to formally assess at this time (e.g., due to contradiction in regards to individual precautions: orthopedic, ambulatory).

1 PROFOUND (DEPENDENT): The person assessed is unable to perform any meal preparation tasks due to significant physical and/or cognitive deficits.

0 UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
TRANSFERS

This includes mat, bed, chair and car transfers, but not transfers into and out of the bath/shower. Score in each discipline should refer to the most difficult transfer situation for person assessed.

LEVEL

9  NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

8  MINIMAL (INDEPENDENT): The person assessed is able to perform transfer activities independently without assistive devices.

7  MILD (MOSTLY INDEPENDENT): The person assessed is able to perform transfer activities independently with assistive devices.

6  MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed requires only verbal or standby assistance for transfer activity. For example, the person assessed needs someone present during performance of the activity because of fatigue, occasional loss of balance or other factors may at times make independent transfer unsafe. This may or may not include the use of assistive devices.

5  MODERATE (MINIMUM ASSISTANCE): The person assessed requires minimal physical assistance of one person for transfer activity. For example, the person assessed may need physical assistance for positioning of legs, footrests or adaptive devices, etc.

4  MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed needs a moderate amount of assistance by one other person. For example, physical effort must be exerted by the assisting person, but the person assessed can effectively assist in the transfer activity.

3  SEVERE (MAXIMUM ASSISTANCE): The person assessed, while participating in the activity, needs the maximum assistance of one or two persons in transfers. For example, the assisting person can transfer the person assessed alone, but needs to be physically turned for pivoting, may require significant effort by the assisting person to come in a sitting or standing position, or may have to lean on assisting person; if balance is lost, it cannot be regained due to weakness or poor equilibrium.

2  SEVERE-TO-PROFOUND (DEPENDENT): The person assessed participates in the activity, but continues to require the assistance of two or more persons to complete a transfer.

1  PROFOUND (DEPENDENT): The person assessed does not perform any part of transfer activity and requires assistance of two or more persons to complete a transfer. Use of a mechanical lifting device may be required.

0  UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
**LOWER EXTREMITY FUNCTION**

Functional usage of the involved lower extremity is the primary consideration in assignment of a level. Use of an adaptive device is permissible to achieve these levels. In this scale, 50% of normal is considered a fair grade muscle. Score given refers to the more involved lower extremity. Weight-bearing for purposes of assessment refers to the ability of person assessed to support their weight, not orthopedic restrictions due to surgery and/or injury.

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.</td>
</tr>
<tr>
<td>8</td>
<td>MINIMAL (INDEPENDENT): The involved lower extremity is utilized normally in all functional activities. The involved lower extremity has normal ROM, strength and coordination.</td>
</tr>
<tr>
<td>7</td>
<td>MILD (MOSTLY INDEPENDENT): Full functional use is only slightly limited and/or the involved lower extremity has slight deficits in strength, ROM or coordination.</td>
</tr>
<tr>
<td>6</td>
<td>MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed utilizes the involved lower extremity to support full weight and/or the lower extremity has 50-75% of normal strength, ROM and coordination.</td>
</tr>
<tr>
<td>5</td>
<td>MODERATE (MINIMUM ASSISTANCE): The person assessed utilizes the involved lower extremity to support 25-50% of weight or extremity has 25-50% of normal strength, ROM and coordination.</td>
</tr>
<tr>
<td>4</td>
<td>MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed utilizes the involved lower extremity of 25% or less of weight supporting and/or the involved lower extremity has 25% or less of normal strength, ROM and coordination.</td>
</tr>
<tr>
<td>3</td>
<td>SEVERE (MAXIMUM ASSISTANCE): The involved lower extremity can be used as a mini-assist with prompting or facilitation and can maintain weight bearing after set-up. Has 10% or less of normal strength, ROM and coordination.</td>
</tr>
<tr>
<td>2</td>
<td>SEVERE-TO-PROFOUND (DEPENDENT): The involved lower extremity can be used as a mini-assist, i.e. for balance, if continuously assisted and/or has 10% of less of normal strength, ROM and/or coordination.</td>
</tr>
<tr>
<td>1</td>
<td>PROFOUND (DEPENDENT): The involved lower extremity is completely non-functional. The involved lower extremity has no voluntary movement, and cannot accept weight without assistance.</td>
</tr>
<tr>
<td>0</td>
<td>UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.</td>
</tr>
</tbody>
</table>
LOWER EXTREMITY SENSATION/PROPRIOCEPTION

terpretation of superficial pain, proprioception and light touch will be assessed to
terminate assignment of level.

