

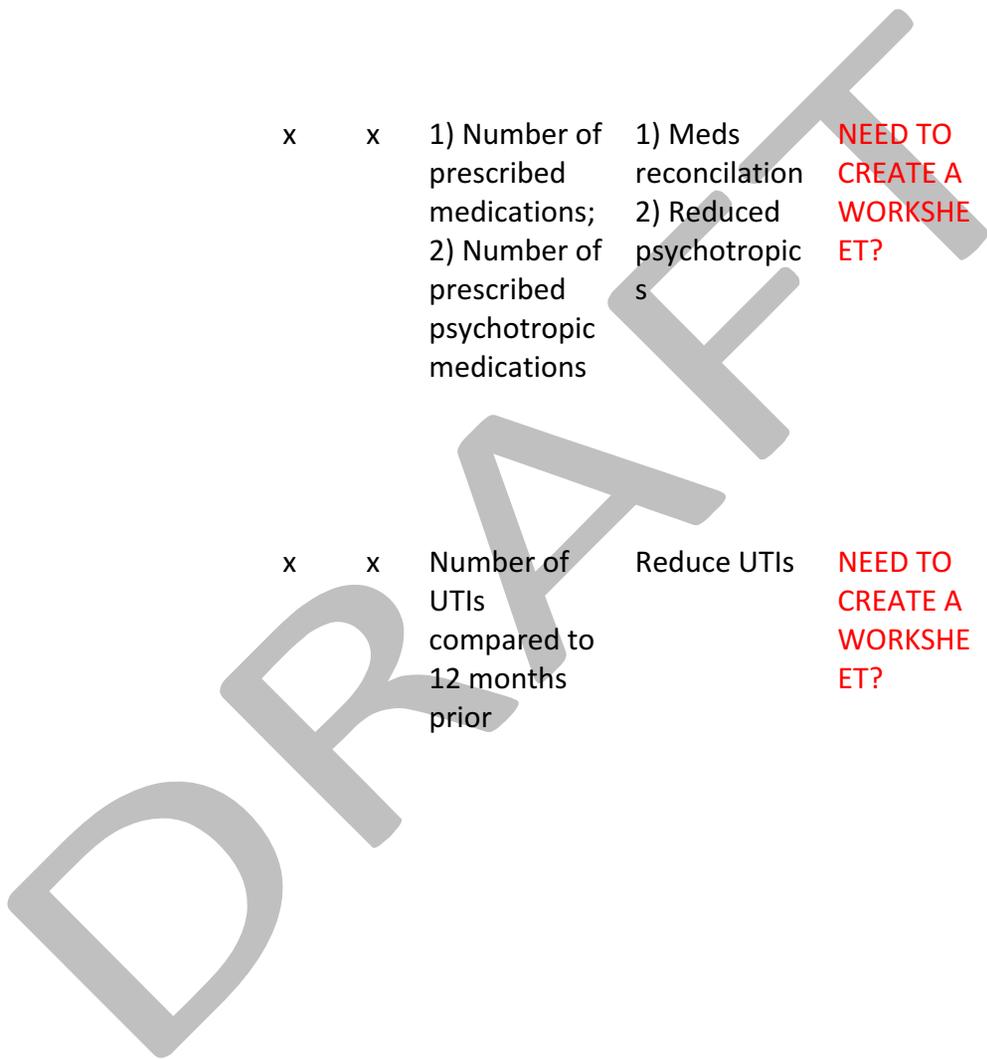
NADSA Service Delivery Outcomes of Interest
Population: Older adults and persons with dementia

		Core	Optimal	Level 1	Level 2	Level 3	Level 4	Measure	Outcome/Indicator Goal	Tool	Level and Method	Frequency
Indicators	Health Domain											
	Falls Rate	x		x	x	x	x	1) Number of falls at the center compared to 12 months prior 2) Reduce number of falls in the home	Reduce falls Reduce falls	1) Tinetti or 2) Get Up and Go	Individual: Assess fall risk of individuals using selected tool Aggregate: Count the number of falls at the center monthly for 12 months; compare to 12 months prior	Individual: Every 6 months until identified as fall risk,, then monthly Aggregate: Monthly
	Nutrition Risk	x		x	x	x	x	1) Measure/monitor of food consumption 2) Measure/monitor weight loss/gain	Identify participants at risk of poor nutrition	1) TOPS Nutrition Risk tool or 2) NEED AN ALTERNATIVE PUBLIC DOMAIN TOOL	Individual: Assess nutrition risk using selected tool Aggregate: Count the number of individuals at risk of	On admission

Medications	x	x	x	1) Number of prescribed medications; 2) Number of prescribed psychotropic medications	1) Meds reconciliation 2) Reduced psychotropics	malnutrition monthly for 12 months; compare to 12 months prior Individual: Count the number of medications in each of the two categories; note and report discrepancies and concerns	Initially and every 3 or 6 months
Urinary Tract Infections	x	x	x	Number of UTIs compared to 12 months prior	Reduce UTIs	Individual: Assess/monitor UTIs using selected tool; note and report discrepancies and concerns to MD Aggregate: Count the number of UTIs monthly for 12 months,	Monthly

