Community Support Services Common Assessment Project

Software Report Specifications

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CCIM Community Care Information Management

ACCESS TO INFORMATION

Revision History

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1. Document Purpose

The purpose of this document is to provide a minimum set of requirements for end user and management reports development within CSS organization software. The reports will be utilized by users within CSS organizations who complete the interRAI CHA assessment with their clients. This set of reports will be common across all CSS organizations and will allow users to view and analyze captured assessment information for clients or view reports at an aggregate level based on the report type. Organizations have the option to create additional reports to meet their needs in addition to the CSS CAP defined reports.

2. Assumption

The design and intent of each report has been analyzed and reviewed by different members of CSS organizations as well as researchers who developed the interRAI CHA tool. Their feedback was vital in making sure the report elements and design aligns with each report objective. The final product delivered in the automated solution should resemble the look and feel in the report mock up.

Note

The data elements reflected in the report specifications are based on the interRAI CHA form elements specification. If there is any inconsistency in what is stated in this report specification document and the interRAI CHA form, the elements in the interRAI CHA form should be used for report development.

3. Report Specification Overview

This section provides a description of the attribute categories for the report specifications. Once the application has been further defined and a detailed design has been developed, LHIN/HSPs may discover the need for new reporting requirements. The following attribute categories are specified in each report:

Report Name: A unique name for each report, this name should be displayed at the top of every page of the report.

Report Objective: A description of the report including its purpose and use (this may not be displayed as part of the report).

Report Conditions: Certain rules that must be adhered to for generating the information in the reports.

Report Users: Set of users or user groups as defined by the organization.

Report Schedule and Delivery: The time the report would be made available to users.

Report Format: A list of output recommendations to optimize the look and feel of the report e.g., Excel, PDF etc.

Search Criteria: A list of search parameters or conditions that may drive the information displayed in the report.

Sort Criteria: Allows users to sort report data elements in ascending or descending order.

Report Filter: A list of user defined parameters which includes parameter names and associated values that may be used to narrow down elements displayed in a report based on the parameter selected.

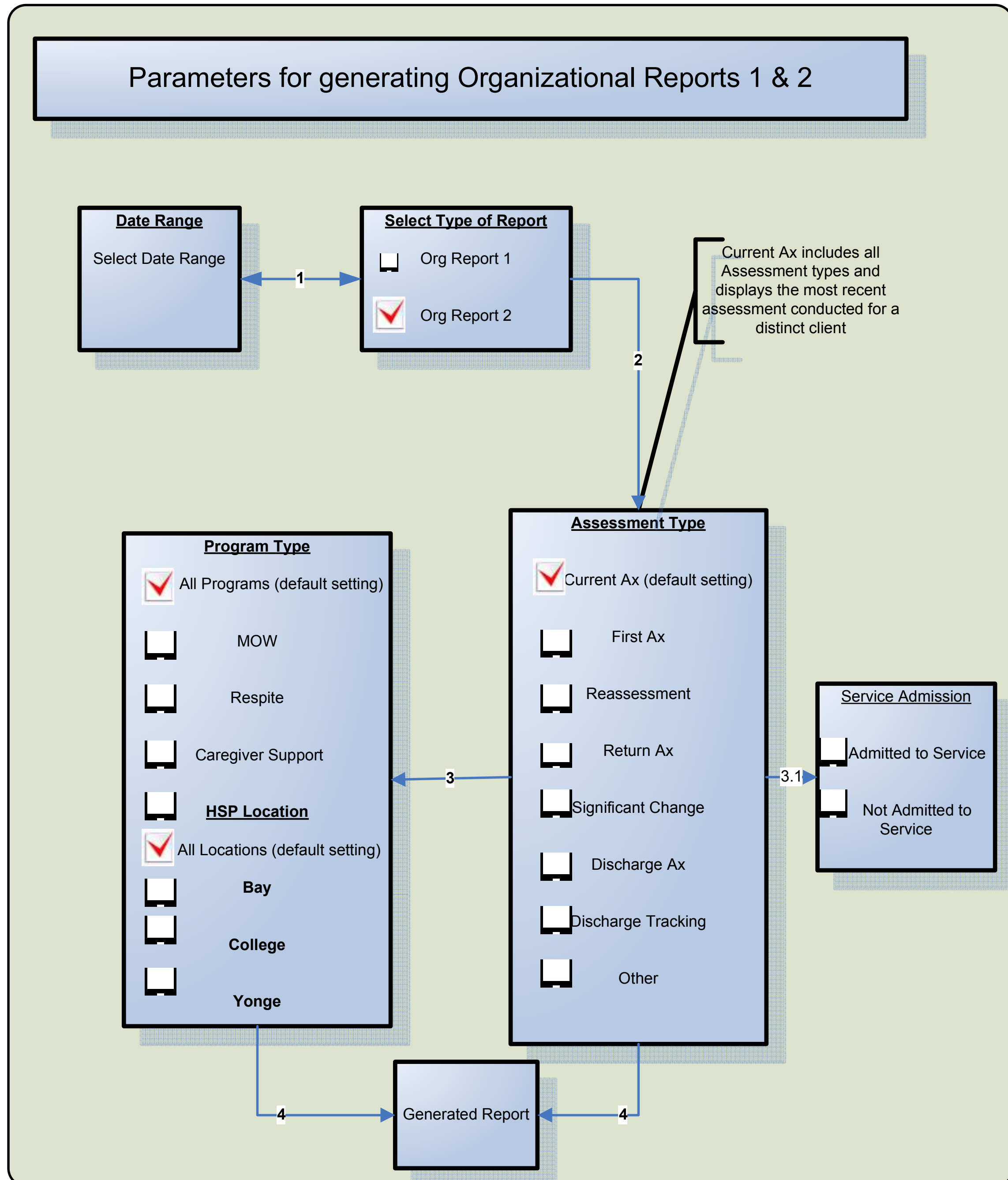
Report Header: Customizable header for report information such as name, organization logo, etc.

Report Data Element: Data elements and values displayed in a report.

Sample Report Layout: A visual sample layout that displays the report content and format.

4. Report Parameters

IMPORTANT* The project has added additional filters for program type, location and service admission but these are considered optional for the vendors. The project is limited to reporting on the data that is captured within the CHA assessment and this limitation also extends to the search parameters. The project included the optional filters in the report specifications to inform vendors that these search parameters are vital to generating meaningful reports for their clients.



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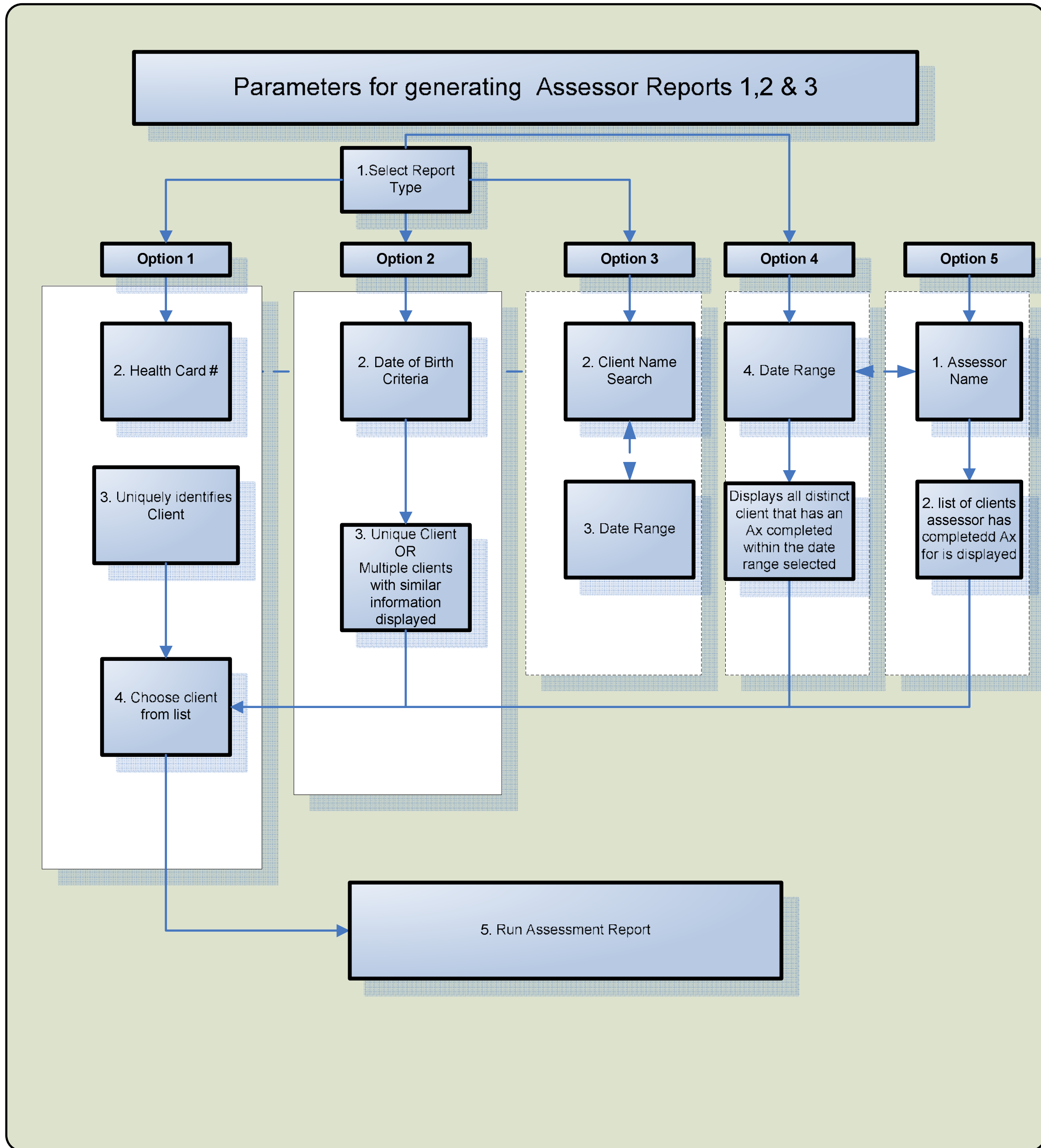

