12-28-92
Vol. 57 No. 249
Pages 61557-61758

federal register

Monday
December 28, 1992

FEDERAL REGISTER Published daily, Monday through Friday, (not published on Saturdays, Sundays, or on official holidays), by the Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408, under the Federal Register Act (49 Stat. 500, as amended; 44 U.S.C. Ch. 15) and the regulations of the Administrative Committee of the Federal Register (1 CFR Ch. I). Distribution is made only by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

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This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 92–NM–143–AD; Amendment 39–8433; AD 92–26–06]

Airworthiness Directives; British Aerospace Model BAe 125–800A Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain British Aerospace Model BAe 125–800A series airplanes, that requires the installation of an indicator label on certain circuit breakers that must be disabled by the flight crew during smoke drill procedures. This amendment is prompted by a report that certain additional circuit breakers must be clearly identified in order to ensure that the flight crew disables them in an emergency. The actions specified by this AD are intended to prevent reduced effectivity of smoke elimination and passenger evacuation procedures by allowing the crew to disable all appropriate circuit breakers in an emergency situation.

DATES: Effective February 1, 1993.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of February 1, 1993.

ADDRESSES: The service information referenced in this AD may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041–0414. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. William Schroeder, Aerospace Engineer, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (206) 227–2148; fax (206) 227–1320.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include an airworthiness directive (AD) that is applicable to certain British Aerospace Model BAe 125–800A series airplanes was published in the **Federal Register** on October 2, 1992 (57 FR 45584). That action proposed to require the installation of an indicator label on certain circuit breakers that must be disabled by the flight crew during smoke drill procedures.

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the single comment received.

The commenter supports the proposed rule.

After careful review of the available data, including the comment noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

The FAA estimates that 137 airplanes of U.S. registry will be affected by this AD, that it will take approximately 1 work hour per airplane to accomplish the required actions, and that the average labor rate is $55 per work hour. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be $7,535, or $55 per airplane. This total cost figure assumes that no operator has yet accomplished the requirements of this AD.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption "**ADDRESSES.**"

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

Section 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

92–26–06. British Aerosapce: Amendment 39–8433. Docket 92–NM–143–AD.

Applicability: All Model BAe 125–800A series airplanes on which Modification No. 253284A has not been installed; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent the crew from failing to disable all appropriate circuit breakers in an emergency, accomplish the following:

(a) Within 3 months after the effective date of this AD, install Modification No. 253284A by painting the perimeters of the "A SCRN" and "B SCRN" heat control circuit breakers with matte white (non-cellulose) paint, in accordance with British Aerospace Service Bulletin SB.24–288–3284A, dated February 7, 1992.

(b) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Standardization Branch, ANM–113, FAA,

Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Standardization Branch.

Note: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Standardization Branch, ANM–113.

(c) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(d) The installation shall be done in accordance with British Aerospace Service Bulletin SB.24–288–3284A, dated February 7, 1992.

(Note: The issue date of that service bulletin is indicated only on "page 1 of 7"; no other page of the document is dated.)

This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC 20041–0414. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

(e) This amendment becomes effective on February 1, 1993.

Issued in Renton, Washington, on December 2, 1992.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate Aircraft Certification Service

[FR Doc. 92–31382 Filed 12–24–92; 8:45 am]

BILLING CODE 4910–13–M

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14 CFR Part 39

[Docket No. 92–NM–72–AD; Amendment 39–8432; AD 92–26–05]

Airworthiness Directives; British Aerospace Model ATP Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain British Aerospace Model ATP series airplanes, that requires a one-time functional inspection to detect tightness or seizure of the nose wheel steering quadrant pivot and the upper steering control toggle link assembly, and repair, replacement, or refit, if necessary. This amendment also requires, under certain circumstances, a further visual inspection of the support channels/structure for deformation or cracks, and repair or replacement of damaged parts. This amendment is prompted by a report of an airplane running off the runway as a result of failure of the nose wheel steering quadrant support structure. The actions specified by this AD are intended to prevent failure of the nose wheel steering structure, which could adversely affect the controllability of the airplane.

DATES: Effective February 1, 1993.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the **Federal Register** as of February 1, 1993.

ADDRESSES: The service information referenced in this AD may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC. 20041–0414. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: William Schroeder, Aerospace Engineer, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (206) 227–2148; fax (206) 227–1320.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations to include an airworthiness directive (AD) that is applicable to certain British Aerospace Model ATP series airplanes was published in the **Federal Register** on July 23, 1992 (57 FR 32747). That action proposed to require a one-time functional inspection to detect tightness or seizure of the nose wheel steering quadrant pivot and the upper steering control toggle link assembly, and repair, replacement, or refit, if necessary. That action also proposed to require, under certain circumstances, a further visual inspection of the support channels/structure for deformation or cracks, and repair or replacement of damaged parts.

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the single comment received.

The commenter supports the proposed rule, but recommends that it be issued as a telegraphic AD or immediately adopted rule to assure timely action to prevent failure of the nose wheel steering structure, which could adversely affect the controllability of the airplane. The FAA does not concur with the commenter's suggestion. Although the FAA recognizes the unsafe condition presented by this situation, as was described in the preamble to the notice, the FAA could not justify that an immediate safety of flight problem existed, especially in light of the fact that the entire U.S. fleet of British Aerospace Model ATP series airplanes had already been inspected in accordance with the proposed requirements. None of the operators found a steering linkage binding problem and no additional action in accordance with the related service bulletin was required. In developing this AD action, the FAA considered these items, and determined that it was not impracticable to provide notice and the opportunity for public comment on the proposed rule.

After careful review of the available data, including the comment noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

The FAA estimates that 10 airplanes of U.S. registry will be affected by this AD. The FAA has been advised that all 10 affected airplanes have been inspected in accordance with the requirements of this AD. Therefore, currently, this AD action imposes no additional economic burden on any U.S. operator.

However, should an unmodified airplane be imported and placed on the U.S. Register in the future, it will take approximately .5 work hour per airplane to accomplish the proposed actions, at an average labor rate of $55 per work hour. Based on these figures, the total cost impact of the AD is estimated to be $28 per airplane.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is

contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

92–26–05. British Aerospace: Amendment 39–8432. Docket 92–NM–72–AD.

Applicability: Model ATP series airplanes, serial numbers 2001 through 2044, inclusive; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent reduced controllability of the airplane, accomplish the following:

(a) Within 30 days after the effective date of this AD, perform a one-time functional inspection to detect tightness or seizure of the nose wheel steering quadrant pivot and the upper steering control toggle link assembly, in accordance with British Aerospace Service Bulletin ATP–32–37, dated February 14, 1992.

(1) If the quadrant pivot/upper toggle link attachment bolt can be turned freely, in accordance with paragraph 2.A.(1) through 2.A.(8) of the Service Bulletin, no further action is necessary.

(2) If the quadrant pivot/upper toggle link attachment bolt is still tight, prior to further flight, if possible, remove and replace the bolt; in accordance with paragraphs 2.A.(9) and 2.A.(8) of the Service Bulletin. After this procedure, if the bolt turns freely, no further action is necessary.

(3) If the quadrant pivot/upper toggle link attachment bolt is found to be seized and cannot be removed, prior to further flight, check to see if the upper toggle link is free to rotate about the bolt, in accordance with paragraphs 2.A.(10) through 2.A.(12) of the Service Bulletin.

(i) If the upper toggle link is free to rotate about the bolt, prior to the accumulation of 50 landings after the functional inspection required by this AD, accomplish paragraph (a)(4) of this AD.

(ii) If the upper toggle link is not free to rotate about the bolt, prior to further flight, accomplish paragraph (a)(4) of this AD.

(4) If the upper toggle link has been checked in accordance with paragraph (a)(3)(i) or (a)(3)(ii) of this AD, repair the quadrant pivot/upper toggle link and bolt assembly, visually inspect the support channels/structure for deformation or cracks, and repair or replace any deformed or cracked structure, in accordance with paragraph 2.B. of the Service Bulletin.

(b) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Standardization Branch, ANM–113. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Standardization Branch, ANM–113.

Note: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Standardization Branch, ANM–113.

(c) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

(d) The inspections, repair, and replacement shall be done in accordance with British Aerospace Service Bulletin ATP–32–37, dated February 14, 1992. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. Copies may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC. 20041–0414. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

(e) This amendment becomes effective on February 1, 1993.

Issued in Renton, Washington, on December 2, 1992.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate Aircraft Certification Service.

[FR Doc. 92–31381 Filed 12–24–92; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

45 CFR Parts 302 and 303

RIN 0970–AA91

Child Support Enforcement Program: Review and Adjustment of Child Support Orders

AGENCY: Office of Child Support Enforcement (OCSE), ACF, HHS.

ACTION: Final rule.

SUMMARY: These regulations implement the requirements of section 103(c) of the Family Support Act of 1988 (Pub. L. 100–485) which are effective October 13, 1993. Section 103(c) requires periodic review of child support orders and adjustment, as appropriate, in accordance with State guidelines for support award amounts. These regulations implement the requirement that States have a process under which child support orders in IV–D cases are periodically reviewed not later than 36 months after the establishment of the order or the most recent review, and adjusted, as appropriate, in accordance with State guidelines. These regulations also implement the requirement that States notify each parent subject to a child support order in the State, being enforced under Title IV–D, of the right to request a review of the order. Final rules implementing certain other requirements of section 103(c) which were effective October 13, 1990 were published separately (57 FR 30658, dated July 10, 1992).

EFFECTIVE DATE: These regulations are effective on and after October 13, 1993.

FOR FURTHER INFORMATION CONTACT: Marianne Clifford Upton, OCSE Division of Policy and Planning, (202) 401–5373.

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

This regulation contains no information collection requirements that are subject to OMB review under the Paperwork Reduction Act of 1980 (Pub. L. 96–511).

Statutory Authority

These regulations are published under the authority of section 466(a)(10) of the Social Security Act (the Act), as amended by Public Law 100–485 and the general authority of section 1102 of the Act, which requires the Secretary to publish regulations that may be necessary for the efficient

administration of the functions for which he is responsible under the Act.

Background

Review and Adjustment of Child Support Orders

Historically, State laws governing modification of child support orders have required that the party seeking a change in the award amount must prove that a material change in circumstances has occurred since entry of the order. Several States require that the change in circumstances be substantial and continuing. Still others impose a condition that the change be one that could not have been contemplated at the time the order was initially established. Meeting this burden of proof has often made obtaining a change in the amount of child support a difficult undertaking for many parties. The existence of such a standard has frequently meant the need for an adversary proceeding and protracted litigation to demonstrate the occurrence of a sufficient change in circumstances or to resist an allegation that the requisite change in circumstances has occurred.

Section 103 of the Family Support Act of 1988 (Pub. L. 100–485) requires that States must use guidelines as a rebuttable presumption in all proceedings for the award of child support and that review and adjustment of child support orders be done "in accordance with guidelines." These provisions evidence Congressional intent to make obtaining an adjustment in the amount of child support easier by requiring a process in which the standard for modification must be related to State child support guidelines. The enactment of these requirements reflects a recognition that the traditional burden of proof for making a change in the amount of support ordered may have contributed to many awards remaining unchanged throughout the life of the order and thus, inadequate or inappropriate with the passage of time. It also signals a need for States to at least expand, if not replace, the traditional "change in circumstances" test as the legal prerequisite for changing the amount of child support to be paid, by making State guidelines the presumptively correct amount of support to be paid.

Beginning with the enactment of the Child Support Enforcement Amendments of 1984 (Pub. L. 98–378), each State had to establish guidelines for child support award amounts in the State, as a condition of State IV–D plan approval. These guidelines were not binding, but had to be made available to all judges and other officials with authority to determine award amounts.

Under section 103(a) of Public Law 100–485, Congress required that States must use guidelines and that the amount of the child support award computed according to the guidelines is rebuttably presumed to be the correct amount to be awarded. A written finding or specific finding on the record of the support proceeding that the application of the guidelines would be unjust or inappropriate in a particular case, as determined by State criteria, is sufficient to rebut the presumption in that case. To ensure that the use of the guidelines will result in appropriate support award amounts, section 103(b) of Public Law 100–485 requires that States review guidelines at least once every four years.

Final regulations governing these aspects of section 103 were published in the **Federal Register** on May 15, 1991 (56 FR 22335). In response to comments, OCSE stressed that the use of guidelines is not limited to setting the initial award, and that guidelines must be used to modify existing orders.

The challenge of keeping child support orders up-to-date has emerged as an issue of concern for legislators, policymakers, IV–D personnel, the judiciary, child advocates, and parents. Analysis done by the HHS Office of the Inspector General (OIG) suggests that States and AFDC recipients would benefit substantially if State IV–D agencies reviewed child support orders of $50 per month or less in cases in which the State and/or Federal wage data indicates that the absent parent's income is more than $10,000 per year (see OIA–05–87–00035). This study also suggests that non-AFDC families would benefit substantially if State IV–D agencies determined the income of absent parents from State and/or Federal wage data in non–AFDC cases with low child support orders and informed custodial parents how a modification might affect the amount of support awarded.

Child support orders established prior to the adoption of State guidelines may be grossly inadequate. Even the use of guidelines in establishing the initial award amount does not ensure that orders, over time, continue to meet the support standards set by the guidelines. To address this problem, section 103(c) of Public Law 100–485 phases-in a requirement for the periodic adjustment of support orders, in accordance with the support guidelines in the State.

Under section 103(c), the Act is amended by inserting a new section 466(a)(10). Section 466(a)(10)(A), effective October 13, 1990, requires State procedures for review and adjustment of orders, consistent with a plan indicating how and when child support orders are to be reviewed and adjusted. Review may take place at the request of either parent subject to the order or at the request of a State IV–D agency. Any adjustment to the award must be in accordance with the State's guidelines, which must be used as a rebuttable presumption in establishing or adjusting support obligations in the State.

Section 466(a)(10)(B), effective October 13, 1993 (or earlier at State option), requires the State to have implemented a process whereby orders being enforced under title IV–D will be reviewed no later than 36 months after establishment of the order or the most recent review of the order and adjusted in accordance with the State's guidelines for support award amounts. Review is required in IV–D cases in which support rights are assigned to the State, unless the State has determined that review would not be in the best interests of the child and neither parent has requested a review. This encompasses child support orders in cases in which benefits under the AFDC, Title IV–E foster care, or Medicaid programs are currently being provided. It does not include orders in former AFDC, Title IV–E foster care, or Medicaid cases, even if the State retains an assignment of support rights to the extent of any unpaid support that accrued under the assignment which remains due to the State after assistance terminates. In IV–D cases in which there is no current assignment of support rights to the State, including former recipients of AFDC, Title IV–E foster care, or Medicaid benefits receiving continued IV–D services, review is required at least once every 36 months only if a parent requests it. In all IV–D cases, if such a review indicates that adjustment of the support amount is appropriate, the State must proceed to adjust the award accordingly.

Section 466(a)(10)(C) requires States to have procedures for notifying each parent subject to an order in effect in the State, being enforced under title IV–D, of their rights concerning reviews and proposed adjustments. Each parent must be notified of the right to request the State to review the order; of any review, at least 30 days before it commences; and of a proposed adjustment or determination that there should be no change in the award amount. In the latter case, the parent must be given at least 30 days after notification to initiate proceedings to challenge the proposed adjustment or determination.

Proposed regulations governing all section 103(c) requirements were published in the Federal Register on August 15, 1990 (55 FR 33414). Final rules implementing only those review and adjustment requirements which are effective October 13, 1990 were published on July 10, 1992 (57 FR 30658). Section 303.8(a) of the final rule published earlier contains definitions designed to clarify key aspects of the review and adjustment process. Under § 303.8(a)(1)(i), "adjustment" means an upward or downward change in the amount of child support based upon an application of the State guidelines for setting and adjusting child support. Under § 303.8(a)(1)(ii), "adjustment" also means the provision for the health care needs of the child through health insurance or other means.

Section 303.8(a)(2) defines "parent" to include any custodial parent or noncustodial parent (or for purposes of requesting a review, any other person or entity who may have standing to request an adjustment to the child support order). "Review" is defined in § 303.8(a)(3) as an objective evaluation, conducted through a proceeding before a court, quasi-judicial process, or administrative body or agency, of information necessary for application of the State's guidelines for support to determine the appropriate support award amount, and the need for a provision in the order addressing the child(ren)'s health care needs through health insurance or other means under State guidelines.

Section 303.8(b) of the final rule published earlier requires the State to have a written and publicly available plan indicating how and when child support orders in effect in the State will be periodically reviewed and adjusted. It also specifies the requirements that the State must meet between October 13, 1990 and October 12, 1993, with respect to orders being enforced in IV–D cases.

In accordance with section 103(e) of Public Law 100–485, OCSE conducted two-year demonstration projects in Colorado, Delaware, Florida, and Illinois to test and evaluate model procedures for reviewing child support award amounts. Project findings corroborated that many child support orders are inadequate, outdated, and not reflective of parental ability to pay. At the conclusion of the projects, adjusted orders had been obtained in over 3,200 cases across the four projects. These cases represented 10 percent of those initially selected for review. [Another 17 percent were pending at the conclusion of the demonstration projects.] The vast majority (87%) of the modifications were upward adjustments in the child support award. The average percentage increase in the monthly support obligation ranged from 47 percent in Delaware to 135 percent in Illinois. Across the four projects, the average percentage increase was 92 percent.

We urge interested parties to examine the findings of these demonstration projects, as well as the results of a similar project initiated earlier in Oregon, to determine innovative methods for conducting review and adjustment processes on an ongoing basis. States may find the practical experiences and various approaches of other jurisdictions beneficial in implementing the review and adjustment requirements. To this end, OCSE will continue to broadly disseminate reports of the experiences of the demonstration States and best practices of other jurisdictions as they integrate review and adjustment into their routine support enforcement program operations.

In response to numerous comments urging us to delay publication of final regulations until completion of the demonstration projects mentioned previously, we decided to publish this separate rule governing the requirements for review and adjustment which are effective October 13, 1993. This action has enabled us to benefit from the experience and wisdom gained from the review and adjustment demonstration projects.

Description of Regulatory Provisions

Required State Laws—Section 302.70

With the issuance of the final rule with respect to the review and adjustment requirements which are effective October 13, 1990, regulations at 45 CFR 302.70(a)(10) require that States enact necessary laws and have procedures in effect for the review and adjustment of support orders, in accordance with the requirements of 45 CFR 303.8. We amend § 302.70(a)(10) to specify the requirements for review and adjustment by the respective effective dates. Current § 302.70(a)(10) is redesignated as paragraph (a)(10)(i) to require that States enact laws and implement procedures for review and adjustment of child support orders in accordance with § 303.8 (a) and (b) effective on October 13, 1990 until October 12, 1993. Paragraph (a)(10)(ii) requires States to enact laws and implement procedures for review and adjustment of child support orders in accordance with § 303.8 (a) and (c) through (f), effective on October 13, 1993, or earlier at State option.

Provision of Services in Interstate Cases—Section 303.7

This final rule amends § 303.7 (b) and (c) to add review and adjustment activities to the required functions to be performed by initiating and responding States in interstate IV–D cases. Paragraph (b) is amended by adding new subparagraph (6) which requires an initiating State to send a request for review of a child support order to another State within 20 calendar days of determining that review of a child support order should be requested in such other State and receipt of information necessary for conducting the review, in accordance with § 303.8(f)(1). We add a new subparagraph (v) to § 303.7(c)(7) to include review and adjustment of child support orders upon request, in accordance with § 303.8(f)(2), to the services a IV–D agency in a responding State must provide if necessary in interstate IV–D cases. We amend paragraph (c)(8) to replace the term "modification" with the term "adjustment" to make the terminology of the regulation consistent with the language of P.L. 100–485. Section 303.8(f) of this regulation sets forth specific requirements for review and adjustment in interstate cases. We address and clarify these interstate review and adjustment responsibilities in greater detail under the section of this preamable which explains § 303.8(f) of the regulation.

Review and Adjustment of Orders—Section 303.8

Section 303.8(c)—Periodic Review and Adjustment After October 13, 1993

Section 303.8(c) contains the requirements that are effective October 13, 1993, or earlier at State option, regarding review of child support orders being enforced under the IV–D program. Beginning at that time, under paragraph (c)(1), the State must have in effect and use a process for review and adjustment of child support orders in effect in the State, including a process for challenging any proposed adjustment or other determination. The review and adjustment process may be conducted within a State's judicial arena, within an administrative process structure available within an executive agency, within a combination of the judicial and administrative systems, or within any other designated forum at the discretion of the State. The law does not mandate that the IV–D agency substitute for or assume the functions of a court or administrative forum which has the legal authority in the State to adjust child support orders. Alternatively,

nothing in the law precludes a State, if it so chooses, from extending such authority to the IV–D agency.

Notice of the Right to Request Review. Paragraph (c)(2) requires that the State must notify each parent subject to a child support order in the State being enforced under Title IV–D of the right to request a review of the order. It further requires that the parents be notified of the appropriate place and manner in which the request for review should be made. States may meet this requirement by sending a one-time notice to each parent subject to an order in the State.

This requirement applies in all cases in which there is a valid order in effect, which can be adjusted under State law, including orders entered as a result of interstate activity, such as those obtained or registered in the State through the Uniform Reciprocal Enforcement of Support Act (URESA) or the Revised Uniform Reciprocal Enforcement of Support Act (RURESA). We recognize that a URESA order is a separate order which stands on its own merit. Such order may be additional to a divorce decree or other order for support, and may be in a different amount than such other orders. On the other hand, in some cases, a URESA order may be the only order in effect. This requirement recognizes that in some instances, there may be orders in effect and being enforced in more than one State. As a result, it is possible that the parents involved in such cases may receive multiple notices from different States regarding the right to request a review of the order. The responsibilities of initiating and responding States for requesting and conducting reviews and adjusting child support award amounts in interstate cases are discussed in greater detail later in this preamble.

The duty to send a notice of the right to request a review does not, however, extend to those cases in which a State, acting in a responding capacity, has registered or entered an order for enforcement purposes only and, under State law, cannot modify the underlying child support award amount. In these cases, the State is providing only enforcement services such as income withholding or State income tax refund offset, and the State's jurisdiction over the parties is limited to the specific purpose of enforcement.

Periodic Publicizing of Right to Request Review. Paragraph (c)(3) requires States to periodically publicize the right to request a review as part of its support enforcement services as required under § 302.30 and to include notice of this right as part of the information on IV–D services required under § 303.2(a)(2). Thus, States must regularly and frequently publicize information about the availability of review and adjustment services, as well as all other support enforcement services, through public service announcements. States could, for instance, incorporate appropriate information about review and adjustment of child support orders in any pertinent notices to child support recipients and obligors or use other media such as brochures, pamphlets, radio, television, posters, and billboards. Additionally, States could sponsor advertising campaigns or utilize public service announcements to inform parents of the right to request review of child support orders.

Frequency and Conditions of Reviews. Paragraph (c)(4) specifies the frequency and conditions under which child support orders in effect in the State and being enforced under Title IV–D must be reviewed. With certain exceptions, States must review, at 36-month intervals after establishment of the order or the most recent review, child support orders in IV–D cases in which rights to child support are assigned to the State. In IV–D cases in which there is no assignment of support rights to the State, reviews are required only upon the request of either parent.

Although the statute requires periodic reviews only in cases in which rights to child support are assigned to the State under section 402(a)(26) of the Act (i.e., AFDC cases), we are using our authority under section 1102 of the Act to publish regulations that are necessary for the efficient administration of the IV–D program to require such reviews in all IV–D cases in which support rights are assigned to the State. This includes, in addition to cases assigned as a condition of receipt of AFDC under 45 CFR 232.11, title IV–E foster care cases in which the support rights are assigned under section 471(a)(17) of the Act and non-AFDC Medicaid cases in which the rights to medical support or to payments for medical care from any third party are assigned under 42 CFR 433.146. In any non-AFDC Medicaid case in which the support order does not provide for the health care needs of the children or the custodial parent does not have satisfactory health insurance other than Medicaid, a review is required to determine the need to provide in the order for the health care needs of the children, through health insurance or other means.

Regulations implementing the requirement for extension of IV–D services to non-AFDC Medicaid recipients and continuation of IV–D services to former AFDC recipients were published in the **Federal Register** on February 26, 1991 (56 FR 7988). IV–D services include those unrelated to securing medical support under §§ 303.30 and 303.31, unless the non-AFDC Medicaid recipient notifies the IV–D agency that child support enforcement services unrelated to securing medical support are not wanted. Individuals who have assigned medical support rights must cooperate with the IV–D agency in establishing paternity and in securing medical support, unless the Medicaid agency determines that good cause for not cooperating exists. Other than the fact that medical support rights are assigned and a duty to cooperate with the IV–D agency in establishing paternity and securing medical support exists, a non-AFDC Medicaid case is similar to a non-AFDC case. Therefore, if a support order requiring the provision of health insurance or otherwise addressing the health care needs of the children already exists in a non-AFDC Medicaid case, a review of the child support order is not required every 36 months unless a parent requests a review.

For the purpose of review and adjustment requirements, former AFDC cases which continue to receive IV–D services are considered to be non-AFDC cases, such that review is not required in such cases unless requested by either parent. Similarly, cases in which the State, by virtue of a previous assignment of rights to child support, is entitled to arrearages, but in which continued services are no longer being provided to the former recipient, are not subject to the mandatory review requirement.

These requirements are discussed more extensively in the Response to Comments section of this preamble.

Exceptions to Mandatory Review. Paragraph (c)(4) also sets forth three exceptions to the mandatory review requirement. First, under paragraph (c)(4)(i), review is not required in cases in which support rights are assigned to the State, as defined at § 301.1, if the State determines, in accordance with § 303.8(c)(5), that a review would not be in the best interests of the child and neither parent has requested a review.

Paragraph (c)(4)(ii) specifies the second exception, by providing that review is not required in IV–D cases, in which there is no assignment of support rights to the State, if neither parent requests a review.

Lastly, paragraph (c)(4)(iii) exempts from mandatory review any IV–D case in which medical support rights are assigned under 42 CFR 433.146, but in which child support rights are not assigned under 45 CFR 232.11 or section 471(a)(17) of the Act, the order requires

the provision of health insurance, and neither parent has requested a review. Recipients of Medicaid are required under section 1912(a)(1) of the Act to assign to the State their rights to support for medical care from any third party and to cooperate with the State in establishing paternity and securing medical support. Effective July 1, 1988, section 9142 of Public Law 100–203 amended section 454(4) of the Act to require that State IV–D agencies provide IV–D services to families who have assigned their rights under section 1912 of the Act as a condition of receipt of Medicaid. The IV–D agency must provide all appropriate IV–D services to Medicaid recipients referred to the IV–D agency, whether or not they are also eligible for AFDC, without an application or application fee.

Circumstances Under Which Review Would Not Be in the Best Interests of the Child. Paragraph (c)(5) provides that, in cases in which support rights are assigned to the State as defined in § 301.1, a State must determine that a review of the child support order would not be in the best interests of a child if there has been a finding of good cause as set forth at 45 CFR 302.31(c) and 45 CFR 232.40 through 232.49 or 42 CFR 433.147(c) and the State or local IV–A, XIX, or IV–E agency has determined that support enforcement may not proceed without risk of harm to the child or caretaker relative.

Section 466(a)(10)(B)(i) provides that the State's determination regarding whether a review would not be in the best interests of the child must be in accordance with regulations of the Secretary. In the proposed rule, we requested input from commenters as to how to best define "not in the best interests of the child." These regulations reflect our decision, in consideration of many insightful comments, to limit the "not in the best interests of the child" exception to mandatory reviews to cases in which good cause for not cooperating has been determined to exist. Since the statute specifies that the regulations of the Secretary dictate the State's determinations in this regard, States may not establish or use other criteria for determining that a review would not be in the best interests of the child.

Under section 466(a)(10)(B)(i), a review is not required in any case in which an assignment of support rights is in effect, if the State has determined that such a review would "not be in the best interests of the child and neither parent has requested review." This creates a two-prong test, both conditions of which must be satisfied to meet the exception to the requirement that a review be conducted. Even if it is determined that good cause exists, a request by a parent would require a review. This could result in requests from absent parents in cases in which good cause for not cooperating exists and in which the IV–D agency is therefore not pursuing support. However, we believe this to be a remote possibility because § 303.11(b)(10) permits States to close cases in which there has been a finding of good cause as set forth at §§ 302.31(c) and 45 CFR 232.40 through 232.49 and the State or local IV–A or IV–E agency has determined that support enforcement may not proceed without risk of harm to the child or caretaker relative.

Pre-Review Notice. Paragraph (c)(6) contains the requirements for notifying each parent subject to a child support order in effect in the State in advance of any review. Under paragraph (c)(6)(i), States must notify each parent of any review at least 30 calendar days before commencement of the review.

The requirement that States provide advance notice prior to conducting a review is applicable in all IV–D cases, regardless of whether the State is proceeding with a mandatory review or whether the review was requested by a parent. Notices must be issued to both parties, including the requesting party. The purpose of the notice is to advise the parties that a review will be conducted. We strongly encourage that the language in the notice be "reader-friendly": i.e., clear and easy to understand. The notice can serve as a vehicle for requesting information from the parties, explaining the steps in the process, and advising of the date, time, and location of hearings, if any. The notice can be tailored to fit the particular State circumstances. If State due process or other rules established for the review process allow, the notice requirement may be satisfied by sending a copy of the petition, motion, or administrative notice to each party, provided that any hearing on such pleading not occur until 30 calendar days following the mailing or service of the notice. This requirement is further explained in the Response to Comments section of this preamble.

Information Requirements. Under paragraph (c)(6)(ii), States must notify each parent of any information necessary to conduct the review and the date by which such information must be provided. States are encouraged to incorporate both aspects of this requirement in the notice issued 30 calendar days in advance of a review. This requirement to provide information was included as authority for States to advise parties of the types of information needed to conduct the review, such as wage statements, income tax returns, health insurance coverage verification, financial affidavits, completed guideline worksheets, or other documents. Any information necessary for computing the child support obligation using State guidelines should be listed and the parties urged to submit any additional facts or documents they wish to have considered during the review process. If a State's statute or procedures which specify guideline computation requirements permit the imputing of income to a party (as a way of dealing with either a lack of necessary financial information to calculate the support amount or situations of voluntary underemployment or unemployment), States are encouraged to advise parties in the notice that failure to provide the specified information may result in imputing income to that party for purposes of determining the amount or entry of an adjusted order.

States are also encouraged to consider requiring that parties, in all cases or perhaps only certain categories of cases, furnish on a routine basis, financial information directly pertinent to the application of State guidelines to either the court or administrative agency which entered the child support order or which will be conducting any review. States may wish to consider adopting legislation which requires any party to a child support order to file, with the court or administrative agency which entered the order, on a regular basis, a financial statement relevant to the guidelines. For example, at least one State requires, by statute, any absent parent to complete, at the request of the IV–D agency, a statement under oath, providing specified information. Under this law, such information includes, but is not limited to, the absent parent's monthly income, his or her total income for the previous year, the number and name of his or her dependents and the amount of support he or she provides to each, the nature and extent of his or her assets, and such other information as requested. Under this State's law, at the agency's request, such statements must be completed annually. Failure to comply is considered to be a class A misdemeanor.

As part of its guideline, another State specifies that "a party to a child support proceeding shall exchange relevant information on finances or dependents every 3 years, and shall be encouraged to update a support order voluntarily using the updated information and the guideline." Adoption of similar laws or practices may help eliminate the necessity of having to first file a modification petition in order to

conduct any discovery activities. As several commenters noted, until an action is pending before a court or administrative forum, proceedings to obtain information and other evidence cannot be initiated.

Post-Review Notice and Challenge. Paragraph (c)(7) specifies the requirements for providing notices following any review. Under paragraph (c)(7), following any review, the State must notify each parent subject to a child support order in effect in the State of: (i) A proposed adjustment or a determination that there should be no change in the order and (ii) each parent's right to initiate proceedings to challenge the proposed adjustment or determination, not less than 30 calendar days after the notice.

The post-review notice serves to inform the parties of the findings and decision of the reviewer, whether such review is conducted by a court, through a quasi-judicial process, or by an administrative body or agency. Depending upon how a State establishes its review process, the post-review notice can take the form of a standardized letter issued by the IV–D agency indicating the review findings, a judicial order, a recommendation of a mediator or referee, an administrative finding, or other document reflecting the results of the review.

Each State has discretion and flexibility in determining how the proposed adjustment or determination not to adjust the order may be challenged by a party. The only statutory requirement is that the State provide the parties at least 30 calendar days to initiate proceedings to challenge the determination. In the four demonstration projects, if an adjustment of the child support award amount was indicated as a result of the review, all four States initiated the adjustment process in conjunction with the notification of the review results. As a result, there was considerable overlap between completion of the review process which included a response to the challenges received and the initiation of the process to adjust the order.

All four projects informed the parents in the notification of review of the opportunity to challenge or contest the result indicated by the review. All four projects had specific time periods within which a challenge must be received and established procedures for responding to challenges made. Although each of the States' procedures varied, the most commonly used approach to a challenge was to review any new or additional information provided by the parent and recompute the amount of child support using guidelines. The parties were notified of the redetermination and asked to stipulate to entry of an order reflecting the findings of the review. As a rule, none of the demonstration States conducted more than two reviews before referring a case for legal action. We believe that arrangements similar to those used in the demonstration States which allow for a reexamination or additional review upon challenge and allow an opportunity to present evidence to the judicial or administrative authority which ultimately decides whether to adjust or not adjust the order satisfy the intent of the Congress that an opportunity to challenge the findings be provided.

In any State which establishes its review and adjustment process entirely within a judicial arena, with court staff conducting the reviews, the post-review notice requirement may be fulfilled by permitting the parties to challenge the court's decision through appeal. We believe that the availability of an appeal satisfies the statutory right to challenge the adjustment or determination and meets the intent of Congress that parties have an opportunity to challenge a decision. In a judicial setting, hearings provide an opportunity for parties to present evidence and make objections prior to entry of the ruling. Generally, the ruling of the court is considered final, except for purposes of appeal, on the date the order is signed by the judge, unless a subsequent judgment must be filed. Upon entry of the order, the appeal period begins to run. In most States, the time to appeal ends 30 calendar days after entry of the order. The appeal right affords a party the opportunity to have a higher court examine the decision to determine whether error or an abuse of discretion occurred.

Adjustments to Child Support Orders. Paragraph (c)(8) requires that following any review, the State must adjust the order, or determine that there should be no adjustment, as appropriate, in accordance with the State's guidelines for setting support awards and paragraph (d), which addresses the basis for petitioning for an adjustment. This would also include determinations which indicate the need to provide for the health care needs of the children, through health insurance or other means, in the order. Further discussion of the adjustment phase of the process follows in our discussion of paragraph (d) concerning the basis for petitioning for adjustment and later in the Response to Comments section of this preamble.

Basis for Seeking Adjustment—Section 303.8(d)

Section 303.8(d) specifies the requirements States must meet with respect to seeking adjustments to child support orders in IV–D cases. Paragraph (d)(1) requires that inconsistency between the existent child support order amount and the amount of child support which results from application of the State guidelines must be an adequate basis, under State law, for petitioning for an adjustment of an order in a IV–D case, regardless of whether or not the order was established using guidelines.

Two exceptions to this requirement are set forth in subparagraphs (d)(1)(i) and (ii). The first exception is allowed if the inconsistency does not meet a reasonable quantitative standard established by the State, as permitted under subparagraph (d)(2). Paragraph (d)(2) provides that States may establish a quantitative standard based upon either a fixed dollar amount or percentage, or both. This quantitative standard, or threshold, is to be used as a basis for determining whether the inconsistency is sufficient to justify proceeding with a petition or motion for adjustment of an award, not as a criterion for deciding whether to review. Threshold standards are not mandatory if States adjust all orders regardless of the degree of inconsistency with the guidelines. However, thresholds may serve to prevent inundating the adjustment process with cases in which the variance in amount between the current order and the amount an application of guidelines would require is minimal. The reasonable quantitative standard and change in circumstances topics are further discussed and explained in the Response to Comments section of this preamble.

The quantitative standard contemplated by § 303.8(d)(2) should be used as a post-review decision-making tool. It should not be considered a restriction on the requirement that the court or administrative process must use guidelines in setting and modifying support or a limitation on the authority of the court or other authority to find, in a particular case, that an award based on guidelines is unfair or inappropriate. In making any adjustment to the amount of support, the judicial or administrative process must apply the State guidelines and, pursuant to § 302.56(f), the child support award calculated to be due under the guidelines is rebuttably presumed to be the correct amount of support to be paid.

Under subparagraph (d)(1)(ii), a second exception to the requirement that an inconsistency between the

current amount of support and the amount of support resulting from application of the guidelines is permitted. This exception is allowed if the basis for the inconsistency is the fact that the amount of the current child support award resulted from a rebuttal of the guideline amount and there has not been a change in the circumstances which resulted in rebuttal of the guideline amount at the time the current order was established. This exception recognizes the existence of cases in which the amount of child support was initially established using guidelines, but the court or administrative authority determined that the amount presumed to be correct was unfair or inappropriate, and set an amount which varies from the guideline amount. Consequently, reapplication of guidelines in such cases may always reflect inconsistency simply because the amount of the current support award was established as a rebuttal of the guideline amount. In these cases, the petitioner would have to show a change in the circumstances which resulted in the original rebuttal of the guideline amount.

Need for Provision for Health Care Needs. Paragraph (d)(3) requires that if the review indicates the need to provide for the health care needs of the children in the order, through health insurance coverage or other means, such need must constitute adequate justification under State law to petition for adjustment of the order to provide for the health care needs of the children, regardless of whether an adjustment in the amount of child support ordered is necessary. It further stipulates that in no event shall the eligibility for or receipt of Medicaid be considered to meet the need to provide for the child's health care needs in the order.

This provision effectively requires that the review process must include a determination of whether the health care needs of the children are being met, other than through Medicaid, either through health insurance coverage available to the custodial parent, health insurance coverage available to the absent parent, or other means. Even if adjustment of the child support award amount is not sought, the need to provide for the health care needs of the children must be a sufficient reason to seek adjustment of the order. As defined in § 303.8(a), "review" includes a determination of the need to provide for the child's health care needs in the order through health insurance coverage or other means. "Adjustment" means "provision for the child's health care needs, through health insurance coverage or other means."

Providing for the health care needs of children is an integral part of the general obligation that parents have to support their children. Ensuring that children have available medical care is essential to their general welfare. Private insurance provided by parents to cover their children who are eligible for Medicaid assistance also reduces the public costs of supporting a child and results in significant cost savings or cost avoidance to the government under the Medicaid program.

As part of the final regulations published on May 15, 1991 (56 FR 22335) governing presumptive guidelines, State guidelines are required, under § 302.56(c)(3) to take into consideration the child(ren)'s health care needs. As we stated in response to comments on that rule, States have flexibility to determine how their guidelines will provide for the health care needs of the children as long as the requirements of § 302.56(c)(3) are met. Since guidelines must in some way address the children's health care needs, any review of the child support order using guidelines would, by necessity, include a determination of the children's health care needs. Similarly, since any adjustment to the child support order resulting from a review must be in accordance with guidelines, the health care needs of the children must be taken into consideration as part of the application of the guidelines. Furthermore, regulations governing securing and enforcing medical support at § 303.31(b)(2) require IV-D agencies to petition the court or administrative authority to include health insurance that is available to the absent parent at reasonable cost in new and modified court or administrative orders, unless the custodial parent and children have satisfactory health insurance other than Medicaid.

Timeframes for Review and Adjustment—Section 303.8(e)

Section 303.8(e) specifies the timeframes for review and adjustment activities. Paragraph (e)(1) requires that in any case in which support rights are assigned to the State under § 301.1, the State must determine, within 15 calendar days of October 13, 1993, or the date the child support order is 36 months old, whichever date occurs later, whether a review should be conducted, as required under § 303.8(c)(4). Subsequent determinations about whether to conduct a review must be made in accordance with paragraph (c)(4), at 36-month intervals based upon the date the child support order was adjusted or the date an order was entered determining that the child support order should not be adjusted, or, in any case in which a petition or motion for adjustment was not filed following a review, the date upon which the post-review challenge period ended. Paragraph (e)(2) requires that within 15 calendar days of receipt of a request for a review, the State must determine whether a review should be conducted, as required under § 303.8(c)(4).

Paragraph (e)(3) specifies that within 180 calendar days of determining that a review should be conducted, or locating the non-requesting parent, if necessary, whichever occurs later, the State must perform four required activities. The State has 180 calendar days to: (1) Send the notice or serve process required under paragraph (c)(6) that a review will be conducted; (2) conduct the review of the order; (3) send the notice required under paragraph (c)(7); and (4) adjust the order, or determine that the order should not be adjusted, in accordance with paragraph (c)(8).

To ensure that States are subject to timeframes for conducting review and adjustment activities, the proposed rule proposed to add a reference to modification in the timeframes for establishing an order under § 303.4(d), which was added by final regulations, establishing standards for program operations, including timeframes for processing cases, published August 4, 1989 (54 FR 32284). As proposed, the addition of modification to § 303.4(d) would have required States to modify an order for support or complete service of process necessary to commence proceedings to modify a support order within 90 calendar days of locating an absent parent.

However, as a result of comments received regarding this proposal, as well as the findings of the demonstration projects regarding the average span of time involved from case selection through disposition, we have carefully reconsidered the proposed timeframe requirement. We believe that the timeframe should be measured from the date an order is determined to be eligible for review based on its age or the date of a request, allow for a reasonable period to determine whether a review is required, take into consideration the statutory pre- and post-review notice requirements, and accommodate the variations among State legal structures with respect to how child support orders can be legally adjusted.

The findings of the demonstration projects substantiate that a 180-calendar-day timeframe is both necessary and reasonable. The time for completing the review and adjustment

process experienced in the demonstration States was measured from case selection as the starting point. Location of the non-requesting parent was not a criteria for selection, but a post-selection, pre-review activity. Thus, time devoted to location was a component of the processing times used to compute the average length of time the review and adjustment process encompasses. The 180-calendar-day timeframe imposed by these regulations does not commence to run until the non-requesting parent is located or determination to review is made, whichever is later. Further discussion of these requirements and the rationale for establishing the 15-calendar-day and 180-calendar-day timeframes is presented in the Response to Comments section of this preamble.

Interstate Requirements—Section 303.8(f)

Section 303.8(f) designates the requirements for conducting review and adjustment activities across State lines. The inherent complications in enforcing and establishing child support orders when parties live in different States or move from the State in which the original order was entered are no less difficult when review and adjustment of orders is added to the configuration. We are equally mindful of the complexities in reviewing cases with multiple orders in different amounts as a result of intervening URESAs or modified registered orders, in determining the effect of an adjustment made by one State on other orders in existence in other States, and in improving communications about cases among States.

The National Conference of Commissioners on Uniform State Laws (NCCUSL) is currently redrafting URESA/RURESA and will address review and adjustment of orders in interstate cases in the revised act. The Commission on Interstate Child Support, established by section 126 of Public Law 100–485, is gathering public input on possible reform and improvement to the interstate system, as well as working closely with the NCCUSL on the redraft of URESA. The work of both the NCCUSL and the Interstate Commission is scheduled for completion in 1992. These bodies are scrutinizing the complex legal, jurisdictional, and operational issues involved in review and adjustment of child support orders in interstate cases. OCSE is involved in, and will follow, developments as a result of these groups' efforts, in anticipation that answers and guidance on the many interstate concerns will emerge.

However, in order to provide States essential guidance as they begin to review and adjust child support orders under the new requirements, we believe that Federal rulemaking is necessary at this time to clarify the roles and responsibilities of initiating and responding States in performing review and adjustment activities in interstate cases.

Initiating State Responsibilities

Paragraph (f)(1) specifies the responsibilities of an initiating State with respect to review and adjustment requirements. Paragraph (f)(1)(i) requires that the State in which there is an assignment of rights to child support, as defined under § 301.1, must, in any case in which support rights are assigned to the State under § 301.1, determine within 15 calendar days of October 13, 1993, or the date the child support order is 36 months old, whichever date occurs later, whether a review should be conducted, as required under § 303.8(c)(4) and in which State a review and adjustment will be sought. As stated previously, this requirement encompasses orders in cases currently receiving benefits through the AFDC, title IV–E foster care, or Medicaid programs, and does not apply to cases involving former recipients of public assistance or cases in which the State retains an assignment of support rights to the extent of any unpaid support that accrued under the assignment which remains due to the State after assistance terminates.

Subsequent determinations about whether to conduct a review must be made in accordance with paragraph (c)(4), at 36-month intervals based upon the date the child support order was adjusted or the date an order was entered determining that the child support order should not be adjusted, or, in any case in which a petition or motion for adjustment was not filed following a review, the date upon which the post-review challenge period ended.

We use our regulatory authority under section 1102 of the Act to require that States must also request review every 36 months in any case in which support rights are assigned to the State but where an order for child support was entered in another State. In meeting this requirement, States are governed by the requirements of §§ 303.7(b)(7) and 303.8(f)(1), applicable to initiating States. This places responsibility upon the State to review or request that another State review the child support order in all cases in which support rights are assigned to the State, as defined by § 301.1. Again, this would not encompass IV–D cases involving former recipients of AFDC, title IV–E foster care benefits, or Medicaid, or cases in which the State retains an assignment of support rights, after public assistance has ceased to be provided, to the extent of any unpaid support remaining due to the State under such assignment.

Paragraph (f)(1)(ii) requires that the State in which a request for review is made, must, within 15 calendar days of a request for a review, determine whether a review should be conducted, as required under § 303.8(c)(4) and in which State a review and adjustment will be sought.

The State in which a request for review is made or in which there is an assignment of support rights is required to determine whether a review should be conducted and if so, in which State the review should take place or be requested. The factors which States must evaluate in making a decision as to whether a review must be conducted are governed by § 303.8(c)(4) which specifies the conditions under which a review is not required. For example, a review is not required in a case in which there is an assignment of support rights to the State and the State determines that a review would not be in the best interests of the child and neither parent has requested a review. The factors which States might evaluate in making a decision as to the suitable forum for conducting the review and making any appropriate adjustment to the child support order include the location of existing order(s), the present residence of each party, and jurisdiction over the parties.

Paragraph (f)(1)(iii) provides that if the State determines under paragraph (f)(1)(i) or paragraph (f)(1)(ii) that it should review a child support order in effect in the State, it must provide notice, conduct a review, and adjust the order, or determine that the order should not be adjusted, in accordance with paragraphs (c)(6) through (8), and complete these activities within the 180-calendar-day timeframe in paragraph (e)(2). If the initiating State has an order which can be reviewed locally, even if one or both of the parties is no longer a resident, the case does not become an interstate case for review and adjustment purposes, and the provisions of §§ 303.8(c) through (e) given the review process. We believe this is the most efficient and preferred approach, as it prevents the establishment of multiple orders in various jurisdictions.

However, the initiating State may determine that it is more appropriate to request that a review be conducted in another State because there is an order in such other State that can be adjusted.

In these instances, the provisions of paragraph (f)(1)(iv) would apply.

Paragraph (f)(1)(iv) requires that if the State determines under paragraph (f)(1)(i) or paragraph (f)(1)(ii) to request a review of an order in another State, it must send a request for review to that State within 20 calendar days of receipt of sufficient information to conduct the review and provide that State with sufficient information to act on the request. Under this provision, the initiating State must transmit a case to the State it determines is an appropriate place for a review, indicating on the standardized interstate transmittal form that a review is requested and attaching documents necessary to permit review in the responding State.

The current requirements of §§ 303.7(b)(3) and (4) governing providing sufficient, accurate information for the responding State to act on the request, and providing any additional information requested by the responding State also apply to requests for review.

Paragraph (f)(1)(v) specifies the requirements for transmitting requests for review to other States. If the request for review is the first contact between the initiating and responding States in the case, the request for review must be sent to the interstate central registry in the responding State. However, if the initiating State has previously referred the case to a responding State for action, the initiating State may request a review of the order (if it can be modified under the responding State's law) by sending the request for review directly to the local office or agency working the case, rather than routing the request as a new action through the interstate central registry of the responding State.

Paragraph (f)(vi) requires the initiating State to send, to the parent in the initiating State, a copy of any notice issued by a responding State in connection with the review and adjustment of an order, within 5 working days of receipt of such notice by the initiating State.

Responding State Responsibilities. Paragraph (f)(2) details the responsibilities of a responding State in response to receipt of a request for a review from another State. Paragraph (f)(2)(i) requires that, within 15 calendar days of receipt of a referral from another State requesting review of an order in effect in the responding State, the appropriate processing agency in the responding State must determine whether a review should be conducted, in accordance with § 303.8(c)(4) and the responding State's procedures for review and adjustment of child support orders. We have included a 15-calendar-day timeframe for the responding State in order to address requests for review of orders that are less than 36 months old. The determination of whether or not to conduct a review in such situations is governed by the responding State's procedures for review and adjustment of child support orders. This affords the responding State an opportunity to examine the case to determine whether the child support order should be reviewed using as a basis the requirement that reviews must be conducted at 36-month intervals after the establishment of the order or the most recent review. It also makes clear that the decision of whether a review should be conducted is made by the appropriate processing agency, rather than by the central registry. Therefore, the 15 calendar days begin to run upon receipt of the request from the central registry. However, in no event, should a responding State make a good cause determination not to review an order based on the best interests of the child, if the initiating State has requested a review. The determination that good cause not to review an order exists in any case in which there is an assignment of support rights to the State shall be made only by the State to which such assignment of rights to support has been made.

Paragraph (f)(2)(ii) requires that within 180 calendar days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the responding State must send the notice to each parent that a review will be conducted, conduct a review, send the notice of the proposed adjustment or determination that there should be no adjustment, and adjust the order or determine that the order should not be adjusted, in accordance with paragraphs (c)(6) through (8).

Although we devote a separate section of this final regulation to interstate processing of required and requested reviews, the determination of whether a case should be reviewed, the processing steps, and timeframes are identical to those applicable in an intrastate case. Once the case is received in the responsible local office, the procedures involved in conducting the review should be no different than those used in intrastate cases. A State may not establish a separate process for handling requests for review from other States. If the information received is inadequate, the provisions of § 303.7(c)(4)(ii) require the responding State to notify the IV–D agency in the initiating State of the necessary corrections or additions to the interstate form or documentation. As provided under § 303.7(c)(4)(iii), if the documentation received with a case is inadequate and cannot be remedied by the responding IV–D agency without the assistance of the initiating State, the IV–D agency must process the interstate IV–D case to the extent possible pending necessary action by the initiating State.

Under paragraph (f)(2)(iii), States may meet the notice requirement of § 303.7(c)(8) by sending notice of the review required under § 303.8(c)(6) to the parent in the initiating State through the IV–D agency in the initiating State. Thus, a responding State would not have to prepare and issue two different notices contemplated by the mutual existence of the requirement under § 303.8(c)(6)(i) that advance notice of any review be sent to each parent and the requirement under § 303.7(c)(8) that the responding State IV–D agency provide timely notice to the IV–D agency in the initiating State in advance of any formal hearings which may result in the establishment or modification of an order. This requirement effectively permits the advance notice of review to the parent in the initiating State to also serve as the notice to the initiating State itself, by requiring that the notice be transmitted to the parent through the initiating State IV–D agency. As explained previously, § 303.8(f)(1)(vi) requires the initiating State to forward any notices, to the parent in the initiating State, within 5 working days of receipt of the notice from the responding State.

Paragraph (f)(3) specifies that the applicable laws and procedures for review and adjustment of child support orders, including the State guidelines for setting child support awards, established to § 302.56, are those of the State in which the review and adjustment, or determination that there be no adjustment, take place.

Response to Comments

In response to the Notice of Proposed Rulemaking published August 15, 1990, in the **Federal Register** (55 FR 33414), we received comments from over 70 commenters, representing national organizations, State and local IV–D agencies, advocacy groups, and private citizens. The comments concerning the 1993 requirements and our responses are as follows:

Periodic Review and Adjustment After October 13, 1993—Section 303.8(c)

1. Comment: Numerous commenters questioned what duties are placed by the Act on the State IV–D agency. Can only a IV–D agency conduct review or can other State entities such as the court system?

Response: While nothing in the Act requires the IV–D agency to be the entity responsible for the review and adjustment of orders, nothing prevents the IV–D agency from doing so or from playing an integral role. We retain flexibility in the regulations to allow States to allocate the various review and adjustment functions according to historical practice or to the exercise of State discretion. We recognize the possible distinction between the State and the IV–D agency.

Nothwithstanding this flexibility to develop a workable process in the State, the IV–D agency retains overall responsibility for ensuring that the requirements are met. Placement of certain review and adjustment functions within other organizational entities or branches of government in no way diminishes the responsibility of the IV–D agency to ensure that, overall, the State is in compliance with all Federal requirements.

Because the Act refrains from specifying which State entity is required to conduct the review and adjustment process, "review" is broadly defined in § 303.8(a) to encompass many possible alternatives. Because these regulations do not necessarily place responsibility on the State IV–D agency to conduct reviews and make adjustments, a State has the discretion and the flexibility to design a review process that will be effective within or as a complement to its respective child support enforcement program. For example, under one possible model, States which use administrative processes for the establishment of child support awards, which allow for fair hearings and rights of appeal, may find it feasible to use such procedures for the review and adjustment process.

2. Comment: One commenter warned that unless constitutionally-sound State legislation provides for administration modification of judicial orders, it will be necessary in an administrative process State for a judicial or quasi-judicial decision-maker to conduct reviews in cases in which the existent order was established through a judicial process.

Response: We encourage States to consider the various options available for implementing an effective mechanism for conducting reviews of child support orders. In some States, the preferred forum may be the State judicial system. In States which designate that review and adjustment be done entirely by the same entity which entered the initial order, the review and adjustment activities of the State IV–D agency may be limited to filing the action, issuing the notices of the right to request review, and facilitating the exchange of information.

As indicated previously, we urge States to examine the work of the States which conducted demonstration projects. These projects illustrate that various approaches for reviewing and adjusting orders are feasible. In all of the demonstration projects, the review was a fairly simple and straightforward task once the necessary financial information was obtained. Reviews were conducted by computing a new support amount based on the application of the child support guidelines and the required financial information. In Colorado, modification technicians conducted the reviews. In Delaware, mediators or masters conducted reviews if mediation was used; if stipulations were used, child support specialists conducted the reviews. Child support case analysts were responsible for the reviews in Florida, while in Illinois, reviews were conducted by modification unit staff members. If adjustments to orders were appropriate, the demonstration project States varied somewhat in how the adjustments were sought. For example, Colorado used an expedited judicial process: If the IV–D agency could not obtain a stipulation, cases were heard before court referees or commissioners; if either party disagreed with the referee's decision, cases were referred to a judge. Delaware used an expedited quasi-judicial process with family court mediators conducting mediation sessions to obtain stipulations. If stipulations could not be obtained, cases were referred for a hearing before a court master. Any party disagreeing with the master's ruling could request a de novo hearing before a judge. In Florida, IV–D staff attempted to obtain stipulations prior to legal referral; hearings were conducted by either a hearing officer or a judge. Illinois employed dual judicial and administrative processes for establishing orders. However, the use of the administrative process was limited to cases not previously or currently under the court's jurisdiction.

Oregon used an administrative process for establishing child support orders where no court order for child support existed. If a court order was subsequently established, as in a divorce action, the administrative order was superseded. Alternatively, if a court order already existed when a case acquired IV–D status, no administrative order was established. Because Oregon enforced both administratively and judicially established orders, modifying these orders had to proceed through the appropriate process. The Final Report on the Oregon Child Support Updating Project (February 1991) explains that the project was able to test the relative efficacy of using an administrative and a judicial process to modify support orders. According to the report, modification of orders through the judicial process did not take significantly longer than those modified through the administrative process. The report emphasized, however, that this result may have occurred because the project was able to arrange expedited docketing and priority calendaring for court hearings. The report further noted that the advantages of an administrative process were more evident with respect to the costs of modifying orders. The report cited data that the comparative cost per case to modify child support orders was considerably lower for administrative modification ($496 per case) than for judicial modification ($770 per case).

Role of the IV–D Agency

1. Comment: Many commenters offered opinions concerning the conflicts of interest discussion in the preamble to the proposed rule. In that document we presented our position that the IV–D agency does not provide legal services *per se*. Several commenters explained the difficulties and dilemmas often encountered because of various, and often contradictory, rulings and interpretations of the role of the IV–D program and staff in their jurisdiction in relation to the individuals receiving IV–D services.

Response: The issue of "legal representation" of parties in child support proceedings is a matter to be determined by State law, regulations, or bar association requirements. There are no Federal statutory or regulatory requirements addressing this matter. The IV–D agency, on the other hand, must perform certain functions in accordance with Federal statutory and regulatory requirements. As required under § 303.20(f), States must have staff to achieve the standards for an effective program which must include attorneys or prosecutors to represent the agency in court or administrative proceedings with respect to the establishment and enforcement of orders of paternity and support. Generally, conflicts of interest should not arise, but if they do exist, the State must resolve the conflict and still perform the requisite functions.

Clearly, Congress has mandated that each party to a child support order in effect in the State and being enforced through the IV–D program has a right to request a review of that order. In addition, if appropriate, the State must adjust the order, in accordance with

State guidelines for setting child support award amounts. However, this does not mean that the IV–D agency or its attorneys must "represent" the parties in the process of conducting a review and/or adjusting the order. The State's role is not to advocate either an increase or a reduction in the amount of the order, but rather, to facilitate whatever adjustment is appropriate in accordance with the guidelines.

We are aware that some States have developed processes through which the review is conducted by the IV–D agency. Following the review, any adjustments are made through the judicial or administrative process in place in the State for setting child support orders, without any necessity of "representation" of either party by the IV–D agency in an advocacy capacity. Several States are exploring *pro se* procedures for enabling the parties to have better and easier access to the judicial or administrative process to obtain an adjustment.

It is our understanding that a number of States, through legislation and bar association opinions, have taken the position that neither the custodial parent nor the non-custodial parent is the "client" of the IV–D program or the attorneys who work for the IV–D program. Additionally, we are aware that several States are making statutory, regulatory, and procedural changes to clarify or redefine the IV–D agency's relationship with the parties in IV–D cases. Some of the efforts States are taking to address these concerns include: removing references to the parent or child as "clients" in all statutes, regulations, policies, forms, and legal pleadings; captioning all legal pleadings relating to the delivery of IV–D services for establishment and enforcement of child support in the name of the State and clearly specifying that the IV–D attorney is not the attorney for either of the parents; and notifying both parents, in writing, that the IV–D agency or its attorneys do not represent either parent and that either parent may obtain private counsel.

2. Comment: Several commenters stressed the need to recognize that in some States the IV–D agency cannot initiate proceedings to reduce child support obligations due to an inherent conflict of interests that would apparently exist in those States because of their administrative structure. They cited ethical problems which would arise for a IV–D attorney in seeking results on behalf of the one party in a case which are directly contrary to the interests of another party in the same case for whom the attorney has previously provided services.

Response: Because the statute does not differentiate between the parties with respect to the right to request a review, each parent is entitled to make a request. Consequently, it is conceivable that a review may be requested by an absent parent for the purpose of obtaining a reduction in the amount of child support previously ordered. As indicated by several commenters, in the IV–D context, the issue of client representation has not been universally resolved. As previously indicated, a growing number of State bar associations, attorneys general, or legislatures have issued opinions or statutory interpretations providing guidance to practitioners.

For those cases which were not terminated from the review process, the number of downward adjustments in the demonstration projects was very low. In only 170 cases, representing five percent of the total modifications obtained, did a lower support award amount result. Of these 170 cases, 150 (88 percent) occurred in Colorado and Delaware. Only six downward modifications occurred in Florida, and in Illinois, only 14 of the approximately 1400 orders modified resulted in a reduction in the amount of child support. While Delaware had the largest number of downward adjustments (82 orders representing 10.7 percent), Delaware also had 19 cases in which a downward adjustment was indicated, but the obligor agreed to no change. Delaware also had 139 cases in which the modification disposition was "no change." The earlier project in Oregon reflected that overall, 81 percent of the adjusted orders were for increases in the monthly support obligation and 19 percent produced decreases in the monthly obligation. Moreover, in Oregon, downward adjustments tended to be situations in which the original order had been entered by default, with income imputed to the obligor. In these instances, the subsequent availability of information as to the obligor's income produced a lower support order. These reported data illustrate that an expected high income of downward adjustments did not materialize. The results reflect that the impact of downward adjustments was minimal.

Making the review and adjustment process more accessible does not imply that it must be the responsibility of the IV–D agency to directly operate the process or to initiate all petitions for adjustment. It is, of course, permissible and for simplicity, may be desirable, for the IV–D agency to perform these functions in States which do not perceive that there are conflict of interests problems. Within a review process, a IV–D agency may be able to seek voluntary agreements consenting to an adjustment, without taking an advocacy role. Such agreements could be ratified and given legal effect through the judicial, quasi-judicial, administrative, or other designated process in which reviews are conducted. If a stipulation for an adjustment to the order cannot be reached, the case could be submitted to the designated judicial or administrative process for a hearing on the merits of whether an adjustment is appropriate.

It is also permissible under the statute and this regulation for States to allocate the required functions within the review and adjustment process among various entities (courts, administrative hearing officers, IV–D agency staff, etc.). Thus, the potential for perceived conflicts of interest arising in some States if the IVS–D agency is required to seek downward adjustments on behalf of parties in cases in which it previously represented the interests of the other party in the same case may be reduced or avoided by careful and clear designation of these functions to another entity. However, should a State establish a process outside of the IV–D agency, it is imperative that the IV–D agency remain ultimately responsible for ensuring that all Federal requirements under the Act and regulations are satisfied.

3. Comment: Several commenters contended that even if there is no attorney-client relationship with either party, and the IV–D agency is considered the client of the IV–D attorney, the interests of the agency in reducing AFDC dependency, promoting economic self-sufficiency of families, and seeing that children are adequately supported may be compromised if the IV–D agency or its agents advocate for or represent individuals seeking downward adjustments.

Response: Providing an avenue or opportunity for parties to a child support order to access the court for the purpose of updating or changing a child support obligation does not mean that the State places itself in an advocacy role with respect to the interests of either party, and does not create an attorney-client relationship between the IV–D agency and either party. As aptly stated by one commenter, if States are unbiased in the application of child support guidelines, then they should proceed with a review in all eligible cases regardless of the nature of the request or the anticipated outcome. In some cases, a downward adjustment may even be advantageous to the child if it results in an amount of support

which can be paid fully, regularly, and timely by the obligor.

4. Comment: One commenter noted that an implied attorney/client relationship can arise if the custodial parent reasonably believes that one exists based upon the conduct of the attorney and communications between the IV–D attorney and the agency.

Response: Although many States have and will continue to make efforts to resolve any problems in this area, we are mindful of and acknowledge the concern raised by commenters concerning the posture a State IV–D agency or its attorneys and other staff may have taken previously in the case or perceptions and beliefs the parties may have regarding the IV–D agency/attorney's role Furthermore, we recognize that even in States which have made it clear that no attorney-client relationship is created by virtue of the application for or delivery of IV–D services, rules governing the legal profession may dictate ethical responsibilities and certain duties of disclosure on the part of attorneys dealing with "unrepresented persons." However, these are matters which State law and individuals bound by such professional rules of conduct must address at the State level, and not issues governed by Federal law and regulations on the IV–D program.

We encourage States to enact legislation or obtain an Attorney General opinion that specifically identifies who the IV–D agency and its attorneys represent. It may also be helpful for States to include an explicit statement on the IV–D application or referral form that provision of IV–D services does not constitute or create an attorney-client relationship between either party and the State IV–D agency or its employees or agents. Such a statement could also specify that IV–D attorneys are bound by and will follow State and Federal rules and policy. The interests of the applicant or recipient of IV–D services, although important, do not prescribe the IV–D attorney's activities as they might in a private attorney-client relationship.

5. Comment: One commenter questioned whether an application for IV–D services is required in situations in which the party making the request for a review is not the named recipient of IV–D services.

Response: If the case is currently receiving services through the IV–D program, a separate or additional application for IV–D services under § 302.33 is not necessary even if the individual requesting a review is not the original applicant. The statute requires that notice of the right to request a review be provided to both parties, not just the individual who applied for services through the IV–D program. The statute specifies that non-custodial parents in IV–D cases are entitled to notice of the right to request a review of the child support order and the right to request a review by virtue of being a party to a IV–D case. Although there is no requirement to do so, a State may, at its option, take applications for services and required fees from non-custodial parents in existent IV–D cases. However, if a IV–D agency is asked to conduct a review in a non-IV–D case, the requesting party must apply for services and pay the fee before IV–D services may be provided. Certainly, a review and adjustment process may be generally available in the State, independent of the IV–D program, to any party seeking an adjustment.

Pro SE Processes

1. Comment: Several commenters responded to the preamble discussion in the proposed rule regarding establishing *pro se* processes. One commenter suggested that *pro se* be used for cases seeking review sooner than they would otherwise be eligible on the 36-month cycle.

Response: We encourage States to establish simple procedures that do not unduly burden a party seeking a review and adjustment of a child support order. States may find it useful to develop *pro se* procedures and/or establish means to provide legal services in cases in which an adjustment is sought. *Pro se* was suggested as a mechanism for improving access to the legal process (judicial or administrative) to parties seeking a change in a child support order without the necessity of retaining legal counsel. For example, if a review is requested sooner than the interval for conducting mandatory reviews, a State may suggest *pro se* or other alternative routes to the individual seeking the review. The suggested use of *pro se* procedures is not intended as a way for States to avoid their statutory responsibilities for responding to requests for review from either party to a child support order, but a way to reduce the expense and time for the parties and the State wherever appropriate.

Several States have successfully implemented such a *pro se* process. In Michigan, forms and instructions are available through the Friend of the Court to enable parties to file their own actions. New Hampshire has developed a "do it yourself" modification kit which is available to any party upon request, and which offers another option if review through the State review plan is not possible or not elected. In September 1991, OCSE published, through its contract with the American Bar Association Center on Children and the Law, a monograph, "Developing Effective Procedures for *Pro Se* Modification of Child Support Awards" which examines selected State practices and policy issues in developing a successful *pro se* modification program. In order to enable parties to accomplish their legal objectives through self-representation, *pro se* processes may contemplate that the State, courts, IV–D agency, or other sources make copies of guideline worksheets and charts, rebuttal criteria, and other explanations publicly available in order for the parties to effectively proceed *pro se*.

Notice of the Right to Request Review—Sections 303.8(c) (2) and (3)

1. Comment: Several questions were raised by commenters concerning the effective dates of the notice requirements.

Response: The effective date for the notification of the right to request review is October 13, 1993, or such earlier date as the State may select. In response to many questions received concerning this notice requirement, OCSE issued a letter to State IV–D Directors on November 28, 1990 clarifying this requirement. As specified in the final rules published earlier which govern the review and adjustment requirements which are effective October 13, 1990, the pre-review and post-review notices are required in any case in which a review is conducted under the State's plan specifying how and when child support orders in IV–D cases are to be reviewed.

2. Comment: A number of commenters inquired as to alternatives for meeting the requirement for notifying each parent subject to an order in effect in the State being enforced through the IV–D program of the right to request a review.

Response: Paragraph (c)(2) specifies that this requirement may be met by sending a one-time notice to each parent in a IV–D case in which there is a child support order in the State. Such notices could also be incorporated in any informational materials presented to the parties at the time the order is originally entered. Some court clerks routinely distribute instructions to parties, which could be expanded to include information about the right to request review. Adding a specific review clause in every child support order at the time of establishment or adjustment is another alternative for satisfying this notice requirement with respect to new cases. This requirement affords States flexibility in creating mechanisms for

notifying each parent of the right to request review, provided that the methods selected are reasonably calculated to provide the necessary notification of both the right to request review and how and where to exercise this right.

3. Comment: One commenter inquired whether a newspaper advertisement about the availability of reviews would satisfy this mandate.

Response: Although there is no requirement for proof of actual receipt, section 466(a)(10)(C)(ii) of the Act contemplates that the notice be issued in a matter reasonably calculated to reach the intended recipients, as it directs that notice be given to "each parent." Therefore, placing an advertisement in a newspaper of general circulation will not, in itself, suffice to meet this requirement, as it is conceivable that not all parents who should receive the required notice will receive it. Certainly, States may consider advertisement as a means of complying with paragraph (c)(3), which requires the State to periodically publicize the right to request a review as part of its support enforcement services as required under § 302.30 and to include notice of this right as part of the information on IV–D services required under § 303.2(a)(2).

4. Comment: Several commenters questioned the propriety of including other information in the one-time notice.

Response: We use our regulatory authority under section 1102 of the Act to require that the notice under paragraph (c)(2) inform the parents where and how to make their requests for review. Section 1102 authorizes the Secretary of HHS to publish regulations (not inconsistent with the Act) which are necessary to efficiently administer his functions under the Act. Although the Act only requires that "notice of the right to request a review" be provided, we believe it is essential for the notice document to designate how and to whom the request must be made. Giving more detailed instructions about making requests for reviews may actually serve to reduce the number of inquiries for further information as well as misdirected or incomplete requests.

5. Comment: Some commenters asked that we specify in regulations how a parent exercises the right to request a review. They inquired whether parents must make a one-time decision about whether to have a triennial review or if they may decide every 36 months whether they want a review. These commenters further inquired whether a State may limit the time a party has to elect a review, and if so, what is considered an adequate opportunity to exercise the option.

Response: We believe that requiring parents to elect only once whether or not a review is desired, which binds all future actions, is too restrictive. Therefore, parents cannot be required to make a one-time decision. States may not limit the time a parent has to request a review, for example, to no later than three months after the order is 36 months old. However, States may limit the frequency with which they conduct reviews, to, for example, once every 24 months. If they choose, States may include in the notice information about these and other matters, such as explanations of specific procedures or a telephone number or address to contact for further details about the review process.

Frequency and Conditions of Reviews—Section 303.8(c)(4)

1. Comment: Numerous commenters questioned whether States must act in advance of October 13, 1993 to address cases in which the child support order will be over 36 months old on October 13, 1993. Several objected to the proposal for targeting cases for review and OCSE's interpretation of the statutory requirement. Some asked whether a State must initiate review of all AFDC cases with orders that have not been reviewed or adjusted in the last 36 months or whether a State may phase-in a review process beginning on October 13, 1993.

Response: Section 466(a)(10)(B) of the Act, added by section 103(c) of Public Law 100–485 states that "(b)eginning 5 years after enactment [October 13, 1993] . . . States must implement a process for the periodic review and adjustment of orders. . . ." In the preamble to the proposed rule, we stated that this section effectively requires that orders in AFDC cases that were entered or last modified before October 13, 1990 must be reviewed before October 13, 1993, upon request of either parent or a State child support enforcement agency. Furthermore, in the proposed § 303.8(b)(1), we specified that the State plan for periodic review and modification must "target for review" orders in IV–D cases in which there is an assignment of support rights to the State. After reviewing the comments received and deliberating on the language of the statute, we have deleted the requirement that between 1990 and 1993, States, must conduct reviews and adjust all pre-October 13, 1990 orders upon request prior to October 13, 1993. It is our position that because the requirement for reviews at 36-month intervals is effective starting October 13, 1993, a State has no explicit duty prior to that date to conduct reviews other than as specified in its plan for how and when orders are to be periodically reviewed and adjusted as required under § 303.8(b). However, as a practical matter, if the State's plan and procedures do not address orders older than 36 months, and if these older cases are not actually processed through to completion with respect to review and adjustment, the number of such cases awaiting appropriate handling on October 13, 1993 may be overwhelming.

Althoiugh there is no mandate to do so, States may find it advantageous to the best interests of the children involved and the taxpayer to examine these older cases in a measured way beginning now, in anticipation of the requirement for mandatory triennial reviews. Since reviews are required only in cases in which the support rights are assigned to the State and in which the order is 36 months old or more, the impact of mandatory reviews may not be as severe as expected. Unpublished tabulations from the Bureau of the Census Current Population Studies, Child Support and Alimony Supplement 1988, reflect that of the 2.4 million women with children from an absent parent who are recipients of AFDC, 41 percent had support awards. According to the data, on these 990,000 awards, approximately 51 percent are over 3 years old. Thus, a nationwide total of 550,000 orders would be subject to review. The impact of reviewing these eligible orders would be further reduced by findings of good cause and inability to locate obligors. In this context, and given the potential benefits to children and taxpayers, we do not believe the statutory requirement is overly burdensome. To reap these benefits and to further minimize the volume of cases requiring reviews beginning on October 13, 1993, a number of States are already reviewing, in manageable installments, AFDC cases with orders over 36 months old.

2. Comment: One commenter questioned whether an AFDC IV–D case would be considered flawed for audit purposes if the court order is more than 36 months old and a review was not conducted.

Response: Audit regulations governing substantial compliance with the requirements for review and adjustment of child support orders have not yet been published. This issue will be addressed in those regulations.

Compelling evidence about inadequate and out-of-date support awards prompted enactment of the review and adjustment provisions in the first instance. Therefore, it is essential

that States examine cases in which there is an assignment of support rights to the State and begin reviewing (and updating as necessary) any cases with orders over three years old as soon as possible.

As previously indicated, some States have implemented plans under which the entire AFDC caseload is being reviewed in equal monthly increments in advance of the October 13, 1993 effective date, so that the number of cases with orders which have not been reviewed for over 36 months will be far fewer, and more manageable. For example, subsequent review of a case reviewed in June 1991 would not be required until June 1994. However, within 15 calendar days of October 13, 1993, in any IV–D case in which child support rights are assigned to the State and the current child support order was established on or before October 13, 1990 and not subsequently reviewed, the State must determine whether to initiate a review in order to comport with the statutory requirement that orders be reviewed "not later than 36 months after the establishment of the order or the most recent review." Advance planning in recognition of the potential impact of reviewing certain cases at 36-month intervals is crucial.

3. Comment: One commenter suggested allowing a one-year grace period to review all existent orders required to be reviewed that are older than 36 months on October 13, 1993.

Response: Unlike the Child Support Enforcement Amendments of 1984 (Pub. L. 98–378), wherein the statute permitted States needing legislation to come into compliance some additional time to enact such legislation, the Family Support Act of 1988 (Pub. L. 100–485) makes no such provision of additional time after October 13, 1993, to phase-in a review process. Moreover, because the 1993 requirements are effective a full five years after enactment of the Family Support Act, States have considerable advance notice in order to adopt any necessary laws, to anticipate the number of cases potentially needing review when the 36-month requirement becomes effective, and to otherwise address the operational implementation in a meaningful way. Further delay would only result in children being deprived of the appropriate amount of support to which they are entitled.

Under the timeframe requirements for conducting review and adjustment activities set forth in § 303.8(e), and explained in detail later in this Response to Comments section, States have 15 calendar days after October 13, 1993 to determine whether to initiate a review of any order in which a review is required in cases with orders older than 36 months on October 13, 1993. The timeframe requirements provide that States must complete the review and adjustment activities within 180 days of determining that a review is required or locating the non-requesting parent, whichever occurs later.

4. Comment: Another commenter requested that we address for audit purposes situations in which the child support order is older than 36 months at the time of application for IV–D services.

Response: A State may not specify a time period during which a new IV–D case must receive services before the case becomes eligible to be considered for review. A State must initiate a review of any case in which a review is required (cases in which there is an assignment of rights) or requested (by either parent in a non-AFDC case), in accordance with § 303.8(c)(4), regardless of the length of time services through the IV–D program have been provided. With the limited exception under § 303.72(a)(3)(iii) allowing States to limit past-due support amounts submitted for Federal income tax refund offsets to amounts which have accrued since the IV–D agency began to enforce the support order, States may not deny or restrict any services, including review, based on the length of time a case has been receiving IV–D services. Accordingly, the duration a case has been receiving IV–D services may not be a criterion for evaluating requests for review. Certainly, the order in which requests for review are received may be a factor in determining the relative order in which the request is processed within the framework of the required timeframes.

5. Comment: One commenter inquired whether the review must be initiated, or actually completed, not later than 36 months after establishment of the order or the most recent review.

Response: The timeframes established under § 303.8(e) allow States a 15-calendar-day period within which to determine whether a review is required based upon the age of the order, the timing of the last review, or a request from either parent. Because the time allotted for conducting various review activities and actually completing the review through entry of an adjustment or determination that there be no adjustment may span up to 180 calendar days, or longer, if location is required, we consider the date of the "most recent review" to be either the date on which the order adjusting or determining not to adjust the order was signed by the judge or administrative hearing officer or, where no petition for adjustment was filed by either parent or the IV–D agency following the most recent review, the date that the 30-day period for challenging the review findings expired.

We recognize the possibility that in some cases, no action will be taken by either parent or the State following the review to petition for adjustment of the order. Therefore, since an order adjusting the amount of support or determining not to adjust the order may not exist in such instances, the date for the next required review must be based upon when the last review was concluded, that is, the date upon which the period for challenging the results of the review elapses. In any case in which a petition for adjustment is filed with the judicial or administrative process which results in entry of an order adjusting or determining not to adjust the previous order, the date the judicial or administrative hearing official signs the order is the date from which the 36-month period for determining the age of the order runs. Furthermore, we believe that using the date the order is signed is the customary practice and the simplest for case tracking and monitoring purposes, even if such order specifies an earlier effective date for the change in the obligation, within the limitations permitted under § 303.106(b), governing retroactive modification of orders. Thus, States can incorporate, within an automated case tracking and monitoring system, a trigger or flagging of each case on a 36-month cycle measured from either the date the most recent order was signed, or where appropriate, the date upon which the post-review challenge period ended. However, absent a request for a review in a non-AFDC case, the State need not conduct a review.

6. Comment: Several commenters objected to our proposed requirement that States must establish procedures specifying circumstances under which orders will be reviewed more frequently than every 36 months. Commenters indicated that to direct that States establish an inclusive list of all circumstances in which child support orders would be reviewed more frequently than every 36 months would create an impossible task. One commenter requested that States not be required to impose guidelines for reviewing orders more frequently than every 36 months, because either party has an absolute right to petition the court at any time, if they believe the support order is no longer equitable. The commenter argued that such a guideline requirement could unnecesarily restrict this right to petition the court.

Response: We agree with these commenters and have not included a

requirement in the final rule that States must have procedures specifying the circumstances under which reviews would be conducted more frequently than the minimum interval of "no later than 36 months after the establishment of the order or the most recent review" as mandated by statute.

States will undoubtedly encounter requests for reviews more frequently than every 36 months or other interval established by the State for conducting mandatory reviews. Although States are not required to conduct reviews more frequently than every 36 months, there are certainly circumstances which would warrant a review sooner than 36 months after the most recent order was established. Changes in the financial circumstances which may justify an adjustment in the amount of child support are unpredictable events. A party may offer a reason that would be considered a suitable basis for adjustment (such as proof of a salary increase or decrease) and ask for another review. For example, if a minimum support amount is ordered because the obligor is unemployed or employed part-time at the time the order is entered and the custodial parent or IV–D agency learns one year later that the obligor has secured significantly higher paying employment, a review may be warranted. Alternatively, if the obligor becomes permanently disabled, a review may be warranted although three years have not elapsed since the last review. These situations may occur at intervals sooner than 36 months following the previous decision to adjust or not adjust the order.

The statute does not place a limit on the number or frequency of requests for review a party may make, but requires reviews not later than 36 months after establishment of the order or the most recent review. Thus, States have the flexibility to establish their own criteria for performing more frequent reviews.