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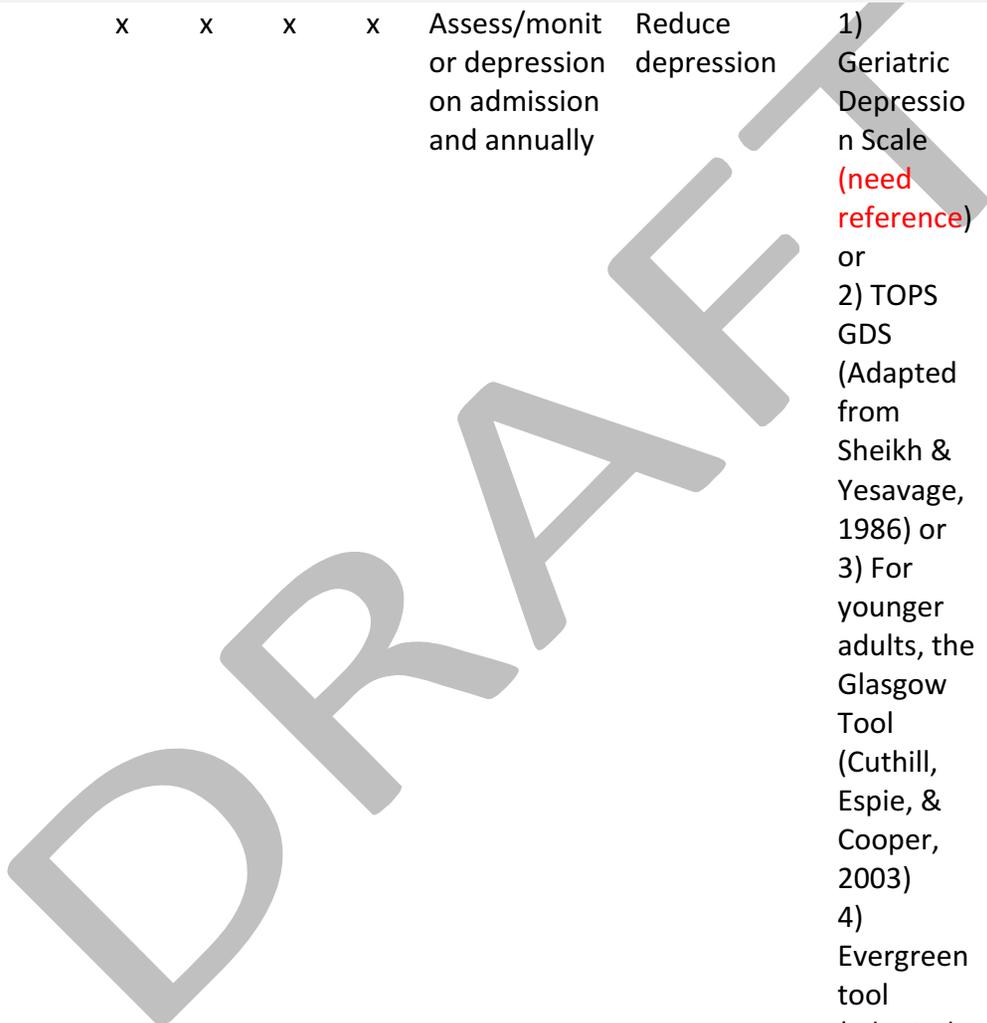


							compare to 12 months prior		
Blood Pressure	x		x	x	Measure/monitor blood pressure	Blood pressure-maintain WNL	Blood pressure screen NEED TO CREATE A WORKSHEET?	Individual: Conduct blood pressure screen; note and report discrepancies and concerns to MD	On admission and monthly
Blood Sugar/Hb1Ac		x		x	Measure/monitor blood sugar/HbA1c	Blood sugar-maintain WNL	Health screen NEED TO CREATE A WORKSHEET?	Individual: Health screening of individuals at risk of diabetes; compare most recent lab results with prior results	Blood sugar: On admission and per MD order Hb1Ac: Each time a lab test is conducted
Pain	x			x	Assess/monitor pain	Reduce pain	1) TOPS Pain Scale (Revised from Wong, Hockenberry-Eaton, Wilson, Winkelstein)	Individual: Assess/monitor pain using selected tool; note and report discrepancies and concerns to MD	Monthly

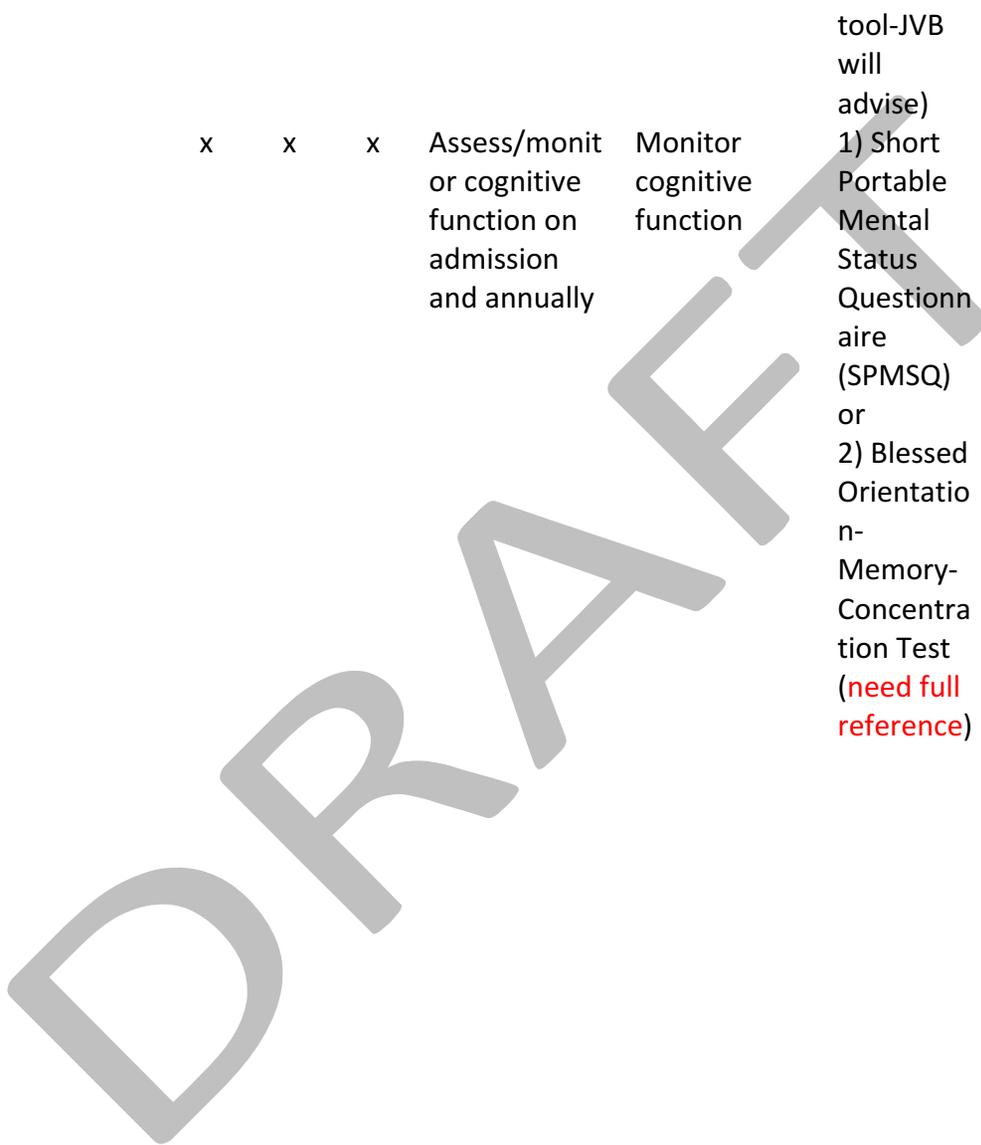
BMI	x	x	Body Mass Index (CMS recommended core measure)	Maintain BMI within 10% +/- deviation	n, & Schwartz [2001]) or2) PAINAD (Warden, Hurley, Volicer, 2003) or3) Serial Trial Intervention (Kovach et al., 2006)	Calculate BMI NEED TO CREATE A WORKSHEET?	Individual: Calculate from height and weight data gathered at the center; note and report discrepancies and concerns to MD	Annually, or per care plan
Subtotals	5	3						