Parameters for generating Assessor Reports 1,2 & 3
1.Select Report Type
Option 1
Option 2
Option 3
Option 4
Option 5
2. Health Card #
2. Date of Birth Criteria
2. Client Name Search
4. Date Range
1. Assessor Name
3. Uniquely identifies Client
3. Unique Client OR Multiple clients with similar information displayed
3. Date Range
Displays all distinct client that has an Ax completed within the date range selected
2. list of clients assessor has completedd Ax for is displayed
4. Choose client from list
5. Run Assessment Report

5. Assessor Reports

AR-1: Client's CAPs and Outcomes

Report Name:	Client's CAPs and Outcomes
Report ID:	Assessor Report #1
Req #	Display a Client's CAPs and Outcomes

Report Objective:

1. Provides a quick overview of the client's health status based on triggered CAPs and Outcome scores.

Report Conditions:

1. To ease readability of the report, only triggered CAPs should be displayed; all other CAPs not triggered should not be displayed.

2. CAPs triggered by the core CHA should always be listed first before any CAPs triggered from the Functional Supplement.

Report Users:

Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling and Delivery Requirements:

The report will be a self-serve and should be available to assessors any time within the assessment software.

Report Format:

Excel, CSV, PDF.

1. Search Criteria

One or more combinations of search criteria may be entered to generate client assessment information for this report.

Search Criteria Elements	Entry Description	Valid Values
Client Name	Client's First and/or Last Name	Alphanumeric
Health Card Number	Client's Health Card Number	12 digit numeric search field with 2 digit alphanumeric version code
Date of Birth	Client's Date of Birth	YYYY-MM-DD
Assessor Name/Assessor ID	Assessor's first and/or last name Assessor's Identification number	Alphanumeric

Search Conditions:

- Combination of search parameters that should narrow down the results displayed for a client report.
- If no match is found, a "no record found" message should be displayed and no report will be generated.
- Selection of a client record from the list of clients should display assessment reports for the selected client.
- The most recent assessment report should be displayed at the top of the list.

#	Description	Display Conditions
1	Health Card number search criteria only (uniquely identifies each client).	List of assessment reports associated with the client is displayed.
2	Client Name Search – wild card* search should return all client (s) that match the search criteria entered.	A list of client(s) that match the search criteria should be displayed. The user may then select a client from the displayed list which will then display all assessment reports associated with the client.
3	Date of Birth	A list of clients that match the search criteria should be displayed. The user may then select a client from the displayed list, which will then display all assessment reports associated with the client.
4	Date range (recommended to narrow down search results with a combination of another search parameter).	Displays a list of assessment records for clients within the date range selected. If the user selects a client from the list, a list of assessment records for that client must be displayed.
5	Assessor Name	Display list of client assessments completed by the assessor.

2. Sort Criteria

Sort in ascending or descending order by:

- Client name
- Date

3. Report Header (from Section A – core CHA)

The report header must display the following information.

Column 1	Column 2
First Name:	Primary Language:
Last Name:	Marital Status:
Health Card Number:	Date Case opened:
Case Record Number:	Last Assessment Date:
Birth Date:	Current Assessment Date:
Gender:	Reason for Assessment:
Residential Living Status (Q11)	Assessor:
Living Arrangement (Q12):	Assessment Completed + Supplements:

4. Report Data Elements

For list of CAPs and Outcome scores, values and description please refer to interRAI –CHA specification.

Column Name	Description	Data Element/Type
CAPs	Displays list of triggered CAPs. The ability to expand and collapse each CAP section within the report should be provided.	Refer to list of CAPs interRAI–CHA specification.
	Display list of questions that contribute to the particular triggered CAP (refer to interRAI specification) and this section may be expanded or collapsed.	Alphanumeric e.g., G1ab – Meal Preparation Difficulty
Notes	Display notes content of items within the assessment that constitute a triggered CAP. Each note within the section for the item must be shown in the report according to the order of display in the assessment form.	
Code	The numeric level description for the triggered CAP.	Numeric
Description	Describes the trigger level for the CAP.	Description of the code value
Actions Taken	Displays 8 different categories of actions required to be taken.	Check box associated with each CAP and questions that contribute to make up the

	The checkboxes should be displayed as part of the report template; not required to be an entry form to store data.	CAP: 1. Will be addressed in service plan. 2. Previously addressed /no further intervention required. 3. Client declined Intervention. 4. Addressed by another source. 5. Deferred. 6. Further investigation. required/Reassessment needed. 7. Other (checkbox n/a this should be displayed as a blank field in the report template which will allow text entry when exported to Excel).
Date		Date (checkbox n/a)
Key Outcomes	Displays the 8 key outcome scales and its respective severity level.	The outcome scale name e.g., (DRS) – Depression Rating Scale 0 – 14.
Score	Displays the score value based on the severity level of the scale.	Numeric value
Description	Describes the score value of the scale based on the severity level.	A description of the score value e.g., DRS Scale: 2 – some symptoms of depression, intervention might be helpful.
Informal Helper Status (*Functional Supplement Section M:2a,2b, 2c)*	Items 2a, 2b, and 2c within section of the Functional Supplement (refer to FS form).	Items as displayed within Section M of the Functional supplement.
Score	Numeric value of the coded response.	Numeric e.g. 0,1
Description	Description of the numeric value.	No = 0 Yes = 1
Hospital Use, Emergency Room Use and Physician visit (*CHA Section M: 2a,2b,2c)*	Items in # of times for 2a, 2b,and 2c within section M of the Core CHA Form.	Items as displayed within Section M of the Core CHA.
# of Times	The number of times of hospital use, emergency room visit and physician visit.	Numeric

5. **Page Footer:**

#	Description	Alignment
1	Page number	Left aligned
2	Print Date Time stamp	Left aligned

Refer to Appendix for sample report layout.

AR-2: Client Progression Report

Report Name:	Client Progression Report
Report ID:	Assessor Report #2
Req #	Understand client's health status over time

Report Objectives:

1. Show CAPs and Outcome Measures for one client over time.
2. Always show the first assessment as a baseline assessment.

Report Conditions:

1. To ease readability triggered CAPs must be displayed before all other CAPs not triggered.
2. CAPs triggered by the core CHA should always be listed first before any CAPs triggered from the Functional Supplement.

Report Users:

Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling Requirements:

The report will be a self-serve and should be available to assessors any time within the assessment software.

Report Format:

Excel, CSV, PDF.

1. Search Criteria

One or more combinations of search criteria may be entered to generate client assessment information for this report.

Search Criteria Elements	Entry Description	Valid Values
Client Name	Client's First and/or Last Name	Alphanumeric
Health Card Number	Client's Health Card Number	12 digit numeric search field with 2 digit alphanumeric version code
Date of Birth	Client's Date of Birth	YYYY-MM-DD
Assessor Name/Assessor ID	Assessor first and/or last name Assessor Identification number	Alphanumeric

2. Search Conditions:

- Combination of search parameters that should narrow down the results displayed for a client report.
- If no match is found a "no record found" message should be displayed and no report will be generated.
- Selection of a client record from the list of clients should display assessment reports for the selected client
- The most recent assessment report should be displayed at the top of the list.

#	Description	Display Conditions
1	Health Card number search criteria only (uniquely identifies each client).	List of assessment reports associated with the client is displayed.
2	Client Name Search – wild card* search should return all client (s) that match the search criteria entered.	A list of client(s) that match the search criteria should be displayed. The user may then select a client from the displayed list which will then display all assessment reports associated to the client.
3	Date of Birth	A list of clients that match the search criteria should be displayed. The user may then select a client from the displayed list, which will then display all assessment report associated to the client.
4	Date range (recommended to narrow down search results with a combination of another search parameter.	Displays a list of assessment records for clients within the date range selected. If the user selects a client from the list a list of assessment records for that client must be displayed.
5	Assessor Name	Display list of client assessments completed by the assessor.