Although States are not required to conduct reviews more frequently than every 36 months, we urge States to consider the best interests of children in establishing any criteria for conducting reviews more frequently than at 36-month intervals. Should a State choose to review orders more frequently than required by Federal requirements, States are encouraged to adopt an objective standard applicable to all requests rather than making subjective decisions about whether a case qualifies for a review. If a State does not allow, or restricts the availability of review if a request is made sooner than the interval established by the State for conducting reviews, it may wish to identify alternative avenues for review and consider referring requestors whose requests are made sooner than the established frequency to these other alternatives. One premise of the review and adjustment legislation was that child support orders become inadequate over time and that a mechanism for routinely checking the adequacy of the award amount which can be easily accessed by the parties is necessary. We urge States to respond to what we believe to be the spirit and intent of the Congress in enacting this provision of the Family Support Act: to promote easier access to opportunities to seek adjustments in child support award amounts based on changes in the circumstances of the individuals affected by the obligations.

Exceptions to Mandatory Review—Section 303.8(c)(4)(i)–(iii)

1. Comment: One commenter contended that because reviews are required in AFDC cases, but are not required unless a parent requests in non-AFDC cases, the statute fails to promote equal treatment.

Response: We disagree. In conducting reviews and determining whether adjustments are warranted, States may not differentiate between non-AFDC cases and cases in which there is an assignment of support rights to the State. The only distinction made in the statute is whether reviews are mandatory (cases in which there is an assignment of support rights to the State) or performed only upon request (non-AFDC cases in which there is no such assignment to the State). Procedures used for reviewing cases and standards for making adjustments should be identical regardless of the public assistance status of a case.

It is our position that the State has an affirmative duty to seek reviews in cases in which there is an assignment of support rights to the State. However, Congress did not mandate reviews in non-AFDC IV–D cases if neither parent requests a review. Requiring States to conduct reviews only upon request in non-AFDC IV–D cases may eliminate the unnecessary expense of time, paperwork, and personnel if the parties themselves do not want a review. It does place an affirmative duty on a parent to make the request in such cases. It also signals a need to make known the existence of this service and to clearly explain the processes and potential outcomes of a review so that the parties can make an informed decision.

Data from the five demonstration projects reflect an overwhelmingly low rate of authorization to conduct reviews among non-AFDC IV–D cases. In Oregon, authorizations were received in only 16 percent of the 1,626 non-AFDC IV–D cases determined to be eligible for review. Consistent findings are reflected among the other four demonstration projects. In Illinois, for example, fully 60 percent of non-AFDC cases with orders eligible for review were terminated from the review process due to lack of authorization. Reasons cited by non-AFDC obligees for refusing the available review indicate concerns about "rocking the boat" and jeopardizing compliance with current support payments or good relations with the obligor. In instances where payments are not being made, non-AFDC obligees claim that a review would be a waste of time. Other responses reflect a desire to avoid going to court, seeing the other parent, or risking custody or visitation issues being raised.

Circumstances Under Which Review Would Not Be in the Best Interests of the Child—Section 303.8(c)(5)

1. Comment: Several commenters recommended that the responsibility for defining "best interests" be left to the States. Many other commenters suggested that we define the circumstances in which a "review would not be in the best interests of a child" to be instances in which a determination of good cause not to cooperate in establishing paternity or securing support has been rendered in an AFDC case.

Response: In the preamble to the proposed rule, we indicated that we had not otherwise defined "best interests of the child" in the proposed rule, and solicited comments regarding this provision. We specified that one approach to establishing a complete definition of the best interests of the child would be to tie the definition to that contained in AFDC regulations at 45 CFR 232.41 for refusal to cooperate. We further stated that another approach would allow States to establish criteria which would define the best interests of the child for purposes of reviewing an order, since a review and adjustment of a previously established order may not necessitate the cooperation of the custodial parent. Of the suggestions offered in response to our solicitation, we elected to follow those of the commenters who urged that the "best interests of the child" be linked to good cause determinations in cases in which the support rights are assigned to the State.

Circumstances under which cooperation in establishing paternity or securing support is against the best interests of the child for which good cause may be determined are specified

in § 232.42. Regulations of the Health Care Financing Administration (HCFA) [42 CFR 433.147(c)(1)] governing waiver of cooperation in obtaining medical care support and payments require that the good cause determination be in accordance with factors specified in 45 CFR part 232 for other good cause determinations.

The "good cause" exception to required reviews does not require a separate determination of good cause circumstances. Under § 303.31(b), upon receiving notice from IV–A, IV–E, or Medicaid agency that there has been a claim of good cause for failure to cooperate, the IV–D agency will suspend all activities to establish paternity or secure support until notified of a final determination by the appropriate agency. Additionally, under § 303.31(c), the IV–D agency will not undertake to establish paternity or secure support in any case for which it has received notice from the IV–A, IV–E, or Medicaid agency that there has been a finding of good cause unless there has been a determination by the IV–A, IV–E, or Medicaid agency, as appropriate, that support enforcement may proceed without the participation of the caretaker relative. Therefore, unless there has been a determination under § 232.41 that good cause exists, and that child support enforcement may not proceed without risk of harm to the child or caretaker relative, a case in which there is an assignment of support rights must be reviewed.

In proposed § 303.8(c)(4), we specified that in a IV–D case in which there is an assignment of support rights to the State, an increase in support or the availability of health insurance must be considered to be in the best interests of the child unless either parent demonstrates it would not be in the child's best interests after a hearing. We have not included such a provision in the final rule, for several reasons. First, such a rule would essentially require a review to be done in order to determine whether a review should be done, since without a review, it may be difficult to determine whether an increase is likely or that health insurance is available. Secondly, the statute links the best interests test to whether a review should be conducted, not to whether an adjustment should be entered. Thirdly, such a rule implies that a hearing be conducted to determine whether a result would be in the child's best interest, which may be burdensome on States. Fourthly, such a requirement may reflect a misinterpretation of the statutory language in section 466(a)(10)(B)(i) of the Act which specifies a "not in the best interests of the child" test for when a review is not required rather than an "in the best interests of the child" test governing when a review is required.

2. Comment: Several commenters urged that "not in the best interests" be governed by the outcome of the review such that requests to increase the child support award amount should be honored and requests to decrease the child support award amount should be refused.

Response: We cannot support this approach. Section 466(a)(10)(B)(i) clearly specifies that an exception is permitted for cases in which a "review" would not be in the best interests of the child. It does not, however, provide any exception in the event the "adjustment or determination that there be no adjustment" would not be in the best interests of the child. Thus, the statute plainly connects the "child's best interest" test to the review, not the adjustment. The test applies to the process, not the results. States cannot fail to proceed with a required review or refuse a request to pursue a potential downward adjustment on the basis that the possible outcome would not be in a child's best interests. Decisions of whether or not to conduct reviews cannot be predicated on speculation that the results may be unfavorable to one or the other party or the child.

Furthermore, because review is defined in § 303.8(a) as an objective evaluation, conducted through a proceeding before a court, quasi-judicial process, or administrative body or agency, of information necessary for application of the State's guidelines for support to determine the appropriate child support award amount and the availability of health insurance, it implies the absence of any preconceived ideas or biases about the outcome. It also requires consistent and uniform application of presumptive guidelines in all cases. Thus, once the review begins, it should proceed to completion. If a party is dissatisfied with the result and wishes to challenge the determination, an opportunity to do so must be available. To allow parties the option to stop a review in progress to prevent undesired results would render meaningless the statutory language which provides that the parties be given notice following any review of the proposed adjustment or determination that there be "no adjustment." The decision-maker may determine that the order should not be adjusted, but cannot render such a determination absent a review.

Pre-Review Notice Requirement—Section 303.8(c)(6)

1. Comment: Several commenters requested removal of the 30-calendar-day notice requirement, so that reviews could begin immediately upon receipt of the necessary information.

Response: We recognize that in certain cases, waiting for the 30 calendar days to expire may create unnecessary delay. The 30-calendar-day requirement placed upon the notice is statutory. Until the 30 calendar days elapse, the formal review cannot begin, even if all the necessary information is available in advance. States may request that the parties consent, on a case-by-case basis, to waive the 30-calendar-day requirement and begin the review once the necessary information is available. However, without an amendment to the statute, the requirement cannot be changed or deleted. We have taken the notice requirements into consideration in determining timeframes for completion of review and adjustment activities.

Obtaining Information to Conduct Reviews—Section 303.8(c)(6)(ii)

1. Comment: A number of commenters suggested the need for administrative agencies to obtain subpoena power in order to more efficiently obtain necessary information from parties and other sources.

Response: We urge States to consider practices used by the States which conducted the demonstration projects as well as other jurisdictions to improve the information gathering and verification process. For example, in Illinois, the principal method for obtaining the information necessary to conduct a review was through a computer-generated administrative subpoena automatically issued to obligors' employers and sent by certified mail at the same time the initial notice packets were sent to both parents. Illinois officials reported positive responses from employers. In fact, the information contained in the employer responses to the administrative subpoenas was sufficient for conducting reviews, as well as a valuable source of current address information.

Colorado, another demonstration State, issued administrative subpoenas to any obligor who failed to return an affidavit for child support issued with the initial notice. The administrative subpoenas, served via certified mail or a process server, directed the obligor to bring specified financial information to an adjustment hearing at the IV–D office. If the obligor failed to appear as directed after service of an

administrative subpoena, a motion to compel could be filed, requiring the obligor to appear for a court hearing. Because information on the financial situation of both parents is necessary for application of Colorado guidelines, administrative subpoenas could also be served upon non-AFDC obligees who failed to return affidavits after two notices.

Another alternative would be for the court or administrative agency to include a provision in each new or adjusted order which requires each party to produce an annual income statement or for such a requirement to be adopted as a matter of State law. If a party then fails to comply, they have violated a term of the order, or if the requirement is statutory, a State law, which may be punishable by contempt or fine, as governed by State law, court rule, or the language of the order itself.

2. Comment: Some commenters requested that we specify what information should be shared or exchanged between the parties as part of the review process. Several raised issues concerning confidentiality and safeguarding requirements. One commenter suggested that making the provision of information a term of every support order in all States would benefit States responding to requests for review in interstate cases.

Response: States should investigate options such as clauses in the orders or statutory authorization requiring that certain information be exchanged between the parties or filed with the court or agency to reduce the need for elaborate and protracted discovery. The required information should be limited to the necessary data required to compute the support award using State guidelines. Limiting the scope of information required and informing the parties in advance of the responsibility to provide it and that it will be shared will make the requirement less burdensome and minimize possible breach of confidentiality claims.

3. Comment: Several commenters noted problems with ensuring the accuracy and completeness of information provided by the parties or obtained from automated databases. Some contended that it is unreasonable to expect or assume that the necessary information can be easily obtained, and that discovery techniques to compel disclosure are often cumbersome.

Response: We encourage States to consider alternative solutions to these operational concerns, from simplifying existing discovery techniques to possibly developing and requiring the use of standardized financial affidavits. Additionally, States may wish to consider contacting employers or other income sources to obtain, verify, and update wage information. Many States routinely ask employers or other income sources to confirm income in the course of imposing income withholding. Certainly, such practices could be extended to the review process as a means of ensuring the reliability of the information.

With the exception of Federal income tax data and income information obtained from the Internal Revenue Service, Federal regulations do not specify verification requirements or procedures for using information obtained on behalf of IV–D cases. The same policies and procedures developed by the State for verifying IV–D information generally should be applied to verifying information obtained for use in the review process. The key point is that verified data, not unsubstantiated allegations, should form the basis of the decision-making process.

Scope of a Review

1. Comment: Several commenters inquired whether automated reviews would satisfy the requirement for conducting reviews.

Response: As defined in § 303.8(a)(3), a review is an objective evaluation, conducted through a proceeding before a court, quasi-judicial process, or administrative body or agency, of information necessary for application of the State's guidelines for support to determine the appropriate support award amount and the availability of health insurance. By definition, review contemplates more than a computer match of a case against wage reporting systems, public assistance records, unemployment insurance rolls, and other automated databases. Because review is intricately connected to guidelines for setting child support awards and is designed to result in a determination of the appropriate amount of child support to be paid, a key component of the process is the computation of the child support amount using presumptive State guidelines. Typically, in most States, this will require gathering information sufficient to complete a worksheet or performs calculations, much of which may be known only to the parties involved. Some States have automated the State guidelines. Unless the databases accessed by the State permit retrieval of the necessary information sufficient to conduct a review as defined in § 303.8(a)(3), such access cannot be considered a complete review. In States which permit income to be imputed to a party in certain situations for the purpose of applying support guidelines, information from databases may be the only objective evidence available and considered sufficient for conducting a review in those instances. If a review is required, a full review must be conducted to reach a decision that the order be adjusted upward, downward, or not at all. Only a review could produce a "determination that there should be no change." Thus, the review itself is a "screen" to determine whether an adjustment in the amount of child support should be sought. In situations in which a review is not required, such as a case in which the support order is less than a year old, relying on information from automated databases to determine whether a complete review is warranted is permissible, unless supplemental information is brought to the attention of the agency conducting the review.

The experience of the Oregon Child Support Updating Project in using partial automated reviews indicated that sole reliance on computer matching to conduct reviews cannot ensure the accuracy of the information used to compute the appropriate child support amount under State guidelines. Oregon determined that case disposition using the Partial Automated Review (PAR) process often took longer and required greater work than the full manual procedure. Under the PAR process, the child support agent accessed automated data sources, computed a new child support award amount using that data, and notified the parents of the result. Because the results were often based on incomplete data, parents usually submitted additional information, which required that the support amount be recalculated. The initial computations obtained under PAR created false parental expectations in many situations, with the consequence that staff time had to be diverted to responding to complaints and explaining why the final result was lower or higher than expected.

Two reasons were cited in the final report on the Oregon project to explain the difficulty with PAR. First, for every case in which adequate Oregon Employment Wage Commission (EWC) earnings information was available for the obligor, the child support agent prepared a child support calculation worksheet and a proposed consent agreement and attached these documents to the initial notice letters to both parents. Because both parents rarely agreed to the new support amount specified in the notice, preparing the documents was usually wasted effort. Secondly, the simulated child support calculation was based only on financial information obtained from EWC or

imputed. If either parent provided additional earnings or allowable deductions information in response to the notice, the child support agent had to calculate a new child support amount.

2. Comment: One commenter argued that to complete a full review on all cases would require significant additional resources and cause unnecessary work.

Response: If an order is eligible for review based on its age, a State may not substitute a pre-screening or a partial review for a complete review by speculating as to the ultimate outcome. If, however, an objective evaluation of the circumstances in a particular case indicates no apparent change in the parents' situation (*e.g.* the obligation was originally established under guidelines, neither the obligee nor the obligor's income have changed), the State could readily assess that no adjustment is appropriate and notify the parties accordingly, allowing the parties the right to challenge such determination. States are also permitted to establish a reasonable quantitative standard, or threshold, to guide decisions whether to petition for an adjustment following a review. This topic is discussed more extensively elsewhere in this preamble.

To reduce the need suggested by the commenter for additional resource requirements and the possibility of unnecessary work, we encourage States to adopt procedures and other means. that facilitate entering adjusted orders on the basis of stipulations or consent agreements between the parties, as long as the appropriate amount of child support to be paid is determined in accordance with State guidelines. For example, all of the demonstration projects originally proposed to test a consent-oriented approach to obtaining adjusted orders, with streamlined or simplified administrative, quasi-judicial, or expedited judicial processes. Prior to processing a case through the regular judicial or administrative channels, project staff would attempt to obtain stipulations to a modified order based on guidelines.

In their demonstration projects, Colorado, Delaware, and Florida were able to obtain adjusted orders based upon out-of-court stipulations. Data from the Colorado project reflect that 62 percent of adjusted orders were accomplished by consent of the parties. Similarly, in Florida, 77 percent of the adjusted orders were obtained through stipulation of the parties. The vast majority (99.6 percent) of Delaware's modifications were obtained through the mediation process. In Illinois, all but one of the 1,382 adjusted orders were obtained through the judicial process. In Oregon, overall, 42 percent of the adjusted orders were obtained by consent of the parents, 28 percent were obtained by default, and 30 percent were obtained in an administrative or judicial hearing.

States have considerable latitude and flexibility in determining the site and degree of formality for reviews, as long as required reviews are conducted through a proceeding before a court, quasi-judicial process, administrative body or agency, notices are issued, timeframes are met, and guidelines are used, in compliance with Federal law and regulations. The experiences of the demonstration project States illustrate that not every case in which an adjustment is warranted requires a full judicial or administrative hearing to obtain a disposition.

Permissive Review

1. Comment: Several commenters questioned whether reviews may be pursued in non–AFDC cases without a request from a parent. They asked whether, in a non-AFDC IV–D case, a potential adjustment could be forced upon unwilling parties if the State chooses to review and the review results in a determination that the child support amount should be changed. If a State decides to review absent a request, is there a right to refuse the review before it is conducted or must the parties await the review results and then challenge the determination?

Response: The Act requires that States review, upon the request of either parent, any order that does not have an assignment of support rights as defined in § 301.1. The law does not preclude a State from going beyond the statutory requirement, therefore, States may conduct a review of all non-AFDC IV–D cases with orders. The notice of the rights to request a review required at § 303.8(c)(2) would provide parents with information on the circumstances under which the State would conduct a review. If the State determines that a review is warranted, even if not requested, either or both parents have a right to initiate proceedings to challenge the proposed adjustment or any other determination made on the basis of the review. Therefore, while such a review may be conducted without a request from either party, to conduct a review absent a request may be an inefficient use of State resources.

With respect to the question concerning the right to refuse a review conducted on the State's own initiative, once the State has decided to conduct a review absent a request from either parent, the review and adjustment process may proceed to completion despite the parents' objections. The parties may not refuse the review. The opportunity to challenge the proposed adjustment is available to the parents following notification of the results of the review or within the judicial or administrative proceedings for adjusting the order. Certainly, a State may not close a case or deny further services to a non-AFDC custodial parent who did not request, and refuses to cooperate in, a review conducted at the State's initiative. Based on the experiences in the demonstration projects, we believe that States' efforts will be focused upon conducting the required and requested reviews, and if the State chooses, reviews on their own initiative with which the parties are cooperative, rather than devoting time and expense to elective activities in which both parties are unwilling participants in the process.

The reason for not requesting a review may be a lack of knowledge that review is available. This underscores the importance of notifying the parties of the right to request a review. In its preliminary report on the Wisconsin Order Revision Pilots, the Institute for Research on Poverty, University of Wisconsin-Madison, cites various reasons why custodial parents might not pursue an action to upgrade an order which could potentially increase the income available for the children in their custody. These reasons include: (1) A perception that the existing award is "final"; (2) lack of knowledge as to how to pursue a change; (3) an assumption that the process would be too expensive; (4) fear of "rocking the boat" (causing custody or visitation issues to surface); (5) fear that action would produce a lower award; and (6) lack of awareness of the effect of inflation on the real value of the support award over time. The Oregon Child Support Updating Project conducted a telephone survey or interviews of non-AFDC parents who failed to return a review authorization form, in order to better understand why parents did not authorize a review of their child support orders. Numerous reasons were mentioned by parents for not authorizing a review. Many responses suggested that obligees believed it was pointless to adjust a support amount that the obligor was not presently paying. Other obligees seemed concerned that the obligor may stop paying support if the ordered amount was increased. Still others appeared to have some problems with the forms or were concerned about what direction (upward or downward) the adjustment

would take. Similar findings are indicated in the results among the other four demonstration projects. Across the four projects, non-AFDC cases were terminated from the review process at a much higher rate (72 percent) than AFDC cases (60 percent), principally because of a lack of authorization or cooperation needed from non-AFDC IV–D cases to conduct a review. Reasons typically cited for refusing a review mirror those raised in the earlier Wisconsin and Oregon updating projects. Review terminations in AFDC cases generally resulted from AFDC case closings, inability to locate the obligor, or lack of employer or income information upon which the review could be conducted.

Basis for Seeking Adjustment—Section 303.8(d)

1. Comment: Several commenters requested regulatory language to enhance their efforts in securing legislative amendments to change their statutory change in circumstances requirements. As indicated by the commenters, in most States, the party seeking the modification of a child support order, must allege and prove that a material, significant change in circumstances has occurred since establishment of the current order before a change is warranted. As noted by commenters, this burden in many States has traditionally been quite stringent, often requiring that parties prove that the claimed change in circumstances could not have been contemplated at the time of entry of the original order.

Response: As required under section 467(b)(2) of the Act, added by section 103(a) of Public Law 100–485, effective October 13, 1989, there shall be a rebuttable presumption, in any judicial or administrative proceeding for the award of child support, that the amount of the award which would result from the application of guidelines for child support award amounts within the State is the correct amount of child support to be awarded. In § 303.8(d)(1), we specify that inconsistency between the existent child support award amount and the amount of child support which results from an application of the State guidelines must be an adequate basis, under State law, for petitioning for an adjustment of an order in a IV–D case. Two exceptions to this requirement are permitted. The first exception is allowed if the State establishes a reasonable quantitative standard based upon either a fixed dollar amount or percentage, or both, as a basis for determining whether an inconsistency between the existent child support award amount and the amount of support which results from application of the guidelines is adequate grounds for petitioning for adjustment of the order. The second exception is permitted if the inconsistency is due to the fact that the amount of the current child support award resulted from a rebuttal of the guideline amount and there has not been a change in the circumstances which resulted in the rebuttal of the guideline amount.

In recent years, several States have adopted legislation expanding the definition of material or substantial change in circumstances to specify that adoption of guidelines alone constitutes a requisite change in circumstances or otherwise addressing the application of guidelines in modification proceedings. Illinois permits a one-time modification of those orders established before the guidelines were implemented to adjust the child support award to guideline levels, without the necessity of proving a change in circumstances. Appellate courts in at least two States have ruled that the adoption of support guidelines changed the rules for determining child support. One opinion holds that the material change in circumstances test no longer applies, that the question now is whether there is a "significant variance" between the guidelines and the amount of child support agreed to by the parties or ordered by the judge, and that, had the State legislature intended that the guideline statute could only be invoked upon a change in circumstances, it would have clearly said so.

2. Comment: One commenter suggested that States, in establishing the threshold, consider percentage amounts rather than fixed dollar amounts, noting that a $10 change makes a greater impact on a $50 monthly award than a $100 monthly award. Another commenter stressed that setting the threshold too low would literally bury the system with cases requesting upward or downward adjustments where there are minor fluctuations in either party's income; setting the threshold too high would foreclose cases otherwise appropriate for adjustment.

Response: We do not prescribe a particular fixed dollar or percentage in the regulation, as we believe this will allow States the necessary flexibility and discretion to establish an appropriate and reasonable quantitative standard. If a State establishes a threshold test, we urge the State not to aim too high or too low. In establishing a threshold, States may wish to consider adopting one which combines a "percentage or fixed dollar amount, whichever is lesser" so as to make the test more equitable across both income levels and family size. For example, meeting a 20 percent increase/decrease test is considerably more difficult in the case of a $500 order for three children than a $150 order for one child. In the former situation, the order would have to increase/decrease under guidelines by at least $100 in order to meet the threshold. In the latter, a $30 difference would suffice to warrant seeking an adjustment.

We encourage States to consider the experiences of the demonstration project States as well as other jurisdictions which have adopted thresholds applicable to review and adjustment processes. For example, Colorado and Florida will seek adjustment if there is a difference of at least 10 percent (plus or minus) from the current order amount. Illinois requires a change of plus or minus 10 percent and at least $5 in the order amount. Delaware requires a change of at least $25 in the monthly order amount. At the time of the Oregon project's inception, the criterion for modification in the State was that the moving party allege and prove a "substantial change in circumstances since entry of the order." Processing modifications became less burdensome and more predictable when Oregon adopted a guidelines-based modification standard and implemented an administrative criterion for the project of plus or minus 10 percent of the current support amount, and at least $25 per month as the minimum requisite change. We encourage States not only to examine the approaches adopted elsewhere, but to involve and work closely with the judiciary, the private bar, parents' groups, and other concerned parties in establishing the percentage or fixed dollar amount, or both, as a threshold.

We recognize that the traditional "substantial change in circumstances" test is applicable in many States. However, we believe that, by requiring States to use guidelines as a rebuttable presumption of the correct amount of support to be paid and requiring periodic review and adjustment, if appropriate, in accordance with such support guidelines, the Congress intended that States use guidelines as the basis for determining the need to change the amount of the child support award, rather than any other standard. The adoption of a threshold amount constituting a change sufficient to proceed with a request for an adjustment, following a review, will allow the review to be the means through which potential eligibility or

suitability of an order for adjustment is determined.

Establishment of a threshold will enable a reviewer to ascertain, based on a calculation of the amount of support presumed to be correct under guidelines, whether an adjustment is warranted. For example, if the VI–D agency conducts a review and determines that the proposed change in the amount of support does not meet the threshold established by the State for determining whether to petition for an adjustment, the IV–D agency does not have to proceed to file a petition. Certainly, under such circumstances, the decision by the IV–D agency not to proceed with a petition or motion to adjust the order does not preclude either parent from filing such a petition through the judicial or administrative process, either through counsel or *pro se*. We encourage States to include, as part of the notice sent to each parent concerning the right to request a review and other publicity about the review and adjustment process, information about any thresholds used in the review process and the avenues available for obtaining adjustments to the support order.

3. Comment: Several commenters suggested that the threshold be merely a starting point for deciding whether an adjustment is warranted. One commenter asked that we consider permitting States to use the numeric standard in concert with non-quantifiable standards to ensure that determinations about the appropriateness of adjustment are accurate.

Response: We believe that using the reasonable quantitative standard, or threshold, as merely the starting point or using non-quantifiable standards along with guidelines would provide more latitude to apply additional critieria to decide whether adjustment is warranted than was intended by the Act. Because the Act ties adjustment directly to guidelines, any latitude or variance should come from the guidelines computation itself and the opportunity afforded parties to rebut the presumption that the guideline amount is the correct amount of child support to be awarded in a case. We do not believe that requiring stricter criteria for adjustment beyond inconsistency with guidelines is necessary, because the opportunity to present other non-quantifiable evidence is a component of the right to rebut the presumption by demonstrating that application of the guidelines in a particular case would be unfair or inappropriate.

As indicated earlier, the reasonable quantitative standard, or threshold, established by the State should be used as a basis for deciding whether to petition for an adjustment. Presumptive guidelines, not the threshold established by the State, must be the basis upon which the judicial or administrative entity with authority to adjust child support order determines whether or not to adjust the order. Therefore, even if an established threshold is not met in a particular case, such that the IV-D agency or other reviewer decides not to proceed with a petition to adjust the order, the court or administrative authority may still act upon a petition from either parent, apply the guidelines, and establish an adjusted order.

4. Comment: One commenter observed that because guidelines are to be used as a rebuttable presumption, any order established under guidelines which differs from the guideline amount is immediately inconsistent. The commenter indicated that it may be inappropriate to petition for an adjustment merely because of an inconsistency due solely to a rebuttal of the presumption. The commenter suggested that all financial factors originally considered by the court should be reviewed when determining whether an adjustment is warranted.

Response: We agree with the commenter's analysis and have incorporated an exception to the inconsistency with guidelines requirement in § 303.8(d)(1) to address such situations. The exception encompasses cases in which the inconsistency between the current child support award amount and the amount of support required under guidelines is due to the fact that the amount of the current support award resulted from a rebuttal of the guideline amount and there has not been a change in the circumstances which resulted in the rebuttal of the guideline amount. The existence of situations such as that illustrated by the commenter underscores the importance of compliance with the requirement regarding written findings or specific findings on the record of a judicial or administrative proceeding for the award of child support regarding rebuttal of the guidelines. As required by § 302.56(g), findings that rebut the guidelines shall state the amount of support that would have been required under the guidelines and include a justification of why the order varies from the guidelines. Having such information available should prove beneficial in determining whether an adjustment is appropriate due to an inconsistency or whether the exception is applicable in a particular case.

Need for Provision for Health Care Needs

1. Comment: One commenter indicated a belief that determining the availability of health insurance will not result in enough benefits to the child to justify a substantial investment in staff time.

Response: Since December 2, 1985, under § 303.31(b)(1), IV-D agencies have been required to petition the court or administrative authority to include health insurance that is available to the absent parent at reasonable cost in new or modified court or administrative orders for support, unless the custodial parent and the children have satisfactory health insurance other than Medicaid. The IV-D agency is also required to petition the court or administrative authority to include medical support whether or not health insurance at reasonable cost is actually available to the absent parent at the time the order is entered or modification of current coverage to include the children is immediately possible. Additionally, since September 16, 1988, under § 303.31(b)(4), IV-D agencies are required to petition the court or administrative body to modify support orders to include a requirement for medical support in the form of health insurance, in cases identified under State criteria as having high potential for obtaining medical support. Thus, medical support responsibilities are not new requirements for States.

We believe that requiring States to determine the need to provide for the health care needs of the children as part of the review process reinforces the existent medical support enforcement requirements. Furthermore, the review process serves as a convenient way to deal with both the financial support and the health care needs of the children in the same transaction and to eliminate duplication of effort. Section 302.56(c)(3) requires that State guidelines for setting child support award amounts must provide for the children's health care needs, through health insurance coverage or other means.

In all five demonstration project States, modification for medical support could be sought independently of any change in the amount of the child support award and associated legal standards. In the earlier demonstration project in Oregon, some provision was made for obligors to carry medical insurance for their supported children in all but four percent of the adjusted orders. Oregon determined that a major benefit of reviewing previous support orders was the high proportion of

adjusted orders that included a provision for the obligor to carry medical insurance. Among the orders adjusted through the Oregon project, 63 percent of orders in AFDC cases, 75 percent of orders in former AFDC cases, and 54 percent of orders in non-AFDC cases did not previously provide for the health care needs of the children, but did so as a result of the adjustment process. Data from the other demonstrations projects indicate similar outcomes. For example, modifications for medical support were obtained in conjunction with adjustments in the order amount in 69 percent of the cases in Colorado and nearly half of the cases in Illinois.

Given the high cost of health care and the relatively nominal cost of health insurance, OCSE considers medical support to be generally advantageous to children. In cases in which there is an assignment of support rights, as defined under § 301.1, medical support need not be sought if the custodial parent has satisfactory health insurance coverage other than Medicaid available on behalf of the children. However, as provided under § 303.31(b)(2)(i), the medical support requirement is not dependent on the absent parent actually having coverage available at reasonable cost at the time the order is entered or adjusted. With respect to non-AFDC cases not receiving Medicaid, the decision to petition for inclusion of medical support is guided by a determination of high potential cases under State criteria required under § 303.31(b)(3) and the consent of the individual applying for IV–D services, as specified under § 303.31(c).

Timeframes for Review and Adjustment—Section 303.8(e)

1. Comment: Numerous commenters objected to placing timeframes for review and adjustment with those governing establishment of support obligations. In general, most commenters urged us to put timeframes in a separate section, apart from the timeframes in § 303.4. Many commenters expressed concern that the proposed wording and inclusion with the establishment requirements made the timeframe confusing, and subject to the potential misinterpretation that every time a parent was located or paternity was established, a review had to be conducted. Most commenters urged us to wait until the reports from the review and adjustment demonstration projects were completed before establishing timeframes (and before making regulations effective).

Response: In response to these comments, the final regulation specifies two explicit timeframes which must be met by States in conducting review and adjustment activities. Section 303.8(e)(1) requires that in any case in which support rights are assigned to the State under § 301.1, the State must determine, within 15 calendar days of October 13, 1993, or the date the child support order is 36 months old, whichever date occurs later, whether a review should be conducted. Subsequent determinations about whether to conduct a review must be made in accordance with paragraph (c)(4), at 36-month intervals based upon the date the child support order was adjusted or the date an order was entered determining that the child support order should not be adjusted, or, in any case in which a petition or motion for adjustment was not filed following a review, the date upon which the post-review challenge period ended.

Section 303.8(e)(2) imposes a 15-calendar-day timeframe on the State for making a determination whether a review should be conducted where a request for a review is made, based upon the date of receipt of a request. Section 303.8(e)(3) specifies a 180-calendar-day period for conducting specified review and adjustment activities, measured from the date of determining that a review should be conducted or locating the non-requesting parent, if necessary, whichever is later. Our decision to expand the timeframe from the 90 days specified on the proposed rule is based upon the suggestions of commenters and indications from the experiences in the demonstration projects, as well as recognition of the need to incorporate the statutory 30-day pre-notice and 30-day post-notice requirements.

The findings and experiences of the demonstration projects substantiate that a 180-calendar timeframe is both necessary and reasonable. The time for completing the review and adjustment process experienced in the demonstration States was measured from case selection as the starting point. Location of the non-requesting parent was not a criteria for selection, but a post-selection, pre-review activity. Thus, time devoted to location was a component of the processing times used to compute the average length of time the review and adjustment process encompasses. The 180-calendar-day timeframe imposed by these regulations does not commence to run until the non-requesting parent is located or determination to review is made, whichever is later. We believe including location as a necessary prerequisite allows States additional time of up to 75 calendar days after determining location is necessary to access location sources and ensure that locate information is sufficient to take the next appropriate action in the case, as required by § 303.3(b)(3).

In the Oregon Child Support Updating Project, modified orders required an average of 200 calendar days to be established, measured from the date a case was selected for review to the date a modified order was entered. This average was achieved using expedited court dockets in the nine participating counties, involving designating a half day of court time each month strictly for handling modification cases. The Oregon demonstration project found no significant difference in time required to obtain adjusted orders by administrative process (190 calendar days) as compared to judicial processes (212 calendar days). As noted in the "Findings from the Third Year Research" (September 1991) under Oregon's project, the greater time required to obtain judicial modifications prompted Oregon to adopt legislation giving the Oregon Support Enforcement Division authority to modify all orders under its jurisdiction—both those established by administrative process and those established by judicial process—through an administrative process. Under this law, administratively-modified orders that had been originally established by a judge, will still be ratified and approved by a judge. Because such a process is anticipated to eliminate delays associated with docketing court hearings, the change to a totally administrative process is expected to reduce the calendar time required to obtain an adjusted order. Third-year supplemental data from the Oregon project reflect that the method used for obtaining the adjusted order also influenced the amount of time required to complete the process. The average time was significantly less for adjusted orders obtained by consent (146 calendar days) than those obtained by default (217 calendar days) or after a judicial or administrative hearing (248 calendar days).

Data from the demonstration projects conducted in Colorado, Delaware, Florida, and Illinois reflect that the overall average length of time from case selection to adjustment across all four projects for 3,207 cases in which adjustment activities were completed was 195 calendar days. In Delaware, the average time required was 174 calendar days and in Illinois, an average of 171 calendar days was necessary. The average time to obtain an adjusted order in the Florida project was 162 calendar days. Colorado experienced the longest

average time (252 calendar days) from selection to adjustment. This average was clearly affected by the method by which the adjustment was obtained. Of the orders adjusted, 576 were obtained by stipulation of the parties, representing 62 percent of the total cases modified. The average time required for processing these cases was 216 calendar days. Cases in which obtaining an adjustment involved a court hearing, including modified orders by default, took longer, and affected the overall average amount of time required. Data from the demonstration projects also indicate that interstate cases do take longer, but only about one month longer. In Colorado, for example, findings indicate that, on average, adjusting an interstate case took only nine days longer than an in-State case. These findings are consistent with those from the Oregon project. In Oregon, the average calendar time to obtain an adjusted order was only slightly longer (16–19 calendar days) for cases in which one parent lived in the State than for cases in which both parents lived in the State.

During the 180-calendar-day timeframe, all necessary preliminary activities must occur, including preparation of any pleadings and documents necessary before issuance of the advance notice of the review. Following the issuance of the notice, and as explicitly required by statute, at least 30 calendar days must elapse before the review is actually conducted. This period should be the time for gathering information, both from the parties and by accessing any other databases or information sources available to the State (labor/wage screens or employer inquiries, for example).

The balance of the period following the 30-calendar-day pre-review period allows time for conducting the review, determining whether an adjustment is warranted, preparing any written findings, sending the post-review notice of the results to the parties, petitioning for adjustment, where indicated, and adjusting the order or determining that no adjustment should be made, no later than the 180th calendar day following the determination that a review should be conducted or locating the non-requesting parent, whichever occurs later. Depending upon the State's processes for conducting reviews and making adjustments to child support orders, each of the various activities within the 180-calendar-day timeframe may be the responsibility of a different entity, including the IV–D agency, the judicial or administrative process, and the parties.

2. Comment: Several commenters contended that a timeframe is not intended by Congress because review and adjustment are not mentioned in section 121 of Public Law 100–485, which requires the Secretary to establish time limits within which States must accept and respond to requests for assistance in establishing and enforcing support orders, including requests to locate absent parents, establish paternity and initiate proceedings to establish and collect support awards.

Response: We disagree with the commenter's contention that Congress intended that no timeframes apply to the process for review and adjustment of orders. As set forth in section 452(a) of the Act, OCSE is required to establish such standards for State programs as determined to be necessary to assure that such programs will be effective. Additionally, as specified in section 452(h) of the Act, these standards shall include standards establishing time limits governing the period or periods within which a State must accept and respond to requests for assistance in establishing and enforcing orders. While the statute mentions the kinds of requests included, the specific activities enumerated are by no means inclusive of the various activities involved in establishing and enforcing support orders for which standards or time limits are appropriate. We use our regulatory authority, under section 1102 of the Act, to impose a timeframe requirement for completion of review and adjustment activities. The timeframe of 180 calendar days means that review and adjustment falls outside of the basic expedited processes requirement under § 303.101(b)(2), which requires that actions to establish or enforce child support must be completed from time of successful service of process to the time of disposition within the following timeframes: 90 percent in 3 months, 98 percent in 6 months, and 100 percent in 12 months.

Review and Adjustment in Interstate Cases—Section 303.8(f)

1. Comment: One commenter asked that regulations address whether a rendering court has jurisdiction to honor a request to adjust an order for support if neither party presently resides in that State.

Response: We believe that absent any controlling Federal law, State law governs such circumstances. Therefore, it would be inappropriate to delineate in regulations matters within the authority of each State. Generally, a court which enters a child support order retains continuing subject matter jurisdiction to review and adjust such order and continuing personal jurisdiction over the parties regardless of their present residence provided that the court had personal jurisdiction over the parties at the time the order was entered.

If the rendering court had personal jurisdiction over the parties at the time the order was entered, such jurisdiction is not lost with respect to actions flowing out of the original order such as enforcement or adjustment, regardless of where the parties are presently situated. However, a rendering court, although it may have ongoing jurisdiction, may decline to exercise such jurisdiction if it considers itself to be an inconvenient forum because none of the parties to the original action currently reside in or have any present connection with that State. For example, following a divorce decree in one State, both parties may have relocated to other States. Instead of conducting the review "long-distance" or forcing both parties to litigate the adjustment in the original court, one party could register the child support order in the court of another State which has personal jurisdiction over the other party.

2. Comment: One commenter inquired whether States will be required to share their review and adjustment criteria with all other States so that in interstate cases the initiating jurisdiction can provide necessary documentation for the responding State to act on the request and so that individuals affected will know in advance what criteria will be used to make a determination.

Response: In Decemeber 1990, OCSE distributed a "State At A Glance" directory on computer diskette to each State, which contains State profile information about each State as well as specific documentation requirements for each of the various establishment and enforcement functions, including modification. This publication may be a valuable resource for States in preparing requests for review for referral to other States. OCSE is exploring the possibility of periodically updating this reference tool to reflect changes in State law and practices.

3. Comment: Several commenters urged that regulations include a separate section on interstate review and adjustment.

Response: Accordingly, we added § 303.8(f) to address specific requirements for providing review and adjustment services in interstate cases.

Executive Order 12291

The Secretary has determined, in accordance with Executive Order 12291, that this proposed rule does not

constitute a "major" rule. A major rule is one that is likely to result in:

(1) An annual effect on the economy of $100 million;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

This rule implements specific requirements of Public Law 100–485. We expect the additional costs to the States will be less than $100 million. Any costs will be administrative and can be minimized through careful State planning. We believe increased collections as a result of adjustments to child support award amounts and the imposition of immediate wage withholding in these cases will exceed increased administrative costs.

Regulatory Flexibility Analysis

The Secretary certifies, under 5 U.S.C. 605(b), as enacted by the Regulatory Flexibility Act (Pub. L. 96–354), that this proposed regulation will not result in a significant impact on a substantial number of small entities. The primary impact is on State governments and individuals, which are not considered small entities under the Act.

List of Subjects in 45 CFR Parts 302 and 303

Child support, Grant programs—social programs, Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance Program No. 93.023, Child Support Enforcement Program)

Dated: May 16, 1992.

Jo Anne B. Barnhart,

Assistant Secretary for Children and Families.

Dated: July 22, 1992.

Louis W. Sullivan,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on December 18, 1992.

For the reasons set out in the preamble, 45 CFR chapter III is amended as follows:

PART 302—STATE PLAN REQUIREMENTS

1. The authority citation for part 302 continues to read as follows:

Authority: 42 U.S.C. 651 through 658, 660, 664, 666, 667, 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

2. Section 302.70 is amended by revising paragraph (a)(10) to read as follows:

§ 302.70 Required State laws.

(a) * * *

(10) Procedures for the review and adjustment of child support orders:

(i) Effective on October 13, 1990 until October 12, 1993, in accordance with the requirements of §§ 303.8 (a) and (b) of this chapter; and

(ii) Effective October 13, 1993, or an earlier date the State may select, in accordance with the requirements of § 303.8 (a) and (c) through (f) of this chapter.

* * * * *

PART 303—STANDARDS FOR PROGRAM OPERATIONS

3. The authority citation for part 303 continues to read as follows:

Authority: 42 U.S.C. 651 through 658, 660, 663, 664, 666, 667, 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

4. Section 303.7 is amended by adding paragraph (b)(6), by adding paragraph (c)(7)(v), and by amending paragraph (c)(8) by replacing the word "modification" with the word "adjustment," to read as follows:

§ 303.7 Provision of services in interstate IV–D cases.

* * * * *

(b) * * *

(6) Send a request for review of a child support order to another State within 20 calendar days of determining that a request for review of the order should be sent to the other State and of receipt of information from the requestor necessary to conduct the review in accordance with §§ 303.8(f)(1) of this part.

(c) * * *

(7) * * *

(v) Reviewing and adjusting child support orders upon request in accordance with § 303.8(f)(2) of this part.

* * * * *

5. Section 303.8 is amended by adding new paragraphs (c), (d), (e), and (f) to read as follows:

§ 303.8 Review and adjustment of child support orders.

* * * * *

(c) *Review of child support orders.* Effective October 13, 1993 or an earlier date the State may select, the State must, when providing services under this chapter:

(1) Have in effect and use a process for review and adjustment of child support orders in effect in the State, including a process for challenging a proposed adjustment or determination.

(2) Notify each parent subject to a child support order in the State of the right to request a review of the order, and the appropriate place and manner in which the request should be made.

(3) Periodically publicize the right to request a review as part of its support enforcement services as required under § 302.30 of this chapter and include notice of this right as part of information on IV–D services under § 303.2(a)(2) of this part.

(4) Review child support orders at 36-month intervals after establishment of the order or the most recent review, unless:

(i) In a case in which there is an assignment as defined in § 301.1 of this chapter, the State determines, in accordance with § 303.8(c)(5) of this section, that a review would not be in the best interests of the child and neither parent has requested a review; or

(ii) In a case in which there is no such assignment of support rights to the State, neither parent has requested a review; or

(iii) In a case in which medical support rights are assigned under 42 CFR 433.146, but child support rights are not assigned to the State under § 232.11 of this title or § 471(a)(17) of the Act, the order requires the provision of health insurance coverage, and neither parent has requested a review; or

(5) Determine that a review of the child support order would not be in the best interests of a child if there has been a finding of good cause as set forth at §§ 302.31(c) and 232.40 through 232.49 of this title or under 42 CFR 433.17(c), and the State of local IV–A, XIX, or IV–E agency has determined that support enforcement may not proceed without risk of harm to the child or caretaker relative.

(6) Notify or serve process upon each parent subject to a child support order in effect in the State of:

(i) Any review of such order at least 30 calendar days before commencement of the review, and

(ii) Any information necessary to conduct the review that each parent must provide and the date by which such information must be provided.

(7) Following any review, notify each parent subject to the child support order of:

(i) A proposed adjustment or a determination that there should be no adjustment in the order; and

(ii) Each parent's right to initiate proceedings to challenge the proposed adjustment or other determination, not

less than 30 calendar days after the notice.

(8) Adjust the order, or determine that there should be no adjustment, as appropriate, in accordance with the State's guidelines for setting child support awards and paragraph (d) of this section.

(d) *Basis for seeking adjustment.* (1) Inconsistency between the existent child support award amount and the amount of child support which results from application of the State guidelines must be an adequate basis, under State law, for petitioning for an adjustment of an order in a IV–D case, unless:

(i) the inconsistency does not meet a reasonable quantitative standard established by the State, in accordance with paragraph (d)(2) of this section or

(ii) the inconsistency is due to the fact that the amount of the current child support award resulted from a rebuttal of the guideline amount and there has not been a change in the circumstances which resulted in the rebuttal of the guideline amount.

(2) The State may establish a reasonable quantitative standard based upon either a fixed dollar amount or percentage, or both, as a basis for determining whether an inconsistency between the existent child support award amount and the amount of support which results from application of the guidelines is adequate grounds for petitioning for adjustment of the order.

(3) The need to provide for the child's health care needs in the order, through health insurance or other means, must be an adequate basis under State law to petition for adjustment of an order to provide for the children's health care needs, regardless of whether an adjustment in the amount of child support is necessary. In no event shall the eligibility for or receipt of Medicaid be considered to meet the need to provide for the child's health care needs in the order.

(e) *Timeframes for review and adjustment.* (1) In any case in which support rights are assigned to the State under § 301.1 of this part, the State must determine, within 15 calendar days of October 13, 1993 or the date the child support order is 36 months old, whichever date occurs later, whether a review should be conducted, as required under paragraph (c)(4) of this section. Subsequent determinations about whether to conduct a review must be made in accordance with paragraph (c)(4) of this section, at 36-month intervals based upon the date the child support order was adjusted or the date an order was entered determining that the child support order should not be adjusted, or, in any case in which a petition or motion for adjustment was not filed following a review, the date upon which the post-review challenge period ended.

(2) Within 15 calendar days of receipt of a request for a review, the State must determine whether a review should be conducted, as required under paragraph (c)(4) of this section.

(3) Within 180 calendar days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, a State must:

(i) Send the notice or serve process required under paragraph (c)(6) of this section that a review will be conducted;

(ii) Conduct a review of the order;

(iii) Send the notice of the proposed adjustment or determination that there should be no adjustment as required under paragraph (c)(7) of this section; and

(iv) Adjust the order or determine that the order should not be adjusted in accordance with paragraph (c)(8) of this section.

(f) *Interstate review and adjustment.* Effective October 13, 1993, or such earlier date the State may select:

(1) *Initiating State responsibilities.* The State in which a request for review is made, or in which there is an assignment of rights to support, as defined under § 301.1 of this part, must:

(i) In any case in which support rights are assigned to the State under § 301.1, determine, within 15 calendar days of October 13, 1993, or the date the child support order is 36 months old, whichever date occurs later, whether a review should be conducted, as required under paragraph (c)(4) of this section, and in which State a review and adjustment will be sought. Subsequent determinations about whether to conduct a review must be made in accordance with paragraph (c)(4) of this section, at 36-month intervals based upon the date the child support order was adjusted or the date an order was entered determining that the child support order should not be adjusted, or, in any case in which a petition or motion for adjustment was not filed following a review, the date upon which the post-review challenge period ended.

(ii) Within 15 calendar days of receipt of a request for a review, determine whether a review should be conducted, as required under paragraph (c)(4) of this section, and in which State a review and adjustment will be sought.

(iii) If the State determines under paragraph (f)(1)(i) or paragraph (f)(1)(ii) of this section that it should review a child support order in effect in the State, the State shall, within the 180-calendar-day timeframe for review and adjustment of child support orders set forth in paragraph (e)(2) of this section, send the notice that a review will be conducted to each parent, conduct a review, provide notice to the parties of the right to challenge the proposed adjustment or other determination, and adjust the order or determine that the order should not be adjusted, in accordance with paragraphs (c) (6) through (8) of this section.

(iv) If the State determines under paragraph (f)(1)(i) or paragraph (f)(1)(ii) of this section to request a review of a child support order in another State, send a request for review to that State within 20 calendar days of receipt of sufficient information to conduct the review and provide that State with sufficient information on the requestor to act on the request, in accordance with the requirements of § 303.7(b)(6) of this part.

(v) If the request for review is the first contact between the initiating and responding States in the case, send the request for review to the interstate central registry in the responding State. However, if the initiating State has previously referred the case to a responding State for action and determines under paragraph (f)(1)(i) or paragraph (f)(1)(ii) of this section that the child support order should be reviewed in that responding State, the request for review may be sent directly to the appropriate agency in the responding State for processing.

(vi) Send, to the parent in the initiating State, a copy of any notice issued by a responding State in connection with the review and adjustment of an order, within 5 working days of receipt of such notice in the initiating State.

(2) *Responding State responsibilities.* (i) Within 15 calendar days of receipt of a request for a review of a child support order in the responding State, the appropriate processing agency in the responding State must determine whether a review should be conducted, in accordance with paragraph (c)(4) of this section and the responding State's procedures for review and adjustment of child support orders.

(ii) Within 180 calendar days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the responding State must send the notice that a review will be conducted to each parent, conduct a review, adjust the order or determine that the order should not be adjusted, and provide the notice of the adjustment or determination and the right to challenge the adjustment or determination in accordance with

paragraphs (c) (6) through (8) of this section.

(iii) The State may meet the notice requirements of § 303.7(c)(8) of this part by sending the notices of the review required under paragraphs (c)(6) and (c)(7) of this section to the parent in the initiating State through the IV–D agency in the initiating State.

(3) *Applicable laws and procedures.* The applicable laws and procedures for review and adjustment of child support orders, including the State guidelines for setting child support awards, established in accordance with § 302.56 of this chapter, are those of the State in which the review and adjustment, or determination that there be no adjustment, take place.

[FR Doc. 92–31106 Filed 12–24–92; 8:45 am]
BILLING CODE 4190–11–M

GENERAL SERVICES ADMINISTRATION

48 CFR Parts 501, 502, 504, 508, 510, 515, 530, and 533

[APD 2800.12A CHGE 44]

General Services Administration Acquisition Regulation; Miscellaneous, Changes

AGENCY: Office of Acquisition Policy, GSA.

ACTION: Final rule.

SUMMARY: The General Services Administration Acquisition Regulation (GSAR), Chapter 5, is amended to revise section 501.603–70 to modify the training requirements under the Contracting Officer Warrant Program; to revise section 501.670–4 to modify the requirements for legal review of contract modifications; to revise section 502.101 to modify the definition of "Agency Competition Advocate" and "Contracting Activity Competition Advocate;" to revise section 504.201 to clarify circumstances when contract award data is to be submitted to the paying office; to revise section 504.803 to provide for maintaining evidence of submission of award data in the contract file; to revise section 508.304–5 to eliminate the requirement for use of the GSA–1533 Utility Contract; to delete section 508.371; to revise section 510.011 to add instructions to modify FAR 52.210–1 to update the address and phone number and to delete reference to certain Business Service Centers; to revise section 515.406–1 to eliminate the exception for utility contracts from use of the uniform contract format; to revise section 515.414–70 to provide for use of the GSA–3503 in utility contracts; to add section 530.470 and to revise 533.104 to clarify from whom the notice of a protest after award must be received and the number of days refers to calendar days.

EFFECTIVE DATE: January 1, 1993.

FOR FURTHER INFORMATION CONTACT: Teresa Elmendorf, Office of GSA Acquisition Policy (202) 501–1224.

SUPPLEMENTARY INFORMATION:

A. Executive Order 12291

The Director, Office of Management and Budget (OMB), by memorandum dated December 14, 1984, exempted certain agency procurement regulations from Executive Order 12291. The exemption applies to this rule.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act is not applicable because the changes made in this final rule do not have a significant effect beyond the internal operating procedures of the agency or have a significant cost or administrative impact on contractors or offerors and, therefore, are not subject to publication for comment under section 22 of the Office of Federal Procurement Policy Act, 41 U.S.C. 418b.

C. Paperwork Reduction Act

This rule does not contain any recordkeeping or information collection requirements that require the approval of OMB under 44 U.S.C. 3501 et seq.

List of Subjects in 48 CFR Parts 501, 502, 504, 508, 510, 515, 530, and 533

Government procurement.

Accordingly, 48 CFR parts 501, 502, 504, 508, 510, 515, 530 and 533 are amended to read as follows:

1. The authority citation for 48 CFR parts 501, 502, 504, 508, 510, 515, 530, and 533 continues to read as follows:

Authority: 40 U.S.C. 486(c).

PART 501—GENERAL SERVICES ADMINISTRATION ACQUISITION REGULATION SYSTEM

2. Section 501.603–70 is amended by revising paragraph (h)(1)(iv)(K) to read as follows:

501.603–70 Contracting officer warrant program (COWP).

* * * * *

(h) * * *

(1) * * *

(iv) * * *

(K) Public Utility Contracts—24–40 hours (Applicable to personnel handling public utility procurements)

* * * * *

3. Section 501.670–4 is amended by revising paragraph (a)(3) to read as follows:

501.670–4 Legal review.

(a) * * *

(3) Award of any contract which requires pre-award or post-award clearance by the Office of Acquisition Policy or by a service or regional clearance office under GSA Order, Contract Clearance (APD 2800.1C), and any modifications thereof valued at $25,000 or greater.

* * * * *

PART 502—DEFINITION OF WORDS AND TERMS

4. Section 502.101 is amended by revising the definition of "Agency competition advocate" and "contracting activity competition advocate" to read as follows:

502.101 Definitions.

Agency competition advocate means the Deputy Associate Administrator for Acquisition Policy.

* * * * *

Contracting activity competition advocate means the (1) Deputy Associate Administrator for Acquisition Policy, (2) FSS Competition Advocate, Office of Commodity Management, (3) IRMS Competition Advocate, Office of Information Resources Management Policy, (4) Special Assistant to the Director, Program Support Office, FPRS, (5) Deputy Regional Administrator for Regions 2, 3, 4, 5, 6, 7, 9, and the National Capital Region and (6) the Senior Advisor to the Regional Administrator for Regions 8 and 10. The Deputy Associate Administrator for Acquisition Policy serves as the contracting activity competition advocate for Central Office contracting activities outside of FSS, IRMS, and FPRS.

* * * * *

PART 504—ADMINISTRATIVE MATTERS

5. Section 504.201 is revised to read as follows:

504.201 Procedures.

(a) Contracting Officers are required to send documentation to the paying office on all contracts where a delivery order will be generated by GSA. The documentation shall consist of a "Duplicate Original" of the entire contract or modification, except as provided in paragraph (c), below.

(b) The Contracting Officer shall certify that the "Duplicate Original" is a true copy of the contract or

modification by means of a handwritten signature, in ink, on the award or modification form (i.e., SF 26, 33, 1442, etc.). The certification requirement does not apply to:

(1) Leases of real property;

(2) Schedule contracts; or

(3) Standard or GSA multipage purchase/delivery order carbon forms.

(c) For Federal Supply Service contracts entered into the FSS–19 system and subject to the requirement in paragraph (a), above, distribution to the paying office shall be accomplished through the use of a system-generated contract listing.

6. Section 504.803 is amended by revising paragraph (a)(23) to read as follows:

504.803 Contents of contract files.

(a) * * *

(23) Contractual action. Successful bid or proposal and all pertinent correspondence applicable to the contractual action including evidence of submission of contract award data to paying office, if applicable (see 504.201). Subcontracting plans that are incorporated in and made a material part of a contract, as required by FAR 19.705–5(a)(5), and the successful competing contractor's certificate of procurement integrity required by FAR 3.104–9(b), should be filed under this tab.

* * * * *

PART 508—REQUIRED SOURCES OF SUPPLIES AND SERVICES

7. Section 508.304–5 is revised to read as follows:

508.304–5 Agency acquisition.

Contracting officers shall notify the Public Utilities Services Division (PPU) in accordance with FAR 8.304–5(g), when a utility service supplier refuses to execute a contract.

508.371 [REMOVED]

8. Section 508.371 is removed.

PART 510—SPECIFICATIONS, STANDARDS, AND OTHER PURCHASE DESCRIPTIONS

9. Section 510.011 is amended by adding paragraph (j) to read as follows:

510.011 Solicitation provisions and contract clauses.

* * * * *

(j) When the provision at 52.210–1, Availability of Specifications Listed in the GSA Index of Federal Specifications, Standards and Commercial Item Descriptions, is used in solicitations, the contracting officer is authorized to deviate from the FAR provision by substituting 490 L'Enfant Plaza, SW, Suite 8100, for the street address and 202–755–0325 or 0326 for the telephone numbers of the GSA Specification Unit shown in the provision. Business Service Centers in Chicago, IL; Los Angeles, CA; and Auburn, WA, also must be deleted from the provision because these offices no longer maintain and distribute Federal specifications and standards.

PART 515—CONTRACTING BY NEGOTIATION

10. Section 515.406–1 is amended by revising paragraph (a) to read as follows:

515.406–1 Uniform contract format.

(a) Leases of real property are exempted from the requirement for use of the uniform contract format.

* * * * *

11. Section 515.414–70 is amended by revising paragraph (b) to read as follows:

515.414–70 GSA Forms.

* * * * *

(b) The GSA Form 3503, Representations and Certifications, may be used in solicitations and contracts, except leases of real property.

* * * * *

PART 530—COST ACCOUNTING STANDARDS

12. Section 530.201–5 is revised to read as follows:

530.201–5 Waiver.

Requests to waive CAS requirements under FAR 30.201–5 shall be submitted to the CAS Board through the Associate Administrator for Acquisition Policy.

13. Subpart 530.4 is added consisting of section 530.470 to read as follows:

Subpart 530.4 Cost Accounting Standards

530.470 Waiver of Cost Accounting Standard 9904.412–40(c).

The Associate Administrator for Acquisition Policy (V) on a non-delegable basis may waive the cost assignment provisions of 48 CFR 9904.412–40(c). Requests for waivers shall be forwarded to the Associate Administrator with supporting documentation and rationale. A copy of each approved waiver will be furnished by the Associate Administrator to the CAS Board's Executive Secretary.

PART 533—PROTESTS, DISPUTES, AND APPEALS

14. Section 533.104 is amended by revising paragraph (c) to read as follows:

533.104 Protests to GAO.

* * * * *

(c) *Protests after award.* The procedures in paragraph (a) of this section apply to the handling of protests filed with GAO after award. If the protest is received from GAO (not from protester or any other party) within 10 calendar days after an award, contract performance must be suspended under FAR 33.104(c) unless the HCA determines in writing that contract performance is in the best interests of the United States or that urgent and compelling circumstances that significantly affect the interests of the United States do not permit waiting for the GAO's decision. The written determination and findings (D&F), in the format shown at 501.704–70(e)(2), should be prepared by the contracting officer for signature of the HCA. The D&F must be concurred in by the Regional Counsel (on regional procurements), and the appropriate AGC. After the D&F is approved, it must be returned to the AGC who notifies GAO of the agency's findings and intended action before contract performance is authorized.

* * * * *

Dated: December 7, 1992.

Richard H. Hope, III,

Associate Administrator for Acquisition Policy.

[FR Doc. 92–31084 Filed 12–23–92; 8:45 am]

BILLING CODE 6820–61–M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1033

[Ex Parte No. 334 (Sub-Nos. 8 and 8A)]

Joint Petitions for Rulemaking on Railroad Car Hire Compensation and for Exemption of Arbitration Rule and Motion to Dismiss

AGENCY: Interstate Commerce Commission.

ACTION: Revisions to final rules.

SUMMARY: The Commission has revised two of its final rules scheduled to become effective January 1, 1993, governing the 10-year phased deprescription of the car hire rates. As revised, the final rules now treat cars rebuilt on or after January 1, 1991, essentially the same as they treat new cars.

EFFECTIVE DATE: The decision revising the rules is effective on December 28, 1992. The new rules, including these revisions, are effective January 1, 1993.

FOR FURTHER INFORMATION CONTACT:

Richard B. Felder, (202) 927–5610 [TDD for hearing impaired: (202) 927–5721.]

SUPPLEMENTARY INFORMATION: The Commission adopted final rules governing car hire rates in a decision served and published in the **Federal Register** on November 10, 1992, at 57 FR 53450. That decision became effective December 10, 1992. It provided that the rules will become effective January 1, 1993. Based on petitions for reconsideration that were filed, the Commission has revised §§ 1033.1(a)(3) and 1033.1(b)(1) of the new rules. The revisions were made so that new cars and cars rebuilt since January 1, 1991, would be treated similarly. The final rules, including the revisions to these sections, will still become effective January 1, 1993.

Additional information is contained in the Commission's decision. To purchase a copy of the full decision, write to, call, or pick up in person from: Dynamic Concepts, Inc., Room 2229, Interstate Commerce Commission Building, Washington, DC 20423. Telephone: (202) 289–4357/4359. [Assistance for the hearing impaired is available through TDD services (202) 927–5721.]

Regulatory Flexibility Analysis

The Commission certified in its decision served November 10, 1992, that its action will not have a significant impact on a substantial number of small entities. The Petitions for Reconsideration did not challenge that certification, and the revisions of the rules adopted on reconsideration affect only two sections. As treating recently rebuilt cars and recently purchased cars similarly will not have a material effect on small purchased cars similarly will not have a material effect on small entities, the Commission certifies that its action will not have a significant impact on a substantial number of small entities.

This action will not significantly affect either the quality of the human environment or the conservation of energy resources.

List of Subjects

49 CFR Part 1033

Railroads.

49 CFR Part 1039

Agricultural commodities, Intermodal transportation, Railroads.

Decided: December 21, 1992.

By the Commission, Chairman Philbin, Vice Chairman McDonald, Commissioners Simmons and Phillips. Vice Chairman McDonald and Commissioner Simmons would have granted the stay.

Sidney L. Strickland, Jr.,

Secretary.

For the reasons set forth in the preamble, title 49, chapter X, part 1033 of the Code of Federal Regulations is amended as follows:

PART 1033—CAR SERVICE

1. The authority citation for Part 1033 continues to read as follows:

Authority: 49 U.S.C. 10321, 10326, 11121, and 11122; 5 U.S.C. 553.

2. In section 1033.1 Paragraphs (a)(3) and (b)(1) are revised to read as follows:

§ 1033.1 Car hire rates.

(a) * * *

(3) *Fixed rate car.* Any car placed in service or rebuilt prior to January 1, 1991 or for which there was a written and binding contract to purchase, rebuild, or build prior to July 1, 1990, regardless of whether such car bore railroad reporting marks prior to January 1, 1991. Cars purchased or rebuilt on or after January 1, 1991, or under contract after July 1, 1990, will be deemed to be market rate cars. Provided, however, that for a period of one year from January 1, 1993, all cars shall be deemed to be fixed rate cars.

* * * * *

(b) * * *

(1) Except as provided in paragraph (b)(3) of this section, for a 10-year period beginning January 1, 1993, the prescribed rates shall continue to apply to fixed rate cars without regard to the aging of such cars subsequent to December 31, 1990.

* * * * *

[FR Doc. 92–31417 Filed 12–24–92; 8:45 am]

BILLING CODE 7035–01–M

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49 CFR Part 1180

[Ex Parte No. 282 (Sub-No. 12)]

Transfer or Operation of Lines of Railroads in Reorganization

AGENCY: Interstate Commerce Commission.

ACTION: Final rule; correction.

SUMMARY: On December 3, 1992 at 57 FR 57112 the Commission amended the procedures to be followed in allowing transfers or operations of lines of bankrupt rail carriers under bankruptcy reorganization. A revision is necessary to show the correct wording of one of the sentences adopted in this proceeding.

EFFECTIVE DATE: January 4, 1993.

FOR FURTHER INFORMATION CONTACT: Joseph Levin, (202) 927–6287 [TDD for hearing impaired: (202) 927–5721].

SUPPLEMENTARY INFORMATION:

List of Subjects in 49 CFR Part 1180

Railroads.

For the reasons set forth in the preamble, title 49, chapter X, part 1180 of the Code of Federal Regulations amended on December 3, 1992 at 57 FR 57112 is amended as follows:

PART 1180—RAILROAD ACQUISITION, CONTROL, MERGER, CONSOLIDATION PROJECT, TRACKAGE RIGHTS, AND LEASE PROCEDURES

1. The authority citation for part 1180 continues to read as follows:

Authority: 49 U.S.C. 10321, 10505, 11341, 11343–11346; 5 U.S.C. 553 and 559; and 11 U.S.C. 1172.

§ 1180.20 [Corrected]

2. In § 1180.20, paragraph (c), the second sentence is corrected by removing the word "different" and adding in its place the word "greater".

Sidney L. Strickland, Jr.,

Secretary.

[FR Doc. 92–31418 Filed 12–24–92; 8:45 am]

BILLING CODE 7035–01–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration (NOAA)

50 CFR Part 672

Groundfish of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Approval of a fishery management plan amendment.

SUMMARY: NMFS announces the approval of Amendment 26 to the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP). The amendment continues the authorization of time/area closures around Kodiak Island to protect king and Tanner crab habitat areas. The action is intended to promote the recovery of these crab stocks and further the goals and objectives of the FMP that governs fishing for Gulf of Alaska groundfish.

ADDRESSES: Copies of the environmental assessment may be obtained from the North Pacific Fishery Management Council, P.O. Box 103136, Anchorage, AK 99510 (907–271–2809).

SUPPLEMENTARY INFORMATION: During its June 23–28, 1992, meeting, the North

Pacific Fishery Management Council (Council) recommended Amendment 26 for review by the Secretary of Commerce (Secretary) under section 304(b) of the Magnuson Fishery Conservation and Management Act (Magnuson Act). A notice of availability of Amendment 26 was published in the **Federal Register** on September 25, 1992 (57 FR 44355). It invited review of, and comment on, the amendment until November 20, 1992. A full description of these time/area closures and their justification was published on October 15, 1992 (57 FR 47321).

Response to Comments

Two letters of comment were received during the comment period. Comments are summarized and responded to below.

Comment 1: Regulations implementing Amendment 26 and its predecessor, Amendment 18, exemplify a wise approach to the conservation of the crab resource without unnecessarily impacting commercial fishing operations.

Response: NMFS notes this comment.

Comment 2: NMFS invited comment on the enforcement concerns about aerial monitoring of the time/area closures to non-pelagic trawl gear when pelagic trawl gear could still be deployed in the closed areas. These concerns are unfounded in the Gulf of Alaska (GOA). Pollock is the only pelagic trawl fishery in the GOA. All other groundfish trawl fisheries are prosecuted with non-pelagic trawl gear. Additionally, all non-pelagic groundfish fisheries are restricted by a single halibut bycatch limit that is apportioned into seasonal allowances. When a seasonal allowance is reached, the GOA is closed to directed fishing for groundfish by vessels using trawl gear, except that fishing for pollock with pelagic trawl gear may continue when directed fishing for pollock is open. The only time pelagic and non-pelagic trawl gear operations simultaneously occur in the GOA is when directed fisheries for pollock and other groundfish are both open. The trawl fleet normally fishes for pollock at the beginning of each quarterly reporting period when quarterly apportionments of the annual pollock quota become available. Quarterly apportionments are harvested within a short time period and the trawl fleet typically shifts to other groundfish species during the remainder of the quarter. Therefore, monitoring of the non-pelagic trawl gear closures around Kodiak Island may only be complicated during the seasonal openings of the pollock fishery. NMFS enforcement need not resort to aerial monitoring in this case, but could simply confirm a vessel's participation in the pelagic trawl pollock fishery by checking observer reports, landings documents, or vessel logbooks.

Response: NMFS concurs that enforcement of the Kodiak Island closures to trawl gear other than pelagic trawl gear is possible. However, aerial surveillance of areas closed to specified gear types is the most effective and least costly and intrusive means to monitor such closures. NMFS may pursue an FMP amendment in the future that would prohibit the deployment of all trawl gear in the Kodiak Island time/area closures implemented under Amendment 26.

Comment 3: Fisheries enforcement would be enhanced if the time/area closures implemented under Amendment 26 applied to all trawl operations. Allowing only pelagic trawls in the closed areas renders aerial enforcement ineffective. As a result, enforcement of these closures will continue to require air/sea coordination to board and verify whether pelagic or non-pelagic trawl gear activity is occurring. The U.S. Coast Guard does not object to the regulations implementing Amendment 26 because they continue current practices and minimize impacts on pelagic trawl fisheries in the Kodiak Island area.

Response: NMFS notes this comment. Also, see response to Comment 2.

Amendment 26 authorizes time/area closures around Kodiak Island to protect sensitive king and Tanner habitat areas from on-bottom trawl operations by continuing the effectiveness of such closures that were authorized under Amendment 18 to the FMP (54 FR 50386, December 6, 1989) and for which authorization would have expired on December 31, 1992. Section 672.24 (d)(1) and (d)(3), in 50 CFR part 672 currently implement Amendment 26.

The Secretary has determined that Amendment 26 is consistent with the Magnuson Act and other applicable laws as authorized under section 304 of the Magnuson Act.

Dated: December 17, 1992.

William W. Fox, Jr.,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 92–31127 Filed 12–23–92; 8:45 am]

BILLING CODE 3510–22–M

Proposed Rules

Federal Register
Vol. 57, No. 249
Monday, December 28, 1992

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF JUSTICE

8 CFR Part 3

[AG Order No. 1641–92]

Executive Office for Immigration Review; Deportation Proceedings: Alien Convicted of Aggravated Felony

AGENCY: Department of Justice.

ACTION: Proposed rule.

SUMMARY: This proposed rule amends 8 CFR Part 3 by requiring an Immigration Judge to conduct a hearing on the merits within 30 days after the filing of the order to show cause in the case of an alien who is charged in the order as an alien who has been convicted of an aggravated felony. The Immigration Judge may not grant more than one continuance absent extraordinary or compelling circumstances. If an appeal is taken from an order of deportation, the Board of Immigration Appeals shall decide the appeal within 60 days of the filing thereof.

DATES: Written comments must be received no later than January 27, 1993.

ADDRESSES: Please submit written comments, in triplate, to Director, Policy Directives and Instructions Branch, Immigration and Naturalization Service, room 5304, 425 I Street NW., Washington, DC 20536.

FOR FURTHER INFORMATION CONTACT: Gerald S. Hurwitz, Counsel to the Executive Director, Executive Office for Immigration Review, Suite 2400 Skyline Tower, 5107 Leesburg Pike, Falls Church, Virginia 22041, (703) 756–6470; Robert K. Bingham, Acting Associate General Counsel, Office of the General Counsel, Room 7048, Immigration and Naturalization Service, 425 I Street, NW, Washington, DC 20436, (202) 514–2895.

SUPPLEMENTARY INFORMATION: The proposed rule amends section 3.14 of Part 3 by adding a new paragraph (c) requiring the Executive Office of Immigration Review to expedite the administrative hearing and appeals of aliens charged, under section 241(a)(2)(A)(iii) of the Immigration and Naturalization Act (Act), as amended, as an alien convicted of an aggravated felony. In addition, the proposed rule amends section 3.3 to provide that an appeal from an order of deportation pursuant to section 241(a)(2)(A)(iii) shall be decided by the Board of Immigration Appeals within 60 days of the filing of the Notice of Appeal; and to limit the time that parties in such an appeal to file their briefs. This rule would implement the congressional mandate to protect society from serious criminal offenders pursuant to sections 242 (h)–(i) and 242A of the Act by facilitating their removal as expeditiously as possible upon a finding of deportability under section 241(a)(2)(A)(iii).

In accordance with 5 U.S.C. 605(b), the Attorney General certifies that this proposed rule does not have a significant adverse economic impact on a substantial number of small entities. This proposed rule is not a major rule within the meaning of section 1(b) of E.O. 12291, nor does this proposed rule have Federalism implications warranting the preparation of a Federalism Assessment in accordance with E.O. 12612.

List of Subjects in 8 CFR Part 3

Administrative practice and procedure, Immigration, Organization and functions (Government agencies).

For the reasons set out in the preamble, 8 CFR part 3 is proposed to be amended as set forth below.

PART 3—EXECUTIVE OFFICE FOR IMMIGRATION REVIEW

1. The authority citation for part 3 continues to read as follows:

Authority: 5 U.S.C. 301; 8 U.S.C. 1103, 1252 note, 1252b, 1362; 28 U.S.C. 509, 510, 1746; 5 U.S.C. 301; Sec. 2, Reorganization Plan No. 2 of 1950, 3 CFR, 1949–1953 Comp., p. 1002.

2. Section 3.3 is amended by adding a sentence at the end of paragraph (c) and by adding a new paragraph (d) to read as follows:

§ 3.3 Notice of appeal.

* * * * *

(c) *Briefs.* * * * In an appeal governed by paragraph (d) of this section, the brief of the appealing party must be filed within 10 days after service of the transcript of the hearing, and the opposing party shall be allowed ten days to respond.

(d) *Aggravated felony.* An appeal from an order of deportation pursuant to section 241(a)(2)(A)(iii) of the Act shall be considered and decided by the Board within 60 days of the filing of the Notice of Appeal. In extraordinary and compelling circumstances the Board may extend this 60 days period for an additional time not to exceed 60 days.

3. Section 3.14 is amended by adding a new paragraph (c) to read as follows:

§ 3.14 Jurisdiction and commencement of proceedings.

* * * * *

(c) When an Immigration Judge has jurisdiction over an alien charged with being deportable pursuant to section 241(a)(2)(A)(iii) of the Act, the hearing must be scheduled and completed within 30 days after the commencement of proceedings. In extraordinary and compelling circumstances the Immigration Judge may continue the hearing, or extend the scheduled date for a hearing, provided that the hearing is completed no more than 60 days after the commencement of proceedings.

Dated: December 14, 1992.

William P. Barr,

Attorney General.

[FR Doc. 92–31340 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 92–NM–211–AD]

Airworthiness Directives; British Aerospace Model ATP Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the adoption of a new airworthiness directive (AD) that is applicable to all British Aerospace Model ATP series airplanes. This proposal would require an inspection to detect cracking of the aft end of the wing rib boom angles on the left and right engine, and repair or replacement of the wing rib boom angle assemblies, if necessary. This proposal

is prompted by the detection of cracks during routine maintenance of the wing rib boom angles at the main landing gear (MLG) actuator attachment point. The actions specified by the proposed AD are intended to prevent structural failure of the actuator attachment point, which could lead to collapse of the MLG.

DATES: Comments must be received by February 22, 1993.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM–103, Attention: Rules Docket No. 92–NM–211–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from British Aerospace, PLC, Librarian for Service Bulletins, P.O. Box 17414, Dulles International Airport, Washington, DC. 20041–0414. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: William Schroeder, Aerospace Engineer, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (206) 227–2148; fax (206) 227–1320.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposed rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket Number 92–NM–211–AD." The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM–103, Attention: Rules Docket No. 92–NM–211–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056.

Discussion

The United Kingdom Civil Aviation Authority (CAA), which is the airworthiness authority for the United Kingdom, recently notified the FAA that an unsafe condition may exist on all British Aerospace Model ATP series airplanes. The CAA advises that one operator of a Model ATP series airplane detected a fatigue crack in a wing rib boom angle at the main landing gear (MLG) actuator attachment point. Fatigue cracking will reduce the strength of the attachment of the MLG actuator support structure to the airframe. This condition, if not detected and corrected, could result in structural failure of the actuator attachment point, which could lead to collapse of the MLG.

British Aerospace has issued Service Bulletin ATP–57–13, dated September 18, 1992, which describes procedures for a visual inspection to detect cracking of the aft end of the wing rib boom angles on the wing rib outboard of the left and right engine, and replacement of the wing rib boom angle assemblies, if necessary. The CAA classified this service bulletin as mandatory.

This airplane model is manufactured in the United Kingdom and is type certificated for operation in the United States under the provisions of § 21.29 of the Federal Aviation Regulations and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the CAA has kept the FAA informed of the situation described above. The FAA has examined the findings of the CAA, reviewed all available information, and determined that AD action is necessary for products of this type design that are certificated for operation in the United States.

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would require a visual inspection to detect cracking of the aft end of the wing rib boom angles on the wing rib outboard of the left and right engine, and repair or replacement of the wing rib boom angle assemblies, if necessary. The actions would be required to be accomplished in accordance with the service bulletin described previously.

The requirements of this rule are considered interim action until final action is identified, at which time the FAA may consider further rulemaking.

The FAA estimates that 10 airplanes of U.S. registry would be affected by this proposed AD, that it would take approximately 2 work hours per airplane to accomplish the proposed actions, and that the average labor rate is $55 per work hour. Based on these figures, the total cost impact of the proposed AD on U.S. operators is estimated to be $1,100, or $110 per airplane. This total cost figure assumes that no operator has yet accomplished the proposed requirements of this AD action.

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption "ADDRESSES."

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend 14 CFR part 39 of the Federal Aviation Regulations as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1421 and 1423; 49 U.S.C. 106(g); and 14 CFR 11.89.

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

British Aerospace: Docket 92–NM–211–AD.

Applicability: All Model ATP series airplanes, certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent structural failure of the main landing gear actuator attachment point, which could lead to collapse of the main landing gear, accomplish the following:

(a) Within 200 hours time-in-service after the effective date of this AD, conduct a visual inspection to detect cracking of the aft end of the wing rib boom angles on the wing rib outboard of the left and right engine, in accordance with British Aerospace Service Bulletin ATP–57–13, dated September 18, 1992.

(b) If no crack is detected, no further action is required.

(c) If any crack is detected and that crack does not extend beyond bolt hole X, accomplish either paragraph (c)(1) or (c)(2) of this AD.

(1) Prior to further flight, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(2) Within 150 hours time-in-service after accomplishing the initial inspection, reinspect the wing rib boom angles for crack propagation, in accordance with British Aerospace Service Bulletin ATP–57–13, dated September 18, 1992.

(i) If no additional crack propagation is detected, prior to the accumulation of 300 hours time-in-service after the initial inspection in accordance with paragraph (a) of this AD, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(ii) If additional crack propagation is detected or if cracking has exceeded the limits specified in paragraphs (d) or (e) of this AD, prior to further flight, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(d) If any crack is detected and that crack extends beyond bolt hole X, but not beyond bolt hole Y or down towards bolt hole A, accomplish either paragraph (d)(1) or (d)(2) of this AD.

(1) Prior to further flight, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(2) At intervals not to exceed 25 hours time-in-service, reinspect the wing rib boom angles for additional crack propagation, in accordance with British Aerospace Service Bulletin ATP–57–13, dated September 18, 1992.

(i) If no additional crack propagation is detected during any of the repeat inspections, prior to the accumulation of 150 hours time-in-service after the initial inspection in accordance with paragraph (a) of this AD, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(ii) If additional crack propagation is detected during any of the repeat inspections or if any crack propagation has exceeded the limits specified in paragraphs (d) or (e) of this AD, prior to further flight, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(e) If any crack is detected and that crack extends beyond bolt hole Y or into bolt hole A, prior to further flight, repair or replace the wing rib boom angle assembly in accordance with a method approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate.

(f) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Standardization Branch, ANM–113, FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Standardization Branch, ANM–113.