VEL

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a
person assessed is functioning within normal limits in this area. The involved
extremities have normal sensation of superficial pain, light touch and proprioception.

MINIMAL (INDEPENDENT): Testing shows person assessed has intact sensation and
proprioception in both lower extremities.

MILD (MOSTLY INDEPENDENT): The person assessed may have mild impairment in sensation
and/or proprioception but is able to compensate and function normally.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed has deficits in sensation
and/or proprioception which minimally impair person assessed's functional activity. May
require occasional verbal cueing to attend to involved extremities.
-The person assessed has profound loss of proprioception and sensation but is able to
compensate with good skills for protecting deficit limb(s) and general position
awareness.

MODERATE (MINIMUM ASSISTANCE): The person assessed has impairment in sensation and/or
proprioception which moderately affects person assessed's functional activity. Frequent
verbal cueing is required to attend to involved extremities.
-The person assessed has profound loss of proprioception and sensation and is aware of
skills necessary to protect deficit limb(s) and spontaneously demonstrates these skills
75% of the time.

MODERATE-TO-SEVERE (MANYERATE ASSISTANCE): The person assessed has impairment in
sensation and/or proprioception which moderately affects person assessed's functional
activity. Verbal and physical cues are required to attend to involved extremities.
-The person assessed has profound loss of proprioception and sensation and is beginning
to learn compensatory techniques to protect the limb(s) and spontaneously demonstrates
these skills 50% of the time.

SEVERE (MAXIMUM ASSISTANCE): The person assessed has impairment in sensation and/or
proprioception which maximally affects functional activity. The person assessed requires
constant verbal and physical cues to attend to involved extremities.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed's sensation and/or proprioception
is functionally absent. Does not express denial of involved extremities.

PROFOUND (DEPENDENT): The person assessed's sensation and/or proprioception is
functionally absent and person assessed displays denial of involved extremities.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred
or dies before being seen, or when a necessary evaluation process has not been completed
prior to coding the person assessed.
BED MOBILITY

Inctional bed mobility is the primary consideration in assignment of a level.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area. This includes rolling, bridging, scooting supine, and moving supine to sitting to supine.

MINIMAL (INDEPENDENT): The person assessed is able to perform bed mobility skills independently without use of side rails.

MILD (MOSTLY INDEPENDENT): The person assessed is able to perform bed mobility skills independently with use of side rails.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed requires only verbal or standby assistance for rolling, bridging, scooting supine and moving supine to and from sitting.

MODERATE (MINIMUM ASSISTANCE): The person assessed requires minimal assistance of one person for bed mobility skills (e.g., may need physical assistance for positioning of legs or for initiation of movement).

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed needs a moderate amount of assistance of one person (e.g., physical effort must be exerted in assistance, but the person assessed is able to effectively assist in the activity of rolling, scooting supine, bridging, and moving supine to and from sitting).

SEVERE (MAXIMUM ASSISTANCE): The person assessed, while participating in the activity, needs maximum assistance of one person in bed mobility skills (e.g., the assisting person must physically turn the person assessed for rolling, physically move person assessed during supine scooting or physically assist in bridging, or assist at trunk and lower extremities when moving supine to sitting).

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed participates in the activity, but requires maximum assistance of two people to complete all bed mobility.

PROFOUND (DEPENDENT): The person assessed is not capable of assisting or participating in bed mobility skills.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
WHEELCHAIR ACTIVITIES

fers to the person assessed's ability to propel the chair, perform chair adjustment (e.g., not rest, arm rest, application of breaks, etc.) and position self, and will apply only to individuals projected to be wheelchair users for a significant amount of time at discharge.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area or person assessed is expected to be functional ambulator at discharge.