3. Sort Criteria

Sort in ascending or descending order by:

- Client name
- Date

4. Report Header (from Section A – core CHA)

The report header must display the following information:

Column 1	Column 2
Client First:	Primary Language:
Last Name:	Marital Status:
Health Card Number:	Date Case opened:
Case Record Number:	Last Assessment Date:
Birth Date:	Current Assessment Date:
Gender:	Reason for Assessment:
Residential Living Status (Q11)	Assessor:
Living Arrangement (Q 12):	Assessment Completed + Supplements:

5. Report Data Elements

For list of CAPs and Outcome scores values and description please refer to the interRAI –CHA specification.

Column Name	Description	Data Element/Type
Triggered CAPs	Displays rows of CAPs triggered.	Refer to list of CAPs as per interRAI –CHA specification.
The first base assessment	The first base assessment completed for the client. -	1. First Assessment 2. Assessor Name 3. Date of assessment
Columns indicating the 3 most recent assessment for a client	The last 3 consecutive assessments completed for the client. Condition: display a maximum of 3 consecutive previous assessments. Suppress columns if no assessment is applicable for columns.	1. Assessment # 2. Assessor Name 3. Date of assessment
Change Since Last Assessment	Indicates the degree of improvement or depreciation of client health status when compared between the	1. No Change 2. Improved 3. Increased Need/ Deteriorated Value comparison description <table><tr><td>Change</td><td>Ax 2</td><td>Ax1</td></tr></table>

<table>
<tr><td></td><td>previous Ax and current Ax CAP results.</td><td><table><tr><td>since last Ax</td><td></td><td></td></tr><tr><td>No change</td><td>Triggered with potential for improvement</td><td>Triggered with potential for improvement</td></tr><tr><td>Improved</td><td>1 = Triggered moderate risk status</td><td>2 = Triggered high risk status</td></tr><tr><td>Increased Need</td><td>1=Not triggered</td><td>0=Not triggered</td></tr></table></td></tr>
<tr><td>Total number of CAPs triggered</td><td>The sum of all triggered CAPs displayed in each assessment column.</td><td></td></tr>
<tr><td>Key Outcomes</td><td>Displays list of Key Outcomes and it’s scale range.</td><td>The outcome scale name.
Example: Depression Rating Scale 0 – 14</td></tr>
<tr><td>Key Outcome Scores</td><td>Display the outcome score for each client assessment.</td><td>Numeric</td></tr>
<tr><td>Informal Helper Status:

2a: Informal helper is unable to continue in caring activities.</td><td>Item 2a, within Section M of the Functional Supplement.</td><td>Items displayed within Section M of the Functional Supplement.</td></tr>
<tr><td>2b: Primary informal helper expresses feelings of distress, anger and depression.</td><td>Item 2b, within Section M of the Functional Supplement.</td><td>Items displayed within Section M of the Functional Supplement.</td></tr>
<tr><td>2c: Family or close friends report being overwhelmed by person’s illness.</td><td>Item 2c, within Section M of the Functional Supplement.</td><td>Items displayed within Section M of the Functional Supplement.</td></tr>
<tr><td>Score</td><td>Numeric value of coded response for section listed above.</td><td>Numeric e.g. 0, 1</td></tr>
<tr><td>Description</td><td>A description of the</td><td>Example</td></tr>
</table>

	numeric value.	No = 0 Yes = 1
Hospital Use and Emergency Room Use, Physician Visit		
Inpatient acute hospital with overnight stay.	Item 2a, within Section M of the core CHA form.	Item displayed within Section M.
Emergency Room visit (not counting overnight stay).	Items in for 2b, within Section M of the core CHA form.	Item displayed within Section M.
Physician visit (or authorized assistant or practitioner).	Items in for 2c, within Section M of the core CHA form.	Item displayed within Section M.
Number of Times	The number of times of hospital use, emergency room visit and physician.	Numeric

6. Page Footer:

#	Description	Alignment
1	Page number.	Left aligned
2	Print Date Time stamp.	Left aligned

Refer to Appendix for sample report layout.

AR-3: Client Assessment Summary Report

Report Name:	Client Assessment Summary Report
Report ID:	Assessor Report #3
Req #	Provide a summary of client's last assessment

Objectives:

1. Provides a summary view of a client's last assessment.
2. Align with IAR view of assessment.
3. Will provide information from MH and FS supplement if completed.
4. Display outcome scores with descriptions.

Report Conditions:

1. This report will be generated based on client's most recent assessment.
2. If Functional and Mental Health supplements were not triggered and were completed the assessment information should be generated as part of the report.
3. If Functional and Mental Health supplements were not triggered and not completed only the label headings for the supplements section in the report must be displayed with no data.

Report Users:

Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling Requirements:

The report will be a self-serve and should be available to assessors any time within the assessment software.

Data Source:

Assessment Database

Report Format:

Excel, CSV, PDF.

1. Search Criteria

One or more combinations of search criteria may be entered to generate client assessment information for this report.

Search Criteria Elements	Entry Description	Valid Values
Client Name	Client's First and/or Last Name	Alphanumeric
Health Card Number	Client's Health Card Number	12 digit numeric search field with 2 digit alphanumeric version code
Date of Birth	Client's Date of Birth	YYYY-MM-DD
Assessor Name/Assessor ID	Assessor first and/or last name Assessor Identification number	Alphanumeric

2. Search Conditions:

- Combination of search parameters that should narrow down the results displayed for a client report.
- If no match is found a "no record found" message should be displayed and no report will be generated.
- Selection of a client record from the list of clients should display assessment reports for the selected client
- The most recent assessment report should be displayed at the top of the list.

#	Description	Display Conditions
1	Health Card number search criteria only (uniquely identifies each client).	List of assessment reports associated with the client is displayed.
2	Client Name Search – wild card* search should return all client (s) that match the search criteria entered.	A list of client(s) that match the search criteria should be displayed. The user may then select a client from the displayed list which will then display all assessment reports associated with the client.
3	Date of Birth	A list of clients that match the search criteria should be displayed. The user may then select a client from the displayed list, which will then display all assessment report associated with the client.
4	Date range (recommended to narrow down search results with a combination of another search parameter).	Displays a list of assessment records for clients within the date range selected. If the user selects a client from the list a list of assessment records for that client must be displayed.
5	Assessor Name	Display list of client assessments completed by the assessor.

3. Sort Criteria

Sort in ascending or descending order by:

- Client name
- Date

4. Report Header (from Section A – core CHA)

The report header must display the following information:

Column 1	Column 2
Client First:	Primary Language:
Last Name:	Marital Status:
Health Card Number:	Date Case opened:
Case Record Number:	Last Assessment Date:
Birth Date:	Current Assessment Date:
Gender:	Reason for Assessment:
Residential Living Status (Q11)	Assessor:
Living Arrangement (Q 12):	Assessment Completed + Supplements:

5. Report Data Elements

Data items displayed are specific questions from sections within the Core CHA, Functional and Mental Supplements and the respective coding responses provided.

Core CHA Assessment Section	Coding Response Values
Section C: Cognition C1: Cognitive Skills for Daily Decision Making - Making decisions regarding tasks of daily life	0. Independent 1. Modified independence 2. Minimally impaired 3. Moderately impaired 4. Severely impaired 5. No discernible consciousness, coma
Section D Communication and Vision D1. Making self understood (expression) Expressing information content - both verbal and non-verbal	0. Understood 1. Usually understood 2. Often understood 3. Sometimes understood 4. Rarely or never understood
D2. Ability to understand others (comprehension) Understanding verbal information content (however able with hearing appliance normally used)	0. Understands 1. Usually understands 2. Often understands 3. Sometimes understand 4. Rarely or never understands
D3. Hearing Ability to hear (with hearing appliance normally used)	0. Adequate 1. Minimal difficulty 2. Moderate difficulty 3. Severe difficulty 4. No hearing
D4. Vision	0. Adequate

Ability to see in adequate light (with glasses or other visual appliance normally used)	1. Minimal difficulty 2. Moderate difficulty 3. Severe difficulty 4. No vision
Section E: Mood and Behaviour Indicators of possible depressed, anxious, or sad mood: E1d. Repetitive health complaints E1h. Withdrawal from activities of interest	0. Not present 1. Present but not exhibited in last 3 days 2. Exhibited on 1-2 of last 3 days 3. Exhibited daily in last 3 days **Note:** A reference text *"Functional Supplement: Section C Mood and Behaviour"* shall be displayed to indicate the same section exists in the Functional Supplement.
Section F: Psychosocial Well-Being F1 Social Relationships: 1f: Neglected, abused, or mistreated	0. Never 1. More than 30 days ago 2. 8 to 30 days ago 3. 4 to 7 days ago 4. In last 3 days 8. Unable to determine
Section G: Functional Status G1: IADL self performance and capacity G1a: Meal preparation G1b: Ordinary housework G1c: Managing finances G1d: Managing medications G1e: Phone use G1f: Stairs G1g: Shopping G1h: Transportation	0. Independent 1. Set-up help only 2. Supervision 3. Limited assistance 4. Extensive assistance 5. Maximal assistance 6. Total dependence 8. Activity did not occur
G2:ADL Self – Performance G2a: Bathing G2b: Personal hygiene G2c: Dressing upper body G2d: Dressing lower body G2e: Walking G2f: Locomotion	0. Independent 1. Independent set-up help only 2. Supervision 3. Limited assistance 4. Extensive assistance 5. Maximal assistance 6. Total dependence 8. Activity did not occur
Section H: Continence H1: Bladder Continence	0. Continent 1. Control with catheter or ostomy 2. Infrequent incontinent 3. Occasionally incontinent 4. Frequently incontinent 5. Incontinent 8. Did not occur
Section I: Disease Diagnoses I1b: Other fracture during last 30 days (or since	0. Not present 1. Primary diagnosis/diagnoses for