Note: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Standardization Branch, ANM–113.

(g) Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on December 18, 1992.

Bill R. Boxwell,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 92–31344 Filed 12–23–92; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF STATE

Bureau of Politico-Military Affairs

22 CFR Part 121

[Public Notice 1747]

Amendent to the International Traffic in Arms Regulations (ITAR)

AGENCY: Department of State.

ACTION: Proposed rule.

SUMMARY: This proposed rule is the result of an advanced notice of proposed rulemaking published in **Federal Register**, 56 FR 43894, dated September 5, 1991. This proposed rule is intended to amend the regulations implementing section 38 of the Arms Export Control Act, which governs the export of defense articles and defense services. The Department previously amended the U.S. Munitions List by adding category XV for space-related articles and moving certain spacecraft-related items from the coverage of categories VIII and XI into the new category XV.

This proposed rule is intended to reduce the burden on exporters by clarifying that all remote sensing type satellites are covered under the U.S. Munitions List (USML). In addition, the language on components, parts, accessories and associated equipment has been modified in order to begin the process of moving some components of satellites off the USML to the Commerce Control List (CCL). Only those components which are specifically designed or modified for the satellites or other equipment controlled in category XV will themselves be controlled in category XV. All other components of satellites not specifically designed for one or more of the satellites controlled in category XV will be controlled under the CCL. At the same time, the new language in paragraph (e) cites five parameters, all five of which must be met, in order for radiation hardened microelectronic circuits to be controlled under category XV of the USML.

DATES: Comments must be submitted on or before January 27, 1993.

ADDRESSES: Written comments should be sent to: Kenneth M. Peoples, Office of Defense Trade Controls, SA–6, room 200, U.S. Department of State, Washington, DC 20522–0602, fax (703) 875–6647. Public comments will be made available for public inspection.

FOR FURTHER INFORMATION CONTACT: Kenneth M. Peoples, Office of Defense Trade Controls, Department of State, tel. (703) 875–6619, or Thomas Oldenburg, Office of Advanced Technology, Department of State, tel. (202) 647–2432.

SUPPLEMENTARY INFORMATION: On November 16, 1990, the President signed Executive Order 12735 on Chemical and Biological Weapons Proliferation and directed various other export control measures. The measures directed by the President include removal from the USML of all items contained on the COCOM dual-use list (also known as the "CORE" list) unless significant U.S. national security interests would be jeopardized. In

implementing this directive, the Department headed an interagency working group which reviewed the coverage of spacecraft and related components and determined that in the time allotted for this exercise, specific items could not be determined for removal. Therefore, in further implementation of the Presidential directive, the Department of State began chairing a space technical working group comprised of the Departments of State, Commerce, Defense, other national security agencies, NASA and other interested agencies. The group meets to recommend the movement of commercial satellites and related articles identified by the COCOM IL off the USML except for such commodities and technical data that it recommends be kept on the USML for reasons related to the U.S. national security. Previously, the group proposed the creation of Category XV, including the language for Global Positioning Service (GPS) receivers and commercial communications satellites and their components and technical data and defense services, all of which have been formally moved into Category XV. This proposed rule stipulates that all remote sensing type satellites and their related ground stations will continue to be controlled under new Category XV (b) of the USML, except for passive, receive-only ground stations for such satellites. This proposed rule constitutes the STWG's final recommendation. At the conclusion of the requisite thirty day public comment period, the group will review the comments and recommend a final rule, which in turn will conclude the rationalization exercise.

Note that this proposed rule changes the language of all of the headings for the various paragraphs in Category XV as outlined in previous **Federal Register** Notices. Paragraph (a) continues to cover all military satellites, but paragraph (b) now covers only "remote sensing" type satellites, paragraph (c) now covers only communications satellites, paragraph (d) now covers GPS receivers, paragraph (e) now covers components, parts, accessories, associated and attached equipment for the commodities in category XV, and paragraph (f) now covers technical data and defense services for the commodities in category XV.

This amendment involves a foreign affairs function of the United States and thus is excluded from the major rule procedures of Executive Order 12291 (46 FR 13193) and the procedures of 5 U.S.C. 553 and 554. Nevertheless, this amendment is being published as a notice of proposed rulemaking in order to provide the public with an opportunity to comment and provide advice and suggestions regarding the proposal. The period for submission of comments will close 30 days after publication of this notice of proposed rulemaking. In addition, this rule affects collection of information subject to the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), and will serve to reduce the burden on exporters by clarifying USML coverage of space-related articles. The relevant information collection is to be reviewed by the Office of Management and Budget under control no. 1404–0013.

Accordingly, for the reasons set forth in the preamble, it is proposed that title 22, chapter I, subchapter M (consisting of parts 120 through 130) of the Code of Federal Regulations, be amended as set forth below:

List of Subjects in 22 CFR Part 121

Arms and Munitions, Exports.

PART 121—THE UNITED STATES MUNITIONS LIST

1. The authority citation for part 121 continues to read as follows:

Authority: Sec. 38, Arms Export Control Act, 90 Stat. 744 (22 U.S.C. 2778); E.O. 11958, 42 FR 4311; 22 U.S.C. 2658.

2. In § 121.1, category XV is amended by revising paragraphs (a) through (e) and by adding paragraph (f) to read as follows:

§ 121.1 General. The United States Munitions List.

* * * * *

Category XV—Spacecraft Systems and Associated Equipment

*(a) Spacecraft and associated hardware, including ground support equipment, specifically designed or modified for military use.

(b) Remote sensing satellite systems as follows:

*(1) All Remote sensing satellites;

(2) Ground control stations for remote sensing satellites as follows:

(i) Ground control stations for telemetry, tracking and control of such satellites; or

(ii) Passive ground stations for remote sensing satellites having any of the following characteristics:

(a) Employing any of the cryptographic items controlled under Category XIII of this subchapter; or

(b) Employing any uplink command capability.

Note: for export licensing controls over any passive ground receive only stations for remote sensing satellites not having any of the above parameters nor any systems or major components controlled elsewhere under this subchapter, see the Commerce Control List.

(c) Communications satellites (excluding ground stations and their associated equipment and technical data not enumerated elsewhere in this § 121.1; for controls on such ground stations, see the Commerce Control List) with any of the following characteristics:

1. Anti-jam capability. Antennas and/or antenna systems with ability to respond to incoming interference by adaptively reducing antenna gain in the direction of the interference.

2. Antennas:

(i). With aperture (overall dimension of the radiating portions of the antenna) greater than 30 feet; or

(ii). With sidelobes less than or equal to −35dB; or

(iii). Designed, modified, or configured to provide coverage area on the surface of the earth less than 200 nm in diameter, where "coverage area" is defined as that area on the surface of the earth that is illuminated by the main beam width of the antenna (which is the angular distance between half power points of the beam).

3. Designed, modified or configured for intersatellite data relay links that do not involve a ground relay terminal ("cross-links").

4. Spaceborne baseband processing equipment that uses any technique other than frequency translation which can be changed several times a day on a channel by channel basis among previously assigned fixed frequencies.

5. Employing any of the cryptographic items controlled under Category XIII (b) of this section.

6. Employing radiation-hardened devices controlled elsewhere in this § 121.1 that are not embedded in the satellite in such a way as to deny physical access. (Here "embedded" means that the device either cannot feasibly be removed from the satellite or be used for other purposes.)

7. Having propulsion systems which permit acceleration of the satellite on-orbit (i.e., after mission orbit injection) at rates greater than 0.1g.

8. Having attitude control and determination systems designed to provide spacecraft pointing determination and control better than 0.02 degrees azimuth and elevation.

9. Having orbit transfer engines ("kick-motors") which remain permanently with the spacecraft and are capable of being restarted after achievement of mission orbit and providing acceleration greater than 1g. (Orbit transfer engines which are not designed, built, and shipped as an integral part of the satellite are controlled under Category IV of this section.)

(d) Global Positioning System (GPS) receiving equipment specifically designed, modified or configured for military use; or GPS receiving equipment with any of the following characteristics:

1. Designed for encryption or decryption (e.g., Y-Code) of GPS precise positioning service (PPS) signals;

2. Designed for producing navigation results above 60,000 feet altitude and at 1,000 knots velocity or greater;

3. Specifically designed or modified for use with a null steering antenna or including a null steering antenna designed to reduce or avoid jamming signals;

4. Designed or modified for use with unmanned air vehicle systems capable of delivering at least a 500 kg payload to a range of at least 300 km.

Note: GPS receivers designed or modified for use with military unmanned air vehicle systems with less capability are considered to be specifically designed, modified or configured for military use and therefore covered under this subparagraph.

Any GPS equipment not meeting this definition is subject to the jurisdiction of the Department of Commerce (DOC). Manufacturers or exporters of equipment under DOC jurisdiction are advised that the U.S. Government does not assure the availability of the GPS P-Code for civil navigation. It is the policy of the Department of Defense (DOD) that GPS receivers using P-Code without clarification as to whether or not those receivers were designed or modified to use Y-Code will be presumed to be Y-Code capable and covered under this subparagraph. The DOD policy further requires that a notice be attached to all P-Code receivers presented for export. The notice must state the following: "ADVISORY NOTICE: This receiver uses the GPS P-Code signal, which by U.S. policy, may be switched off without notice."

(e) Components, parts, accessories, attachments, and associated equipment (including ground support equipment) as follows:

(1) Specifically designed, modified or configured for the articles in paragraphs (a) through (d) of this category.

(2) Radiation hardened microelectronic circuits that are specifically designed or rated to meet or exceed all five of the following characteristics:

Note: For export controls on all other radiation hardened microelectronic circuits not captured below, see the Commerce Control List.

(i) A total dose of 5×10^5 Rads (Si);

(ii) A dose rate upset of 5×10^8 Rads (Si)/Sec.;

(iii) A neutron dose of 1×10^{14} N/cm^2;

(iv) A single event upset of 1×10^{-7} or less error/bit/day; and

(v) Single event latch-up free and having a dose rate latch-up of 5×10^8 Rads(Si)/sec or greater.

(f) Technical data (as defined in § 120.21) and defense services (as defined in § 120.8) directly related to the defense articles enumerated in paragraphs (a) through (f) of this category. (See § 125.4 for exceptions.) Technical data directly related to the manufacture or production of any defense articles enumerated elsewhere in this category that are designated as Significant Military Equipment (SME) shall itself be designated SME. In addition, detailed design, development, production or manufacturing data for all spacecraft systems and specifically designed or modified components thereof, regardless of which U.S. Government agency has jurisdiction for export of the hardware. (See § 125.4 for exceptions.) This restriction does not include that level of technical data (including marketing data) necessary and reasonable for a purchaser to have assurance that a U.S.-built item intended to operate in space has been designed, manufactured and tested in conformance with specified contract requirements (e.g., operational performance, reliability, lifetime, product quality, or delivery expectations), as well as data necessary at evaluate in-orbit anomalies and to operate and maintain associated ground equipment.

* * * * *

Dated: November 30, 1992.

R. Rand Beers,

Deputy Assistant Secretary of State, Bureau of Politico-Military Affairs.

[FR Doc. 92–31366 Filed 12–24–92; 8:45 am]

BILLING CODE 4710–25–M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 61 and 69

[CC Docket No. 91–213; FCC 92–442]

Transport Rate Structure and Pricing

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; correction.

SUMMARY: The FCC inadvertently did not publish in the **Federal Register** a certification statement required by the Regulatory Flexibility Act. The FCC has determined that the Regulatory Flexibility Act does not apply to the proposed rules in CC Docket No. 91–213, Transport Rate Structure and Pricing, FCC 92–442, which appeared in the **Federal Register** on November 17, 1992 (57 FR 54205), because, if promulgated, these rules would not have a significant economic impact on a substantial number of small business entities, as defined by section 601(3) of the Federal Regulatory Act. For this reason, the FCC did not prepare an initial Regulatory Flexibility Act analysis.

FOR FURTHER INFORMATION CONTACT: Melissa Newman, (202) 632–9342.

SUPPLEMENTARY INFORMATION: This notice corrects the FCC's Further Notice of Proposed Rulemaking, CC Docket No. 91–213, FCC 92–442, adopted September 17, 1992, and released October 16, 1992, which appeared in the **Federal Register** on November 17, 1992 (57 FR 54205), FR Doc. 92–27747, by adding a certification statement that the Regulatory Flexibility Act does not apply to this rulemaking.

The following correction is made in CC Docket No. 91–213, Transport Rate Structure and Pricing, FCC 92–442, which was published in the **Federal Register** on November 17, 1992 (57 FR 54205):

1. After the first full paragraph in the third column on page 54207, the following should be inserted:

Regulatory Flexibility Act

We certify that the Regulatory Flexibility Act of 1980 does not apply to this rulemaking proceeding because the proposed rules, if adopted, would not have a significant economic impact on a substantial number of small business entities, as defined by section 601(3) of the Regulatory Flexibility Act. Carriers providing interstate transport services directly subject to the proposed rule amendment do not quality as small businesses since they are dominant in their field of operation. The Commission will, however, take appropriate steps to ensure that the special circumstances of the smaller LECs are carefully considered in resolving those issues. The Secretary shall send a copy of this Notice of Proposed Rulemaking, including the certification, to the Chief Counsel for Advocacy of the Small Business Administration in accordance with paragraph 603(a) of the Regulatory Flexibility Act. Pub. L. No. 96–354, 94 Stat. 1164, 5 U.S.C. 601 *et seq.* (1980).

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 92–31349 Filed 12–24–92; 8:45 am]

BILLING CODE 6712–01–M

47 CFR Part 73

[MM Docket No. 87–268, DA 92–1714]

Broadcast Service; Advanced Television Systems

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; extension of comment period.

SUMMARY: This action, in response to a request to extend comment period filed by The Association of America's Public Television Stations, the Corporation for Public Broadcasting and the Public Broadcasting Service, extends the deadline for submitting comments and reply comments in the Third Further Notice of Proposed Rule Making portion of the Memorandum Opinion and Order/Third Report and Order/Third Further Notice of Proposed Rule Making in the above-cited docket (57 FR 53679, November 12, 1992, FR Doc. 92–27348). The Third Further Notice of Proposed Rule Making segment of that decision solicited comment on issues fundamental to the implementation of advanced television service in this

country. The deadline for comments was originally due December 21, 1992, and is extended to January 7, 1993. The deadline for accepting reply comments was scheduled for January 29, 1993, and is not extended to February 8, 1993.

DATES: Comments are now due on January 7, 1993, and reply comments are due on February 8, 1993.

ADDRESSES: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Gina Harrison, Policy and Rules Division, Mass Media Bureau, (202) 632–7792.

SUPPLEMENTARY INFORMATION:

Order

In the Matter of: Advanced Television System and Their Impact upon the Existing Television Broadcast Service.

Adopted: December 17, 1992; Released: December 18, 1992.

Comment Date: January 7, 1993.

Reply Comment Date: February 8, 1993.

By the Chief, Mass Media Bureau.

1. This action extends the deadline for filing comments and reply comments in response to the Memorandum Opinion and Order/Third Report and Order/Third Further Notice of Proposed Rule Making in the above-cited docket (7 FCC Rcd 6924, 1992) pertaining to the implementation of advanced television service in this country. The deadline for initial comments was originally set for December 21, 1992, and the deadline for accepting reply comments for January 29, 1993.

2. The Association of America's Public Television Stations, the Corporation for Public Broadcasting and the Public Broadcasting Service request extension of the comment deadline to January 7, 1993 in order that they can give fuller and more careful consideration to the important issues raised, and to reach a consensus on their recommendations to the Commission. They argue that the press of business has made it difficult to address these issues, particularly in light of the December 16, 1992 deadline for filing reply comments to a Second Further Notice of Proposed Rule Making in this same proceeding (7 FCC Rcd 3340, 1992).

3. In light of the foregoing, the Bureau finds that good cause exists for an extension. Pursuant to 47 CFR 0.283, the deadline for filing comments in this proceeding is extended to January 7, 1993. The deadline for filing reply comments is extended commensurately until February 8, 1993.

Federal Communications Commission.

Roy J. Stewart,

Chief, Mass Media Bureau.

[FR Doc. 92–31363 Filed 12–24–92; 8:45 am]

BILLING CODE 6712–01–M

Notices

Federal Register
Vol. 57, No. 249
Monday, December 28, 1992

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forest Service

Agua/Caballos Timber Sale, Carson National Forest, Rio Arriba County, NM

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an Environmental Impact Statement.

SUMMARY: The Department of Agriculture, Forest Service will prepare an Environmental Impact Statement (EIS) to disclose the environmental consequences of the Agua/Caballos Project, a timber sale proposal. After examining the project in light of the ten points of significance, 40 CFR 1509.25, it is my decision as responsible official to prepare an EIS for this project.

The Draft EIS will be issued by fall/winter of 1993, with the Final EIS planned for the spring, 1994.

DATE: Comments concerning the project should be received in writing by the Forest Service. Interested public will be notified of the comment due date.

ADDRESSES: Send written comments to Graciela A. Terrazas, El Rito District Ranger, P.O. Box 56, El Rito, NM 87530 or Gene Onken, Interdisciplinary Team Leader, Canjilon Ranger District, P.O. Box 488, Canjilon, NM 87515. The telephone number is (505) 581–4554 in El Rito and (505) 684–2486 in Canjilon, respectively.

FOR FURTHER INFORMATION CONTACT: Graciela A. Terrazas, El Rito District Ranger or Gene Onken, Interdisciplinary Team Leader; addresses and phone numbers above.

SUPPLEMENTARY INFORMATION:

Proposed Action

The Carson National Forest, El Rito Ranger District, proposes to harvest timber within a portion of the approximately 24,000 acre Agua/Caballos Project area. Implementation is projected for September, 1994. The USDA Forest Service will be the lead agency.

Location

Agua/Caballos Project Area is on the Carson National Forest, El Rito Ranger District, in Rio Arriba County, New Mexico. It is located on the south end of the Vallecitos Federal Sustained Yield Unit (VFSYU), in Township 25 North, Range 7 East, Sections 1, 2, 3, 4, 9, 10, and 11; and Township 26 North, Range 6 East, Sections, 1, 12, 25, and 36, and 36 Township 26 North, Range 7 East Sections 4, 5, 6, 7, 8, 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 32, 33, 34, 35, and 36, and Township 26 North, Range 8 East, Sections 5, 7, 8, 17, 18, 19, 20, 29, 30, 31, 32; and Township 27 North, Range 6 East, Sections 25 and 36 and Township 27 North, Range 7 East, Sections 30 and 31.

Purpose

The purpose of the proposed action is to meet the intent of the Vallecitos Federal Sustained Yield Unit (VFSYU) by providing stability to the local, affected northern New Mexico communities of Cañon Plaza, Vallecitos, La Madera, Las Tablas, Petaca, Tres Piedras, Ojo Caliente, El Rito, and Canjilon. This proposal also tiers to the Carson National Forest Land and Resource Management Plan (USDA, 1986) which directs that timber sales be offered at a rate of 5.5 million board feet (MMBF) per year to Duke City Lumber, the single, approved, responsible operator for the VFSYU, plus 1.0 MMBF to smaller, local operators. The Agua/Caballos Project could contribute to two-year's mill operation, more or less, depending on the decision and timber sale scheduling.

Decisions

The decisions to be made are as follows:

Should a timber sale(s) be used to help achieve the desired future condition?

If so, which areas in the Agua/Caballos analysis area should be harvested and what vegetation conditions should be created in the harvest areas?

What products should be offered (sawtimber, firewood, vigas, poles) and who much?

How should the slash be treated?

What, if any, roads should be reconstructed? Should new roads be built?

What, if any, roads should be obliterated or closed?

Which areas should be thinned?

Which areas should be allocated to old growth?

Improvements/Opportunities

Scoping

The project is in the initial stages of scoping. The Interdisciplinary Team will involve the public and media with letters to organizations, media and individuals on a large mailing list, meetings, and an open house and field trip to obtain issues, concerns, and comments on the proposed action and the alternatives as they are developed.

The Key Issues for the project have not been determined.

Alternatives: Alternatives will be developed to respond to key public issues.

Supplemental Information for Public Participation

There will be a 45-day comment period on the draft EIS. A public participation plan will be prepared for the project within the next few months. The Forest Service believes, at this early stage, it is important to give reviewers notice of several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Power Corp.* v. *NRDC, 435 U.S. 519, 553 (1978).* Also, environmental objections that could be raised at the draft environmental impact statement stage but are not raised until after completion of the final environmental impact statement may be waived or dismissed by the courts. *City of Angoon* v. *Hodel,* 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris,* 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45-day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider them and respond to them in the final environmental impact statement.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the proposed action and

the draft environmental impact statement should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

Dated: December 18, 1992.

Leonard L. Lucero,

Forest Supervisor.

[FR Doc. 92-31351 Filed 12-24-92; 8:45 am]

BILLING CODE 3410-11-M

Upper Sunday Timber Sales and Associated Activities; Kootenai National Forest, Lincoln and Flathead Counties, Montana; Intent To Prepare an Environmental Impact Statement

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an Environmental Impact Statement.

SUMMARY: Notice is hereby given that the Forest Service, USDA, is gathering information in order to prepare an Environmental Impact Statement (EIS) for a proposal to harvest timber, reforest the site, and construct haul roads in the southern portion of the Sunday Creek drainage. The Sunday Creek drainage is located approximately 34 air miles northeast of Libby, Montana.

The Forest Service proposes to harvest approximately 19 million board feet of timber through application of a variety of harvest methods on approximately 1,556 acres of forest land. The proposal also includes approximately 7.2 miles of new road construction and 1.5 miles of road reconstruction to access the specific harvest units.

The EIS will tier to the Kootenai National Forest Land and Resource Management Plan and Final EIS of September 1987, which provides program goals, objectives, and standards and guidelines for conducting management activities in this area. All activities associated with the proposal will be designed to maintain high quality wildlife, fisheries, and watershed objectives.

DATES: Comments concerning the scope and implementation of this proposal must be received in writing on or before January 27, 1993.

ADDRESSES: The Responsible Official is Jane P. Kollmeyer, District Ranger, Fortine Ranger District, P.O. Box 116, Fortine, Montana, 59918. Written comments and suggestions concerning the scope of the analysis may be sent to her at that address.

FOR FURTHER INFORMATION CONTACT: Rob Carlin, Project Coordinator, Fortine Ranger District. Phone: (406) 882-4451.

SUPPLEMENTARY INFORMATION: The decision area contains approximately 12,374 acres within the Kootenai National Forest in Lincoln and Flathead Counties, Montana. All of the proposed projects are located in the Sunday Creek drainage with sub-drainages of Tom, Advent, Blessed and Skillet Creek included. The legal location of the decision area is as follows: Sections 4, 5, 6, 7, 8, 9, 16, 17, 18, 19, 20, 21, and 30 of Township 32 North, Range 25 West; Sections 1, 2, 11, 12, 13, 14, 23, 24, and 25 of Township 32 North, Range 26 West; and Sections 26, 27, 28, 29, 32, 33, 34, and 35 of Township 33 North, Range 25 West; Principle Montana Meridian.

All proposed activities are outside the boundaries of any roadless area or any areas considered for inclusion to the National Wilderness System as recommended by the Kootenai National Forest Plan or by any past or present legislative wilderness proposals.

Prescribed harvest treatments in this proposal are as follows:

Prescription	Acres (approx.)	No. of units	Maximum opening size (acres)
Intermediate Harvest	51	1	0
Sanitation/Salvage Harvest	273	11	<1
Special Shelterwood Harvest with Reserve Trees	309	10	38
Shelterwood Harvest with Reserve Trees	105	4	32
Seed Tree Harvest with Reserve Trees	645	21	40
Clearcut Harvest with Reserve Trees	173	6	40

The prescriptions included in this proposal are defined as follows:

Intermediate Harvest—Some individual trees are selected and designated for harvest. The remaining trees provide a fully stocked stand of the highest quality, most vigorous individuals, with little disturbance to the existing forest habitat conditions.

Sanitation/Salvage Harvest—Trees selected for harvest include the salvage of dead and down merchantable trees; as well as, all lodgepole pine susceptible to a mountain pine beetle infestation. The remaining stand is fully stocked with species other than lodgepole pine.

Special Shelterwood Harvest with Reserve Trees—Harvest would be designed to maintain two important components of old growth forests; large diameter trees and existing down woody material on site. All windfirm large diameter trees (up to 25 per acre) greater than 17 inches diameter at breast height would be reserved on each acre and remain through the next rotation. All other merchantable trees would be harvested. Most existing large down woody material would be left on site.

Shelterwood Harvest with Reserve Trees—Twenty to thirty trees would be selected and designated to remain on each acre to provide seed, shade, and site protection. All other merchantable trees would be harvested. Once seedlings reestablish in the stand, six to ten trees per acre would be selected to remain through the next rotation and form the upper story of a multi-storied stand. All other seed and shelterwood trees would be harvested.

Seed Tree Harvest with Reserve Trees.—Six to ten seed producing trees would be selected and designated to remain on each acre. All other merchantable trees would be harvested. All or some of the six to ten seed trees may be retained as reserve trees, while those not selected to be retained would be removed once new seedlings become established. Reserve trees would remain through the next rotation and form the upper story of a multi-storied stand.

Clearcut Harvest with Reserve Trees—All windfirm trees (one to four per acre) would be selected and designated to remain on site as reserve trees. Reserve trees would remain through the next rotation and form the upper story of a multi-storied stand. All other merchantable trees would be harvested.

The Kootenai National Forest Land and Resource Management Plan provides overall management objectives in individual delineated management areas (MA's). The proposed projects encompass three predominant MA's; 12, 13, and 15. Only two include timber harvest; 12 and 15. Briefly described, MA 12 is managed to maintain or enhance non-winter big-game habitat (summer/fall) and produce a programmed yield of timber. MA 15 focuses on timber production using various silvicultural practices. This MA also provides for other resource values such as soil, air, water, wildlife, recreation, and forage for domestic livestock. MA 13 is managed for the special habitat necessary for old growth dependent wildlife. No harvest is proposed for this management area.

Issues: Tentatively, several issues of concern have been identified through the scoping process. These issues are briefly described below:

- Old Growth—What effect will the proposed action have on old growth, including effects on size, and location?
- Timber Supply—How will the proposed action help satisfy local and national needs?
- Management Intensity—How many acres should be harvested, and how much timber should be cut from each acre?
- Road Construction—What type of road construction is needed, and what are the effects of road construction on different aspects of the resource?
- Riparian Area Management—What effects will the proposed action have on riparian areas?
- Forest Health—A large portion of the trees in the Upper Sunday drainage are at high risk due to susceptibility to bark beetle populations. What effect will the proposed action have to reduce susceptibility to bark beetles?

Public Involvement and Scoping: Public participation to this point has been extensive. On July 16, 1992 a proposal for timber harvest in the Upper Sunday Decision Area was taken to the public at an open house. Alternatives to that proposal were then identified and again submitted to the public in the form of an information sheet. A public field trip to the decision area was conducted on September 19, 1992. Comments were requested in writing during all of these public involvement efforts. Consultation with appropriate State and Federal agencies has been initiated. Taking into account the comments received and information gathered during analysis it was decided to prepare an EIS for the Upper Sunday Timber Sales. Comments received prior to this notice will be included in the documentation for the EIS.

This environmental analysis and decision making process will enable additional interested and affected people to participate and contribute to the final decision. Public participation will be requested at several points during the analysis. The Forest Service will be seeking information, comments, and assistance from Federal, State, local agencies and other individuals or organizations who may be interested in or affected by the proposed projects. This input will be used in preparation of the draft and final EIS.

The scoping process will include:

- Identifying potential issues.
- Identifying major issues to be analyzed in depth.
- Exploring additional alternatives which will be derived from issues recognized during scoping activities.
- Identifying potential environmental effects of this project and alternatives (i.e. direct, indirect, and cumulative effects and connected actions).

The analysis will consider a range of alternatives, including the proposed action, no action, and other reasonable action alternatives.

Estimated Dates for Filing: The draft EIS is expected to be filed with the Environmental Protection Agency (EPA) and to be available for public review by April, 1993. At that time EPA will publish a Notice of Availability of the draft EIS in the **Federal Register**. The comment period on the draft EIS will be 45 days from the date the EPA publishes the Notice of Availability in the **Federal Register**.

The final EIS is scheduled to be completed by July, 1993. In the final EIS, the Forest Service is required to respond to comments and responses received during the comment period that pertain to the environmental consequences discussed in the draft EIS and applicable laws, regulations, and policies considered in making a decision regarding the proposal.

Reviewer's Obligations: The Forest Service believes, at this early stage, it is important to give reviewers notice of several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 553 (1978). Also, environmental objections that could be raised at the draft environmental impact statement stage may be waived or dismissed by the courts. *City of Angoon* v. *Hodel*, 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris*, 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45 day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider and respond to them in the final EIS.

To assist the Forest Service is identifying and considering issues and concerns on the proposed action, comments on the draft environmental impact statement should be as specified as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

Responsible Official: Jane P. Kollmeyer, District Ranger, Fortine Ranger District, Kootenai National Forest, P.O. Box 116, Fortine, Montana, 59918, is the Responsible Official. As the Responsible Official she will decide which, if any, of the proposed projects will be implemented. The Responsible Official will document the decision and reasons for the decision in the Record of Decision. That decision will be subject to Forest Service Appeal Regulations.

Dated: December 17, 1992.

Jane P. Kollmeyer,

District Ranger, Fortine Ranger District.

[FR Doc. 92–31352 Filed 12–24–92; 8:45 am]

BILLING CODE 3410–11–M

Motorized Vehicle Use, Salem and Potosi Ranger Districts, Mark Twain National Forest; Crawford, Dent, Iron, Reynolds, Shannon and Washington Counties, MO

AGENCY: Forest Service, USDA.

ACTION: Revised Notice of Intent to prepare an environmental impact statement. (This notice replaces the Notice of Intent published April 14, 1992, FR Vol 57, No. 72 p. 12910.)

SUMMARY: The Forest Service, USDA, will prepare an environmental impact statement (EIS) to analyze a range of alternatives regarding the use of recreational motorized off highway vehicles (OHV) on National Forest

System lands within the adjacent Salem and Potosi Ranger Districts, Mark Twain National Forest, in response to various public demands including no motorized off highway vehicle use.

DATES: The anticipated distribution dates of the draft environmental impact statement and the final environmental impact statement are changed to June, 1993, and September, 1993, respectively.

ADDRESSES: Send any written comments to Darsan Wang, Forest Supervisor's Office, 401 Fairgrounds Road, Rolla, MO 65401.

FOR FURTHER INFORMATION CONTACT: Darsan Wang, Recreation Specialist (314) 364–4621.

SUPPLEMENTARY INFORMATION: The purpose of the proposed action is to respond to expressed public demands for motorized use by all-terrain vehicles, motorcycles, dune buggies, and 4x4 drive off highway vehicles over parts of the adjoining Salem Ranger District and Potosi Ranger District. The option of no motorized off highway vehicles will be considered. Consideration of motorized trails for ATVs and motorcycles has been underway on both Districts for some time. There has been previous scoping initiatives by both Districts. The information gathered is relevant to the decision to be made and will be used along with any new information received. In April, 1990, both Districts issued separate decisions based on the NEPA process to establish an ORV trail. Both decisions were appealed and subsequently withdrawn by the Deciding Officers. Off highway motor vehicles have been extensively used on both Districts in the past and presently. Under the Forest Plan, the Forest Service transportation system and designated OHV trails are available for OHV use unless closed to this type use on specific roads. Cross-country use is prohibited. Unauthorized use has been a problem with the proliferation of OHVs.

The draft EIS is expected to be filed with the Environmental Protection Agency (EPA) and to be available for public review by June, 1993. At that time copies of the draft EIS will be distributed to interested and affected agencies, organizations, and members of the public for their review and comment. EPA will publish a Notice of Availability of the draft EIS in the **Federal Register**. The comment period on the draft EIS will be 60 days from the date the EPA publishes the Notice of Availability in the **Federal Register**.

The Forest Service believes it is important to give reviewers notice of this early stage of public participation and of several court rulings related to public participation in the environmental review process. First, reviewers of a draft EIS must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp* v. *NRDC, 435 U.S. 519,553 (1978).* Also, environmental objections that could have raised at the draft stage but that are not raised until after completion of the final Environmental Impact Statement may be waived or dismissed by the court. *City of Angoon* v. *Hodel*, 803 F.2d. 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris*, 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in these proposed actions participate by the close of the 60-day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider and respond to them in the final EIS.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the draft EIS should be as specific as possible. Comments may address the adequacy of the draft environmental impact statement or the merits of the alternatives discussed; reviewers may wish to refer to the Council on Environmental Quality regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3.

The final EIS is scheduled to be completed by September, 1993. In the final EIS, the Forest Service is required to respond to comments and responses received during the comment period that pertain to the environmental consequences discussed in the draft EIS and applicable laws, regulations, and policies considered in making a decision regarding the proposal. The Forest Service is the lead agency. B. Eric Morse is the responsible official. As the responsible official, he will decide which, if any, of the alternatives will be implemented. The responsible official will document the decision and reasons for the decision in the Record of Decision. That decision will be subject to Forest Service Appeal Regulations (36 CFR part 217).

Dated: December 14, 1992.

B. Eric Morse,

Forest Supervisor.

[FR Doc. 92–31353 Filed 12–24–92; 8:45 am]

BILLING CODE 3410–11–M

Waggit Environmental Impact Statement; Six Rivers National Forest, Trinity County, CA

AGENCY: USDA, Forest Service.

ACTION: Cancellation of notice of intent to prepare an Environmental Impact Statement.

SUMMARY: The Notice of Intent (NOI) to prepare an Environmental Impact Statement (EIS) which proposed timber management and road construction within the Mad, Rock and Backbone Compartments located on the Mad River Ranger District of Six Rivers National Forest, Trinity County, California was published in the December 10, 1991 **Federal Register** (56 FR 64492). The Forest Service hereby gives notice that the NOI to prepare this EIS is rescinded.

FOR FURTHER INFORMATION CONTACT: Marcia Andre, District Ranger, Mad River Ranger District, Star Route Box 300, Bridgeville, CA 95526. Telephone: (707) 574–6233.

Dated: December 17, 1992.

Martha J. Ketelle,

Deputy Forest Supervisor.

[FR Doc. 92–31354 Filed 12–24–92; 8:45 am]

BILLING CODE 3410–11–M

Wallow Environmental Impact Statement; Ladder and North Trinity Compartments, Trinity and Humboldt County, CA

AGENCY: USDA, Forest Service.

ACTION: Cancellation of notice of intent to prepare an Environmental Impact Statement.

SUMMARY: The Notice of Intent (NOI) to prepare an Environmental Impact Statement (EIS) which would analyze timber management and road construction within the Ladder and North Trinity Compartments located on the Lower Trinity Ranger District of Six Rivers National Forest, Humboldt County, California was published in the April 19, 1991 **Federal Register** (56 Fr 16066). The project area is now located within a Category 1 Habitat Conservation Area and within Critical Habitat for the northern spotted owl. The Forest Service gives notice that the NOI to prepare this EIS is hereby rescinded.

FOR FURTHER INFORMATION CONTACT: Lawrence L. Cabodi, District Ranger, Lower Trinity Ranger District, P.O. Box 68, Willow Creek, CA 95573. Telephone: (916) 628–2118.

Dated: December 14, 1992.

Martha J. Ketelle,

Deputy Forest Supervisor.

[FR Doc. 92–31355 Filed 12–24–92; 8:45 am]

BILLING CODE 3410–11–M

Cumulative Watershed Effects Analysis for Timber Management in Grouse Creek Basin, Humboldt County, CA

AGENCY: USDA, Forest Service.

ACTION: Cancellation of notice of intent to prepare an Environmental Impact Statement.

SUMMARY: The Notice of Intent to prepare an Environmental Impact Statement which proposed to address cumulative watershed effects and associated timber management in the Grouse Creek basin, located on the Lower Trinity Ranger District of Six Rivers National Forest, Humboldt County, California published in the October 22, 1990 **Federal Register** (55 FR 42590), is hereby rescinded.

FOR FURTHER INFORMATION CONTACT: Lawrence L. Cabodi, District Ranger, Lower Trinity Ranger District, P.O. Box 68, Willow Creek, CA 95573. Telephone: (916) 628–2118.

Dated: December 9, 1992.

Martha J. Ketelle,

Deputy Forest Supervisor.

[FR Doc. 92–31356 Filed 12–24–92; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Taking and Importing of Marine Mammals Incidental and Commercial Fishing Operations

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of removal of Pelly certification.

SUMMARY: The Marine Mammal Protection Act (MMPA) requires that 6 months after the importation of yellowfin tuna has been banned from a nation, certification of the importation prohibition be made to the President. Certification under this provision is considered a certification for the purposes of section 8(a) of the Fishermen's Protective Act (the Pelly Amendment). The Pelly Amendment requires periodic review of the activities of the national subject to the importation prohibition to determine if the reasons for which the certification was made no longer prevail. NMFS has lifted the intermediary nation yellowfin tuna embargoes that were in place against Canada, Malaysia, the Netherlands Antilles, Singapore, and the United Kingdom and, therefore, the Secretary of Commerce has removed the Pelly certifications that resulted from those embargoes.

EFFECTIVE DATE: The termination of these Pelly Certifications was effective December 14, 1992.

ADDRESSES: Michael Tillman, Acting Director, Office of Protected Resources, NMFS, 1335 East-West Highway, Silver Spring, MD 20910.

FOR FURTHER INFORMATION CONTACT: Wanda L. Cain, Office of Protected Resources, NMFS, 1335 East-West Highway, Silver Spring, MD 20910 (301/713–2055).

SUPPLEMENTARY INFORMATION: On January 31, 1992, the United States imposed a court-ordered prohibition on the importation of all yellowfin tuna and yellowfin tuna products from Canada, Malaysia, the Netherlands Antilles, Singapore, and the United Kingdom.

On July 31, 1992, the Secretary of Commerce certified to the President that the intermediary nation embargoes on all yellowfin tuna and yellowfin tuna products from these countries had been in effect for 6 months. As required by the MMPA, this certification is considered a certification for purposes of section 8(a) of the Fishermen's Protective Act of 1967 (the Pelly Amendment, 22 U.S.C. 1978). The Pelly Amendment authorizes, at the discretion of the President, a restriction on imports of fish and fish products from certified nations to the extent such restrictions are sanctioned by the General Agreement on Tariffs and Trade. No sanctions were recommended or imposed as a result of the certification of these intermediary nations.

On October 26, 1992, the President signed the International Dolphin Conservation Act of 1992. Among other things, this Act amended the MMPA to provide a legislative definition of "intermediary nation". As a result, NMFS was able to lift the intermediary nation embargoes on yellowfin tuna and yellowfin tuna products from several countries (57 FR 59979).

NMFS, therefore, announces that the Pelly Certifications imposed on Canada, Malaysia, the Netherlands Antilles, Singapore, and the United Kingdom as a result of intermediary nation yellowfin tuna embargoes, were removed on December 14, 1992, as a result of the lifting of those intermediary nation embargoes.

Dated: December 21, 1992.

William W. Fox, Jr.,

Assistant Administrator for Fisheries.

[FR Doc. 92–31379 Filed 12–24–92; 8:45 am]

BILLING CODE 3510–22–M

Endangered Species; Permits

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Issuance of modification No. 2 to Permit No. 585.

SUMMARY: On June 16, 1987, notice was published in the **Federal Register** (52 FR 22835) that Permit No. 585 had been issued to the Southeast Fisheries Center, National Marine Fisheries Service, 75 Virginia Beach Drive, Miami, Florida 33149.

Notice is hereby given that on December 16, 1992, as authorized by the provisions of the Endangered Species Act of 1973 (16 U.S.C. 1531–1543) and the Regulations Governing Endangered Fish and Wildlife (50 CFR parts 217–222), NMFS modified Permit No. 585 to extend the effective date through March 31, 1993.

The modified Permit is available for review by interested persons in the following offices by appointment:

Office of Protected Resources, NMFS, NOAA, 1335 East-West Highway, room 7324, Silver Spring, Maryland 20910 (301/713/2289); and

Director, Southeast Region, NMFS, 9450 Koger Boulevard, St. Petersburg, Florida 33702 (813/893–3366).

Dated: December 16, 1992.

Michael F. Tillman,

Acting Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 92–31378 Filed 12–24–92; 8:45 am]

BILLING CODE 3510–22–M

DEPARTMENT OF DEFENSE

Office of the Secretary

DOD Government-Industry Technical Data Committee

AGENCY: Office of the Under Secretary of Defense (Acquisition).

ACTION: Notice.

SUMMARY: Pursuant to section 807 of Public Law 102–120, the National Defense Authorization Act for Fiscal Years 1992 and 1993, a Government-Industry Technical Data Committee has been formed. The committee will make recommendations to the Secretary of Defense for the final regulations

required by subsection (a) of 10 U.S.C. 2320, "Rights in Technical Data."

The committee's January and February meetings are scheduled for January 12–13, 1993, and February 9–10, 1993, from 9:30 a.m. to 4 p.m. at the Herman Lay Room, the U.S. Chamber of Commerce, 1615 "H" Street, NW., Washington, DC 20062–2000. These meetings will be open to the public. For more information, please contact the Committee Executive Secretary, Angelena Moy at (703) 693–5639.

Dated: December 21, 1992.

L.M. Bynum,

Alternate OSD Federal Register, Liaison Officer, Department of Defense.

[FR Doc. 92–31342 Filed 12–24–92; 8:45 am]

BILLING CODE 3810–01–M

Government-Industry, Technical Data Committee; Meeting Cancellation

AGENCY: Office of the Under Secretary of Defense (Acquisition).

ACTION: Notice of cancellation.

SUMMARY: Pursuant to section 897 of Public Law 102–120, the National Defense Authorization Act for Fiscal Years 1992 and 1993, a Government-Industry Technical Data Committee has been formed. The committee will make recommendations to the Secretary of Defense for the final regulations required by subsection (a) of 10 U.S.C. 2320, "Rights in Technical Data."

The committee meetings scheduled for January 6–7, 1993, are hereby cancelled. For more information, please contact the Committee Executive Secretary, Angelena Moy at (703) 693–5639.

SUPPLEMENTARY INFORMATION: The Department of Defense published the notice on November 13, 1992 (57 FR 53890).

Dated: December 21, 1992.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 92–31341 Filed 12–24–92; 8:45 am]

BILLING CODE 3810–01–M

DEPARTMENT OF EDUCATION

[CFDA 84.060A]

Formula Grant Program Under the Indian Education Act of 1988, Subpart 1; Notice Inviting Applications for New Awards for Fiscal Year (FY) 1993

Purpose: Provides grants for supplementary projects that meet the special educational and culturally related academic needs of Indian children. This program should be seen as an opportunity for local educational agencies to support those elements of the National Education Goals and the AMERICA 2000 Education Strategy that are relevant to their unique missions.

Eligible Applicants: Local educational agencies (LEAs) and certain schools operated by Indian Tribes and organizations (Tribal schools) that received funds under this program in fiscal year 1988, and, if sufficient funds are available, LEAs and Tribal schools that were not grantees in fiscal year 1988 and to schools operated by the Bureau of Indian Affairs (BIA).

Deadline for Transmittal of Applications: March 12, 1993. Applicants not meeting the deadline will not be considered for funding in the initial allocation of awards. Applications not meeting the deadline may be considered for funding if the Secretary determines, under section 5316(b) of the Indian Education Act, that funds are available and that reallocation of those funds to those applicants would best assist in advancing the purposes of the program. However, the amount and date of an individual award, if any, made under section 5316(b) of the Act may not be the same to which the applicant would have been entitled if the application had been submitted on time.

Deadline for Intergovernmental Review: May 10, 1993.

Applications Available: January 8, 1993.

Available Funds: The appropriation for this program for fiscal year 1993 is $56,330,000, which should be sufficient to fund all eligible applicants. Therefore, the Department encourages all eligible applicants to apply, including those entities that were not grantees under the program in fiscal year 1988.

Estimated Range of Awards: $700 to $1,400,000.

Estimated Average Size of Awards: $47,000.

Estimated Number of Awards: 1,200.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 36 months.

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 75, 77, 79, 80, 81, 82, 85, and 86; and (b) The regulations for this program in 34 CFR parts 250 and 251.

For Applications or Information Contact: Sandra Spaulding, U.S. Department of Education, 400 Maryland Avenue, SW., room 2177, Washington, DC 20202–6335. Telephone: (202) 401–1907 (FTS 441–1907). Deaf and hearing impaired individuals may call the Federal Dual Party Relay Service at 1–800–877–8339 (in the Washington, DC 202 area code, telephone 708–9300) between 8 a.m. and 7 p.m., Eastern time.

Program Authority: 25 U.S.C. 2601–2606, 2651.

Dated: December 18, 1992.

John T. MacDonald,

Assistant Secretary, Elementary and Secondary Education.

[FR Doc. 92–31369 Filed 12–24–92; 8:45 am]

BILLING CODE 4000–01–M

FEDERAL COMMUNICATIONS COMMISSION

Public Information Collection Requirements Submitted to Office of Management and Budget for Review

December 17, 1992.

The Federal Communications Commission has submitted the following information collection requirements to OMB for review and clearance under the Paperwork Reduction Act of 1980 (44 U.S.C. 3507).

Copies of these submissions may be purchased from the Commission's copy contractor, Downtown Copy Center, 1990 M Street, NW, suite 640, Washington, DC 20036, (202) 452–1422. For further information on these submissions contact Judy Boley, Federal Communications Commission, (202) 632–7513. Persons wishing to comment on these information collections should contact Jonas Neihardt, Office of Management and Budget, room 3235 NEOB, Washington, DC 20503, (202) 395–4814.

OMB Number: 3060–0384.

Title: Section 64.904, Annual Auditor's Certification.

Action: Extension of a currently approved collection.

Respondents: Business or other for-profit.

Frequency of Response: Annually.

Estimated Annual Burden: 19 responses; 500 hours average burden per response; 9,500 hours total annual burden.

Needs and Uses: Over the years, several methods have been adopted by the Commission, such as structural separation, which required carriers to establish separate corporate entities for their common carrier and data processing services. Structural separation provided maximum separation of cost; however, it proved to be inefficient and not in the public interest. Recently, the Commission developed a system of accounting separation. To deter cost shifting both in the form of misallocation of joint and common costs and in the form of improper intracorporate transfer pricing, the Commission adopted cost allocation standards in 1987 and also imposed a requirement for the one-time filing of cost allocation manuals by the Tier 1 local

exchange carriers and dominant interexchange carriers. These carriers are required to file annually the report of an auditor attesting that: (1) The cost system in place reflects the carrier's cost manual requirements; and (2) the cost allocations performed in accordance with that system are the product of accurate methods. In CC Docket No. 90–623, Computer III Remand Proceedings: Bell Operating Company Safeguards and Tier 1 Local Exchange Company Safeguards, the Commission codified the auditor's attestation requirement. The Commission strengthened the standard to be used by independent auditors in preparing their reports on carrier's cost allocation manual implementation and results by requiring that the independent auditors provide the same level of assurance in audits as they provide in a financial statement audit engagement. The Commission also clarified that the independent auditors must evaluate the results of the carrier's cost allocation manuals in light of the requirements of the manuals as well as the Commission's joint cost rules and rules and regulations including 47 CFR 32.23, 32.27, 64.901 and 65.903 in force as of the date of the auditor's report. Independent auditors must follow all of the ten standards of generally accepted auditing standards (GAAS) in preparing the required reports. The attestation requirement is imposed to ensure that the carriers are properly implementing their cost allocation manual. The independent audits serve as an important aid to the Commission's monitoring program. Without this information, the Commission would not be able to efficiently carry out its responsibilities.

OMB Number: 3060–0439.

Title: Regulations Concerning Indecent Communications by Telephone (sector 64.201).

Action: Extension of a currently approved collection.

Respondents: Individuals or households, and businesses or other for-profit (including small businesses).

Frequency of Response: On occasion reporting.

Estimated Annual Burden: 10,200 responses; .16 hours average burden per response; 1,632 hours total annual burden.

Needs and Uses: Section 64.201 contains several information collection requirements including: (1) A requirement that certain common carriers block access to indecent messages unless the subscriber seeks access from the common carrier (telephone company) in writing; (2) a requirement that adult message service providers notify their carriers of the nature of their programming; and (3) a requirement that a provider of adult message services request that their carrier identify it as such in bills to its subscribers. Section 223 of the Communications Act of 1934, as amended, imposes fines and penalties on those who knowingly use the telephone to make obscene or indecent communications for commercial purposes. The fines and penalties are applicable to those who use the telephone, or permit their telephone to be used, for obscene communications to any person and to those who use the telephone for indecent communications to persons under 18 years of age or to adults without their consent. The information requirements are imposed on carriers, adult message service providers and those who solicit their services to ensure that minors are denied access to material deemed indecent.

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 92–31350 Filed 12–24–92; 8:45 am]

BILLING CODE 6712–01–M

FEDERAL MARITIME COMMISSION

Agreement(s) Filed; Port of Portland and James River II, Inc., et al.

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, DC Office of the Federal Maritime Commission, 800 North Capitol Street, NW., 9th Floor. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within 10 days after the date of the **Federal Register** in which this notice appears. The requirements for comments are found in § 572.603 of title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 224–200307–004.

Title: Port of Portland and James River II, Inc., DBA Western Transportation Terminal Leasing Agreement.

Parties:

The Port of Portland ("Port")
James River II, Inc., DBA Western Transportation

Synopsis: The modification removes the Port's ability to repossess House 103; leases a portion of the premises to the Port of Cascade Locks and sets new rental rates.

Agreement No.: 224–200565–001.

Title: Port Everglades Marine Terminal Operating Co., Inc. ("PEMTOC") Agreement.

Parties:

Eller & Company, Inc.
Sel Maduro (Florida), Inc.
Strachan Shipping Company
Harrington & Company, Inc.

Synopsis: The subject Agreement authorizes the parties, as shareholders in PEMTOC, to operate a common user container terminal at Port Everglades or other locations in Broward County, Florida.

Agreement No.: 202–010676–057.

Title: South Europe/U.S.A. Freight Conference.

Parties:

Achille Lauro
Compania Trasatlantic Espanola, S.A.
Evergreen Marine Corporation (Taiwan) Ltd.
Farrell Lines, Inc.
Italia di Navigazione, S.p.A.
Jugolinija
Lykes Lines
A.P. Moller Maersk Line
Nedlloyd Lines
Sea-Land Service, Inc.
P & O Containers Limited
Zim Israel Navigation Company, Ltd

Synopsis: The proposed amendment modifies the provisions in Article 6.4 governing the committee structures under the Agreement. It also sets forth guidelines for members to follow in negotiating service contracts.

Agreement No.: 203–011393.

Title: United States/Canary Islands and West Africa Carrier Discussion Agreement.

Parties:

Lykes Bros. Steamship Co., Inc.
Safbank Line, Ltd.

Synopsis: The proposed Agreement authorizes the parties to meet, discuss and agree upon rates, charges and practices in the trade between United States ports and points (excluding ports in Alaska and Hawaii), and all ports and points in the range from the northern border of Mauritania to the southern border of Angola and the Canary Islands and to all inland points in Mali, Burkina, Niger, Chad, Central African Republic and Zambia. Adherence to any agreement reached by the parties is strictly voluntary.

Dated: December 21, 1992.

By Order of the Federal Maritime Commission.

Joseph C. Polking,

Secretary.

[FR Doc. 92–31332 Filed 12–24–92; 8:45 am]

BILLING CODE 6730–01–M

Availability of List of Non-Vessel-Operating Common Carriers in Compliance with the Bonding Requirements of 46 CFR Part 583

Notice is given that a revised list of non-vessel-operating common carriers in compliance with the bonding requirements of 46 CFR part 583 is available. This list is effective five days after publication of this notice in the **Federal Register**. For copies of this list please contact: Office of Tariffs, Bureau of Tariffs, Certification and Licensing,

800 North Capitol Street, NW., Washington, DC 20573. (202) 523–5818.

Joseph C. Polking

Secretary.

[FR Doc. 92–31331 Filed 12–24–92; 8:45 am]

BILLING CODE 6730–01–M

FEDERAL RESERVE SYSTEM

Banc One Corporation; Acquisition of Company Engaged in Permissible Nonbanking Activities; Correction

This notice corrects a previous Federal Register notice (FR Doc. 92-29708) published at page 58021 of the issue for Tuesday, December 8, 1992.

Under the Federal Reserve Bank of Cleveland, the entry for Banc One Corporation is revised to read as follows:

A. Federal Reserve Bank of Cleveland (John J. Wixted, Jr., Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101:

1. Banc One Corporation, Columbus, Ohio, and Banc One West Virginia Corporation, Charlestown, West Virginia; to acquire 100 percent of the voting shares of Key Centurion Bancshares, Inc., Charleston, West Virginia, and thereby indirectly acquire Charleston National Bank, Charleston, West Virginia; Citizens National Bank of St. Albans, St. Albans, West Virginia; Beckley National Bank, Beckley, West Virginia; The National Bank of Logan, Logan, West Virginia; The National Bank of Commerce of Williamson, Williamson, West Virginia; Boone National Bank, Madison, West Virginia; Nicholas County Bank, Summersville, West Virginia; The Central National Bank of Buckhannon, Buckhannon, West Virginia; The Lincoln National Bank of Hamlin, Hamlin, West Virginia; Security National Bank & Trust Company, Wheeling, West Virginia; The First National Bank of New Martinsville, New Martinsville, West Virginia; Peoples Bank of Charles Town, Charles Town, West Virginia; and The First Huntington National Bank, Huntington, West Virginia; Union Bancorp of West Virginia, Clarksburg, West Virginia, and thereby indirectly acquire Union National Bank of West Virginia, Clarksburg, West Virginia, and First National Bank of Philippi, Philippi, West Virginia; Wayne Bancorp, Inc., Wayne, West Virginia, and thereby indirectly acquire Wayne County Bank, Inc., Wayne, West Virginia; and First National Company, Pikeville, Kentucky, and thereby indirectly acquire The First National Bank of Pikeville, Pikeville, Kentucky. In connection with this proposal, Banc One West Virginia Corporation has applied to become a bank holding company.

In connection with this application, Applicants also propose to acquire Reliable Mortgage Company, Charleston, West Virginia, and thereby engage in mortgage banking activities, pursuant to § 225.25(b)(1)(iii) of the Board's Regulation Y.

Comments on this application must be received by January 6, 1993.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31384 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

Citizens, Inc., et al.; Notice of Applications to Engage de novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than January 19, 1993.

A. Federal Reserve Bank of Cleveland (John J. Wixted, Jr., Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101:

1. Citizens, Inc., Evans City, Pennsylvania; to engage *de novo* in the activity of making, acquiring, or servicing loans or other extensions of credit, pursuant to § 225.25(b)(1) of the Board's Regulation Y.

B. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. Withee Bank Shares, Inc., Withee, Wisconsin; to engage *de novo* in developing and owning a low-income housing project under the Farmers Home Administration 515 program, pursuant to § 225.25(b)(6) of the Board's Regulation Y.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31385 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

Farmers & Merchants Bancshares, Inc., et al.; Formations of; Acquisitions by; and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Unless otherwise noted, comments regarding each of these applications must be received not later than January 21, 1993.

A. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. Farmers & Merchants Bancshares, Inc., Burlington, Iowa; to become a bank holding company by acquiring 100 percent of the voting shares of Farmers & Merchants Bank & Trust, Burlington, Iowa.

B. Federal Reserve Bank of Kansas City (John E. Yorke, Senior Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. Midwest National Bancshares, Inc., Midwest City, Oklahoma; to merge with Harrah National Bancshares, Inc., Harrah, Oklahoma, and thereby indirectly acquire The National Bank of Harrah, Harrah, Nebraska.

C. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 400 South Akard Street, Dallas, Texas 75222:

1. Heritage Bancshares, Inc., Dover, Delaware; to become a bank holding company by acquiring 87.33 percent of the voting shares of Wharton Bank and Trust Company, Wharton, Texas.

D. Federal Reserve Bank of San Francisco (Kenneth R. Binning, Director, Bank Holding Company) 101 Market Street, San Francisco, California 94105:

1. Security Bank Holding Company Employee Stock Ownership Plan, Coos Bay, Oregon; to become a bank holding company by acquiring 29.3 percent of the voting shares of Security Bank Holding Company, Coos Bay, Oregon, and thereby indirectly acquire Security Bank, Coos Bay, Oregon.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31386 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

Garwin Bancorporation; Acquisition of Company Engaged in Permissible Nonbanking Activities

The organization listed in this notice has applied under § 225.23(a)(2) or (f) of the Board's Regulation Y (12 CFR 225.23(a)(2) or (f)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to acquire or control voting securities or assets of a company engaged in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than January 21, 1993.

A. Federal Reserve Bank of Chicago (David S. Epstein, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. Garwin Bancorporation, Garwin, Iowa; to acquire Garwin Insurance Agency, Garwin, Iowa, and thereby engage in the activity of operating a general insurance agency in a town with a population not exceeding 5,000, pursuant to § 225.25(b)(8)(iii) of the Board's Regulation Y.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31387 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

Norwest Corporation; Acquisition of Company Engaged in Permissible Nonbanking Activities

Norwest Corporation, Minneapolis, Minnesota, has applied to acquire Community Title Guaranty Company, Lombard, Illinois, and thereby engage in its title insurance agency activities pursuant to § 4(c)(8)(G) ("exemption G") of the BHC Act and § 225.25(b)(8)(vii) of the Board's Regulation Y (12 CFR 225.25(b)(8)(vii). The Board has previously approved this activity for exemption G companies. *See*, First Wisconsin Corporation, 75 Federal Reserve Bulletin 31 (1989); *American Land Title Association v. Board of Governors of the Federal Reserve System*, 892 F.2d 1059 (DC Cir. 1989). In connection with its title insurance agency activities, Applicant will perform title abstracting through searches and examinations of titles to real estate.

Applicant also proposes to conduct real estate closing or settlements. In particular, these activities will include: reviewing the title commitment to determine the status of the title, verifying payoffs on existing loans secured by the real estate, reviewing the purchase agreement to identify any requirements contained in the agreement and ensuring their satisfaction, verifying the amount of and then calculating the pro rating of special assessments and taxes at closing, establishing a time and place for the closing, updating the title insurance commitment to the date of closing, preparing the checks, the deed, and affidavits required for the closing and authorization letters, conducting the closing and ensuring all parties properly execute the appropriate documents, collecting funds from the parties, preparing the HUD settlement statement, deed of trust, mortgage notice, Truth-in-Lending statement, and the purchaser's affidavits, and recording all these documents as required under law.

Section 4(c)(8) of the BHC Act provides that a bank holding company may, with prior Board approval, engage directly and indirectly in any activities "which the Board after due notice and opportunity for hearing has determined (by order or regulation) to be so closely related to banking or managing or controlling banks as to be a proper incident thereto."

A particular activity may be found to meet the "closely related to banking" test if it is demonstrated that banks have generally provided the proposed activity; that banks generally provide services that are operationally or functionally so similar to the proposed activity so as to equip them particularly well to provide the proposed activity; or that banks generally provide services that are so integrally related to the proposed activity as to require their provision in a specialized form. *National Courier Ass'n v. Board of Governors*, 516 F.2d 1229, 1237 (DC Cir.

1975) ("National Courier"). In addition, the Board may consider any other basis that may demonstrate that the activity has reasonable or close relationship to banking or managing or controlling banks. "Board Statement Regarding Regulation Y," 49 Federal Register 808 (1984).

In determining whether an activity meets the second, or proper incident to banking, test of section 4(c)(8), the Board must consider whether the performance of the activity by an affiliate of a holding company "can reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interest, or unsound banking practices."

Applicant maintains that banks provide these real estate closing services as a normal element of their real estate lending activity. Also, many of the above activities are conducted in basic loan transactions performed by banks especially in the secured real estate lending area. Accordingly, Applicant believes the proposed activities should be regarded as closely related to banking.

Applicant also maintains that the substantial overlap between the tasks of preparing a title insurance binder and performing a real estate settlement allow for increased efficiencies if conducted by the same company. Also, the customer will receive increased convenience through one-stop-shopping for these services. Accordingly, the proposed activities should be regarded as a proper incident to banking.

In publishing the proposal for comment, the Board does not take any position on issues raised by the proposal under the BHC Act. Notices of the proposal is published solely in order to seek the views of interested persons on the issues presented by the application and does not represent a determination by the Board that the proposal meets or is likely to meet the standard of the BHC Act.

Any comments or requests for a hearing should be submitted in writing and received by William W. Wiles, Secretary, Board of Governors of the Federal Reserve System, Washington DC 20551, not later than January 21, 1993.

Any request for a hearing on this application must, as required by § 262.3(e) of the Board's Rules of Procedures (12 CFR 262.3(e)), be accompanied by a statement of reasons why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

This application may be inspected at the office of the Board of Governors or the Federal Reserve Bank of Minneapolis.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31388 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

Willard Belton Simmons, Jr., et al.; Change in Bank Control Notices; Acquisitions of Shares of Banks or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. Once the notices have been accepted for processing, they will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than January 19, 1993.

A. Federal Reserve Bank of Atlanta (Zane R. Kelley, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303:

1. Willard Belton Simmons, Jr., Daphne, Alabama; to acquire an additional 7.2 percent, for a total of 25.9 percent, of the voting shares of FirstBanc Holding Company, Inc., Robertsdale, Alabama, and thereby indirectly acquire First Bank of Baldwin County, Robertsdale, Alabama.

B. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63166:

1. Charles Tuck, Jr. and Frances L. Tuck, Springfield, Missouri; to acquire an additional 1.67 percent, for a total of 10.39 percent, of the voting shares of Citizens National Bancorp, Inc., Springfield, Missouri, and thereby indirectly acquire Citizens National Bank of Springfield, Springfield, Missouri.

Board of Governors of the Federal Reserve System, December 21, 1992.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 92-31389 Filed 12-24-92; 8:45 am]

BILLING CODE 6210-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[Program Announcement Number 315]

Demonstration Program for State Health Departments to Conduct Health Consultations and Public Health Assessment Activities; Amendment

A notice announcing the availability of Fiscal Year 1993 funds for cooperative agreements for conducting health consultations and public health assessment activities was published in the **Federal Register** on November 25, 1992, [57 FR 55540]. This notice extends the deadline date for application submission to February 1, 1993. Also, the notice is amended as follows:

On page 55540, second column, under the heading "Availability of Funds," after the second sentence, insert the following: "However, consideration will also be given to funding a single application up to the maximum available amount of approximately $150,000 for a meritorious proposal that, if well executed, would not only meet but exceed program requirements and produce desired impact." The next sentence is revised to read: "It is expected that the awards will begin on or about April 15, 1993, for a 12-month budget period within a 12-month project period."

On page 55542, third column, under the heading "Application Submission and Deadline," the first sentence is revised to read: "The original and two copies of application PHS Form 5161-1 must be submitted to Henry S. Cassell, III, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., room 300, Mailstop E-13, Atlanta, Georgia 30305, on or before February 1, 1993."

All other information and requirements of the November 25, 1992, **Federal Register** notice remain the same.

Dated: December 21, 1992.

Walter R. Dowdle,

Acting Administrator, Agency for Toxic Substances and Disease Registry.

[FR Doc. 92-31377 Filed 12-24-92; 8:45 am]

BILLING CODE 4160-70-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA–066–4331–13]

Notice of Closure on Public Land; Riverside County, California

AGENCY: Bureau of Land Management; Interior.

ACTION: Notice of closure to vehicular traffic on public land for the protection of cultural resources.

SUMMARY: Notice is hereby given that Public Land in the area of the mouth and alluvial fan of Toro Canyon is closed to all vehicular traffic.

San Bernardino Meridian, California

T.7S., R.7E.,
Section 10.

The purpose of this notice is to establish a supplemental rule to help protect archaeological resources.

Exceptions to the closure would include law enforcement patrol and emergency services and administratively approved access for actions such as monitoring, research studies, mining activities, and access to private lands. Other actions would be considered on a case by case basis.

A map of the area described above may be viewed in the Palm Springs-South Coast Resource Area office. This closure is necessary to protect archaeological resources.

EFFECTIVE DATE: This closure is effective upon publication in the **Federal Register** and shall remain in effect until rescinded by the authorized officer.

FOR FURTHER INFORMATION CONTACT: Mike Mitchell, Archaeologist, Palm Springs-South Coast Resource Area, 63–500 Garnet Ave., North Palm Springs, CA 92258–2000, (619) 251–0812.

SUPPLEMENTARY INFORMATION: Authority for this Closure and Restriction Order may be found in 43 CFR 8364.1. Violation of this closure is punishable by a fine not to exceed $10,000 and/or imprisonment not to exceed 12 months. Resource monitoring over the last year has shown that archaeological resources are being directly impacted by vehicular traffic.

Dated: December 16, 1992.

Russell L. Kaldenberg,

Area Manager.

[FR Doc. 92–31357 Filed 12–24–92; 8:45 am]

BILLING CODE 4310–40–M

[ID–943–03–4210–04; IDI–27201]

Notice of Exchange and Order Providing for Opening of Public Lands; Idaho

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Exchange and Opening Order.

SUMMARY: The United States has issued an exchange conveyance document to the State of Idaho under section 206 of the Federal Land Policy and Management Act. In addition to providing official public notice of the exchange, this document contains an order which opens lands received by the United States to the public land, mining, and mineral leasing laws.

EFFECTIVE DATE: January 27, 1993.

FOR FURTHER INFORMATION CONTACT: Sally Carpenter, BLM, Idaho State Office, 3380 Americana Terrace, Boise, Idaho, (208) 384–3163.

1. In an exchange made under the provisions of section 206 of the Act of October 21, 1976, 90 Stat. 2756, 43 U.S.C. 1716, the following described lands have been conveyed from the United States:

Boise Meridian

T. 16 N., R. 4 W.,
Sec. 8, NE¼NW¼;
Sec. 17, NW¼NW¼;
Sec. 18, E½NE¼.
T. 17 N., R. 4 W.,
Sec. 6, lots 6 and 7 and E½SW¼;
Sec. 7, lots 1 and 2, E½NW¼ and NE¼SW¼;
Sec. 18, lots 1, 3, and 4, SE¼NW¼, and E½SW¼;
Sec. 19, lots 1 and 5, E½NW¼, NE¼SW¼, E½SW¼NW¼, E½NW¼SW¼, and N½SE¼SW¼.
T. 17 N., R. 5 W.,
Sec. 1, E½SW¼SW¼, E½SW¼, and SE¼;
Sec. 11, NE¼NE¼SE¼, S½NE¼SE¼, SW¼SW¼SE¼, E½SW¼SE¼, and SE¼SE¼;
Sec. 12, SW¼NE¼, S½NW¼, N½SW¼, and W½SE¼;
Sec. 13, SW¼NE¼, S½NW¼, and N½S½;
Sec. 14, E½NE¼, NW¼NE¼, and NE¼SE¼;
Sec. 23, NW¼SE¼SW¼, E½SW¼SE¼SW¼, and E½SE¼SW¼;
Sec. 24, E½NE¼;
Sec. 25, NW¼NE¼, SE¼NE¼, and E½SE¼;
Sec. 27, SW¼NE¼ and NE¼SW¼;
Sec. 28, E½NE¼SE¼SE¼ and S½SE¼SE¼;
Sec. 32, SW¼SW¼;
Sec. 34, S½;
Sec. 35, SE¼SE¼.

Comprising 6,221.70 acres of public lands.

2. In exchange for these lands, the United States acquired the following described lands:

Boise Meridian

T. 13 N., R. 4 W.,
Sec. 16.
T. 16 N., R. 5 W.,
Sec. 2, lot 3;
Sec. 4, NE¼SW¼;
Sec. 5, N½SW¼ and SE¼SW¼;
Sec. 6, lots 1, 5, and 6;
Sec. 8, SE¼NE¼ and E½NW¼;
Sec. 9, NW¼NW¼, SE¼NW¼, SE¼SW¼, and W½SE¼;
Sec. 10, SW¼;
Sec. 11, NE¼;
Sec. 15, NW¼NE¼, NW¼NW¼, N½SW¼, and SW¼SW¼;
Sec. 19, lots 3 and 4 and E½SW¼;
Sec. 21, NW¼NE¼ and N½NW¼;
Sec. 23, SE¼NW¼ and E½SW¼;
Sec. 24, E½NW¼.
T. 16 N., R. 6 W.,
Sec. 1, NW¼SE¼;
Sec. 10, E½SE¼;
Sec. 14, S½NE¼;
Sec. 23, SE¼SW¼ and SE¼;
Sec. 24, SW¼ and S½SE¼;
Sec. 25, W½;
Sec. 26, N½ and N½S½;
Sec. 27, NW¼NW¼ and S½;
Sec. 28, SE¼NE¼ and NE¼SE¼.
T. 18 N., R. 4 W.,
Sec. 4, lot 1 and SE¼ NE¼.
T. 19 N., R. 4 W.,
Sec. 27, NW¼SW¼;
Sec. 33, SE¼SE¼.
T. 13 N., R. 5 W.,
Sec. 2, SW¼NW¼ and W½SW¼;
Sec. 3, SE¼NW¼ and W½SE¼;
Sec. 10, NE¼NE¼;
Sec. 11, SW¼NE¼, NW¼, N½SW¼, and W½SE¼;
Sec. 16;
Sec. 36, NE¼NE¼, W½NE¼, W½, and SE¼SE¼.
T. 14 N., R. 5 W.,
Sec. 36.
T. 15 N., R. 6 W.,
Sec. 1, lots 1 and 2, S½NE¼, and SE¼;
Sec. 16.
T. 16 N., R. 6 W.,
Sec. 35, N½N½;
Sec. 36.
T. 13 N., R. 7 W.,
Sec. 16.
T. 14 N., R. 7 W.,
Sec. 36, N½, SW¼, and S½SE¼.
T. 15 N., R. 7 W.,
Sec. 36, lots 1 to 4, inclusive.

Comprising 6,239.20 acres of State lands.

The purpose of the exchange was to acquire State lands which have important wildlife and riparian values as well as important habitat for Columbia sharp-tailed grouse. The public interest was sell served through completion of this exchange. The values of the Federal and State lands were appraised at $330,000 and $330,700, respectively.

3. At 9 a.m. on January 27, 1993, the reconveyed State lands described in

paragraph 2 will be opened to the operation of the public land laws generally, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. All valid applications received at or prior to 9 a.m. on January 27, 1993, shall be considered as simultaneously filed at that time. Those received thereafter shall be considered in the order of filing.

4. At 9 a.m. on January 27, 1993, the reconveyed State lands described in paragraph 2 will be opened to location and entry under the United States mining laws and to the operation of the mineral leasing laws, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. Appropriation of any of the lands described in paragraph 2 under the general mining laws prior to the date and time of restoration is unauthorized. Any such attempted appropriation, including attempted adverse possession under 30 U.S.C. 38 (1988), shall vest no rights against the United States. Acts required to establish a location and to initiate a right of possession are governed by State law where not in conflict with Federal law. The Bureau of Land Management will not intervene in disputes between rival locators over possessory rights since Congress has provided for such determinations in local courts.

Dated: December 17, 1992.

William E. Ireland,

Chief, Realty Operations Section.

[FR Doc. 92–31358 Filed 12–24–92; 8:45 am]

BILLING CODE 4310–GG–M

[ID–942–03–4730–02]

Idaho: Filing of Plats of Survey

The plat of survey of the following described land was officially filed in the Idaho State Office, Bureau of Land Management, Boise, Idaho, effective 9 a.m., December 16, 1992.

The plat, in two sheets, representing the dependent resurvey of portions of the east boundary, subdivisional lines, subdivision of section 26, and the 1963–1968 adjustments of the 1879 meander lines of Henrys Fork, and the survey of portions of the 1991 meanders of Henrys Fork and islands in section 26, T. 7 N., R. 39 E., Boise Meridian, Idaho, Group No. 816, was accepted December 14, 1992.

This survey was executed to meet certain administrative needs of this Bureau.

All inquiries concerning the survey of the above-described land must be sent to the Chief, Branch of Cadastral Survey, Idaho State Office, Bureau of land Management, 3380 Americana Terrace, Boise, Idaho, 83706.

Dated: December 16, 1992.

Duane E. Olsen,

Chief Cadastral Surveyor for Idaho.

[FR Doc. 92–31359 Filed 12–24–92; 8:45 am]

BILLING CODE 4310–66–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research Act of 1984—Bell Communications Research, Inc.

Notice if hereby given that, on November 6, 1992, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301 *et seq.* ("the Act"), Bell Communications Research, Inc. ("Bellcore") filed a written notification on behalf of Bellcore and Citicorp International Communications, Inc. ("CICI") simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) the identities of the parties and (2) the nature and objectives of the venture. The notification was filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to section 6(b) of the Act, the identities of the parties are Bellcore, Livingston, NJ; and CICI, Long Island City, NY. Bellcore and CICI entered into an agreement effective as of October 1, 1992, to engage in cooperative research of network based directory services to better understand the technologies for the provision of directory services as exchange and exchange access services, including research prototype fabrication for the experimental demonstration of such technologies.

Joseph H. Widmar,

Director of Operations, Antitrust Division.

[FR Doc. 92–31336 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Notice Pursuant to the National Cooperative Research Act of 1984—Bell Communications Research, Inc.

Notice is hereby given that, on November 6, 1992, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301 *et seq.* ("the Act"), Bell Communications Research, Inc. ("Bellcore") filed a written notification on behalf of Bellcore and Digital Equipment Corporation ("DEC") simultaneously with the Attorney General and the Federal Trade Commission disclosing: (1) The identities of the parties and (2) the nature and objectives of the venture. The notification was filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to section 6(b) of the Act, the identities of the parties are Bellcore, Livingston, NJ; and DEC, Maynard, MA. Bellcore and DEC entered into an agreement effective as of October 5, 1992, to engage in cooperative research of multimedia databases, computer based video services, information retrieval systems, and high-speed computer communications to better understand the feasibility and application of these technologies for exchange and exchange access services, including experimental prototype fabrication for the demonstration of such technologies.

Joseph H. Widmar,

Director of Operations, Antitrust Division.

[FR Doc. 92–31337 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Notice Pursuant to the National Cooperative Research Act of 1984

Notice is hereby given that, on October 1, 1992, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301, *et seq.* ("the Act"), Cable Television Laboratories, Inc. ("CableLabs") has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing additions to the membership. The notifications were filed for the purpose of extending the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Specifically, the following parties have become members of CableLabs: New Heritage Associates, Des Moines, IA; Buckeye Cablevision, Inc., Toledo, OH; and CUC Broadcasting Limited, Scarborough, Ontario, CANADA.

No other changes have been made in either the membership or planned activity of CableLabs. The membership remains open.

On August 8, 1988, CableLabs filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the Federal Register pursuant to section 6(b) on September 7, 1988 (53 FR 34593).

The last notification was filed with the Department on May 18, 1992. A notice was published in the Federal

Register pursuant to section 6(b) of the Act on July 24, 1992 (57 FR 33012).

This submission will also serve as notification with respect to the following joint research ventures to which CableLabs is a member although there is no change in membership of any of the joint research ventures:

Cable Television Laboratories, Inc./PCN America, Inc.
Date of original notification: March 25, 1991
Federal Register notice: June 14, 1991(56 FR 27539)
Most recent **Federal Register** notice: July 9, 1992 (57 FR 30510)

Cable Television Laboratories, Inc./Tele-Communications, Inc./Viacom International, Inc./Public Broadcasting Service
Date of original notification: November 27, 1991
Federal Register notice: February 3, 1992 (57 FR 4061)
Most recent **Federal Register** notice: July 9, 1992 (57 FR 30511)

Cable Television Laboratories, Inc./General Instrument Corp./NEXUS Engineering
Date of original notification: June 27, 1991
Federal Register notice: July 25, 1991 (56 FR 34075)
Most recent **Federal Register** notice: July 24, 1992 (57 FR 33012)

Cable Television Laboratories, Inc./General Instrument Corp.
Date of original notification: September 20, 1990
Federal Register notice: November 1, 1990 (55 FR 46111)
Most recent **Federal Register** notice: July 9, 1992 (57 FR 30510)

Cable Television Laboratories, Inc./Advanced Television Test Center, Inc.
Date of original notification: October 2, 1989
Federal Register notice: November 8, 1989 (54 FR 46997)
Most recent **Federal Register** notice: July 9, 1992 (57 FR 30509)

Cable Television Laboratories, Inc./General Instrument Corp./Scientific-Atlanta, Inc.
Date of original notification: June 21, 1991
Federal Register notice: August 1, 1991 (56 FR 36847)
Most recent **Federal Register** notice: July 9, 1992 (57 FR 30510)

Joseph H. Widmar,

Director of Operations, Antitrust Division.

[FR Doc. 92–31338 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Notice Pursuant to the National Cooperative Research Act of 1984: "IHPTET Fiber Development Consortium"

Notice is hereby given that, on November 17, 1992, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301 *et seq.* ("the Act"), General Motors Corporation filed a written notification simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) the identities of the parties to and (2) the nature and objectives of the "IHPTET Fiber Development Consortium." The notification was filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to section 6(b) of the Act, the parties to the Consortium are Allied Signal Aerospace Company, Phoenix, AZ; AVCO Corporation, Stratford, CT; General Electric Company, Cincinnati, OH; General Motors Corporation, Detroit, MI; Teledyne Industries, Inc., Toledo, OH; United Technologies Corporation, West Palm Beach, FL; and Williams International, Walled Lake, MI, and its general area of planned activity is to identify opportunities for joining aspects of their independent research and development efforts pertaining to advanced fibers for use in composites for parts and components of advanced aircraft propulsion engines. The objectives are to avoid inefficient duplication of effort and expense, accelerate the development of advanced fibers for ceramic, metal matrix, and intermetallic matrix composites for gas turbine engines to meet the U.S. Government's Integrated High Performance Turbine Engine Technology goals (with a primary emphasis on fiber technology for ceramic matrix composites) and promote a United States advanced fiber manufacturing capability. To meet these objectives, the parties will collect, exchange, and analyze research information in these areas; conduct or direct joint research in the most promising of these high risk/high cost areas; and perform further acts allowed by the National Cooperative Research Act that would advance the Parties' objectives in this area. Membership in the Consortium remains open, and the parties intend to file additional written notification disclosing all changes in membership to the Consortium.

Joseph H. Widmar,

Director of Operations, Antitrust Division.

[FR Doc. 92–31335 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Notice Pursuant to the National Cooperative Research Act of 1984; Petrotechnical Open Software Corporation

Notice is hereby given that, on October 19, 1992, pursuant to section 6(a) of the National Cooperative Research Act of 1984, 15 U.S.C. 4301, *et seq.* ("the Act"), Petrotechnical Open Software Corporation ("POSC") has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing changes in its membership. The notifications were filed for the purpose of extending the protections of the Act limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances.

Specifically, the following additional parties have become new, non-voting members of POSC: Australian Geological Survey Organisation, Canberra, Australia; Merak Projects Ltd., Calgary, Alberta, Canada; the Norwegian Petroleum Directorate, Stravanger, Norway; Base Line Computer Corporation, Southlake, TX; UNISQL, Incorporated, Austin, TX; Geomath International, Rueil-Malmaison, France; and Britannia Data Management, London, England.

No other changes have been made in either the membership or planned activity of POSC.