MINIMAL (INDEPENDENT): The person assessed is independent in all wheelchair activities, and is able to perform self-positioning, wheelchair adjustments and negotiation of architectural barriers including curbs, or has achieved functional ambulation status.

MILD (MOSTLY INDEPENDENT): The person assessed is independent in the majority of wheelchair activities including self-positioning and wheelchair adjustment, but requires assistance for more difficult tasks such as negotiating curbs and high degrees of incline. This may also apply to the person assessed who is a functional ambulator but might, because of poor endurance, use the wheelchair when out in the community.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed functionally propels wheelchair over 1000 feet, including uneven terrains and a five degree incline. Requires assistance with wheelies, curbs and architectural barriers.

MODERATE (MINIMUM ASSISTANCE): The person assessed functionally propels wheelchair over 300 feet.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed functionally propels wheelchair between 150-300 feet.

SEVERE (MAXIMUM ASSISTANCE): The person assessed functionally propels the wheelchair short distances. Assistance may be required for wheelchair adjustments and self-positioning.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed propels the wheelchair, but not in a functional manner. The person assessed may require assistance for wheelchair adjustments and self-positioning.

PROFOUND (DEPENDENT): The person assessed does not perform any wheelchair activity (self-positioning, wheelchair adjustment or propulsion).

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
AMBULATION

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed is capable of independent ambulation for functional distances* without assistive devices, but may have a disturbed gait pattern that is not functionally limiting.

MILD (MOSTLY INDEPENDENT): The person assessed is capable of independent ambulation for functional distances* with assistive devices, or displays a moderate to major gait pattern abnormality.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed requires only verbal or standby assist for ambulation with or without an assistive device. (e.g. the individual needs someone present during ambulation because of fatigue, occasional loss of balance, or other factors which made independent gait unsafe.)

MODERATE (MINIMUM ASSISTANCE): The person assessed is capable of ambulation with or without assistive devices with minimal physical assistance of one person, or lacks endurance for functional distances.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is capable of ambulating with or without assistive devices with moderate assistance of one person.

SEVERE (MAXIMUM ASSISTANCE): The person assessed, while participating in the activity, requires maximum assist of one to two people for balance, bracing or advancing of one or both lower extremities. This may or may not include the use of the parallel bars or assistive device.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is capable of standing only with the assistance of one or more people and/or bracing one or both lower extremities and/or assistive devices.

PROFOUND (DEPENDENT): The person assessed is not capable of any mode of ambulation (may be able to tolerate tilt table).

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.

Functional distance is distance to meet activities of daily living (ADLs), recreational, and social needs.
STAIRS

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed is able to ascend or descend stairs a functional distance without a handrail and without an assistive device.

MILD (MOSTLY INDEPENDENT): The person assessed is able to ascend or descend stairs a functional distance with handrail and/or with an assistive device.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): Needs only verbal cues or standby guarding for assist to ascend and descend stairs with a handrail with or without an assistive device. The person assessed may require verbal cues for advancement and placement of assistive device and/or lower extremities.

MODERATE (MINIMUM ASSISTANCE): The person assessed is able to ascend and descend stairs a functional distance with minimum assistance of one person and handrail (with or without assistive device) may continue to need minimum assistance and/or verbal guidance for advancement and placement of assistive device on lower extremities.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is able to ascend and descend stairs a functional distance with moderate assistance of one person and handrail with or without assistive device (requires constant help to advance assistive device or place it properly).

SEVERE (MAXIMUM ASSISTANCE): The person assessed is able to ascend and descend stairs a functional distance with moderate assistance of two people and handrail with or without assistive device. Needs moderate assistance with positioning of assistive device, and/or lower extremities.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is able to ascend and descend stairs a functional distance with the maximal assistance of two people and handrail with or without assistive device. Needs maximal assist with positioning assistive device.