last assessment if less than 30 days) I1m: Cancer	current stay 2. Diagnosis present, receiving active treatment 3. Diagnosis present, monitored but no active treatment
Section J: Health Conditions J1: Falls	0. No fall in last 90 days 1. No fall in last 30 days but fell 21 -90 days ago 2. One fall in last 30 days 3. Two or more falls in last 30 days
J6 Pain Symptoms J6a: Frequency with which person complains or shows evidence of pain	0. No pain 1. Present but not exhibited in last 3 days 2. Exhibited on 1-2 days of last 3 days 3. Exhibited daily in last 3 days
J6b: Intensity of highest level of pain present	0. No Pain 1. Mild 2. Moderate 3. Severe 4. Times when pain is horrible or excruciating
J6c: Consistency of pain	0. No Pain 1. Single episode during last 3 days 2. Intermittent 3. Constant
J6d: Breakthrough pain	0. No 1. Yes
J6e: Pain control	0. No issue of pain 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required 2. Controlled adequately by therapeutic regimen 3. Controlled when therapeutic regimen followed, but not always followed as ordered 4. Therapeutic regimen followed, but pain control not adequate 5. No therapeutic regimen being followed for pain; pain not adequately controlled

Functional CHA - Assessment	Coding Response Values
Section C – Mood and Behaviour C2 : Behaviour Symptoms C2f: Resists care	0. Not present 1. Present but not exhibited in last 3 days 2. Exhibited on 1 -2 of last 3 days 3. Exhibited daily in last 3 days **Note:** A text reference *"Core Assessment Section E Mood"* shall be displayed as a reference that the same section exists in the Core CHA.
Section D: Functional Status D1a: Transfer toilet	0. Independent 1. Independent, set-up help only 2. Supervision 3. Limited assistance 4. Extensive assistance 5. Maximal assistance 6. Total dependence 8. Activity did not occur during entire period
Section E: Continence E2: Bowel Continence	0. Continent 1. Control with ostomy 2. Infrequently incontinent 3. Occasionally incontinent 4. Frequently incontinent 5. Incontinent 7. Did not occur **Note:** A reference text *"Core Assessment Section H Continence"* should be displayed as a reference that the same section exists in the Core CHA.
Section G: Health Conditions G2: Instability of Conditions G2a: End- stage disease; 6 or fewer months to live	0. No 1. Yes **Note:** A reference text *"Core Assessment Section J - Health Conditions"* should be displayed as a reference that the same section exist sin the Core CHA.
Section J: Medications J1: Adherent with medications prescribed by physician	0. Always adherent 1. Adherent 80% of time or more 2. Adherent 80% of time including failure to purchase prescribed medications 8. No medications prescribed

Section M: Social Relations M1a: Relationship to person	1. Child or child-in–law 2. Spouse 3. Partner/significant other 4. Parent/guardian 5. Sibling 6. Other relative 7. Friend 8. Neighbour 9. No informal helper Note: capture values for Helper 1 and Helper 2
M1b: Lives with person	0. No 1. Yes, 6 months or less 2. Yes, more than 6 months 8 No informal helper Note: capture values for Helper 1 and Helper 2
Areas of informal helper during last 3 days	0. No 1. Yes 8 No informal helper Note: capture values for Helper 1 and Helper 2
M1c: IADL Help	Note: capture values for Helper 1 and Helper 2
M1d: ADL Help	Note: capture values for Helper 1 and Helper 2
Informal Helper Status M2a: Informal helper(s) is unable to continue in caring activities.	0. No 1. Yes
M2c: Family or close friends report feeling overwhelmed by person's illness.	0. No 1. Yes

Mental Health Supplement Assessment		Coding Response
Section E: Self Injurious Ideation or Attempt E1a: Considered performing a self injurious act		0. Never 1. More than 1 year ago 2. 31 days – 1 year ago 3. 8 – 30 days ago 4. 4 – 7 days ago 5. In last 3 days
E2a: Intimidation of others or threatened violence		0. Never 1. More than 1 year ago 2. 31 days – 1 year ago 3. 8 – 30 days ago 4. 4 – 7 days ago 5. In last 3 days
Column Name	**Description**	**Valid Values**
Key Outcomes and Measure: Displays list of Key Outcomes and the scale description for the values generated in the assessment.	Example: Pain scale - Independent valid value = 0	Numeric
Informal Helper Status 2a: Informal helper is unable to continue in caring activities.	Item 2a, within Section M of the Functional Supplement	Items displayed within Section M of the Functional Supplement
2b: Primary informal helper expresses feelings of distress, anger and depression.	Item 2b, within Section M of the Functional Supplement	Items displayed within Section M of the Functional Supplement
2c: Family or close friends report being overwhelmed by person's illness.	Item 2c, within Section M of the Functional Supplement	Items displayed within Section M of the Functional Supplement
Score	Numeric value of coded response for section	Numeric e.g., 0, 1

	listed above.	
Description	A description of the numeric value.	Example: No = 0 Yes = 1
Hospital Use and Emergency Room Use, Physician Visit		
Inpatient acute hospital with overnight stay	Item 2a, within Section M of the core CHA form	Item displayed within Section M
Emergency Room visit (not counting overnight stay)	Items in for 2b, within Section M of the core CHA form	Item displayed within Section M
Physician visit (or authorized assistant or practitioner)	Items in for 2c, within Section M of the core CHA form	Item displayed within Section M
Number of Times	The number of times of hospital use, emergency room visit and physician	Numeric

6. Page Footer:

#	Description	Alignment
1	Page number	Left aligned
2	Print Date Time stamp	Left aligned

Refer to Appendix for sample report layout.

6. Organizational (HSP) Reports

Organizational Reports 1 and 2 Snapshot View

The elements shown in the table should be applied to *Organizational Report 1 and 2* as it provides a snapshot summary view of all active distinct clients based on the demographic elements of the interRAI CHA. This summary view must be displayed on the top each of the detailed reports. In addition, if report filters are selected it should change the values displayed in both the snapshot summary view as well as the detailed report view.

Data Elements

Group By	Measures
Total Number of Clients	Sum of all active distinct clients within the organization: *Condition for display* 1. Active clients (excluding discharged clients) 2. Current or last ***completed*** assessment completed for the client (includes all assessment types) 3. Must be for distinct clients within the date range selection
Gender	
Male & Female	Distinct count of client by gender type.
	Percentage of client by gender type (total # of M or F divided by total # of clients multiplied by 100).
Reason for Assessment	
1. First Assessment 2. Routine Assessment 3. Return Assessment 4. Significant Change in Status Reassessment 5. Discharge covers last 3 days of service 6. Discharge tracking only 7. Other	Distinct client count for each reason for assessment category .
	Percentage of client for each reason for assessment category (total # of clients for each category divided by the total # of clients multiplied by 100).
Age Range	
1. 0-19 2. 20-54 3. 55-64 4. 65 -74 5. 75-84 6. > 85	Distinct client count for each age range category.
	Percentage of clients within each age range category (total # of clients for each category divided by total # of clients multiplied by 100).

Marital Status	
1. Never Married 2. Married 3. Partner/Significant Other 4. Widowed 5. Separated 6. Divorced	Distinct client count for each marital status category. Percentage of clients for each marital status category (total # of clients within each category divided by total # of clients multiplied by 100).
Living Arrangements	
1. Alone 2. With Spouse/Partner Only 3. With Spouse/Partner and others 4. With Child (not spouse or partner) 5. With Parent(s) or Guardians 6. With Siblings 7. With Other Relatives 8. With non - relatives	Distinct client count for each living arrangement category. Percentage of clients for each living arrangement category (total # of clients for each category divided by total # of clients multiplied by 100).
Residential Living Status	
1. Private home/apartment/ rented room 2. Board and care 3. Assisted living or semi-independent living 4. Mental health residence 5. Group homes for persons with physical disability 6. Setting for persons with intellectual disability 7. Psychiatric hospital or unit 8. Homeless (with or without shelter) 9. Long- term care facility (nursing home) 10. Rehabilitation hospital/unit 11. Hospice facility /palliative care unit 12. Acute care hospital 13. Correctional facility 14. Other	Distinct client count for each living arrangement category. Percentage of clients for each residential living status (total # of clients for each category divided by total # of clients multiplied by 100).
Referral Source	
1. General Hospital 2. CSS Organizations 3. Long Term Care Homes 4. CCAC 5. Community Health Centers 6. Other Community Agencies 7. Family Physician 8. Self 9. Family 10. Friend 11. Other	Distinct client count for each referral source category. Percentage of clients for each referral source category (total # of clients for each category divided by total # of clients multiplied by 100).