On January 14, 1991, POSC filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the **Federal Register** pursuant to section 6(b) of the Act on February 7, 1991, 56 FR 5021. The last notification was filed with the Department on July 20, 1992. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on August 20, 1992, 57 FR 37840.

Joseph H. Widmar,

Director of Operations, Antitrust Division.

[FR Doc. 92–31339 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act

In accordance with Department policy, 28 CFR 50.7, notice is hereby given that on December 18, 1992, a proposed Consent Decree in *United States* v. *PBM Enterprises, et al.*, Civil Action No. 88CV–74073–DT, was lodged in the United States District Court for the Eastern District of Michigan. The Complaint filed by the United States alleged claims under Section 107 of the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA"), 42 U.S.C. 9607(a), for costs incurred by the United States in responding to the release or threat of release of hazardous substances at the PBM Enterprises Site located at 10100 Harrison Road in Romulus, Michigan ("the Site"). The Consent Decree requires defendants PBM Enterprises,

Edward F. Martin, William B. Matakas, and Phillipa C. Matakas to pay $190,000 to reimburse the United States Environmental Protection Agency for unrecovered past response costs at the Site.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments concerning the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, U.S. Department of Justice, P.O. Box 7611, Ben Franklin Station, Washington, DC 20044, and should refer to *United States* v. *PBM Enterprises, et al.*, D.J. Ref. No. 90–11–3–347.

The proposed Consent Decree may be examined at any of the following offices: (1) the United States Attorney for the Eastern District of Michigan, 231 West Lafayette, Detroit, Michigan, 48226 (contact Assistant United States Attorney Geneva Halliday; (2) the U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604–3590 (contact Assistant Regional Counsel Richard Nagle); and the Consent Decree Library, 601 Pennsylvania Avenue, NW., Washington, DC 20044, (202) 347–2072. Copies of the proposed Consent Decree may be obtained in person or by mail from the Consent Decree Library, 601 Pennsylvania Avenue, NW., Washington, DC 20044, telephone (202) 347–7829. For a copy of the Consent Decree please enclose a check in the amount of $4.25 (25 cents per page reproduction charge) payable to Consent Decree Library.

Vicki A. O'Meara,

Acting Assistant Attorney General, Environmental and Natural Resources Division.

[FR Doc. 92–31333 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

Lodging of Consent Decree Pursuant to the Clean Water Act

In accordance with Departmental policy at 28 CFR 50.7, notice is hereby given that on December 10, 1992, a proposed consent decree in *United States* vs. *NICOR National Louisiana, Inc.*, Civil Action No. 92–0960, was lodged with the United States District Court for the Eastern District of Louisiana. The complaint filed by the United States sought injunctive relief and civil penalties for violations by defendant NICOR National Louisiana, Inc. (NL) of sections 301 and 402 of the Clean Water Act and the terms and conditions of its National Pollutant Discharge Elimination System (NPDES) permit issued by the U.S. Environmental Protection Agency (EPA) in 1989. The proposed consent decree imposes a $225,000 penalty for these violations.

For a period of thirty (30) days from the date of this publication, the Department of Justice will receive written comments relating to the proposed consent decree from persons who are not parties to the action. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, U.S. Department of Justice, Washington, DC 20530, and should refer to *United States* vs. *NICOR National Louisiana, Inc.*, DOJ # 90–5–1–3379.

The proposed consent decree may be examined at the offices of the United States Attorney for the Eastern District of Louisiana, 400 Poydras Street, Suite 1900, New Orleans, Louisiana and at the office of the United States Environmental Protection Agency, Region VI, 1445 Ross Avenue, Dallas, Texas 75202 (Attention: Quinton Farley, Assistant Regional Counsel). A copy of the consent decree may also be examined at the Environmental Enforcement Section Document Center, 601 Pennsylvania Avenue, NW., Washington, DC 20004. Copies of the decree may be obtained in person or by mail from the Environmental Enforcement Section Document Center. Such requests should be accompanied by a check in the amount of $2.00 (25 cents per page reproduction charge) payable to "Consent Decree Library". When requesting copies, please refer to *United States* vs. *NICOR National Louisiana, Inc.*, DOJ # 90–5–1–1–3379.

Vicki A. O'Meara,

Acting Assistant Attorney General, Environment and Natural Resources Division.

[FR Doc. 92–31334 Filed 12–24–92; 8:45 am]

BILLING CODE 4410–01–M

DEPARTMENT OF LABOR

Employment Standards Administration

Wage and Hour Division; Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination; Decisions

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data more made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of other Federal statutes referred to in 29 CFR part 1, Appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the payment of wages determined to be prevailing by the Secretary of Labor in accordance with the Davis-Bacon Act. The prevailing rates and fringe benefits determined in these decisions shall, in accordance with the provisions of the foregoing statutes, constitute the minimum wages payable on Federal and federally assisted construction projects to laborers and mechanics of the specified classes engaged on contract work of the character and in the localities described therein.

Good cause is hereby found for not utilizing notice and public comment procedure thereon prior to the issuance of these determinations as prescribed in 5 U.S.C. 553 and not providing for delay in the effective date as prescribed in that section, because the necessity to issue current construction industry wage determinations frequently and in large volume causes procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedeas decisions thereto, contain no expiration dates and are effective from their date of notice in the **Federal Register**, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled "General Wage Determination Issued Under the Davis-Bacon And Related Acts," shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest

in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department. Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Division of Wage Determinations, 200 Constitution Avenue, NW., room S–3014, Washington, DC 20210.

Corrections to General Wage Determination Decisions

Pursuant to the provisions of the Regulations set forth in title 29 of the Code of Federal Regulations, part 1, § 1.6(d), the Administrator of the Wage and Hour Division may correct any wage determination that contains clerical errors.

Corrections being issued in the Government Printing Office document entitled "General Wage Determinations Issued Under the Davis-Bacon and Related Acts" are indicated by Volume and are included immediately following the transmittal sheet(s) for the appropriate Volume(s).

Volume I

Wage Decision No. NY91–3, Modification Nos. 5 Through 9

Pursuant to the Regulations, 29 CFR part 1, § 1.6(d), such corrections shall be included in any bid specifications containing the wage determinations, or in any on-going contracts containing the wage determinations in question, retroactively to the start of construction.

Modification to General Wage Determination Decisions

The number of decisions listed in the Government Printing Office document entitled "General Wage Determinations Issued Under the Davis-Bacon and Related Acts" being modified are listed by Volume, State, and page number(s). Dates of Publication in the **Federal Register** are in parentheses following the decisions being modified.

Volume I

Kentucky:
KY91–25 (Feb. 22, 1991) ..... p. All
KY91–26 (Feb. 22, 1991) ..... p. All
KY91–27 (Feb. 22, 1991) ..... p. All
KY91–28 (Feb. 22, 1991) ..... p. All
New Jersey:
NJ91–2 (Feb. 22, 1991) ..... p. 701 pp. 705
NJ91–3 (Feb. 22, 1991) ..... p. 721 pp. 725, 727–728
South Carolina: SC91–23 (Feb. 22, 1991). p. All

Volume II

Illinois: IL91–19 (Feb. 22, 1991) p. All
Indiana: IN91–18 (Feb. 22, 1991) p. All

General Wage Determination Publication

General wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled "General Wage Determinations Issued Under the Davis-Bacon And Related Acts". This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country. Subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. (202) 783–3238.

When ordering subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the three separate volumes, arranged by State. Subscriptions include an annual edition (issues on or about January 1) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates will be distributed to subscribers.

Signed at Washington, DC this 18th day of December 1992.

Alan L. Moss,

Director, Division of Wage Determinations.

[FR Doc. 92–31184 Filed 12–24–92; 8:45 am]

BILLING CODE 4510–27–M

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Records Schedules; Availability and Request for Comments

AGENCY: National Archives and Records Administration, Office of Records Administration.

ACTION: Notice of availability of proposed records schedules; request for comments.

SUMMARY: The National Archives and Records Administration (NARA) publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Records schedules identify records of sufficient value to warrant preservation in the National Archives of the United States. Schedules also authorize agencies after a specified period to dispose of records lacking administrative, legal, research, or other value. Notice is published for records schedules that: (1) Propose the destruction of records not previously authorized for disposal, or (2) reduce the retention period for records already authorized for disposal. NARA invites public comments on such schedules, as required by 44 U.S.C. 3303a(a).

DATES: Request for copies must be received in writing on or before February 11, 1993. Once the appraisal of the records is completed, NARA will send a copy of the schedule. The requester will be given 30 days to submit comments.

ADDRESSES: Address requests for single copies of schedules identified in this notice to the Records Appraisal and Disposition Division (NIR), National Archives and Records Administration, Washington, DC 20408. Requesters must cite the control number assigned to each schedule when requesting a copy. The control number appears in the parentheses immediately after the name of the requesting agency.

SUPPLEMENTARY INFORMATION: Each year U.S. Government agencies create billions of records on paper, film, magnetic tape, and other media. In order to control this accumulation, agency records managers prepare records schedules specifying when the agency no longer needs the records and what happens to the records after this period. Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. These comprehensive schedules provide for the eventual transfer to the National Archives of historically valuable records and authorize the disposal of all other records. Most schedules, however, cover records of only one office or program or a few series of records, and many are updates of previously approved schedules. Such schedules also may include records that are designated for permanent retention.

Destruction of records requires the approval of the Archivist of the United States. This approval is granted after a thorough study of the records that takes into account their administrative use by the agency of origin, the rights of the Government and of private persons directly affected by the Government's activities, and historical or other value.

This public notice identifies the Federal agencies and their subdivisions requesting disposition authority, includes the control number assigned to each schedule, and briefly describes the records proposed for disposal. The records schedule contains additional information about the records and their disposition. Further information about

the disposition process will be furnished to each requester.

Schedules Pending:

1. Department of the Air Force (N1–AFU–93–1). Routine background files to the Journal of Military Assistance, 1963–72.

2. Department of the Air Force (N1–AFU–93–2). Routine records of the Education Services Program.

3. Department of the Army (N1–AU–91–6). Files relating to changes in the organization of installation support activities.

4. Department of Commerce, National Institute of Standards and Technology (N1-167–92–3). Records of the U.S. Metric Board.

5. Department of Commerce, Patent and Trademark Office (N1–241–92–1). Case folders of registered attorneys and agents.

6. Department of Commerce, Patent and Trademark Office (N1–241–92–2). Records of the Office of Enrollment and Discipline.

7. Department of Health and Human Services, Health Care Financing Agency (N1–440–93–2). Case files of the MEDICARE Geographic Classification Review Board.

8. Department of Labor, Employees Compensation Appeals Board (N1–386–92–1). Legislative reference files.

9. Department of State, Bureau of Politico-Military Affairs (N1–59–92–31). Routine, facilitative, and duplicative records of the Office of Defense Relations and Security Assistance.

10. General Services Administration (N1–269–93–1). Records relating to Real and Personal Property Management.

11. National Archives and Records Administration (N2–121–93–1). Glass plate photographic negatives, the images of which have been copied, accessioned from the General Services Administration, Public Buildings Service

Dated: December 15, 1992.

Don W. Wilson,

Archivist of the United States.

[FR Doc. 92–31360 Filed 12–24–92; 8:45 am]

BILLING CODE 7515–01–M

PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

Notice of Recommendations for Amendments to the Columbia River Basin Fish and Wildlife Program (Measures for Resident Fish and Wildlife)

December 18, 1992.

AGENCY: Pacific Northwest Electric Power and Conservation Planning Council (Northwest Power Planning Council).

SUMMARY: Pursuant to the Pacific Electric Power Planning and Conservation Act (the Northwest Power Act, 16 U.S.C. 839, et seq.) interested parties have submitted to the Pacific Northwest Electric Power and Conservation Planning Council (Council) recommendations for amendments to resident fish and wildlife provisions of the Columbia River Basin Fish and Wildlife Program (program). Copies of the recommendations are now available, and comments are solicited.

Background: The Council is in the last phase of a four-part process to amend the Columbia River Basin Fish and Wildlife Program (program). In phases one through three, the Council adopted amendments regarding salmon and steelhead. The Council is now initiating the fourth phase, in which resident fish and wildlife amendments to the program will be considered.

Opportunity for Comment: The Council will receive written comment on the recommendations through 5 p.m. Pacific time, February 11, 1993. Comments should be clearly marked "Phase Four Comments," and submitted to the Council's Public Affairs Division, 851 SW. Sixth Avenue, suite 1100, Portland, Oregon 97204. After the close of comment on the recommendations, the Council will propose program amendments, and opportunities for comment on these proposed amendments, including hearings in the four states, will be afforded. The Council expects to make final decisions on the proposed amendments in October 1993.

FOR FURTHER INFORMATION CONTACT: A summary of the recommendations is available. For the summary, or for copies of the recommendations, contact the Council at 851 SW. Sixth Avenue, suite 1100, Portland, Oregon 97204 or (503) 222–5161, toll free 1–800–222–3355.

Edward W. Sheets,

Executive Director.

[FR Doc. 92–31361 Filed 12–24–92; 8:45 am]

BILLING CODE 0000–00–M

DEPARTMENT OF THE TREASURY

Public Information Collection Requirements Submitted to OMB for Review

Dated: December 18, 1992.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Public Law 96–511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 3171 Treasury Annex, 1500 Pennsylvania Avenue, NW., Washington, DC 20220.

Bureau of the Public Debt

OMB Number: 1535–0082.

Form Number: PD F 5237.

Type of Review: Extension.

Title: Subscription for Purchase of U.S. Treasury Securities—State and Local Governments Series One-Day Certificates of Indebtedness.

Description: This form will be used to collect account establishment information from State and Local Government entities wishing to purchase demand deposit U.S. Treasury securities—State and Local Government Series. Information on the form will be encoded to create book-entry accounts on the records of the Bureau of the Public Debt.

Respondents: State or local governments.

Estimated Number of Respondents: 30,000.

Estimated Burden Hours Per Response: 8 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 4,000 hours.

OMB Number: 1535–0083.

Form Number: PD F 5238.

Type of Review: Extension.

Title: Request for Redemption of U.S. Treasury Securities—State and Local Government Series One-Day Certificates of Indebtedness.

Description: This form will be used to collect account redemption information from State and Local Government securities wishing to redeem demand deposit U.S. Treasury securities—State and Local Government Series. Information on the forms will be encoded to process redemptions of book-entry accounts on the records of the Bureau of the Public Debt.

Respondents: State of local governments.

Estimated Number of Respondents: 30,000.

Estimated Burden Hours Per Response: 3 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 2,000 hours.

Clearance Officer: Vicki S. Ott, (304) 420–6553, Bureau of the Public Debt, 200 Third Street, Parkersburg, West VA 26106–1328.

OMB Reviewer: Milo Sunderhauf, (202) 395–6880, Office of Management and Budget, Room 3001, New Executive

Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports, Management Officer.

[FR Doc. 92–31364 Filed 12–24–92; 8:45 am]

BILLING CODE 4810–40–M

Public Information Collection Requirements Submitted to OMB for Review

Dated: December 18, 1992.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Public Law 96–511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 3171 Treasury Annex, 1500 Pennsylvania Avenue, NW., Washington, DC 20220.

Internal Revenue Service

OMB Number: 1545–1135.

Form Number: IRS Form 8817.

Type of Review: Extension.

Title: Allocation of Patronage and Nonpatronage Income and Deductions.

Description: Form 8817 is used by taxable Farmer Cooperatives to indicate their income and deductions by patronage and nonpatronage source. IRS uses this information to improve the classification of returns for examination, and to enhance taxpayer compliance.

Respondents: Farms, Businesses or other for-profit.

Estimated Number of Respondents/ Recordkeepers: 1,650.

Estimated Burden Hours Per Respondent/Recordkeeper:

Recordkeeping—17 hours, 2 minutes

Learning about the law or the form—30 minutes

Preparing, copying, assembling, and sending the form to the IRS—48 minutes

Frequency of Response: Annually.

Estimated Total Reporting/ Recordkeeping Burden: 22,726 hours.

Clearance Officer: Garrick Shear, (202) 622–3869, Internal Revenue Service, Room 5571, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer Milo Sunderhauf, (202) 395–6880, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 92–31362 Filed 12–24–92; 8:45 am]

BILLING CODE 4830–01–M

Sunshine Act Meetings

Federal Register
Vol. 57, No. 249
December 28, 1992

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given of the Board's meeting described below. The Board will also conduct a public hearing pursuant to 42 U.S.C. 2286b and invites any interested persons or groups to present any comments, technical information, or data concerning the Department of Energy's Operational Readiness Review and other matters related to the resumption of plutonium operations in Building 707 at the Rocky Flats Plant.

TIME AND DATE: 5:30 p.m. January 12, 1993—Department of Energy presentations; 8:00 p.m.—Opportunity for interested persons to present oral comments concerning the matters to be considered.

PLACE: The Boulder Broker Inn, The Ballroom, 555–30th Street, Boulder, Colorado 80303.

STATUS: Open. While the Government in the Sunshine Act does not require that the scheduled briefing be conducted in a meeting, the Board has determined that an open meeting in this specific case furthers the public interests underlying both the Sunshine Act and the Board's enabling legislation.

MATTERS TO BE CONSIDERED: The open public meeting and hearing will address the Department of Energy's Operational Readiness Review and other matters related to the resumption of plutonium operations in Building 707 at the Rocky Flats Plant. The Department of Energy will take appropriate measures to safeguard any classified or controlled nuclear information it presents at this meeting. The public hearing portion is independently authorized by 42 U.S.C. 2286b.

FOR FURTHER INFORMATION CONTACT: Kenneth M. Pusateri, General Manager, Defense Nuclear Facilities Safety Board, 625 Indiana Avenue, NW, Suite 700, Washington, DC 20004, (202) 208–6400. This is not a toll free number.

SUPPLEMENTARY INFORMATION: Requests to speak at the hearing may be submitted in writing or by telephone. We ask that commentators describe the nature and scope of the oral presentation. Those who contact the Board prior to close of business on January 8, 1993, will be scheduled for time slots, beginning at approximately 8:00 p.m. The Board will post a schedule for those speakers who have contacted the Board before the hearing. The posting will be made at the entrance to the Ballroom at The Boulder Broker Inn at the start of the 5:30 p.m. meeting.

Anyone who wishes to comment, provide technical information or data may do so in writing, either in lieu of, or in addition to making an oral presentation. The Board members may question presenters to the extent deemed appropriate. The Board will hold the record open until January 22, 1993, for the receipt of materials. A transcript of the meeting will be made available by the Board for inspection by the public at the Defense Nuclear Facilities Safety Board's Washington office and a the DOE's public reading room at DOE's Front Range Community College, 3645 West 112 Avenue, Westminster, CO 80030.

The Board specifically reserves its right to further schedule and otherwise regulate the course of the meeting and hearing, to recess, reconvene, postpone or adjourn the meeting, conduct further reviews, and otherwise exercise its power under the Atomic Energy Act of 1954, as amended.

Dated: December 22, 1992.

Kenneth M. Pusateri,

General Manager

[FR Doc. 92–31495 Filed 12–22–92; 4:54 pm]

BILLING CODE 6820–KD–M

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Agency Meeting

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that at 10:03 a.m. on Tuesday, December 22, 1992, the Board of Directors of the Federal Deposit Insurance Corporation met in closed session to consider the following:

Matters relating to the Corporation's corporate and supervisory activities.

Matters relating to an assistance agreement with an insured bank.

Recommendations concerning administrative enforcement proceedings.

Reports of the Office of Inspector General.

Matters relating to the cross-guaranty provisions of the Federal Deposit Insurance Act and issuance of notices of assessment of liability pursuant to those provisions.

Recommendation regarding the liquidation of a depository institution's assets acquired by the Corporation in its capacity as receiver, liquidator, or liquidating agent of those assets:

Case No. 47,846 VMS National Properties' Bankruptcy Reorganization Plan

In calling the meeting, the Board determined, on motion of Director C.C. Hope Jr. (Appointive), seconded by Director Stephen R. Steinbrink (Acting Comptroller of the Currency), concurred in by Acting Chairman Andrew C. Hove, Jr., and Director Jonathan L. Fiechter (Acting Director, Office of Thrift Supervision), that Corporation business required its consideration of the matters on less than seven days' notice to the public; that no earlier notice of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting by authority of subsections (c)(2), (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10) of the "Government in the Sunshine Act" (5 U.S.C. 552b(c)(2), (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), (c)(9)(B), and (c)(10)).

The meeting was held in the Board Room of the FDIC Building located at 550—17th Street, NW., Washington, DC.

Dated: December 22, 1992.

Federal Deposit Insurance Corporation

Robert E. Feldman,

Deputy Executive Secretary.

[FR Doc. 92–31496 Filed 12–22–92; 4:55 pm]

BILLING CODE 6714–01–M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., Wednesday, January 6, 1993.

PLACE: 2033 K St., NW., Washington, DC, 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Enforcement Matters.

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 202–254–6314.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 92–31589 Filed 12–23–92; 2:42 pm]

BILLING CODE 6351–01–M

NUCLEAR REGULATORY COMMISSION

DATES: Weeks of December 28, 1992, January 4, 11, and 18, 1993.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Open and Closed.

MATTERS TO BE CONSIDERED:

Week of December 28

Tuesday, December 29

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of January 4—Tenative

Tuesday, January 5

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of January 11—Tentative

Monday, January 11

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of January 18—Tentative

Thursday, January 21

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

ADDITIONAL INFORMATION: On December 21 and December 22 "Continuation of 12/18 Briefing on Investigative Matters" (Closed—Ex. 5 & 7) were held. By a vote of 5–0 on December 22, the Commission determined pursuant to U.S.C. 552b(e) and § 9.107(a) of the Commission's rules that "Briefing by Executive Branch" (Closed—Ex. 1) be held on December 22 and on less than one week's notice to the public.

Note: Affirmation sessions are initially scheduled and announced to the public on a time-reserved basis. Supplementary notice is provided in accordance with the Sunshine Act as specific items are identified and added to the meeting agenda. If there is no specific subject listed for affirmation, this means that no item has as yet been identified as requiring any Commission vote on this date.

To verify the Status of Meeting Call (recording)—(301) 504–1292.

CONTACT PERSON FOR MORE INFORMATION: William Hill (301) 504–1661.

Dated: December 22, 1992.

William M. Hill, Jr.,

SECY Tracking Officer, Office of the Secretary.

[FR Doc. 92–31588 Filed 12–23–92; 2:41 pm]

BILLING CODE 7590–01–M

Corrections

Federal Register
Vol. 57, No. 249
Monday, December 28, 1992

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 374

[FRL–3908–9]

Citizen Suits Under Section 310 of the Comprehensive Environmental Response, Compensation, and Liability Act

Correction

In rule document 92–27702 beginning on page 55038 in the issue of Monday, November 23, 1992, make the following correction:

§ 374.3 [Corrected]

On page 55041, in the second column, in § 374.3(c), in the second line "statement" should read "state".

BILLING CODE 1505–01–D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 314

[Docket No. 85N–0214]

RIN 0905–AB63

Abbreviated New Drug Application Regulations

Correction

In rule document 92–9320 beginning on page 17950 in the issue of Tuesday, April 28, 1992, make the following correction:

§ 314.54 [Corrected]

1. On page 17982, in the third column, in § 314.54(a)(2), in the 5th line, "§ 314.50(d)," should read "§ 314.50(d)(2)".

BILLING CODE 1505–01–D

DEPARTMENT OF LABOR

Mine Safety and Health Administration

30 CFR Part 100

RIN 1219–AA44

Criteria and Procedures for Proposed Assessment of Civil Penalties

Correction

In rule document 92–30840 beginning on page 60690 in the issue of Monday, December 21, 1992, make the following correction:

§ 100.4 [Corrected]

On page 60697, in § 100.4(b), in the third column, in the eighth line, "January 1, 1992" should read "January 1, 1991".

BILLING CODE 1505–01–D

OFFICE OF GOVERNMENT ETHICS

5 CFR Part 2638

RIN 3209–AA07

Executive Agency Ethics Training Programs; Amendments

Correction

In rule document 92–29939 beginning on page 58399 in the issue of Thursday, December 10, 1992, make the following corrections:

1. On page 58399, in the second column, in the third line from the bottom, "supplement" should read "supplemental".

2. On page 58400, in the first column, **SUBPART G—EXECUTIVE AGENCY ETHICS TRAINING PROGRAMS** was misspelled.

§ 2638.703 [Corrected]

3. On the same page, in § 2638.703(a)(1):

a. In the first column, in the last line, after "as amended" insert "by".

b. In the second column, in the second line, "Comp , p 306;" should read "Comp., p. 306;".

BILLING CODE 1505–01–D

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

[Docket No. P–90–1W; Notice 1]

Transportation of Natural and Other Gas by Pipeline; Petition for Waiver; Panhandle Eastern Corporation

Correction

In notice document 92–30216 beginning on page 59198 in the issue of Monday, December 14, 1992, make the following correction: On page 59200, in the first column, in paragraph (5), in the fifth line, "to pipe to the" should read "to pipe to be".

BILLING CODE 1505–01–D

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 31

[T.D. 8436]

RIN 1545–AP91

Deposits of Employment Taxes

Correction

In rule document 92–23233 beginning on page 44099 in the issue of Thursday, September 24, 1992, make the following corrections:

1. On page 44100, in the second column, under the heading "B. Annual Determination and Lookback Period", in the second paragraph, in the third line from the bottom "apply or the" should read "apply for the".

2. On the same page, in the third column, under the heading "D. Semi-Weekly Rule", in paragraph 2., in the fifth line from the bottom "in single" should read "in a single".

3. On page 44101, in the first column, under the heading "G. Safe Harbor", in the fourth paragraph, in the third line from the bottom "remit that taxes" should read "remit the taxes".

4. On the same page, in the second column, under the heading "I. Special Rules for Backup Withholding Amounts", in the penultimate line "other other employment" should read "other employment".

BILLING CODE 1505–01–D

federal register

Monday
December 28, 1992

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 456 and 483
Medicare and Medicaid; Resident Assessment in Long Term Care Facilities; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 456 and 483

[HSQ–180–P]

RIN 0938–AE61

Medicare and Medicaid; Resident Assessment in Long Term Care Facilities

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: Sections 1819(b)(3) and 1919(b)(3) of the Social Security Act (the Act) require long term care facilities participating in the Medicare and Medicaid programs to conduct periodic assessments of each resident's functional capacity. Sections 1819(f)(6) and 1919(f)(6) of the Act require the Secretary to specify a minimum data set of core elements and common definitions for use by the facilities, to establish guidelines for use of the data set, and to designate one or more assessment instruments which a State may require facilities to use. This proposed rule would set forth these required items. It would also implement sections 1819(e)(5) and 1919(e)(5), which require the States to specify a resident assessment instrument (RAI) to be used by long term care facilities in complying with sections 1819(b)(3) and 1919(b)(3).

To conform the regulations to section 4214(d)(1)(A) of the Omnibus Budget Reconciliation Act of 1987, we would also revise sections of part 456 that deal with Inspections of Care. We would substitute "intermediate care facility for the mentally retarded" for intermediate care facility and eliminate skilled nursing facility. Also, "mental hospitals" and "psychiatric facilities" would be substituted for institutions for mental diseases.

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on February 26, 1993.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HSQ–180–P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Due to staffing and resource limitations, we cannot accept audio, visual, or facsimile (FAX) copies of comments.

In commenting, please refer to file code HSQ–180–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in room 309–G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202–690–7890).

FOR FURTHER INFORMATION CONTACT: Sue Nonemaker, (410) 966–6825.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Social Security Act (the Act), long term care facilities must meet certain requirements in order to participate in the Medicare and Medicaid programs. Sections 1819(a) through (d) of the Act set forth the requirements for Medicare skilled nursing facilities (SNFs), and sections 1919 (a) through (d) set forth the requirements for Medicaid nursing facilities (NFs). The State responsibilities relating to Medicare SNFs are set forth in section 1819(e), the Federal responsibilities in section 1819(f), and joint State-Federal responsibilities in sections 1819 (g) through (i). The State responsibilities relating to Medicaid NFs are set forth in section 1919(e), the Federal responsibilities in section 1919(f), and joint State-Federal responsibilities in sections 1919 (g) through (i).

The requirements that SNFs and NFs must meet in order to qualify to participate in the Medicare and Medicaid programs are set forth at 42 CFR part 483, subpart B ("Requirements for Long Term Care Facilities"). These requirements are enforced through a survey process which provides for annual recertification surveys and additional surveys as needed. The surveys are conducted by State agencies under contract with the Health Care Financing Administration (HCFA) and are monitored through its ten regional offices.

Certain new requirements regarding resident assessment were published in the **Federal Register** on February 2, 1989 (54 FR 5316). These new requirements conform with sections 4201(a)(3) and 4211(a)(3) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203). Public Law 100–203 added sections 1819(a)(3), (e)(5), and (f)(6), and sections 1919(a)(3), (e)(5), and (f)(6) of the Act. Public Law 100–203, as subsequently amended, requires that—

- Long term care facilities participating in the Medicare and Medicaid programs conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity;
- The assessment describe the resident's capability to perform daily life functions and significant impairments in functional capacity;
- Effective October 1, 1990, the assessment be based on a uniform minimum data set (MDS) of core elements and common definitions specified by the Secretary;
- The Secretary specify the MDS and guidelines for using it no later than January 1, 1989;
- Long term care facilities use a resident assessment instrument specified by the State;
- The instrument specified by the State be either specified by the Secretary or approved by the Secretary as consistent with the MDS of core elements, common definitions, and utilization guidelines specified by the Secretary; and
- No later than April 1, 1990, the Secretary designate one or more resident assessment instruments.

These provisions of the Act were the basis of the new requirements published as part of a final rule on February 2, 1989. The rule added 42 CFR 483.20 ("Level A requirement: Resident assessment"), which sets forth resident assessment requirements for long term care facilities. But, while the rule set forth the requirements for resident assessment, it did not set forth the MDS consisting of core elements and common definitions, guidelines for using the MDS, and one or more resident assessment instruments.

Public Law 100–203 also amended a part of the Act which deals with Inspection of Care (IoC) reviews. IoC reviews are independent professional reviews to determine quality of care and appropriateness of the levels of care furnished to Medicaid recipients in Medicaid participating facilities. The reviews are the responsibility of the State and may either be conducted by teams of State employees or by outside teams under contract to the State.

Section 4212(d)(1)(A) of Public Law 100–203 removed references to skilled nursing facilities (SNFs) and substituted references to intermediate care facilities

for the mentally retarded (ICFs/MR) in place of intermediate care facilities (ICFs) in section 1903(g)(1) of the Act, which relates to IoC reviews. However, the law specifies that this change shall not apply to a State until the Secretary has determined that the State has specified its resident assessment instrument and has begun conducting surveys under the new survey and certification process. Therefore, States must continue to conduct IoC reviews in NFs (on October 1, 1990, ICFs other than ICFs/MR became NFs) until the resident assessment process and the new survey and certification process is fully implemented.

II. Provisions of the Proposed Regulation

To conform the regulations to section 4212(d)(1)(A) of Public Law 100–203, we would revise the sections of Part 456 that make specific reference to IoC reviews of SNFs and ICFs. We would substitute "ICFs/MR" for SNFs and ICFs. In addition, we would substitute the terms "mental hospitals" and "psychiatric facilities" for Institutions for Mental Diseases (IMDs). Since Public Law 100–203 excludes SNFs and ICFs from the provisions of section 1903(g)(1) of the Act, this means that the only types of IMDs remaining are mental hospitals and psychiatric facilities. Accordingly, we would substitute the terms "mental hospitals" and "psychiatric facilities" for IMDs. The sections involved are—

§ 456.1(b)(5)	"Inspections of care and services in institutions".
§ 456.600	"Purpose [of Subpart I ("Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases")]".
§ 456.601	"Definitions [of terms used in Subpart I]".
§ 456.602(c), (d), and (f).	"Inspection team".
§ 456.603	"Financial interests and employment of team members".
§ 456.608	"Personal contact with and observation of recipients and review of records".
§ 456.609	"Determinations by team".
§ 456.610	"Basis for determinations".
§ 456.612	"Copies of reports".
§ 456.651	"Definitions [of terms used in Subpart J ("Penalty for Failure to Make a Satisfactory Showing of an Effective Institutional Utilization Control Program")]".
§ 456.654	"Requirements for content of showings and procedures for submittal".

The resident assessment instrument (RAI) is designed to produce "a comprehensive, accurate, standardized, reproducible assessment of each [long term care facility] resident's functional capacity" required by sections 4201(a)(3) and 4211(a)(3) of Public Law 100–203. To meet this requirement, we have designed an RAI comprised of the MDS and the Resident Assessment Protocols (RAPs). States may choose to specify it or to specify an alternate RAI approved by HCFA.

We would revise the current § 483.20(b)(1) to state that facilities must make a comprehensive assessment of each resident's needs, using the RAI specified by the State, and that the assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

In October 1988, HCFA contracted with the Research Triangle Institute (RTI) to develop the RAI (HCFA Contract No. 500–88–0055). During the period October 1988 to March 1990, RTI and its principal subcontractors, the Hebrew Rehabilitation Center for Aged, Brown University, and The University of Michigan, assisted HCFA in developing an RAI, to include the MDS (which appears at the proposed § 483.315(b)(1)). A complete copy of the RAI developed by RTI, along with instructions and guidelines, appears in the appendix to this preamble, and a description of the development of the elements of the RAI and guidelines follows below:

A. The Development of the MDS

The principal task in developing the RAI was specifying the MDS. The MDS is a minimum set of screening and assessment elements, including common definitions and coding categories, needed to perform a comprehensive assessment of a long-term care facility resident. Its development involved two major activities: (1) Organizing and analyzing the recommendations of clinical experts and persons knowledgeable about the assessment needs of nursing facility residents as to what core elements to include in the data set, including creating a conceptual framework to organize these elements; and (2) conducting extensive reliability testing of this data set, including producing training materials for nurse assessors. We have included in the proposed MDS only those individual core data elements that—

- Are necessary to consider in developing a plan of care;
- Show acceptable levels of inter-rater reliability (that is, if two assessors were independently to gather this information, they would reach a similar conclusion about a resident's status and care needs);
- Are cost-efficient to gather (that is, the time and resources needed by nursing staff to collect and record this information would be commensurate with the information's utility in planning a resident's care);
- Assess a resident's actual performance and functioning levels, rather than their potential performance and function;
- Describe evident conditions or behaviors (that is, "resident expresses sadness", rather than describe conditions and behaviors that are not readily manifested, such as, "resident feels sad");
- Provide a time frame for assessing the behavior or condition (for example, "within the last 7 days" or "bedfast at least 22 hours per day"); and
- When applicable, specify the frequency and intensity of services required (for example, in the assessment of a need for specialized rehabilitation therapies such as physical, occupational, or speech therapy)

The framework for performing a comprehensive assessment is found at the current § 483.20(b)(2), which states:

The comprehensive assessment must include at least the following information:

(i) Medically defined conditions and prior medical history;
(ii) Medical status measurement;
(iii) Physical and mental functional status;
(iv) Sensory and physical impairments;
(v) Nutritional status and requirements;
(vi) Special treatments or procedures;
(vii) Mental and psychosocial status;
(viii) Discharge potential;
(ix) Dental condition;
(x) Activities potential;
(xi) Rehabilitation potential;
(xii) Cognitive status; and
(xiii) Drug therapy.

In devising the MDS, HCFA and its contractors first reviewed over 60 assessment instruments developed for the purposes of preadmission screening, State case-mix payment determination, nursing facility management, and geriatric research. We asked States using standardized assessment instruments to forward their forms to us for analysis. Twelve instruments that met a criterion for comprehensiveness consistent with the areas detailed in the current § 483.20(b) were reviewed further to identify common items, definitions, and coding categories.

Most previously used instruments measured activities of daily living (ADLs), mobility, and selected nursing care needs and services. However, few instruments measured behavioral disorders, mood disturbances, activities potential and cognitive functioning. Not one assessment tool addressed

residents' preferences for, and involvement in, activities. Based on this review of existing instruments, HCFA concluded that none could serve "as is" or with simple modifications as the MDS or RAI. However, this analysis of common assessment items and definitions did provide a starting point for developing the first draft of the MDS.

The second stage of MDS development focused on the formation of a Clinical Consultant Panel and a National Advisory Committee of professionals from a spectrum of disciplines, including: nursing; social work; medicine; physical, occupational, and speech therapy; pharmacy; and nutrition. We also included resident advocates, individual nursing facility providers, nursing facility industry representatives, regulators, and statistical experts in these deliberations.

Based on the suggestions of these expert consultants, HCFA's contractors prepared and circulated for comment 38 drafts of the MDS to various provider groups, consumer organizations, professional associations, and State government representatives, over a 6-month period. We received comment from approximately 90 organizations and 200 individuals. This developmental process resulted in an MDS suitable for field testing.

The goal of field testing was to produce an MDS with elements having both high inter-rater reliability and clinical utility. The first field test of the MDS occurred in 10 nursing facilities in North Carolina and Massachusetts in May–June 1989. HCFA contractors analyzed the use of the MDS for 383 nursing facility residents in these 10 facilities.

This field trial of the MDS provided objective evidence for retaining, modifying, or dropping proposed MDS items. We concluded from our analysis of this field test that 39 percent of the items were reliable and should be retained in their tested form; 40 percent required some modification and additional testing; and 21 percent of items were dropped. After sharing these findings with the Clinical Consultant Panel and the National Advisory Committee, HCFA's contractors produced a revised MDS.

We subjected this revised MDS to additional field testing with 123 residents in 15 nursing facilities in North Carolina, Massachusetts, Ohio, Minnesota, and Connecticut from December 1989–February 1990. The result of this research and testing is the MDS at the proposed § 483.315(b)(1). It consists of the following information:

- Identification and background information;
- Cognitive patterns;
- Communication/hearing patterns;
- Vision patterns;
- Physical functioning and structural problems;
- Continence in last 14 days;
- Psychosocial well-being;
- Mood and behavior patterns;
- Activity pursuit patterns;
- Disease diagnoses;
- Health conditions;
- Oral/nutritional status;
- Oral/dental status;
- Skin condition;
- Medication use; and
- Special treatment and procedures.

In addition to conducting additional reliability testing of MDS elements, this second field test used MDS items to construct valid "resident assessment protocols." Despite extensive review and consultation with a clear attempt to reduce the number of data elements in the MDS, we encourage comment on whether there may be still more items that are valuable for care planning purposes.

B. Resident Assessment Protocols

In the Appendix, we set forth proposed resident assessment protocols (RAPs). We are using the term "resident assessment protocols" to refer to structured frameworks for organizing MDS elements and gathering additional clinically relevant information about an individual that contributes to care planning.

Although a required part of the proposed RAI at § 483.315(b)(2), the RAPS would not be listed in the regulations text because we believe that, to be truly responsive to the needs of the health care community, the RAPS should be flexible and easy to change and update without the necessity of revising the CFR each time. In addition, States have the option of using the RAPS developed by HCFA in specifying an RAI, or developing their own frameworks for additional assessment, as long as they meet the HCFA criteria for approval at the proposed § 483.315(c)(2). Although the RAPS in the Appendix are not part of the regulations text, we encourage public comment on their usefulness.

The proposed RAPS would require facility staff to make a structured review of MDS elements and additional clinical items to identify resident problems, complicating conditions, and risk factors around which a multi-dimensional view of the resident's unique physical, mental, and psychosocial status can be constructed. At the proposed § 483.315(b), we would require that, in order to receive Secretarial approval, a State's alternate RAI must include triggers and frameworks for additional assessment.

A critical part of the RAI is the "trigger." Triggers are specific MDS elements that prompt additional assessment using the RAPS. HCFA's proposed RAI includes 18 RAPS. These RAPS would cover the following care areas that collectively address the comprehensive assessment and quality of care requirements currently at § 483.20(b)(2)(i) through (xiii) and at paragraphs (a) through (1) of § 483.25 ("Level A requirement: Quality of care."):

- Delirium;
- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living and functional rehabilitation potential;
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being;
- Mood state;
- Behavior problems;
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

An example of how RAPs are triggered would be that a psychosocial well-being problem would be suggested if any of the following is checked on the MDS form:

- G2a ("Covert/open conflict with and/or repeated criticism of staff").
- G2b ("Unhappy with roommate").
- G2c ("Unhappy with residents other than roommate").
- G2d ("Openly expresses conflict/anger with family or friends").
- G3b ("Expresses sadness/anger/empty feeling over lost roles/status").

Besides assessing the reliability of all MDS items, HCFA's contractors tested the validity of the RAPs during field tests that were completed in June 1990.

The results of these field tests indicate that HCFA's proposed RAI, composed of the MDS and RAPs, is a feasible system for use by long term care facilities to collect resident information for the development of appropriate plans of care for nursing facility residents. Detailed reports of the field test findings can be obtained from the HCFA contact person listed in this preamble.

RAPs are not intended to prescribe clinical courses of action or to usurp appropriate professional judgment. We include RAPs as part of the RAI to provide frameworks for additional assessment if the MDS indicates that it

may be warranted. RAPs complement the MDS to ensure a comprehensive, accurate, reproducible assessment of individualized resident needs for use in care planning.

Each of the 18 RAPs proposed in the Appendix organizes a systematic approach for evaluating targeted clinical information to assist facility staff in thinking about care planning and treatment decisions. For a given resident, we propose that facility staff use only those RAPs triggered by specific MDS elements or additional clinical items. The RAP Trigger Legend in the Appendix summarizes the relationship between MDS items that serve as triggers and RAPs.

Because RAPs build on MDS items, we suggest strongly that the facility delegate completion of a particular RAP to the most knowledgeable facility staff who can address that care area, whether it be nursing personnel, therapists, social workers, activity specialists, or physicians. Whenever possible, it is desirable that the person who gathered information for the MDS triggered item(s), complete the RAP associated with those triggers.

The RAP Summary in the HCFA RAI which appears in the Appendix is one means by which the long term care facility can document the care planning decision resulting from applying relevant RAPs. At the proposed § 483.315(c)(2), we would state that an alternate resident assessment instrument must include structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning. The State is not required to use the term "RAP" in an alternate instrument, and a State's protocols may include all, some, or none of the same RAPs contained in HCFA's RAI. States must, however, specify a standardized format for documentation of information obtained from additional assessment and care-planning decisions.

We expect that the use of the MDS and RAPs would ultimately reduce the amount of time required to complete the assessment, including the paperwork associated with assessment and care planning practices and related requirements. The RAI process would minimize duplication of effort by various disciplines involved in evaluating a resident by providing a standard core of information as well as a centralized location for assessment data. The standardized documentation process would also minimize the time necessary to retrieve information from the clinical record as well as allow various disciplines to access relevant information now compiled in a central source. We believe that the efficiency of the RAI will be even more obvious after the MDS is computerized.

C. Long Term Care Facility Requirements

1. Frequency of Assessments

As required by sections 4008(h)(2)(C) and 4801(e)(3) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508), the current § 483.20(b)(4) requires long term care facilities to assess a resident—

- No later than 14 days after admission;
- No later than October 1, 1991 for current Medicaid residents;
- No later than January 1, 1991 for current Medicare residents;
- Promptly after a significant change in the resident's physical or mental condition; and
- In no case, less often than once every 12 months.

These requirements pertain to completion of the comprehensive assessment, which consists of the MDS, triggers and RAPs in HCFA's RAI.

We would delete the current § 483.20(b)(3), which is reserved, and redesignate the current § 483.20(b)(4) as § 483.20(b)(2). (We would delete the current § 483.20(b)(2), because the 13 elements it lists would be included in the 16 MDS items and the other RAI data required at § 483.315(b).) We would then revise the newly redesignated § 483.20(b)(2) to state that, while each facility must conduct an admission assessment when a resident is first admitted, it need not conduct one if the resident is readmitted unless the resident has experienced a significant change in status. A readmission is a return to the facility following a temporary absence for hospitalization or for therapeutic leave. If a significant change in status has occurred, we propose that long term care facilities apply the procedures for conducting an assessment after a significant change in status.

To initiate care planning, the long term care facility must collect as much information as possible for the MDS elements and any additional data elements found in an approved State RAI within 14 days after admission.

We realize that rigid enforcement of the current requirement at § 483.20(b)(4)(i) that assessments be conducted no later than 14 days after admission from individuals admitted on or after October 1, 1990 may mean that the clinical status of a newly admitted resident may affect the validity and reliability of some MDS elements, and thus their clinical utility for care planning purposes. Therefore, at the proposed § 483.20(b)(2)(i) (A) through (C), we would set forth circumstances under which a long term care facility may amend the MDS information collected during the 14 days post-admission period up until the 21st day after admission. These are situations when—

- All information necessary for performing the assessment is not available during the 14-day post-admission period but can be obtained afterward;
- Further observation and interaction with the resident reveals the need to alter the initial assessments in any of the following MDS domains: cognitive patterns, communication patterns, potential for self-care improvement/rehabilitation, psychosocial well-being, mood and behavior patterns, nutritional status, and activity pursuit patterns; and
- The resident's condition is unstable upon admission because he or she is experiencing an acute illness or flare-up of a chronic problem and the acute illness or chronic problem is controlled by the 21st day.

The proposed definition of "significant change" in § 483.20(b)(2)(iv) is particularly important because of the impact it can have on the use of long term care facility resources, particularly nursing staff. Defining "significant change" too broadly can lead staff to perform excessive assessments. The additional information about the resident gained from these assessments may not materially enhance care planning or treatment. Conversely, defining "significant change" too narrowly can contribute to staff not paying sufficient and timely attention to resident changes in physical and cognitive functioning. Not reassessing residents under such circumstances can contribute directly to increasing the rate of functional and cognitive decline among residents.

At § 483.20(b)(2)(iv), we would state that a significant change is one or more of the following:

- Apparent permanent deterioration or improvement in two or more activities of daily living, communication, and/or cognitive abilities, or any combination of deterioration in two or more areas that appears to be permanent;
- Non-reversible loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself;
- Deterioration in behavior, mood, or relationships that requires staff intervention;

• Deterioration in a resident's health status when this places the resident's life in danger;

• A factor associated with a serious clinical complication that has not responded to treatment;

• A new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;

• A marked and sudden improvement in the resident's status.

Examples of changes in a resident's condition that are probably transitory and therefore not significant include:

• Anticipated, easily reversible side effects of psychotropic medication while attempting to establish a clinically effective dose level;

• Short-term acute illness or episodic event such as a mild fever secondary to a cold from which facility staff expect full recovery of the resident's pre-morbid functional abilities and health status;

• Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions such as depressive symptoms in a resident previously diagnosed with bipolar disease when an appropriate course of treatment is in progress; or

• The resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.

At § 483.20(b)(2)(iv), we propose that within 14 calendar days after the facility determines or should have determined that the resident's change in status is likely to be permanent, staff must complete a full comprehensive assessment within 14 days of this determination.

To minimize the burden on facility staff in collecting MDS information, we propose in the MDS instructions in the Appendix that if the long term care facility has already completed and posted Sections I and III ("Identification Information" and "Customary Routine" respectively) of the MDS found at § 483.315(b)(1) to the resident's record, then the long term care facility need not collect this information upon a return stay or readmission.

The current § 483.20(b)(5) requires that facilities must examine each resident quarterly and that the resident's assessments be revised as necessary to assure accuracy. At the proposed § 483.20(b)(3), we would be more specific, stating that the following core MDS elements be a part of that quarterly review, with the resident's status for each of these items noted in the resident's record:

• Section B: Cognitive patterns.

—Item 2 (Memory); and

—Item 4 (Cognitive skills for daily decisionmaking).

• Section C: Communication/hearing patterns.

—Item 4 (Making self understood); and

—Item 5 (Ability to understand others).

• Section E: Physical functioning and structural problems.

—Item 1b–f (activity of daily living self-performance); and

—Item 3a (Bathing).

• Section F: Continence in last 14 days.

—Item 1 (Continence self-control categories).

• Section H: Mood and behavior patterns.

—Item 2 (Mood persistence); and

—Item 3 (Problem behavior).

• N Section J: Disease diagnoses. Note only those diseases diagnosed in the last 90 days that have a relationship to current activity of daily living status, behavior status, medical treatments, or risk of death.

• N Section L: Oral/nutritional status. Item 2c (Weight loss).

• N Section O: Medication use. Item 4 (Days received the following medication).

• N Section P: Special treatment and procedures.

—Item 3b (Trunk restraint); and

—Item 3d (Chair prevents rising).

We would state at § 483.20(b)(3) that the assessment and plan of care must be revised if indicated by the quarterly review.

2. Use of Assessments

At the proposed § 483.20(b)(4), we would require facilities to maintain all resident assessments completed within the most recent 2-year period in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. This would include assessments, quarterly reviews and RAP summaries. This differs from the current requirement for use of assessments at § 483.20(b)(6) only in that it would set a specific 2-year time frame. We believe that having up to 2 years of assessment information in the active record would aid nursing facility staff in closely monitoring resident changes in functional and cognitive status.

3. Development of a National Resident Assessment System of Records

We propose as a requirement of participation at § 483.20(b)(6) that long term care facilities encode the MDS in a machine-readable form, and be capable of routinely reporting this information to a system of records maintained by HCFA and/or States beginning October 1, 1994. We will collect MDS data only, and believe that the development of an information system containing MDS data on all nursing home residents across the nation has many uses. These uses are:

• Facility Management. The requirement to computerize the MDS and report this information to a national data base would foster the growth of more sophisticated management information systems in long term care facilities. The information potential that lies in resident assessment data can be expected to lead to ways in which long term care facilities can use these data to improve the cost-effectiveness of services delivery.

• Identification of Effective Care Patterns. Computerized resident assessment data would be a valuable resource to monitor trends in the nursing home industry. As with data developed for the hospital industry, such as the Uniform Hospital Discharge Data Survey, the national resident assessment database would provide important insights into the structure of the industry and use of resources. When linked with information about long term care facilities collected routinely by States during the annual certification survey and entered into HCFA's OSCAR (Online Survey Certification and Reporting) system, computerized assessment data would be used rigorously to evaluate policy and program options in long-term care delivery and financing. A national data base provides the foundation for national, regional, interstate, and intrastate analyses. The influence of the following organizational and financing factors on resident outcomes can be examined using resident assessment data:

Payment differentials (case-mix payment);
Staffing patterns (especially nurse staffing);
Organizational structures (for example, swing beds, specialized care units, hospital-based versus freestanding nursing facilities, hospital geriatric evaluation units, and preadmission screening programs); and
Physician participation.

Care-related factors as they influence care outcomes (for example, site of admission), duration of prior hospital stay (adjusted for DRG), and resident's social support network, also can be taken into consideration in assessing policy and program options.

• Quality Monitoring. The quality of service provided in long term care facilities can be more effectively monitored through the survey and certification process with profiles of

both individual residents and facilities. Profiles of individual residents provide capability for targeted reviews, increasing the probability of detecting facility-wide problems. The availability of a comprehensive national database of resident characteristics and services permits development of expected norms from a variety of outcome measures. Individual resident outcomes can be compared with these norms. In the aggregate, facilities can be compared for their prevalence of negative outcomes (for example, pressure sores, restraints, falls, catheters), a comparison that is not meaningful when done at the level of the individual resident.

A computerized database also permits development of longitudinal norms. By linking residents' sequential assessments, norms would be developed for diminution of function and resolution of acute problems. With Medicaid payment policies focusing increasingly on case-mix adjustments, longitudinal resident assessment data could be used to calculate norms for transition probabilities (that is, residents changing from one case-mix group to another). Understanding these transitions would allow for the identification of residents who improve or deteriorate more rapidly than like residents; this would allow a unique approach to identify the effects of both good and poor care.

Achieving the full potential of the resident assessment initiative requires that long term care facilities be capable of storing, retrieving, and routinely reporting the information found in the MDS to the States and HCFA in a machine-readable form. In particular, we request comment on the following issues:

- What specific uses would State agencies have for these data? Should States accumulate and maintain their own data sets? This is particularly important when States use MDS information for the survey and certification process, and as the basis for nursing facility case-mix classification payment systems.
- What advantages or disadvantages do States see in collecting and/or reporting to HCFA MDS data for 100 percent of the facilities versus a sample of the facilities?
- Would reports on HCFA national data bases provide useful information to States for making comparisons for management, performance, measurements, and research purposes?
- How should MDS data flow from the facilities to HCFA? To the States? With assessments occurring on a resident-centered schedule (that is, on admission and on anniversaries thereafter, and "on significant change in a resident's status"), on what schedule should facilities be responsible for submitting MDS data?
- What auditing procedures should be developed to ensure accuracy of the information entered into the national data base? For example, facilities would be required to submit data in a State specified format (in States specifying an RAI other than the HCFA designated RAI). How should States certify the format and validity of data from individual facilities? What data verification procedures should be required by facilities before submitting data (for example, double entry)?
- What privacy and confidentiality concerns surround use of the data base? For example, who should have routine access?
- How timely would the data that is to be maintained be?
- If facilities computerize their records, what requirement would remain for a hard copy of the MDS in the residents' records? Once the MDS is completed and entered into the data system, what edits of it should be permitted without requiring the facility to produce a new electronic record or hard copy for the resident? What should be the facility's responsibility to maintain invalidated records (both electronic and hard copies)?
- How and to what extent should we standardize electronic formats? How can we assure that these formats are reviewed on an ongoing basis and revised to be consistent with technological changes?

4. Accuracy of Assessments

- The current § 483.20(c)(3) states that, effective October 1, 1990, an individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties. We would add a sentence to § 483.20(c)(3) to clarify that clinical disagreement does not constitute a material and false statement.

5. Guidelines for Using the Resident Assessment Instrument

Field tests have demonstrated that it is essential that long term care facilities observe and communicate directly with the resident to accurately complete a comprehensive assessment. In the utilization guidelines proposed in the Appendix, we discuss how long term care facilities should use a variety of information sources to complete the assessment including—

- A discussion of resident performance levels with nurse aides and assistants on all shifts;
- A discussion of the resident's status with an attending physician;
- A discussion of the resident's status with family members;
- A discussion of the resident's status with appropriate licensed health professionals who have observed, evaluated, or treated the resident; and
- The resident's records, including the admission record, medical plan of care, resident plan of care, documentation of services provided to the resident, reports of any diagnostic testing, consultation, or other services, medication administration record, copies of any transfer data provided to another health care facility, and summaries of previous discharges.

D. State Requirements for Resident Assessment

Sections 1819(e)(5) and 1919(e)(5) of the Act require each State to specify an RAI for use in the long term care facilities that are located in that State and that participate in the Medicare and Medicaid programs. We would state this in the introductory text at § 483.315 ("Specification of resident assessment instrument") and also would specify that the State has the option of using the RAI designated by HCFA, which is comprised of the proposed MDS at § 483.315(b)(1), the proposed 18 RAPS that appear in the Appendix of this document as well as in II.B. of this preamble, and the requirements for use of the RAI at the proposed § 483.20. We also would propose that, if it chooses, the State may specify an alternate instrument. An alternate instrument must be approved by the Secretary, using the criteria at § 483.315(c).

At § 483.315(a), we would set forth the following State responsibilities in specifying an RAI:

- Within 30 days of notification from HCFA of the HCFA-designated RAI or changes to it, the State would be required to specify the HCFA-designated RAI or notify HCFA of its intent to specify an alternate instrument.
- After specifying an instrument, the State would be required to assure facility implementation by providing the necessary technical direction and training to facilities.
- States would have a 4-month period in which to work with HCFA to secure approval of an alternate instrument. If after 4 months the State has failed to meet the criteria for approval of an alternate instrument, it would be required to specify the HCFA-designated instrument.

• Within 30 days of receiving HCFA approval of an alternate RAI, the State would be required to specify the RAI for use by all Medicare and Medicaid long term care facilities. HCFA approval of an alternate RAI would continue for a period of 2 years, after which it must be renewed.

• A State would be required to request and receive approval from HCFA before modifying its RAI. Amendments requiring HCFA reapproval include adding or reordering core MDS assessment items, adding new RAPs or combining care areas under a single RAP, or adding triggers that would require additional assessment. If a State specifies the HCFA-designated RAI, it must adopt revisions as HCFA issues them.

At § 483.315(b), we would set forth the elements of the HCFA-designated RAI. It would consist of the—

• MDS (§ 483.315(b)(1));
• RAPs (§ 483.315(b)(2)); and
• Requirements for the use of the RAI that appear at § 483.20 (§ 483.315(b)(3)).

At § 483.315(c), we would state that to receive approval, an alternate instrument must contain:

• The MDS at § 483.315(b)(1). All data elements and corresponding coding categories specified in the MDS must be contained in the State's instrument. The State may not alter the MDS definitions or the coding categories used with each MDS element or elements within a section. If proposing to reorder major sections of the MDS or the placement of items within sections, the State must provide a conversion table between its instrument and the MDS, and the data supplied to HCFA from the MDS must be ordered in the same manner as designated in paragraph (b)(1) of this section.

The State may include in its RAI data elements additional to those in the MDS to meet unique operational needs provided there is no conflict with elements included in the MDS.

• Resident Assessment Protocols (RAPS). An alternate RAI must include structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning. The State is not required to use the term "RAP" in an alternate instrument, and a State's protocols may include all, some, or none of the same RAPs contained in HCFA's RAI.

If the State creates alternative RAPs through combining care areas, it must provide a cross-walk chart from its RAPs to the care areas listed below.

The RAI must include assessment triggers, based on MDS elements or other information requirements, that screen which residents are subject to additional assessment. If States select alternative triggers or information requirements, they must provide supporting documentation for their decisions. This documentation may take the form of citations from the professional medical journals or reports, results of field testing, or the consensus of experts that the State uses to assist in designing these RAPs.

States must also specify a standardized format similar to the RAP summary form that long term care facilities will use to document information derived from RAPs about the nature of problems, complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems. There must be provision for identification of the location of the assessment results and for certification of completion and accuracy.

An alternate RAI must provide frameworks for comprehensive assessment in the following care areas:

• Cognitive loss/dementia;
• Visual function;
• Communication;
• Activities of daily living functional potential;
• Rehabilitation potential (combined with the activities of daily living in the HCFA-designated RAPs);
• Urinary incontinence and indwelling catheter;
• Psychosocial well-being (There are three distinct HCFA-designated RAPs that bear on psychosocial functioning: mood, behavior, and delirium);
• Activities;
• Falls;
• Nutritional status;
• Feeding tubes;
• Dehydration/fluid maintenance;
• Dental care;
• Pressure ulcers;
• Psychotropic drug use; and
• Physical restraints.

Our approval of a State's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. Our approval of the RAI does not include attributes related to formatting, for example, print type, color coding, or changes such as printing triggers on the assessment form.

States may allow facilities some flexibility in form design (for example, print type, color, shading, or integrating triggers) or to use a computer-generated printout of the RAI without our approval. However, the State must assure that any RAI form in the resident's record accurately and completely represents the State's RAI as approved by us in accordance with § 483.20(b). That is, the facility must provide an RAI that includes all and only the items on the State RAI with the exact wording and in the same sequence. This applies to either pre-printed forms or computer generated printouts.

E. Changes to the MDS and the RAPs

Sections 4201(c) and 4211(c) of Pub. L. 100–203 require that the Secretary evaluate implementation of the resident assessment process. These evaluations will inform Congress about the strengths and weaknesses of the MDS and resident assessment information as these data relate to resident care planning for long term care facilities.

Because we recognize that clinical advances in the care of residents in long term care facilities should be taken into account in periodic review and revision of the MDS, we encourage public comment on developing a mechanism for advising HCFA on the need and methods to update the RAPs as well as the core elements and common definitions that make up the MDS.

F. Coordination of the Resident Assessment Process with PASARR and Other Assessment Systems

Sections 1819(b)(3)(E) and 1919(b)(3)(E) of the Act require that the resident assessment be coordinated with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort. For example, facilities may permit the State mental health and mental retardation authority to use the annual resident assessment, conducted by the NF, as the basis for their annual PASARR (Preadmission Screening and Annual Resident Review). We are soliciting comments on this and other methods for accomplishing the required coordination. We also invite comment as to how we may ensure that facilities fulfill this requirement and how we can coordinate the annual resident assessment with other assessment protocols, such as home health assessments and hospital discharge assessments.

III. Regulatory Impact Statement

Executive Order 12291 (E.O. 12291) requires us to prepare and publish an initial regulatory impact analysis for any proposed regulation that meets one of the E.O. 12291 criteria for a "major rule"; that is, that would be likely to result in—

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or,

• Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare an initial regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a proposed regulation would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all long term care facilities (Medicare Skilled Nursing Facilities and Medicaid Nursing Facilities) and Intermediate Care Facilities to be small entities. Individuals and States are not included in the definition of a small entity.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital which is located outside a Metropolitan Statistical Area and has fewer then 50 beds.

We are not preparing a rural impact statement since we have determined, and the Secretary certifies that this proposed rule would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

This proposed rule reflects the requirements of section 4012(d)(1)(A) of Public Law 100–203 regarding IoC and sections 4201(a)(3) and 4211(a)(3) of Public Law 100–203 regarding resident assessments in long term care facilities. Because long term care facilities may perceive these regulations as having greater economic impact than we anticipate, we are preparing the following voluntary analysis which conforms to the requirements of E.O. 12291 and the RFA.

We expect that the net effect of the proposed revisions regarding IoC would be to reduce State agency costs since State agencies would no longer be required to compile and submit quarterly showings for SNFs and ICFs that are not ICF/MRs once the State has specified its RAI. IoC reviews in SNFs and ICFs would then be combined with survey and certification reviews. Although these reviews would be conducted on a sample basis rather than a complete review of all Medicaid residents, the reviews would be more comprehensive. Thus, we estimate that the time required would be nearly the same. Therefore, we believe these provisions regarding IoC will not have a significant economic impact.

The statute requires the Secretary to specify an MDS of common elements and definitions and utilization guidelines for use by long term care facilities in conducting resident assessments of Medicare and Medicaid beneficiaries and to designate one or more RAIs for use by the States.

The MDS and the RAI were developed to comply with the resident assessment provisions of Public Law 100–203. The resident assessment process is used to evaluate needs for care and provides a foundation for the development of the plan of care.

The use of the MDS as the core of the comprehensive assessment requirement will improve the quality of long term care facility services by assuring that the assessment is consistently based on all information that is necessary to evaluate a resident's needs. Accurate and comprehensive resident assessments can improve the accuracy of the care planning process and ultimately, the care provided.

Through a contract with Research Triangle Institute (RTI), the MDS was field tested in over 30 long term care facilities in five States to assure that it is practical and effective. According to a RTI's "Report on the Small Scale Trial of the Minimum Data Set for Resident Assessment and Care Screening (MDS)" dated January 15, 1990, nurses participating in the field test averaged approximately 90 minutes to complete the MDS once they became familiar with it. Most facilities currently perform an assessment of the residents' needs for care-planning purposes and will be required to perform a comprehensive assessment at 42 CFR 483.20, effective October 1, 1990. RTI estimates that, based on limited field tests, the MDS may add 30 minutes to what long term care facilities currently spend for initial assessments of newly admitted residents.

Additionally, it is estimated that requirements to perform assessments on a quarterly basis and on a significant change in the resident's status may add up to a net increase of 10 minutes per assessment. On an average, this may add as much as 60 minutes per year per resident for those residents who are in facilities for a full year. Annual reassessments are estimated to result in no net increase since they should be offset by what facilities are currently doing.

Most of the nurse assessors participating in RTI field tests felt that the MDS definitions were "somewhat similar" to the definitions used in their facilities' current assessment process. They also believed that the "MDS definitions were more comprehensive" as well as "more resident focused". Most nurses felt that the time spent completing the MDS was worthwhile.

The RAPs referred to in Section II.B. of the preamble and identified in the Appendix were piloted in trials involving 400 long term care facility residents. In a May 21, 1990 memorandum, RTI stated that "The RAPs help focus problem identification and structure the review of assessment information—prior to care planning." RIT reported an average of 5 minutes per resident was required to identify which RAPs were triggered by the MDS, with an average of seven RAPs triggered per resident. If the MDS/RAI were computerized, even less time would be required to identify residents whose conditions would trigger RAPs.

It is not possible to estimate the average amount of time required to complete the RAPs because of the diversity in the clinical conditions of residents and differences in the amount of time required to complete various RAPs. Resources required to utilize the RAPs will vary widely depending on the complexity of the resident's status and clinical problems.

Additionally, there is no requirement for facilities to use the RAPs contained in the RAI designated by the Secretary. Rather, facilities are required to use the frameworks for additional assessment contained in the RAI specified by the State. States may choose to use all, some or none of the RAPs proposed in the appendix as long as the State's RAI includes frameworks for additional assessment and meets the criteria used by HCFA to grand approval of an alternate instrument. Because of this lack of uniformity, it is not possible to determine the actual amount of time needed to complete the alternative RAPs developed by the States or estimate the average number of State-developed alternative RAPs that would be triggered by a resident's condition.

We would require long term care facilities to computerize the MDS by October 1, 1994, to support MDS reporting requirements. Computerized resident assessment data would provide a valuable resource for both the clinical staff and administrators of long-term care facilities. Data could be used by

facilities to monitor an individual resident's progress as well as to identify facility-level trends or problems. Information could also be compiled to generate administrative reports to identify management concerns or to assist in meeting other regulatory requirements.

The requirement to report MDS information to a national data base will foster the growth of more sophisticated management information systems in long term care facilities. The information potential that lies in a resident assessment data base can be expected to lead to improvements in clinical and operational management for long term care facilities.

We anticipate that some additional cost will result from computerizing the MDS. (Depending on the policies of HCFA and State Medicaid agencies, these costs could be reimbursed as either operating costs or capital costs or both.)

Many issues surrounding computerization of the MDS, such as facility requirements regarding the frequency and process for transmission of data, have not yet been determined. However, it is possible to estimate the order of magnitude of facility costs by looking at the types of equipment and tasks that would be necessary. They include:

- Hardware: We estimate hardware costs to be under $2000 per facility (based on an IBM-compatible 8086-based microcomputer with 640K memory, 20Mb hard disk, monochrome monitor and dot-matrix printer). Larger facilities (100 or more beds) may desire a faster or more sophisticated machine at approximately $500 more. Facilities may also need a modem for telecommunication of data, at approximately $250.
- Software: Small facilities (under 100 beds) desiring to meet only the requirement for data submission could use a simplistic software package; in theory, even a word processing package (available for less than $100) could be used to meet the requirement. However, it is anticipated that virtually all facilities will choose more capable programs, some of which could be used to meet other clinical or operational needs (that is, care planning, order entry, quality assurance, billing) or other regulatory requirements for reporting of resident information. We estimate that such packages will be available on the market for approximately $200–300 in large volume; in smaller volumes the costs would rise to approximately $500.
- Supplies and maintenance of equipment: We estimate the cost of supplies necessary for collection and transmission of data (that is, diskettes or computer paper) to be less than $200 per year. Some costs would also be associated with the maintenance of computer equipment, such as the replacement of disk drives or memory chips. If hardware is amortized over a relatively short period of time (that is, three years), then the additional costs of maintenance should be low; we estimate no more than $200–300 per year.
- Training: Training of personnel would be required, with approximately four hours of training estimated based on preliminary experiences with the system in Wisconsin. We estimate a one time cost of approximately $60 of paid staff time for training of clinical staff members inputting MDS data; the cost would be less to train clerical staff members. The cost of travel to a training center would need to be added, though we anticipate that training would be provided in multiple sites around a State once the system is implemented. Using the experience of New York in implementing a resident assessment system for case-mix reimbursement, a maximum of two data entry persons would be sufficient for facilities of up to 100 beds. We estimate initial costs for training to be approximately $120 plus travel for a 100 bed facility. Turnover of trained staff would require additional expenditures over time.
- Data entry: Facilities would have flexibility in the method used to input data. Data could be entered directly by a clinical staff member (that is, the nurse responsible for coordinating or completing the assessment), from a hard copy of a completed MDS by a clerical staff member, or by a keypunch operator the facility may contract with to key in the data. With entry of an MDS requiring approximately 347 keystrokes, we estimate that keypunch operators would require approximately 15 minutes to enter each MDS; less skilled personnel (that is, other than keypunch operators) may require approximately one-half hour. Circumstances under which facilities will collect and may be required to transmit MDS data include the admission assessment and annual updates as well as on "significant change" in the resident's status. Additionally, time would be required for data validation and preparation of data for transmission. Based on our previous estimate of 2.3 MDSs per bed (annual plus "significant change") per year, we estimate total operational costs for facility staff to input data for a 100-bed facility to be approximately $3450 per year (based on 230 hours). We estimate the cost of contracting with a commercial service to input data to be approximately $1125 per year, based on an hourly rate of $15. However, this underrepresents actual facility costs, as a substantial amount of facility staff time would be required to prepare the MDS forms for data entry and validate the key punched data.

We have based these estimates on outside ranges (that is, the maximum number of keystrokes needed to input the initial and subsequent assessments as well as to perform data validation). Consequently, we believe the costs to facilities to input data may be lower in actual practice.

Our estimates reflect the costs associated with computerization of the MDS only. No data entry would be required for quarterly reviews of the MDS or completion of the RAPs.

The foregoing preliminary estimates may actually overstate anticipated costs because they do not take into account cost-savings achieved improving long term care facilities' management information systems and data bases. Assessment data may be used by facilities for diverse purposes such as facility monitoring or to project staffing requirements. In addition, in many long term care facilities computers and computer programs already exist that can accommodate the necessary changes with little added cost. Further, long term care facilities will be compensated for a portion of the costs of maintaining and transmitting the MDS through payment mechanisms in accordance with sections 1861(v)(1) and 1902(a)(13) of the Act.

In conclusion, while we believe that long term care facilities would bear some incremental costs associated with this proposal, we believe that the costs would be insignificant when compared to the anticipated increased quality of care for long term care facility residents as well as the potential uses of the mechanized data by the facilities. We expect numerous benefits to result from the RAI. Resident outcomes will improve and potential program savings will be realized. Anecdotal reports from a number of facilities indicate that staff are identifying resident care problems with the RAI of which they had been unaware previously. Examples of these problems include delirium, mood state disorders, dehydration, rehabilitation potential related to incontinence, and risk of falling. Preliminary results from our evaluation indicate the RAI is able to improve the facility's ability to evaluate problems that would have been identified previously only with an indepth specialty evaluation. For example, research nurse assessors using the RAI were able to identify residents with potentially curable causes of

incontinence. These causes of incontinence had been missed earlier by the facility unless the resident underwent an evaluation by a urologist or other specialist dealing with incontinence.

Use of the RAI would also reduce the likelihood of inappropriate decline in a resident's status. Our utilization guidelines require that the resident be examined, using a subset of MDS items, at least quarterly and that a resident who experiences a significant change in status receive a comprehensive assessment within 14 days. Early assessment would allow facilities to identify problems and implement appropriate interventions before the condition of the resident declines precipitously. Early assessment may result in a savings to Medicare Part A in terms of decreased hospitalizations. Additionally, early assessment of the causes of a functional decline would enable facilities to intervene early in the decline cycle, thereby minimizing poor outcomes and the need for extensive diagnostic testing conducted outside the facility.

Comprehensive assessment using the RAI would assist facilities in their efforts to help residents achieve the highest practicable levels of physical, mental and psychosocial well-being. Studies and anecdotal reports indicate that increasing the independence of residents results in decreased demands on staff and material resources. Various RAPs promote the concept of the highest practicable level of well-being by challenging staff to identify resident strengths and implement interventions to assist residents to reach their full potential (for example, increasing a resident's ability to ambulate is inherent in the ADL Rehabilitation, Physical Restraints, and Falls RAPs.) By improving resident outcomes and preventing problems from developing, we believe that the RAI has tremendous potential to decrease costs associated with reversible causes of incontinence, fractures related to falls, and the treatment of pressure ulcers.

In that this discussion of costs is not conclusive, we encourage comments and any applicable data describing Federal, State, and facility costs, as well as benefits to residents and potential program savings. Further, as stated in part II.C. of this preamble, the Secretary of HHS is required to report to Congress by January 1, 1992, for Medicare, and January 1, 1993, for Medicaid, the overall effects of the resident assessment process, including estimated costs of resident assessment on the operation of long term care facilities throughout the country.

IV. Information Collection Requirements

Sections 4204(b) and 4214(d) of Public Law 100–203 provide a waiver of paperwork reduction review, specifying that Chapter 35 of title 44 U.S.C. "shall not apply to information required for purposes of carrying out this part and implementing the amendments made by this part."

V. Response to Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, we will consider all comments that we receive by the date and time specified in the "Date" section of this preamble, and, if we proceed with a final rule, we will respond to the comments in the preamble of that rule.

List of Subjects

42 CFR Part 456

Administrative practice and procedure, Grant programs-health, Health facilities, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

For the reasons set forth in the preamble, 42 CFR parts 456 and 483 would be amended as follows:

A. Part 456 is amended to read as follows:

PART 456—UTILIZATION CONTROL [AMENDED]

2. The authority citation for part 456 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

3. In § 456.1(b), the introductory text is republished and paragraph (b)(5) and Table 1 are revised to read as follows:

§ 456.1 Basis and purpose of part.

* * * * *

(b) The requirements in this part are based on the following sections of the Act. Table 1 shows the relationship between these sections of the Act and the requirements in this part.

* * * * *

(5) *Inspection of care and services in institutions.* Sections 1902(a)(26) (B) and (C) and 1902(a)(31) (B) and (C) require that the plan provide for periodic inspections and reports, by a team of professional persons, of the care being provided to each recipient in mental hospitals, psychiatric facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) participating in Medicaid.

* * * * *

Table 1

[This table relates the regulations in this part to the sections of the Act on which they are based.]

Subpart A—General	1902(a)(30) 1902(a)(33)(A)
Subpart B—Utilization Control: All Medicaid Services	1902(a)(30)
Subpart C—Utilization Control:	
Hospitals—	
Certification of need for care	1903(g)(1)(A)
Plan of care	1903(g)(1)(B)
Utilization review plan (including admission review)	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
Subpart D—Utilization Control: Mental Hospitals—	
Certification of need for care	1903(g)(1)(A)
Medical evaluation and admission review	1902(a)(26)(A) 1903(g)(1)(C)
Plan of care	1902(a)(26)(A) 1903(g)(1)(B)

Table 1—Continued

[This table relates the regulations in this part to the sections of the Act on which they are based.]

Admission and plan of care requirements for individuals under 21	1902(a)(26)(A) 1903(g)(1) (B), (C)
Utilization review plan	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
Subpart E—Utilization Control: Skilled Nursing Facilities—	
Certification of need for care	1903(g)(1)(A
Medical evaluation and admission review	1902(a)(26)(A) 1903(g)(1)(C)
Plan of care	1902(a)(26)(A) 1903(g)(1)(B)
Utilization review plan	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
Discharge plan	1902(a)(30)
Subpart F—Utilization Control: Intermediate Care Facilities—	
Certification of need for care	1903(g)(1)(A)
Medical evaluation and admission review	1902(a)(31)(A) 1903(g)(1)(C)
Plan of care	1902(a)(31)(A) 1903(g)(1)(B)
Utilization review plan	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
Subpart G—Inpatient Psychiatric Services for Individuals Under Age 21: Admission and Plan of Care Requirements	1905 (a)(16) and (h)
Subpart H—Utilization Review Plans: FFP, Waivers, and Variances for Hospitals, Mental Hospitals and Skilled Nursing Facilities.	1902(a)(30) 903(i)(4)
Subpart I—Inspections of Care in Intermediate Care Facilities for the Mentally Retarded, Psychiatric Facilities, and Mental Hospitals.	1902(a)(26) (B), (C), (31)(B), (C) 1903(g)(1)

4. The heading of subpart I is revised to read as follows:

Subpart I—Inspections of Care in Intermediate Care Facilities for the Mentally Retarded, Psychiatric Facilities, and Mental Hospitals

5. Section 456.600 is revised to read as follows:

§ 456.600 Purpose.

This subpart prescribes requirements for periodic inspections of care and services in intermediate care facilities for the mentally retarded (ICFs/MR), psychiatric facilities, and mental hospitals.

6. Section 456.601 is revised to read as follows:

§ 456.601 Definitions.

For purposes of this subpart—

Facility means a mental hospital, psychiatric facility, or an intermediate care facility for the mentally retarded.

Intermediate care facility for the mentally retarded means institutions for the mentally retarded or persons with related conditions but excludes Christian Science sanatoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

Mental hospital means that it primarily cares for patients with psychiatric diagnoses.

Psychiatric facility includes a facility or program that provides inpatient psychiatric services for individuals under 21, as specified in § 441.151 of this chapter, but does not include psychiatric wards in acute care hospitals.

7. In § 456.602, paragraph (c) is revised, paragraphs (d) and (f) are removed, and paragraphs (e), (g), and (h) are redesignated as paragraphs (d), (e), and (f), respectively, to read as follows:

§ 456.602 Inspection team.

* * * * *

(c) For a mental hospital or psychiatric facility, each team must have a psychiatrist or physician knowledgeable about mental institutions and other appropriate mental health and social service personnel.

* * * * *

8. Section 456.603 is revised to read as follows:

§ 456.603 Financial interests and employment of team members.

A member of a team that reviews care in a mental hospital, psychiatric facility, or an institution for the mentally retarded or persons with related conditions—

(a) May not have a financial interest in any institution of that same type but may have a financial interest in other facilities or institutions; and

(b) May not review care in an institution where he is employed but may review care in any other facility or institution.

9. Section 456.608 is revised to read as follows:

§ 456.608 Personal contact with and observation of recipients and review of records.

(a) For recipients under age 21 in psychiatric facilities and recipients in ICFs/MR, the team's inspection must include—

(1) Personal contact with and observation of each recipient; and

(2) Review of each recipient's medical record.

(b) For recipients age 65 or older in mental hospitals, the team's inspection must include—

(1) Review of each recipient's medical record; and

(2) If the record does not contain complete reports of periodic assessments required by § 441.102 of this chapter or, if such reports are inadequate, personal contact with and observation of each recipient.

10. Section 456.609 is revised to read as follows:

§ 456.609 Determinations by team.

The team must determine in its inspection whether—

(a) The services available in the facility are adequate to—

(1) Meet the health needs of each recipient,

(2) Promote his maximum physical, mental, and psychosocial functioning.

(b) It is necessary and desirable for the recipient to remain in the facility;

(c) It is feasible to meet the recipient's health needs through alternative institutional or noninstitutional services; and

(d) Each recipient under age 21 in a psychiatric facility and each recipient in an institution for the mentally retarded or persons with related conditions is receiving active treatment as defined in § 441.154 of this chapter.

11. In § 456.610, paragraphs (b) and (e) are revised, paragraph (f) is removed, and paragraphs (g) and (h) are redesignated as paragraphs (f) and (g), respectively, to read as follows:

§ 456.610 Basis for determinations.

* * * * *

(b) The attending physician reviews prescribed medications—

(1) At least every 30 days in psychiatric facilities and mental hospitals; and

(2) At least quarterly in ICFs/MR;

* * * * *

(e) The recipient receives adequate services, based on observations such as the following:

(1) Cleanliness.

(2) Absence of bedsores.

(3) Absence of signs of malnutrition or dehydration.

(4) Apparent maintenance of maximum physical, mental, and psychosocial function.

* * * * *

12. Section 456 .612 is revised to read as follows:

§ 456.612 Copies of reports.