Emotional/Cognitive Domain	Core	Optimal	Level 1	Level 2	Level 3	Level 4					
Depression	x		x	x	x	x	Assess/monitor depression on admission and annually	Reduce depression	1) Geriatric Depression Scale (need reference) or 2) TOPS GDS (Adapted from Sheikh & Yesavage, 1986) or 3) For younger adults, the Glasgow Tool (Cuthill, Espie, & Cooper, 2003) 4) Evergreen tool (adapted from Iowa	Individual: Assess/monitor depression using selected tool; note and report discrepancies and concerns to MD Aggregate: Count and compile data monthly re: the number of individuals who are depressed or are at risk for depression; compare to 6 months prior	Every 6 months or acuity of score dictates follow-up

Indicators



Cognition	x	x	x	x	Assess/monitor cognitive function on admission and annually	Monitor cognitive function	tool-JVB will advise) 1) Short Portable Mental Status Questionnaire (SPMSQ) or 2) Blessed Orientation-Memory-Concentration Test (need full reference)	Individual: Assess/monitor level of cognition using selected tool; note and report discrepancies and concerns to MD Aggregate: Count the number of individuals whose cognition levels are below normal range monthly for 6 months; compare to 6 months prior	On admission and every 6 months thereafter
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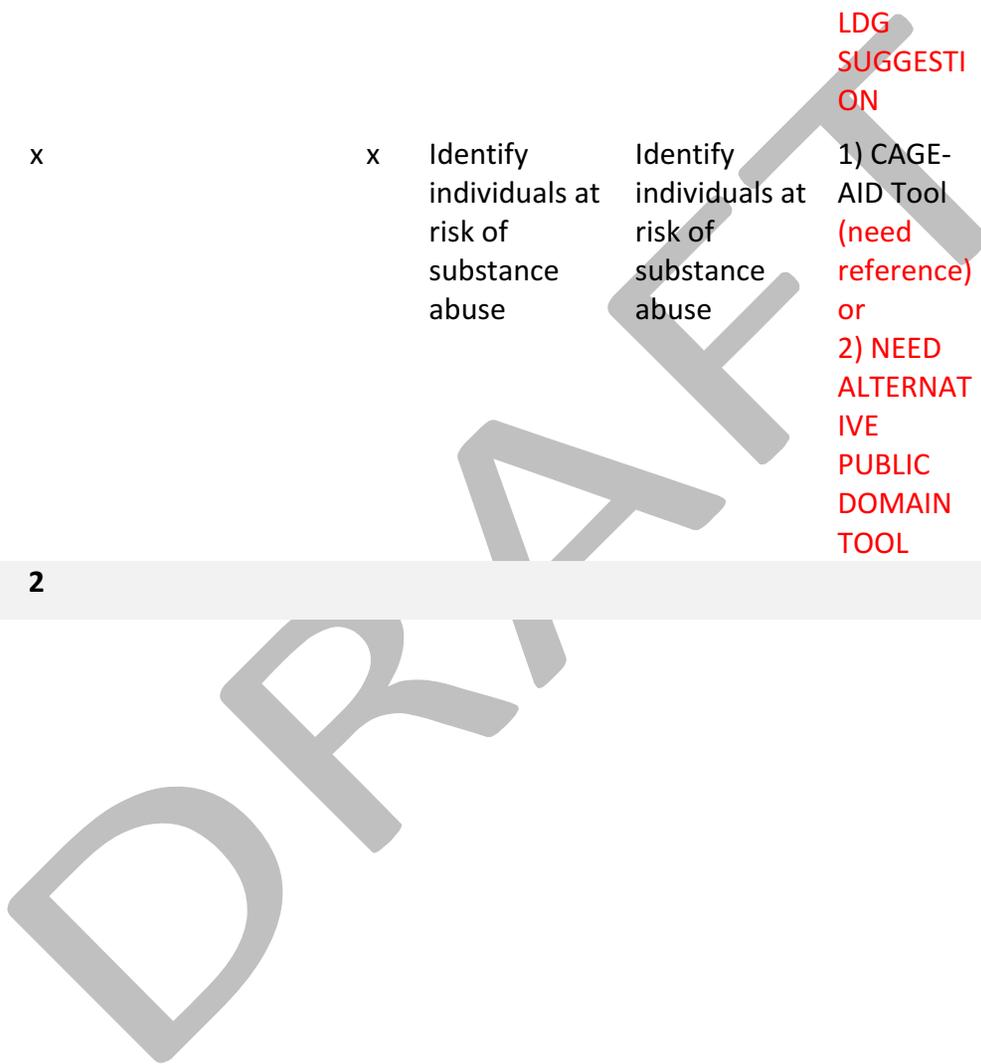
Quality of Life (QOL)	x	x	x	Assess/monitor or quality of life	Increase quality of life	1) Dementia Quality of Life (DQoL) Self-Esteem Sub-Scale Revised from Brod, Stewart, Sands, & Walton (1999) or2) Alz Dementia Expanded (adapted from Logsdon, 1996) or3) AD Expanded Proxy Version (adapted from Logsdon, 1996)	Individual: Assess/monitor quality of life using selected tool; note and report discrepancies and concerns to MD	On admission and every 6 months thereafter
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Loneliness and Social Isolation	x	x	x	Assess/monit or loneliness and social isolation	Reduce loneliness and social isolation	Revised R-UCLA Loneliness Scale (Adapted from Russell, 1996)	Individual: Assess/monito r loneliness and social isolation using tool; note and report discrepancies and concerns to MD	On admission and every 6 months thereafter
Self-Perceived Health	x		x	Assess/monit or self-perceived health	Monitor self-perceived health	1) PAM tool (CAADS proprietary y-share pending) or 2) Easter Seals Subjective Health Question (unpublish ed-share pending) or 3) Stanford Self-Rated Health Measure	Individual: Assess/monito r self-perceived health using selected tool; note and report discrepancies and concerns to MD	On admission and every 6 months thereafter