Languages	
Top 5 language and “Other” category (HSPs should provide their top 5 languages to their vendors).	Distinct client count for each top 5 language category.
	Percentage of clients for each top 5 language category (total # of clients for each category divided by total # of clients multiplied by 100).
	Top 5 should be calculated by the system and then the rest goes into “Other” category.

Refer to Appendix for sample report layout.

OR-1: Clinical Report

Objectives:
Understand acuity of an organization based on CAPs and outcome measures on a particular day or date range of all current completed assessments for all active distinct clients. Show for the organization the distinct client count for each CAP and outcome measure.

Report Conditions:
Sum of all active distinct client within the organization:
Condition for display

4. Active clients (excluding discharged clients).
5. Current or last assessment with a completed status completed for the client (includes all assessment types unless specific parameters are chosen.
6. Must be for distinct clients within the date range selection).

Report Users: Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling Requirements: The report will be a self-serve and should be available to assessors any time within the assessment software.

Data Source: Assessment database.

Report Format: Excel, CSV, PDF.

1. **Search Criteria:**
   Organizations/LHINs may define date range specification to generate the report.

2. **Optional Report Filters:**
   Organizations may provide a list of filter elements to be included for this report. Please note that the elements defined or displayed in the report parameters diagram as per the following categories listed below must be included as part of additional organizational software requirements exclusive of CSS CAP-defined software requirements in order for organizations to have this displayed in the organizational report 1 and 2:
   - Program Types
   - Services
   - Location
   - Service Admission

   Important: The selection of a particular filter element may change the values displayed in the report and snapshot view. The default filter setting can be defined by HSPs and other elements should be disabled unless selected by the user.

Report Measure:

1. The distinct client count for each CAP listed.
2. Percentage of distinct clients for each CAP listed.
3. Service Admission measure - number of clients admitted to service and/or not admitted to service based on the filter selected.

3. Report Data Elements

Group By	Measures
Functional Performance CAPs	
1. Physical Activities Promotion 2. Instrumental ADL (IADL) 3. Activities of Daily Living 4. Home Environment Optimization 5. Institutional Risk	Display the distinct client count for each CAP listed for this category. Display the percentage clients for each CAP in this category.
Cognition and Mental Health CAPs	
1. Cognitive Loss 2. Communication 3. Mood 4. Abusive Relationship 5. Behaviour	Display the distinct client count for each CAP listed for this category. Display the percentage clients for each CAP in this category.
Social Life CAPs	
1. Informal Support 2. Social Relationship	Display the distinct client count for each CAP listed for this category. Display the percentage clients for each CAP in this category.
Clinical Issues CAPs	
1. Falls 2. Pain 3. Cardio – Respiratory 4. Pressure Ulcer 5. Undernutrition 6. Dehydration 7. Feeding 8. Prevention 9. Appropriate Medications 10. Tobacco and Alcohol Use 11. Urinary Incontinence 12. Bowel Condition	Display the distinct client count for each CAP listed for this category. Display the percentage clients for each CAP in this category.

Scales and Outcomes	
Cognitive Performance Scale (CPS)	**Measures**
1. Intact (0) 2. Borderline Impairment (1) 3. Mild Impairment (2) 4. Moderate Impairment (3) 5. Moderate Severe Impairment (4) 6. Severe Impairment (5) 7. Very Severe Impairment (6)	Range 0 – 6 Display the distinct client count for each scale within this range. Display the percentage of clients for each scale within this range.
ADL Self – Performance Scale (Completed Functional Supplement)	
1. Independent (0) 2. Supervision Required (1) 3. Limited Impairment (2) 4. Extensive Assistance Required I (3) 5. Extensive Assistance Required ii (4) 6. Dependant (5) 7. Total Dependence (6)	Range 0 – 6 Display the distinct client count for each scale within this range. Display the percentage of clients for each scale within this range.
Depression Rating Scale	
1. No symptoms of depression (0) 2. Some symptoms of depression – intervention may be helpful (1 -2) 3. Possible depression (3 -5) 4. Possible severe depression (6 -14)	Range 0 – 14 Display the distinct client count for each scale within this range. Display the percentage of clients for each scale within this range.
Changes in Health, End –Stage Disease and Signs and Symptoms (CHESS)	
1. Stable (0) 2. Low level of medical complexity and instability (1) 3. Mild level of medical complexity and instability (2) 4. Moderate level of medical complexity and instability (3) 5. High level of medical complexity and instability (4) 6. Very High level of medical complexity and instability (5)	Range 0 – 5 Display the distinct client count for each scale within this range. Display the percentage of clients for each scale within this range.

Pain Scale	Measures
1. No Pain (0) 2. Mild Pain (1) 3. Moderate Pain – daily pain that is mild or moderate (2) 4. Excruciating Pain – daily pain that is severe and horrible (3)	Range 0 – 3
	Display the distinct client count for each scale within this range.
	Display the percentage of clients for each scale within this range.
Self – Reliance Index	
1. Self – Reliant (0) 2. Impaired (1)	0 or 1
	Display the distinct client count for each scale within this range.
	Display the percentage of clients for each scale within this range.
Instrumental Activities of Daily Living Involvement	
1. Independent (0) 2. Limited Assistance Required (1 -7) 3. Extensive Assistance Required (8-14) 4. Dependent (15 -20) 5. Total Dependence (21)	Range 0 -21
	Display the distinct client count for each scale within this range.
	Display the percentage of clients for each scale within this range.
Method of Assigning Priority Levels	
1. Low (1) 2. Mild (2) 3. Moderate (3) 4. High (4) 5. Very High (5)	Range 1 - 5
	Display the distinct client count for each scale within this range.
	Display the percentage of clients for each scale within this range.

Informal Helper Status	
1. Informal helper is unable to continue in caring activities. 3. Primary informal helper expresses feelings of distress, anger and depression. 4. Family and close friends report being overwhelmed by person's illness.	Distinct client count for assessment records where response type coded ***No*** for each item.
	Percentage of distinct client assessment record where response type coded ***No*** for each item.
	Distinct client count for assessment records where response type coded ***Yes*** for each item.
	Percentage of distinct client assessment record where response type coded ***Yes*** for each item.
Hospital Use, Emergency Room Use, Physician Visit	
1. In- patient acute hospital with overnight stay 2. Physician visit 3. Emergency Room visit	Distinct client count for assessment records where response type coded equals ***None*** for each item.
	Percentage of distinct client assessment record where response type coded equals ***No***ne for each item.
	Distinct client count for assessment records where response coded are for None, ***1-5*** times and More than 5 times for each item.
	Percentage of distinct client assessment record where response type coded are within the range of 1-5 times for each item.
	Distinct client count for assessment response type coded is ***greater than 5*** times for each item.
	Percentage of distinct client assessment record where response type coded is ***greater than 5*** times for each item.

1.1.1

4. Page Footer:

#	Description	Alignment
1	Page number	Left aligned
2	Print Date Time stamp	Left aligned

Refer to Appendix for sample report layout.

OR-2: Clinical Report

Objectives:

1. Provide an overview of all active clients of the organization on their acuity at a point in time.
2. This report will provide the ability to download information for further analysis.
3. The ability to navigate to sections within the report.

Report Conditions:
Sum of all active distinct client within the organization:
Condition for display

1. Active clients (excluding discharged clients).
2. Current or last assessment with a completed status for the client (includes all assessment types).
3. Must be for distinct clients within the date range selection.

Report Users: Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling Requirements: The report will be a self-serve and should be available to assessors any time within the assessment software.

Data Source: Assessment Software.

Report Format: Excel, CSV, PDF.

1. **Search Criteria**

   Organizations/LHINs may define date range specification to generate the report.

2. **Optional Report Filters**

   Organizations may provide list of filter elements to be included for this report. Please note that the elements defined or displayed in the report parameters diagram as per the following categories listed below must be included as part of additional organizational software requirements exclusive of CSS CAP- defined software requirements in order for organizations to have this displayed in the organizational report 1 and 2:
   - Program Types
   - Services
   - Location
   - Service Admission

   Important
   The selection of a particular filter element may change the values displayed in the report and snapshot view. The default filter setting can be defined by HSPs, and other elements should be disabled unless selected by the user.

   Vendors must provide the ability for users to navigate to specific sections within the report: e.g., selection of Section N should automatically navigate user to Section N of the report through a filter or drop down list selection.

3. **Report Measure**

1. The total # of distinct clients for each data item based on the valid values.
2. Percentage of distinct clients for each data item based on the valid values.
3. Service Admission measure: number of clients admitted to service and/or number of clients not admitted to service based on the filter selected.