The agency must send a copy of each inspection report to—

(a) The facility inspected;

(b) The facility's utilization review committee;

(c) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid; and

(d) Other State agencies that use the information in the reports to perform their official function, including, if inspection reports concern mental hospitals and psychiatric facilities, the appropriate State mental health authorities.

13. Section 456.651 is revised as follows:

§ 456.651 Definitions.

For purposes of this subpart—

Facility, with respect to inpatient psychiatric services for individuals under 21, includes a psychiatric program as specified in § 441.151 of this chapter.

Level of care means one of the following types of inpatient services: hospital, mental hospital, intermediate care facility for the mentally retarded, or psychiatric services for individuals under 21.

Long-stay services means services provided to a recipient after a total of 60 days of inpatient stay (90 in the case of mental hospital services) during a 12-month period beginning July 1, not counting days of stay paid for wholly or in part by Medicare.

14. In § 456.654, the introductory text in paragraph (a) is republished, and paragraphs (a)(7) and (a)(8) are revised to read as follows:

§ 456.654 Requirements for content of showings and procedures for submittal.

(a) An agency's showing for a quarter must—

* * * * *

(7) For each on-site review in a mental hospital, or intermediate care facility that primarily cares for mental patients, or inpatient psychiatric facility, list the name and qualifications of one team member who is a physician; and

(8) For each on-site review in an intermediate care facility for the mentally retarded that does not primarily care for mental patients, list the name and qualifications of one team member who is either a physician or registered nurse.

* * * * *

B. Part 483 is amended to read as follows:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

1. The authority citation for part 483 continues to read as follows:

Authority: Secs. 1102, 1819(a)–(f), 1861 (j) and (l), 1863, 1871, 1902(a)(28), 1905 (a), (c) and (d), and 1919(a)–(f) of the Social Security Act (42 U.S.C. 1302, 1395i–3(a)–(f), 1395x (j) and (l), 1395hh, 1395z, 1396a(a)(28), and 1396d (c) and (d), and 1396r(a)–(f)), unless otherwise noted.

2. In § 483.20, the section heading and paragraphs (b) and (c) are revised to read as follows:

§ 483.20 Level A requirement: Resident assessment.

* * * * *

(b) *Comprehensive assessments.*

(1) *Resident assessment instrument.* The facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) *When required.*

Comprehensive assessments must be conducted:

(i) Within 14 days after admission, excluding readmissions in which there is not a significant change in the resident's physical or mental condition (A "readmission" is defined as a return to the facility following a temporary absence for hospitalization or for therapeutic leave.). Assessment information may be amended up to 21 days after admission if—

(A) All information necessary for performing the assessment is not available to staff during the initial 14-day period;

(B) Further resident observation and interaction indicates a need to alter the initial assessment of cognitive patterns, communication patterns, potential for self-care improvement/rehabilitation, psychosocial well-being, mood and behavior patterns, nutritional status, and activity pursuit patterns;

(C) The resident's condition is unstable upon admission.

(ii) No later than October 1, 1991 for residents of a nursing facility admitted prior to October 1, 1991.

(iii) No later than January 1, 1991 for residents of a skilled nursing facility admitted prior to January 1, 1991.

(iv) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A significant change is one or more of the following:

(A) Apparent permanent deterioration or improvement in two or more activities of daily living, communication, and/or cognitive abilities; or any combination of deterioration in two or more areas that appears to be permanent.

(B) Non-reversible loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself.

(C) Deterioration in behavior, mood, or relationships that requires staff intervention.

(D) Deterioration in a resident's health status when this places the resident's life in danger.

(E) A factor associated with a serious clinical complication that has not responded to treatment.

(F) A new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time.

(G) A marked and sudden improvement in the resident's status.

(v) No less often than once every 12 months in any case.

(3) *Quarterly Review.* The minimum data set (MDS) is at § 483.315(b)(1) of this chapter. Facilities must examine residents and review the following core MDS elements quarterly and revise the assessment and plan of care if indicated:

(i) Section B: Cognitive patterns.

(A) Item 2 (Memory); and

(B) Item 4 (Cognitive skills for daily decisionmaking).

(ii) Section C: Communication/hearing patterns.

(A) Item 4 (Making self understood); and

(B) Item 5 (Ability to understand others).

(iii) Section E: Physical functioning and structural problems.

(A) Items 1b–f (activity of daily living self-performance); and

(B) Item 3a (Bathing).

(iv) Section F: Continence in last 14 days. Item 1 (Continence self-control categories).

(v) Section H: Mood and behavior patterns.

(A) Item 2 (Mood persistence); and

(B) Item 3 (Problem behavior).

(vi) Section J: Disease diagnoses. Note only those diseases diagnosed in the last 90 days that have a relationship to current activity of daily living status, behavior status, medical treatments, or risk of death.

(vii) Section L: Oral/nutritional status. Item 2c (Weight loss).

(viii) Section O: Medication use. Item 4 (Days received the following medication).

(ix) Section P: Special treatment and procedures.

(A) Item 3b (Trunk restraint); and

(B) Item 3d (Chair prevents rising).

(4) *Use.* The facility must maintain all resident assessments completed within the previous 2 years in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.

(5) *Coordination.* The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(6) *ADP requirement:* Effective October 1, 1994, the facility must:

(i) Encode the information contained in the MDS in a machine-readable (that is, computerized) format. The facility must be capable of computerized retrieval of the information contained in the MDS for the initial comprehensive assessment, annual updates, and information entered because of residents experiencing a "significant change" in status.

(ii) Be capable of routinely transmitting the information required in § 483.315(b)(1) of this chapter in a format and in accordance with particular data screens specified by HCFA or the State to a system of records maintained by HCFA.

(c) *Level B requirement: Accuracy of assessments.*

(1) *Coordination.*

(i) Each assessment must be conducted or coordinated, with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(2) *Certification.* Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(3) *Penalty for falsification.* An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties. Section 1819(b)(3)(B)(ii)(II) of the Act allows for civil penalties of up to $5,000 in some cases. Clinical disagreement does not constitute a material and false statement.

* * * * *

3. New subpart F, consisting of § 483.315, is added to read as follows:

Subpart F—Requirements That Must Be Met by States and State Agencies: Resident Assessment

§ 483.315 Specification of resident assessment instrument.

Sections 1819(e)(5) and 1919(e)(5) of the Act require the State to specify the resident assessment instrument (RAI) to be used by long term care facilities in the State for their use in complying with § 483.20, which requires long term care facilities to conduct initial and periodic assessment of each resident's functional capacity. The RAI may be either the one designated by the Secretary at paragraph (b) of this section or an alternate instrument specified by the State and approved by the Secretary, using the criteria at paragraph (c) of this section.

(a) The State responsibilities in specifying an RAI are as follows:

(1) Within 30 days of notification from HCFA of the HCFA-designated RAI or changes to it, the State must specify the HCFA-designated RAI or notify HCFA of its intent to specify an alternate instrument.

(2) After specifying an instrument, the State must assure facility implementation by providing the necessary technical direction and training to facilities.

(3) States have a 4-month period in which to work with HCFA to secure approval of an alternate instrument. If after 4 months the State has failed to meet the criteria for approval of an alternate instrument at paragraph (c) of this section, it must specify the HCFA-designated instrument.

(4) Within 30 days of receiving HCFA approval of an alternate RAI, the State must specify the RAI for use by all Medicare and Medicaid long term care facilities. Generally, HCFA approval of an alternate RAI continues for a period of 2 years, after which it must be renewed. However, if in the interim HCFA modifies the HCFA designated RAI, paragraph (a)(1) of this section applies.

(5) A State must request and receive approval from HCFA before modifying its RAI. Amendments requiring HCFA reapproval include adding or reordering core MDS assessment items, adding new RAPs or combining care areas under a single RAP, or adding triggers that would require additional assessment. If a State specifies the HCFA-designated RAI, it must adopt revisions as HCFA issues them.

(b) The HCFA-designated RAI consists of the following:

(1) The following uniform minimum data set (MDS):

BILLING CODE 4120-03-M

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
BACKGROUND INFORMATION AT INTAKE/ADMISSION

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	(First) (Middle Initial) (Last)
2.	DATE OF CURRENT ADMISSION	Month — Day — Year
3.	MEDICARE NO. (SOC. SEC. or Comparable No. if no Medicare No.)	
4.	FACILITY PROVIDER NO.	Federal No.
5.	GENDER	1. Male 2. Female
6.	RACE/ ETHNICITY	1. American Indian/Alaska Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
7.	BIRTHDATE	Month — Day — Year
8.	LIFETIME OCCUPATION	
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)* Prior stay at this nursing home — a. Other nursing home/residential facility — b. MH/psychiatric setting — c. MR/DD setting — d. *NONE OF ABOVE* — e.
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to Item 13) — a. MR/DD with Organic Condition Cerebral palsy — b. Down's syndrome — c. Autism — d. Epilepsy — e. Other organic condition related to MR/DD — f. MR/DD with no organic condition — g. Unknown — h.
13.	MARITAL STATUS	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced
14.	ADMITTED FROM	1. Private home or apt. 2. Nursing home 3. Acute care hospital 4. Other
15.	LIVED ALONE	0. No 1. Yes 2. In other facility
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier — a. Observation revealed additional information — b. Resident unstable at admission — c.

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	Month — Day — Year
2.	MARITAL STATUS	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced
3.	ADMITTED FROM	1. Private home or apt. 2. Nursing home 3. Acute care hospital 4. Other
4.	LIVED ALONE	0. No 1. Yes 2. In other facility

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1.	CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)	*(Check all that apply. If all information UNKNOWN, check last box only* CYCLE OF DAILY EVENTS Stays up late at night (e.g., after 9 pm) — a. Naps regularly during day (at least 1 hour) — b. Goes out 1+ days a week — c. Stays busy with hobbies, reading, or fixed daily routine — d. Spends most time alone or watching TV — e. Moves independently indoors (with appliances, if used) — f. *NONE OF ABOVE* — g. EATING PATTERNS Distinct food preferences — h. Eats between meals all or most days — i. Use of alcoholic beverage(s) at least weekly — j. *NONE OF ABOVE* — k. ADL PATTERNS In bedclothes much of day — l. Wakens to toilet all or most nights — m. Has irregular bowel movement pattern — n. Prefers showers for bathing — o. *NONE OF ABOVE* — p. INVOLVEMENT PATTERNS Daily contact with relatives/close friends — q. Usually attends church, temple, synagogue (etc.) — r. Finds strength in faith — s. Daily animal companion/presence — t. Involved in group activities — u. *NONE OF ABOVE* — v. UNKNOWN—Resident/family unable to provide information — w.

END

Signature of RN Assessment Coordinator: _____ Date: _____

Signatures of Others Who Completed Part of the Assessment:

_____ _____ _____ _____

_____ _____ _____ _____

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	ASSESSMENT DATE	Month — Day — Year
2.	RESIDENT NAME	(First) (Middle Initial) (Last)
3.	SOCIAL SECURITY NO.	
4.	MEDICAID NO. (If applicable)	
5.	MEDICAL RECORD NO.	
6.	REASON FOR ASSESSMENT	1. Initial admission assess. 2. Hosp/Medicare reassess. 3. Readmission assessment 4. Annual assessment 5. Significant change in status 6. Other (e.g., UR)
7.	CURRENT PAYMENT SOURCE(S) FOR N.H. STAY	*(Billing Office to indicate; check all that apply)* Medicaid [a.] Medicare [b.] CHAMPUS [c.] VA [d.] Self pay/Private insurance [e.] Other [f.]
8.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* Legal guardian [a.] Other legal oversight [b.] Durable power attrny./ health care proxy [c.] Family member responsible [d.] Resident responsible [e.] *NONE OF ABOVE* [f.]
9.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* Living will [a.] Do not resuscitate [b.] Do not hospitalize [c.] Organ donation [d.] Autopsy request [e.] Feeding restrictions [f.] Medication restrictions [g.] Other treatment restrictions [h.] *NONE OF ABOVE* [i.]
10.	DISCHARGE PLANNED WITHIN 3 MOS.	*(Does not include discharge due to death)* 0. No 1. Yes 2. Unknown/uncertain
11.	PARTICIPATE IN ASSESSMENT	a. Resident 0. No 1. Yes [a.] b. Family 0. No 1. Yes 2. No family [b.]
12.	SIGNATURES AND SECTIONS COMPLETED	Signature of RN Assessment Coordinator _____ Date: _____ Signatures of Others Who Completed Part of the Assessment and Sections Completed

SECTION B. COGNITIVE PATTERNS

1	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes *(Skip to SECTION E)*
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem [a.] b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem [b.]
3.	MEMORY/ RECALL ABILITY	*(Check all that resident normally able to recall during last 7 days)* Current season [a.] Location of own room [b.] Staff names/faces [c.] That he/she is in a nursing home [d.] *NONE OF ABOVE* are recalled [e.]

▨ = Code the appropriate response ☐ = Check all the responses that apply

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4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0. Independent—decisions consistent/reasonable 1. Modified Independence—some difficulty in new situations only 2. Moderately Impaired—decisions poor; cues/supervision required 3. Severely Impaired—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	*(Check if condition over last 7 days appears different from usual functioning)* Less alert, easily distracted [a.] Changing awareness of environment [b.] Episodes of incoherent speech [c.] Periods of motor restlessness or lethargy [d.] Cognitive ability varies over course of day [e.] *NONE OF ABOVE* [f.]
6.	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities in **last 90 days** 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance, if used)* 0. Hears adequately—normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situations only—speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* Hearing aid, present and used [a.] Hearing aid, present and not used [b.] Other receptive comm. techniques used (e.g., lip read) [c.] *NONE OF ABOVE* [d.]
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* Speech [a.] Writing messages to express or clarify needs [b.] Signs/gestures/sounds [c.] Communication board [d.] Other [e.] *NONE OF ABOVE* [f.]
4.	MAKING SELF UNDERSTOOD	*(Express information content—however able)* 0. Understood 1. Usually Understood—difficulty finding words or finishing thoughts 2. Sometimes Understood—ability is limited to making concrete requests 3. Rarely/Never Understood
5.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content—however able)* 0. Understands 1. Usually Understands—may miss some part/intent of message 2. Sometimes Understands—responds adequately to simple, direct communication 3. Rarely/Never Understands
6.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed over **last 90 days** 0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. Adequate—sees fine detail, including regular print in newspapers/books 1. Impaired—sees large print, but not regular print in newspapers/books 2. Highly Impaired—limited vision; not able to see newspaper headlines; appears to follow objects with eyes 3. Severely Impaired—no vision or appears to see only light, colors, or shapes
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) [a.] Experiences any of following: sees halos or rings around lights, sees flashes of light; sees "curtains" over eyes [b.] *NONE OF ABOVE* [c.]
3.	VISUAL APPLIANCES	Glasses; contact lenses; lens implant; magnifying glass 0. No 1. Yes

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE — *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days

2. ADL SUPPORT PROVIDED — *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist

			(1) SELF-PERF.	(2) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCOMOTION	How resident moves between locations in his/her room and adjacent corridor on same floor (IF in wheelchair, self-sufficiency once in chair)		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
3.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. *Code for most dependent in self-performance and support.* Bathing Self-Performance codes appear below)		
		0. Independent—No help provided	a.	b.
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		

4. BODY CONTROL PROBLEMS — *(Check all that apply during last 7 days)*

- Balance—partial or total loss of ability to balance self while standing — a.
- Bedfast all or most of the time — b.
- Contracture to arms, legs, shoulders, or hands — c.
- Hemiplegia/hemiparesis — d.
- Quadriplegia — e.
- Arm—partial or total loss of voluntary movement — f.
- Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) — g.
- Leg—partial or total loss of voluntary movement — h.
- Leg—unsteady gait — i.
- Trunk—partial or total loss of ability to position, balance, or turn body — j.
- Amputation — k.
- *NONE OF ABOVE* — l.

5. MOBILITY APPLIANCES/ DEVICES — *(Check all that apply during last 7 days)*

- Cane/walker — a.
- Brace/prosthesis — b.
- Wheeled self — c.
- Other person wheeled — d.
- Lifted (manually/ mechanically) — e.
- *NONE OF ABOVE* — f.

6. TASK SEGMENTATION — Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them
0. No 1. Yes

7. ADL FUNCTIONAL REHABILITATION POTENTIAL

- Resident believes he/she capable of increased independence in at least some ADLs — a.
- Direct care staff believe resident capable of increased independence in at least some ADLs — b.
- Resident able to perform tasks/activity but is very slow — c.
- Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) — d.
- *NONE OF ABOVE* — e.

8. CHANGE IN ADL FUNCTION — Change in ADL self-performance in last 90 days
0. No change 1. Improved 2. Deteriorated

SECTION F. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL *(Code for resident's performance over all shifts)*

0. *CONTINENT* — Complete control
1. *USUALLY CONTINENT* — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT* — BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT* — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT* — Had inadequate control; BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	INCONTINENCE RELATED TESTING	*(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*	
		Resident has been tested for a urinary tract infection	a.
		Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination	b.
		NONE OF ABOVE	c.
3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan — a.	
		External (condom) catheter — b.	
		Indwelling catheter — c.	
		Intermittent catheter — d.	
		Did not use toilet room/ commode/urinal — e.	
		Pads/briefs used	f.
		Enemas/irrigation	g.
		Ostomy	h.
		NONE OF ABOVE	i.
4.	CHANGE IN URINARY CONTINENCE	Change in urinary continence/appliances or programs in last 90 days 0. No change 1. Improved 2. Deteriorated	

IF RESIDENT IS COMATOSE, SKIP TO SECTION J

SECTION G. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT

- At ease interacting with others — a.
- At ease doing planned or structured activities — b.
- At ease doing self-initiated activities — c.
- Establishes own goals — d.
- Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) — e.
- Accepts invitations into most group activities — f.
- *NONE OF ABOVE* — g.

2. UNSETTLED RELATIONSHIPS

- Overt/open conflict with or repeated criticism of staff — a.
- Unhappy with roommate — b.
- Unhappy with residents other than roommate — c.
- Openly expresses conflict/anger with family or friends — d.
- Absence of personal contact with family/friends — e.
- Recent loss of close family member/friend — f.
- *NONE OF ABOVE* — g.

3. PAST ROLES

- Strong identification with past roles and life status — a.
- Expresses sadness/anger/empty feeling over lost roles/status — b.
- *NONE OF ABOVE* — c.

SECTION H. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		— Tearfulness, emotional groaning, sighing, breathlessness	b.
		— Motor agitation such as pacing, handwringing or picking	c.
		— Failure to eat or take medications, withdrawal from self-care or leisure activities	d.
		— Pervasive concern with health	e.
		— Recurrent thoughts of death—e.g., believes he/she about to die, have a heart attack	f.
		— Suicidal thoughts/actions	g.
		NONE OF ABOVE	h.
2.	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up"	
		0. No 1. Yes	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)*	
		0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	a.
		VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	b.
		PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	c.
		SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	d.
4.	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		NONE OF ABOVE	c.
5.	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category)	
		0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	Change in mood in last 90 days	
		0. No change 1. Improved 2. Deteriorated	
7.	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days	
		0. No change 1. Improved 2. Deteriorated	

SECTION I. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—1/3 to 2/3 of time 3. None			
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	b.	*NONE OF ABOVE*	e.
		Inside NH/off unit	c.		

4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Spiritual/religious activities	f.
		Crafts/arts	b.	Trips/shopping	g.
		Exercise/sports	c.	Walking/wheeling outdoors	h.
		Music	d.	Watch TV	i.
		Read/write	e.	*NONE OF ABOVE*	j.
5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/choices			
		0. No 1. Yes			

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		HEART/CIRCULATION		PSYCHIATRIC/MOOD	
		Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
		Cardiac dysrhythmias	b.	Depression	q.
		Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
		Hypertension	d.	SENSORY	
		Hypotension	e.	Cataracts	s.
		Peripheral vascular disease	f.	Glaucoma	t.
		Other cardiovascular disease	g.	OTHER	
		NEUROLOGICAL		Allergies	u.
		Alzheimer's	h.	Anemia	v.
		Dementia other than Alzheimer's	i.	Arthritis	w.
		Aphasia	j.	Cancer	x.
		Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
		Multiple sclerosis	l.	Explicit terminal prognosis	z.
		Parkinson's disease	m.	Hypothyroidism	aa.
		PULMONARY		Osteoporosis	bb.
		Emphysema/Asthma/COPD	n.	Seizure disorder	cc.
		Pneumonia	o.	Septicemia	dd.
				Urinary tract infection—in last 30 days	ee.
				NONE OF ABOVE	ff.
2.	OTHER CURRENT DIAGNOSES AND ICD-9-CM CODES	a.			
		b.			
		c.			
		d.			
		e.			
		f.			

SECTION K. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*			
		Constipation	a.	Pain—resident complains or shows evidence of pain daily or almost daily	j.
		Diarrhea	b.	Recurrent lung aspirations in last 90 days	k.
		Dizziness/vertigo	c.	Shortness of breath	l.
		Edema	d.	Syncope (fainting)	m.
		Fecal impaction	e.	Vomiting	n.
		Fever	f.	*NONE OF ABOVE*	o.
		Hallucinations/delusions	g.		
		Internal bleeding	h.		
		Joint pain	i.		
2.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	*NONE OF ABOVE*	d.

3.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating	a.
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem	b.
		NONE OF ABOVE	c.

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.
2.	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* HT (in.) a. WT (lb.) b.	
		c. Weight loss (i.e., 5%+ in last 30 days; or 10% in last 180 days) 0. No 1. Yes	c.
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a.	
		Insufficient fluid; dehydrated b.	
		Did NOT consume all/almost all liquids provided during last 3 days c.	
		Regular complaint of hunger	d.
		Leaves 25%+ food uneaten at most meals	e.
		NONE OF ABOVE	f.
4.	NUTRITIONAL APPROACHES	Parenteral/IV a.	
		Feeding tube b.	
		Mechanically altered diet c.	
		Syringe (oral feeding) d.	
		Therapeutic diet e.	
		Dietary supplement between meals	f.
		Plate guard, stabilized built-up utensil, etc.	g.
		NONE OF ABOVE	h.

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingivae); swollen or bleeding gums; oral abscesses, ulcers or rashes	e.
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers	
		1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved	
		2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater	
		3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue	
		4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone	
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	
4.	SKIN PROBLEMS/ CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		Skin desensitized to pain, pressure, discomfort	b.
		Protective/preventive skin care	c.
		Turning/repositioning program	d.
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e.
		Wound care/treatment (e.g., pressure ulcer care, surgical wound)	f.
		Other skin care/treatment	g.
		NONE OF ABOVE	h.

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3.	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)*	
		Antipsychotics	a.
		Antianxiety/hypnotics	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days*	
		Chemotherapy a.	
		Radiation b.	
		Dialysis c.	
		Suctioning d.	
		Trach. care e.	
		IV meds	f.
		Transfusions	g.
		O_2	h.
		Other _____	i.
		NONE OF ABOVE	j.
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:*	
		Speech—language pathology and audiology services	k.
		Occupational therapy	l.
		Physical therapy	m.
		Psychological therapy (any licensed professional)	n.
		Respiratory therapy	o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-days? 0. No 1. Yes 2. No tests performed	
3.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	a.
		Trunk restraint	b.
		Limb restraint	c.
		Chair prevents rising	d.

BILLING CODE 4120-03-C

(2) The Resident Assessment Protocols (RAPs) and triggers that are established by HCFA. HCFA issues the RAPs, and any changes, in the State Operations Manual (HCFA Pub. 7). The RAPs are available from HCFA upon request.

(3) The requirements for use of the RAI that appear at § 483.20.

(c) To receive Secretarial approval, a State's alternate instrument must contain—

(1) The MDS at paragraph (b)(1) of this section. All data elements and corresponding coding categories specified in the MDS must be contained in the State's instrument. The State may not alter the MDS definitions or the coding categories used with each MDS element or elements within a section. If proposing to reorder major sections of the MDS, the State must provide a conversion table between its instrument and the MDS, and the data supplies to HCFA from the MDS must be ordered in the same manner as designated in paragraph (b)(1) of this section. The State may include in its RAI data elements additional to those in the MDS to meet unique operational needs provided there is no conflict with elements included in the MDS.

(2) Resident Assessment Protocols (RAPs). An alternate RAI must include structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning. The State is not required to use the term "RAP" in an alternate instrument, and a State's protocols may include all, some, or none of the same RAPs contained in HCFA's RAI.

(i) Crosswalk. If the State creates alternative RAPs through combining care areas, it must provide a cross-walk chart from its RAPs to the care areas listed below in paragraph (b)(2)(iv) of this section.

(ii) Triggers. Each RAP must include assessment triggers, based on MDS elements or other information requirements, that screen which residents are subject to additional assessment. If States select alternative triggers or information requirements, they must provide supporting documentation for their decisions. This documentation may take the form of citations from professional medical journals and reports, results of field testing, or the consensus of experts that the State uses to assist in designing these RAPs.

(iii) Format. States must also specify a standardized format that long term care facilities will use to document information derived from RAPs about the nature of problems, complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems. There must be provision for identification of the location of the assessment results and for certification of completion and accuracy.

(iv) Frameworks for care areas. An alternate RAI must provide frameworks for comprehensive assessment in the following care areas:

(A) Cognitive loss/dementia.
(B) Visual function.
(C) Communication.
(D) Activities of daily living functional potential.
(E) Rehabilitation potential (In the RAPs designated by HCFA, the rehabilitation RAP is combined with the activities of daily living RAP.)
(F) Urinary incontinence and indwelling catheter.
(G) Psychosocial well-being. (In the RAPs designated by HCFA, there are three distinct RAPs that bear on psychosocial functioning: mood, behavior, and delirium.)
(H) Activities.
(I) Falls.
(J) Nutritional status.
(K) Feeding tubes.
(L) Dehydration/fluid maintenance.
(M) Dental care.
(N) Pressure ulcers.
(O) Psychotropic drug use.
(P) Physical restraints.

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance, and No. 13.714, Medical Assistance Program)

Dated: March 14, 1991.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: August 14, 1991.

Louis W. Sullivan.

Secretary.

Editorial Note: The following appendix will not appear in the Code of Federal Regulations.

Appendix

Resident Utilization System

Definitions
A. Utilization Guidelines
B. Minimum Data Set and Common Definitions
C. Resident Assessment Protocols
D. Criteria for Evaluation of Alternative Instruments

Resident Assessment System

Definitions

- *Minimum Data Set (MDS)*—minimum set of screening and assessment elements, including common definitions and coding categories, needed to assess comprehensively an individual nursing home resident. The items in the MDS standardize communication within facilities, between other facilities, and between facilities and outside agencies about resident problems and conditions.
- *Common Definitions*—standardized explanations of each element specified in the MDS.
- *Coding Categories*—the levels of measurement for each element included in the MDS.
- *Triggers*—levels of measurement (coding categories) of MDS elements that serve to identify residents who may require further evaluation using resident assessment protocols designated by the State.
- *Resident Assessment Protocols (RAPs)*—structured frameworks for organizing MDS elements, and additional clinically relevant information about an individual that contribute to care planning. (The State is not required to use the term "resident assessment protocol" in defining structured frameworks.)
- *Resident Assessment Instrument*—a standardized system comprised of the Minimum Data Set and Resident Assessment Protocol, including triggers, that result in a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities.
- *Utilization Guidelines*—Instructions concerning when and how to use the resident assessment instrument.

Resident Assessment Instrument Specified by HCFA

HCFA is responsible for specifying the minimum data set and its common definitions, utilization guidelines, and for designating one or more resident assessment instruments. A State may specify HCFA's resident assessment instrument for use by long term care facilities in the State for conducting assessments.

HCFA's proposed resident assessment instrument follows. The resident assessment instrument is comprised of:

- The utilization guidelines (attachment A);
- The MDS of core elements and common definitions (attachment B); and
- And the resident assessment protocols, triggers and instructions for use (attachment C).

State Specified Resident Assessment Instrument

States may specify a resident assessment instrument designated by HCFA or specify its own instrument

provided it includes the utilization guidelines (attachment A), the minimum data set of core elements and common definitions (attachment B), and is approved by HCFA. The proposed criteria that HCFA will use to evaluate alternate assessment instruments is in attachment D.

Attachment A—Utilization Guidelines

Utilization Guidelines for Resident Assessment Instruments

A. General Guidelines

Use the resident assessment instrument for conducting comprehensive assessments of your residents. The resident assessment instrument provides information on the resident's condition, helps develop a plan of care and is a means by which a long term care facility can track changes in resident status.

Assess all residents in long term care facilities that participate in Medicare or Medicaid regardless of payor source.

Adhere to the MDS definitions specified within the sections of the MDS and detailed in the definition supplement. In addition to direct observation and communication with the resident, use a variety of information sources to complete the assessment. These information sources may include, but are not limited to:

- Discussion of resident performance levels with nurse aides and assistants on all shifts;
- Discussion of the resident's status with an attending physician;
- Discussion of the resident's status with family members;
- Discussion of the resident's status with appropriate licensed health professionals who have observed, evaluated, and/or treated the resident; and/or
- The resident's record, including the admission record, medical plan of care, resident plan of care, documentation of services provided to the resident, reports of any diagnostic testing, consultation, or other services, medications administration record, copies of any transfer data provided to another health care facility, and summaries of previous discharges.

A registered nurse is responsible for conducting or coordinating each resident assessment. This person may:

- Use instructional material prepared by HCFA to train other facility staff to gather MDS information and to inform them of the circumstances requiring completion of the MDS;
- Delegate responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, social workers, activities specialists, physical, occupational, or speech therapists, attending physicians, dietitians, and pharmacists;
- Establish facility policies and procedures to assure that key clinical personnel on all shifts are knowledgeable about the information found in the resident's most current MDS and report changes in resident's status that may affect the accuracy of this information; or
- Establish facility policies and procedures that instruct staff how to integrate MDS information with existing facility resident assessment and care planning practices.

Have the registered nurse coordinating the assessment sign and certify the completion of the assessment. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties. Clinical disagreement does not constitute a material and false statement.

Place *all* completed resident assessments in the resident's record. All resident assessments completed within the last two years must be easily retrievable from the record if requested by representatives of State or Federal survey and certification agencies.

B. Frequency of Assessment

Federal requirements mandate that long term care facilities assess residents using the resident assessment instrument specified by the State:

- Within 14 days of admission to the facility;
- Promptly after a significant change in the resident's physical or mental condition; and
- In no case, less often than once every 12 months.

The facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

Specific utilization guidelines for conducting these assessments and quarterly reviews are as follows:

At Admission

Conduct an assessment within 14 days, if this is the resident's first stay or return stay (not a readmission) in the facility. A readmission is a return to the facility following a temporary absence for hospitalization or for therapeutic leave. Do not conduct an assessment if the resident is readmitted unless the resident has experienced a significant change in status. If a significant change in status has occurred, apply the procedures for conducting an assessment after a significant change in status (see below).

Do not complete Section I. *Identification Information* of the MDS if this information has previously been collected and posted to the resident's record.

To initiate care planning, collect as much information as possible for MDS elements and any additional data elements found in an approved State resident assessment instrument within 14 days post-admission.

If any of the following three circumstances occurs, you may amend MDS information collected during the 14 day post-admission period up until the 21st day after admission:

- Staff have no way to complete an item by the fourteenth day because information to complete the assessment is not available. For example, staff wish to interview a family member of a severely cognitively impaired resident because the family member is the most knowledgeable person about the resident's prior customary routines, accident history, recent changes in cognitive and functional status, and activity preferences. However, the resident is admitted on a Monday and the family member cannot visit the facility until sixteen days after admission.
- Further observation and interaction with the resident reveals the need to alter the initial assessments in any of the following MDS domains: cognitive patterns; communication patterns; potential for self-care improvement/ rehabilitation; psychosocial well-being; mood and behavior patterns; and activity pursuit patterns. If any of the core items in these domains is altered by the 21st day, the assessor shall show these changes on the admission assessment, and shall initial and date such amendments.
- Upon admission, the resident's condition is unstable because he/she is experiencing an acute illness or flare-up of a chronic problem and the acute illness or chronic problem is controlled by the 21st day. If any of the MDS core items is altered by the 21st day, the assessor should show the change on the admission assessment, and should initial and date the amendments. If the acute episode or chronic problem has not stabilized by the 21st day after admission, and the resident's physical, mental, or psychosocial status has declined, the facility must complete a new MDS (see "Significant Change in Status").

At a Significant Change in a Resident's Status

A "significant change" means any of the following:

- Deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appears permanent. For example, simultaneous functional *and* cognitive decline is often experienced by residents with chronic, degenerative illness such as Alzheimer's Disease or pronounced functional changes following a stroke.
- Loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself, such as, spoon, toothbrush, or comb. Such losses must be permanent and not attributable to identifiable, reversible causes such as drug toxicity from introducing a new medication, or an episode of acute illness such as influenza.
- Deterioration in behavior, mood, and/or relationships where staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention.
- Deterioration in a resident's health status, where this change: places the resident's life in danger, e.g., stroke, heart condition, or diagnosis of metastatic cancer; is associated with a serious clinical complication, e.g., initial development of a stage III or stage IV pressure ulcer, the initial onset of nonrelieved delirium, or recurrent loss of consciousness; or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, e.g., Alzheimer's Disease or diabetes.
- A serious clinical complication.
- A new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time.
- Onset of a significant weight loss (5% in last 30 days or 10% in last 180 days).
- A marked and sudden improvement in the resident's status, for example, a comatose resident regaining consciousness.

Document in progress notes the initial identification of a significant change in status.

Once you determine that the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of this determination.

Do *not* assess the resident if declines in a resident's physical, mental, or psychosocial well-being are attributable to:

- Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level.
- Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect full recovery of the resident's pre-morbid functional abilities and health status.
- Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease.

At Least Annually

Each resident must have a full, comprehensive assessment no later than 12 months following the last full assessment.

Quarterly Reviews

To track resident status between assessments, and to ensure monitoring critical indicators of the gradual onset of significant declines in resident status, examine the resident and review the following MDS core elements for all residents quarterly. Document the results of the assessment and revise the plan of care if indicated:

- Section B: Cognitive Patterns

—Item 2 (Memory); and
—Item 4 (Cognitive Skills for Daily Decisionmaking).

- Section C: Communication/Hearing Patterns

—Item 4 (Ability to Make Self Understood); and
—Item 5 (Ability to Understand Others).

- Section E: Physical Functioning and Structural Problems

—Items 1b-f (ADL Self-Performance); and
—Item 3a (Bathing).

- Section F: Continence in Last 14 Days

—Item 1 (Continence Self-Control Categories).

- Section H: Mood and Behavior Patterns

—Item 2 (Mood Persistence); and
—Item 3 (Problem Behavior).

- Section J: Disease Diagnoses

—Note only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, behavior status, medical treatments, or risk of death.

- Section L: Oral/Nutritional Status

—Item 2b (Weight loss (i.e., 5% on last 30 days; or 10% in last 180 days)).

- Section O: Medication Use

—Item 4 (Days Received The Following Medication).

- Section P: Special Treatment and Procedures

—Item 3b (Devices and Restraints—Trunk restraint); and
—Item 3d (Devices and Restraints—Chair prevents rising).

Attachment B—Minimum Data Set and Common Definitions

Minimum Data Set

In addition to the form for background information, there are 16 sections that make up the MDS, lettered from A to P. Each section contains one or more items labelled sequentially with corresponding definitions. For instance, the third item in section B is labelled "B3", the second item in section P is "P2".

The MDS has been formatted to assist the assessor determine the appropriate type of response for each item. The appropriate response for unshaded answer boxes is a check mark [√]. Items with a lightly shaded box require a numeric response, either a number, such as height or weight, or a preassigned code. Darkly shaded boxes do not require an answer and should be left blank. Complete all items unless the instructions tell you to "skip" over the next item (or several items) and go on to another. In cases where information is unavailable despite exhaustive probing, enter "NA" for "not available" or the approved "no information available" code, a circled dash.

The Minimum Data Set of common elements follows. Supplemental coding instructions and common definitions follow the MDS.

BILLING CODE 4120-03-M

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
BACKGROUND INFORMATION AT INTAKE/ADMISSION

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	(First) (Middle Initial) (Last)
2.	DATE OF CURRENT ADMISSION	Month Day Year
3.	MEDICARE NO. (SOC. SEC. or Comparable No. if no Medicare No.)	
4.	FACILITY PROVIDER NO.	Federal No.
5.	GENDER	1. Male 2. Female
6.	RACE/ ETHNICITY	1. American Indian/Alaska Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
7.	BIRTHDATE	Month Day Year
8.	LIFETIME OCCUPATION	
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)* Prior stay at this nursing home — a. Other nursing home/residential facility — b. MH/psychiatric setting — c. MR/DD setting — d. *NONE OF ABOVE* — e.
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to Item 13) — a. MR/DD with Organic Condition Cerebral palsy — b. Down's syndrome — c. Autism — d. Epilepsy — e. Other organic condition related to MR/DD — f. MR/DD with no organic condition — g. Unknown — h.
13.	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated
14.	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing home 4. Other
15.	LIVED ALONE	0. No 1. Yes 2. In other facility
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier — a. Observation revealed additional information — b. Resident unstable at admission — c.

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	Month Day Year
2.	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated
3.	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing home 4. Other
4.	LIVED ALONE	0. No 1. Yes 2. In other facility

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1. CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)

(Check all that apply. If all information UNKNOWN, check last box only.)

CYCLE OF DAILY EVENTS
- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- *NONE OF ABOVE* — g.

EATING PATTERNS
- Distinct food preferences — h.
- Eats between meals all or most days — i.
- Use of alcoholic beverage(s) at least weekly — j.
- *NONE OF ABOVE* — k.

ADL PATTERNS
- In bedclothes much of day — l.
- Wakens to toilet all or most nights — m.
- Has irregular bowel movement pattern — n.
- Prefers showers for bathing — o.
- *NONE OF ABOVE* — p.

INVOLVEMENT PATTERNS
- Daily contact with relatives/close friends — q.
- Usually attends church, temple, synagogue (etc.) — r.
- Finds strength in faith — s.
- Daily animal companion/presence — t.
- Involved in group activities — u.
- *NONE OF ABOVE* — v.

UNKNOWN—Resident/family unable to provide information — w.

END

Signature of RN Assessment Coordinator: _____ Date: _____

Signatures of Others Who Completed Part of the Assesament:

_____ _____ _____ _____

_____ _____ _____ _____

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	ASSESSMENT DATE	Month — Day — Year
2.	RESIDENT NAME	(First) (Middle Initial) (Last)
3.	SOCIAL SECURITY NO.	
4.	MEDICAID NO. (If applicable)	
5.	MEDICAL RECORD NO.	
6.	REASON FOR ASSESSMENT	1. Initial admission assess. 2. Hosp/Medicare reassess. 3. Readmission assessment 4. Annual assessment 5. Significant change in status 6. Other (e.g., UR)
7.	CURRENT PAYMENT SOURCE(S) FOR N.H. STAY	*(Billing Office to indicate; check all that apply)* Medicaid (a.) VA (d.) Medicare (b.) Self pay/Private insurance (e.) CHAMPUS (c.) Other (f.)
8.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* Legal guardian (a.) Family member responsible (d.) Other legal oversight (b.) Resident responsible (e.) Durable power attrny./ health care proxy (c.) *NONE OF ABOVE* (f.)
9.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* Living will (a.) Feeding restrictions (f.) Do not resuscitate (b.) Medication restrictions (g.) Do not hospitalize (c.) Other treatment restrictions (h.) Organ donation (d.) *NONE OF ABOVE* (i.) Autopsy request (e.)
10.	DISCHARGE PLANNED WITHIN 3 MOS.	*(Does not include discharge due to death)* 0. No 1. Yes 2. Unknown/uncertain
11.	PARTICIPATE IN ASSESSMENT	a. Resident 0. No 1. Yes (a.) b. Family 0. No 1. Yes 2. No family (b.)
12.	SIGNATURES AND SECTIONS COMPLETED	Signature of RN Assessment Coordinator _____ Date: _____ Signatures of Others Who Completed Part of the Assessment and Sections Completed

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes *(Skip to SECTION E)*
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem (a.) b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem (b.)
3.	MEMORY/ RECALL ABILITY	*(Check all that resident normally able to recall during last 7 days)* Current season (a.) That he/she is in a nursing home (d.) Location of own room (b.) *NONE OF ABOVE* are recalled (e.) Staff names/faces (c.)

■ = Code the appropriate response ☐ = Check all the responses that apply

December 19, 1990

4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0. Independent—decisions consistent/reasonable 1. Modified Independence—some difficulty in new situations only 2. Moderately Impaired—decisions poor; cues/supervision required 3. Severely Impaired—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	*(Check if condition over last 7 days appears different from usual functioning)* Less alert, easily distracted (a.) Changing awareness of environment (b.) Episodes of incoherent speech (c.) Periods of motor restlessness or lethargy (d.) Cognitive ability varies over course of day (e.) *NONE OF ABOVE* (f.)
6.	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities in last 90 days 0. No change 1. Improved 2. Deteroriated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing applicance, if used)* 0. Hears adequately—normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situations only—speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* Hearing aid, present and used (a.) Hearing aid, present and not used (b.) Other receptive comm. techniques used (e.g., lip read) (c.) *NONE OF ABOVE* (d.)
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* Speech (a.) Signs/gestures/sounds (c.) Writing messages to express or clarify needs (b.) Communication board (d.) Other (e.) *NONE OF ABOVE* (f.)
4.	MAKING SELF UNDERSTOOD	*(Express information content—however able)* 0. Understood 1. Usually Understood—difficulty finding words or finishing thoughts 2. Sometimes Understood—ability is limited to making concrete requests 3. Rarely/Never Understood
5.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content—however able)* 0. Understands 1. Usually Understands—may miss some part/intent of message 2. Sometimes Understands—responds adequately to simple, direct communication 3. Rarely/Never Understands
6.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed over last 90 days 0. No change 1. Improved 2. Deteroriated

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. Adequate—sees fine detail, including regular print in newspapers/books 1. Impaired—sees large print, but not regular print in newspapers/books 2. Highly Impaired—limited vision; not able to see newspaper headlines; appears to follow objects with eyes 3. Severely Impaired—no vision or appears to see only light, colors, or shapes
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) (a.) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes (b.) *NONE OF ABOVE* (c.)
3.	VISUAL APPLIANCES	Glasses; contact lenses; lens implant; magnifying glass 0. No 1. Yes

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE — *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days

2. ADL SUPPORT PROVIDED — *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist

			(1) SELF-PERF.	(2) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCO-MOTION	How resident moves between locations in his/her room and adjacent corridor on same floor (IF in wheelchair, self-sufficiency once in chair)		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
3.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. *Code for most dependent in self-performance and support.* Bathing Self-Performance codes appear below) 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence	a.	b.

4. BODY CONTROL PROBLEMS *(Check all that apply during last 7 days)*

- Balance—partial or total loss of ability to balance self while standing — a.
- Bedfast all or most of the time — b.
- Contracture to arms, legs, shoulders, or hands — c.
- Hemiplegia/hemiparesis — d.
- Quadriplegia — e.
- Arm—partial or total loss of voluntary movement — f.
- Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) — g.
- Leg—partial or total loss of voluntary movement — h.
- Leg—unsteady gait — i.
- Trunk—partial or total loss of ability to position, balance, or turn body — j.
- Amputation — k.
- *NONE OF ABOVE* — l.

5. MOBILITY APPLIANCES/DEVICES *(Check all that apply during last 7 days)*

- Cane/walker — a.
- Brace/prosthesis — b.
- Wheeled self — c.
- Other person wheeled — d.
- Lifted (manually/mechanically) — e.
- *NONE OF ABOVE* — f.

6. TASK SEGMENTATION — Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them
0. No 1. Yes

7. ADL FUNCTIONAL REHABILITATION POTENTIAL

- Resident believes he/she capable of increased independence in at least some ADLs — a.
- Direct care staff believe resident capable of increased independence in at least some ADLs — b.
- Resident able to perform tasks/activity but is very slow — c.
- Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) — d.
- *NONE OF ABOVE* — e.

8. CHANGE IN ADL FUNCTION — Change in ADL self-performance in **last 90 days**
0. No change 1. Improved 2. Deteriorated

SECTION F. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL *(Code for resident's performance over all shifts)*

0. *CONTINENT* — Complete control
1. *USUALLY CONTINENT* — BLADDER, incontinent episodes once a week or less. BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT* — BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT* — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT* — Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

- a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed
- b. BLADDER CONTINENCE — Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

2. INCONTINENCE RELATED TESTING *(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*

- Resident has been tested for a urinary tract infection — a.
- Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination — b.
- *NONE OF ABOVE* — c.

3. APPLIANCES AND PROGRAMS

- Any scheduled toileting plan — a.
- External (condom) catheter — b.
- Indwelling catheter — c.
- Intermittent catheter — d.
- Did not use toilet room/commode/urinal — e.
- Pads/briefs used — f.
- Enemas/irrigation — g.
- Ostomy — h.
- *NONE OF ABOVE* — i.

4. CHANGE IN URINARY CONTINENCE — Change in urinary continence/appliances or programs in **last 90 days**
0. No change 1. Improved 2. Deteriorated

IF RESIDENT IS COMATOSE, SKIP TO SECTION J

SECTION G. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/INVOLVEMENT

- At ease interacting with others — a.
- At ease doing planned or structured activities — b.
- At ease doing self-initiated activities — c.
- Establishes own goals — d.
- Pursues involvement in life of facility (e.g., makes/keeps friends, involved in group activities; responds positively to new activities; assists at religious services) — e.
- Accepts invitations into most group activities — f.
- *NONE OF ABOVE* — g.

2. UNSETTLED RELATIONSHIPS

- Covert/open conflict with or repeated criticism of staff — a.
- Unhappy with roommate — b.
- Unhappy with residents other than roommate — c.
- Openly expresses conflict/anger with family or friends — d.
- Absence of personal contact with family/friends — e.
- Recent loss of close family member/friend — f.
- *NONE OF ABOVE* — g.

3. PAST ROLES

- Strong identification with past roles and life status — a.
- Expresses sadness/anger/empty feeling over lost roles/status — b.
- *NONE OF ABOVE* — c.

SECTION H. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		— Tearfulness, emotional groaning, sighing, breathlessness	b.
		— Motor agitation such as pacing, handwringing or picking	c.
		— Failure to eat or take medications, withdrawal from self-care or leisure activities	d.
		— Pervasive concern with health	e.
		— Recurrent thoughts of death—e.g., believes he/she about to die, have a heart attack	f.
		— Suicidal thoughts/actions	g.
		NONE OF ABOVE	h.
2.	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	a.
		VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	b.
		PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	c.
		SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	d.
4.	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		NONE OF ABOVE	c.
5.	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category) 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	Change in mood in **last 90 days** 0. No change 1. Improved 2. Deteriorated	
7.	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in **last 90 days** 0. No change 1. Improved 2. Deteriorated	

SECTION I. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—1/3 to 2/3 of time 3. None			
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	b.	*NONE OF ABOVE*	e.
		Inside NH/off unit	c.		

4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Spiritual/religious activities	f.
		Crafts/arts	b.	Trips/shopping	g.
		Exercise/sports	c.	Walking/wheeling outdoors	h.
		Music	d.	Watch TV	i.
		Read/write	e.	*NONE OF ABOVE*	j.
5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/choices 0. No 1. Yes			

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		HEART/CIRCULATION		**PSYCHIATRIC/MOOD**	
		Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
		Cardiac dysrhythmias	b.	Depression	q.
		Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
		Hypertension	d.	**SENSORY**	
		Hypotension	e.	Cataracts	s.
		Peripheral vascular disease	f.	Glaucoma	t.
		Other cardiovascular disease	g.	**OTHER**	
		NEUROLOGICAL		Allergies	u.
		Alzheimer's	h.	Anemia	v.
		Dementia other than Alzheimer's	i.	Arthritis	w.
		Aphasia	j.	Cancer	x.
		Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
		Multiple sclerosis	l.	Explicit terminal prognosis	z.
		Parkinson's disease	m.	Hypothyroidism	aa.
		PULMONARY		Osteoporosis	bb.
		Emphysema/Asthma/COPD	n.	Seizure disorder	cc.
		Pneumonia	o.	Septicemia	dd.
				Urinary tract infection—in last 30 days	ee.
				NONE OF ABOVE	ff.
2.	OTHER CURRENT DIAGNOSES AND ICD-9-CM CODES	a. _____ b. _____ c. _____ d. _____ e. _____ f. _____			

SECTION K. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*			
		Constipation	a.	Pain—resident complains or shows evidence of pain daily or almost daily	j.
		Diarrhea	b.	Recurrent lung aspirations in last 90 days	k.
		Dizziness/vertigo	c.	Shortness of breath	l.
		Edema	d.	Syncope (fainting)	m.
		Fecal impaction	e.	Vomiting	n.
		Fever	f.	*NONE OF ABOVE*	o.
		Hallucinations/delusions	g.		
		Internal bleeding	h.		
		Joint pain	i.		
2.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	*NONE OF ABOVE*	d.

3.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating	a.
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem	b.
		NONE OF ABOVE	c.

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.
2.	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* HT (in.) a. WT (lb.) b.	
		c. Weight loss (i.e., 5%+ in last 30 days; or 10% in last 180 days) 0. No 1. Yes	c.
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a.	
		Insufficient fluid; dehydrated b.	
		Did NOT consume all/almost all liquids provided during last 3 days c.	
		Regular complaint of hunger	d.
		Leaves 25%+ food uneaten at most meals	e.
		NONE OF ABOVE	f.
4.	NUTRITIONAL APPROACHES	Parenteral/IV a.	
		Feeding tube b.	
		Mechanically altered diet c.	
		Syringe (oral feeding) d.	
		Therapeutic diet e.	
		Dietary supplement between meals	f.
		Plate guard, stabilized built-up utensil, etc.	g.
		NONE OF ABOVE	h.

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingivae); swollen or bleeding gums; oral abscesses, ulcers or rashes	e.
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers 1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved 2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater 3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue 4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone	
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	

4.	SKIN PROBLEMS/ CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		Skin desensitized to pain, pressure, discomfort	b.
		Protective/preventive skin care	c.
		Turning/repositioning program	d.
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e.
		Wound care/treatment (e.g., pressure ulcer care, surgical wound)	f.
		Other skin care/treatment	g.
		NONE OF ABOVE	h.

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3.	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)*	
		Antipsychotics	a.
		Antianxiety/hypnotics	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days*	
		Chemotherapy a.	
		Radiation b.	
		Dialysis c.	
		Suctioning d.	
		Trach. care e.	
		IV meds	f.
		Transfusions	g.
		O_2	h.
		Other _____	i.
		NONE OF ABOVE	j.
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:*	
		Speech—language pathology and audiology services	k.
		Occupational therapy	l.
		Physical therapy	m.
		Psychological therapy (any licensed professional)	n.
		Respiratory therapy	o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-days? 0. No 1. Yes 2. No tests performed	
3.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	a.
		Trunk restraint	b.
		Limb restraint	c.
		Chair prevents rising	d.

BILLING CODE 4120-03-C

Supplemental Coding Instructions and Common Definitions

Below are instructions to supplement the instructions and definitions found on the MDS itself. Some MDS items are not defined in this section as they are self-explanatory. The numbering and lettering correspond to the elements of the MDS.

Sections—Form 1

Minimum Data Set Nursing Facility Resident Assessment and Care Screening (MDS) Background Information at Intake/Admission

This assessment is to be completed upon initial admission or return stay (not a readmission following temporary hospitalization or for therapeutic leave). It is designed to give insight into the resident's life prior to admission (for initial admissions) and to document any significant change in the resident's status since his/her last admission (for readmissions).

I. Identification Information

1. *Resident Name:* Please print. Use the following format: First Name, Middle Initial, Last Name.

2. *Date of Current Admission:* The most recent date the resident was admitted to this facility. If the resident left the facility for any reason (e.g., transfer to another nursing home, discharge home) and was *officially* discharged by the nursing facility, record the *most recent* admission date.

Example: Resident was first admitted to the facility on 10/10/87. He was treated at a local hospital for several days on three occasions since admission, but was never officially discharged from the nursing facility. Therefore, 10/10/87 is considered the resident's current date of admission.

3. *Medicare No. (Soc. Sec. or Comparable No. if no Medicare No.):* Enter the resident's Medicare Number. If the resident does not have a Medicare number, enter the resident's social security number.

4. *Facility Provider Number:* The identification number assigned to the nursing home by the Medicare/Medicaid program(s). Some homes may have only a Federal identification number and space is provided for this.

5. *Gender:* Code 1 for male, 2 for female.

6. *Race/Ethnicity:* Choose only one answer.

7. *Birthdate:* Use all boxes to record date. For months and days with only one digit, place a zero in the first box (e.g., for Janaury 2, 1918 should be recorded:

Month		Day		Year			
0	0	0	2	1	9	1	2

8. *Lifetime Occupation:* Record job title or describe the profession in which the resident was mainly engaged before retiring or entering the facility. A woman whose primary work was within her own home should be recorded as a "homemaker."

9. *Primary Language:* The language the resident primarily speaks and/or understands.

10. *Residential History Past 5 Years:* Check all settings the resident lived in during the five years prior to this admission. Exclude short-term stays for treatment or rehabilitation where the resident was expected to return home. The setting must designate the resident's primary residence (i.e., the place the resident would have called "home" during this time).

MH/psychiatric setting—mental health facility, psychiatric hospital, psychiatric ward of a general hospital, psychiatric group home.

MR/DD setting—mental retardation or developmental disabilities facility, including MR/DD institutions, intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

None of Above—If the resident has not lived in any of these settings in the past 5 years, check the box NONE OF ABOVE.

11. *Mental Health History:* Includes a primary or secondary diagnosis of psychiatric illness or developmental disability; EXCLUDE organic brain syndrome, Alzheimer's Disease and related dementia.

12. *Conditions Related to MR/DD Status:* Record all conditions that are:

- Related to MR/DD status;
- Were manifested before age 22; and
- Are likely to continue indefinitely.

If the resident does not have mental retardation/developmental disabilities (MR/DD), check the first box, "Not Applicable—No MR/DD" and move to item 13. If the resident does exhibit MR/DD, but his/her status is not manifested in any of the conditions listed, check "MR/DD with no organic condition". If information about MR/DD condition is not available, check "Unknown."

13. *Marital Status:* Code the resident's current marital status.

14. *Admitted from:* Indicate where the resident was staying immediately prior to the current date of admission to the facility. Code only one answer.

15. *Lived Alone:* To determine the resident's living situation and availability of formal and/or informal social supports prior to the current date of admission to the facility.

If the resident was living in another facility (i.e., nursing facility, group home, sheltered care, board and care home), code "2" in the answer box. If the resident was NOT living in another facility, record either code "0" or "1".

Examples:

A woman living on her own whose daughters take turns sleeping at her home so she'll never be alone at night should be coded "0" (No).

A person living in his own apartment on the second floor of a two-family home with constant input from his family living on the first floor would be coded "0" (No).

16. *Admission Information Amended:* Denotes that MDS admission information has been changed/updated for the following reason(s): accurate information unavailable earlier, observation revealed additional information or resident unstable at admission. These changes/updates can be made up to the 21st day of residency only.

II. Background Information at Return/Readmission

Complete this section whenever a resident returns to the facility following an external discharge.

III. Customary Routine (Only at First Admission)

1. *Customary Routine:* This element gives insight into the resident's usual life style and daily routine *in the year prior to his/her first admission to a nursing facility.* Code the resident's routine rather than his/her goals (e.g., if resident would have liked to have had daily contact with relatives but didn't, do not check "Daily contact with relatives/close friends").

If the form is being completed for an admission from another facility or institutional setting, answer for the resident's routine prior to the resident's first nursing facility or other institutional admission.

Note that under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a "NONE OF ABOVE" category is available. This response pertains ONLY to the choices in the category above it. For example, if the person does not engage in any of the items listed under CYCLE OF DAILY EVENTS, indicate this by checking the "NONE OF ABOVE" box.

If *no* information is available about any customary routine, check the final box entitled "UNKNOWN". If, however, an individual item is unknown, write "NA" for "not available" or use the approved "no information available"

code, a circled dash, in the corresponding box.

Goes out 1+ days a week—Resident goes out of home for whatever reason (e.g., socialization, fresh air, clinic visit).

Distinct food preferences—(e.g., vegetarian; kosher; hates brussels sprouts).

Use of alcoholic beverage(s) at least weekly—Drank more than one alcoholic beverage per week.

Wakens to toilet all or most nights—Resident awakens to use the toilet at least once during the night all or most of the time.

Has irregular bowel movement pattern—"Irregular" means an unpredictable or variable pattern of bowel elimination regardless of whether or not the resident would prefer the pattern to be different.

Daily contact with relatives/close friends—Includes visits and telephone calls; does not include *only* exchange of letters.

Usually attends church, temple, synagogue (etc.)—Refers to religious involvement regardless of type (e.g., regular churchgoer; watches T.V. evangelist, involvement in church/temple committees/groups).

Daily animal companion/presence—Companion/presence refers to involvement with animals (e.g., house pet; seeing-eye dog; daily feeding birds in yard/park).

Unknown—If the resident/family cannot provide any information and the record does not contain the information, check the final box entitled "UNKNOWN".

Signature of RN Assessment Coordinator: The RN Assessment Coordinator should sign her/his name and date of completion of this form.

Signature of Others Who Completed Part of the Assessment: Signature of others who participated in the completion of this form and date of entry.

Sections—Form 2

Minimum Data Set for Nursing Facility Resident Assessment and Care Screening (MDS) (Status in Last 7 Days, Unless Otherwise Indicated)

Section A. Identification and Background Information

1. *Assessment Date:* Sets the designated endpoint of the common observation period for specific MDS items. Used as a reference point from which all periods of observation are timed by counting back the appropriate length of time (7 days, 14 days, etc.). Various staff members may document the resident's response for MDS items at different times but should use the established time period as their period of observation.

The month and day of the assessment should be two digits each (use "0" (zero), as a filler) and the year should be four digits.

2. *Resident Name:* Enter the resident's name in the following order: First Name, Middle Initial, Last Name.

3. *Social Security No.:* Fill in the resident's social security number.

4. *Medicaid No. (if applicable):* Enter the resident's Medicaid Number.

5. *Medical Record No.:* The unique identifier for the resident assigned by the facility.

6. *Reason for Assessment:* Code the one most appropriate response. See MDS utilization guidelines.

7. *Current Payment Source(s) for N.H. Care:* Payment source(s) for nursing facility care actually billed during the most recent month, according to the billing office—not the medical record. Code multiple payment sources if applicable. Exclude sources of payment for services other than for the nursing facility stay (e.g., exclude physician visit; prescriptions, durable medical equipment).

8. *Responsibility/Legal Guardian:* Person(s) responsible for participating in decisions about the resident's health care and treatment. Check all that apply.

Legal guardian—A legal guardian must be court-appointed.

Durable Power Attorney/Health Care Proxy—Designates a person who is legally responsible for the resident's legal affairs or a person is responsible for making health care decisions for the resident if the resident becomes unable to make decisions for him/herself. Durable power of attorney/health care proxy can be revoked if the resident later becomes able to make his/her own decisions.

9. *Advanced Directives:* The resident's (or proxy) preferences regarding treatment options. There must be supporting documentation in the resident's medical record to code these elements. Check all that apply.

Living Will—A document that specifies a resident's preferences about measures used to prolong life when there is a terminal prognosis.

Do not resuscitate—Indicates that, in case of respiratory or cardiac failure, the resident/family/legal guardian have directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used.

Do not hospitalize—Indicates that the resident is not to be hospitalized, even if he/she has a medical condition that would usually require hospitalization.

Organ donation—Indicates that the resident wishes his/her organs to be available for transplantation upon his/her death.

Autopsy request—Indicates that the resident/family/legal guardian has requested an autopsy be performed upon the death of the resident. (Note: Family/legal guardian must still be contacted for permission prior to performance of procedure.)

Feeding restrictions—Indicates that the resident/family/legal guardian does not wish for the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if he/she is not able to be nourished by oral means.

Medication restrictions—Indicates that the resident/family/legal guardian does not wish for the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy).

Other treatment restrictions—Indicates that the resident/family/legal guardian does not wish for the resident to receive certain medical treatments. Examples include, but are not restricted to, blood transfusions, tracheostomy, respiratory intubation, etc.

10. *Discharge Planned Within 3 Months:* The facility expects the resident will be discharged within three months. Planned discharge can be to another care setting or to a residential setting. A prognosis of death *is not* to be recorded as a planned discharge.

12. *Signatures:* The RN Assessment Coordinator should sign and date the MDS to certify its completion. Other staff members that complete part of the assessment should sign their name, professional credentials and date as well as indicate the sections they completed.

Section B. Cognitive Patterns

The resident's ability to remember, think coherently and organize daily self-care activities.

1. *Comatose:* The resident must have a recorded neurological diagnosis of "coma" or "persistent vegetative state". If the resident is comatose, skip the remainder of Section B as well as Sections C (Communication/Hearing Patterns), D (Vision Patterns), G (Psychosocial Well-Being), H (Mood and Behavior Patterns), and I (Activity Pursuit Patterns).

2. *Memory:* The resident's capacity to remember both recent and long-past events.

3. *Memory/Recall Ability:* The resident's capabilities related to memory and orientation ability.

Current season—Resident is able to correctly name the current season.

Location of own room—Resident is able to locate and recognize own room. Resident does not need to know the number of his/her room but can find his/her way to room.

Staff names/faces—Resident is able to distinguish staff from family members, strangers, visitors and other residents (resident does not have to know staff member's name; only recognize the fact that he/she is a staff member).

4. *Cognitive Skills for Daily Decision-Making:* The resident's ability to make everyday decisions about the tasks or activities of daily living. Examples of daily decisions may be choosing items of clothing; determining mealtimes; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary).

Independent—Resident organizes daily routine and makes decisions in a consistent and reasonable fashion.

Modified Independence—Resident organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in decision-making when faced with new tasks or situations.

Moderately Impaired—Resident's decisions are poor; resident requires reminders, cues and supervision in planning, organizing, and correcting daily routines.

Severely Impaired—Resident's decision-making is severely impaired; resident never (or rarely) made decisions.

5. *Indicators of Delirium—Periodic Disordered Thinking/Awareness:* Many illnesses in nursing home residents are manifested as acute confusional states. Delirium may be characterized by changes in mental status or behavior that deviates from the resident's usual state. For example, some residents who are usually alert and noisy may become very quiet; those who are considered quiet and cooperative may suddenly become belligerent; or those who are usually able to find their way about the unit may get "lost." Check all that apply.

6. *Change in Cognitive Status:* Change in the resident's cognitive status, skills or abilities over the last 90 days. Changes include, but are not limited to, changes in level of consciousness, cognitive skills for daily decision making, short- or long-term memory, thinking/awareness or recall.

Section C. Communication/Hearing Patterns

The resident's ability to hear, understand and communicate with others.

1. *Hearing:* The resident's ability to hear (with environmental adjustments, if necessary) for the past seven-day period. Evaluate hearing ability with appliance, if used.

Heard adequately—Hears all normal conversational speech; including when using the telephone, watching television or while engaged in other group activities.

Minimal difficulty—Hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.

Special situation only—Hearing deficient, but resident compensates when speaker adjusts tonal quality and speaks distinctly, or resident can hear only when speaker's face is clearly visible.

Highly impaired—Hears only some sounds; frequently fails to respond even when speaker adjusts tonal quality, speaks distinctly, or faces resident; absence of useful hearing (e.g., no comprehension of conversational speech even when speaker makes maximum adjustments).

2. *Communication Devices/ Techniques:*

Hearing aid, present and used—Hearing aid is available to resident and *regularly* used.

Hearing aid, present and not used—Hearing aid is available to resident but is *not regularly* used (e.g., owns hearing aid which is broken or used episodically).

Other receptive communication technique—Something the resident uses to enhance interaction with others (e.g., reading lips).

3. *Modes of Expression:* The types of communication the resident uses to make needs and wishes known. Check all that apply.

4. *Making Self Understood:* The resident's ability to express/ communicate requests, needs, opinions, urgent problems, and converse socially (whether in speech, writing, sign language, or a combination of these).

Understood—Resident expresses ideas clearly.

Usually Understood—Resident has difficulty finding right words or finishing thoughts, resulting in response delays; resident requires some prompting to make self understood.

Sometimes Understood—Resident has limited ability but is able to express concrete requests regarding basic needs (e.g., regarding food, drink, sleep, toilet).

Rare/Never Understood—At best, understanding is limited to staff interpretation of highly individual, resident-specific body language (e.g., indicated presence of pain or need to toilet).

5. *Ability to Understand Others:* The resident's ability to comprehend verbal information. The intent is to describe comprehension rather than hearing.

Understands—Resident clearly comprehends the speaker's message(s); resident demonstrates through words or actions/behaviors that he/she comprehends.

Usually Understands—Resident may miss some part or intent of the message but comprehends most of it; resident may have periodic difficulties in integrating information but generally demonstrates comprehension by responding (words or actions).

Sometimes Understands—Resident demonstrates frequent difficulties in integrating information; responds only to simple and direct questions and directions; comprehension is enhanced when the speaker rephrases or simplifies the message(s) and/or uses gestures.

Rare/Never Understands—Resident demonstrates very limited ability to understand communication; difficult to determine if the resident comprehends messages based on his/her verbal and nonverbal responses; or resident can hear sounds but does not understand messages.

6. *Change in Communication/ Hearing:* Any change in the resident's ability to express, understand, or hear information over the last 90 days.

Section D. Vision Patterns

Resident's visual abilities/limitations in adequate lighting and with the assistance of visual appliance, if used.

1. *Vision:* The resident's ability, over the past 7 days, to see close objects in adequate lighting using whatever visual appliance he/she usually uses for close vision (e.g., glasses, magnifying glass). "Adequate" light is defined as that which is sufficient or comfortable for a person with normal vision.

2. *Visual Limitations/Difficulties:* Visual limitations/difficulties related to diseases that commonly occur in the aged (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases).

a. *Side Vision Problems:* Decreased awareness of the objects in peripheral vision (e.g., leaves food on side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self.)

b. *Resident experiences:* Resident complains about seeing halos or rings around lights, seeing flashes of light or seeing "curtains" over eyes. These conditions may be symptomatic of treatable eye problems.

3. *Visual Appliances:* Includes any type of eyeglasses, contact lenses (removable or implanted) or magnifying glass.

Section E. Physical Functioning and Structural Problems

1. *ADL Self-Performance:* Resident's self-care performance in each activity of daily living (e.g., what the resident actually did for him/herself and/or what type of assistance staff actually provided for each activity) during the last 7 days. In coding self-performance select the appropriate performance description (0. Independent—4. Total Dependence) for each ADL category. *Do not consider set-up help* when coding self-performance. Set-up help will be coded in Item 2, "ADL Support," if it was provided. *Example:* A resident who performs personal hygiene independently once hygienic items are set-up for him should receive a self-performance code of "0", independent in personal hygiene. *Note:* Consider the resident's performance during all shifts as function may vary from time to time.

2. *ADL Support Provided:* The maximum amount of support provided to the resident for each ADL category during the last 7 days. (Code regardless of resident's self-performance classification). *Note:* Consider the amount of support provided during all shifts as function and type of staff support may vary.

Set-up help—Providing resident with the materials/devices necessary to perform an activity independently (e.g., for personal hygiene—setting up wash basin and grooming articles; for locomotion—handing resident a walker; for eating—cutting meat and opening containers at meals).

Examples

If a resident can perform personal hygiene with set-up of appropriate materials but receives one person's physical assistance for perineal care, code "2" (one-person physical assist).

If a hoyer lift is used in transferring, code for the maximum amount of persons needed to be present. Code "3," two+ persons physical assist, if the lift requires two.

If a resident receives one-person physical assistance to transfer out of bed in the a.m. and two-person physical assistance to transfer back into bed later in the day, code "3," two+ persons physical assist, in the ADL support column for transfer.

3. *Bathing:* How resident takes full-body bath, sponge bath/shower, and transfers in/out of tub/shower (Exclude washing of back and hair). Code for *most dependent* using the bathing self-performance codes provided (0. Independent—no help provided to 4. Total dependence).

4. *Body Control Problems:* Physical impairments that may affect the resident's self-performance in activities of daily living.

Bedfast—In bed or recliner in room 22 hours or more per day. Includes bedfast with bathroom privileges.

Contracture to arms, legs, shoulders, or hands—Restriction of full range of motion of any joint due to deformity, disuse, pain, etc. Includes loss of range of motion in fingers, wrists, elbows, shoulders, hips, knees and ankles.

Partial or total loss of voluntary leg or arm movement—Includes motion lost because of contractures (whether muscle shortening only or bony deformity); decreased range of motion; spasticity; uncontrollable leg or arm movement. Includes being in a cast.

Hemiplegia/hemiparesis—Paralysis of only one half of the body.

Amputation—Loss of part or all of any limb.

5. *Mobility Appliances/Devices:* Appliances, devices or personal assistance protocols used or followed when resident performs routine daily activities. Do not include aids or protocols used only under special circumstances.

Cane/walker—Includes residents who walk by pushing a wheelchair for support.

Wheeled self—Includes hand-propelled and motorized wheelchair as long as resident takes some responsibility for his/her own mobility.

6. *Task Segmentation:* Residents who are more independent in personal care tasks (such as eating, bathing, grooming, dressing) when the associated activities are broken into small steps. These residents usually have some problem with memory, thinking or paying attention to the task, due to such problems as dementia, head injury, CVA, or depression. Some residents will receive this care because of body control problems only.

Examples

Resident is able to wash his/her face when handed a facecloth and asked to "wash your face" (vs. setting a wash basin in front of him/her with various grooming supplies with the expectation he/she will bathe).

Resident is more independent in eating when just one food item and one utensil are presented to him/her at a time (vs. placing a tray with the entire meal and several utensils before him/her.)

7. *ADL Functional Rehabilitation Potential:* Describe beliefs and characteristics related to the resident's function during the last 7 days that may indicate that the resident has the capacity for greater independence.

8. *Change in ADL Function:* Changes in the resident's ADL status, skills or abilities in the last 90 days. Changes include but are not limited to changes in self-performance, amount of support, body control problems and ADL potential.

Section F. Continence in Last 14 Days

The resident's pattern of bladder and bowel continence/control in the previous 14 Day Period.

1. (a and b) *Bladder and Bowel Continence:* Control of urinary bladder function and/or bowel movement. Describes the resident's pattern of bladder/bowel control, with toileting schedules, bladder/bowel training programs or appliances, if used. This category does not refer to the resident's ability to toilet him/herself. For bladder incontinence, the difference between a code of "3" frequently incontinent and "4" incontinent is determined by the presence (3) or absence (4) of any bladder control.

Examples

A resident who is taken to the toilet after every meal, before bed, and once during the night and is never wet or soiled, is considered to be continent.

A resident who uses appliances without leakage (e.g., catheter or ostomy) is considered to be continent.

2. *If Incontinent of Bladder:* Complete This Item Only if The Resident's Bladder Continence Equals 2, 3 or 4. Skip to Section F3 if bladder continence code equals 0 or 1 AND no catheter is employed. Identifies whether or not incontinent residents have been tested for urinary tract infection or checked for fecal impaction during the prior 14 days.

3. *Appliances and Programs:*

Any scheduled toileting plan—Staff take the resident to the toilet or remind him/her to go to the toilet at scheduled times of the day.

Indwelling catheter—Catheter that is held in position in the bladder.

Intermittent catheter—Catheter that is used to obtain urine from the bladder but does not remain in place.

Did not use toilet room/commode/urinal—Resident never used any of these items during the last 7 days.

Pads/briefs used—This category includes any type of absorbent devices whether worn by the resident or placed on the bed or chair for protection. This category does *not* include the routine use of pads on beds when a resident is never or rarely incontinent.

Enemas/irrigation—Any type of enema or bowel irrigation. Includes ostomy irrigations.

Ostomy—Any type of ostomy of the gastrointestinal or genitourinary tract.

4. *Change in Urinary Continence:* Change in resident's urinary continence status in the last 90 days. Includes changes in self-control categories, appliances or programs.

Section G. Psychosocial Well-Being

A non-comatose resident's overall level of emotional adjustment to the nursing facility environment, including his/her general attitude, evidence of adaptation to surroundings and change in relationship patterns. Section G is comprised of three parts, each having multiple responses. The responses selected in each area—Sense of Initiative/Involvement, Unsettled Relationships, and Past Roles—should be confirmed by the resident's behavior (either verbal or non-verbal) in the past 7 days.

1. *Sense of Initiative/Involvement:* The degree to which the resident is involved in the nursing home community and takes initiative in activities. The primary source of information for these items is the resident. Staff who have regular contact with the resident may also be consulted.

To determine if the resident is *at ease interacting with others,* think about how the resident behaves during the time you spend with him/her. How does the resident behave with other residents, staff, visitors?

To determine if the resident is *at ease doing planned or structured activities,* think about how he/she responds to such activities. Does he/she feel comfortable with the structure or restricted by it?

Is the resident *at ease doing self-initiated activities:* (e.g., leisure activities such as reading, watching TV, talking with friends; work activities such as folding personal laundry, organizing belongings). Does he/she spend most of his/her time alone? Or is the resident always looking for someone to find something for him/her to do?

To determine if someone *establishes own goals,* think about whether or not the resident makes statements like "I hope I am able to walk again" or "I would like to get up early and visit the beauty parlor." Resident goals can be as traditional as wanting to learn how to walk again following a hip replacement or wanting to live to say goodbye to a loved one. In addition, some things may not be stated verbally. If a resident has her/his own way of living at the facility (e.g., organizing own activities or setting own pace), this person could be seen as establishing his/her own goals.

Does the resident pursue involvement in life of facility? Does the resident partake of facility events, socialize with peers, discuss activities?

Is the resident willing to try group activities? Does the resident accept *invitations into most group activities* even if he/she decides the activity is not for him/her and leaves. Or does the resident regularly refuse to attend group programs?

2. *Unsettled Relationships:* The quality and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff and with other residents). Do you see signs of conflict or generally harmonious interpersonal relationships? These items refer to conflict or disagreement outside the range of *normal* criticisms or requests—i.e., beyond a reasonable level.

Examples of *conflict with staff* include: resident chronically complains about some staff members to other staff; verbal criticisms of staff in therapeutic group situations that cause disruption within group; or a pattern of constant disagreement over routines of daily living.

Examples of *unhappiness with roommate* include frequent requests for roommate changes, grumbling about the roommate spending too long in the bathroom or complaining about the roommate rummaging in their things.

Examples of *unhappiness with residents other than roommate* include chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization.

An *absence of contact with family/close friends,* as indicated by the resident not having visitors or telephone calls from significant others in the last 7 days.

Resident *openly expresses conflict/anger with family or friends,* as indicated by expressing feelings of abandonment, ungratefulness, lack of understanding, hostility regarding relationships with family/friends.

Recent loss of close family member/friend—includes family member/friend moving to a more distant location, even temporarily (e.g., for the winter months); death or incapacitation; recent severing of a significant relationship.

Resident openly expresses conflict/anger with family or close friends. Listen for expressions of feelings of abandonment, ungratefulness, lack of understanding, hostility regarding relationships with family/friends.

3. *Past Roles:* The resident's recognition and/or acceptance of his/her feelings regarding his/her new role/status, as a function of entering the nursing home.

Strong identification with past roles and life status—as indicated by the resident enjoying telling stories about his/her past; taking pride in past accomplishments or family life; overt connections with previous lifestyle (e.g., commemorating family events, celebrating lifelong traditions).

Expresses sadness/anger/empty feelings over lost roles/status—as indicated by expressing feelings with statements such as "I'm not the man I used to be"; "I wish I had been a better mother to my children"; "I'm not capable of doing the things I always liked to do." May also cry when reminiscing about past accomplishments.

Section H. Mood and Behavior Patterns

1. *Sad or Anxious Mood:* The presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety. A type of painful mood characterized by explicit verbal or gestural expressions of feeling "depressed," or one of its synonyms such as feeling sad, miserable, blue, hopeless, empty or tearful. It can be a disorder of mood which is usually, but not always, accompanied by a "painful mood" and calling for relief on the grounds that it is severely, or unnecessarily, distressing and/or threatening to physical health and life, and/or interfering with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal. Code all verbal and demonstrated signs that apply.

2. *Mood Persistence:* Sad or anxious mood intrudes on daily life over last 7 days—not easily altered by attempts to "cheer resident up."

3. *Problem Behavior:* The presence of problem behaviors which cause disruption to facility residents or staff, including those which are potentially disruptive even though staff and residents have appeared to adjust to their occurrence. Problem behaviors include:

- Wandering—moves with no rational purpose, seemingly oblivious to needs or safety.
- Verbally abusive—others are threatened, screamed at, or cursed at.
- Physically abusive—others are hit, shoved, scratched, or sexually abused.
- Socially inappropriate/disruptive behavior—resident makes disruptive sounds, is noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, hoarding, rummaging through others' belongings.

4. *Resident Resists Care:* Problem behaviors related to delivery of nursing care/treatment to the resident that should prompt further causal evaluation (e.g., fear of pain, fear of falling, poor

comprehension, anger, poor relationships). Signs of resistance may be verbal and/or physical.

5. *Behavior Management Program:* Management of problem behaviors through clinical intervention in which staff have made attempts to understand the resident's "agenda" behavior (i.e., the meaning underlying the problem behavior) and have developed evidence of structure and continuity of care in the program. This category does not include behavioral management by physical restraints or psychotropic drugs if these are the only interventions.

Examples:

A. Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S' behavior for several days, staff noticed that her tablemate was in the habit of moving in close to Mrs. S to take her food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. All staff have been made aware that Mrs. S must be seated for each meal at a small table of two.

B. Provisions for safely monitored wandering (may include the use of "secure bands" or any electronic device that activates an alarm when the resident wanders away from a designated area).

6. *Change in Mood:* Change in any aspect of sad or anxious mood that has been expressed verbally or demonstrated physically in the last 90 days. Changes include increased/decreased number of signs/symptoms or change in the frequency or intensity of behaviors associated with sad or anxious mood.

7. *Change in Problem Behavior:* Change in any problem behavior including but not limited to wandering, verbally abusive, physically abusive, and socially inappropriate behavior in the last 90 days. Includes increased/decreased number of signs/symptoms or change in the frequency or intensity of the behavior(s).

Section I. Activity Pursuit Patterns

The amount and types of interests and activities that the resident currently pursues, as well as those activities the resident would like to pursue.

1. *Time Awake:* The periods of a typical day (over the last 7 days) when the resident is awake all or most of the time (i.e., naps no more than one hour in the period).

2. *Average Time Involvement in Activities:* The proportion of available free time that the resident spends involved in activities, which is an indicator of the resident's overall activity level. Includes time spent in solitary activities (such as reading, letter writing), as well as group activities. Exclude time the resident spent in receiving treatments or completing ADLs in scoring this item.

Most—More than ⅔ of the resident's available time is spent in activities.

Some—⅓ to ⅔ of the resident's available time is spent in activities.

Little—Less than ⅓ of the resident's available time is spent in activities.

None—None of the resident's available time is spent in activities.

3. *Preferred Activity Settings:* The activities, circumstances or settings that the resident prefers, including though not limited to, those in which the resident appears to be at ease.

4. *General Activity Preferences:* Activities in which the resident prefers to participate, regardless of whether that activity is currently available to the resident or the resident currently engages in the activity. Check for each activity preferred. If none are preferred, check "NONE OF ABOVE".