PROFOUND (DEPENDENT): The person assessed is not capable of ascending and descend stairs functional distances or any form of stair climbing.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
COMMUNITY REINTEGRATION

The functional ability to perform in the community, focusing on environmental and physical factors to include car transfers and mobility (either wheelchair or ambulation). The functional level is based on the most limiting factor, not all factors listed.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area. Able to independently function in all factors of the community on admission.

MINIMAL (INDEPENDENT): The person assessed is independent without supervision within a community setting, including unfamiliar situations.

MILD (MOSTLY INDEPENDENT): The person assessed responds independently to environmental and physical situations, but requires extra time, equipment or other compensatory techniques for performance in the community.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed responds to environmental and physical factors with only verbal cueing. The person assessed may require verbal cueing for proper use of adaptive equipment.

MODERATE (MINIMUM ASSISTANCE): The person assessed responds to the environmental and physical factors with minimal physical assistance. Minimal assistance of one person or maximal verbal cues are required for proper utilization of adaptive equipment.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed responds to the environmental and physical factors with a moderate amount of assistance of one person. For example, physical effort must be exerted by the assisting person, but the person assessed can effectively assist in the transfer or mobility activity.

SEVERE (MAXIMUM ASSISTANCE): The person assessed responds to the environmental and physical factors by participating in the activity with the maximal assistance of one or two people.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed makes attempts to respond to environmental and physical factors, but continues to require the assistance of two or more people. The person assessed will require a wheelchair lift for transportation.

PROFOUND (DEPENDENT): No attempts to respond to environmental and physical factors after constant verbal and physical assist. The person assessed is not medically stable for community outing.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
LEISURE ACTIVITY SKILLS

This element assesses the functional ability of leisure activity skills; identifying, planning, and following through with leisure lifestyle.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed selects a leisure activity of interest and initiates involvement in that activity, independently utilizing leisure problem-solving techniques. The person assessed makes independent decisions about a leisure lifestyle, with demonstrated cognitive awareness of personal values and the benefits of leisure.

MILD (MOSTLY INDEPENDENT): The person assessed selects a leisure activity of interest and initiates involvement in that activity, independently utilizing leisure problem-solving techniques. The person assessed makes independent decisions about a leisure lifestyle, with demonstrated cognitive awareness of personal values and benefits of leisure. The person assessed may need assistive devices to participate in leisure activities.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed spontaneously elaborates on their own leisure history, demonstrating the ability to make decisions. The person assessed is able to select an activity of interest, requires verbal cueing times one to become involved in activity. The person assessed attempts to identify personal leisure values and benefits.

MODERATE (MINIMUM ASSISTANCE): The person assessed is beginning to elaborate on their own leisure history after prompting/questioning, and selects an activity of interest from those presented, and on occasion demonstrates the ability to problem solve in his/her leisure.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is able to verbalize/identify leisure interests after leisure activity list is presented, and will select an activity of interest after activity choices are presented. The person assessed is able to engage in a chosen activity with verbal cues. The person assessed is beginning to verbalize/demonstrate problem-solving techniques after assist from therapist.

SEVERE (MAXIMUM ASSISTANCE): The person assessed is able to identify leisure interests (responds with yes and no gestures), after leisure activity list is presented and engages in leisure activity chosen by therapist when verbal cues and hands-on assist is given.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is unable to identify leisure interests, after assistance, but does make attempts to participate in leisure activities when continual assistance is given (verbal cues and hands on assist).

PROFOUND (DEPENDENT): The person assessed is comatose/semicomatose and/or unresponsive.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
COMMUNICATION/SOCIAL INTERACTION

This includes skills related to communication and participating with others in therapeutic (structured) and social (unstructured) situations. This represents how one deals with personal needs together with the needs of others.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area. The person assessed is able to initiate communication/social interaction appropriately with staff, other persons assessed, and family members.

MINIMAL (INDEPENDENT): Although initial deficits have been noted, the person assessed spontaneously initiates appropriate communication with staff, other persons assessed and family members after therapeutic intervention has been initiated.