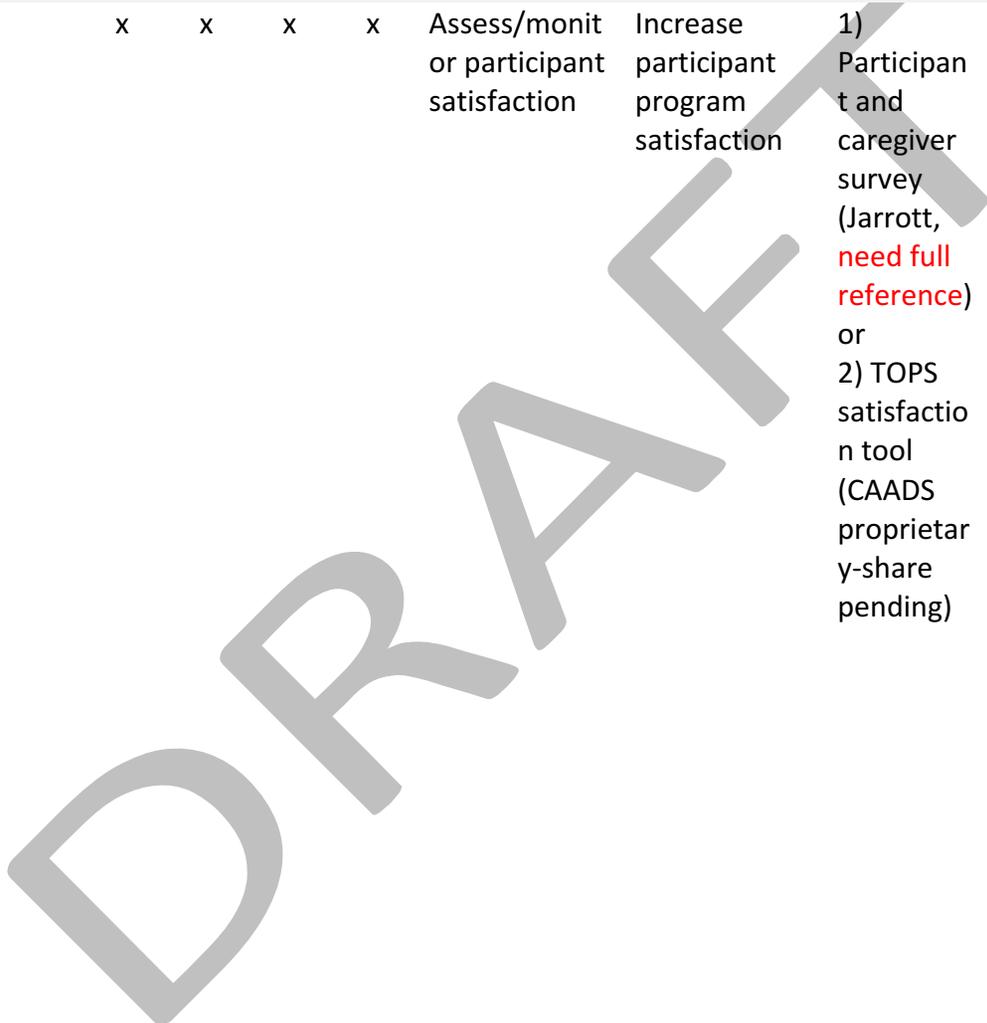
Substance abuse screening **	x	x	Identify individuals at risk of substance abuse	Identify individuals at risk of substance abuse	(Lorig et al., 1996) LDG SUGGESTION 1) CAGE-AID Tool (need reference) or 2) NEED ALTERNATIVE PUBLIC DOMAIN TOOL	Individual: Screen individuals for substance abuse risk using selected tool; note and report discrepancies and concerns to MD	On admission
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Subtotals	4	2					
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Person-Centered Domain	Core	Optimal	Level 1	Level 2	Level 3	Level 4					
Participant satisfaction	x		x	x	x	x	Assess/monitor or participant satisfaction	Increase participant program satisfaction	1) Participant and caregiver survey (Jarrott, need full reference) or 2) TOPS satisfaction tool (CAADS proprietary-share pending)	Individual: Assess individual satisfaction with program using selected tool; monitor and resolve discrepancies Aggregate: Assess participant satisfaction with program scores monthly for 12 months; calculate % satisfied as proportion of participant population; compare to 12 months prior	Every 12 months