Exercise/sports—Includes any type of physical activity (e.g., dancing, sports).

Spiritual/Religious Activities—Includes participation in religious services as well as watching them on television.

5. *Prefers More or Different Activities:* The resident has expressed an interest in pursuing other activities that are NOT offered at the facility. Residents who resist attendance/involvement in activities offered at the facility should also be included in this category. Also include instances where the activity is provided, but the resident would like to have other choices in carrying out the activity.

Section J. Disease Diagnoses

Diseases that are associated with the resident's current ADL status, cognition, behavior, medical treatments and/or risk of death. These conditions drive the current care plan. Identify current conditions affecting the resident, not those that have been resolved or no longer affect the resident's functioning.

1. *Diseases:*

Cardiac dysrhythmias—Disorder of heart rate or rhythm.

Cerebrovascular Accident (CVA/Stroke)—Includes intracranial bleeds, cerebral thromboses, infarcts, emboli; also includes TIAs (transient ischemic attacks).

Peripheral vascular disease—Venous or arterial.

Dementia—Other than Alzheimer's—Includes Organic Brain Syndrome (OBS) or Chronic Brain Syndrome (CBS), senility, Senile Dementia, Multi-infarct Dementia, dementia related to neurologic diseases other than Alzheimer's.

Aphasia—Communication disorder, often found in stroke patients in which the person has difficulty using speech, writing, or signs; or trouble understanding spoken or written language.

Emphysema/Asthma/COPD—Includes COPD (Chronic Obstructive Pulmonary Disease) or COLD (Chronic Obstructive Lung Disease); chronic restrictive lung diseases such as Asbestosis; chronic bronchitis.

Manic depressive (bipolar disease)—Bipolar is the current terminology for manic depressive disease.

Anemia—Includes anemia of any etiology.

Arthritis—Includes degenerative join disease (DJD), osteoarthritis (OA), rheumatoid arthritis (RA).

Diabetes Mellitus—Includes insulin dependent diabetes mellitus (IDDM) and diet controlled diabetes mellitus (NIDDM or AODM).

Explicit terminal prognosis—The resident is expected to die from primary diagnosis within 6 months. This should be supported by physician documentation.

Allergies—Includes all drug and food allergies; contact dermatitis and allergies that cause itchy eyes, runny nose or sneezing. Includes all allergies, not just those that are currently reactive.

Septicemia—Morbid condition associated with bacterial growth in the blood.

Urinary tract infection—Includes chronic and acute symptomatic infection in last 30 days.

2. *Other Current Diagnoses and ICD–9 Diagnoses:* Identify conditions OTHER THAN those listed in Item J1 that affect the resident's functioning or plan of care. These conditions drive the current care plan. Identify current conditions, not those that have been resolved or no longer affect the resident's functioning.

ICD–9 codes must be entered for every diagnosis listed under Item J2. If this information is not available in the medical record, check the list of common ICD–9–CM codes in Appendix A. If the code is not available from either of these sources, consult *ICD–9–CM*: The International Classification of Diseases.

Section K. Health Conditions

Identify specific problems or symptoms that affect or could affect the resident's health or functional status, or are risk factors for functional decline. Check all signs or symptoms occurring or present within the past 7 days, unless

indicated (e.g., lung aspirations—last 90 days).

1. *Problem Conditions*:

Dizziness/vertigo—The resident feels the sensation that he/she is turning or his surroundings are whirling around him.

Edema—Excessive accumulation of fluid in tissues, either localized or generalized.

Internal bleeding—Bleeding may be frank, such as bright red blood, or occult, such as guiac positive/hemoccult positive stools. Indicator may be black, tarry stools.

Syncope—Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery (i.e., fainting).

2. *Accidents*:

Fell—Note timeframes in both items.

Hip Fracture—Note timeframe.

3. *Stability of Conditions*: Denotes whether the resident is experiencing an unstable or acute condition.

Section L. Oral/Nutritional Status

1. *Oral Problems*:

Chewing Problem—Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., residents with ill-fitting dentures or with neurologic impairments related to chewing).

Swallowing Problem—Symptoms may include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time or excessive drooling.

2. *Height and Weight*:

a. *Height*: Round height to the nearest whole inch.

b. *Weight*: If the resident's weight is taken more than once a month, record the most recent weight. Round weight to the nearest whole pound.

c. *Weight Loss*: Weight loss of 5%+ in last 30 days; or 10% in last 180 days.

3. *Nutritional Problems*:

Insufficient fluids; dehydrated—Condition that occurs when output of water exceeds water intake.

Examples:

- Resident usually takes in less than six 8 oz. glasses of fluid daily (fluid to include beverages, soup, gelatin, ice cream, etc.).
- Resident has clinical signs of dehydration.
- Resident's fluid loss exceeds the amount of fluids he/she takes in (i.e., loss from vomiting, diarrhea, sweating exceeds fluid replacement).

Did not consume all/almost all liquids provided during last 3 days—Liquids include water, juices, gelatin, soup, ice cream/sherbet, coffee, etc.

4. *Nutritional Approaches*:

Parenteral/IV—Intravenous fluids or hyperalimentation given continuously or intermittently. This category does NOT include IV medication (See item P1).

Feeding tube—Any type of tube which delivers food/nutritional substances directly into the gastrointestinal (GI) system.

Syringe feeding—Use of syringe to deliver oral nourishment.

Mechanically altered diet—A diet ordered to be prepared so that its consistency is altered to facilitate oral intake (e.g., soft, pureed, ground).

Therapeutic diet—A diet ordered to treat problem conditions (e.g., calorie specific, low salt, lactose free).

Supplement between meals: Any type of dietary supplement (e.g., high protein/calorie shake, 3 p.m. snack for insulin dependent diabetic).

Plate guard, stabilized built-up utensils—Any type of specialized or altered equipment to facilitate resident participation in the eating process.

Section M. Oral/Dental Status

1. *Oral Status and Disease Prevention*: Check all that apply.

Carious—Pertains to tooth decay and disintegration (cavities).

Section N. Skin Condition

The condition of the resident's skin as well as skin treatments received by the resident in the last 7 days.

1. *Stasis Ulcer*: An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency. May also be referred to as a venous ulcer or ulcer related to Peripheral Vascular Disease (PVD).

2. *Pressure Ulcers*: Ischemic ulceration or necrosis of tissues overlying a bony prominence that has been subjected to pressure or friction. Other terms used to describe this condition include bed sores and decubitus ulcers. Record the stage of development corresponding to the most severe pressure ulcer on the resident's body.

3. *History of Resolved/Cured Pressure Ulcers*: Pressure ulcers that were resolved/cured during the last 90 days. Identification of this condition is important because it is a risk factor for development of subsequent pressure ulcers.

4. *Skin Problems/Care:* Includes skin conditions that may present risk factors for more serious problems as well as the type of skin care the resident has received during the prior 7 days.

Protective/preventive skin care—Includes any care given for preventive or protective purposes (e.g., diabetic foot care, moisturizing lotions, elbow protectors, booties).

Wound care/treatment—Care or treatments to any type of wound (e.g., pressure ulcer, surgical wound, skin tear). May include, but is not limited to, debridement, dressings, irrigations, etc

Section N. Medication Use

Determine the resident's pattern of medication use over the past 7 days.

1. *Number of medications:* The number of different medications (over-the-counter and prescription) the resident has used in the past 7 days. Count only those medications actually administered and received by the resident over the last 7 days.

Count the number of different medications (not the doses or different dosages). For example, Digoxin 0.25 mg po given on Tuesday and Thursday and Digoxin 0.125 mg po given on Monday, Wednesday and Friday is one medication. Also, if both the generic and brand name of a single drug are administered, consider them as one medication.

2. *New Medications:* Code "1" if the resident has received new medications in last 90 days; code "0" if the resident has not received any new medications in the last 90 days.

3. *Injections:* The number of days, during the past 7 days, that the resident received any type of injection.

4. *Days Received the Following Medication:* The number of days that the resident has taken each type of medication, in the past 7 days.

Write the appropriate number of days, out of the prior 7 days, in the answer box. If the resident has not used any medications from a drug category record "0" (zero). If the resident uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (decanoate) given every couple of weeks or monthly), record "1".

Example of Medication Sheet Recording:

Haldol 0.5 mg po BID prn—given once a day on Monday, Wednesday, and Thursday.

Ativan 1 mg po QAM—given every day.

Restoril 15 mg po QHS prn—given Tuesday and Wednesday.

Coding of Example:

Antipsychotics—3 days

Antianxiety/hypnotics—7 days

Antidepressants—0 days

5. *Previous Medication Results:* Skip This Question If The Resident Is Currently Receiving Antipsychotics, Antidepressants, or Antianxiety/Hypnotics. Psychoactive drugs are considered to have been effective if they

reduced the intensity or frequency of a behavior problem or reduced the presence or intensity of a mood problem as long as the resident is free of significant side effects (e.g., excess sedation).

Section P. Special Treatments and Procedures

1. *Special Treatments and Procedures:*

a. *Special Care:* All treatments received by the resident in the last 14 days.

Chemotherapy—Given by any route. Includes any type of chemotherapy (antineoplastic drug) given by any route the resident is currently taking whether it is received at the nursing facility or other facility.

Radiation—Includes radiation therapy or radiation implant. May occur at nursing facility or other facility.

Dialysis—Includes dialysis which occurs at nursing facility or other facility.

Suctioning—Includes nasopharyngeal or tracheal aspiration.

IV meds—Includes any medication given by intravenous push or drip.

Transfusions—Includes transfusions of blood or ANY blood products (e.g., platelets).

O_2—Includes continuous or intermittent oxygen via mask, cannula, etc.

b. *Therapies:* The number of days particular therapy services were received by the resident for at least 10 minutes each day during the last 7 days.

Psychological therapy—Therapy given by psychiatrist, psychologist, psychiatric nurse or psychiatric social worker.

2. *Abnormal Lab Values:* Any abnormal lab values during the prior 3 month period. This item refers to lab values that are abnormal when compared to standard values, not abnormal for the specific resident.

3. *Devices and Restraints:* The frequency with which the resident was restrained by any of the four devices listed, over the past 7 days.

For each restraint type, record:

"0" if not used in past 7 days

"1" if used, but used less than daily, in past 7 days

"2" if used on a daily basis in past 7 days

Attachment C—Resident Assessment Protocols and Instructions

Instructions for Using HCFA's Resident Assessment Protocols

Each of the 18 resident assessment protocols (RAPs) organizes comprehensively clinical information to assist long term care facility staff in thinking about care planning and treatment decisions. A RAP has two parts: (1) a RAP KEY that summarizes all MDS elements applicable to thinking about assessment and care planning in that particular clinical area; and (2) instructions, including clinical background information and suggested approaches to additional assessment. Upon completing a RAP, staff will have:

- Identified the unique problems the resident has that may affect adversely his/her highest practicable physical, mental, and psychosocial functioning.
- Identified factors that place the resident's highest practicable physical, mental, and psychosocial functioning at risk.
- Considered whether the identified problems and risk factors could be prevented or reversed, and evaluated the extent to which the resident is able to attain a higher level of well-being and functional independence.
- Evaluated ongoing care practices for that resident by, for example, considering alternative therapies and the need for medical consultation, or consultation(s) by other health professionals such as occupational or physical therapists.

To use RAPs, long term care facility staff shall follow these steps:

- As specified in the utilization guidelines, complete MDS elements, using common definitions.
- Review MDS information. Use the Resident Assessment Protocol Trigger Legend Worksheet that shows which MDS elements serve as triggers for each RAP.
- If MDS item(s) and code(s) trigger a RAP(s), circle those RAP(s) that have been triggered.
- Complete triggered RAPs following instructions for each RAP. Delegate completion of a particular RAP to the facility staff who can address that care area most knowledgeably, whether it be nursing personnel, therapists, social workers, activity specialists, or physicians. Whenever possible, get the person(s) who completed the MDS trigger(s) for that RAP to apply the full RAP.
- After completing a RAP, use the Resident Assessment Protocol Summary to document decisions about care planning and to specify where in the resident's record summary information gained from the assessment has been noted, for example, progress note or care plan.

This summary information must include, as appropriate to the individual resident, documentation of problems, complications, and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed to care planning for the specific problems identified.

- The registered nurse coordinating the assessment must sign and date the Resident Assessment Protocol Summary verifying that the triggered RAPs have been applied.

BILLING CODE 4120-03-M

Resident's Name:	Medical Record No.:

Signature of RN Assessment Coordinator: _____

RESIDENT ASSESSMENT PROTOCOL SUMMARY

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.
2. Document problems, complications, and risk factors; the need for referral to appropriate health professionals; and the reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facility routinely keeps such information, such as problem sheets or nurses' progress notes.
3. Show location of this information.

RAP Problem Area	Care Planning Decision		Location of Information
	Proceed	Not Proceed	
DELIRIUM	☐	☐	
COGNITIVE LOSS/DEMENTIA	☐	☐	
VISUAL FUNCTION	☐	☐	
COMMUNICATION	☐	☐	
ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐	☐	
URINARY INCONTINENCE AND INDWELLING CATHETER	☐	☐	
PSYCHOSOCIAL WELL-BEING	☐	☐	
MOOD STATE	☐	☐	
BEHAVIOR PROBLEM	☐	☐	
ACTIVITIES	☐	☐	
FALLS	☐	☐	
NUTRITIONAL STATUS	☐	☐	
FEEDING TUBES	☐	☐	
DEHYDRATION/FLUID MAINTENANCE	☐	☐	
DENTAL CARE	☐	☐	
PRESSURE ULCERS	☐	☐	
PSYCHOTROPIC DRUG USE	☐	☐	
PHYSICAL RESTRAINTS	☐	☐	

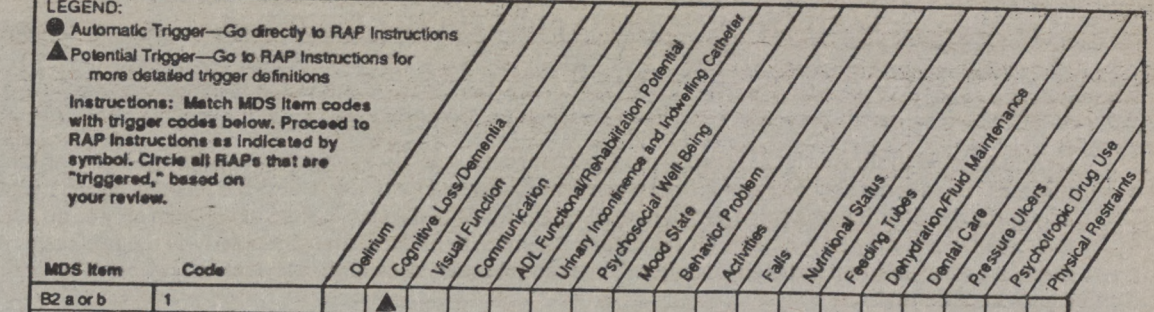
RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND

LEGEND:

● Automatic Trigger—Go directly to RAP Instructions

▲ Potential Trigger—Go to RAP Instructions for more detailed trigger definitions

Instructions: Match MDS item codes with trigger codes below. Proceed to RAP instructions as indicated by symbol. Circle all RAPs that are "triggered," based on your review.



MDS Item	Code
B2 a or b	1
B3 a,b,c,d	fewer than 3 ✓
B4	0,1,2
	1,2,3
B5 a,b,c,d,e	any ✓
B6	2
C4	2,3
C5	1,2,3
	2,3
C6	2
D1	1,2,3
D2 a	✓
E1 a,b,c,d,e,f	3,4
E3 a	3,4
E4 a,b,d,e,h,j	any ✓
E7 a,b	any ✓
E8	2
F1 b	2,3,4
F3 b,c,d,f	any ✓
G2 a,b,c,d	any ✓
G3 b	✓
H1 a,b,c,d,e,f,g	any ✓
H1 d	✓
H2	1
H3 a,b,c or d	1,2
H6	2
H7	2
I2	0,2,3
I5	1
J1 ee	✓
J2	260, 261, 262
	263, 263.0, 263.1
	263.2, 263.8, 263.9
	276.5
	291.0, 292.81
	293.0, 293.1
K1 b,c,f,h,n	any ✓
K2 a,b	any ✓
L1 c	✓
L2 c	1
L3 a,d,e	any ✓
L3 b	✓
L3 c,e	✓
L4 a,b	any ✓
L4 a,c,d,e	any ✓
L4 b	✓
M1 a,c,d,e	any ✓
M1 f	not ✓
N2	1,2,3,4
N4 c,d,e,f,g	none ✓
O4 a,b,c	1-7
P3 b,c, or d	1,2

RESIDENT ASSESSMENT PROTOCOL: DELIRIUM

I. PROBLEM

Delirium (acute confusional state) is a common indicator or nonspecific symptom of a variety of acute, treatable illnesses. It is a serious problem, with high rates of morbidity and mortality, unless it is recognized and treated appropriately. Delirium is never a part of normal aging. Some of the classic signs of delirium may be difficult to recognize and may be mistaken for the natural progression of dementia, particularly in the late stages of dementia when delirium has high mortality. Thus careful observation of the resident and review of potential causes are essential.

Delirium is characterized by fluctuating states of consciousness, disorientation, decreased environmental awareness, and behavioral changes. The onset of delirium may vary, depending on the severity of the cause(s) and the resident's health status; however, it usually develops rapidly, over a few days or even hours. Even with successful treatment of cause(s) and associated symptoms, it may take several weeks before cognitive abilities return to pre-delirium status.

Successful management depends on accurate identification of the clinical picture, correct diagnosis of specific cause(s), and prompt nursing and medical intervention. Delirium is often caused and aggravated by multiple factors. Thus, if you identify and address one cause, but delirium continues, you should continue to review the other major causes of delirium and treat any that are found.

II. TRIGGERS

Delirium problem suggested if:

1. ANY Indicator of Disordered Thinking **[B5a, B5b, B5c, B5d, B5e = any checked]**

2. Cognitive/Communication/Behavior Decline **[B6 = 2 or C6 = 2 or H7 = 2]**

3. Mood Decline **[H6=2]** AND ANY of following:

   - Motor Agitation **[H1c = checked]**
   - Withdrawal **[H1d = checked]**
   - Hallucinations/Delusions **[K1g = checked]**

4. Alcohol Withdrawal, Drug-induced, Acute or Subacute Delirium
   [J2 = 291.0, 292.81, 293.0, or 293.1]

III. GUIDELINES

Detecting signs and symptoms of delirium requires careful observation. Knowledge of a person's baseline cognitive abilities facilitates evaluation.

- Staff should become familiar with residents' cognitive function by regularly observing the resident in a variety of situations so that even subtle but important changes can be recognized.

When observed in this manner, the presence of any trigger signs/symptoms may be seen as a potential marker for acute, treatable illness.

An approach to detection and treatment of the problem can be selected by reviewing the items that follow in the order presented. Also refer to the RAP KEY for guidance on the MDS items that are relevant.

DIAGNOSES AND CONDITIONS

By correctly identifying the underlying cause(s) of delirium, you may prevent a cycle of worsening symptoms (e.g., an infection-fever-dehydration-confusion syndrome) or a drug regimen for a suspected cause that worsens the condition. The most common causes of delirium are associated with circulatory, respiratory, infectious, and metabolic disorders. However, finding one cause or disorder does not rule out the possibility of additional contributing causes and/or multiple interrelated factors.

MEDICATIONS

Many medications given alone or in combination can cause delirium.

- If necessary, check doctor's order against med sheet and drug labels to avoid the common problem of medication error.
- Review the resident's drug profile with a physician.
- Review all medications (regularly prescribed, PRN, and "over-the-counter" drugs).

Number of medications. The greater the number, the greater the possibility of adverse drug reaction/toxicity.

- Review meds to determine need and benefit (ask if resident is receiving more than one drug class of drug to treat a condition).
- Check to determine whether nonpharmacological interventions have been considered (e.g., a a behavior management program rather than antipsychotics to address the needs of a resident who is physically or verbally abusive).

New medications.

- Review to determine whether there is a temporal relationship between onset or worsening of delirium and start of new medication.

Drugs that cause delirium.

1. PSYCHOTROPIC
   Antipsychotics
   Antianxiety/hypnotics
   Antidepressants
2. CARDIAC
   Digitalis glycosides (Digoxin),
   Antiarrhythmics, such as quinidine, procainamide (Pronestyl), disoprymide (Norpace)
   Calcium channel blockers, such as verapamil (Isoptin), nifedipine (Procardia), and diltiazem (Cardizem)
   Antihypertensives, such as methyldopa (Aldomet), propanolol (Inderal)
3. GASTROINTESTINAL
   H2 antagonists such as cimetidine (Tagamet) and ranitidine (Zantac)
4. ANALGESICS such as Darvon, narcotics (e.g., morphine, dilaudid)
5. ANTI-INFLAMMATORY
   Corticosteroids such as prednisone
   Nonsteroidal anti-inflammatory agents such as ibuprofin (Motrin)
6. OVER-THE-COUNTER DRUGS, especially those with anticholinergic properties
   Cold remedies (antihistamines, pseudoephedrine)
   Sedatives (antihistamines, e.g., Benadryl)
   Stay-awakes (caffeine)
   Antinauseants
   Alcohol

PSYCHOSOCIAL

After serious illness and drug toxicity are ruled out as causes of delirium, consider the possibility that the resident is experiencing psychosocial distress that may produce signs of delirium.

Isolation.

- Has the resident been away from people, objects and situations?
- Is resident confused about time, place and meaning?
- Has the resident been in bed or in an isolated area while recuperating from an illness or receiving a treatment?

Recent loss of family/friend. Loss of someone close can precipitate a grief reaction that presents as acute confusion, especially if the person provided safety and structure for a demented resident.

- Review the MDS to determine whether the resident has experienced a recent loss of a close family member/friend.

Depression/sad or anxious mood. Mood states can lead to confusional states that resolve with appropriate treatment.

- Review the MDS to determine whether the resident exhibits any signs or symptoms of sad or anxious mood or has a diagnosis of a psychiatric illness.

Restraints. Restraints often aggravate the conditions staff are trying to treat (e.g., confusion, agitation, wandering).

- Did the resident become more agitated and confused with their use?

Recent relocation.

- Has the resident recently been admitted to a new environment (new room, unit, facility)?
- Was there an orientation program that provided a calm, gentle approach with reminders and structure to help the new resident settle into the environment?

SENSORY LOSSES

Sensory impairments often produce signs of confusion and disorientation, as well as behavior changes. This is especially true of residents with early signs of dementia. They can also aggravate a confusional state by impairing the resident's ability to accurately perceive or cope with environmental stimuli (e.g., loud noises; onset of evening). This can lead to the resident experiencing hallucinations/delusions and misinterpreting noises and images.

Hearing.

- Is hearing deficit related to easily remedied situations — impacted ear wax or hearing aid dysfunction?
- Has sensory deprivation led to confusion?
- Has physician input been sought?

Vision.

- Has vision loss created sensory deprivation resulting in confusion?
- Have major changes occurred in visual function without the resident's being referred to a physician?

DELIRIUM RAP KEY

TRIGGERS

Delirium problem suggested if:

1. ANY indicator of Disordered Thinking **[B5a, B5b, B5c, B5d, B5e = any checked]**

2. Cognitive/Communication/Behavior Decline **[B6 = 2 or C6 = 2 or H7 = 2]**

3. Mood Decline **[H6 = 2]** AND ANY of following:

   - Motor Agitation **[H1c = checked]**
   - Withdrawal **[H1d = checked]**
   - Hallucinations/Delusions **[K1g = checked]**

4. Alcohol Withdrawal, Drug-induced, Acute or Subacute Delirium **[J2=291.0, 292.81, 293.0, or 293.1]**

GUIDELINES

Factors that may be associated with signs and symptoms of delirium:

1. **Diagnoses and Conditions.** Cardiac dysrhythmias **[J1b]**, CHF **[J1c]**, CVA **[J1k]**, Emphysema/Asthma/COPD **[J1n]**, Pneumonia **[J1o]**, Anemia **[J1v]**, Cancer **[J1x]**, Diabetes **[J1y]**, Hypothyroidism **[J1aa]**, Septicemia **[J1dd]**, Urinary tract infection **[J1ee]**, Fecal impaction **[K1e]**, Fever **[K1f]**, or Dehydration **[L3b]**. Myocardial infarction, any viral or bacterial infection (e.g., meningitis, infectious diarrhea), Surgical abdomen, Head trauma, Hypothermia, Hypoglycemia, Hyperthyroidism, or Transient Ischemic Attack (TIA) **[J2 and medical record]**.

2. **Medications.** No. of meds **[O1]**, New meds **[O2]**, Antipsychotics **[O4a]**, or Antianxiety/hypnotics **[O4b]**, Cardiac meds, GI meds, Analgesics, Antinflammatory, Anticholinergics **[from med charts]**.

3. **Psychosocial.** Isolation **[G2e; from record]**, Recent loss **[G2f]**, Sad or anxious mood **[H1]**, Restraints **[P3b, P3c, P3d]**, or Recent relocation **[Intake I2]**.

4. **Sensory impairment.** Hearing **[C1]** or Vision **[D1]**.

Clarifying information to be considered in establishing a diagnosis: Alzheimer's **[J1h]**, Time of onset within hours to days **[from record or observation]**; Sleep disturbance **[from record or observation]**

Environment conducive to reducing symptoms: Quiet, well-lit, calm, familiar objects **[from observation]**; Task segmentation **[E6]**

RESIDENT ASSESSMENT PROTOCOL: COGNITIVE LOSS/DEMENTIA

I. PROBLEM

Approximately 60% of residents in nursing facilities exhibit signs and symptoms of decline in intellectual functioning. Recovery will be possible for less than 10% of these residents — those with a reversible condition such as an acute confusional state (delirium). For most residents, however, the syndrome of cognitive loss or dementia is chronic and progressive, and appropriate care focuses on enhancing quality of life, sustaining functional capacities, minimizing decline, and preserving dignity.

Confusion and/or behavioral disturbances present the primary complicating care factors. Identifying and treating acute confusion and behavior problems can facilitate assessment of how chronic cognitive deficits affect the life of the resident.

For residents with chronic cognitive deficits, a therapeutic environment is supportive rather than curative and is an environment in which licensed and nonlicensed care staff are encouraged (and trained) to comprehend a resident's experience of cognitive loss. With this insight, staff can develop care plans focused on three main goals: (1) to provide positive experiences for the resident (e.g., enjoyable activities) that do not involve overly demanding tasks and stress; (2) to define appropriate support roles for each staff member involved in a resident's care; and (3) to lay the foundation for reasonable staff and family expectations concerning a resident's capacities and needs.

II. TRIGGERS

A cognitive loss/dementia problem is suggested if two or more of the following deficits are present:

- Short-term Memory Problem **[B2a = 1]**
- Long-term Memory Problem **[B2b = 1]**
- Two or More Memory Recall Problems **[B3a, B3b, B3c, B3d = fewer than three checked]**
- Some Decision-making Problem **[B4 = 1, 2 or 3]**
- Problem Understanding Others **[C5 = 1, 2 or 3]**
- Diagnosis of Alzheimer's Disease **[J1h = checked]**; Dementia other than Alzheimer's **[J1i = checked]**; Mental Retardation **[INTAKE I12 b-f = any checked]**; Parkinson's Disease **[J1m = checked]**; or Aphasia **[Jlj = checked]**

III. GUIDELINES

Review the following MDS items to investigate possible links between these factors and the resident's cognitive loss and quality of life. The three triggers identify residents with differing levels of cognitive loss. Even for those who are most highly impaired, the RAP seeks to help identify areas in which staff intervention might be useful. Refer to the RAP KEY for specific MDS items and other specific issues to consider.

NEUROLOGICAL

Fluctuating Cognitive Signs and Symptoms/Neurological Status. Co-existing delirium and progressive cognitive loss can result in erroneous impressions concerning the nature of the resident's chronic limitations. Only when acute confusion and behavioral disturbances are treated, or when the treatment effort is judged to be as effective as possible, can a true measure of chronic cognitive deficits be obtained.

Recent Changes in the Signs/Symptoms of the Dementia Process. Identifying these changes can heighten staff awareness of the nature of the resident's cognitive and functional limitations. This knowledge can assist staff in developing reasonable expectations of the resident's capabilities and in designing programs to enhance the resident's quality of life. This knowledge can also challenge staff to identify potentially reversible causes for recent losses in cognitive status.

Mental Retardation, Alzheimer's Disease, and Other Adult-Onset Dementias. The most prevalent neurological diagnoses for cognitively impaired residents are Alzheimer's disease and multi-infarct dementia. But increasing numbers of mentally retarded residents are in nursing facilities, and many adults suffering from Down's syndrome appear to develop dementia as they age. The diagnostic distinctions among these groups can be useful in reminding staff of the types of long-term intellectual reserves that are available to these residents.

MOOD/BEHAVIOR

Specific treatments for behavioral distress, as well as treatments for delirium, can lessen and even cure the behavioral problem. At the same time, however, some behavior problems will not be reversible, and staff should be prepared (and encouraged) to learn to live with their manifestations. In some situations where problem/distressed behavior continues, staff may feel that the behavior poses no threat to the resident's safety, health, or activity pattern and is not disruptive to other residents. For the resident with declining cognitive functions and a behavioral problem, you may wish to consider the following issues:

- Have cognitive skills declined subsequent to initiation of a behavior control program (e.g., psychotropic drugs or physical restraints)?
- Is decline due to the treatment program (e.g., drug toxicity or negative reaction to physical restraints)?
- Have cognitive skills improved subsequent to initiation of a behavior control program?
- Has staff assistance enhanced resident self-performance patterns?

CONCURRENT MEDICAL PROBLEMS

Major Concurrent Medical Problems. Identifying and treating health problems can positively affect cognitive functioning and the resident's quality of life. Effective therapy for congestive heart failure, chronic obstructive pulmonary disease, and constipation can lead, for example, to functional and cognitive improvement. Comfort (pain avoidance) is a paramount goal in controlling both acute and chronic conditions for cognitively impaired residents. Verbal reports from residents should be one (but not the only) source of information. Some residents will be unable to communicate sufficiently to pinpoint their pain.

FUNCTIONAL LIMITATIONS

Extent and Rate of Change of Resident Functional Abilities. Functional changes are often the first concrete indicators of cognitive decline and suggest the need to identify reversible causes. You may find it helpful to determine the following:

- To what extent is resident dependent for locomotion, dressing and eating?
- Could the resident be more independent?
- Is resident going downhill (e.g., experiencing declines in bladder continence, locomotion, dressing, vision, time involved in activities)?

SENSORY IMPAIRMENTS

Perceptual Difficulties. Many cognitively impaired residents have difficulty identifying small objects, positioning a plate to eat, or positioning the body to sit in a chair. Such difficulties can cause a resident to become cautious and ultimately cease to carry out everyday activities. If problems are vision-based, corrective programs may be effective. Unfortunately, many residents have difficulty indicating that the source of their problem is visual. Thus, the cognitively impaired can often benefit if tested for possible visual deficits.

Ability to Communicate. Many individuals suffering from cognitive deficits seem incapable of meaningful communication. However, many of the seemingly incomprehensible behaviors (e.g., screaming, aggressive behavior) in which these individuals engage may constitute their only form of communication. By observing the behavior and the pattern of its occurrence, one can frequently come to some understanding of the needs of individuals with dementia. For example, residents who are restrained for their own safety may become noisy due to bladder or bowel urgency.

- Is resident willing/able to engage in meaningful communication?
- Does staff use non-verbal communication techniques (e.g., touch, gesture) to encourage resident to respond?

MEDICATIONS

Psychoactive medications can be a factor in cognitive decline. If necessary, review Psychotropic Drug Use RAP.

INVOLVEMENT FACTORS

Opportunities for Independent Activity. Staff can encourage residents to participate in the many available activities, and staff can guard against assuming an overly protective attitude toward residents. Decline in one functional area does not indicate the need for staff to assume full responsibility in that area nor should it be interpreted as an indication of inevitable decline in other areas. Review information in the MDS when considering the following issues:

- Are there factors that suggest that the resident can be more involved in his/her care (e.g., instances of greater self-performance; desire to do more independently; retained ability to learn; retained control over trunk, limbs, and/or hands)?
- Can resident participate more extensively in decisions about daily life?
- Does resident retain any cognitive ability that permits some decision making?
- Is resident passive?
- Does resident resist care?
- Are activities broken into manageable subtasks?

Extent of Involvement in Activities of Daily Life. Programs focused on physical aspects of the resident's life can lessen the disruptive symptoms of cognitive decline for some residents. Consider the following:

- Are residents with some cognitive skills and without major behavioral problems involved in the life of the facility and the world around them?
- Can modifying task demands, or the environmental circumstances under which tasks are carried out, be beneficial?
- Are small group programs encouraged?
- Are special environmental stimuli present (e.g., directional markers, special lighting)?
- Do staff regularly assist residents in ways that permit them to maintain or attain their highest predictable level of functioning (e.g., verbal reminders, physical cues and supervision regularly provided to aid in carrying out ADLs; ADL tasks presented in segments to give residents enough time to respond to cues; pleasant, supportive interaction)?
- Has the resident experienced a recent loss of someone close (e.g., death of spouse, change in key direct care staff, recent move to the nursing facility, decreased visiting by family and friends)?

FAILURE TO THRIVE

Cognitively impaired residents can reach the point where their accumulated health/neurological problems place them at risk of clinical complications (e.g., pressure ulcers) and death. As this level of disability approaches, staff can review the following:

- Do emotional, social, and/or environmental factors play a key role?
- If a resident is not eating, is this due to a reversible mood problem, a basic personality problem, a negative reaction to the physical and interactive environment in which eating activity occurs, or a neurological deficit such as deficiency in swallowing or loss of hand coordination?
- Could an identified problem be remedied through improved staff education — trying an antidepressant medication, referral to OT for training or an innovative counseling program?
- If causes cannot be identified, what reversible clinical complications can be expected as death approaches (e.g., fecal impaction, UTI, diarrhea, fever, pain, pressure ulcers)?
- What interventions are or could be in place to decrease complications?

COGNITIVE LOSS/DEMENTIA RAP KEY

TRIGGERS

A cognitive loss/dementia problem deficit and retained abilities suggested if two or more of the following deficits are present:

- Short-term Memory Problem **[B2a = 1]**
- Long-term Memory Problem **[B2b = 1]**
- Two or More Memory Recall Problems **[B3a, B3b, B3c, B3d = less than 3 checked]**
- Some Decision-making Problem **[B4 = 1, 2, or 3]**
- Problem Understanding Others **[C5 = 1, 2 or 3]**
- Diagnosis of Alzheimer's **[J1h = checked]**; Dementia other than Alzheimer's **[J1i= checked]**; Mental Retardation **[INTAKE I12b-f = any checked]**; Parkinson's **[J1m = checked]**; or Aphasia **[Jlj = checked]**

GUIDELINES

Factors to review for relationship to cognitive loss:

1. **Neurological.** Delirium **[B5]**, Cognitive decline **[B6]**, Alzheimer's and other dementias **[J1h, J1i]**, MR/DD status **[INTAKE I12]**.

Confounding Problems that may require resolution or suggest reversible causes:

2. **Mood/behavior.** Sad mood or Mood decline **[H1, H6]**, Behavior problem or behavior decline **[H3, H7]**, Anxiety disorder **[J1p]**, Depression **[J1q]**, Manic depressive disorder **[J1r]**, Other psychiatric disorders **[J2]**.

3. **Concurrent medical problems.** CHF **[J1c]**, Other cardiovascular disease **[J1g]**, CVA **[J1k]**, Emphysema/Asthma/COPD **[J1n]**, Cancer **[J1x]**, Diabetes **[J1y]**, Hypothyroidism **[J1aa]**.

4. **Functional limitations.** ADL task segmentation **[E6]**, Decline in ADL or continence **[E8; F4]**.

5. **Sensory impairment.** Hearing/visual problems **[C1; D1]**, Rarely/never understands **[C5]**, Impaired tactile sense **[N4b]**.

6. **Medications.** Antipsychotics, Antianxiety/hypnotics, Antidepressants **[O4]**.

7. **Involvement factors.** New admission **[INTAKE I2]**, Trunk or chair restraint **[P3]**, Withdrawal from activities **[H1d]**, Encouragement of small group programs **[from record]**.

8. **Failure to thrive.** Terminal prognosis **[J1z]**, Clinical complications **[K1; L3; N2]**.

RESIDENT ASSESSMENT PROTOCOL: VISUAL FUNCTION

I. PROBLEM

The aging process leads to a gradual decline in visual acuity: a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The aged eye requires about 3-4 times more light in order to see well than the young eye.

The leading causes of visual impairment in the elderly are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. In addition, visual perceptual deficits (impaired perceptions of the relationship of objects in the environment) are common in the nursing home population. Such deficits are a common consequence of cerebrovascular events and are often seen in the late stages of Alzheimer's disease and other dementias. The incidence of all these problems increases with age.

In 1974, 49% of all nursing home residents were described as being unable to see well enough to read a newspaper with or without glasses. In 1985, over 100,000 nursing home residents were estimated to have severe visual impairment or no vision at all. Thus vision loss is one of the most prevalent losses of residents in nursing facilities. A significant number of residents in any facility may be expected to have difficulty performing tasks dependent on vision as well as problems adjusting to vision loss.

The consequences of vision loss are wide-ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities. This RAP is primarily concerned with identifying two types of residents: 1) Those who have treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma; Diabetes, retinal hemorrhage); and 2) those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances. Further, the assumption is made that residents with new acute conditions will have been referred to followup as the conditions were identified (e.g., sudden loss of vision; recent red eye; shingles; etc). To the extent that this did not occur, the RAP KEY followup questions will cause staff to ask whether such a referral should be considered.

II. TRIGGERS

The Visual Function RAP triggers three types of residents:

1. Residents with treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma; Diabetes, retinal hemorrhage). For glaucoma, the issue to be considered will revolve around proper use of eye medications; for diabetes, the issue centers on the possible referral for laser treatment to arrest retinal hemorrhage.

   Some Vision Impairment but not functionally blind **[D1=1 or 2]** AND presence of Glaucoma OR Diabetes **[J1t, J1y = any checked]**.

2. Residents with visual problems who are able to understand others AND make themselves understood. In most instances, these residents are able to participate in a thorough eye exam, including testing of visual acuity. The key question for these residents centers on whether current daily functioning is seriously limited by visual acuity problems.

   Vision impairment OR Side Vision problems **[D1 = 1, 2 or 3 or D2a = checked]** AND Can Both Make Self Understood AND Understand Others **[C4 = 0, 1 or 2 and C5 = 0, 1 or 2]**

3. Residents with visual problems who are not able to understand others OR make themselves understood. In most instances these residents are unable to cooperate in a thorough eye exam, including testing of visual acuity. They are triggered to ensure screening for disease that might put them at risk of blindness, as well as to determine whether the resident or family have concerns about how the visual deficit is restricting the resident.

   Vision impairment OR Side Vision problems **[D1=1, 2 or 3 or D2a = checked]** AND Cannot Make Self Understood OR Understand Others **[C4=3 or C5=3]**

III. GUIDELINES

Visual impairment may be related to many causes, and one purpose of this section is to screen for the presence of major risk factors and to review the resident's recent treatment history. This section also includes items that ask whether the visually impaired resident desires or has a need for increased functional use of eyes.

Eye medications: Of greatest importance is the review of medications related to glaucoma (phospholine iodide, pilorarpine, propine, epineprin, Timoptic or other Beta-Blockers, diamox, or Neptazane).

- Is the resident receiving his/her eye medication as ordered?
- Does the resident experience any side effects?

Diabetes Cataracts, Glaucoma, or Macular Degeneration: Diabetes may affect the eye by causing blood vessels in the retina to hemorrhage (retinopathy). All these conditions are associated with decreased visual acuity and visual field deficits. If resident is able to cooperate it is very possible to test for glaucoma and retinal problems.

Exam by ophthalmologist or optometrist since problem noted:

- Has the resident been seen a consultant?
- Have the recommendations been followed (e.g. medications, refraction [new glasses], surgery)?
- Is the recommendation compatible with the resident's wishes (e.g., medical rehab. vs. surgery)?

If neurological diagnosis or dementia exam by physician since problem noted. Check the medical record to see if a physician has examined the resident for visual/perceptual difficulties. Some residents with diseases such as myethenia gravis, stroke, and dementia will have such difficulties associated with central nervous system in the absence of diseases of the eye.

Sad or anxious mood: Some residents, especially those in a new environment, will complain of visual difficulties. Visual disorganization may improve with treatment of the sad or anxious mood.

Appropriate use of visual appliances: Residents may have more severe visual impairment when they do not use their eyeglasses. Residents who wear reading glasses for walking, for example, may misperceive their environment and bump into objects or fall.

- Are glasses labelled or color coded in a fashion that enables the resident/staff to determine when they should be used?
- Are the lenses of glasses clean and free of scratches?
- Were glasses recently lost? Were they being recently used, and now they are missing?

Functional need for eye exam/new glasses: Many residents with limited vision will be able to use the environment with little or no difficulty, and neither the resident nor staff will perceive the need for new visual appliances. In other circumstances, needs will be identified, and for residents who are capable of participating in a visual exam, new appliances, surgery to remove cataracts, etc. can be considered.

- Does resident have peripheral vision or other visual problem that impedes his/her ability to eat food, walk on the unit, or interact with others?
- Is resident's ability to recognize staff limited by a visual problem?
- If resident is having difficulty negotiating his environment or participating in self-care activities because of visual impairment has he/she been referred to low vision services?
- Does resident report difficulty seeing TV/reading material of interest?
- Does resident express interest in improved vision?
- Has resident refused to have eyes examined? How long ago did this occur? Has it occurred more than once?

Environmental modifications: Residents whose vision cannot be improved by refraction, or medical and/or surgical intervention may benefit from environmental modifications.

- Does the resident's environment enable maximum visual function (e.g. low-glare floors and table surfaces, night lights)?
- Has the environment been adapted to resident's individual needs (e.g. large print signs marking room, color coded tape on dresser drawers, large numbers on telephone, reading lamp with 300 watt bulb)? Could the resident be more independent with different visual cues (e.g., labeling items, task segmentation) or other sensory cues (e.g., cane for recognizing there are objects in path)?

Acute Problems that may have been missed: Eye pain, blurry vision, double vision, sudden loss of vision: These symptoms are usually associated with acute eye problems.

- Has resident been evaluated by a physician or ophthalmologist?

Residents with communication impairments may be very difficult to assess. Residents who are unable to understand others may have problems following the directions necessary to test visual acuity.

VISUAL FUNCTION RAP KEY

TRIGGERS

Potential for acute, reversible visual function problems suggested if:

1. Some Vision Impairment but not functionally blind [D1 = 1 or 2] AND Glaucoma OR Diabetes [J1t, J1y = any checked]

Potential for improved visual function suggested if:

2. Vision Impairment OR Side Vision problems [D1 = 1, 2 or 3 or D2a = checked] AND Can Make Self Understood AND Can Understand Others [C4 = 0, 1 or 2 and C5 = 0, 1 or 2]

3. Vision Impairment OR Side Vision problems [D1 = 1, 2 or 3 or D2a = checked] AND Cannot Make Self Understood OR Understand Others [C4 = 3 or C5 = 3]

GUIDELINES

Issues and problems to be reviewed that may suggest need for intervention:

1. Eye medications [from record]

2. Diabetes [J1y], Cataracts, Glaucoma or Macular Degeneration [J1s, J1t; J2]

3. Exam by ophthalmologist since problem noted [from record]

4. Neurological diagnosis or dementia [J1h, J1i, J1j, J1k, J1m; J2]

5. Sad or Anxious Mood [H1]

6. Appropriate use of visual appliances [D3; from record, observation]

7. Functional need for eye exam/new glasses [from observation]

8. Environmental modifications [from record, observation]

9. Other acute problems: Eye pain, blurry vision, double vision, sudden loss of vision [from record, observation]

RESIDENT ASSESSMENT PROTOCOL: COMMUNICATION

I. PROBLEM

Good communication enables residents to express emotion, listen to others, and share information. It also eases adjustment to a strange environment and lessens social isolation and depression.

EXPRESSIVE communication problems include changes/difficulties in: speech and voice production, finding appropriate words, transmitting coherent statements, describing objects and events, using nonverbal symbols (e.g., gestures), and writing. RECEPTIVE communication problems include changes/difficulties in: hearing, speech discrimination in quiet and noisy situations, vocabulary comprehension, vision, reading, and interpreting facial expressions.

When communication is limited, assessment focuses on reviewing several factors: underlying causes of the deficit, the success of attempted remedial actions, the resident's ability to compensate with nonverbal strategies (e.g., ability to visually observe nonverbal signs and signals), and the willingness and ability of staff to engage with residents to ensure effective communication. As language use recedes with dementia, both the staff and the resident must expand their nonverbal communication skills — one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, tone of voice, and posture all are powerful means of communicating with the demented resident, and recognizing and using all practical means is the key to effective communication.

II. TRIGGERS

The resident has the potential for improved communication and the RAP should be completed when the following problems are present.

Potential for improved communication is suggested if:

1. Poor Expression or Understanding [**C4 = 2 or 3 or C5 = 2 or 3**] AND
   Some Decision-Making Ability [**B4 = 0, 1 or 2**]

2. Poor Expression or Understanding [**C4 = 2 or 3 or C5 = 2 or 3**] AND
   No Decision-Making Ability [**B4 = 3**] AND
   No CVA or Neurological Problems [**J1h, J1i, J1j, J1k, J1m = none checked**]

Potential for improved hearing is suggested if:

3. Some Decision-Making Ability [**B4 = 0, 1 or 2**] AND ANY Hearing Problem [**C1 = 1, 2 or 3**]

III. GUIDELINES

The communication trigger suggests residents for whom a corrective communication treatment program may be beneficial. Specify those residents with potentially correctable problems. An effective review requires a special effort by staff to overcome any preconceived notions or fixed perceptions they may have about the resident's probable responsiveness to treatment. These perceptions may be based on the failure of prior treatment programs, as well as on assumptions that may not have been recently tested about the resident's unwillingness to begin a corrective program.

The triggers identify three types of residents:

1. Those with serious communication deficits who have retained some ability to make decisions. Such residents should have some ability to participate in a restorative communication treatment program.

2. Those with serious communication deficits in addition to no apparent ability to make decisions but no underlying CVA or neurological problems. These residents may have behavioral, mood, or environmental limitations that complicate their communication problem.

3. Those with hearing deficits and some ability to make decisions. These residents should have the intellectual ability to be considered for participation in a restorative hearing program

Review items listed on the RAP KEY as follows:

Confounding Problems.

As these confounding problems lessen or further decline is prevented, the resident's communication abilities should be reviewed.

Components of Communication.

Details of resident strengths and weaknesses in understanding, hearing and expression are the direct or indirect focus of any treatment program.

Possible Links with Causes of Communication Deficits.

- For chronic conditions that are unlikely to improve, consider communication treatments or interventions that might compensate for losses (e.g., for moderately impaired residents with Alzheimer's, the use of short, direct phrases and tactile approaches to communication can be effective).
- Are there acute or transitory conditions which if successfully resolved may result in improved ability to communicate?
- Are medications in use that could cause or complicate communication deficits, where titration or substitution may result in improved ability to communicate?
- Are opportunities to communicate limited in ways that could be remedied — e.g., availability of partners?

Treatment/Evaluation History.

- Has resident received an evaluation by an audiologist or speech-language pathologist? How recently?
- Has the resident's condition deteriorated since the most recent evaluation?
- If such an evaluation resulted in a plan of care, has it been followed as specified?

COMMUNICATION RAP KEY

TRIGGERS

Potential for improved communication suggested if:

1. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND Some Decision-Making Ability [B4 = 0, 1 or 2]

2. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND No Ability to Make Decisions [B4 = 3] AND No CVA/Neurological Problems [J1h, J1i, J1j, J1k, J1m = none checked]

Potential for improved hearing suggested if:

3. Some Decision-Making Ability [B4 = 0, 1 or 2] AND ANY Hearing Problem [C1 = 1, 2 or 3]

GUIDELINES

Confounding problems that may require resolution:

1. Decline in cognitive status [B6]
2. Decline in ADL status [E8]
3. Increased mood problems [H6]

Components of communication to be considered:

1. Hearing/Vision [C1; D1]
2. Comm. devices/Modes of expression [C2, C3]
3. Decline in communication/hearing [C6]
4. Medical status of ear — discharges, cerumen accumulation, hearing changes [from record or exam]

Factors to be reviewed for possible relationship to communication problems:

1. **Chronic Conditions.** Alzheimer's/Other dementia [J1h, J1i], Aphasia [J1j], CVA [J1k], Parkinson's [J1m], Emphysema/Asthma/COPD [J1n], Cancer [J1x], Psychiatric disorders [J2]
2. **Transitory Conditions.** Delirium [B5], Depression [J1q], Infections [J1o, J1dd, J1ee; K1f], Acute episode [K3b]
3. **Medications.** Psychotropics [O4], Narcotics, Parkinson's meds, Gentamycin, Tobramycin, Aspirin toxicity [from record]
4. **Opportunities to Communicate.** Quality/quantity of communication is (or is not) commensurate with apparent ability to communicate [staff judgement]

Clarifying issues to be considered:

1. Memory [B2; B3]
2. Recent audiology/language pathology evaluation [P1k; from record]

RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES OF DAILY LIVING—FUNCTIONAL REHABILITATION POTENTIAL

I. PROBLEM

Personal mastery of ADL and mobility are as crucial to human existence in the nursing home as they are in the community. The nursing home is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress — invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle-wasting can be expected.

The ADL RAP assists staff in setting positive and realistic goals, weighing the advantages of independence against risks to safety and self-identity. In promoting independence staff must be willing to accept a reasonable degree of risk and active resident participation in setting treatment objectives.

Rehabilitative goals of several types can be considered:

- To restore function to maximum self-sufficiency in the area indicated;
- To replace hands-on assistance with a program of task segmentation and verbal cueing;
- To restore abilities to a level that allows the resident to function with fewer supports;
- To shorten the time required for providing assistance;
- To expand the amount of space in which self-sufficiency can be practiced;
- To avoid or delay additional loss of independence; and
- To support the resident who is certain to decline in order to lessen the likelihood of complications (e.g., pressure ulcers and contractures).

II. TRIGGERS

The three MDS triggers suggest the types of residents for whom special care interventions may be most important. Such residents may have either the need and potential to improve or the need for services to prevent decline.

The two rehabilitation triggers will select all residents:

(1) Who have some ability to make decisions and who have more substantial ADL problems; or
(2) Who are more self-sufficient but who are thought to have potential for increased ADL self-sufficiency.

The maintenance trigger selects residents who lack cognitive skills. These individuals depend totally on others to ensure that their ADL status does not decline precipitously and that they do not develop complications.If a resident falls into one of these groups, the RAP should be completed.

Rehabilitative/Restorative plans suggested if resident has:

1. Some Ability to Make Decisions **[B4 = 0, 1 or 2]** AND Extensive Assistance/Total Dependence in 1 or more ADL areas **[E1a, E1b, E1c, E1d, E1e or E1f = 3 or 4 OR E3a = 3 or 4]**

2. Some Ability to Make Decisions **[B4 = 0, 1 or 2]** AND Needs no more than Limited Assistance in All ADL areas **[E1a, E1b, E1c, E1d, E1e and E1f = 0, 1 or 2 AND E3a = 0, 1 or 2]** AND Potential for More Self-Sufficiency Noted **[E7a, E7b = any checked]**

Maintenance/Complication Avoidance plans suggested if resident has:

3. No Ability to Make Decisions **[B4 = 3]** AND No Memory **[B2a = 1 AND B2b =1]** AND Some or Rare/No Understanding **[C5 = 2 or 3]**

III. GUIDELINES

Base an approach to a resident's ADL difficulty on clinical knowledge of:

- The causes of dependence;
- The expected course of the problem(s); and
- Which services work or do not work.

The MDS goal is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonably established. Many ADL-restricted residents can regain partial ability for self-care. Certain types of disease-generated losses will respond to therapy. In addition, the removal of inappropriate restraints and the close monitoring of potentially toxic medications can often result in increased functioning.

Use the items in the ADL RAP KEY to consider the resident's risk of decline and chance of rehabilitation. Responses to these items permit a focused approach to specific ADL deficits (i.e., selecting and describing the specific ADL areas where decline has been observed or improvement is possible). The first thing that needs to be considered is the possible presence of confounding problems that may require resolution before rehabilitation goals can be reasonably attempted.

The second task is to clarify the resident's potential for improved functioning. The clinician might find the following sequence of questions useful in initiating an evaluation:

- Does the resident have the ability to learn? To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status? How disabled is the resident, and does status vary?
- Is mobility severely impaired?
- Is trunk, leg, arm and/or hand use severely impaired?
- Are there distinct behavioral problems?
- Are there distinct mood problems?
- Is the resident motivated to work at a rehabilitative program?

Where rehabilitation goals are envisioned, use of the ADL Supplement will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the Supplement can assist in the evaluation of all those triggered into the RAP. Part 2 of the Supplement can be helpful when a treatment program is under consideration.

ADL SUPPLEMENT
(Attaining maximum possible independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered— In areas physical help provided, indicate reason(s) for this help.	DRESSING	BATHING	TOILETING	LOCOMOTION	TRANSFER	EATING
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc.						
Physical Limitations: Weakness, limited range of motion, poor coordination, visual impairment, pain, etc.						
Facility Conditions: Policies, rules, physical layout, etc.						

PART 2: Possible ADL goals				If wheelchair, check: ☐		
INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment— Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby ☐	Positions self in preparation	Opens/pours/ unwraps/cuts etc.
	Grasps/puts on upper/ lower body	Turns on water/adjusts temp.	Removes/ opens clothes in preparation	Walks on unit ☐	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building ☐ (uses elevator)	Prepares chair/bed (locks pads, moves covers)	Scoops/spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors ☐	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces ☐	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other ☐	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other
			Other			

ADL FUNCTIONAL/REHABILITATION POTENTIAL RAP KEY

TRIGGERS

REHABILITATION/RESTORATIVE plans suggested if:

1. Some Ability to Make Decisions **[B4=0, 1 or 2]** AND Extensive Assistance/Total Dependence in 1 or more ADL areas **[E1a, E1b, E1c, E1d, E1e or E1f = 3 or 4 OR E3a = 3 or 4]**

2. Some Ability to Make Decisions **[B4=0, 1 or 2]** AND Needs no more than limited assistance in ALL ADL areas **[E1a, E1b, E1c, E1d, E1e, and E1f = 0, 1 or 2 AND E3a = 0, 1 or 2]** AND Potential for More Self-Sufficiency noted **[E7a, E7b = any checked]**

MAINTENANCE/COMPLICATION AVOIDANCE plans suggested if:

3. No Ability to Make Decisions **[B4 = 3]** AND No Memory **[B2a = 1 AND B2b = 1]** AND Some or Rare/No Understanding **[C5 = 2 or 3]**

GUIDELINES

Confounding problems that may require resolution:

1. Delirium **[B5]**
2. Persistent mood problem **[H2]**
3. Daily behavior problem **[H3]**
4. Decline in mood/behavior **[H6, H7]**
5. Unstable/acute health problem **[K3]**
6. Use of Psychoactive medications **[O4]**

Clarifying issues to be considered:

1. Prior improvement in cognition, ADLs, mood, or behavior **[B6; E8; H6; H7]**
2. Communication and vision **[C; D]**
3. Explicit terminal prognosis **[J1z]**
4. Trunk/limb control and ability to stand **[E4]**
5. Complete ADL Supplement Part 1 for all triggered residents; for a resident with rehabilitation potential, complete ADL Supplement Part 2

RESIDENT ASSESSMENT PROTOCOL: URINARY INCONTINENCE AND INDWELLING CATHETER

I PROBLEM

Urinary incontinence is the inability to control urination in a socially appropriate manner. Nationally, 50% of nursing home residents are incontinent. Incontinence causes many problems, including skin rashes, falls, isolation, and pressure ulcers, and the potentially troubling use of indwelling catheters. In addition, continence is often an important goal to many residents, and incontinence may affect residents' psychological well-being and social interactions. Urinary incontinence is curable in many elderly residents but realistically not all will benefit from an evaluation. Catheter use increases the risk of life-threatening infections, bladder stones and cancer. Use of catheters also contributes to patient discomfort and the needless use of toxic medications often required to treat the associated bladder spasms. For many (but not all) residents, urinary incontinence is curable, and safer and more comfortable approaches are often practical for residents with indwelling catheters.

This RAP, the purpose of which is to improve incontinence, goes far beyond bladder training. Even if a patient is not believed to be a candidate for bladder training, the assessment should still be done since many other treatable conditions may be found, the treatment of which will not only improve incontinence, but the overall quality of life for the patient.

The goal of this assessment is to detect reversible causes of incontinence, such as infections and medications, and situationally induced incontinence; to identify individuals whose incontinence is caused by harmful conditions such as bladder tumors or spinal cord diseases; and to consider the appropriateness of catheter use. Staff judgment is clearly required to realize these aims. Detailed instructions are provided to facilitate this clinical process.

Continence depends on many factors. Urinary tract factors include a bladder that can store and expel urine and a urethra that can close and open appropriately. Other factors include the resident's ability (with or without staff assistance) to reach the toilet on time (locomotion), his/her ability to adjust clothing so as to toilet (dexterity), cognitive function and social awareness (e.g., recognizing the need to void in time and in an appropriate place), and the resident's motivation. Fluid balance and the integrity of the spinal cord and peripheral nerves will also have an effect on continence. Change in any one of these factors can result in incontinence, although alterations in several factors are common before incontinence develops.

II. TRIGGERS

A urinary continence or indwelling catheter problem is suggested if:

1. Occasional, Frequent, or Frank Urinary Incontinence **[F1b = 2, 3 or 4]**

2. Use of Catheter or Pads **[F3b, F3c, F3d, F3f = any checked]**

Exclusions for Triggers: Comatose **[B1]** or Explicit terminal prognosis **[J1z]**. Other exclusions may apply especially after the reversible problems have been addressed. These are noted at the beginning of each section.

III. GUIDELINES

For residents with incontinence (including those with condom catheters), all MDS items described in Section A should be addressed, unless exclusionary criteria have been met. If incontinence persists, complete Section B and, if necessary, Section C For residents with indwelling catheters, first complete Sections A and B and then complete Section D.

A. ITEMS NECESSARY TO EVALUATE INCONTINENCE OR NEED FOR CATHETER

Review the reversible problems listed on the RAP KEY. Virtually all are easily diagnosed, and their treatment will improve not only incontinence but functional status as well. Also, most of these factors can be identified by a nurse, but some will take a physician's order to carry out.

UTI.

Urinary tract infections are common causes of incontinence, especially new incontinence. Therefore, they should be looked for in all residents. If a clean catch urine is not feasible and the resident both has no memory recall and requires at least extensive assistance in self-transfer [**E1b = 3 or 4**] you may choose to forego catheterization to obtain a specimen, since identification and treatment of UTIs in this population has not been shown to make a difference.

- Send a clean catch or sterile urine specimen for microscopic analysis. If >5 WBC are found, send a fresh and sterilely obtained specimen for urine culture. If UTI is found, consider treatment.
- For residents with an indwelling catheter, a new catheter should be sterilely inserted to obtain the specimen.

Fecal Impaction.

Impaction is very common and can cause incontinence by preventing the bladder from emptying well. Thus, check for impaction in all residents who are incontinent.

- To find bowel impaction, insert a gloved finger into resident's rectum.
- The finding of no stool or small amount of soft stool indicates that impaction is unlikely to be the cause of incontinence. A record demonstrating that the resident has recently passed stool is not sufficient to rule out bowel impaction.

Delirium.

If present, this is the most important problem. Often when delirium is treated, incontinence will resolve. In the meantime, regular toileting will help.

Lack of toilet access.

Daily use of restraints can result in a resident's inability to get to the toilet; quick staff response is necessary. The toilet may also be too far away for a resident who does not get adequate warning (e.g., there may not be a toilet room near the activities room). Environmental modifications such as a bedside commode, urinal, or a room closer to the toilet can be useful. To remain continent, residents may also require more staff support, such as more timely responses to requests for assistance.

Immobility.

Immobility correlates highly with incontinence in many nursing home residents. Improving the resident's ability in transferring, locomotion and toileting will often reduce incontinence, as will providing timely staff assistance when needed.

Depression.

Severe depression can result in loss of the motivation to stay dry. Prompted toileting is often helpful as a means of positive reinforcement.

Congestive Heart Failure (CHF) or Pedal Edema.

CHF and pedal edema are especially troublesome when the resident is lying down: diuresis overwhelms the bladder. Treatment of these conditions is not difficult and will improve both incontinence and functional status.

Recent Stroke.

Once the resident is stable, delirium has cleared, and locomotion has improved, continue workup if incontinence persists. Most stroke patients are continent at this point.

Diabetes Mellitus.

Diabetes with persistently high blood sugar causes fluid loss that can cause or worsen incontinence. Treatment will improve incontinence and functional status.

Medications.

Many medications can affect the bladder or urethra and result in incontinence. Physicians would usually discontinue suspect medication if possible, weighing the risks and benefits of doing so. For instance, where a calcium channel blocker is used for mild hypertension, another medication might be easily substituted; a medication for arrhythmia, however, might not have an appropriate substitute.

- Review all medications — regularly prescribed, occasional or "PRN", and any nonprescribed ("over-the-counter") medications.

Medications that can affect continence include the following classes and types of drugs:

1. Diuretics, especially those that act quickly, such as furosemide (Lasix), bumetanide (Bumex), and metolozone (Zaroxylyn), and, less frequently, thiazide agents such as hydrochlorothiazide.

2. Sedative hypnotics, i.e., sleeping pills and antianxiety drugs such as diazepam (Valium), lorazepam, Xanax, Halcion, and Dalmane.

3. Any drug with anticholinergic properties:

   - Antipsychotics (e.g., Haldol, Mellaril)
   - Antidepressants (e.g., Elavil, Triavil)
   - Narcotics (e.g., Morphine, Dilaudid, Darvon)
   - Medication for Parkinson's disease (except Sinemet and Deprenyl)
   - Disopyramide
   - Antispasmodics (e.g., Donnatal, Bentyl)
   - Antihistamines (e.g., medications for colds)

4. Calcium channel blockers (e.g., verapamil, nimodipine, nicardipine, nifedipine, and diltiazem).

5. Drugs that affect the sympathetic nervous system:

   - Alpha blockers (e.g., prazosin and phenoxybenzamine)
   - Alpha stimulants (e.g., ephedrine, pseudoephedrine, phenyipropanolamine, and nosedrops)

B. OTHER POTENTIAL CAUSES OR FACTORS CONTRIBUTING TO INCONTINENCE OR USE OF CATHETERS

Much of the information asked for above will appear in a completed MDS. However, other items of information should be obtained and reviewed if incontinence persists. Identification and treatment of these factors will frequently not only improve incontinence, but may prevent further deterioration such as paralysis. However, in the resident who both has no memory recall [B3e = checked], requires at least extensive assistance in self-transfer [E1b = 3 or 4], and is free of related pain, there is, as of yet, no evidence that identification and treament of such factors would benefit the resident.

Pain

Pain in the bladder, or related to urination, is a distinctly rare and abnormal symptom in the incontinent patient, and often indicates another pathological process, which may be treatable. Physician evaluation is recommended.

Excessive or Inadequate Urine Output.

If daily urine output is less than 1 liter, incontinence may worsen because of very strong, concentrated urine. A daily output over 1.5 liters can overwhelm the bladder. If present, the identification of the underlying cause of the high urine output (e.g., diabetes, high calcium, or excessive fluid intake) is required before restricting fluids.

- The amount of fluid excreted daily should be measured for 1 to 2 days. This can be done using a voiding record or, if patient is severely incontinent, by inserting a temporary catheter.

Atrophic Vaginitis.

Caused by reduced amount of the female hormone estrogen, this condition causes or contributes to incontinence in many women.

- Examine vagina for evidence of estrogen deficiency.

Optimally, a pelvic exam checks for signs of atrophic vaginitis.

If a resident is impaired, or appropriate equipment is not readily available, an exam may be done in the resident's bed by spreading the labia and looking inside for redness, dryness, pinpoint hemorrhages, or easy bleeding.

- Pain or irritation during the insertion of a catheter is another useful sign of the condition (catheterization normally may be uncomfortable, but should not be painful).
- Atrophic vaginitis can be treated with a low dose of oral conjugated estrogens. Contraindications to estrogen therapy include a history of breast or endometrial cancer.

Abnormal Lab Values.

Several conditions detectable only by laboratory tests can cause incontinence. These include high blood calcium or glucose and Vitamin B12 deficiency. It is also important to check the blood urea nitrogen (BUN) or creatinine because some causes of incontinence also can damage the kidneys. All of these tests should have been done within the last 60 days, except the B12, which should have been checked within the past 3 years.

Serious Conditions That Cause or Accompany Incontinence (To Be Considered By Primary Doctor).

A doctor or a nurse practitioner can identify potentially life-threatening conditions that cause or accompany urinary incontinence. These include bladder cancer or bladder stones, prostate cancer, spinal cord or brain lesions (such as slipped discs and metastatic tumors), poor bladder compliance, and tabes dorsalis.

- Bladder cancer or stones are suggested by the presence of any amount of blood in the urine (even in microscopic amounts) without evidence of UTI. To investigate for bladder cancer, the first morning urine is sent for 2 or 3 days for cytology examinations. Residents more likely to have bladder cancer are men, smokers, and those with suprapubic pain or discomfort, a history of work exposure to certain dyes, or recent onset of urge incontinence. The physician will decide who is worked up or referred to a urologist.
- Suspected prostate cancer can be detected by a rectal exam.
- Spinal cord diseases are detected by a neurological exam.
- Decreased bladder compliance can result in damage to the kidneys and should be suspected in residents with a history of conditions that result in decreased bladder compliance (pelvic radiation therapy, abdominal/pelvic resection, radical hysterectomy or prostatectomy; or spinal cord disease).
- Another cause of incontinence is tabes dorsalis (an advanced stage of syphilis), which is treatable with antibiotics.

C. FINAL EVALUATION IF INCONTINENCE PERSISTS

After the above causes of easily treatable incontinence have been eliminated and the most serious underlying conditions have been investigated, conclude the evaluation with an assessment of the four causes of incontinence that are due to abnormalities within the bladder itself. The following section first describes these abnormalities and then describes the tests to detect their presence. A variety of treatment options is available for each type of incontinence, including treatment and care plans appropriate for every resident. In each case, the care plan can be tailored to the needs and characteristics of the resident with dementia, immobility, etc. Notably, bladder training and medications have been shown to significantly improve incontinence in even severely demented residents. The options are discussed in full detail in the educational material.

Exclusions: Although demented residents have been shown to benefit from targeted therapy, certain patients have a low probability of responding. Therefore, if a resident has no memory recall **[B3e = checked]**, is extensively dependent in self-transfer **[E1b or c = 3 or 4]**, and the facility's ability to toilet the resident on a regular schedule is limited, then the patient may not benefit from this part of the evaluation, and should be managed with pads, frequent turning and changing, or external catheters. Indications for an indwelling catheter are: the resident is in a coma or has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable urethral blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

The bladder abnormalities can be simply understood: either (1) the bladder contracts when it should not ("uninhibited bladder"), abruptly soaking the patient ("urge incontinence"); or (2) the bladder fails to contract when it should ("atonic" or underactive bladder), so that urine builds up and spills over as "overflow incontinence." Alternatively the urethra, through which the bladder empties, is either (3) blocked by an obstruction (e.g., a large prostate) or (4) unable to close tightly enough ("stress incontinence").

By doing a "stress test" and measuring the amount of urine that remains in the bladder after voiding (Post Void Residual — PVR) these conditions can be separated: the uninhibited bladder generally has little residual urine (<100 ml) and a negative stress test, while the atonic bladder has a much larger residual (e.g., >400 ml). Women with stress incontinence (it is rare in men) generally have <100 ml residual urine and a positive stress test. Men with a blocked urethra (rare in women) generally have >100 ml residual urine and a negative stress test.

Post-Void Residual (PVR).

The PVR (post-void residual) is the amount of urine left in the bladder after a void. Research has shown that many elderly people have large amounts left in the bladder after a void, even though they demonstrate no signs of this. That is, they do not feel full or uncomfortable, they have a good urine output, and do not seem to have a large bladder by palpation or percussion. Also, in men, a high PVR can signal a variety of problems, and in both men and women, knowledge of the PVR can help guide the selection of medication. Therefore, a PVR should be determined in all patients who reach this point of the evaluation. In some cases, a physician's order may be necessary to perform a PVR. If the physician chooses not to allow this, it should be documented in the chart.

- When the resident feels relatively full, he/she should void as normally as possible into a commode, bedpan, urinal, or a toilet equipped with a collection device (hat). Measure volume voided. Within 15 minutes of voiding, under sterile conditions, insert a nonpermanent catheter to measure the residual volume (PVR). Adding the volume voided to PVR gives the Total Bladder Volume (TBV).

Attention to several points will ensure that the test is done correctly. First, if the resident cannot void intentionally, do the test after an episode of incontinence. Second, after allowing the urine to drain, apply gentle pressure with your hand to the abdomen to increase the drainage. When the urine has stopped draining, withdraw the catheter slowly, continuing to press on the lower abdomen. If possible, have the resident sit up during the catheter withdrawal. Under sterile conditions, the risk of causing an infection is under 3%. Residents with known valvular heart disease (who receive antibiotic prophylaxis for dental work) probably should receive a dose of antibiotics before the PVR is checked.

Kidney Ultrasound Test for Men With a PVR Greater Than 100 ml.

- Ultrasound of the kidneys is indicated in male residents with a PVR greater than 100 ml to rule out hydronephrosis (inability of the kidneys to drain properly), which could be due to bladder obstruction and result in preventable kidney damage.

This test has no risks (compared to the risk of the dye injection in an IVP). Evidence of urine backing into the kidneys strongly suggests the need for urologic referral; if this is not done, the resident needs chronic indwelling catheterization.

Bladder Stress Test for Female Patients.

- Bladder Stress Test. When the resident has a relatively full bladder, but not a strong urge to void, have her stand or assume as upright a position as possible, relax, and cough vigorously or strain. The test is positive if there is immediate leakage similar in volume and circumstance to usual incontinence. The stress test is negative if there is a delay of more than 5 seconds, no leakage, or leakage of only a few drops, or if it is dissimilar to the usual volume and circumstance of leakage.
- Measure void plus PVR as described above (i.e., calculate Total Bladder Volume).
- Repeat Stress Test. If the bladder stress test is negative AND the Total Bladder Volume is less than 200 ml, another test is needed for verification. Insert a sterile catheter into the bladder (preferably do this while the catheter for PVR measurement is still in the bladder) and fill it with at least 200 ml of sterile water, if possible. Remove the catheter, have the patient stand up (if possible), and repeat the stress test as above.

D. FINAL EVALUATION FOR RESIDENTS WITH INDWELLING CATHETERS

After the resident with an indwelling catheter has been treated for infection and all the other treatable conditions listed above, a voiding trial can be attempted — unless the resident has terminal illness, stage 3 or 4 pressure ulcers, or untreatable urethral blockage. This trial may reveal that the catheter is not necessary after all.

Exclusions: The resident is in a coma or has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable urethral blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

- If appropriate, institute a voiding trial.

(1) Before removing the catheter, record urine output every 6 hours for one or two days. Use this record to plan when to remove the catheter so that the expected urine will not be over 800 mls during the time of the voiding trial.

(2) Remove catheter and observe. For example, if the resident usually puts out 500 ml on the day shift, remove the catheter at the beginning of that shift and observe; if resident has not voided by the end of the shift, wait until the volume gets higher, but do not exceed a volume of 800 ml.

(3) If resident is able to void, check the PVR, as detailed in **Section C**.

- If volume is greater than 400 ml, reinsert indwelling catheter permanently or until resident can be referred to a urologist.
- If PVR is between 100 and 400 ml, observe resident carefully as urinary retention may redevelop over a few days to a few weeks. If not, check for presence of incontinence: if present, complete **Section C** (above).
- If PVR is less than 100 ml, check for presence of incontinence; if present, complete **Section C** (above).

(4) If resident has not voided by the time the expected volume is 800 ml, and there is no sensation of fullness, no urge to void, and no void, reinsert an indwelling catheter and record the volume. Residents who fail the voiding trial need either urologic referral, if appropriate, or permanent catheterization.

(5) If the resident has no memory recall, is unable to transfer independently, and has incontinence that is resistant to all therapy for more than 2 weeks after removing the catheter, a catheter may be reinserted if deemed appropriate by the staff.

URINARY INCONTINENCE AND INDWELLING CATHETER RAP KEY

TRIGGERS

Incontinence care plan suggested if:

1. Incontinent 2+ Times a Week
   [F1b = 2, 3 or 4]

2. Use of Catheter or Pads
   [F3b, F3c, F3d, F3f = any checked]

EXCLUSIONS: Comatose **[B1 = 1]** or Explicit terminal prognosis **[J1z = checked]**

GUIDELINES

Possible reversible problems to be reviewed in evaluating incontinence or need for catheter:

1. Conditions: UTI **[F2a; J1ee]**, Fecal Impactions **[F2b; K1e]**, Delirium **[B5]**, Depression **[J1q]**, Edema **[K1d]**
2. Environment: Locomotion **[E1c]**, Lack of access to toilet, Barriers **[observation]**, Restraints **[P3]**
3. Diagnoses: CHF **[J1c]**, CVA **[J1k]**, Parkinson's **[J1m]**, Diabetes **[J1y]**
4. Medications: Diuretics, Parkinson's meds, Disopyramide, Antispasmodics, Antihistamines, Drugs that stimulate or block sympathetic nervous system, Calcium channel blockers (verapomil, nifedipine, diltiozem), Narcotics **[from record]**
5. Psychoactive Medications: Antipsychotics, Antianxiety/hypnotics, Antidepressants **[O4]**

Other Potential factors contributing to incontinence or use of catheter:

1. Conditions: Pain; Excessive or inadequate urine output, Atrophic vaginitis, Cancer of bladder, prostate, brain, or spine, tabes dorsalis **[from record or exam]**
2. Abnormal Lab Values: High blood calcium, high blood glucose, low B_{12}, High BUN or Creatinine **[from record]**

Final evaluation if incontinence persists:

1. Specific Tests: Not indicated when Comatose **[B1]** or both No memory recall **[B3e]** AND Dependent in Transfer, Locomotion **[E1b, E1c]**, for others, do: Post Void Residual, bladder stress test for females, reflux test (kidney ultrasound) for males with PVR >100 ml

Final evaluation for residents with indwelling catheters:
If indwelling catheter **[F3c]**, do Voiding Trial unless terminal illness **[J1z]**, stage 3/4 pressure ulcer **[N2]** and/or untreatable urethral blockage **[J2]**

RESIDENT ASSESSMENT PROTOCOL: PSYCHOSOCIAL WELL-BEING

I. PROBLEM

Well-being refers to feelings about self and social relationships. Positive attributes include initiative and involvement in life; negative attributes include distressing relationships and concern about loss of status. On average, 30% of residents in a typical nursing facility will experience problems in this area, two-thirds of whom will also have serious behavior and/or mood problems. When such problems coexist, initial treatment is often focused on mood and behavior manifestations. In such situations, treatment for psychosocial distress is dependent on how the resident responds to the primary mood/behavior treatment regimen.

II. TRIGGERS

A psychosocial well-being problem is suggested if:

1. One or More Problems With Relationships **[G2a, G2b, G2c, G2d = any checked]**

2. Grief Over Lost Status/Roles **[G3b = checked]**

III. GUIDELINES

Sequentially review the items found on the RAP KEY.

Confounding Problems.

Treatment for mood/behavior problems are often immediately beneficial to well-being.

- Do mood/behavior problems affect well-being?
- Did the mood/behavior problems appear before the reduced sense of well-being?
- Have ongoing treatment programs been effective?

Situational Factors That May Impede Ability to Interact With Others.

Environmental and situational problems are often amenable to staff intervention without the burden of staff having to "change the resident."

- Have key social relationships been altered/terminated?
- Have changes in the resident's environment altered access to others or to routine activities — for example, room assignment, use of physical restraints, assignment to new dining area?

Resident Characteristics That May Impede Ability to Interact With Others.

These items focus on areas where the resident may lack the ability to enter freely into satisfying social relationships. They represent substantial impediments to easy interaction with others and highlight areas where staff intervention may be crucial.

- Do cognitive/communication deficits or a lack of interest in activities impede interactions with others?
- Does resident indicate unease in social relationships?

Lifestyle Issues.

Residents can withdraw or become distressed because they feel life lacks meaning.

- Was life more satisfactory prior to entering the nursing facility?
- Is resident preoccupied with the past, unwilling to respond to the needs of the present?
- Has the facility focused on a daily schedule that resembles the resident's prior lifestyle?

Additional Information to Clarify the Nature of the Problem.

Supplemental assessment items can be used to specify the nature of the well-being problem for residents for whom a well-being care plan is anticipated. These items represent topics around which to phrase questions and to establish a trusting exchange with the resident. Each item includes the positive and negative end of a continuum, representing the possible range that staff can use in thinking about these issues. Staff can use or not use the items in this list. For those items selected, the following issues should be considered:

- How do staff/resident perceive the severity of the problem?
- Has the resident ever demonstrated (while in the facility) strengths in the area under review?
- Are corrective strategies now being used? Have they been used in the past? To what effect?
- Is this an area that might be improved?

PSYCHOSOCIAL WELL-BEING RAP KEY

TRIGGERS

Well-being problem suggested if:

1. One or More Problems With Relationships **[G2a, G2b, G2c, G2d = any checked]**

2. Grief Over Lost Status/Roles **[G3b = checked]**

GUIDELINES

Confounding problems:
1. Increasing/persistent sad mood **[H2, H6]**
2. Increasing/daily disturbing behavior **[H3, H7]**

Situational factors that may impede ability to interact with others:
1. Loss of family member, friend, or staff close to resident **[G2f; from record]**
2. Initial use of physical restraints **[P3]**
3. Change in room assignment or new admission **[Intake I2; from record]**

Resident characteristics that may impede ability to interact with others:
1. Delirium/cognitive decline **[B5, B6]**
2. Communication deficit/decline **[C4, C5, C6]**
3. Locomotion deficit/use of wheelchair **[E1c, E5c, E5d]**
4. Ill at ease interacting with others **[G1]**
5. Diseases that impede communication — Alzheimer's **[J1h]**, Other dementia **[J1i]**, Depression **[J1q]**, terminal prognosis **[J1z]**, Mental retardation **[Intake I12]**
6. Uninvolved in activities **[I2, I4]**

Lifestyle issues:
1. Strong identification with past roles/status **[G3a]**
2. Incongruence of current and prior style of life **[Intake III]**
3. Length of time problem existed **[from record]**

Supplemental problem clarification issues [from resident/family if necessary]:
1. Ability to relate to others
   - — Skill/unease in dealing with others
   - — Reaches out/distances self
   - — Friendly/unapproachable
   - — Flexible/ridiculed by others

2. Relationships resident could draw on
   - — Supported/isolated
   - — Many friends/friendless

3. Dealing with grief
   - — Moving through grief/bitter and inconsolable
   - — Religious faith/feels punished

RESIDENT ASSESSMENT PROTOCOL: MOOD STATE

I. PROBLEM

About 15% of nursing home residents will have a major depression; about 30% will exhibit noticeable symptomatic signs of a mood state problem. Such signs are often expressed as sad mood, feelings of emptiness, anxiety or unease. They are also manifested in a wide range of bodily complaints and dysfunctions, such as loss of weight, tearfulness, agitation, aches and pains.