4. **Report Data Element**

Core CHA	
Section B: Intake and Initial History	**Valid Values**
2a: First Nations 2b: Metis 2c: Inuit	0 - No 1 - Yes
3: Primary language	HSPs may define primary language category they want displayed in the report.
4a: Long term care facility 4b: Board and Care Home assisted 4c: Mental health residence 4d: Psychiatric hospital or unit 4e: Setting for persons with intellectual disability	0 - No 1 - Yes

Section C: Cognition	Valid Values
C1: Cognitive skills for daily decision making	0 – Independent 1 – Modified independent 2 – Minimally impaired 3 – Moderately impaired 4 – Severely impaired 5 – No discernable consciousness
C2: Memory/Recall ability	0 – Yes memory ok 1 – Memory problem
C3:Change in decision making as compared to 90 days ago or less than 90 days ago	0 – Improved 1 – No change 2 – Decline 8 - Uncertain
Section D: Communication and Vision	**Valid Values**
D1: Making self understood	0 – Understood 1 – Usually understood 2 – Often understood 3 – Sometimes understood 4 – Rarely or never understood
D2: Ability to understand others (comprehension)	0 – Understands 1 – Usually understands 2 – Often understands 3 – Sometimes understands 4 – Rarely or never understands
D3: Hearing	0 – Adequate 1 – Minimal difficulty 2 – Moderate difficulty 3 – Severe difficulty 4 – No hearing
D4: Vision	0 – Adequate 1 – Minimal difficulty 2 – Moderate difficulty 3 – Severe difficulty 4 – No vision

Section E: Mood Indicators of Possible Depressed, Anxious or Sad Mood	Valid Values
1a: Made negative statements	0 – Not present 1 – Present but not exhibited in last 3 day 2 – Exhibited on1 – 2 days of last 3 days 3 – Exhibited daily in last 3 days
1b: Persistent anger with self or others	
1c: Expressions including non verbal of what appears to be unrealistic fear	
1d: Repetitive health complaints	
1e: Repetitive anxious complaints	
1f: Sad, pained or worried facial expressions	
1g: Crying, tearfulness	
1h: Withdrawal from activities of interest	
1i: Reduced social interactions	
2. Self – Reported Mood 2a: Little interest or pleasure in things you normally enjoy?	0 – Not in last 3 days 1 – Not in last 3 days, but often feels that way 2 – In 1-2 in last 3 days 3 – Daily in last 3 days 8 – Person could not (would not respond)
2b: Anxious, restless, or uneasy?	
2c: Sad, depressed or hopeless?	
Section F: Psychosocial Well - Being	**Valid Values**
1 Social Relationships 1a: Participation in social activities of long standing interest	0 – Never 1 – More than 30 days ago 2 – 8 to 30 days ago 3 – 4 to 7 days ago 4 – In last 3 days 8 – Unable to determine
1b: Visit with a long-standing social relation or family member	
1c: Other interaction with long-standing social relation or family member e.g., telephone, email	
1d: Conflict or anger with family or friends	
1d:Fearful of a family member or close acquaintance	
1f: Neglected, abused or mistreated	
2. Lonely (Self – reported) 2. Says or indicates that he/she feels lonely	0 – No 1 – Yes
3. Change in social activities in last 90 days (or since last assessment if less than 90 days ago)	0 – No decline 1 – Decline, not distressed 2 – Decline, distressed
4. Length of time alone during the day (morning and afternoon)	0 – Less than 1 hour 1 – 1-2 hours 2 – More than 2 hours but less than 8 hours 3 – 8 hours or more
5. Major life stressors in last 90 days	0 – No 1 – Yes
Section G: Functional Status	**Valid Values**
1a: Meal preparation	For items 1a – 1h two values will be displayed (performance & capacity). Refer to mock up and form specification: 0 – Independent
1b: Ordinary housework	
1c: Managing finances	
1d: Managing medications	

1e: Phone use 1f: Stairs 1g: Shopping 1h: Transportation	1 – Set – up help only 2 - Supervision 3 – Limited assistance 4 – Extensive assistance 5 – Maximal assistance 6 – Total Dependence 8 – Activity did not occur (no values displayed for capacity scoring)
2a: Bathing 2b: Personal hygiene 2c: Dressing upper body 2d: Dressing lower body 2e: Walking 2f: Locomotion	0 – Independent 1 – Set – up help only 2 - Supervision 3 – Limited assistance 4 – Extensive assistance 5 – Maximal assistance 6 – Total dependence 8 – Activity did not occur during entire period
3. Primary mode of locomotion indoors	0 – Walking, no assistance 1 – Walking, using assistive device 2 – Wheelchair, scooter 3 – Bed-bound
4a: Total hours of exercise or physical activity in the Last 3 days	0 – None 1 – Less than 1 hour 2 – 1- 2 hours 3 – 3 - 4 hours 4 – More than 4 hours
4b: In the last 3 days, number of days went out of the house or building in which he/she resides	0 – No days out 1 – Did not go out in last 3 days, but usually goes out over a 3 day period 2 – 1-2 days 3 – 3 days
5. Change in ADL Status as compared to 90 days ago or since last assessment if less than 90 days ago	0 – Improved 1 – No change 2 – Declined 8 – Uncertain
6. Driving 6a: Drove car (vehicle) in the last 90 days	0 – No 1 – Yes
6b: If drove in last 90 days, assessor is aware that someone suggested that person limits or stops driving	0 – No 1 – Yes
Section H: Incontinence	**Valid Values**
1. Bladder continence	0 – Continent 1 – Control with any catheter or ostomy 2 – Infrequently incontinent 3 – Occasionally incontinent 4 – Frequently incontinent 5 – Incontinent

	8 – Did not occur
Section I: Disease Diagnoses	**Valid Values**
1a: Hip fracture during last 30 days	0 – Not present 1 – Primary diagnosis, for current stay 2 – Diagnosis present, receiving active treatment 3 - Diagnosis present, monitored but no active treatment
1b: Other fracture during last 30 days	
1c: Alzheimer's disease	
1d: Dementia other than Alzheimer's disease	
1e: Stroke/CVA	
1f: Coronary heart disease	
1g: Chronic obstructive pulmonary disease	
1h: Congestive heart failure	
1i: Anxiety	
1j: Bipolar	
1k: Depression	
1l: Schizophrenia	
1m: Cancer	
1n: Diabetes mellitus	
Section J: Health Conditions	**Valid Values**
1: Falls	0 – No fall in last 90 days 1 – No fall in last 30 days, but fell 31 – 90 days ago 2 – One fall in last 30 days 3 – Two or more falls in last 30 days
2. Recent falls	0 – No 1 – Yes Blank (first assessment, or more than 30 days since last assessment)
3a: Dizziness	0 – Not present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1 of last 3 days 3 – Exhibited on 2 of last 3 days 4 – Exhibited daily in last 3 days
3b: Unsteady gait	
3c: Chest pain	
3d: Abnormal thought process	
3e: Delusions	
3f: Hallucinations	
3g: Acid reflux	
3h: Constipation	
3i: Diarrhea	
3j: Vomiting	
3k: Difficulty falling asleep or staying asleep, waking up too early, restlessness and non restful sleep	
3l: Too much sleep	
4. Dyspnea (shortness of breath)	0 – Absence of symptom 1 – Absent at rest, but not present when performed moderate activities 2 – Absent at rest, but present when performed normal day to day activities 3 - Present at rest

5. Fatigue	0 – None 1 - Minimal 2 – Moderate 3 – Severe 4 – Unable to commence any normal day-to-day activities
Section J: Health Conditions	**Valid Values**
6.Pain Symptoms 6a: Frequency with which person complains of or shows evidence of pain	0 – No pain 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1 - 2 of last 3 days 3 – Exhibited daily in last 3 days
6b: Intensity of highest level of pain present	0 – No pain 1 – Mild 2 – Moderate 3 – Severe 4 – Times when pain is horrible or excruciating
6c: Consistency of pain	0 – No pain 1 – Single episode during last 3 days 2 – Intermittent 3 – Constant
6d: Breakthrough pain	0 – No 1 – Yes
6e: Pain control	0 – No issue of pain 1 – Pain intensity acceptable to person with no treatment 2 – Controlled adequately by therapeutic regimen 3 – Controlled when therapeutic regimen followed but not always followed as ordered 4 – Therapeutic regimen followed but pain control not adequate 5 – No therapeutic regimen being followed for pain; pain not adequately controlled
7a: Conditions/diseases make cognitive, ADL, mood or behaviour patterns unstable (fluctuating, precarious or deteriorating)	0 – No 1 – Yes
7b: Experiencing an acute episode, or a flare-up of a recurrent or chronic problem	0 – No 1 – Yes
Self reported health 8. Ask: “ In general, how would you rate your health?”	0 – Excellent 1 – Good 2 – Fair 3 – Poor 8 – Could not (would not) respond