Indicators



Assistance with ADLs (activities of daily living)	x	x	x	x	Assess/monit or assistance with ADLs	Maintain or improve ADLs	1) Independ ence in ADLs assessme nt (Katz et al, 1970) or 2) CA state ADL Assessme nt Form 0020 (need reference)	<p>Individual: Assess individual need for assistance with ADLs using selected tool; monitor and report discrepancies and concerns to MD</p> <p>Aggregate: Assess participants' need for assistance with ADLs scores monthly for 6 months; calculate % of participant population with need of assistance; compare to 6 months prior</p>	On admission and every 6 months thereafter
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Assistance with IADLs (instrumental activities of daily living)	x	x	x	Assess/monit or assistance with IADLs	Maintain or improve IADLs	1) Lawton Instrumen tal Activities of Daily Living Scale (Lawton & Brody, 1969) or 2) CA state form 0020 (need reference)	<p>Individual: Assess individual need for assistance with IADLs using selected tool; monitor and report discrepancies and concerns to MD</p> <p>Aggregate: Assess participants' need for assistance with IADLs scores monthly for 6 months; calculate % of participant population with need of assistance; compare to 6 months prior</p>	On admission and every 6 months thereafter
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<p>Involvement of participants in developing their own care plan</p>	<p>x</p>	<p>x</p>	<p>Assess/monitor participant involvement in care planning</p>	<p>Increase participant involvement with individual care planning and obtain agreement with respect to mutually established goals</p>	<p>Count number of participants who are involved in their own individual care planning. (NEED TO ENSURE CARE PLANS HAVE A PLACE FOR PARTICIPANTS TO SIGN AS INDICATION OF INVOLVEMENT) NEED TO CREATE A WORKSHEET?</p>	<p>Individual: Assess individual participant's participation in care planning as evidenced by an individual's signature on her/his individual care plan Aggregate: Assess participants' participation in care planning as evidenced by individuals signatures on care plans monthly for 6 months; calculate % of participant population who participate in planning;</p>	<p>Every 6 months</p>
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compare to 6 months prior

Person-centered activities (names on the activity calendar)

x

x

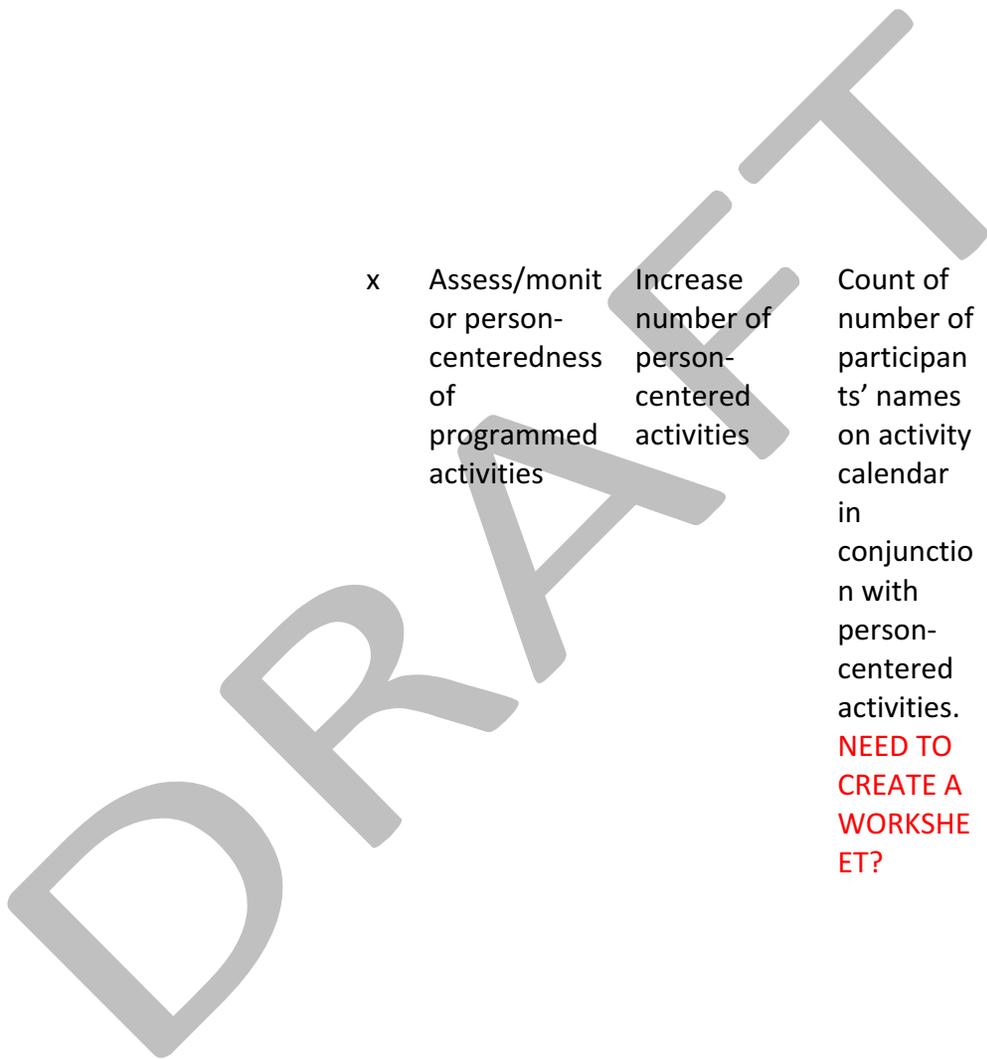
Assess/monitor or person-centeredness of programmed activities