II. TRIGGERS

A Mood State problem is suggested if any of the following are found:

1. Verbal Expressions of Sad or Anxious Mood [H1a = checked].

2. Demonstrated (observable) Signs of Mental Distress [H1b, H1c, H1d, H1e, H1f, H1g = any checked].

3. Persistent Sad or Anxious Mood [H2 = 1].

III. GUIDELINES

Specific conditions stated below suggest the need for an altered/new care strategy. They are not exhaustive; other situations may arise in which staff decide that an altered care plan is necessary. The most obvious are instances of drug-induced side effects (addressed in Psychotropic Drug Use RAP). Residents whose mood problems do not call for care plan alterations are those with stable behavior and no unusual confounding problems.

Many of the questions and issues that follow relate to the MDS items listed on the Mood State RAP KEY. An altered care strategy is suggested when specified conditions are met.

Have Mood State Problems Recently Intensified?

- Were mood problems present 6 months ago?
- Does resident have a cyclic history of decline and improvement in mood state?
- Has loss of appetite with accompanying weight loss occurred?
- Has interest in activities declined, even though resident remains physically capable?

Mood Unimproved and Potentially Reversible Causes Present.

Resolution of delirium (fluctuating consciousness) behavioral, relationship and/or communication problems often affect a resident's mood state. Only when these conditions have been addressed can the nature of a mood problem be fully understood.

- Review record to determine whether there has been a sudden onset or worsening of cognitive symptoms or communication skills following initiation of treatment (e.g., medications)
- Review to determine whether the resident is using any medications known to cause mood shifts, such as: psychotropics; antihypertensives, such as clonidine (Catapres), quanethedine (Ismelin), methlydopa (Aldomet), propeneral (Inderal), and reserpine; cimetidine (Tagamet); cytoxic agents; digitalis; immunosuppressives; sedatives; steroids; or stimulants.

Also, consider the possible presence of other complicating factors, such as:

- Delirium
- Review recent changes in the life of the resident (e.g., death of a child, transfer to new environment, separation from loved ones, loss of functional abilities or change in body image, loss of autonomy)
- Review nature and intensity of relationship and/or behavior problems

ADL decline can be both a cause and a consequence of distressed mood. Reviewing the sequence of ADL and mood decline may be informative. In any case, where mood seems to impair ADL functioning, useful strategies include modifying the physical environment, separating the resident's performance of ADL activities into a series of subtasks, and using verbal reminders and cues.

When Staff/Family Try to "Cheer Up" Resident, Is Mood Unchanged? Does the Resident Lack Initiative?

The passive resident with distressed mood may be overlooked. Such a resident may be erroneously assumed to have no mood state problem.

- Does the resident show little/no initiative?
- Does he/she remain uninvolved in activities (alone or with others)?
- Is the sad mood persistent?

Are There Indications of New or Intensified Problems With Conditions That May Affect Mood Problems?

These conditions include: Alzheimer's Disease, cancer, cardiac disease, metabolic and endocrine disorders (e.g., hypercalcemia, Cushing's disease, Addison's disease, hypoglycemia, hypokalemia, porphyria), Parkinson's disease, stroke, or other neurological disease, and thyroid disease.

Does Sad Mood Appear to Respond to Treatment (e.g., Drug Regimen)?

- Has the mood problem remained relatively unchanged for the last 90 days, or has it improved with the current treatment program?
- Have there been cycles of decline and improvement?
- Is resident receiving medications and/or psychosocial therapy?

MOOD STATE RAP KEY

TRIGGERS

A mood problem suggested if:

1. Verbal Expression of Sad/Anxious Mood **[H1a = checked]**

2. Any Demonstrated Sign of Mental Distress **[H1b, H1c, H1d, H1e, H1f, H1g = any checked]**

3. Mood Persistence **[H2 = 1]**

GUIDELINES

Indicators of the need to consider a new/altered care strategy:

1. Mood decline **[H6]**

2. Mood unimproved **[H6]** AND reversible conditions present

   — Delirium/cognitive decline; Hallucinations/delusions **[B5, B6; K1g]**
   — Communication decline **[C6]**
   — ADL decline **[E8]**
   — Grief due to loss of loved one **[G2]**
   — Recent move into/within facility **[INTAKE I2]**
   — Use of meds known to cause mood shifts (e.g., antihypertensives, cimetidine, clonidine, cytoxic agents, digitalis, guanethidine, immunosuppressive, methyldopa, nitrates, propranolol, reserpine, steroids, stimulants) **[from record]**

3. Mood unimproved **[H6]** AND indication of cognitive ability/memory, decision-making ability, and ability to understand **[B2, B4; C5]** AND ANY of following:

   — Little or no initiative shown **[G1]**
   — Little or no involvement in activities **[I2]**
   — No medications **[O1]**
   — No psychological therapy **[P1n]**

4. Relationship and/or behavioral problems present **[G2; H3]**

Confounding issues to be considered:

1. Communication skills **[C4; C5]**
2. Diseases: Neurological disease **[J1h, J1i, J1j, J1m]**, CVA **[J1k]**, Anxiety **[J1p]**, Depression **[J1q]**, Manic depressive **[J1r]**, Thyroid disease **[J1aa]**, Hypercalcemia, Cushing's, Addison's, Hypoglycemia, Hypokalemia, Porphyria, Psychosis **[J2]**

RESIDENT ASSESSMENT PROTOCOL: BEHAVIOR PROBLEM

I. PROBLEM

Between 60% and 70% of residents in a typical nursing facility exhibit emotional, social, and/or behavior disorders; about 40% have purely behavioral problems (i.e., wandering, verbal abuse physically aggressive and/or socially inappropriate behaviors). Residents with behavior problems also frequently have other related problems. Over 80% of those who have behavior problems will have some type of cognitive deficit; about 75% will have mood and/or relationship problems.

Problem behaviors are often seen as a source of danger and distress to the residents themselves and sometimes to other residents and staff. Nursing facilities often find such residents difficult to cope with, and physicians often seem unaware of the wide range of available treatment and management options. As a result, overuse of physical restraints or psychotropic drugs is not uncommon. About one-half of residents who exhibit "problem" behaviors will be physically restrained, and about one-half will receive psychoactive medications — antipsychotics (neuroleptics), antianxiety agents, and, to a lesser extent, antidepressants. These interventions, however, have potentially serious negative side-effects, and many nurses in nursing facilities report being uncomfortable using only physical restraints and/or psychotropics to manage residents with behavior problems. As a result, there is an increasing trend toward using other interventions and treatments in addressing problem behaviors.

II. TRIGGERS

The MDS trigger items identify two types of residents for whom further review is suggested: residents who exhibit the problem behaviors of wandering, being verbally abusive, being physically aggressive and/or exhibiting socially inappropriate behaviors AND residents who are not currently exhibiting problem behaviors but who are receiving treatment or intervention that might mask or prevent the manifestation of the behavior (e.g. no wandering because restrained).

Review of behavior status is suggested if resident has:

1. One or More Behavior Problems **[H3a, H3b, H3c or H3d = 1 or 2]**

The possibility of elimination or reduced treatment/intervention is suggested if:

2. Behavior Improved **[H7 = 1]** AND Use of Antipsychotics OR Antidepressants **[O4a or O4c = 1 - 7]**

3. Behavior Improved **[H7 = 1]** AND Use of Trunk OR Limb Restraints **[P3b or P3c = 1 or 2]**

III. GUIDELINES

The items in this RAP (and in the RAP KEY) begin with those items that help to draw the distinction between serious behavior problems and others that can be more easily accommodated. This is followed by a section on potential causes or factors involved in the manifestation of problem behaviors the resolution of which might reduce or eliminate the behavior(s).

EVALUATING THE SERIOUSNESS OF BEHAVIOR PROBLEMS

The first trigger identifies residents who currently exhibit some type of problem behavior for which additional or new treatment programs may be considered. Not all behaviors need an extensive intervention. Some behaviors neither endanger nor distress the resident or others. For example, many

hallucinations and delusions (when not a sign of a psychosis or an acute condition such as delirium) are benign. Residents with such behavioral manifestations may be accommodated (e.g., tolerated, behavior rechanneled or redirected) within the environment of the nursing facility. Thus, determining whether a particular behavioral manifestation is a problem is an important step and involves determining the nature and severity of the behavior(s) in question and the effects of the behavior(s).

Observing Specific Behavioral Manifestations in the Most Recent 7-Day Period.

- Review to determine the intensity, duration, and frequency of behavior problems over the last 7-day and 14-day periods. Did these change or vary over time?
- Is there a pattern to the behavior manifestations based on observations over a 7-14 day time period? (Consider such factors as time of day, nature of the environment, what the resident and others were doing at the time the problem behavior was manifested.)

Identifying Stability/Change in the Nature of Behavioral Problems.

Identifying patterns of behaviors over time may help clarify the underlying causes of problem behaviors. For example, such a review may reveal a pattern in which a resident's catastrophic reactions typically occur only in the presence of a particular combination of stressors (e.g., a person who can tolerate large groups for singing but not for meals). Similarly, observing a resident over time may reveal that a resident's seemingly random behaviors are associated with particular events (e.g., yelling/screaming associated with objecting to someone changing the channel during a favored television program; wandering associated with the need to toilet). Addressing the causes of such patterns may reduce or eliminate the behavior.

- How did behavior develop over time? Were problem signs evident earlier in the resident's stay or even earlier in the resident's life?
- Has resident experienced recent changes (e.g., movement to a new unit, assignment of new nonlicensed direct care staff to the unit, change in medication, withdrawal from a treatment program, decline in cognitive status)?

Determining the Ways in Which Behavior Problem Impinges on Other Functioning.

Understanding that a behavior can — but does not always — interfere with a resident's self-performance and treatment regimens is useful in considering the need for interventions. This view can also help to ensure that aggressive treatments or interventions (e.g., physical restraints or antipsychotics) are not introduced simply to keep the resident "looking normal."

- Does the behavior endanger the resident? Others? If so, in what ways does it endanger the resident or others?
- Are behavior problems related to daily variations in functional performance? If so, how?
- Does behavior problem lead to resistance to care?
- Does it lead to difficulties dealing with people and coping in the facility?

REVIEW OF POTENTIAL CAUSES OF BEHAVIOR PROBLEMS

Many behaviors, however, are problematic for the resident or others. Many are directly associated with acute health conditions, neurological diseases, or psychiatric conditions. Still others originate in the resident's reaction to external factors, such as psychotropic medications, the use of physical restraints, and stressors in the environment (e.g., loud noises, changes in familiar routines). Identifying the various factors involved in the manifestation of problem behaviors is critical. Such a process may reveal conditions that can be resolved, thus eliminating or reducing the problem behaviors. Further, distinguishing

among potential causes or interrelationships is essential to developing an appropriate care plan (e.g., distinguishing between behaviors originating with neurological condition as contrasted to a psychotic syndrome). Consideration of the items in the Behavior Problem RAP KEY (as well as in related RAPs as indicated) should facilitate this process.

Cognitive Status Interactions.

Decision-making ability is a key indicator of effective cognitive skills. Resolving acute confusional state or delirium, a potentially reversible problem, can be critical to behavior management. (See Delirium RAP if a diagnosis or signs and symptoms of delirium are present.)

For many residents with chronic progressive dementia, certain behaviors may continue in spite of remedial treatments or interventions. In some instances, the behaviors will be distressing; however, in many instances behaviors can be accommodated. For example, many residents who wander can be accommodated without restraints in a hazard-free environment. Similarly, the needs and patterns of demanding residents or those with catastrophic reactions can often be anticipated or the most disrupting reactions to the distress alleviated. The Cognitive Loss/Dementia RAP refers to several issues that can be considered for such residents. Thus, that RAP should be completed prior to this RAP on Behaviors for residents who have cognitive problems.

Presence of Disturbed Mood and/or Relationship Interactions.

Mood and relationship problems often produce disturbed behaviors. If the underlying problems are resolved, the behavior may lessen or stop.

- Does the resident have an unresolved mood state or relationship problem that may lead to behavior problems (e.g., anxiety disorder and agitation; depression or isolation and verbally abusive behavior)? Refer to the Psychosocial Well-Being RAP and to the Mood State RAP.

- Is there an association among mood state, relationship, and behavior problems?
- Can a cause and effect relationship be determined?
- Does the resident experience a sense of frustration because of rejection by family? If so, does this frustration result in the resident verbally abusing staff or other residents?

Relationship Difficulties That May Affect Behavior.

- Does the presence or absence of other persons precipitate an event?
- Was a combative act prompted by paranoid delusions about another's motives or actions?
- Did recent loss of a loved one, change in staff, an intrafacility move, or placement with a roommate with whom the resident cannot communicate lead to disruptive behavior?

Environmental Conditions.

A review of the resident's behaviors over time may, as noted earlier, reveal a pattern of behaviors that helps identify the causes of the behaviors. Because environmental conditions often have a profound effect on residents' behaviors, these factors should be given special consideration.

- Are staff sufficiently responsive? Do they recognize stressors for the resident and early warning signs of problem behavior?
- Do staff follow the resident's familiar routines?
- Do noise, crowding or dimly lit areas affect resident's behavior?
- Are other residents physically aggressive?

Illness/Conditions.

Sometimes, the onset of acute illnesses and/or the worsening of a chronic illness produces disturbed behaviors. Often identification and treatment of the illness will resolve the problem behavior. In addition, a resident with certain chronic conditions, particularly difficulties in making his/her needs understood or in understanding others may also exhibit problem behaviors that can be eliminated or reduced if more effective methods of communication are adopted by staff and families. Sensory impairments (vision, hearing) may also produce disruptive behaviors that would lessen or disappear if the underlying condition were addressed.

- Can physical health factors close in time to the disturbed behavior be identified (e.g., pain or discomfort from physical conditions such as arthritis, constipation, or headache)?
- Can the observed behavior be associated with an acute illness (e.g., urinary tract infection, other infections, fever, hallucinations/delusions, sleep deprivation, physical trauma, nutritional deficiencies, weight loss, dehydration/insufficient fluids, electrolyte disorder, or acute hypotension)?
- Can the observed behavior be associated with the worsening of a chronic illness (e.g., congestive heart failure, diabetes, psychoses, Alzheimer's disease or other dementia, CVA, or hypoglycemia for a diabetic)?
- What was the role of impaired hearing, vision, or ability to communicate?

Current Treatment Procedures: Positive and Negative Consequences.

A number of treatment or management interventions may affect a resident's behavior. Some may have had a positive effect, while others may exacerbate existing problem behaviors — or produce new problems. Both are important to consider in reaching a decision about whether to proceed with a care plan intervention. For example, review the resident's interest in, use of, or participation in psychological treatment program(s). This review will be especially important for residents who have recently experienced improved behavioral status. For some residents and some management programs, continuation of treatments may be central to maintaining their new-found control. In other cases, either the interventions can be normally reduced (at least on a trial basis), or the side effects of the intervention may be so severe that alterations in the treatment regimen should be considered. For example, a drug or restraint program may result in increased confusion and agitation, reduced ADL self-performance, a decline in mood, or a general decrease in the quality of life for the resident. On the other hand, breaking tasks of daily life down into smaller steps that the resident can comprehend and perform may reduce stress and prevent problem behavior.

- Has the resident been reviewed by a psychiatrist, etc.? When?
- Are there indicators that treatments have helped resident gain increased control over life? What were they?
- Can improvement be attributed to an identifiable treatment?
- If behavioral problems have lessened, can medication or behavior management programs be withdrawn?
- Is the onset or change of behaviors associated with the start of (or change in prescription of) a medication(s)?
- Is the behavior associated with the use of a physical restraint (e.g., increased agitation and anger)?
- Has the resident received care in a specially designed therapeutic unit?
- Are there special staff training/support programs that focus on managing behavior problems? What disciplines are involved? How frequent/consistent is the training?
- Has task segmentation been used to maximize resident involvement?

BEHAVIOR PROBLEM RAP KEY

TRIGGERS

Review of behavior status suggested if:

1. One or More Behavior Problems **[H3a, H3b, H3c or H3d = 1 or 2]**

Review of treatment intervention suggested if:

2. Behavior Improved **AND** Use of Antipsychotics or Antidepressants **[H7 = 1 AND O4a or O4c = 1-7]**

3. Behavior Improved and Use of Trunk or Limb Restraints **[H7 =1 AND P3b or P3c = 1 or 2]**

GUIDELINES

Review and describe problem behavior:

1. **Evaluating the seriousness and stability/change of behavior problems.** Review of intensity, duration, frequency and, if any, pattern of behaviors, their development over time, and their effect on the resident and others **[from record]**.

Review potential causes that could be addressed or resolved:

1. **Cognitive status problems.** Delirium/periodic disordered thinking **[B5, J2]**, Alzheimer's **[J1h]** or other dementia **[J1i]**, effects of stroke **[J1k; from record]**.
2. **Mood and/or relationship problems.** Unsettled relationships **[G2]**, sad or anxious mood **[H1]**, psychiatric diagnosis **[J1p, J1q, J1r]**.
3. **Environmental conditions.** Staff responses, presence of stressful conditions or physically aggressive resident, departure from resident's normal routines **[from record; interviews with staff, resident]**.
4. **Illness/conditions.** Onset of acute illness, worsening of chronic illness, and other related problems, such as CHF **[J1c]**, pneumonia **[J1o]**, diabetes **[J1y]**, septicemia **[J1dd]**, UTI **[J1ee]** or other infection **[from record]**, constipation **[K1a]**, fever **[K1f]**, hallucinations/delusions **[K1g]**, pain **[K1j]**, fall with physical trauma to head **[K2; from record]**.
5. **Communication deficits.** Difficulty making self understood **[C4]** and/or understanding others **[C5]**.
6. **Sensory impairments.** Hearing/visual problems **[C1; D1]**.
7. **Treatment/management procedures.** Antipsychotics, antianxiety/hypnotics, antidepressants **[O4]**, trunk, limb or chair restraints **[P3]**, behavior management program **[H5; from record]**.

RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES

I. PROBLEM

The Activities RAP targets residents for whom a revised activity care plan may be required to identify those residents whose inactivity may be a major complication in their lives. Resident capabilities may not be fully recognized: the resident may have recently moved into the facility or staff may have focused too heavily on the instrumental needs of the resident and may have lost sight of complications in the institutional environment.

Resident involvement in passive as well as active activities can be as important in the nursing home as it was in the community. The capabilities of the average resident have obviously been altered as abilities and expectations change, disease intervenes, situational opportunities become less frequent, and extended social relationships less common. But something that should never be overlooked is the great variability within the resident population: many will have ADL deficits, but few will be totally dependent; impaired cognition will be widespread, but so will the ability to apply old skills and learn new ones; and sense may be impaired, but some type of two-way communication is almost always possible.

For the nursing home, activity planning is a universal need. For this RAP, the focus is on cases where the system may have failed the resident, or where the resident has distressing conditions that warrant review of the activity care plan. The types of cases that will be triggered are: (1) residents who have indicated a desire for additional activity choices; (2) cognitively intact, distressed residents who may benefit from an enriched activity program; (3) cognitively deficient, distressed residents whose activity levels should be evaluated; and (4) highly involved residents whose health may be in jeopardy because of their failure to "slow down."

In evaluating triggered cases, the following general questions may be helpful:

- Is inactivity disproportionate to the resident's physical/cognitive abilities or limitations?
- Have decreased demands of nursing home life removed the need to make decisions, to set schedules, to meet challenges? Have these changes contributed to resident apathy?
- What is the nature of the naturally occurring physical and mental challenges the resident experience in everyday life?
- In what activities is the resident involved? Is he/she normally an active participant in the life of the unit? Is the resident reserved, but actively aware of what is going on around him/her? Or is he/she unaware of surroundings and activities that take place?
- Are there proven ways to extend the resident's inquisitive/active engagement in activities?
- Might simple staff actions expedite resident involvement in activities? For example: Can equipment be modified to permit greater resident access of the unit? Can the resident's location or position be changed to permit greater access to people, views, or programs? Can time and/or distance limitations for activities be made less demanding without destroying the challenge? Can staff modes of interacting with the resident be more accommodating, possibly less threatening, to resident deficits?

II. TRIGGERS

The following sets of MDS based conditions indicate those residents who will require further review, as well as the types of the action that may be required:

1. Revised activity plan suggested if:

Resident Prefers More or Different Activity Choices [I5 = 1]

2. Revised activity care plan suggested to help resident overcome resident distress when ALL THREE of the following conditions met:

   a. Little/No involvement in activities **[I2 = 2 or 3]**
   b. One/More of following indicators of Distress:

      - Unsettled relationships in any area **[G2a ,G2b, G2c, G2d = Any checked]**
      - Sadness over lost roles/status **[G3b = checked]**
      - Verbal expressions of sad mood **[H1a = checked]**
      - Withdrawn — as indicated by complete absence of General Activity Preferences **[I4j = checked]**

   c. Two or more of following indicators of Communication/Cognitive Ability:

      - Short-term memory OK **[B2a = 0]**
      - At least some decision-making ability **[B4 = 0, 1, or 2]**
      - Understood/usually understood by others **[C4 = 0 or 1]**
      - Understood/usually understand others **[C5 = 0 or 1]**

3. Review of activity care plan to determine if its modification might help to overcome resident distress when either of the following conditions met:

   - -a- and -b- conditions above AND resident is bedfast **[E4b = checked]**
   - -a- and -b- conditions above AND resident has No or Only One of the four indicators of Communication/Cognitive ability (c. above).

4. Review of activity care plan suggested if: Most involvement in activities **[I2 = 0]** AND Two or more checked in measurement of time awake **[I1a, I1b, I1c = more than 1 checked]**

III. GUIDELINES

The followup review looks for factors that may impede resident involvement in activities. Although many factors can play a role, age as a valid impediment to participation can normally be ruled out. If age continues to be linked as a major cause of lack of participation, a staff education program may prove effective remedying what may be overprotective staff behavior.

Is Resident Suitably Challenged, Overstimulated? To some extent, competence depends on environmental demands. When the challenge is not sufficiently demanding, a resident can become bored, perhaps withdrawn, may resort to fault-finding and perhaps even behave mischievously to relieve the boredom. Eventually, such a resident may become less competent because of the lack of challenge. In contrast, when the resident lacks the competence to meet challenges presented by the surroundings, he or she may react with anger and aggressiveness.

- Do available activities correspond to resident lifetime values, attitudes, and expectations?
- Does resident consider "leisure activities" a waste of time — he/she never really learned to play, or to do things just for enjoyment?
- Have the resident's wishes and prior activity patterns been considered by activity and nursing professionals?
- Have staff considered how activities requiring lower energy levels may be of interest to the resident — e.g., reading a book, talking with family and friends, watching the world go by, knitting?
- Does the resident have cognitive/functional deficits that either reduce options or preclude involvement in all/most activities that would otherwise have been of interest to him/her?

Health-related factors that may affect participation in activities. Diminished cardiac output, an acute illness, reduced energy reserves, and impaired respiratory function are some of the many reasons that

activity level may decline. Most of these conditions need not necessarily incapacitate the resident. All too often, disease-induced reduction of activity may lead to progressive decline through disuse, and further decrease in activity levels. However, this pattern can be broken: many activities can be continued if they are adapted to require less exertion or if the resident is helped in adapting to a lost limb, decreased communication skills, new appliances, and so forth.

- Is resident suffering from an acute health problem?
- Is resident hindered because of embarrassment/unease due to the presence of health-related equipment (tubes, oxygen tank, colostomy bag, wheelchair)?
- Has the resident recovered from an illness? Is the capacity for participation in activities greater?
- Has an illness left the resident with some disability (e.g., slurred speech,necessity for use of cane/walker/wheelchair, limited use of hands)?
- Does resident's treatment regimen allow little time or energy for participation in preferred activities?

Recent decline in resident status — cognition, communication, function, mood, or behavior. When pathologic changes occur in any aspect of the resident's competence, the pleasurable challenge of activities may narrow. Of special interest are problematic changes that may be related to the use of psychoactive medications. When residents or staff overreact to such losses, compensatory strategies may be helpful — e.g., impaired residents may benefit from periods of both activity and rest; task segmentation can be considered; or available resident energies can be reserved for pleasurable activities (e.g., using usual stamina reserves to walk to the card room rather than to the bathroom) or activities that have individual significance (e.g., sitting unattended at a daily prayer service rather than at group activity program).

- Has staff or the resident been overprotective? Or have they misread the seriousness of resident cognitive/functional decline? In what ways?
- Has the resident retained skills, or the capacity to learn new skills, sufficient to permit greater activity involvement?
- Does staff know what the resident was like prior to the most recent decline? Has the physical/other staff offered a prognosis for the resident's future recovery, or change of continued decline?
- Is there any substantial reason to believe that the resident cannot tolerate or would be harmed by increased activity levels? What reasons support a counter opinion?
- Does resident retain any desire to learn or master a specific new activity? Is this realistic?
- Has there been a lack of participation in the majority of activities which he/she stated as preference areas, even though these types of activities are provided?

Environmental factors. Environmental factors include recent changes in resident location, facility rules, season of the year, and physical space limitations that hinder effective resident involvement.

- Does the interplay of personal, social, and physical aspects of the facility's environment hamper involvement in activities? How might this be addressed?
- Are current activity levels affected by the season of the year or the nature of the weather during the MDS assessment period?
- Can the resident choose to participate in or to create an activity? How is this influenced by facility rules?
- Does resident prefer to be with others, but the physical layout of the unit gets in the way? Do other features in the physical plant frustrate the resident's desire to be involved in the life of the facility? What corrective actions are possible? Have any been taken?

Changes in availability of family/friends/staff support. Many residents wil experience not only a change in residence but also a loss of relationships. When this occurs, staff may wish to consider ways for a resident to develop a supportive relationship with another resident, staff member or volunteer that may increase the desire to socialize with others and/or to attend and/or paticipate in activities with this new friend.

- Has a staff person who has been instrumental in involving a resident in activities left the facility/ been reassigned?
- Is a new member in a group activity viewed by a resident as taking over?
- Has another resident who was a leader on the unit died or left the unit?
- Is resident shy, unable to make new friends?
- Does resident's expression of dissatisfaction with fellow residents indicate he/she does not want to be a part of an activities group?

Possible Confounding Problems to be Considered for Those Now Actively Involved in Activities. Of special interest are cardiac and other diseases that might suggest a need to slow down.

ACTIVITIES RAP KEY

TRIGGERS

1. Revised activity plan suggested if: Resident Prefers More or Different Activity Choices **[I5 = 1]**

2. Revised activity plan suggested to help resident overcome distress if ALL of the following:
   a. Little or no involvement in activities **[I2 = 2 or 3]**
   b. Distress: Any indicators of unsettled relationships **[G2a, G2b, G2c, G2d = any checked]** OR Sadness over lost roles/status **[G3b = checked]** OR Verbal expressions of sad mood **[H1a = checked]** OR Absence of general activity preferences **[I4j = checked]**
   c. Two or more indicators of intact Communication and/or Cognitive Ability:
      — Short-term memory OK **[B2a = 0]**
      — Some decision-making ability **[B4 = 0, 1 or 2]**
      — Understood/usually understood by others **[C4 = 0 or 1]**
      — Understands/usually understands others **[C5 = 0 or 1]**

3. Revised activity plan suggested to determine whether modifications might help resident overcome distress if all of the following:
   a. Little or no involvement in activities **[I2 = 2 or 3]**
   b. Distress: Two or more indicators of unsettled relationships **[G2a, G2b, G2c, G2d = two or more checked]** OR Sadness over lost roles/status **[G3b = checked]** OR Verbal expressions of sad mood **[H1a = checked]** OR Absence of general activity preferences **[I4j = checked]**
   c. Resident is bedfast **[E4b = checked]** OR None or Only One indicator of intact Communication and/or Cognitive Ability:
      — Short-term memory OK **[B2a = 0]**
      — Some decision-making ability **[B4 = 0, 1 or 2]**
      — Understood/usually understood by others **[C4 = 0 or 1]**
      — Understands/usually understands others **[C5 = 0 or 1]**

4. Review of activity plan suggested if: Resident has Most time involvement in activities **[I2 = 0]** AND is awake all or most of time **[I1a, I1b, I1c = more than 1 checked]**

GUIDELINES

Problems to be considered as activity plan is developed:

1. Cognitive status **[B]**
2. Unstable/acute health conditions **[K3]**
3. Number of treatments received **[P1]**
4. Time in Facility **[INTAKE I2]**
5. Use of psychoactive medications **[04]**

Confounding problems to be considered:

Cardiac dysrhythmias **[J1b]**, Hypertension **[J1d]**, CVA **[J1k]**

RESIDENT ASSESSMENT PROTOCOL: FALLS

I. PROBLEM

Falls are a common source of serious injury and death among the elderly. Each year, 40% of nursing home residents fall. Up to 5% of falls result in fractures; an additional 15% result in soft tissue injuries. Moreover, most elders are afraid of falling, and this fear can limit their activities.

In about one-third of falls, a single potential cause can be identified; in two-thirds, more than one risk factor will be involved. Risk factors that are internal to the resident include the resident's physical health and functional status. External risk factors include medication side effects, the use of appliances and restraints, and environmental conditions. Identification and assessment of those who have fallen and those who are at high risk of falling are the goals of this RAP.

II. TRIGGERS

Residents who have fallen at least once are at high risk for future falls, unless underlying causes of the falls can be identified and resolved. Thus, review is suggested if there is potential for additional falls.

1. Fell in Past 30 Days **[K2a = checked]**

2. Fell in Past 31-180 Days **[K2b = checked]**

Identifying and addressing risk factors is also an important preventive step for individuals who are at very high risk of falls but have not yet fallen. The resident who has not yet had a fall is at highest risk when all three conditions listed in the third trigger are met. Elderly persons with all three risks have a nearly certain probability of falling within six months, unless risks can be reduced. Thus, review is suggested for a resident with high risk for initial falls:

3. No Indication of Fall **[K2a, K2b = not checked]** AND TWO OR MORE of following:
   - Use of Any Psychoactive Drugs **[O4a, O4b or O4c = 1-7]**
   - Impaired Sense of Balance **[E4a, E4j = any checked]**
   - Bedfast or Hemi/Quadriplegia or Poor Leg Control **[E4b, E4d, E4e, E4h = any checked]**

III. GUIDELINES

To reach a decision on a care plan, begin by reviewing whether one or more of the major risk factors listed on the RAP KEY are present. Clarifying information on the nature of the risk or type of issue to be considered for the RAP KEY items follows.

Is There a Previous History of Falls, or was the Fall an Isolated Event?

Refer to the MDS, reports of the family, and incident reports.

Internal Risk Factors.

Review to determine whether the items listed on the RAP KEY under the following headings are present. Each of these represents an underlying health problem or condition that can cause falls and may be addressed to prevent future falls.

- Cardiovascular.
- Neuromuscular/functional.
- Orthopedic.
- Perceptual.
- Psychiatric or cognitive.

External Risk Factors.

These risk factors can often be modified to reduce the resident's risk of falls.

- Medications. Certain drugs can produce falls by causing related problems (hypotension, muscle rigidity, impaired balance, other extrapyramidal side effects [e.g., tremors], and decreased alertness). These drugs include: antipsychotics, antianxiety/hypnotics, antidepressants, cardiovascular medications, and diuretics.

- Were these medications administered prior to or after the fall?
- If prior to the fall, how close to it were they first administered?

- Appliances and Devices.

- If the resident who falls (or is at risk of falling) uses an appliance, observe his/her use of the appliance for possible problems.
- Review the MDS and the resident's record to determine whether restraints were used prior to the fall and might have contributed to the fall (e.g., causing a decline function or an increase in agitation).

- Environmental/Situational Hazards. Many easily modifiable hazards (e.g., poor lighting, patterned carpeting, poorly arranged furniture) in the environment may cause falls both in relatively healthy and in frail elderly residents.

For Those Who Have Fallen Previously, Review the Circumstances Under Which the Fall Occurred.

Attempt to gather information on most recent fall. Needed information includes:

- Time of day, time since last meal.
- Was resident doing usual or unusual activity?
- Was he/she standing still or walking? Reaching up or down? Not reaching?
- Was resident in a crowd of people? Responding to bladder/bowel urgency?
- Was there glare or liquid on floors? Foreign objects in walkway? New furniture placement or other changes in environment?
- Is there a pattern of falls in any of the above circumstances?
- If you know what the resident was doing during the fall, have her/him perform that activity and observe (protect resident to ensure that a fall does not occur during this test).

Take necessary vital signs:

- At time of fall, obtain supine and upright blood pressure and heart rate, IF the resident does not have a serious injury such as a fracture of the hip or lower extremity.
- When reproducing circumstances of a fall (e.g., if the resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the residents eats).
- Measure blood pressure and heart rate when the resident is supine AND 1 and 3 minutes after standing; note temperature and respiratory rate.

For Residents At Risk of Future Falls, Review Environmental/Situational Factors to Determine Whether Modifications Are Needed

- Observe resident's usual pattern of interaction with his/her environment — the way he/she gets out of bed, walks, turns, gets in and out of chairs, uses the bathroom. Observations may reveal environmental solutions to prevent falls.
- Observe him/her getting out of bed, walking 20 feet, turning in a 360° circle, standing up from a chair without pushing off with his/her arms (fold arms in front), and using the bathroom.

FALLS RAP KEY

TRIGGERS

Potential for ADDITIONAL FALLS suggested if:

1. Fell in Past 30 Days **[K2a = checked]**
2. Fell in Past 31-180 Days **[K2b = checked]**

High Risk for INITIAL FALL suggested if:

3. No Indications of Falls **[K2a, K2b = not checked]** **AND TWO OR MORE** of the following:
   - — Use of any Psychotropic Drugs **[O4a, O4b or O4c = 1-7]**
   - — Impaired Sense of Balance **[E4a, E4j = any checked]**
   - — Bedfast or Hemi/Quadriplegia or Poor Leg Control **[E4b, E4d, E4e, E4h = any checked]**

GUIDELINES

Review risk factors for falls to identify problems that may be addressed/resolved:

1. **Multiple Falls. [K2a, K2b]**

2. **Internal Risk Factors.**
   a. Cardiovascular: Cardiac dysrhythmia **[J1b]**, Hypotension **[J1e]**, Syncope **[K1m]**
   b. Neuromuscular/functional: CVA **[J1k]**, Parkinson's **[J1m]**, Chronic/acute condition makes unstable **[K3]**, Hemiplegia **[E4d]**, Loss of leg or arm movement **[E4f, E4h]**, Unsteady gait **[E4i]**, Incontinence **[F1]**, Decline in functional status **[E8]**, Seizure disorder **[J1cc]**
   c. Orthopedic: Arthritis **[J1w]**, Joint pain **[K1i]**, Osteoporosis **[J1bb]**, Fracture of the hip **[K2c]**
   d. Perceptual: Impaired hearing **[C1]**, Dizziness/vertigo **[K1c]**
   e. Psychiatric or cognitive: Decline in cognitive skills **[B6]**, Alzheimer's **[J1h]**, Other Dementia **[J1i]**, Delirium **[B5]**, Manic depressive **[J1r]**

3. **External Factors.**
   a. Medications: Psychotropic meds **[O4a, O4b, O4c]** cardiovascular meds and diuretics **[from record]**
   b. Appliances/devices (time started): pacemaker/walker/cane **[E5a; from record]**; physical restraints **[P3b, P3c, P3d]**
   c. Environmental/situational hazards and, if relevant, circumstances of recent fall(s): glare; poor illumination; slippery floors; uneven surfaces; patterned carpets; objects in walkway; new arrangement of objects; recent move into/within facility; proximity to aggressive resident; time of day; time since meal; type of activity; standing still/walking; in a crowded area; reaching/not reaching; responding to bladder/bowel urgency

RESIDENT ASSESSMENT PROTOCOL: NUTRITIONAL STATUS

I. PROBLEM

Malnutrition is not a response to normal aging; it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. Severe malnutrition is, however, relatively rare, and this RAP focuses on signs and symptoms that suggest that the resident may be at risk of becoming malnourished. For many who are triggered, there will be no obvious, outward signs of malnutrition. Prevention is the goal, and early detection is the key.

Early problem recognition can help to ensure appropriate and timely nutritional intervention. For many residents, simple adjustments in feeding patterns may be sufficient. For others, compensation or correction for food intake problems may be required.

Within a nutrition program, food intake is best accomplished via oral feedings. Tube (enteral) feeding is normally limited to residents who have a demonstrated inability to orally consume sufficient food to prevent major malnutrition or weight loss. Parenteral feeding is normally limited to life-saving situations where both oral and enteral feeding is contraindicated or inadequate to meet nutrient needs. Oral feeding is clearly preferred. Depending on the nature of the problem, residents can be encouraged to use finger foods; to take small bites; to use the tongue to move food in the mouth from side to side; to chew and swallow each bite; to avoid food that causes mouth pain, etc. Therapeutic programs can also be designed to review for the need for adaptive utensils to compensate for problems in sucking, closing lips, or grasping utensils; to help the confused resident maintain a fixed feeding routine, etc.

II. TRIGGERS

Nutritional problem suggested if any of following observed:

1. Nutrition Deficiency ICD codes [J2 = 260, 261, 262, 263, 263.0, 263.1, 263.2, 263.8 or 263.9]

2. Weight Loss — Significant unintentional weight loss in the past month (5% or more) or six months (10% or more) is a major risk indicator. [L2c = 1]

3. Taste Alterations [L3a = checked]. Some diseases can disrupt the sense of tastes, and this can affect food intake. For example, some residents undergoing cancer therapy may find protein-like foods to be repugnant; other foods may taste bitter, overly sweet, or have no taste at all.

4. Hunger [L3d = checked]. In the absence of weight loss and in the presence of well-balanced and adequate meals, hunger is inconsistent with a good quality of life. In the presence of weight loss or in the absence of a well designed nutrition program at the facility, hunger can be an early indicator of a deficient food service program for this resident.

5. Parenteral/IV feeding [L4a = checked]. Tube or parenteral feedings may be essential for the resident who is unable to swallow oral nutriment without choking or aspirating (as in cases of Parkinson's disease and amyotrophic lateral sclerosis [ALS]), or if staff have not been able to maintain or improve the resident's nutritional status through oral intake alone.

6. Mechanically altered diet, syringe (oral) feeding, or therapeutic diet [L4c, L4d, L4e = any checked]. An overly managed diet may cause malnutrition because of the resident's refusal to eat a narrow group of selected foods or because of disinterest in the available food. The resident on such a diet must also be monitored to ensure that there is no unintended weight loss.

7. Leaves 25% of food uneaten at most meals [L3e = checked]. Assuming that portions are not excessive, this is an important indicator of the need to identify the cause of the problem. Several factors may account for this pattern: poor appetite secondary to mental or confusional problems or other disease (e.g., Alzheimer's disease, confusion, depression, cancer, food intolerances, gastroparesis secondary to diabetes mellitus, constipation); food quality may be questionable; resident may not be permitted to state food preferences; mealtimes may be poorly spaced; or quality of the food service andwr dining experience may be unacceptable.

8. Presence of pressure ulcers [N2 = 1, 2, 3 or 4]. Malnutrition and weight loss can cause pressure ulcers; pressure ulcers, in turn, can cause malnutrition. Stage II, III, and IV pressure ulcers and major stasis ulcers increase the resident's requirement for calories, protein, and fluid, and, to a lesser extent, vitamin C, zinc, and most other nutrients.

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO CONSUME FOOD

Chewing problems.

Residents with oral abscesses, ill-fitting dentures, teeth that are broken, loose, carious or missing, or those on mechanically altered diets frequently cannot eat enough food to meet their calorie and other nutrient needs. Significant weight loss can, in turn, result in poorly fitting dentures and infections that can lead to more weight loss.

Swallowing problems.

Swallowing problems arise in several contexts: the long-term result of chemotherapy, radiation therapy, or surgery for malignancy (including head and neck cancer); fear of swallowing because of COPD/emphysema/asthma; stroke; hemiplegia or quadriplegia; Alzheimer's disease or other dementia; and ALS.

Reduced ability to feed self.

Reduced ability to feed self can be due to arthritis, contractures, partial or total loss of voluntary arm movement, hemiplegia or quadriplegia, vision problems, inability to perform activities of daily living without significant assistance, and coma.

Possible Medical Causes.

Numerous conditions and diseases can result in increased nutrient requirements (calories, protein, vitamins, minerals, water, and fiber) for residents. Among these are cancer and cancer therapies, Parkinson's disease with tremors, septicemia, pneumonia, gastrointestinal influenza, fever, vomiting, diarrhea and other forms of malabsorption including excessive nutrient loss from ostomy, burns, pressure ulcers, COPD/emphysema/asthma, Alzheimer's disease with concomitant pacing or wandering, and hyperthyroidism.

Malignancy and nutritional consequences of chemotherapy, radiation therapy/surgery. For the resident undergoing therapy aimed at remission or cure, aggressive nutritional support is necessary to achieve the goal; for the resident with incurable malignancy who is undergoing palliative therapy or is not responding to curative therapy, aggressive nutritional support is often medically inappropriate.

Have the wishes of the resident and family concerning aggressive nutritional support been ascertained?

Anemia (nutritional deficiency, not malnutrition). A hematocrit of less than 41% is predictive of increased morbidity and mortality for residents.

> Are shortness of breath, weakness, paleness of mucous membranes and nailbeds, and/or clubbing of nails present?

Chronic COPD increases calorie needs and can be complicated by an elevated fear of choking when eating or drinking.

Shortness of breath (frequently seen with congestive heart failure, hypertension, edema, and COPD/emphysema/asthma). This is another condition that can cause a fear of eating and drinking, with a consequent reduction in food intake.

Constipation/intestinal obstruction/pain can inhibit appetite.

Drug-induced anorexia often causes decreased or altered ability to taste and smell foods.

Delirium.

PROBLEMS TO BE REVIEWED FOR CAUSAL LINK

Mental problems.

Dementia, depression, paranoid fears that food is poisoned, and mental retardation can all lead to anorexia, resulting in significant amounts of uneaten food and subsequent weight loss.

Behavior patterns and problems.

Residents who are fearful, who pace or wander, withdraw from activities, cannot communicate, or refuse to communicate, often refuse to eat or will eat only a limited variety and amount of foods. Left untreated, behavior problems that result in refusal to eat can cause significant weight loss and subsequent malnutrition.

- Does resident use food to gain staff attention?
- Is resident unable to understand the importance of eating?

Inability to Communicate.

For most residents, enjoying food and mealtimes crucially affects quality of life. Inability to make food and mealtime preferences known can result in a resident eating poorly, losing weight, and being unhappy. Malnutrition due to poor communication usually indicates substandard care. Early correction of communication problems, where possible, can prevent malnutrition.

- Does the area in which meals are served lend itself to socialization among residents? Is it a place where social communication can easily take place?
- Has there been a failure to provide adequate staff and/or adequate time in feeding or assisting residents to eat?
- Has there been a failure to recognize the need and supply adaptive feeding equipment for residents who can be helped to self-feed with such assistance?
- Is the resident capable of telling staff that he/she has a problem with the food being served — e.g., finds it to be unappetizing or unattractively presented?

NUTRITIONAL STATUS RAP KEY

TRIGGERS

Malnutrition problem suggested if:

1. Nutritional Deficiency [J2 = 260, 261, 262, 263, 263.1, 263.2, 263.8 or 263.9]
2. Weight loss [L2c = 1]
3. Taste alterations [L3a = checked]
4. Hunger [L3d = checked]
5. Parenteral/IV feeding [L4a = checked]
6. Mechanically altered diet, syringe (oral feeding), or therapeutic diet [L4c, L4d, L4e = any checked]
7. Leaves 25% or more food uneaten at most meals [L3e = checked]
8. Pressure sores [N2 = 1, 2, 3 or 4]

GUIDELINES

Factors that impede ability to consume food:

1. Chewing problems [L1a]
2. Swallowing problems [L1b]
3. Reduced ability to feed self [E2e]
4. Possible medical causes: Cancer [J1x], cancer therapies [P1a, P1b], septicemia [J1dd], pneumonia [J1o], fever [K1f], diarrhea [K1b], ostomy losses [F3h], anemia [J1v], shortness of breath [K1l], and nutrient/medication interactions (e.g., antipsychotics, cardiac drugs, diuretics, laxatives, antacids) [from record]

Problems to be reviewed for possible relationship to nutritional status problem:

1. **Mental problems:** fear that food is poisoned [from record; H1a, H1e], Alzheimer's [J1h], other dementia [J1i], anxiety disorders [J1p], depression [J1q]
2. **Behavior problems:** Slowness in self feeding [E7c], pacing [H1c], wandering [H3a], failure to eat and withdrawal from activities [H1d], throwing food [H3d]
3. **Inability to communicate:** Comatose [B1], unable to make food and mealtime preferences known [C3f], and difficulty making self understood [C4], difficulty understanding others [C5], aphasia [J1j]
4. **Amputation** [E4k].

RESIDENT ASSESSMENT PROTOCOL: FEEDING TUBES

I. PROBLEM

The efficacy of tube feedings is difficult to assess. When the complications and problems are known to be high and the benefits difficult to determine, the efficacy of tube feedings as a long-term treatment for individuals requires careful evaluation.

Where residents have difficulty eating and staff have limited time to assist them, insertion of feeding tubes for the convenience of nursing staff is an unacceptable rationale for use. The only rationale for such feedings is demonstrated medical need to prevent malnutrition or dehydration. Even here, all possible alternatives should be explored prior to using such an approach for long-term feeding, and restoration to normal feeding should remain the goal throughout the treatment program.

Use of nasogastric and nasointestinal tubes can result in many complications including, but not limited to: agitation, self-extubation (removal of the tube by the patient), infections, aspiration, unintended misplacement of the tube in the trachea or lungs, inadvertent dislodgement, and pain.

This RAP focuses on reviewing the status of the resident using tubes. The Nutritional Status and Dehydration/Fluid Maintenance RAPs focus on resident needs that may warrant the use of tubes. To help clarify the latter issue, the following guidelines indicate the type of review process required to ensure that tubes are used in only the exceptional and acceptable situation. As a general rule, residents unable to swallow or eat food and unlikely to eat within a few days due to physical problems in chewing or swallowing (e.g., stroke or Parkinson's disease) or mental problems (e.g., Alzheimer's depression) should be assessed regarding the need for a nasogastric or nasointestinal tube or an alternative feeding method. In addition, if normal caloric intake is substantially impaired with endotracheal tubes or a tracheostomy, a nasogastric or nasointestinal tube may be necessary. Finally, tubes may be used to prevent meal-induced hypoxemia (insufficient oxygen to blood), which occurs with patients with COPD or other pulmonary problems that interfere with eating (e.g., use of oxygen, bronchodilators, tracheostomy, endotracheal tube with ventilator support).

1. Assess causes of poor nutritional status that may be identified and corrected as a first step in determining whether or not a nasogastric or nasointestinal tube is necessary (see Nutritional Status RAP).

   (a) Eating, swallowing and chewing disorders can negatively affect nutritional status (low weight in relation to height, weight loss, serum albumin level, and dietary problems) and the initial task is to determine the potential causes and period of time such problems are expected to persist. Recent lab work should also be reviewed to determine if there are electrolyte imbalances, fluid volume imbalances, BUN, creatinine, low serum albumin, and low serum protein levels before treatment decisions are made. Laboratory measurement of sodium and potassium tell whether or not an electrolyte imbalance exists. Residents taking diuretics may have potassium losses requiring potassium supplements. If these types of imbalances cannot be corrected with oral nutrition and fluids or intravenous feedings, then a nasogastric or nasointestinal tube may be considered.

   (b) Determine whether fluid intake and hydration problems are short-term or long-term.

   (c) Review for gastrointestinal distention, gastrointestinal hemorrhage, increased gastric acidity, potential for stress ulcers, and abdominal pain.

   (d) Identify pulmonary problems (e.g., COPD and use of endotracheal tubes, tracheostomy, and other devices) that interfere with eating or dehydration.

(e) Review for mental status problems that interfere with eating such as depression, agitation, delirium, dementia, and mood disorders.

(f) Review for other problems such as cardiovascular disease or stroke.

2. Determine the need for such a tube. Examine alternatives.

Alternatives to nasogastric and nasointestinal tubes should always be considered. Intravenous feedings should be used for short-term therapy as a treamtent of choice or at least a first option. Jejunostomy-may have some advantages for long-term therapy, although may increase the risk for infection. A gastrostomy is better tolerated by agitated patients and those requiring prolonged therapy (more than 2 weeks). Gastrostomy with bolus feedings is preferable to nasogastric or nasointestinal tubes for long-term therapy for comfort reasons and to prevent the dislodgement and complications associated with nasal tubes. It is also less disfiguring as it can be completely hidden under clothing when not in use.

3 Assure informed consent and right to refuse treatment. Informed consent is essential before inserting a nasogastric or nasointestinal tube. Potential advantages disadvantages, and potential complications need to be discussed. Resident preferences are normally given the greatest weight in decisions regarding tube feeding. State laws and judicial decisions must also be taken into account. If the resident is not competent to make the decision, a durable power of attorney or living will may determine who has the legal power to act on the resident's behalf. Where the resident is not competent or no power of attorney is in effect, the physician may have the responsibility for making a decision regarding the use of tube feeding. In any case, when illness is terminal and/or irreversible, technical means of providing fluids and nutrition can represent extraordinary rather than ordinary means of prolonging life.

4. Monitor for complications and correct/change procedures and feedings when necessary. Periodic changing of the nasogastric and intestinal tubes is necessary, although the appropriate interval for changing tubes is not clear. Assessment and determination of continued need should be completed before the tube is reinserted. Specific written orders by the physician are required.

Individuals at risk of pulmonary aspiration (such as those with altered pharyngeal reflexes or unconsciousness) should be given a nasointestinal tube rather than a nasogastric tube, or other medical alternative. Those at risk for displacement of a nasogastric tube, such as those with coughing, vomiting, or endotracheally intubated, should also be given a nasointestinal tube rather than a nasogastric tube or other medical alternative.

II. TRIGGER

1. Tubes currently in use. **[L4b = checked]**

III. GUIDELINES

COMPLICATIONS OF TUBE FEEDING

To reiterate, serious potential negative consequences include agitation, depression, mood disorders, self-extubation (removal of the tube by the patient), infections, aspirations, misplacement of tube in trachea or lungs, pain, and tube dysfunction. Abnormal lab values can be expected and should be reviewed.

Infection in the trachea or lungs. Gastric organisms grow as a result of alkalizing (raising) the gastric pH. Gastric colonization results in transmission of gastric organisms to the trachea and the development of nosocomial pneumonia. In one study, colonization in 89% of patients within 4 days in ventilated patients with enteral nutrition was found with nosocomial respiratory infection in 62% of the patients studied. Symptoms of respiratory infections to be monitored include coughing, shortness of breath, fever, chest pain, respiratory arrest, delirium, confusion, and seizures.

Aspiration of gastric organisms into the trachea and the lungs. The incidence is difficult to determine, but most studies suggest it is relatively high.

Inadvertent respiratory placement of the tube is the most common side effect of tube placement. In one study, 15% of small-bore nasogastric tubes and 27-50% of nasointestinal tubes were found to be out of their intended position upon radiographic examination without any other evidence of displacement. Respiratory placement can occur in any patient, but is most likely in those who are neurologically depressed, heavily sedated, unable to gag, or endotracheally intubated. Detecting such placement is difficult; the following comments address this issue:

- Radiologic detection is the most definitive means to detect tube displacement. Under this procedure, pneumothorax and inadvertent placement in the respiratory tract can be avoided by first placing the feeding tube in the esophagus with the tip above the xiphoid process and then securing the tube and confirming placement with a chest x-ray. Then the tube may be advanced into the stomach and another x-ray taken to confirm the position. The stylet can then be removed and tube feeding begun. Unfortunately, nursing homes are highly unlikely to have appropriate radiological technology and it is normally unreasonable to expect them to make arrangements to have patients transported to available radiology.

- pH testing of gastric aspirates to determine whether a tube is in the gastric, intestine, or the respiratory area is a promising method for testing feeding tube placement. However, parameters for various secretions from the three areas have not yet been clinically defined.

- Aspiration of visually recognizable gastrointestinal secretions, although a frequently used method of determining placement of tubes, is of questionable value as the visual characteristics of secretions can be similar to those from the respiratory tract.

- Ausculatory method: although "shooshing" or gurgling sounds can indicate placement in the stomach, the same sounds can occur when feeding tubes are inadvertently placed in the pharynx, esophagus and respiratory tract. Although small-bore tubes make the ausculatory method more difficult to use, large-bore nasogastric tubes may also be placed inadvertently in the respiratory tract producing false gurgling.

Inadvertent dislodgement of the tubes. Nonweighted tubes appear to be more likely to be displaced than weighted tubes (with an attached bolus of mercury or tungsten at the tip).

Other complications include: pain, epistaxis, pneumothorax, hydrothorax, nasal alar necrosis, nasopharyngitis, esophagitis, eustachitis, esophageal strictures, airway obstruction, pharyngeal and esophageal perforations. Symptoms of respiratory infections are to be reviewed.

Complications of gastric tract infections and gastric problems. Symptoms include abdominal pain, abdominal distention, stress ulcers, and gastric hemorrhage. There is also a need to monitor for complications including diarrhea, nausea, abdominal distention, and asphyxia. Such complications signal the need for a change in the type of formula or diagnostic work for other pathology.

Complications for the cardiovascular system. Symptoms of cardiac distress or arrest to be monitored include chest pain, loss of heart beat, loss of consciousness, and loss of breathing.

Periodic tests to assure positive nitrogen balance during enteral feeding. Where positive balance is not achieved, a formula with high nitrogen density is needed. The absorptive capacity is impaired in many elderly patients so that serum fat and protein should be monitored. Effective nutrients should result in positive nitrogen balance, maintenance or increases in body weight, triceps skinfold and midarm muscle circumference maintenance, total iron binding capacity maintenance, and serum urea nitrogen level maintenance. Caloric intake and resident weight should be monitored on a regular basis.

FEEDING TUBES RAP KEY

TRIGGERS

Feeding Tube present [L4b = checked]

GUIDELINES

Factors that may impede removal of tube:

1. Comatose [B1]
2. Failure to eat [H1d] AND Resists assistance in eating [H4b; from record]
3. Diagnoses: CVA [J1k], gastric ulcers, gastric bleeding [J2]
4. Chewing problem [L1a]
5. Swallowing problem [L1b]
6. Mouth pain [L1c]
7. Length of time feeding tube has been in use [from record]

Potential complications of tube feeding:

1. Diagnostic conditions: delirium [B5], agitation [H1], anxiety [J1p], depression [J1q], lung aspirations [K1k]
2. Self-extubation (removal of tube by resident) [from record]
3. Limb restraints in use to prevent self-extubation [P3c]
4. Infections in lung/trachea: fever [K1f], shortness of breath [K1l], pneumonia [J1o], placement or dislodgement of tube into lung [from exam, record]
5. Side-effects of enteral feeding solutions: constipation [K1a], diarrhea [K1b], fecal impaction [K1e], abdominal distention or pain [exam], dehydration [L3b]
6. Respiratory problems: pneumothorax, hydrothorax, airway obstruction, acute respiratory distress, respiratory distress [J2; from observation, record]
7. Cardiac distress/arrest: chest pain, loss of heart beat, loss of consciousness, loss of breathing [from observation, record]
8. Abnormal lab values [P2]

RESIDENT ASSESSMENT PROTOCOL: DEHYDRATION/FLUID MAINTENANCE

I. PROBLEM

On average, one can live only four days without water. Water is necessary for the distribution of nutrients to cells, elimination of wastes, regulation of body temperature, and countless other complex processes.

Dehydration is a condition in which water or fluid loss (output) far exceeds fluid intake. The body becomes less able to maintain adequate blood pressure, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. Many distressing symptoms can originate from this conditions, including:

- Dizziness on sitting/standing (blood pressure insufficient to supply oxygen and glucose to brain);
- Confusion or change in mental status (decreased oxygen and glucose to brain);
- Decreased urine output (kidneys conserve water);
- Decreased skin turgor, dry mucous membranes (symptoms of dryness);
- Constipation (water insufficient to rid body of wastes); and
- Fever (water insufficient to maintain normal temperature).

Other possible consequences of dehydration include: decreased functional ability, predisposition to falls (because of orthostatic hypotension), fecal impaction, predisposition to infection, fluid and electrolyte disturbances, and ultimately death.

Nursing home residents are particularly vulnerable to dehydration. It is often difficult or impossible to access fluids independently; the perception of thirst can be muted; the aged kidney can have a decreased ability to concentrate urine; and acute and chronic illnesses can alter fluid and electrolyte balance.

Unfortunately, many symptoms of this condition do not appear until significant fluid has been lost. Early signs and symptoms tend to be unreliable and nonspecific; staff will often disagree about the clinical indicators of dehydration for specific cases; and the identification of the most crucial symptoms of the condition are most difficult to identify among the aged. Early identification of dehydration is thus problematic, and the goal of this RAP is to identify any and all possible high risk cases, permitting the introduction of programs to prevent the condition from occurring.

When dehydration is in fact observed, treatment objectives focus on restoring normal fluid volume, preferably orally. If the resident cannot drink between 2500-3000 cc's every 24 hours, water and electrolyte deficits can be made up via other routes. Fluids can be administered intravenously, subcutaneously, or by tube until resident is adequately hydrated and can take and retain sufficient fluids orally.

II. TRIGGERS

Dehydration suggested if either of following conditions apply:

1. Insufficient fluid/dehydration — actual fluid deficit [**L3b = checked**]

2. Two or more of the following are present:

- Deteriorated cognitive status [**B6 = 2**]
- Deteriorated ADL status [**E8 = 2**]
- Failure to eat or take medications [**H1d = checked**]
- UTI [**J1ee = checked**]
- Dehydration diagnosis [**J2 = 276.5**]
- Diarrhea, fever, or internal bleeding [**K1b, K1f, K1h = any checked**]
- Dizziness/vertigo [**K1c = checked**]
- Vomiting [**K1n = checked**]
- Recent weight loss [**L2c = 1**]
- Did not consume all liquids provided [**L3c = checked**]
- Leaves 25%+ food uneaten [**L3e = checked**]
- Parenteral/IV or feeding tube [**L4a, L4b = any checked**]
- Taking diuretic [**from record**]

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO MAINTAIN FLUID BALANCE

Moderate/severely impaired decision-making Ability.

- Has there been a recent unexplainable change in mental status?
- Does resident seem unusually agitated or disoriented?
- Is resident delirious?
- Is resident comatose?

Comprehension/Communication problems.

- Does dementia, aphasia or other condition seriously limit resident's understanding of others, or how well others can understand the resident?

Body control problems.

- Does resident require extensive assistance to transfer?
- Does resident freely move on the unit?
- Has there been recent ADL decline?

Hand dexterity problem.

- Can resident grasp cup?

Swallowing problems.

- Does resident have mouth sore(s)/ulcer(s)?
- Does resident refuse food, meals, meds?
- Can resident drink from a cup or suck through a straw?

Use of Parenteral/IV.

- Are feeding tubes in use?

RESIDENT DEHYDRATION RISK FACTORS

Dehydration risk factors can be categorized in terms of whether they decrease fluid intake or increase fluid loss. The higher the number of factors, the greater the risk of dehydration. Ongoing fluid loss through the lungs and skin occurs at a normal rate of approximately 500 cc/day and increases with rapid respiratory rate and sweating. Therefore, decreased fluid intake for any reason can lead to dehydration.

Purposeful Restriction of Fluid Intake.

- Has there been a decrease in thirst perception?
- Is resident unaware of the need to intake sufficient fluids?
- Has resident or staff restricted intake to avoid urinary incontinence?
- Are fluid restricted because of diagnostic procedure or other health reason?
- Does sad mood, grief, or depression cause resident to refuse foods/liquids?

Presence of infection, fever, vomiting/diarrhea/nausea, excessive sweating (e.g., a heat wave).

Frequent use of laxatives, enemas, diuretics.

Excessive urine output (polyuria).

Excessive urine output (polyuria) may be due to:

- Drugs (e.g., lithium, phenytoin), alcohol abuse
- Diseases (e.g., diabetes mellitus, diabetes insipidus)
- Other conditions (e.g., hypoaldosteronism, hyperparathyroidism)

Other test results.

Relevant test result to be considered:

- Does systolic/diastolic blood pressure drop 20 points on sitting/standing?
- On inspection, do oral mucous membranes appear dry?
- Does urine appear more concentrated and/or decreased in volume?

DEHYDRATION/FLUID MAINTENANCE RAP KEY

TRIGGER

Dehydration Suggested if:

1. Insufficient Fluid/dehydration **[L3b = checked]**

2. Two or More of following are Present:

   - Deteriorated cognitive status **[B6 = 2]**
   - Deteriorated ADL status **[E8 = 2]**
   - Failure to eat or take medications **[H1d = checked]**
   - UTI **[J1ee = checked]**
   - Dehydration diagnosis **[J2 = 276.5]**
   - Diarrhea, fever, or internal bleeding **[K1b, K1f, K1h = any checked]**
   - Dizziness/vertigo **[K1c = checked]**
   - Vomiting **[K1n = checked]**
   - Recent weight loss **[L2c = 1]**
   - Did not consume all liquids provided **[L3c = checked]**
   - Leaves 25%+ food uneaten **[L3e = checked]**
   - Parenteral/IV or feeding tube **[L4a, L4b = any checked]**
   - Taking diuretic **[from record]**

GUIDELINES

Resident Factors That May Impede Ability to Maintain Fluid Balance:

1. Moderate/severely impaired decision-making ability **[B4]**
2. Comprehension/communication problem **[C4, C5]**
3. Body control problems **[E4, E8]**
4. Hand dexterity problem **[E4g]**
5. Swallowing problem **[L1b]**
6. Use of Parenteral/IV **[L4a]**

Resident Dehydration Risk Factors:

1. Purposeful restriction of fluids **[from record]**
2. Presence of infection **[J1o, J1dd, J1ee]**, diarrhea **[K1b]**, fever **[K1f]**, vomiting **[K1n]**, nausea **[from record]**, excessive urine loss **[from record, exam]**
3. Frequent laxative/enema/diruetic use **[from record]**
4. Excessive urine output **[from record]**
5. Other tests: Standing/sitting blood pressure, status of oral mucous membranes, urine output volume **[from record; exam]**

RESIDENT ASSESSMENT PROTOCOL: DENTAL CARE

I. PROBLEM

Having teeth/dentures that function properly is an important requisite for nutritional adequacy. Having teeth/dentures that are clean and attractive can promote a resident's positive self-image as well as personal appearance thereby enhancing social interactions among residents, residents and staff, and residents and visitors. Good oral health can decrease a resident's risk of oral discomfort and in some instances, systemic illness from oral infections/cancer. Residents at greatest risk due to impaired abilities are primarily those with multiple medical conditions and medications, functional limitations in self-care, and communication deficits. Also at risk are more self-sufficient residents who lack motivation or have no consistent history of performing oral health functions. Residents with a history of alcohol and/or tobacco use have a greater risk of developing chronic oral lesions.

II. TRIGGERS

The Dental Care RAP triggers two types of residents:

- residents with oral hygiene problems; and
- residents with oral/dental health problems who may benefit from dental evaluation

A dental care problem is suggested if the following signs are present:

1. Mouth debris **[M1a = checked]** **OR** Less than daily cleaning of teeth/dentures **[M1f = not checked]**

Potential for oral/dental health problems is suggested if any of the following signs/symptoms are present:

1. Mouth pain **[L1c = checked]** **OR** Broken, loose, carious teeth **[M1d = checked]** **OR** Inflamed gums, oral abscesses, swollen or bleeding gums, ulcers, rashes **[M1e = checked]**

2. Some/all natural teeth lost —does not have or does not use dentures (or partial plates) **[M1c = checked]**

III. GUIDELINES

CONFOUNDING PROBLEMS

Debris on teeth, gums, and oral tissues may consist of food and bacteria-laden plaque that can begin to decay teeth or cause foul denture odors if not removed at least once daily. The purpose of this section is to examine confounding problems (from the MDS) which may be prohibiting a resident from adequately removing oral debris.

Impaired cognitive skills.

- Does the resident need reminders to clean his/her teeth/dentures?
- Does he remember the steps necessary to complete oral hygiene?
- Would he benefit from task segmentation or supervision?

Impaired ability to understand:

- Can the resident follow verbal directions or demonstrations for mouth care?
- If the resident has language difficulties, does he/she know what to do when handed a toothbrush/ toothpaste and placed at the bathroom sink?

Impaired vision.

- Is resident's vision adequate for performing mouth care or checking its adequacy?

Impaired personal hygiene.

- Did the resident receive supervision or assistance with oral/dental care during the last 7 days?
- Has he/she been assessed to see if he/she could do it independently?
- Does the resident have partial/total loss of voluntary arm movement or impaired hand dexterity that interferes with self-care?
- What would the resident need to be more independent?

Motivation/Knowledge of resident who is independent in oral/dental care but still has debris or performs care less than daily.

- Is he/she brushing adequately?
- Does he/she know that it is most important to brush near the gumline?
- Does he/she need to be shown how or be given reinforcement for maintaining good hygiene?

Adaptive equipment for oral hygiene.

- Has the resident tried or would he/she benefit from using a built-up, long-handled, or electric toothbrush, or suction brush for cleaning teeth?
- If resident has dentures, does he/she have denture cleaning devices (e.g., denture brush, soaking bath)?

Resists ADL assistance:

- Does the resident resist mouth care? If so, why (e.g., would rather do own care, painful mouth, apathy related to depression, not motivated—never cared for teeth/mouth, approach of staff, fear)?

Dry mouth from dehydration or medications.

- Dry mouth can contribute to the formation of debris. Is the resident's lips, tongue, or mouth dry, sticky, or coated with film?
- Is the resident taking enough fluids? Is lip balm being applied to resident who has painful, cracking or bleeding lips?
- Is he/she taking any medications that can cause dry mouth (e.g., decongestants, antihistamines, diuretics, antihypertensives, antidepressants, antipsychotics, antineoplastics)?
- If these medications are necessary, has the resident tried saliva substitutes to stimulate moisture?

TREATMENT HISTORY AND OTHER RELEVANT FACTORS

Mouth pain or sensitivity can be related to either minor and easily treatable (e.g., gum irritation from ill-fitting dentures, localized periodontal problem) or more serious problems (e.g., oral abscess, cancer, advanced tooth decay or periodontal disease). The presence of pain may prevent the resident from eating adequately. Residents with cognitive impairment and/or those who have difficulty making their needs known are difficult to assess. They may not complain specifically of mouth pain but may instead have decreased food intake or changes in behavior.

The presence of lesions, ulcers, inflammation, bleeding, swelling, or rashes may be representative of a minor problem (e.g. irritation from wearing dentures for 24 hours/day), which resolves when the cause is alleviated (e.g., combination of mouth care and leaving dentures out). However, these signs may also

indicate more serious problems, even dental emergencies (e.g., infection). If the problem does not resolve with specific local treatment after a couple of days, OR if these signs are accompanied by pain, fever, lymphadenopathy (swollen glands) and/or other signs of local infection (e.g., redness), chewing or swallowing problems, or changes in mental status or behavior, a dental consult should be considered.

- Review mouth for Candidiasis (white areas that appear to be able to be removed — anywhere in mouth, mostly on tongue) for lethargic residents who have one or more of following diagnoses: stroke, Alzheimer's, Parkinson's, anxiety disorder, depression, diabetes, osteoporosis, or septicemia.

Broken, loose, or carious teeth may progress to more severe problems (e.g., dislodging a decayed tooth and swallowing or aspirating it). Although, not emergencies, a dental consult should be considered.

If a resident has lost some or all of his/her natural teeth and does not have dentures (or partial plates) staff should consider if the resident has the cognitive ability and motivation to wear dentures.

- Has a dentist evaluated resident for dentures?
- Why doesn't resident use his/her dentures (or partial plates)?
- Are teeth in good repair?
- Do they fit well?
- Are they comfortable to wear when eating or talking?
- Does the resident like the way he/she looks when wearing them?
- Has a dentist evaluated resident for dentures?
- Has a dental hygienist interviewed and made recommendations regarding oral hygiene care?

Exam by dentist since problem noted. When evaluating a resident with mouth pain or the presence of any of the other trigger signs, check the record to see if a dentist has examined the resident since the problem was first noted.

- Was the current problem addressed?
- What were the recommendations?

Use of anticoagulants.

- Is the resident on coumadin or heparin that would put him/her at risk for bleeding if dental work is necessary?
- Is it noted on the medical record?

Valvular heart disease or prosthesis (e.g., heart valve, false hip, etc.).

- Are either of these conditions present?
- If so are they clearly noted in the medical record so that necessary precautions be taken prior to

DENTAL CARE RAP KEY

TRIGGERS

Dental Care problem suggested if:

1. Mouth Debris [M1a = checked] OR Less Than Daily Cleaning of Teeth/Dentures [M1f = not checked]

Potential for oral/dental health problems suggested if:

2. Mouth Pain [L1c = checked]; Broken, Loose or Carious Teeth [M1d = checked] OR Inflamed Gums, Oral Abscesses, Swollen/Bleeding Gums, Ulcers, Rashes [M1e = checked]

3. Some/All natural teeth lost and does not have or does not use dentures [M1c = checked]

GUIDELINES

Confounding problems to be considered:

1. Impaired cognitive skills [B1, B4]
2. Impaired ability to understand [C1, C5]
3. Impaired vision [D1]
4. Impaired personal hygiene [E2g]
5. Motivation/knowledge [from observation]
6. Adaptive equipment for oral hygiene [from record]
7. Resists ADL assistance [H4b]
8. Dry mouth from hydration [L3b, L3c] or from medications [from medication sheet]

Treatment history/relevant factors:

1. Mouth pain or sensitivity [L1c]
2. Presence of lesions, ulcers, inflammation, bleeding, swelling or rashes [M1e]
3. Broken, loose or carious teeth [M1d]
4. Natural teeth loss/no dentures [M1c]
5. Exam by dentist/dental hygenist since problem noted [from record]
6. Use of anticoagulants [from record]
7. Valvular heart disease or valvular appliance [J1, J2]

RESIDENT ASSESSMENT PROTOCOL: PRESSURE ULCERS

I. PROBLEM

Between 3% and 5% (or more) of residents in nursing facilities have pressure ulcers (pressure sores, decubitus ulcers, bedsores). Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs.

Assessment goals are: (1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

II. TRIGGERS

1. Pressure Ulcer Present. **[N2 = 1, 2, 3 or 4]**

2. Risk Factors for Pressure Ulcer. One or more of the following problems AND NOT receiving any skin care program **[N4c, N4d, N4e, N4f, N4g = not checked]**: (NOTE: these are listed in the order in which they appear in the MDS and RAP KEY — not by type or severity of risk.)

   Impaired Transfer or Bed Mobility. **[E1a or E1b = 3 or 4]** Increased risk occurs when a resident's impaired ability prevents repositioning at regular intervals.

   Bedfast, Hemiplegia, Quadriplegia. **[E4b, E4d, E4e = any checked]** These conditions predispose a resident to immobility, and the extended time (2 hours or less) spent in one position will generate sufficient pressure to cause skin breakdown. Pressure relief at regular intervals (2 hours is maximum) through repositioning can alleviate the problem. Maximum time varies because of other differences in individual skin integrity and presence of other risk factors. A pressure-reducing device (e.g., foam mattress, water mattress, or specialized bed) is helpful, but it can not replace regular repositioning.

   Urinary or bowel incontinence. **[F1a or F1b = 3 or 4]** The presence of urine or feces on the skin for a prolonged time can lead to skin maceration (softening) and subsequent breakdown. Bowel incontinence requires evaluation for the presence of neurologic disorder, bowel disorder, drug side effects, or acute illness.

   Peripheral vascular disease. **[J1f = checked]** Poor circulation places resident at risk of pressure ulcer formation, especially in heels and ankles. Any decrease in blood flow permits ischemia (lack of tissue oxygenation) in areas where pressure is applied. This can happenquite rapidly (i.e., within 2 hours). If peripheral vascular disease is present, physician referral should be considered.

   Diabetes mellitus. **[J1y = checked]** Diabetes, particularly insulin-dependent diabetes, increases risk, probably from the effects of diabetes on vasculature or blood flow. Although not proven, control of blood sugar may minimize this risk factor.

   Hip fracture. **[K2c = checked]** Recent fracture of hip (or lower limb) increases risk in that a fracture can lead to decreased mobility and increased time spent in one position.

   Weight loss. **[L2c = 1]** Weight loss should raise concerns about malnutrition. Malnutrition can lead to decreased skin integrity and muscle weakness, which can impair repositioning ability. Malnutrition also impedes healing.

Pressure ulcer history. **[N3 = 1]** Persons with a history of pressure ulcers are at risk for a recurrence. Current risk factors should be assessed.

Impaired tactile sensory perception. **[N4b = checked]** Skin that is not sensitive to pain, pressure or discomfort may impede ability to change position because of blunted response to pain, which can be a warning that skin pressure is excessive and breakdown imminent.

Medications. **[O4a = 7]** Daily use of antipsychotics, can retard mobility, exacerbate incontinence, or lead to mental confusion — conditions that increase the risk of pressure ulcer formation.

Restraints. **[P3b, P3c or P3d = 2]** Daily use of restraints leads to immobility, increases the time spent in one position, and decreases an individual's ability to change positions. As pressure to a particular area increases (e.g., buttocks or hips), pressure ulcer risk increases.

III. GUIDELINES

Review the MDS items listed on the RAP KEY for relevance in understanding the type of care that may be required.

Complicating Conditions and Treatments.

Consider carefully whether the resident exhibits conditions or is receiving treatments that may either place the resident at higher risk of developing pressure ulcers or complicate their treatment. Such conditions include:

Alzheimer's Disease and other dementias. An impairment in cognitive ability, particularly in severe end-stage dementia, can lead to immobility.

Edema. The presence of extravascular fluid can impair blood flow. If prolonged or excess pressure is applied to an area with edema, skin breakdown can occur.

Antidepressants and antianxiety/hypnotics. These medications can produce or contribute to lessened mobility, worsen incontinence, and lead to or increase confusion.

Things to Consider if the Resident Develops a New Pressure Ulcer or an Ulcer Being Treated is not Resolved.

A variety of factors may explain this occurrence; however, they may suggest the need to evaluate current interventions and modifications of the care plan.

- Review the resident's medical condition and other risk factors to determine whether the care plan (for prevention or cure) addresses all potential causes or complications.
- Review the care plan to determine whether it is actually being followed (e.g., is the resident being turned often enough to prevent ulcer formation).

Things to Consider if the Resident is At Risk for Pressure Ulcers But is Not Receiving Preventive Skin Care.

Even if pressure ulcers are not present, determine why this course of prevention is not being provided to a resident with risk factors.

- Is the resident new to the unit?
- Do few or many risk factors for the development of pressure ulcers apply to this resident?
- Are staff concentrating on other problems (e.g., resolution of behavior problems) so that the risks pressure of ulcers are masked?

PRESSURE ULCERS RAP KEY

TRIGGERS

1. Pressure Ulcer Present **[N2 = 1, 2, 3 or 4]**

2. At Risk for Pressure Ulcer when Both of Following (a&b) True:

   a. One or More of the Following are Present:

   — Bed mobility/Transfer Problem **[E1a or E1b = 3 or 4]**
   — Bedfast, Hemiplegia, Quadriplegia **[E4b, E4d, E4e = any checked]**
   — Incontinence **[F1a or F1b = 3 or 4]**
   — Peripheral Vascular Disease **[J1f = checked]**
   — Diabetes Mellitus **[J1y = checked]**
   — Hip Fracture **[K2c = checked]**
   — Weight Loss **[L2c = 1]**
   — Previous Pressure Ulcer **[N3 = 1]**
   — Impaired Tactile Sense **[N4b = checked]**
   — Daily Antipsychotics **[O4a = 7]**
   — Daily Trunk, Limb or Chair restraints **[P3b, P3c or P3d = 2]**

   b. Absence of ALL of the Following Treatments:

   — Protective/Preventive skin care **[N4c = not checked]**
   — Turning/repositioning **[N4d = not checked]**
   — Pressure relieving beds/chair pads **[N4e = not checked]**
   — Wound care/treatment **[N4f = not checked]**
   — Other skin care/treatment **[N4g = not checked]**

GUIDELINES

Other factors that address or may complicate treatment of pressure ulcers or risk of ulcers:

1. **Diagnoses:** Alzheimer's disease **[J1h]**, Other dementia **[J1i]**, Edema **[K1d]**

2. **Interventions/Programs:**
   Protective/preventive skin care **[N4c]**
   Turning/repositioning **[N4d]**
   Pressure relieving beds/chair pads **[N4e]**
   Wound care/treatment **[N4f]**
   Use of restraints **[P3]**

3. **Medications:**
   Antipsychotics **[O4a]**
   Antianxiety/hypnotics **[O4b]**
   Antidepressants **[O4c]**

RESIDENT ASSESSMENT PROTOCOL: PSYCHOTROPIC DRUG USE

I. PROBLEM

Psychotropic drugs are among the most frequently prescribed agents for elderly nursing home residents. Studies in nursing facilities suggest that 35% to 65% of residents receive psychotropic medications.

When used appropriately and judiciously, these medications can enhance the quality of life of residents who need them. However, all psychotropic drugs have the potential for producing undesirable side effects or aggravating problematic signs and symptoms of existing conditions. An important example is postural hypotension, a condition associated with serious and life-threatening side effects. Severity of delirium side effects is dependent on: the class and dosage of drug, interactions with other drugs, and the age and health status of the resident.

Maximizing the resident's functional potential and well-being while minimizing the hazards associated with drug side effects are important goals of therapy. In reviewing a psychotropic drug regimen there are several rules of thumb:

- Evaluate the need for the drug (e.g., consider amount and type of distress, response to nonpharmacologic interventions, pros and cons of drug side effects in relation to distress without the drug). Distinguish between treating specific diagnosed psychiatric disorders and treating symptoms. Specific psychiatric disorders (e.g., schizophrenia, major depression) have specific drug treatments with published guidelines for dosage and duration of treatment. However, a recorded diagnosis of a psychiatric disorder does not necessarily require drug treatment if symptoms are inactive.
- Start low, go slow. If needed, psychotropic drugs should be started at lowest dosage possible. To minimize side effects, doses should be increased slowly until either there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached.
- Each drug has its own set of actions and side effects, some more serious than others; these should be evaluated in terms of each user's medical-status profile, including interaction with other medications.
- Consider symptoms or decline in functional status as a potential side effect of medication.