Section J: Health Conditions	Valid Values
Tobacco and Alcohol 9a: Smokes tobacco daily	0 – No 1 – Not in last 3 days, but is usually a daily smoker 2 – Yes
9b: Alcohol – Highest number of drinks in any "single sitting" in last 14 days	0 – None 1 – 1 2 – 2 -4 3 – 5 or more
Section K: Nutritional Status	**Valid Values**
1a: Weight loss of 5% or more in Last 30 days or 10% or more in Last 180 days	0 – No 1 – Yes
1b: Dehydrated or BUN/Cre >25	
1c: Fluid intakes less than 1,000 cc per day	
1d: Fluid output exceeds input	
Section L: Medications	**Valid Values**
1. Number of medications	**Range** 1-10 11-15 15 or more
2. Allergy to any drug	0 – No known allergies 1 – Yes
Section M: Treatments & Procedures	**Valid Values**
Prevention: 1a: Blood pressure measured in Last Year	0 – No 1 – Yes
1b: Colonoscopy test in Last 5 Years	
1c: Dental exam in Last Year	
1d: Eye exam in Last Year	
1e: Hearing exam in Last Two Years	
1f: Influenza vaccine in Last Year	
1g: Mammogram or breast exam in Last Two Years	
1h: Pneumovax vaccine in Last Five Years after age 65	
2. Hospital Use, Emergency Room Use, Physician Visit 2a: Inpatient acute hospital with overnight stay	0 1-5 >5
2b: Emergency room visit (not counting overnight stay)	
2c: Physician visit (or authorized assistant or practitioner)	

Section N: Social Supports	Valid Values
1. Strong and supportive relationship with family	0 – No 1 – Yes
Section O: Environmental Assessment	**Valid Values**
Finances: Because of limited funds, during the last 30 days made trade-offs among purchases of any of the following: adequate food, shelter, clothing, prescribed medications etc	0 – No 1 – Yes
Section P: Discharge	**Valid Values**
2. Residential living status at time of discharge	1. Private home/apartment/rented room 2. Board and care 3. Assisted living or semi – independent living 4. Mental health residence 5. Group home for persons with physical disability 6. Setting for persons with intellectual disability 7. Psychiatric hospital unit 8. Homeless 9. Long-term care facility 10. Rehabilitation hospital/unit 11. Hospice facility 12. Acute care hospital 13. Correctional facility 14. Other 15. Deceased

Functional Supplement	
Section B: Cognition	**Valid Values**
Memory Recall Ability: 1a: Procedural Memory OK	0 – Memory OK 1 – Memory Problem
1b: Situational Memory OK	
Periodic Disordered Thinking /Awareness: 2a: Easily distracted	0 – Behaviour not present 1 – Behaviour present, consistent with usual functioning 2 – Behaviour present, appears different from usual functioning
2b: Episodes of disorganized speech	
2c: Mental function varies over the day	
3. Acute change in mental status from person's usual functioning	0 – No 1 – Yes
Section C: Mood and Behaviour	**Valid Values**
1. Indicators of Possible Depressed, Anxious Or Sad Mood: 1a: Recurrent statements that something terrible is about to happen	0 – Not present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1-2 of last 3 days 3 – Exhibited daily in last 3 days
1b: Expressions (including non-verbal) of a lack	

of pleasure in life	
Behaviour Symptoms: 2a: Wandering	0 – Not present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1-2 of last 3 days 3 – Exhibited daily in last 3 days
2b: Verbal abuse	
2c: Physical abuse	
2d:Socially inappropriate or disruptive behaviour	
2e: Inappropriate public sexual behaviour or public disrobing	
2f: Resists care	

Section D: Functional Status	Valid Values
1. ADL Self – Performance: 1a: Transfer toilet	0 – Independent 1 – Independent , set – up help only 2 – Supervision 3 – Limited assistance 4 – Extensive assistance 5 – Maximal assistance 6 – Total dependence 8 – Activity did not occur during entire period
1b: Toilet use	
1c: Bed mobility	
1d: Eating	
2. Locomotion 2a: Time 4-meter (13 foot) walk	30 – 30 or more seconds to walk 4 meters 77 – Stopped before test complete 88 – Refused to do the test 99 – Not tested e.g., does not walk on own
2b: Distance walked	0 – Did not walk 1 – Less than 5 meters 2 – 5 – 49 meters 3 - 50 – 99 meters 4 – 100+ meters 5 – 1+ kilometers (1/2 a mile or more)
2c: Distance wheeled self	0 – Wheeled by others 1 – Used motorized wheelchair 2 – Wheeled self less than 5 meters 3 – Wheeled self 5 -49 meters 4 - Wheeled self 50 -99 meters 5 - Wheeled self 100+ meters 8 – Did not use wheelchair
3. Physical Function Improvement Potential: 3a: person believes he/she is capable of improved performance in physical function	0 – No 1 – Yes
3b: Care professional believes person is capable of improved performance in physical function	

Section E: Continence	Valid Values
1. Urinary collection device (excludes pads and briefs)	0 – None 1 – Condom catheter 2 – Indwelling catheter 3 – Cystostomy, nephrostomy, ureterostomy
2. Bowel continence	0 – Continent 1 – Control with ostomy 2 – Infrequently incontinent 3 – Occasionally incontinent 4 – Frequently incontinent 5 – Incontinent 8 – Did not occur
3. Pads or Briefs worn	0 – No 1 – Yes
Section F: Disease Diagnoses	**Valid Values**
Section F: Disease Diagnoses: 1a: Hemiplegia	0 – Not present 1 – Primary diagnosis/diagnoses for current stay 2 – Diagnosis present; receiving active treatment 3 - Diagnosis present; monitored but no active treatment
1b Multiple Sclerosis	
1c: Paraplegia	
1d: Parkinson's disease	
1e: Quadriplegia	
Infections 1f: Pneumonia	
1g: Urinary tract infarction in last 30 days	
Section G: Health Conditions	**Valid Values**
Balance: 1a: Difficult or unable to move self to standing position unassisted	0 – Not present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1 of last 3 days 3 – Exhibited on 2 of last 3 days 4 – Exhibited daily in last 3 days
Balance: 1b: Difficult or unable to turn self around and face the opposite direction when standing	
Cardiac or Pulmonary: 1c: Difficulty cleaning airway secretions	
Neurological: 1d: Aphasia	
1e: Aspiration	
1f: Fever	
1g: G1 or GU bleeding	
1h: Hygiene	
1i: Peripheral edema	
Instability of Conditions: 2a: End-stage disease, 6 or fewer months to live	0 – No 1 – Yes

Section H: Oral and Nutritional Status	Valid Values
2. Mode of Nutritional Intake	0 – Normal 1 – Modified independent 2 – Requires diet modification to swallow solid food 3 – Requires modification to swallow liquids 4 – Can swallow only pureed solids and thickened liquids 5 – Combined oral and parenteral or tube feeding 6 – Nasogastric tube feeding only 7 – Abdominal feeding tube 8 – Parenteral feeding only 9 – Activity did not occur
3. Dental Or Oral 3a: Wears denture (removable prosthesis)	0 – No 1 – Yes
3b: Has broken, fragmented, loose, or otherwise non – intact natural teeth	
3c: Reports having dry mouth	
3d: Reports difficulty chewing	
Section I: Skin Condition	**Valid Values**
1. Most severe pressure ulcer	0 – No pressure 1 – Any area of persistent skin redness 2 – Partial loss of skin layers 3 – Deep craters in the skin 4 – Break in skin exposing muscle or bone 5 – Not codeable, e.g. necrotic eschar predominant
2. Prior pressure ulcer	0 – No 1 – Yes
3. Presence of skin ulcer other than pressure	0 – No 1 – Yes
4. Major skin problems	0 – No 1 – Yes
5. Skin tear or cuts	0 – No 1 – Yes
6. Other skin conditions or changes in skin condition	0 – No 1 – Yes
7. Foot problem	0 – No foot problems 1 – Foot problems; no limitation in walking 2 – Foot problems limit walking 3 – Foot problems prevent walking 4 – Foot problems; does not walk for other reasons
Section J: Medications	**Valid Values**
1. Adherent with medications prescribed by physician	0 – Always adherent 1 – Adherent 80% of time or more

	2 - Adherent 80% of time including failure to purchase prescribed medications 8 – No medications prescribed
Section K: Treatments and Procedures	**Valid Values**
Treatments: 1a: Chemotherapy	0 – Not ordered and did not occur 1 – Ordered, not implemented 2 – 1 – 2 of last 3 days 8 – Daily in last 3 days
1b: Dialysis	
1c: Infection control	
1d: IV medication	
1e: Oxygen therapy	
1f: Radiation	
1g: Suctioning	
1h: Tracheotomy care	
1i: Transfusion	
1j: Ventilator or respirator	
1k:Wound care	
Programs: 1l: Scheduled toileting program	
1m: Palliative care program	
1n: Turning /repositioning program	
2: Formal Care: a: Home health aides	Number of days: 0 1 2 3 4 5 6 7 Total hours in last week. (Values are indicated in minutes in the form specification. This should be recalculated to hours for the report display for the following range.) <30 minutes 30 minutes – <2hours 2 hours – <4 hours 4 hours – <6 hours 6 hours – <8 hours 8 hours – <10 hours > 10 hours
b: Home nurse c: Homemaking services	
c: Homemaking services	
d: Meals e: Physical therapy	
F: Occupational therapy	
g: Speech-language pathology and audiology services	
h: Psychological therapy	
3. Physically restrained	0 – No 1 – Yes
Section L: Responsibility	**Valid Values**
1a: Personal care	1 – Person 2 - Other
1b: Property	