Increase number of person-centered activities

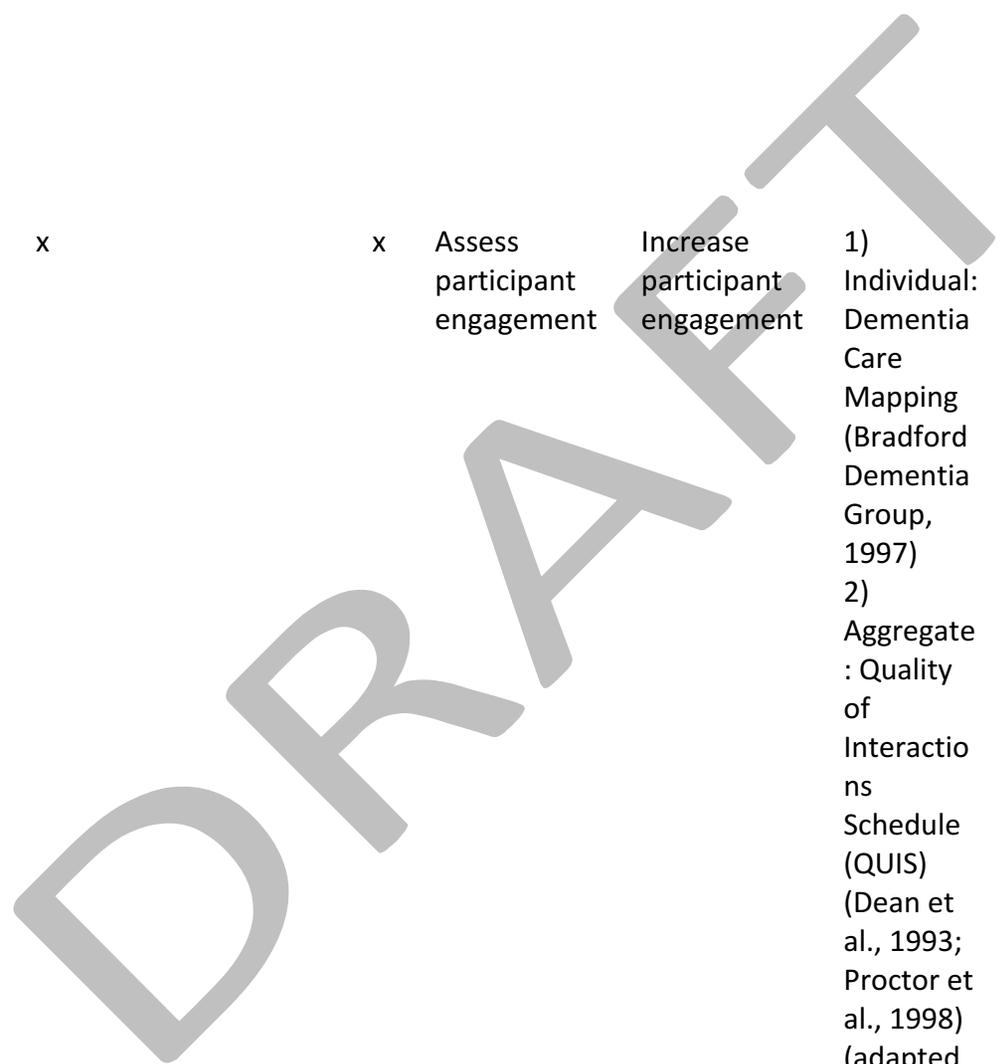
Count of number of participants' names on activity calendar in conjunction with person-centered activities. **NEED TO CREATE A WORKSHEET?**

Individual: Assess calendars for evidence of individual participant's name
Aggregate: Assess participants' names on calendar monthly for 12 months; calculate % of activities listed on calendar with participant names as proportion of total activities on calendar;