MILD (MOSTLY INDEPENDENT): The person assessed interacts appropriately with staff, other persons assessed, and family members in social situations. The person assessed may take more than a reasonable time to adjust to a situation.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed requires supervision (e.g., monitoring, verbal cues, or coaxing), only under stressful or unfamiliar conditions.

MODERATE (MINIMUM ASSISTANCE): The person assessed interacts appropriately with staff, other persons assessed and family members in structured situations or modified environments.

MODERATE-TO-SEVERE (MEDIUM ASSISTANCE): The person assessed interacts appropriately with staff, other persons assessed and family members in structured situations or modified environments. The person assessed may take more than a reasonable time to adjust in the given situation.

SEVERE (MAXIMUM ASSISTANCE): The person assessed initiates communication in a structured setting, but requires frequent verbal cues to interact appropriately.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed makes attempts to communicate in a structured setting, after constant verbal cues and coaxing, but is unable to communicate needs effectively.

PROFOUND (DEPENDENT): The person assessed makes no attempts to communicate to staff, other persons assessed and family members, after constant verbal cues and coaxing.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
ACTIVITY TOLERANCE

The ability to independently remain active in leisure activity and endure every activity, assigned or self-initiated, after participating in a minimum of two other therapy sessions.

LEVEL

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area, and is independently able to remain actively involved for the duration of a selected activity.

MINIMAL (INDEPENDENT): The person assessed has achieved full function in this area after therapeutic intervention, and is able to endure and attend to every activity assigned or self-initiated.

MILD (MOSTLY INDEPENDENT): The person assessed is able to sustain 60 minutes of leisure activity, attends to activity independently, but fatigue may occasionally be a limiting factor.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed is able to sustain 45 minutes of leisure activity, with fatigue possibly limiting an activity.

MODERATE (MINIMUM ASSISTANCE): The person assessed is able to sustain 31 to 44 minutes of leisure activity, with fatigue being a limiting factor.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed is able to sustain 16 to 30 minutes of leisure activity, with fatigue being a limiting factor.

SEVERE (MAXIMUM ASSISTANCE): The person assessed is able to 11 to 15 minutes of leisure activity, with fatigue being a limiting factor.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is able to 1 to 10 minutes of leisure activity, with constant verbal cues and hands-on assist to attend/concentrate to leisure activity.

PROFOUND (DEPENDENT): The person assessed is comatose or semicomatose and/or unresponsive, and makes no attempts to follow instruction.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
UNDERSTANDING OF DISABILITY

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed can express understanding of his/her current situation, changes imposed by the situation, and has realistic expectations for short and long term goals.

MILD (MOSTLY INDEPENDENT):

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed can verbalize fairly realistic expectations for short term goals and start to follow through with discharge plans.

MODERATE (MINIMUM ASSISTANCE): The person assessed starts to express verbal understanding of his/her current limitations by making appropriate statements and asking pertinent questions to seek more information.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed can begin to identify current limitations and what that means to them practically. He/She continues to hold onto the belief that the disability is just temporary and things will return to "normal".

SEVERE (MAXIMUM ASSISTANCE): The person assessed denies current limitations and expects to return to "normal".

SEVERE-TO-PROFOUND (DEPENDENT):

PROFOUND (DEPENDENT): The person assessed is unable to communicate their feelings or understanding of their current situation.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
FAMILY UNDERSTANDING OF DISABILITY

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): Family members express understanding of the person assessed's current situation and the changes imposed by the situation, and have realistic expectation for short and long term goals.

MILD (MOSTLY INDEPENDENT): Family members verbalize fairly realistic expectations for short-term goals and have started to follow through with discharge plans.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): Family members vary in their level of understanding but continue to ask questions and support the person assessed.

MODERATE (MINIMUM ASSISTANCE): Family members express verbal understanding of the person assessed's current limitations by making appropriate statements and asking pertinent questions to seek more information.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Family members have begun to identify current limitations and what that means practically. They continue to hold on to the belief that the disability is just temporary and things will return to "normal".

SEVERE (MAXIMUM ASSISTANCE): Family denies current limitations by repeatedly stating that they are temporary and the family expects the person assessed to return to "normal".