Section M: Social Relations	Valid Values
1a: Relationship to person	*Helper 1* 1 – Child or child in – law 2 – Spouse 3 – Partner/Significant other 4 – Parent /guardian 5 – Sibling 6 – Other relative 7 – Friend 8 – Neighbour 9 – Informal helper *Helper 2* 1 – Child or child in – law 2 – Spouse 3 – Partner/Significant other 4 – Parent /guardian 5 – Sibling 6 – Other relative 7 – Friend 8 – Neighbour 9 – Informal helper
1b: Lives with person	*Helper 1* 0 – No 1- Yes, 6 months or less 2 – Yes, more than 6 months 8 – No informal helper *Helper 2* 0 – No 1- Yes, 6 months or less 2 – Yes, more than 6 months 8 – No informal helper
1c: IADL help	*Helper 1* 0 – No 1 – Yes 8 – No informal helper *Helper 2* 0 – No 1 – Yes 8 – No informal helper
1d: ADL help	*Helper 1* 0 – No 1 – Yes

	8 – No informal helper *Helper 2* 0 – No 1 – Yes 8 – No informal helper
2a: Informal helper is unable to continue in caring activities.	0 – No 1 – Yes
2b: Primary informal helper expresses feelings of distress, anger, or depression.	
2c: Family or close friends report feeling overwhelmed by person's illness.	
3. Hours of informal care and active monitoring during last 3 days.	0 hour – < 2 hours 2 hours – < 4 hours 4 hours – < 6 hours 6 hours – < 8 hours 8 hours – < 10 hours 10 hours or more
Section N: Environmental Assessment	**Valid Values**
1a: Disrepair of the home	0 – No 1 – Yes
1b: Squalid condition	
1c: Inadequate heating or cooling	
1d: Lack of personal safety	
1e: Limited access to home or rooms in home	
2: Lives in an apartment or house re-engineered to be accessible for persons with disabilities.	0 – No 1 – Yes
3a: Availability of emergency assistance	0 – No 1 – Yes
3b: Accessibility to grocery store without assistance.	
3c: Availability of home delivery of groceries	
Section O: Discharge Potential and Overall Status	**Valid Values**
1: One or more care goals met in last 90 days (or since last assessment if less than 90 days).	0 – No 1 – Yes
2: Overall self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days).	0 – Improved 1 – No Change 2 – Deteriorated
3: Number of 10 ADL areas in which person was independent prior to deterioration.	0 – 1 2 – 3 4 – 5 6 – 7 8 – 9 10

4: Number of 8 IADL performance areas in which person was independent prior to deterioration.	0 – 1 2 – 3 4 – 5 6 – 7 8
5: Time of onset of the precipitating event or problem related to deterioration.	0 – Within last 7 days 1 – 8 to 14 days ago 2 – 15 to 30 days ago 3 – 31 to 60 days ago 4 – More than 60 days ago 8 – No clear precipitating event

Mental Health Supplement	
Section B: Mental Health Service History	**Valid Values**
1: Number of lifetime psychiatric admissions.	0 – None 1 – 1–.3 2 – 4 –.5 3 – 6 or more
2: Time since last contact with community mental health agency or professional in the past year.	0 – No contact in last year 1 – 31 days or more 2 – 30 days or less
Section C: Mental State Indicators	**Valid Values**
1a: Self deprecation	0 – Not Present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1-2 of last 3 days 3 – Exhibited daily in last 3 days
1b: Expression of guilt or shame	
1c: Expressions of hopelessness	
1d: Inflated self-worth	
1e: Irritability	
1f: Pressured speech or racing thoughts	
1g: Labile affect	
1h: Flat or blunted affect	
1i: Obsessive thoughts	
1j: Compulsive behaviour	
1k: Intrusive thoughts or flashback	
1l: Episodes of panic	
1m: Unusual abnormal physical movements	
1n: Hygiene	
Section D: Substance Use or Excessive Behaviour	**Valid Values**
1: Number of days in last 30 days consumed alcohol to point of intoxication.	0 – None 1 – 1 day 2 – 2 – 8 days 3 – 9 or more days, but not daily 4 – Daily
2: Patterns of drinking or other substance use in	0 – No

last 90 days: 2a: Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use.	1 – Yes
2b: Person has been bothered by criticism from others about drinking or drug use.	
2c: Person has reported feelings of guilt about drinking or drug use.	
2d: Person had to have a drink or drug use first thing in the morning to steady nerves.	
2e: Person feels social environment encourages or facilitates abuse of drugs or alcohol.	
Section E: Harm to Self and Others	**Valid Values**
1a: Considered performing a self-injurious act	0 – Never 1 – More than 1 year ago 2 – 31 days – 1 year ago 3 – 8 – 30 days ago 4 – 4 – 7 days ago 5 – In last 3 days
1b: Most recent self–injurious attempt	
2: Intent of any self–injurious attempt was to kill him or herself	0 – No 1 – Yes
3: Family, Caregiver, Friend, or Staff expresses concern that person is at risk for self-injury	0 – No 1 – Yes
4a: Intimidation of others or threatened violence	0 – Never 1 – More than 1 year ago 2 – 31 days – 1 year ago 3 – 8 – 30 days ago 4 – 4 – 7 days ago 5 – In last 3 days
4b: Violence to others	
5a: Police intervention for non-violent behaviour	0 – Never 1 – More than 1 year ago 2 – 31days – 1 year ago 3 – 8 – 30 days ago 4 – 4 – 7 days ago 5 – In last 3 days
5b: Police intervention for violent behaviour	
Section F: Behaviour	**Valid Values**
1a: Verbal abuse	0 – Not Present 1 – Present but not exhibited in last 3 days 2 – Exhibited on 1 – 2 of last 3 days 3 – Exhibited daily in last 3 days
1b: Physical abuse	
1c: Socially inappropriate or disruptive behaviour	
1d: Inappropriate public sexual behaviour or public disrobing	
Section G: Stress and Trauma	**Valid Values**
1a: Death of close family member or friend	0 – Never 1 – More than 1 year ago 2 – 31 days – 1 year ago 3 – 8 – 30 days ago 4 – 4 – 7 days ago
1b: Victim of crime	
1c: Victim of sexual assault or abuse	
1d: Victim of physical assault or abuse	
1e: Victim of emotional abuse	

	5 – In last 3 days
2: Describes one or more of these life events (G1) as invoking a sense of horror or intense fear.	0 – No or not applicable 1 – Yes 8 – Could not (would not) respond
Section H: Medications	**Valid Values**
1: Stopped taking psychotropic medication in last 90 days because of side effects.	0 – No, or no psychotropic 1 - Medication
2: Intentional misuse of prescription or over the counter medication in last 90 days.	0 – No 1 – Yes
Section I	
1: Conflict with or repeated criticism of family or friends.	0 – No 1 – Yes

5. Page Footer:

#	Description	Alignment
1	Page number	Left aligned
2	Print Date Time stamp	Left aligned

Refer to Appendix for sample report layout

OR-3: Operational Report

Objectives: Shows the number of assessments within an organization in multiple status.

Report Conditions: None.

Report Users: Only assessors and other authorized staff within an organization will have access to client health data.

Scheduling Requirements: The report will be a self-serve and should be available to assessors and other authorized staff any time within the assessment software.

Data Source: Assessment database.

Report Format: Excel, CSV, PDF.

1. **Search Criteria:**
   Organizations/LHINs may define date range specification to generate the report.

2. **Report Filters:**
   Not applicable.

3. **Report Data Elements:**

Report Element	Description
Assessor Name	The report should be grouped by assessor name.
Assessment Overdue	The number of assessments overdue based on the HSP business rule for assessment timeline completion. (HSPs to are required to provide vendors with this information.)
In Progress	The total number of open assessments not completed, e.g., not submitted.
Number of Reassessment due in next 30 days	The number of reassessments that due to be completed in the next 30 days counting from the current day the report was generated. Note: The reassessment due date is based on the HSP-defined business rule.
Cancelled	The total number of assessments with cancelled status within the date range.
Completed	Total number of assessments assigned a completed status.
Functional Supplement	Total number of functional supplements triggered and completed.
	Total number of functional supplements not triggered and completed.
	Total number of functional supplements triggered and not completed.
Mental Health Supplement	Total number of mental health supplements triggered and completed.
	Total number of mental health supplements not triggered and completed.
	Total number of mental health supplements triggered and not completed.
Deaf/Blind Supplement	Total number of deaf/blind supplements triggered and completed.
	Total number of deaf/blind supplements not triggered and completed.
	Total number of deaf/blind supplements triggered and not completed.
Assisted Living Supplement	Total number of assisted living supplements triggered and completed.

	Total number of assisted living supplements not triggered and completed.
	Total number of assisted living supplements triggered and not completed.

4. Page Footer:

#	Description	Alignment
1	Page number	Left aligned
2	Print Date Time stamp	Left aligned

Refer to Appendix for sample report layout

Appendix

1.1.2 Sample Report Mock – Ups

Vendors: Please refer to the document entitled: ***CSS CAP Assessor and Organizational Report Samples_20110121_v1 0.xls*** which is available by accessing the interRAI CHA Vendor area of the CCIM website: https://www.ccim.on.ca/Vendor/CSSCAP/Pages/Requirements.aspx