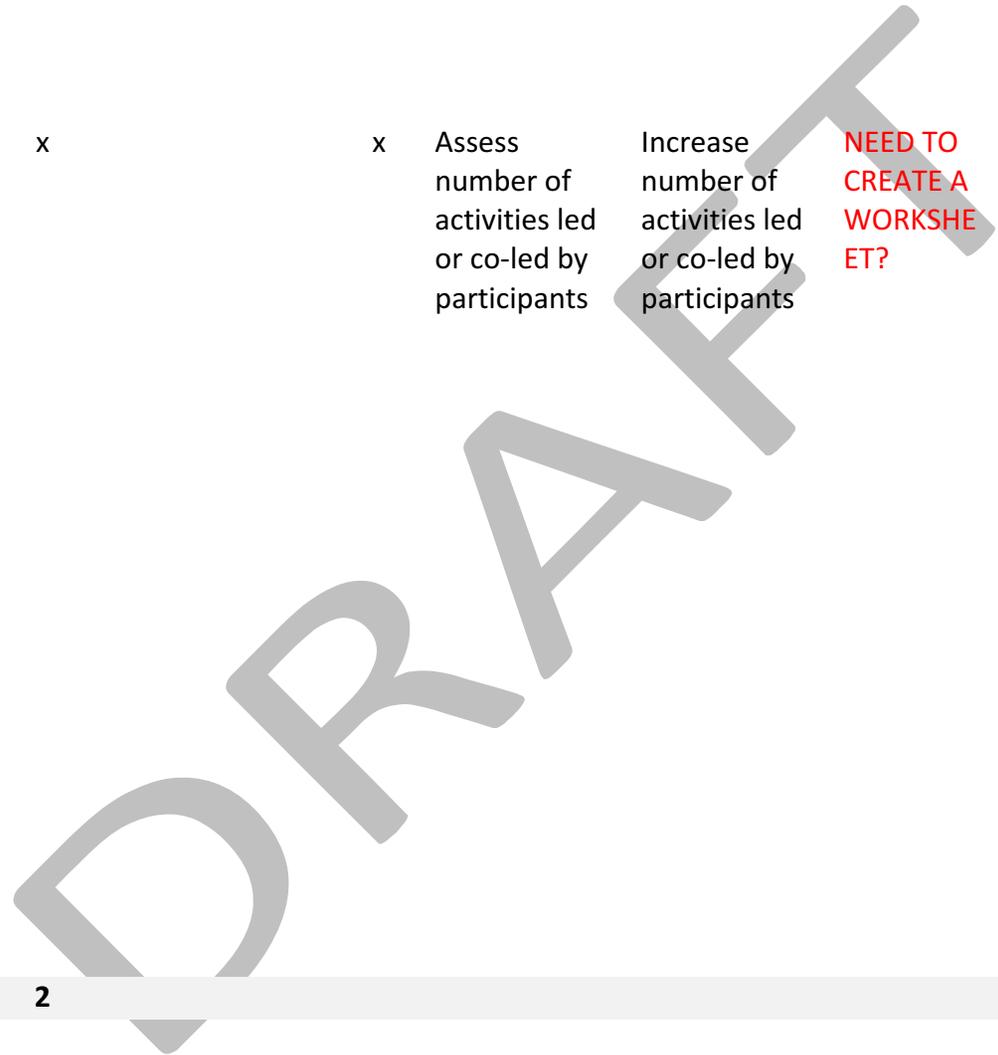
Monthly



Engagement of participants **	x	x	Assess participant engagement	Increase participant engagement	1) Individual: Dementia Care Mapping (Bradford Dementia Group, 1997) 2) Aggregate : Quality of Interactions Schedule (QUIS) (Dean et al., 1993; Proctor et al., 1998) (adapted by Geboy & Meyer-	compare with 12 months prior Individual: Assess individual well-being according to DCM method Aggregate: Using QUIS, assess engagement among participants in program areas (not personal care or health/wellness areas); calculate % of engagement as a proportion of total participant population;	Every 6 months or during specified activities
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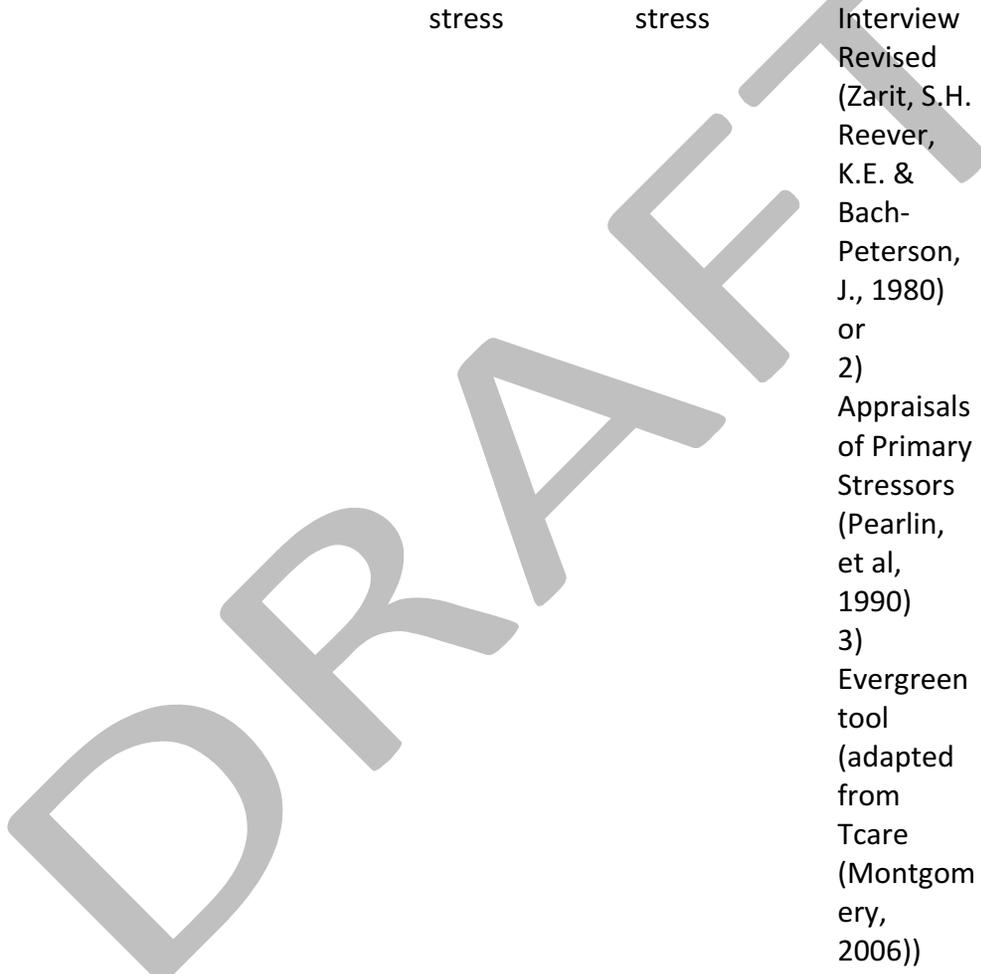
Activities led by participants **	x	x	Assess number of activities led or co-led by participants	Increase number of activities led or co-led by participants	Arnold, 2011) NEED TO CREATE A WORKSHEET?	compile data monthly re: engagement; compare to 6 months prior Aggregate: Count of number of instances in which participants lead person-centered activities monthly for 6 months; calculate % of participant-led activities as a proportion of total activities; compile data re: activities led by participants; compare to 6 months prior	Every 6 months or during specified activities
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Subtotals	5	2
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Caregiver Domain	Core	Optional	Level 1	Level 2	Level 3	Level 4					
Care burden	x		x	x	x	x	Assess/monitor caregiver stress	Reduce caregiver stress	1) Zarit Burden Interview Revised (Zarit, S.H. Reever, K.E. & Bach-Peterson, J., 1980) or 2) Appraisals of Primary Stressors (Pearlin, et al, 1990) 3) Evergreen tool (adapted from Tcare (Montgomery, 2006))	Individual: Assess individual care burden using selected tool; monitor and report discrepancies and concerns to caregiver Aggregate: Assess caregiver burden scores monthly for 12 months; compare average/median/mode scores to 12 months prior	On admission and every 12 months thereafter

Indicators



Quality of life	x	x	x	x	Assess/monit or quality of life	Increase caregiver quality of life	1) TOPS Designed Caregiver Needs Assessme nt (proprieta ry, share pending) or 2) Brod measure of quality of life (need accurate reference)	Individual: Assess individual caregiver QOL using selected tool; note and report discrepancies to caregiver Aggregate: Assess caregiver QOL scores monthly for 12 months; compare average/medi a/mode scores to 12 months prior	On admission and every 12 months thereafter
Caregiver satisfaction	x		x	x	Assess/monit or caregiver satisfaction	Increase caregiver program satisfaction	1) TOPS designed tool (proprieta ry, share pending) (need accurate reference) or 2) Single	Individual: Assess individual caregiver satisfaction with program using selected tool; monitor and resolve discrepancies to caregiver	Every 12 months

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item: If adult day care were no longer available, what changes would you have to make in your life?
(Jarrott & Zarit, need accurate reference)
or
3) Single item: Would you recommend this program to others?

Aggregate:
Assess caregiver satisfaction with program scores monthly for 12 months; calculate % satisfied as proportion of caregiver population; compare to 12 months prior

Caregiver job retention **	x	x	Assess/monitor or caregivers' job retention	Increase caregiver job retention rate	1) TOPS Caregiver Needs Assessment tool (proprietary, share pending) or 2) NEED ALTERNATIVE PUBLIC DOMAIN TOOL	Individual: Assess individual caregiver ability to continue to work (or volunteer) using selected tool; monitor and resolve discrepancies to caregiver Aggregate: Assess caregiver job retention rate monthly for 12 months; calculate % satisfied as proportion of caregiver population; compare to 12 months prior	Every 12 months
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Subtotals 4 0

