# PRISM Data Fields – CARE

The **P**redictive **R**isk **I**ntelligence **S**yste**M** contains valuable information designed to support care management interventions for high-risk clients. It includes information from medical, social service, behavioral health and long term care payments including assessment data from CARE. Information includes Medicare and Medicaid claims, in-patient stays, Emergency Department utilization, and risk factors. The lookback period for data is 15 months for adults and 24 months for children. The following shows the types of data CARE exports to PRISM.

**Long Term Care Assessments**: In PRISM, the entire CARE assessment is not available, however it will show the history of assessments. It lists the type (annual, interim, sig change, initial), status (current, pending, history), Date assessment was done, and the Problem Description. The Problem description is taken verbatim from "reason for assessment" on the CARE Assessment Main screen. When the PRISM user selects a particular assessment from the list, the following information will display:

<u>**Behaviors:**</u> The number of behaviors are displayed and when the PRISM user clicks on this section, it shows the name of behavior, type of behavior, status (current/past), intervention, alterability, and description.

<u>**Fall:**</u> Provides the number of falls listed and when the PRISM user clicks on this section, it shows site (e.g. bedroom, outside), and when occurred (e.g. within 30 days, past 31-180 days).

<u>**Pain:**</u> The number provided is not the client's pain level but rather the amount of impacts listed for pain. When the PRISM user clicks in this section, it specifies the pain impacts (e.g. depression, activity limited, sleep loss, etc.).

<u>**Limitations:**</u> The number listed is the amount of limitations that are on the assessment. When the PRISM user clicks on it, it shows each limitation from all screens.

<u>**Client:**</u> Shows ADSA ID, name, reporting unit and housing (does not pull the address).

<u>**Worker:**</u> Shows current HCS/AAA case manager and their phone number per overview screen.

<u>**PCP:**</u> Shows name, address and start date of any PCP's listed as PCP in contact role. Will show previous PCP's with end date.

**Other details:** The following areas show only the noted response and no further information:

> <u>**ADL Score (0-28):**</u> Does not list the ADL's but only shows the score (0-28);

**Depression Score:** Lists the depression score by number. CARE uses the Patient Health Questionnaire (PHQ), PHQ-2/PHQ-9, a validated depression screening tools to assist in the assessment process. The PHQ-0 is also used in MDS 3.0 and will allow for comparisons across healthcare settings. A score of 10 or more indicates possible depression and the case manager is to document a discussion regarding possible referral;

**CPS Score (0-6):** Lists the CPS score (0-6). The Cognitive Performance Scale (CPS) is made up of the following elements taken from the assessment:

- Is client comatose?
- Can client feed her/himself?
- Can client make her/him understood?
- Rate how client makes decisions
- Short term memory OK? Or MMSE delayed recall (missing one or more)

The following table contains the average relationship between a client's CPS and MMSE score.

| Score meaning | Cognitive performance scale |
|---|---|
| Intact | 0 |
| Borderline Intact | 1 |
| Mild Impairment | 2 |
| Moderate Impairment | 3 |
| Moderate to Severe Impairment | 4 |
| Severe Impairment | 5 |
| Very Severe Impairment | 6 |

**Overall Self-Sufficiency:** Lists what was selected on Independence and Improvement screen (e.g. No change, Deterioration, Improved);

**Self Rated Health Status:** Lists what was selected on the Indicators/Health Indicators screen (e.g. good, fair, poor). This question is an excellent indicator of a client's health status. A client's perspective of his/her health can be a very good predictor of what his/her health status will be;

**Residential Group:** From the Care Plan screen lists the Classification such as A High, B Low, etc. This is the clinical grouping that the client falls into based upon clinical complexity, Cognitive Performance Scale (CPS) score, moods/behavior, and ADL score; and

**In Home Group:** Same as Residential Group.