SEVERE-TO-PROFOUND (DEPENDENT):

PROFOUND (DEPENDENT): Family seems to have no information on the current situation or to what are reasonable expectations.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
DISCHARGE PLANNING

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed will return home, caring for self independently.

MILD (MOSTLY INDEPENDENT): The person assessed will return home with the support of outpatient services, home care services, and/or family assistance.

MILD-TO-MODERATE (MINIMUM ASSISTANCE):

MODERATE (MINIMUM ASSISTANCE): The person assessed will be discharged to a basic care, supervised living, or group home setting.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): The person assessed will return home totally dependent on a care-giver or 24-hour assistance/supervision.

SEVERE (MAXIMUM ASSISTANCE):

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed is at a level of care needing discharge to a nursing home or swing bed setting.

PROFOUND (DEPENDENT): The person assessed was transferred to acute care floor, acute hospital, or other acute rehab facility.

UNABLE TO ASSESS: The person assessed died while they were on the Rehab Unit.
ECONOMIC SITUATION

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed has health insurance (private or Medicare) or government program (Medicaid, Worker's Compensation or PHS).

MILD (MOSTLY INDEPENDENT):

MILD-TO-MODERATE (MINIMUM ASSISTANCE):

MODERATE (MINIMUM ASSISTANCE): The person assessed has health insurance with inadequate rehab benefits.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Application for disability and/or government program is in progress.

SEVERE (MAXIMUM ASSISTANCE): The person assessed has no health insurance and needs to apply for Medicaid, disability or SSI.

SEVERE-TO-PROFOUND (DEPENDENT): The person assessed has no health insurance and does not qualify for government assistance.

PROFOUND (DEPENDENT): The person assessed has no health insurance or assets.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
PSYCHOLOGICAL ADJUSTMENT

This element refers to the psychological response in regards to the cognitive and physical impairments which may affect performance as it relates to maximizing functional capability.

NO PROBLEM NOTED/NOT APPLICABLE: This code is used at admission to indicate that a person assessed is functioning within normal limits in this area.

MINIMAL (INDEPENDENT): The person assessed consistently demonstrates self-motivated behavior and coping skills, with infrequent disruption in performance due to severe stressors, e.g., marital discord, financial concerns, pain.

MILD (MOSTLY INDEPENDENT): The person assessed consistently exhibits self-motivated behavior, with infrequent interference in performance due to mild stressors, such as lack of motivation.

MILD-TO-MODERATE (MINIMUM ASSISTANCE): The person assessed generally exhibits self-motivated behavior, although such behavior may be temporarily compromised by failure experiences and feelings of loss.

MODERATE (MINIMUM ASSISTANCE): Emotional reactions or cognitive deficits don’t limit the person assessed’s ability to participate in therapies, and the person assessed intermittently exhibits self-motivated behavior. For example, the person assessed occasionally takes a passive approach to rehab, but at times initiates goal-directed behavior.

MODERATE-TO-SEVERE (MODERATE ASSISTANCE): Emotional reactions and/or cognitive deficits occasionally limit person assessed’s ability to participate in therapy but the person assessed exhibits self-motivated behavior on isolated occasions. For example, more than 50% of the time, the person assessed takes a passive approach to rehab, but at times will initiate goal-directed behavior.

SEVERE (MAXIMUM ASSISTANCE): Emotional reactions and/or cognitive deficits limit the person assessed’s ability to actively participate most of the time (greater than 75%). However, with minimum staff prompting, the person assessed does demonstrate goal-directed behavior.

SEVERE-TO-PROFOUND (DEPENDENT): Emotional reactions and/or cognitive deficits severely limit rehab efforts. The person assessed is dependent on staff prompting to perform goal-directed behavior.

PROFOUND (DEPENDENT): Emotional reactions and/or cognitive deficits are so severe that rehab efforts are not possible.

UNABLE TO ASSESS: To be used when the person assessed has not been seen, is transferred or dies before being seen, or when a necessary evaluation process has not been completed prior to coding the person assessed.
REFERENCES