System Domain	Core	Optional	Level 1	Level 2	Level 3	Level 4					
Attendance	x		x	x	x	x	Assess/monitor daily/monthly/annual census	Increase ratio of actual attending to scheduled participants	Attendance record NEED TO CREATE A WORKSHEET?	Individual: Record individual attendance daily; monitor and resolve actual/scheduled discrepancies with caregiver Aggregate: Record attendance data of all scheduled participants monthly for 12 months; calculate ratio of actual to scheduled attendance; compare to 1 month prior	Monthly

Indicators

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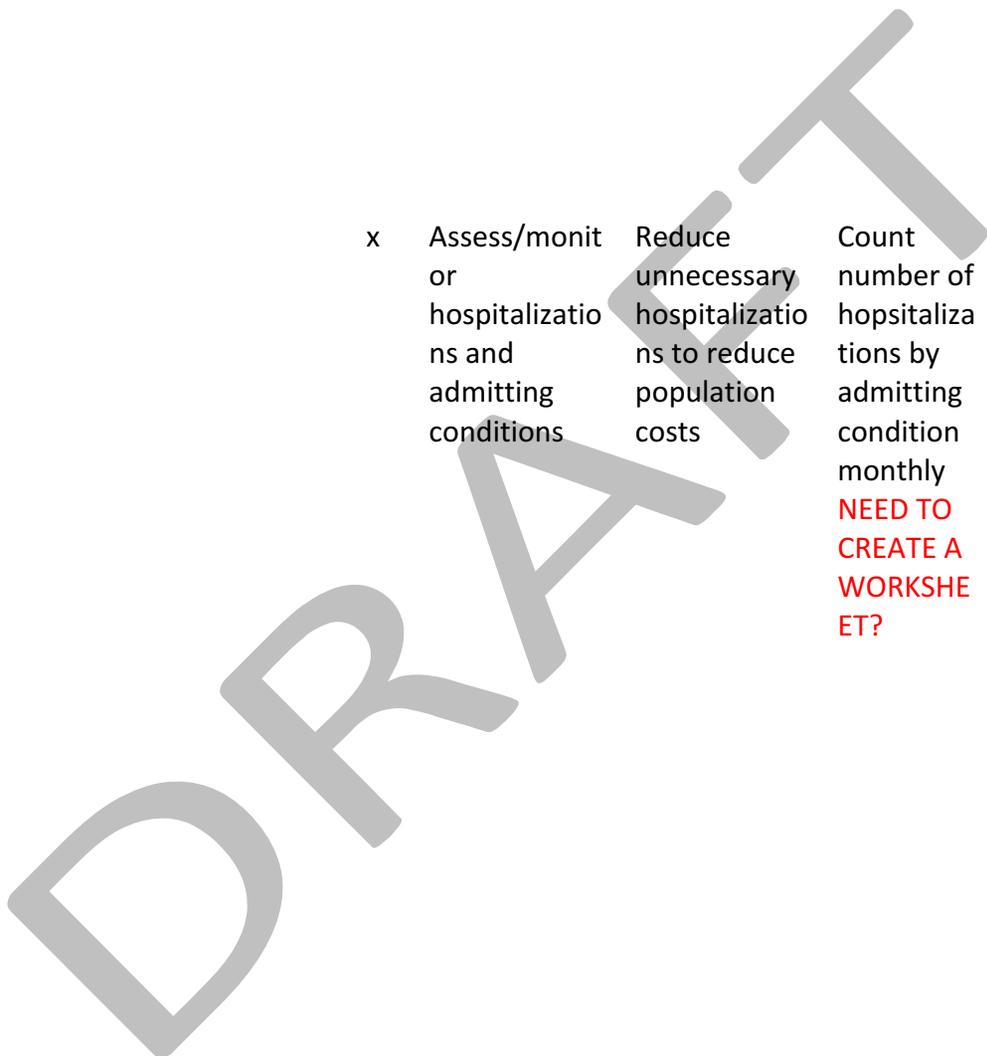
30-day readmission	x	x	x	x	x	Assess/monit or 30-day readmissions	Prevent 30-day readmissions of same condition	Count number of 30-day readmissi ons following hospital visits	<p>Individual: Record individual hospital visits monthly; record subsequent hospital visits within 30 days for same condition; monitor and report discrepancies and concerns to MD</p> <p>Aggregate: Record participant hospital visits and subsequent hospital visits within 30 days for same condition monthly for 12 months; compare to 12 months prior</p>	Monthly
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Nursing facility admissions	x	x	x	x	Assess/monit or nursing facility admissions	Reduce nursing facility admissions to reduce population costs	Count number of nursing facility admissions	Aggregate: Record participant nursing home admissions monthly for 12 months; compare to 12 months prior	Monthly
Emergency department visits	x	x	x	Assess/monit or ED visits	Reduce ED visits to reduce population costs	Count number of ED visits monthly	s NEED TO CREATE A WORKSHEET? Record individual participant ED visits monthly; record subsequent ED visits within 30 days for same condition; monitor and report discrepancies and concerns to MD	Monthly	
							Aggregate: Record participant nursing home admissions monthly for 12		

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					months; compare to 12 months prior		
Hospitalizations and admitting condition **	x	x	Assess/monitor hospitalizations and admitting conditions	Reduce unnecessary hospitalizations to reduce population costs	Count number of hospitalizations by admitting condition monthly NEED TO CREATE A WORKSHEET?	Individual: Record individual participant ED visits monthly; record subsequent ED visits within 30 days for same condition; monitor and report discrepancies and concerns to MD Aggregate: Record participant nursing home admissions monthly for 12 months;	After each hospitalization



						compare to 12 months prior	
Staff interactions **	x		x	Assess staff interactions with participants	1) Aggregate : Quality of Interactions Schedule (QUIS) (Dean et al., 1993; Proctor et al., 1998) (adapted by Geboy & Meyer-Arnold, 2011)	Aggregate: Using QUIS, assess interactions of staff with participants in program areas (not personal care or health/wellness areas); calculate % of interactions as a proportion of total staff population; compile data re: interactions monthly for 12 months; compare to 12 months prior	Every 12 months or during specified activities

Subtotals	5	1
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Levels	1	2	3	4
Subtotals	6	11	19	31

* Survey results: % of survey respondents (N = 27) who agree this indicator should be included in the recommended set of indicators

Indicators listed in order of % respondent agreement (unless noted).

** These indicators fall below a threshold of > 70% support from survey respondents (LDG suggested threshold).

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