II. TRIGGERS

The RAP should be completed when the resident takes any psychotropic drug and one or more of the following 5 combinations of MDS conditions are present:

Potential for Drug-Related Hypotension if:

1. Antipsychotic AND/OR Antidepressant Use **[O4a or O4c = 1-7] AND ANY** of the following:

   - **Hypotension [J1e = checked]**
   - **Dizziness/Vertigo [K1c = checked]**
   - **Syncope [K1m = checked]**
   - **Accidents [K2a, K2b, K2c = any checked]**

Potential for Drug-Related Movement Disorder if:

2. Antipsychotic Use [**O4a = 1-7**] **AND ANY** of the following:

- Parkinson's Disease [**J1m = checked**]
- Poor Balance [**E4a = checked**]
- Unsteady Gait [**E4i = checked**]
- Difficulty Positioning/Turning [**E4j = checked**]
- Tardive Dyskenisia [**J2 = 333.82**]
- Partial/Total Loss of Voluntary Arm/Leg Movement [**E4f, E4h = any checked**]
- Motor Agitation [**H1c = checked**]
- Chewing/Swallowing Problem [**L1a, L1b = any checked**]

Potential for Drug-Related Gait Disturbance (other than antipsychotic induced) if:

3. Antianxiety/hypnotic Use [**O4b = 1-7**] **AND ANY** of the following:

- Poor Balance [**E4a = checked**]
- Unsteady Gait [**E4i = checked**]
- Difficulty Positioning/Turning [**E4j = checked**]
- Dizziness/Vertigo [**K1c = checked**]
- Accidents [**K2a, K2b, K2c = any checked**]

Potential for Drug-Related Cognitive/Behaviorial Impairment if:

4. Any Psychotropic use [**O4a, O4b or O4c = 1-7**] **AND ANY** of the following:

- Delirium/Disordered Thinking [**B5a, B5b, B5c, B5d, B5e = any checked**]
- Withdrawal [**H1d = checked**]
- Depression [**J1q = checked**]
- Hallucinations/Delusions [**K1g = checked**]
- Major Difference in ADL Self-Performance [**E7d = checked**]
- Deterioration in Cognition, Communication, ADL, Continence, Mood and/or Behavior [**B6=2 or C6=2 or E8=2 or F4=2 or H6=2 or H7=2**]

Potential for Drug-Related Discomfort if:

5. Any Psychotropic [**O4a, O4b or O4c = 1-7**] use **AND ANY** of the following:

- Constipation [**K1a = checked**]
- Fecal Impaction [**K1e = checked**]
- Urinary Retention [**J2 = 788.2**]

III. GUIDELINES

If any of the triggered conditions are present, complete the following:

Step One:

Conduct the following reviews:

1. Drug review [from record]

- Length of time between when the drug was first taken and onset of problem
- Dose of drug and how frequently taken
- Number of classes of psychotropics taken
- Reason drug prescribed

2. Review resident's conditions that impair drug metabolism/excretion

- Acute condition(s)
- Dehydration
- Impaired liver/renal function

3. Review behavior/mood/psychiatric status

- Current problem status
- Recent change in mood behavior
- Behavior management program
- Psychiatric conditions

Step Two:

Compare the drugs the resident is currently taking with common side effects listed below. Refer to Tables A, B, and C for clarification.

POTENTIAL PSYCHOTROPIC DRUG-RELATED SIDE EFFECTS

Hypotension.

Postural (orthostatic) hypotension (decrease in blood pressure upon standing) is one of the major risk factors for falls related to psychotropic drugs. It is commonly seen with the low-potency antipsychotic drugs (chlorpromazine, thioridizene) and with tricyclic antidepressants. Both classes of drugs have anticholinergic properties. Within each class, drugs with the most potent anticholinergic properties also seem to produce the greatest hypotensive effects. Symptoms of dizziness/vertigo upon sitting or standing from a lying position, syncope (fainting), and falls/fractures should be seriously considered as potential indicators of psychotropic drug-induced hypotension. In addition, these symptoms may be due to a disturbance of heart rhythm, which could be aggravated by a tricyclic antidepressant. The occurrence of any of the aforementioned symptoms requires assessment of postural vital signs and heart rhythm.

Measurement of postural vital signs. Measure blood pressure and pulse when the resident is lying down. Remeasure blood pressure and pulse after the resident has been on his/her feet for one to five minutes (if unable to stand, ensure after the resident has been sitting). Occasionally,further drops in blood pressure occur after the person has been up for some time. While a drop of more than 20 mm Hg systolic is always abnormal, it is particularly significant if accompanied by dizziness, loss of balance, or standing blood pressure of less than 100 mm Hg. A large drop may be clinically significant even if the lower pressure is not abnormally low, particularly in residents who have some degree of cerebrovascular disease.

Movement Disorder.

High fever AND/OR muscular rigidity. Antipsychotic drugs can interfere with temperature regulation, which can lead to the potentially fatal problem of hyperthermia. Also, when high fever is accompanied by severe muscular rigidity, "neuroleptic malignant" syndrome must be suspected. Fever above 103 degrees in a resident on an antipsychotic drug is a medical emergency because of the disturbed temperature regulation. Even lesser degrees of fever, if accompanied by severe muscular rigidity, are medical emergencies. Temperature must therefore be monitored especially closely in residents on psychotropic drugs with anticholinergic properties. In addition, nonantipsychotic drugs with anticholinergic properties, such as antidepressants, may aggravate fever by impairing sweating.

Parkinson's disease. This condition is known to be aggravated by all antipsychotic drugs. At times it is difficult to know whether parkinsonian symptoms (e.g., tremors, especially of hands; pill-rolling of hands; muscle rigidity of limbs, necks, trunk) are due to Parkinson's disease or to present or recent antipsychotic drug therapy. There should be a strong bias in favor of reducing or eliminating antipsychotic drugs in residents with Parkinson's disease unless there are compelling behavioral or psychotic indications. Antiparkinson drugs should be considered when antipsychotic drugs are clinically necessary in residents with Parkinson's disease.

Five movement disorders are commonly encountered in residents on antipsychotic drugs. All of these disturbances can adversely affect a resident's quality of life as well as increase his/her risk of accidents. The triggered MDS items in Group 2 are signs/symptoms of these disorders. To clarify whether the resident is suffering from one of these disorders, all residents on antipsychotic drugs should be periodically screened for the following conditions:

Parkinsonism. As with Parkinson's disease, this condition may involve ANY combination of tremors, postural unsteadiness, and rigidity of muscles in the limbs, neck, or trunk. Although the most common is a pill-rolling or alternating tremor of the hands, other kinds of tremors are occasionally seen. Occasionally, a resident with Parkinsonism will have no tremor, only rigidity and shuffling gait. Symptoms respond to antiparkinson drugs, but not always completely. Dosage reduction or substitution of nonantipsychotic drug, when feasible, is the preferred management.

Akinesia. This condition is characterized by marked decrease in spontaneous movement, often accompanied by nonparticipation in activity and self-care. It is managed by reducing the antipsychotic drug or adding an antiparkinson drug.

Dystonia. This disorder is marked by holding of the neck or trunk in a rigid, unnatural posture. Usually the head is either hyperextended or turned to the side. The condition is uncomfortable and prompt treatment with an antiparkinson drug can be helpful.

Akathisia — the inability to sit still. The resident with this disorder is driven to constant movement, including pacing, rocking, or fidgeting, which can at times persist for weeks, even after the antipsychotic drug is stopped. The condition responds occasionally to antiparkinson drugs, but less consistently than parkinsonism or dystonia. Sometimes benzodiazepines or beta-blockers are helpful in treating the symptom, although dosage reduction is the most desirable treatment when possible.

Tardive dyskinesia — persistent, sometimes permanent movements induced by long-term antipsychotic drug therapy. Most typical are thrusting movements of the tongue, movements of the lips, or chewing or puckering movements. These involuntary movements can clearly interfere with chewing and swallowing. When they do, the dyskinesia can be suppressed by raising the dose of the antipsychotic drug, but this will make the problem more permanent. When possible, it is usually preferable to reduce or eliminate the antipsychotic drug, because the symptoms of dyskinesia will often decrease over time after drug discontinuation.

Other variations of tardive dyskinesia include abnormal limb movements, such as peculiar and recurrent postures of the hands and arms, or rocking or writhing trunk movements. There is no consistently effective treatment. Withdrawal of the antipsychotic drug leads to eventual reversal of the symptoms over many months in about 50% of cases.

Gait Disturbance (Other Than That Induced by Antipsychotics).
Long-acting benzodiazepine antianxiety drugs have been implicated in increasing the risk of falls and consequent injury by producing disturbances of balance, gait, and positioning ability. They also produce marked sedation, often manifested by short-term memory loss, decline in cognitive abilities, slurred speech, drowsiness in the morning/daytime sedation, and little/no activity involvement. If an antianxiety drug is needed to treat an anxiety disorder, a short-acting benzodiazepine or buspirone would be preferable to a long-acting benzodiazepine. Buspirone is nonsedating and takes several weeks to work. Dosage should be increased slowly.

Cognitive/Behavior Impairment.

Periodic disordered thinking/awareness. These MDS items, which tap the syndrome of acute confusion or delirium, can all be caused or aggravated by psychotropic drugs of any of the major classes. If the resident does not have acute confusion related to a medical illness or severe depression, consider the psychotropic drug as a cause. The most helpful information in establishing a relationship is the linkage between starting the drug and the occurrence of the change in cognitive status.

Depression. Both anti-anxiety and antipsychotic drugs may cause symptoms of depression as a side effect, or may aggravate depression in a resident with a depressive disorder who receives these drugs rather than specific antidepressive therapy.

Hallucinations/delusions. While these are often symptoms of mental illness, all of the major classes of psychotropic drugs can actually produce or aggravate hallucinations. The antidepressant drugs, the more anticholinergic antipsychotic drugs, and the shorter-acting benzodiazepines such as triazolam and lorazepam are most implicated in causing visual hallucinations. Visual hallucinations in the aged are virtually always indicative of brain related disturbance (e.g., delirium) rather than a psychiatric disorder.

Major differences in AM/PM self-performance. All classes of psychotropic drugs can have an effect on a resident's ability to perform activities of daily living. Establishing a link between the time a drug is taken and the change in self-performance is helpful in evaluating the problem.

Decline in cognition/communication. Decline in these areas signals the possibility that the decline is drug-induced and the need to review the relationship of the decline with initiation or change in drug therapy. All major classes of psychotropics can cause impairment of memory and other cognitive skills in vulnerable residents. While memory loss in nursing facility residents is caused primarily by dementing disorders and other neurologic disease, psychotropic drugs, particularly those with anticholinergic side effects, and long-acting benzodiazepines, definitely contribute to memory impairment. In contrast, treatment of depression or psychosis can actually improve usable memory, which is very much disrupted by severe psychiatric illness. If memory worsens after initiating or increasing the dose of a psychotropic drug, consider reducing or discontinuing the drug, or substituting a less anticholinergic drug. For a resident with anxiety, a short-acting benzodiazepine or buspirone is preferable to a long-acting benzodiazepine.

Decline in mood. (See reference to Depression above.)

Decline in behavior. Problem behaviors may be aggravated and worsened by psychotropic drugs as they can contribute to confusion, perceptual difficulties, and agitation.

Decline in ADL status. Drug side effects must always be considered if a resident becomes more dependent in ADLs. In addition, psychotropic drugs can precipitate or worsen bladder incontinence either through a change in cognition or through a direct action on bladder function.

Discomfort.

Constipation/fecal impaction. Any psychotropic drug with anticholinergic effects can cause or aggravate constipation; the effects are pronounced with tricyclic antidepressants and with low-potency antipsychotic drugs such as chlorpromazine or thioridizine. Milder cases of constipation can be treated with stool softeners, bulk-forming agents, and increased fluid; more severe constipation is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible. Antianxiety drugs can contribute to constipation if they sedate the resident to the point that fluid intake or exeresis is impaired. The problem can be handled by switching to a less sedating drug, decreasing dosage, or discontinuing the drug if possible.

Urinary retention. This condition may be manifested by the inability to urinate, or new onset or worsening of urinary incontinence (caused by overflow of urine from a full bladder that cannot empty properly). Any psychotropic drug with anticholinergic properties can produce or aggravate urinary retention. The problem is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible.

Dry mouth. This symptom is a common side effect of any psychotropic drug with anticholinergic properties. Dry mouth can aggravate chewing and swallowing problems. Substituting a less anticholinergic drug may be helpful. Other remedies include artificial saliva or sugar-free mints or candies (sugar contributes to cavity formation).

WHEN TO DISCONTINUE DRUG TREATMENT

1. Drug treatment that is ineffective after a reasonable trial should be discontinued or changed. The definition of a reasonable trial depends on the drug class and therapeutic indication.

2. When a medication is effective, but produces troublesome side effects, either the dose should be reduced or the medication should be replaced by a therapeutically equivalent agent less likely to cause the problematic side effect. If this is not feasible, or if doing it leads to a recurrence of symptoms, specific medical therapy for the troublesome side effects should be considered. For example, if the best drug for treating a resident's depression causes constipation, stool softeners, laxatives, or bulk-forming agents can be prescribed.

3. When a medication is effective and does not cause troublesome side effects, it should be continued for a defined period, and then efforts should be made to taper and eventually discontinue the drug.

4. Psychotropic medication should be prescribed on a permanent basis only if symptoms have recurred on at least two previous attempts to taper the medication after a defined period of therapy.

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS

TABLE A. ANTIPSYCHOTIC (NEUROLEPTIC) DRUGS

Generic Name	Brand Name	Incidence of Side Effects			
		Sedation	Hypotension	Anti-cholinergic Symptoms[1]	Extra-pyramidal Symptoms[2]
Chloropromazine	Thorazine	Marked	Marked	Marked	Mild
Thioridizine	Mellaril	Marked	Marked	Marked	Mild
Acetophenazine	Tindal	Mild	Mild	Moderate	Mild
Perphenazine	Trilafon	Mild	Mild	Moderate	Moderate
Loxapine	Loxitane	Mild	Mild	Moderate	Moderate
Molindone	Moban	Mild	Mild	Moderate	Moderate
Trifluoperazine	Stelazine	Mild	Mild	Mild	Marked
Thiothixene	Navane	Mild	Mild	Mild	Marked
Fluphenazine	Prolixin	Mild	Mild	Mild	Marked
Haloperidol	Haldol	Minimal	Minimal	Mild	Marked

TABLE B. ANTIDEPRESSANT DRUGS

Generic Name	Brand Name	Incidence of Side Effects		
		Sedation	Hypotension	Anti-cholinergic Symptoms[1]
Cyclic antidepressants				
Imipramine	Tofranil	Mild	Moderate	Mod-strong
Desipramine	Norpramin	Mild	Mild-mod	Mild
Doxepin	Adapin Sinequan	Mod-strong	Moderate	Strong
Amitriptyline	Elavil Triavil	Strong	Moderate	Very Strong
Nortriptyline	Aventyl Pamelor	Mild	Mild	Moderate
Maprotiline	Ludiomil	Mod-strong	Moderate	Moderate
Amoxapine*	Asendin	Mild	Moderate	Moderate
Fluoxetine	Prozac	Variable	Nil	Nil
Triazolopyridine Antidepressant				
Trazodone	Desyrel	Mod-strong	Moderate	Mild
MAO inhibitors*	Nardil	Mild	Moderate	Mild
Phenelzine	Parnate	Mild	Moderate	Mild
Tranylcypromine				
	Wellbutrin	None	Nil	Nil
Other				
Bupropion		May cause agitation High incidence of seizures		

* Also a neuroleptic drug with all the neuroleptic side effects.

* Special diet required; many drug interactions.

[1] Anticholinergic sypmtoms include: dry mouth, constipation, urinary retention, blurred vision, confusion, disorientation, short-term memory loss, hallucinations, insomnia, agitation and restlessness, picking behaviors, fever.

[2] Extrapyramidal symptoms include: movement disorders, such as Parkinsonism, dyskinesias, and akathisia (described in text). Antidepressants (except Amoxapine) and antianxiety/hypnotics do not produce extrapyramidal side effects.

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS (cont.)

TABLE C. ANTIANXIETY AND HYPNOTIC DRUGS

Generic Name	Brand Name	Duration of Action
Benzodiazepines		
Triazolam	Halcion	Very short
Oxazepam	Serax	Short
Temazepam	Restoril	Short
Lorazepam	Activan	Short
Alprazolam	Xanax	Medium
Chlorodiazepoxide	Librium	Long
Diazepam	Valium	Long
Chlorazepate	Tranxene	Long
Flurazepam	Dalmane	Very long
Barbiturates		
Antihistamines		
Dephenhydramine	Benadryl	Moderate
Hydroxyzine	Vistaril	Moderate
Chloral hydrate	Noctec	Long
Other		
Buspirone	Buspar	Not meaningful

PSYCHOTROPIC DRUG USE RAP KEY

TRIGGERS

Potential for Drug-Related Hypotension if:

1. Antipsychotic AND/OR Antidepressant Use **[O4a or O4c = 1-7]** AND ANY of the following:
   - — Hypotension **[J1e = checked]**
   - — Dizziness/Vertigo **[K1c = checked]**
   - — Syncope **[K1m = checked]**
   - — Accidents **[K2a, K2b, K2c = any checked]**

Potential for Drug-Related Movement Disorder if:

2. Antipsychotic Use **[O4a = 1-7]** AND ANY of the following:
   - — Partial/Total Loss of Voluntary Arm/Leg Movement **[E4f, E4h = any checked]**
   - — Unsteady Gait **[E4i = checked]**
   - — Partial/Total Loss of Ability to Position, Balance, Turn Body/Balance While Standing **[E4a, E4j = any checked]**
   - — Motor Agitation **[H1c = checked]**
   - — Parkinson's **[J1m = checked]**
   - — Tardive Dyskinesia **[J2 = 333.82]**
   - — Chewing/Swallowing Problem **[L1a, L1b = any checked]**

Potential for Drug-Related Gait Disturbance (other than antipsychotic-induced) **if:**

3. Antianxiety/hypnotic Use **[O4b = 1-7]** AND ANY of the following:
   - — Poor Balance **[E4a = checked]**
   - — Unsteady Gait **[E4i = checked]**
   - — Difficulty Positioning/Turning **[E4j = checked]**
   - — Dizziness/Vertigo **[K1c = checked]**
   - — Accidents **[K2a, K2b, K2c = any checked]**

GUIDELINES

If resident is triggered, review the following:

1. Drug review **[from record]** Length of time between when the drug was first taken and onset of problem; Doses of drug and how frequently taken; Number of classes of psychotropics taken; Reason drug prescribed
2. Review resident's conditions that affect drug metabolism/excretion
   Acute condition **[K3b]**; dehydration **[L3b]**; impaired liver/renal function **[J2; P1c; from record]**
3. Review Behavior/Mood Status:
   Current problem status **[H1, H2, H3]**
   Recent changes **[H6, H7]**
   Behavior management program **[H5]**
   Psychiatric Diagnoses **[J1p, J1q, J1r; J2]**

Then Consider:

- **Clarifying Information For Hypotension:**
  1. Postural changes in vital signs **[from exam]**
  2. Drugs with marked anticholinergic properties **[from record]**

- **Clarifying Information For Movement Disorder:**
  1. High Fever **[K1f]** AND/OR Muscular rigidity **[from record, observation]**
  2. Tremors, especially of hands; pill-rolling of hands; muscle rigidity of limbs, neck, trunk (Parkinsonism) **[from record, observation]**
  3. Marked decrease in spontaneous movement (Akinesia) **[from record, observation]**
  4. Rigid, unnatural, uncomfortable posture of neck or trunk (Dystonia) **[from record, observation]**
  5. Restlessness, inability to sit still (Akathisia) **[from record, observation]**
  6. Persistent movements of the mouth (e.g., thrusting of tongue, movements, of lips, chewing/puckering) AND/OR peculiar and recurrent postures of limbs, trunk (Tardive dyskinesia) **[from record, observation]**

Potential for Drug-Related Cognitive/Behavioral Impairment if:

4. ANY Psychotropic Use **[O4a, O4b or O4c = 1-7]** AND ANY of the following:
   - — Delirium/Disordered Thinking **[B5a, B5b, B5c, B5d, B5e = any checked]**
   - — Withdrawal **[H1d = checked]**
   - — Depression **[J1q = checked]**
   - — Hallucinations/Delusions **[K1g = checked]**
   - — Major Difference in ADL Self-Performance **[E7d = checked]**
   - — Deterioration in Cognition, Communication, ADL, Continence, Mood and/or Behavior **[B6 = 2 or C6 = 2 or E8 = 2 or F4 = 2 or H6 = 2 or H7 = 2]**

Potential for Drug-Related Discomfort if:

5. ANY Psychotropic Use **[O4a, O4b or O4c = 1-7]** AND ANY of the following:
   - — Constipation **[K1a = checked]**
   - — Fecal Impaction **[K1e = checked]**
   - — Urinary Retention **[J2 = 788.2]**

- **Clarifying Information For Gait Disturbances:**
  1. Long-acting benzodiazepines **[from med record]**
  2. Recent dosage increase **[from med record]**
  3. Short-term memory loss; Decline in cognition; Slurred speech **[B2, B6; observation]**
  4. Decreased AM wakefulness; Little/no activity involvement **[I1, I2]**

- **Clarifying Information For Cognitive/ Behavioral Impairment:**

  If neither of the following are present, psychotropic drug side effects can be considered as a major cause of problem:

  1. Acute confusion (delirium) related to medical illness **[B5]**
  2. Depression **[H1, H2]**

- **Clarifying Issues For Drug-Related Discomfort:**

  1. Dehydration **[L3b]**; Reduced dietary bulk; Lack of exercise **[from record]**

  Other potential drug-related discomforts that may require resolution:

  2. Dry mouth, if on antipsychotic or antidepressant **[observation]**

RESIDENT ASSESSMENT PROTOCOL: PHYSICAL RESTRAINTS

I. PROBLEM

Studies of nursing homes show that between 30 and 40% of residents are physically restrained. This is quite serious since negative effects of restraint use include declines in residents' physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections, and development of pressure sores, delirium, agitation, and incontinence. Moreover, restraints have been found in some cases to increase the incidence of falls and other accidents (e.g., strangulation). Finally, residents who are restrained face the loss of autonomy, dignity and self-respect. In effect, the use of physical restraints undercuts the major goals of long-term care — to maximize independence, functional capacity, and quality of life. Thus, the goal of minimizing or eliminating restraint use has become central to both clinical practice and federal law.

The primary reason given for applying restraints is to protect residents from falls and accidents. Facilities are also concerned about potential lawsuits and malpractice claims that might result if residents should fall. Other reasons cited for restraint use include to provide postural support or positioning for residents, to facilitate treatment (e.g., preventing residents from pulling out IV lines or NG tubes), and to manage behaviors such as wandering or physical aggressiveness.

The experience of many health care providers suggests that facility goals can often be met without the use of physical restraints and their negative side effects. In part, this involves identifying and treating health, functional, or psychosocial problems that may be causing the condition for which restraints were ordered (e.g., falls, wandering, agitation). Minimizing use of restraints also involves care management alternatives, such as: modifying the environment to make it safer; maintaining an individual's customary routine; using less intrusive methods of administering medications and nourishment; and recognizing and responding to residents' needs for psychosocial support, responsive health care, meaningful activities, and regular exercise.

II. TRIGGERS

Definition: Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot easily remove and that restricts freedom of movement or normal access to his/her body.

ANY use of trunk restraint, limb restraint, or chair that prevents rising **[P3b, P3c or P3d = 1 or 2]**

III. GUIDELINES

In evaluating and reconsidering the use of restraints for a resident, consider needs, problems, conditions, or risk factors (e.g., for falls) which, if addressed, could eliminate the need for using restraints. Refer to the RAP KEY for specific MDS items to consider as you review the following issues.

WHY ARE RESTRAINTS USED?

The first step in determining whether use of a restraint can be reduced or eliminated is to identify the reasons a restraint was applied.

- Review the resident's record and consult primary caregivers to determine reason for use.

Ask the following questions:

- Why is the resident restrained?
- What type(s) of restraint is used?
- During what time of day is each type(s) used?
- Where is the resident restrained (e.g., own room in bed, chair in hallway)?
- How long is the resident restrained each day?
- Under what circumstances (e.g., when left alone, after family leave, when not involved in structured activity, when eating)?
- Who suggested that the resident be restrained (e.g., staff, family, resident)?

CONDITIONS ASSOCIATED WITH RESTRAINT USE

It may be possible to identify and resolve health/functional/psychosocial needs, risks, or problems that caused restraints to be used. By addressing the underlying condition(s) and cause(s), the facility may eliminate the apparent need for the restraint(s). In addition, a review of underlying needs, risks, or problems may help to identify other potential kinds of treatments. After determining why and how a restraint is used, review the appropriate areas described below.

Problem Behavior.

To determine presence of a behavior problem, review the MDS. If the behavior for which the resident is restrained was not exhibited in the last 7 days, was it because the restraint prohibited the behavior from occurring (e.g., resident was restrained and could not wander)? If a behavior problem was present during the last 7 days or the resident was restrained to prevent a problem behavior, consider the resident to have a behavior problem and review Behavior Problem RAP as indicated.

Many problem behaviors are manifestations of unmet health, functional, and/or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. (See RAP on Behavior Problem). Conditions associated with problem behaviors and restraint use include:

- Delirium (acute confusional state)
- Impaired cognition
- Impaired communication (e.g., difficulty making needs/wishes understood or understanding others)
- Unmet psychosocial needs (e.g., social isolation, disruption of familiar routines, anger with family members)
- Sad or anxious mood
- Resistance to treatment, medication, nourishment
- Psychotropic drug side effects (e.g., motor agitation, confusion, gait disturbance)
- If a behavior management program is in place, does it adequately address the causes of the resident's particular problem behaviors?

Risk of Falls.

Although restraints have not been shown to safeguard residents from injury, one of the most common reasons given by facilities for restraining residents is to prevent falls. In some instances, restraints have been reported to contribute to falls and injuries. Because of the complications associated with restraint use, many physicians and geriatric clinicians recommend exploring alternatives for preventing falls, such as treating health problems and making environmental modifications.

- Review risk factors for falls on RAP KEY. Refer to Falls RAP if these risks are present or if the restraint is being used to prevent falls.

Treatment Regimens.

Another reason facilities give for using restraints is to prevent a resident from removing tubes.

If the resident is being restrained to manage resistance to any type of tube or mechanical device (e.g., indwelling/external catheter, feeding tube, intravenous line, oxygen mask/cannula, wound dressing), review the following to facilitate decision-making:

- Is the tube/mechanical device used to treat a life-threatening condition?
- Does the resident actually need a particular intervention that may be potentially burdensome to him/her? Are there less intrusive treatment options?
- Why is the resident reacting to the tube/mechanical device with resistance? (e.g., Does the device produce discomfort or irritation? Is the resident really resisting or is the device just something to fidget with? Is the treatment compatible with the resident's wishes? Does the resident understand the reason for the method of treatment? Has the resident/family been informed about the risks and benefits of treatment options?)

HCFA Guideline: "If there are medical symptoms which are life threatening (such as dehydration, electrolyte imbalance, urinary blockage) then a restraint may be used temporarily to provide necessary lifesaving treatment. Physical restraints may be used for brief periods to allow medical treatment to proceed, if there is documented evidence of resident or legal approval of the treatment."

- If an indwelling or external catheter is present, review the Urinary Incontinence RAP for alternatives.
- If a feeding tube is present, review the Feeding Tubes RAP

ADL Self-Performance.

In rare instances, a restraint can enhance a resident's ability to be more self-sufficient, IF the restraint use is supportive and time-limited.

Review the MDS to determine if the restraint contributes to the resident's self-performance of an activity (e.g., wheelchair belt supports trunk while resident wheels self, geri-chair used only at meals enables wandering resident to attend to feeding self).

Other Factors.

Resident's Response to Restraints

In evaluating restraint use, it is important to review the resident's reaction to restraints (e.g., positive and negative, such as passivity, anger, increased agitation, withdrawal, pleas for release, calls for help, constant attempts to untie/release self). This will help determine whether presumed benefits are outweighed by negative side effects.

Review MDS items on other potential negative effects of restraint use, such as declines in functional self-performance, body control, skin condition, mood and cognition, since restraints have been in use.

Alternatives to Restraints

Many interventions may be as effective or even more effective than restraints in managing a resident's needs, safety risks, and problems. To be effective the intervention must address the underlying problem. Examples of alternatives include: use of familiar, comfortable chairs; activities that are meaningful to resident; behavior management programs; judicious use of psychotropic drugs to treat active psychiatric disorders (e.g., psychoses, panic disorders); cheduled toileting plans; and regular exercise for agitated residents.

- Review resident's record and confer with staff to determine whether alternatives to restraints have been tried.
- If alternatives to restraints have been tried, what were they?
- How long were the alternatives tried?
- What was the resident's response to the alternatives at the time?
- If the alternative(s) attempted were ineffective, what else was attempted?
- How recently were alternatives other than restraints attempted?

Philosophy and Attitudes.

In reconsidering the use of restraints for a resident, consider the philosophy, values, attitudes, and wishes of the resident regarding restraint use, as well as those of his family/significant others, and caregivers. Consider the impact of restraints on facility environment and morale.

- Is there consensus or differences among affected parties in choosing between resident independence and freedom in favor of presumed safety?

PHYSICAL RESTRAINTS RAP KEY

TRIGGERS

Potential for decline if:

1. ANY use of Trunk Restraint, Limb Restraint, or Chair that Prevents Rising [P3b, P3c or P3d = 1 or 2]

GUIDELINES

Review factors and complications associated with restraint use:

Problem Behavior: Motor agitation [H1c], Any problem behavior [H3], Part of behavior management program [H5]

Risk of Falls: Falls [K2a, K2b];
Antidepressant [O4c];
Impaired balance [E4a, E4j];
Bedfast or Hemi/Quadriplegia or Poor leg control [E4b, E4d, E4e, E4h]

Conditions and Treatments:
Unstable/acute condition [K3a, K3b];
Hip fracture [K2c]; Catheter [F3b, F3c];
Parenteral/IV and/or feeding tube [L4a, L4b];
Wound care/treatment [N4f]; IV meds [P1f];
Respiratory/Oxygen [P1h]

ADL Self-Performance [E1]

Confounding problems to be considered:

1. Delirium [B5]
2. Cognitive loss/dementia [B2, B3, B4]
3. Impaired communication [C4, C5]
4. Unmet psychosocial needs [G1, G2, G3]
5. Sad/anxious mood [H1, H2]
6. Resistance to treatment/meds/nourishment [H4a; observation]
7. Psychotropic drug side effects [O4]

Other factors to be considered:
Resident's response to restraint(s); use of alternatives to restraints; resident/family/staff philosophy, values, wishes, attitudes about restraints [record, observation, discussion]

BILLING CODE 4120-03-C

Attachment D—Approval Criteria for Alternate Instruments

Approval Criteria for Alternate Instruments

To Receive Approval, an Alternate Instrument Must Contain:

- *The Utilization Guidelines.*
- *The MDS.* All data elements and corresponding coding categories specified in the MDS must be contained in the State's instrument. The State may not alter the MDS definitions or the coding categories used with each MDS element. For example, Section E. Activities of Daily Living (ADLs) has five coding categories. The State may not change the order of elements within a section. Therefore, the State cannot specify coding categories with four levels of measurement. The State may propose, however, changing the order of the major sections of the MDS, for example, move Section E. to follow Section R. In those situations, the State must provide a conversion table between its instrument and the MDS, and data supplied to HCFA from the MDS must be ordered in the same manner as designated in this issuance.

The State may include in its resident assessment instrument data elements additional to those in the MDS if the State believes this information will serve unique operational needs such as supporting pre-admission screening, quality assurance, quality incentive, or case-mix payment classification systems. This material will only be reviewed by HCFA to assure there is no conflict with elements included in the MDS, that is, HCFA will not evaluate the merits of including those elements.

- *Resident Assessment Protocols.* An alternate resident assessment instrument may include all, some, or none of the RAPs designated by HCFA.

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

—Cognitive loss/dementia;
—Visual function;
—Communication;
—Activities of daily living functional potential;
—Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
—Urinary incontinence and indwelling catheter;
—Psychosocial well-being (In the instrument designated by HCFA, in addition to a distinct psychosocial well-being protocol, we include three distinct RAPs that bear on psychosocial functioning, that is, "mood", "behavior", and "delirium".);
—Activities;
—Falls;
—Nutritional status;
—Feeding tubes;
—Dehydration/fluid maintenance;
—Dental care;
—Pressure ulcers;
—Psychotropic drug use; and
—Physical restraints.

These care areas may be combined in different ways to create a RAP comparable to that designated by HCFA. For example, the State may have a RAP that combines nutrition and tube feeding or activities of daily living and rehabilitation potential. However, if the State creates alternative RAPs through combining care areas, it must provide a cross-walk chart from its RAPs to the above care areas.

Each RAP the State develops must include assessment triggers, based on MDS elements or other information requirements, that screen which residents are subject to additional assessment.

If a State selects alternative triggers and/or information requirements for its RAI, it should provide supporting documentation for its decisions. Such documentation may take the form of citations from the literature, results of field testing, or the consensus of experts that the State uses to assist in designing these RAPs.

The State must also specify a standardized format that long term care facilities will use to document information derived from RAPs about the nature of problems, complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems. There must be provision for identification of the location of the assessment results and for certification of completion and accuracy. See the RAP formats proposed by HCFA.

Also, be advised that we plan to require MDS data to be transmitted in computer readable form at a later date through rulemaking and instructions, however, we will not gather data nationally from any assessment material beyond the MDS.

[FR Doc. 92–30612 Filed 12–24–92; 8:45 am]
BILLING CODE 4120–03–M

federal register

Monday
December 28, 1992

Part III

Department of Housing and Urban Development

Office of the Secretary

24 CFR Part 574

Housing Opportunities for Persons with AIDS; Interim Rule and Notice

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Secretary

24 CFR Part 574

[Docket No. R–92–1606; FR–3178–I–02]

RIN 2501–AB41

Housing Opportunities for Persons With AIDS

AGENCY: Office of the Secretary, HUD.

ACTION: Interim rule.

SUMMARY: This interim rule is being issued pursuant to a schedule prescribed by the Housing and Community Development Act of 1992 (Pub. L. 102–550, approved October 28, 1992), which amended the program established under the AIDS Housing Opportunity Act (42 U.S.C. 12901). The program provides States and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome (AIDS) or related diseases and their families. The program authorizes entitlement grants and competitively awarded grants for housing assistance and services.

DATES: Effective date: December 28, 1992. Comment due date: February 26, 1993.

ADDRESSES: Interested persons are invited to submit comments regarding this rule to the Office of the General Counsel, Rules Docket Clerk, room 10276, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410–0500. Communications should refer to the above docket number and title. A copy of each communication submitted will be available for public inspection and copying during regular business hours (7:30 a.m. to 5:30 p.m. Eastern Time) at the above address.

FOR FURTHER INFORMATION CONTACT: James N. Forsberg, Director, Office of Special Needs Assistance Programs, (202) 708–4300; TDD: (202) 708–2565); Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410–7000. (Telephone numbers are not toll-free.)

SUPPLEMENTARY INFORMATION:

I. Information Collections

The information collection requirements for the HOPWA program were approved under the Paperwork Reduction Act of 1980 by the Office of Management and Budget (OMB) through January 31, 1993, and assigned OMB control number 2506–0133. Information on the estimated public reporting burden is provided in this document in paragraph I of Section III., Findings and Certifications. Comments regarding burden estimates or any other aspects of the information collection requirements should be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, room 3001, Washington, DC 20503, Attention: HUD Desk Officer, and to the HUD Rules Docket Clerk, at the address stated in the address section above.

II. Introduction

A. Background

The initial Interim Rule for the Housing Opportunities for Persons with AIDS (HOPWA) Program was published in the **Federal Register** on July 20, 1992 (57 FR 32106), establishing regulations for the implementation of a new program during Fiscal Year 1992. The Department also published at that time (57 FR 32124) the Announcement of Allocations for HOPWA that provided for a distribution of $42,935,000 in formula funds to 11 eligible States and 27 eligible metropolitan statistical areas for Fiscal Year 1992 appropriations; a correction to the announcement was published on August 6, 1992 (57 FR 34782). The Department also published a Notice of Funding Availability in the **Federal Register** on August 25, 1992 (57 FR 38552) to announce the competitive program under § 574.200 of the Interim Rule. This notice provided for $4,771,000 in funds to be awarded by competition with applications due to the Department on October 26, 1992.

At the time of publication of the initial Interim Rule, HUD indicated that its procedures for rulemaking, which generally require the publication of a proposed rule with public comment prior to the implementation of a program, were not being followed in order to more expeditiously address the pressing needs for housing and services for persons with AIDS and related diseases. The Department did, however, solicit public comment on the Interim Rule to be considered in the drafting of a final rule. The Department announced a comment due date of September 18, 1992 and received twelve public comments during this period. The comments were submitted by nonprofit organizations, national and local coalitions of AIDS organizations, professional organizations, State, and local governments, representing 47 groups located in 13 States. A number of these comments were highly supportive of those provisions of the Interim Rule that allow flexibility in the selection of activities, the inclusion of supportive services, the amendment and waiver procedures, the potential for HUD-approval for other activities, and the requirement for beneficiary confidentiality. Other comments recommended revisions to the Interim Rule which will be addressed below in this preamble.

Additional revisions are being made to the HOPWA program pursuant to the statutory changes provided by Section 606 of the Housing and Community Development Act of 1992, Public Law 102–550, approved October 28, 1992 (hereafter "the Act"). That statute requires HUD to issue interim regulations within 45 days from the enactment of that Act with the regulations taking effect upon publication. The Act further specifies that final regulations are to be issued within 90 days from the publication of interim regulations, including the opportunity for public comment during a period of not less than 60 days. Statute revisions are addressed below along with any public comments which coincide with the respective statutory provision. Additional technical changes have been identified through the Department's experience in initiating this program and are also addressed below.

B. Statutory Revisions and Related Public Comments

1. Eligible Persons Include Families

Section 606(c)(3) of the Act expanded the term "eligible person" to include "and the family of such a person." While the Department believes that grantees were empowered to assist the families of eligible persons under the existing program, the statutory clarification of the term is reflected throughout the second Interim Rule in the use of "eligible person," which is defined to include the family of the person with AIDS, as a replacement for the terms persons or individuals with AIDS. These revisions also accommodate comments which supported a clarification that a family is eligible under the program.

2. Nonprofits as Eligible Applicants and Project Sponsors

Section 606(d)(1) of the Act revised the term "applicant" to provide that nonprofit organizations are eligible to apply for and receive funding directly from HUD. This authorization is limited to the non-formula allocation of funds for special projects of national significance in section 606(d)(4)(B). These changes are found at §§ 574.3 and 574.200(a)(1) of the rule.

Nonprofit organizations may also continue to serve as project sponsors for grantees under this program. Since the grantees, as governmental jurisdictions are subject to the requirement of having a Comprehensive Housing Affordability Strategy (CHAS), the nonprofit organization serving as project sponsor would have to obtain a certification of consistency of any housing activity with the CHAS of the grantee or, in the case of an EMSA, the CHAS of the jurisdiction where the housing activity is to be located.

The Act further revised the definition of nonprofit, found at § 574.3 of the rule, by replacing the direct reference to section 501(c) of the Internal Revenue Code of 1986 with a description that requires nonprofits to: (i) Be organized under State or local laws; (ii) have no benefit inuring to members, (iii) have acceptable financial accountability, and (iv) have significant AIDS related housing or services among its purposes. The Department interprets this revised definition as including both public and private nonprofit organizations. The rule's use of the fourth component also reflects comments which recommended that all community-based organizations that are selected as project sponsors have prior experience in serving persons with HIV/AIDS.

3. Definition of Project Sponsors

Section 606(c)(3) of the Act creates a definition for project sponsor including any nonprofit organization or governmental housing agency. In the initial Interim Rule, HUD did not specify that only a "housing" agency could operate a project for a grantee. Given the differences in administrative structures of State and local governments, HUD interprets this new definition at § 574.3 to include government agencies that engage in housing activities as an established function of that office, such as providing direct housing assistance and related community development activities, emergency/transitional shelter, residential care, and housing subsidies.

4. Applicants for Formula Allocations to Eligible Metropolitan Statistical Areas

The Act revises the formula allocation section of the program by designating the government that will serve as the applicant for an eligible metropolitan statistical area (EMSA). Section 606(d)(2) stipulates that the city that is the most populous unit of general local government in an EMSA will be allocated the funds for that EMSA. The term "city" is defined by the Act, as provided in § 574.3, as a municipality, and, in some circumstances, a town or township, but it does not include county governments. Under this Interim Rule, county governments are not authorized to receive formula funds, regardless of their status as the most populous unit of general local government in an EMSA. The selection process found at § 574.110 of the initial Interim Rule is eliminated in conformance with the statutory provision.

The statute further requires in section 606(d)(7) that the city applicant for an EMSA provide assurances to HUD that grant funds will be used to address the needs of eligible persons residing within its metropolitan statistical area and that coordination will occur with other localities in that EMSA in providing this assistance. Additions at §§ 574.120, 574.160(c)(5), and 574.420(c) of this rule implement this requirement.

5. Formula Change on Data

The program's formula allocation, at § 574.130, is revised by changing the date of the data used for the number of cases of AIDS. The statute under section 606(d)(3), uses March 31 of the fiscal year immediately preceding the fiscal year of the appropriations as the standard date for this element of the formula. In the first formula allocation, HUD had used data as of September 30 to coincide with the standard dates for the Department's fiscal year.

6. Administrative Costs Authorized

Section 606(f)(2) of the Act authorizes administrative costs for grantees and project sponsors. Under § 574.300(b)(9) of this Interim Rule, a grantee can use up to 3 percent of the grant amount for its own administrative costs for administering the grant and allocating funds to project sponsors. A project sponsor can use up to 7 percent of the amounts it receives for its own administrative costs in carrying out eligible activities, including costs of staff necessary to carry out those activities. This limitation on staff costs may somewhat constrain the amount of funds available under HOPWA for project sponsors that directly provide those supportive services which are staff-intensive, such as assessment, counseling and assistance in gaining access to other benefits and services. However, this 7 percent limitation does not apply to contracted services. This authorization for administrative costs responds to comments which requested that the program authorize administrative costs. Also pursuant to this statutory change, a related reference to staff training and recruitment has been deleted under operating costs at § 574.300(b)(8) as these items are administrative costs.

7. Other Revised Eligible Activities

In addition to administrative costs, other changes were made by the statute to the list of eligible activities at § 574.300(b) (7) and (11). The health services component of supportive services is limited by section 606(g)(1) of the Act to eligible persons who are individuals with AIDS or related diseases. Family members who are otherwise eligible for HOPWA assistance, as discussed above, do not qualify for health services funded by a grant under this program.

The final category of activity, "any other activity proposed by the applicant and approved by HUD," was made applicable to competitive grants only by section 606(e) of the Act. Formula grantees are no longer authorized to use this provision.

8. Prohibition of Fees

The original statute prohibited fees for any service provided by HOPWA funds, directed HUD to use Section 8 provisions to the extent practicable, and required resident rent payments at community residences (42 U.S.C. 12910). The Department implemented these provisions at §§ 574.430 and 574.320. Section 606(f)(1) of the Act prohibits fees for any housing provided to eligible persons. Since the statute did not remove the references to Section 8 and resident rent, the Department interprets this additional provision found at § 574.430 as prohibiting any fees over and above resident rent.

9. Removal of Location Limitation on Short-Term Facilities

Section 606(g)(2)(A) deletes a previous limitation on the location of short-term supported housing for eligible persons. That provision of the Interim Rule at § 574.330(b)(2), which authorized a facility in or contiguous to another emergency or short-term housing facility if that other facility is used exclusively by persons with AIDS or related diseases, was removed from this Interim Rule.

10. Waiver Presumption for Good Faith Efforts

Section 606(g)(2)(B) establishes a presumption for a waiver by HUD of time limits for residency in short-term supported housing facilities in cases where the project sponsor has made a good faith effort to acquire permanent housing for the resident. Section 574.330(a)(2) implements this statutory provision. Clarification was also added at § 574.330(a)(1) that the time

limitations for short-term supported housing are not applicable to rental assistance provided under § 574.300(b)(5).

C. Other Revisions in Response to Public Comments

1. Involvement of Organizations Serving Persons with AIDS

A number of comments were received which recommended that applicants consult with and involve organizations experienced with serving persons with AIDS in their application planning process. The Department agrees and has revised §§ 574.160(c)(5) and 574.240(c)(6) to require that applications submitted for formula and competitive grants contain information on this matter.

2. SRO Units in Community Residences

A number of comments were received recommending changes to enhance single room occupancy (SRO) dwellings, including use of technical assistance to help plan and develop such dwellings. Comments also noted that buildings with SRO units may meet the definition of community residences at § 574.340(a). The initial Interim Rule at § 574.300(b)(9) provides for technical assistance in establishing and operating a community residence. In order for a SRO building to receive technical assistance under a HOPWA grant, it must meet the qualifications for a community residence at § 574.340 in accordance with section 861 of the AIDS Housing Opportunity Act.

3. Timely Expenditure of Funds

Comments on § 574.540 expressed concern that the term timely manner was undefined and non-objective. A clarification is made that funds may be deobligated if not expended within 3 years.

4. Audit Procedures

One comment recommended that the audit procedures for nonprofit organizations be updated. This has been done in § 574.650.

D. Other Points Raised in Public Comments

1. Comments were received that the announcement of formula allocations should specify the process for curing technical deficiencies. The processes for curing technical deficiencies under the formula program provide for greater flexibility than that established for the competitive program in the notice of funding availability (NOFA) for that program. The Department is reluctant to impose the competitive standard given its experience under the first formula allocation under which formula applicants and HUD Field Offices cooperated successfully in correcting deficiencies.

Comments were also received that formula application deadlines could be difficult to meet in the initiation of the applicant's HOPWA program. The first Interim Rule provided flexibility in addressing this concern. The Department may extend the deadline for the submission of a formula application in exceptional circumstances pursuant to the waiver provision at § 574.4.

2. One comment recommended allowing applicants for EMSAs to proportionately share grant amounts with other jurisdictions in that EMSA based on AIDS prevalence, planning council recommendations or other means and to delegate grant management responsibilities to those jurisdictions. Grantees are required by § 574.420 to coordinate with other governments within an EMSA in addressing the needs of eligible persons. The statute provides for only one grantee for each EMSA and the rule therefore does not permit a grantee to diminish or delegate its responsibilities for grant administration under subpart F.

3. Comments were received recommending removal of the provision at § 574.300(c)(1)(i)(C) regarding voluntary nondenominational prayer before meetings of primarily religious organizations. The Department is not adopting this recommendation because it believes that the provision is permissible under the Constitution.

4. Comments recommended that the rental assistance standards at § 574.320 authorize the use of documented open market rental rates or otherwise exempt high cost areas from fair market rent (FMR) provisions. The Department believes that the procedures to establish and update FMRs under the Section 8 program are adequate to address these concerns. The related use of this procedure will provide for greater consistency in HUD programs and avoid redundant administrative activities.

5. The provision for due process in terminating assistance is found at § 574.310(e). One comment contended that this provision does not adequately address participant's rights within the program's administrative procedures which may lead to the loss of housing as compared to the use of judicial procedures for evictions under other HUD programs. The Interim Rule is consistent with other homeless assistance programs operated by the Department where housing assistance is integrated with supportive services.

E. Additional Technical Changes

1. HIV Included

The definition of acquired immunodeficiency syndrome and related diseases at § 574.3 includes infection with the human immunodeficiency virus (HIV). It is the Department's observation that while HIV infection was included under the term "etiologic agent" found in both the original definition and the authorizing statute, it was not clearly understood by interested parties. Therefore, the definition of acquired immunodeficiency syndrome and related diseases now explicitly includes HIV infection.

2. CHAS Consistency

Under § 574.160(a), a clarification is provided that only the State CHAS is applicable for the State application under the formula program.

3. Criteria for Competitive Grants

In implementing the first competitive program, HUD included in the notice of funding availability (NOFA) a rating criterion for the appropriateness of housing and supportive services, under authority existing at § 574.250(b)(2)(vi). This specific criterion has been included in this Interim Rule.

4. Applicability of Housing Quality Standards

Under § 574.310(b) in the first Interim Rule, the housing quality standards (HQS) provision was mistakenly applied to the current residence of an eligible person seeking short-term rent, mortgage, and utility payments under § 574.300(b)(6). Requiring conformance with HQS in this regard could have unintended consequences for residents in incurring unnecessary costs for repairs that in some cases may exceed the value of the requested HOPWA assistance. It could also lead to waiver requests and monitoring activities that delay or restrict assistance intended to address short-term emergency circumstances and temporary needs. Therefore, § 574.310(b) has been revised to delete the reference to § 574.300(b)(6).

5. Community Residence Service Agreement

Section 574.340(b)(1) requires that a written agreement to provide services be entered into by the two parties involved in that community residence. A clarification is made in identifying the parties as the grantee and the community resident's service provider and allowance is made if the grantee is providing the services itself.

6. Submission of Technical Information

A procedural change is provided at § 574.250(a)(3) regarding the grant selection process. To reduce the amount of documentation required to be submitted by all applicants, only those applicants with the highest rated applications within each competitive category will be required to submit detailed technical information. That process of identifying these top applicants is labeled a conditional approval of their applications. However, submission of such additional technical information will be a prerequisite to a grant offer from HUD.

7. Conflict of Interest Exceptions

Section 574.625 contains conflict of interest provisions for this program. This interim rule adds paragraphs (b) and (c) to the section to provide exceptions to be approved to the conflict of interest prohibition under appropriate circumstances. These paragraphs mirror provisions already included in regulations for the HOME program and the Community Development Block Grants program. The Department has found that waiver of the original provision is very time-consuming and difficult and believes that these added paragraphs provide for exceptions to be granted only where it is clearly in the interest of the HOPWA program.

8. Americans With Disabilities Act

References to this new statute were added to the provisions of § 574.600 dealing with nondiscrimination on the basis of handicap and on disability requirements.

F. Environmental Provisions

No public comments were made on Part 50, Protection and Enhancement of Environmental Quality. Since the 1992 Act did not make any changes that would affect the environmental issues, no changes to part 50 have been included here. The final rule incorporating changes to that part based on the previous interim rule will be included in the final rule on changes to part 574.

However, a few technical changes were made to § 574.510 to correct that section on environmental procedures, and environmental information was added to § 574.250(a)(4)(iv) to the list of specific technical information needed in the competitive program after an applicant has received conditional approval.

III. Findings and Certifications

A. Justification for Interim Rulemaking

In general, the Department publishes a rule for public comment before issuing a rule for effect, in accordance with its own regulations on rulemaking, 24 CFR part 10. However, the Housing and Community Development Act of 1992 (Pub. L. 102–550, approved October 28, 1992) requires the Department to submit draft interim regulations to Congress not later than the expiration of the 30-day period beginning on the date of the enactment of that Act, or November 27, 1992. Section 606(k)(1) further provides that following the 15-day period beginning upon the submission of the draft interim regulations to the Congress, HUD must publish interim regulations which will take effect upon publication.

Section 606(k)(2) of the Act provides that the comment period on the interim rule is to be 60 days long; that final regulations must be published following that notice and opportunity for public comment within 90 days of publication of the interim regulations; and that the final regulations will take effect upon publication. The Department invites public comment on this interim rule. The comments received within the 60-day comment period will be considered during the development of the final rule, which will supersede this interim rule.

B. Environmental Impact

A finding of no significant impact with respect to the environment has been made in accordance with HUD regulations at 24 CFR part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969. The finding of no significant impact is available for public inspection between 7:30 a.m. to 5:30 p.m. weekdays in the Office of the Rules Docket Clerk at the above address.

C. Impact on the Economy

This rule does not constitute a "major rule" as that term is defined in section 1(b) of the Executive Order on Federal Regulation issued by the President on February 17, 1981. An analysis of the rule indicates that it does not (1) have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, federal, State, or local government agencies, or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

D. Impact on Small Entities

The Secretary, in accordance with the Regulatory Flexibility Act (5 U.S.C. 605(b)), has reviewed this rule before publication and by approving it certifies that this rule does not have a significant economic impact on a substantial number of small entities, because jurisdictions that are statutorily eligible to receive formula allocations are limited to States and metropolitan statistical areas with a relatively large cumulative number of cases of persons with AIDS.

E. Semiannual Agenda of Rules

This rule was listed as sequence number 1377 under the Office of the Secretary in the Department's Semiannual Agenda of Regulations, published on November 3, 1992 (57 FR 51392, 51408) in accordance with Executive Order 12291 and the Regulatory Flexibility Act.

F. Federalism Impact

The General Counsel, as the Designated Official under section 6(a) of Executive Order 12612, Federalism, has determined that the policies contained in this rule will not have substantial direct effects on States or their political subdivisions, or the relationship between the Federal government and the States, or on the distribution of power and responsibilities among the various levels of government. As a result, the rule is not subject to review under the Order. The rule authorizes entitlement grants to a limited number of States and metropolitan areas and authorizes competitively awarded grants under a limited statutory allocation for housing assistance and services for the Housing Opportunities for Persons with AIDS program, but the grants are administered locally.

G. Impact on the Family

The General Counsel, as the Designated Official for Executive Order 12606, the Family, has determined that this rule, to the extent the funds provided under it are directed to families, has the potential for a beneficial impact on family formation, maintenance and general well-being. The program provides housing assistance and services for individuals with acquired immunodeficiency syndrome or related diseases and their families and defines the term eligible person to include the family of a person with AIDS or related diseases. Such assistance will help enable those families with a participating member

who has AIDS to live in decent, safe, and sanitary housing and receive the supportive services necessary to assist a person with AIDS to live independently. Since the impact on the family is beneficial, no further review is considered necessary.

H. "Takings" Assessment

The General Counsel, as the Designated Official under Executive Order 12630, Government Actions and Interference with Constitutionally Protected Property Rights, has determined that this rule does not have "takings implications" as defined in HUD's "Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings." The Department does not regard the effects of this rule on private property rights as "effectively denying economically viable use of any distinct legally protected property interest of a property owner, or resulting in a permanent or temporary physical occupation, invasion, or deprivation." The rule would authorize acquisition of property by grantees or their project sponsors under the normal State and local governmental procedures for the limited purpose of providing housing assistance for eligible persons.

I. Public Reporting Burden

The information collection requirements contained in this rule have been submitted to the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3520). The Department has determined that the following provisions contain information collection requirements.

TABLE 1.—TABULATION OF ANNUAL REPORTING BURDEN

Description of information collection	Provision of interim rule	Number of respondents	Number of responses per respondent	Total annual responses	Hours per response	Total hours
Applications to HUD:						
—State entitlements	§574.160	11	1	11	8.0	88
—City for EMSA	§574.160	27	1	27	12.0	324
—Competitive awards	§574.240	100	1	100	20.0	2,000
Annual report to HUD	§574.520	48	1	48	12.0	576
Waiver requests to HUD	§574.4 §574.310(c) §574.330(b)	5	1	5	4.0	20
Amendments submitted	§574.180 §574.260	5	1	5	4.0	20
Uniform relocation act appeals process	§574.630	5	1	5	2.0	10
Environmental review recordkeeping	§574.510	48	1	48	4.0	192
Total Burden						3,230

J. Catalog

The Catalog of Federal Domestic Assistance program number for the Housing Opportunities for Persons with AIDS program is 14.241.

List of Subjects in 24 CFR Part 574

AIDS, Community facilities, Disabled, Emergency shelter, Grant programs—housing and community development, Grant programs—social programs, Homeless, Housing, Low and moderate income housing, Nonprofit organizations, Rent subsidies, Reporting and recordkeeping requirements, Technical assistance.

Accordingly, title 24 of the Code of Federal Regulations is amended by revising part 574 to read as follows:

PART 574—HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS

Subpart A—General

Sec.

574.1 Purpose.
574.2 Overview.
574.3 Definitions.
574.4 Waivers.

Subpart B—Formula Entitlements

574.100 Eligible applicants.
574.120 Responsibility of applicant to serve EMSA.
574.130 Formula allocations.
574.140 Eligible persons.
574.150 Eligible activities.
574.160 Application requirements.
574.170 Application review and approval.
574.180 Amendments.
574.190 Reallocation of grant amounts.

Subpart C—Competitive Grants

574.200 Amounts available for competitive grants.
574.210 Eligible applicants.
574.220 Eligible persons.
574.230 Eligible activities.
574.240 Application requirements.
574.250 Grant selection process.
574.260 Amendments.

Subpart D—Uses of Grant Funds

574.300 Eligible activities.
574.310 General standards for eligible housing activities.
574.320 Additional standards for rental assistance.
574.330 Additional standards for short-term supported housing.
574.340 Additional standards for community residences.

Subpart E—Special Responsibilities of Grantees and Project Sponsors

574.400 Prohibition of substitution of funds.
574.410 Capacity.
574.420 Cooperation.
574.430 Fee prohibitions.
574.440 Confidentiality.
574.450 Financial records.

Subpart F—Grant Administration

574.500 Responsibility for grant administration.
574.510 Environmental procedures and standards.
574.520 Performance reports.
574.530 Recordkeeping.
574.540 Obligation and deobligation of funds.

Subpart G—Other Federal Requirements

574.600 Nondiscrimination and equal opportunity.
574.605 Applicability of OMB circulars.
574.610 Drug-free workplace.
574.615 Anti-lobbying certification.
574.620 Debarred or suspended contractors.
574.625 Conflict of interest.
574.630 Displacement, relocation and real property acquisition.
574.635 Lead-based paint.
574.640 Flood insurance protection.
574.645 Coastal barriers.
574.650 Audit.

Authority: 42 U.S.C. 12901–12912.

Subpart A—General

§ 574.1 Purpose.

The Housing Opportunities for Persons with AIDS (HOPWA) program is authorized by AIDS Housing Opportunity Act (AOHA) and amended by the Housing and Community Development Act of 1992 (Pub. L. 102–550, approved October 28, 1992). The program is designed to provide States and localities with resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome or related diseases and their families. The program authorizes entitlement grants and competitively awarded grants for housing assistance and services.

§ 574.2 Overview.

(a) *Available funds.* The Department awards funds appropriated for any fiscal year for the program through a formula allocation and a competitive grant process. The amount of funds available will be specified in an Announcement of Allocations for entitlement grants and a Notice of Funds Availability (NOFA) for competitive grants, both published in the Federal Register. Certain States and cities that are the most populous unit of general local government in eligible metropolitan statistical areas will receive (upon submission of an application and approval by HUD) formula allocations based on their State or metropolitan population and proportionate number of cases of persons with AIDS. They will receive funds under this part for eligible activities that address the housing needs of persons with AIDS or related diseases and their families. All States and units of general local government and nonprofit organizations are eligible to apply for competitive grants to fund projects of national significance. Only those States and units of general local government that do not qualify for formula allocations are eligible to apply for competitive grants to fund other projects.

(b) *Formula entitlements.* Under the Act, 90 percent of appropriated amounts are to be distributed by formula entitlement. See § 574.130(b).

(c) *Competitive grants.* The 10 percent remainder of appropriated funds are awarded through a competitive process. See subpart C of this part.

§ 574.3 Definitions.

Acquired immunodeficiency syndrome (AIDS) or related diseases means the disease of acquired immunodeficiency syndrome or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Applicant means a State or city applying for a formula allocation as described under § 574.100 or a State, unit of general local government, or a nonprofit organization applying for a competitive grant as described under § 574.210.

City means any unit of general local government which is classified as a municipality by the U.S. Bureau of the Census or any other unit of general local government which is a town or township and which, in the determination of the Secretary:

(1) Possesses powers and performs functions comparable to those associated with municipalities;

(2) Is closely settled; and

(3) Contains within its boundaries no incorporated places as defined by the U.S. Bureau of the Census which have not entered into cooperation agreements with such town or township to undertake or to assist in the undertaking of essential community development and housing assistance activities.

Eligible Metropolitan Statistical Area (EMSA) means a metropolitan statistical area that has a population of more than 500,000 and has more than 1,500 cumulative cases of AIDS.

Eligible person means a person with acquired immunodeficiency syndrome or a related disease and the family of such person.

Eligible State means a State that has:

(1) More than 1,500 cumulative cases of AIDS in those areas of the State outside of eligible metropolitan statistical areas that are eligible to be funded through a qualifying city; and

(2) An approved Comprehensive Housing Affordability Strategy (CHAS) as provided by § 574.160. A State may carry out activities anywhere in the State, including within an eligible metropolitan statistical area.

Grantee means a State, unit of general local government, or nonprofit organization receiving a grant directly from HUD under this part.

Low-income individual means any individual or family whose income does not exceed 80 percent of the median income for the area, as determined by HUD, with adjustments for smaller and larger families, except that HUD may establish income ceilings higher or lower than 80 percent of the median income for the area if HUD finds that such variations are necessary because of prevailing levels of construction costs or unusually high or low family incomes.

Metropolitan statistical area means a metropolitan statistical area as established by the Office of Management and Budget.

Moderate rehabilitation means rehabilitation that involves costs that are less than or equal to 75 percent of the value of the building after rehabilitation.

Nonprofit organization means any nonprofit organization (including a State or locally chartered, nonprofit organization) that:

(1) Is organized under State or local laws;

(2) Has no part of its net earnings inuring to the benefit of any member, founder, contributor, or individual;

(3) Has a functioning accounting system that is operated in accordance with generally accepted accounting principles, or has designated an entity that will maintain such an accounting system; and

(4) Has among its purposes significant activities related to providing services or housing to persons with acquired immunodeficiency syndrome or related diseases.

Population means total resident population based on data compiled by the U.S. Census and referable to the same point in time.

Project sponsor means any nonprofit organization or governmental housing agency that receives funds under a contract with the grantee to carry out eligible activities under this part.

Qualifying city means a city that is the most populous unit of general local government in an Eligible Metropolitan Statistical Area (EMSA) and that has an approved Comprehensive Housing Affordability Strategy (CHAS) as provided by § 574.160.

Rehabilitation means the improvement or repair of an existing structure, or an addition to an existing structure that does not increase the floor area by more than 100 percent.

Secretary means the Secretary of the Department of Housing and Urban Development.

State means a State of the United States of America, the District of Columbia, and the Commonwealth of Puerto Rico, or any agency or instrumentality thereof that is established pursuant to legislation and designated by the chief executive to act on behalf of the jurisdiction with regard to provisions of this part.

Substantial rehabilitation means rehabilitation that involves costs in excess of 75 percent of the value of the building after rehabilitation.

Unit of general local government means any city, town, township, parish, county, village, or other general purpose political subdivision of a State; Guam, the Northern Mariana Islands, the Virgin

Islands, American Samoa, the Federated States of Micronesia and Palau, the Marshall Islands, or a general purpose political subdivision thereof; and any agency or instrumentality thereof that is established pursuant to legislation and designated by the chief executive to act on behalf of the jurisdiction with regard to provisions of the National Affordable Housing Act.

§ 574.4 Waivers.

Upon a determination and finding of good cause, the Secretary may waive any requirement of this part in any particular case subject only to statutory limitations. Each waiver must be in writing and must be supported by documentation of the pertinent facts and grounds.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

Subpart B—Formula Entitlements

§ 574.100 Eligible applicants.

(a) Eligible States and qualifying cities, as defined in § 574.3, qualify for formula allocations under HOPWA.

(b) List. A list of qualifying cities and eligible States will be contained in the Announcement of Allocations published annually in the Federal Register.

§ 574.120 Responsibility of applicant to serve EMSA.

The EMSA's applicant shall serve eligible persons who live anywhere within the EMSA, except that housing assistance shall be provided only in localities within the EMSA that have a HUD-approved CHAS and have provided a certification of consistency in accordance with § 574.160(a). In allocating grant amounts among eligible activities, the EMSA's applicant shall address needs of eligible persons who reside within the metropolitan statistical area, including those not within the jurisdiction of the applicant.

§ 574.130 Formula allocations.

(a) *Data sources.* HUD will allocate funds based on the number of cases of acquired immunodeficiency syndrome reported to and confirmed by the Director of the Centers for Disease Control, and on population data provided by the U.S. Census. The number of cases of acquired immunodeficiency syndrome used for this purpose shall be the number reported as of March 31 of the fiscal year immediately preceding the fiscal year for which the amounts are appropriated and allocated.

(b) *Distribution of appropriated funds for entitlement awards.* (1) Seventy-five percent of the funds allocated under the formula is distributed to qualifying cities and eligible States, as described in § 574.100, based on each metropolitan statistical area's or State's proportionate share of the cumulative number of AIDS cases in all eligible metropolitan statistical areas and eligible States.

(2) The remaining twenty-five percent is allocated among qualifying cities, but not States, where the per capita incidence of AIDS for the year, April 1 through March 31, preceding the fiscal year of the appropriation is higher than the average for all metropolitan statistical areas with more than 500,000 population. Each qualifying city's allocation reflects its EMSA's proportionate share of the high incidence factor among EMSA's with higher than average per capita incidence of AIDS. The high incidence factor is computed by multiplying the population of the metropolitan statistical area by the difference between its twelve-month-per-capita-incidence rate and the average rate for all metropolitan statistical areas with more than 500,000 population. The EMSA's proportionate share is determined by dividing its high incidence factor by the sum of the high incidence factors for all EMSA's with higher than average per capita incidence of AIDS.

(c) *Minimum grant.* No grant awarded under paragraph (b) of this section shall be less than $200,000. Therefore, if the calculations under paragraph (b) of this section would result in any eligible metropolitan statistical area or eligible State receiving less than $200,000, the amount allocated to that entity is increased to $200,000 and allocations to entities in excess of $200,000 are proportionately reduced by the amount of the increase.

§ 574.140 Eligible persons.

Persons eligible to receive assistance or services under this part are persons with acquired immunodeficiency syndrome or related diseases who are low-income individuals and their families. A person with AIDS or related diseases or a family member regardless of income is eligible to receive housing information services, as described in § 574.300(b)(1). Any person living in proximity to a community residence is eligible to participate in that residence's community outreach and educational activities regarding AIDS or related diseases, as provided in § 574.300(b)(9).

§ 574.150 Eligible activities.

Grantees under this subpart are authorized to provide, or contract with project sponsors to provide, housing assistance or service activities as described in Subpart D—Uses of Grant Funds. The selection of project sponsors is not subject to the procurement requirements of 24 CFR 85.36

§ 574.160 Application requirements.

(a) *CHAS.* Assistance may not be made available under this subpart unless the applicant has submitted a certification that proposed housing assistance is consistent with a Comprehensive Housing Affordability Strategy (CHAS) submitted to and approved by HUD in accordance with 24 CFR part 91. The applicant's certification of consistency must be submitted by the public official responsible for submitting the CHAS. Where the applicant is a city that is the most populous unit of general local government in an EMSA, it must also obtain and keep on file certifications of consistency from such public officials for each other locality in the EMSA in which housing assistance is provided. Where the applicant is a State, the certification applies to consistency with the State's CHAS.

(b) *Application requirements.* To receive a grant, a State or city applicant for an EMSA applying for a formula grant award on the basis of an allocation under § 574.130 must submit an application that meets the requirements of paragraph (c) of this section, and the application must be submitted within the time period established by HUD in the Announcement of Allocations for Housing Opportunities for Persons with AIDS, published annually in the Federal Register. This Announcement:

(1) Gives the location for obtaining application packages, which provides specific application requirements and guidance;

(2) Specifies the time and the place for submitting completed applications; and

(3) Identifies States and the cities that are the most populous unit of general local government in metropolitan statistical areas eligible to receive funding available under the announcement.

(c) *Application contents.* A formula entitlement grant application, at a minimum, must contain:

(1) A description of the proposed activities, including general locations, and costs;

(2) A description of the number and characteristics of the eligible persons who would be served by the proposed activities;

(3) A description of the public and private resources that are expected to be made available in connection with the proposed activities;

(4) A description of the method of selecting project sponsors;

(5) A description of efforts that have been or will be taken to coordinate proposed activities with State and local government agencies responsible for providing services to persons with AIDS or related diseases, including, where applicable, coordination with agencies administering assistance provided pursuant to the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300). In addition, for city applicants, coordination with other units of general local government located within the metropolitan statistical area to address needs within that area. This description should also describe how community-based nonprofit organizations experienced in caring for persons with AIDS and organizations which represent persons with AIDS have been consulted and involved in the application planning process;

(6) A certification that any building or structure assisted under this part will be maintained as a facility to provide assistance for eligible persons:

(i) For a period of not less than 10 years in the case of assistance involving new construction, substantial rehabilitation or acquisition of a facility; and

(ii) For a period of not less than 3 years in cases involving non-substantial rehabilitation or repair of a building or structure;

(7) Description of how the proposed activities will meet urgent needs that are not being met by available public and private sources. In addition, for city applicants, a description of how the proposed activities will address the needs within the metropolitan statistical area in which the city is located, including areas not within the jurisdiction of the city;

(8) A certification that proposed housing activities are consistent with a CHAS approved by HUD, as described in paragraph (a) of this section;

(9) An assurance that the applicant will:

(i) Supply HUD with information necessary for HUD to perform any applicable environmental review for each property in accordance with the environmental laws and authorities cited in 24 CFR part 50;

(ii) Carry out mitigating measures required by HUD or select alternate eligible property; and

(iii) Not acquire, rehabilitate, convert, lease, repair or construct property to provide housing, or commit HUD, State, local, or other funds to such program activities with respect to any eligible property until HUD approval is received. See § 574.510 of this part for the environmental procedures and standards for applicants for assistance; and

(10) Such other information or certifications as HUD determines to be necessary.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.170 Application review and approval.

The application review and approval process for assistance under this section consists of the following stages:

(a) *Review.* Applications will be reviewed to determine:

(1) Whether the application is adequate in time of submission, form, and completeness;

(2) Whether the applicant, the population to be served and project sponsor, if any, are eligible; and

(3) Whether the proposed activities are eligible for assistance under the program.

(b) *Approval.* The Department will award a grant in the amount determined under § 574.130 of this part to eligible applicants with approved applications.

§ 574.180 Amendments.

(a) A grantee must notify HUD in writing of any substantial change in the approved program of activities. A substantial change is any addition or deletion of an eligible activity, or any change that will significantly alter the scope, location, service area, or objectives of an activity or the number of eligible persons served, that has been approved in an application.

(b) Each amendment request must contain a description of the revised proposed use of funds and, for grantees receiving formula awards, a certification that the proposed use of funds is consistent with the applicable Comprehensive Housing Affordability Strategy. Funds may not be expended for the revised proposed use of funds until:

(1) HUD accepts the revised proposed use; and

(2) For amendments to acquire, rehabilitate, convert, lease, repair or construct properties to provide housing, an environmental review of the revised proposed use of funds has been completed in accordance with § 574.510.

§ 574.190 Reallocation of grant amounts.

Funds allocated to eligible States or to the cities that are the most populous unit of general local government in EMSAs, that do not submit an application by the deadline specified by HUD, will be added to the funds available for formula allocations in the current fiscal year. Any formula funds that become available as a result of deobligations or the imposition of sanctions as provided for in § 574.540 will be added to the funds available for formula allocations in the next fiscal year.

Subpart C—Competitive Grants

§ 574.200 Amounts available for competitive grants.

(a) The Department will set aside 10 percent of the amounts appropriated under this program to fund on a competitive basis:

(1) Special projects of national significance; and

(2) Other projects submitted by States and localities that do not qualify for formula grants.

(b) Any competitively awarded funds that become available as a result of deobligations or the imposition of sanctions, as provided in § 574.540, will be added to the funds available for competitive grants in the next fiscal year.

§ 574.210 Eligible applicants.

(a) All States, units of general local government, and nonprofit organizations, may apply for grants for projects of national significance.

(b) Only those States and units of general local government that do not qualify for formula grants, as described in § 574.100; may apply for grants for other projects as described in § 574.200(a)(2).

(c) Except for grants for projects of national significance, nonprofit organizations are not eligible to apply directly to HUD for a grant but may receive funding as a project sponsor under contract with a grantee.

§ 574.220 Eligible persons.

Persons eligible to receive assistance or services under this part are persons with acquired immunodeficiency syndrome or related diseases who are low-income individuals and their families. A person with AIDS or related diseases or a family member regardless of income is eligible to receive housing information services, as described in § 574.300(b)(1). Any person living in proximity to a community residence is eligible to participate in that residence's community outreach and educational activities regarding AIDS or related diseases, as provided in § 574.300(b)(9).

§ 574.230 Eligible activities.

Grantees under this subpart are authorized to provide, or contract with project sponsors to provide, housing assistance or service activities as

described in Subpart D—Uses of Grant Funds. The selection of project sponsors is not subject to the procurement requirements of 24 CFR 85.36.

§ 574.240 Application requirements.

(a) *Notice of fund availability for competitive grants.* Applications must comply with the provisions of the Department's Notice of Fund Availability (NOFA) to be published in the **Federal Register** in accordance with 24 CFR part 12. The notice:

(1) Gives the location for obtaining application packages, which will provide specific application requirements and guidance;

(2) Specifies the time and the place for submitting completed applications;

(3) States the amount and status of funding available under the notice, including the amounts allocated to each of the two categories of assistance;

(4) Specifies the timing and conditions for curing technical deficiencies in reviewed application;

(5) Provides other appropriate program information and guidance, including purpose, authority, and eligibility; and

(6) Describes the factors relative to each ranking criterion contained in § 574.250 of this part, and indicates the weight or relative importance of the criteria as they will be applied to the funding round announced in the Notice.

(b) *Application requirements.* To receive grant amounts, a State, unit of general local government, or nonprofit organization that elects to apply for a competitive grant award must submit an application that meets the requirements of paragraph (c) of this section and must be submitted within the time period established by HUD in the Notice of Funds Availability.

(c) *Application contents.* A competitive grant application, at a minimum, must contain:

(1) Applicant and project sponsor data, including a description of the applicant and sponsor's past experience in administering programs providing assistance to persons with AIDS, including minority persons, and for nonprofit organizations, description of how it is consistent with the definition of nonprofit organization as provided in § 574.3;

(2) A description of the proposed activities, including site information and costs;

(3) A description of the number and characteristics of the persons who would be served by the proposed activities;

(4) A description of the public and private resources that are expected to be made available in connection with the proposed activities;

(5) A description of the method of selecting project sponsors;

(6) A description of efforts that have been or will be taken to coordinate proposed activities with State and local government agencies responsible for providing services to persons with AIDS or related diseases, including, where applicable, coordination with agencies administering assistance provided pursuant to the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300). The description should also describe how community-based nonprofit organizations experienced in caring for persons with AIDS and organizations which represent persons with AIDS have been consulted and involved in the application planning process;

(7) A certification that any building or structure assisted with amounts under this part will be maintained as a facility to provide assistance for eligible persons:

(i) For not less than 10 years in the case of assistance involving new construction, substantial rehabilitation or acquisition of the building; and

(ii) For not less than 3 years in cases involving non-substantial rehabilitation or repair of a building or structure;

(8) Description of how the proposed activities will meet urgent needs that are not being met by available public and private sources;

(9) For grants for projects of national significance, a description of the innovative nature of the project and its potential for replication in similar localities or nationally;

(10) An assurance that the applicant will:

(i) Supply HUD with information necessary for HUD to perform any applicable environmental review for each property in accordance with the environmental laws and authorities cited in 24 CFR part 50;

(ii) Carry out mitigating measures required by HUD or select alternate eligible property; and

(iii) Not acquire, rehabilitate, convert, lease, repair or construct property to provide housing, or commit HUD, State, local, or other funds to such program activities with respect to any eligible property until HUD approval is received. See § 574.510 of this part for the environmental procedures and standards for applicants for assistance;

(11) For States and units of general local government, a certification that proposed housing activities are consistent with a CHAS approved by HUD (see § 574.160(a)); and

(12) Such other information or certifications as the Secretary determines to be necessary.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.250 Grant selection process.

(a) *Selection process*—(1) *Review.* Applications will be reviewed to determine:

(i) Whether the application is adequate in time of submission, form, and completeness;

(ii) Whether the applicant, the population to be served and project sponsor(s), if any, are eligible;

(iii) Whether the proposed activities are eligible for assistance under the program; and

(iv) Whether the applicant is currently in compliance with the Federal requirements contained in Subpart G—Other Federal Requirements, §§ 574.600–574.650.

(2) *Rating.* Applications received by the deadline will be rated based on the selection criteria provided in paragraph (b) of this section;

(3) *Conditional selection for funding.* The highest rated applications within each of the two categories of assistance will be selected for potential funding in accordance with their ranked order to the extent funds are available. Each conditionally selected applicant will be invited to provide additional project information, as described in paragraph (a)(4) of this section, as a prerequisite to a grant offer from HUD.

(4) *Obtaining additional information.* When an applicant is selected for potential funding, the applicant will be invited by HUD to submit additional project information, which may include:

(i) Documentation to show that the project is feasible;

(ii) Documentation showing site control, as described in § 574.240(c)(2);

(iii) Information necessary for HUD to perform an environmental review under § 574.510; and

(iv) Such other documentation that is necessary for clarification or confirmation of the information in the application, as specified by HUD in writing to the applicant.

(5) *Receipt of additional information.* The required additional information must be received in acceptable form by the deadline established by HUD in a notice of funding availability published in the **Federal Register**. HUD reserves the right to remove any project from further consideration for grant assistance if the required additional information is not received in acceptable form by the established deadline.

(6) *Grant award.* Following receipt of the additional information in acceptable form and following completion of an

acceptable environmental review, HUD will approve the application and send a grant agreement for execution to the applicant.

(b) *Rating criteria for applications for funds for competitive grants—(1) General.* Applications for funds for competitive grants will be assigned a rating score and placed in ranked order, based upon the criteria listed in paragraphs (b)(2) and (b)(3) of this section. The criteria, including the point value for each, will be described in more detail in the Notice of Funds Availability which will be published in the Federal Register.

(2) *Criteria.* HUD will award points for the following criteria:

(i) Applicant capacity;

(ii) Need for the project in the area to be served, including the relative numbers of AIDS cases and per capita AIDS incidence, and the housing needs of eligible persons in the community;

(iii) Appropriateness of housing and supportive services, including how activities carried out with HOPWA funds and other resources will provide a continuum of housing and services to meet the changing needs of eligible persons;

(iv) Extent of leveraged public and private resources for the project;

(v) Extent of local planning and coordination of housing programs for eligible persons and the likelihood of the continuation of State and local efforts; and

(vi) Other criteria as determined by the Secretary and announced in the NOFA.

(3) *Additional criteria for projects of national significance.* For projects of national significance, HUD also will award points for the following criteria:

(i) Innovative nature of the proposal, including the effectiveness of the proposed model(s) for providing supportive housing for eligible persons; and

(ii) Potential for replication of the proposed activity in other similar localities or nationally.

(c) *Ties between applicants.* In the event of a tie between applicants, HUD will use need for the project to determine which application should be selected for potential funding.

(d) *Procedureal error.* If HUD makes a procedural error in a funding competition that, when corrected, would warrant funding of an otherwise eligible application, HUD will select that application for potential funding when sufficient funds become available.

§ 574.260 Amendments.

(a) After an application has been selected for funding, any change that will significantly alter the scope, location, service area, or objectives of an activity or the number of eligible persons served must be justified to HUD and approved by HUD. Whenever any other amendment to the application is made, the grantee must provide a copy to HUD.

(b) Each amendment request must contain a description of the revised proposed use of funds. Funds may not be expended for the revised proposed use of funds until:

(1) HUD accepts the revised proposed use; and

(2) For amendments to acquire, rehabilitate, convert, lease, repair or construct properties to provide housing, an environmental review of the revised proposed use of funds has been completed in accordance with § 574.510.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

Subpart D—Uses of Grant Funds

§ 574.300 Elegible activities.

(a) *General.* Subject to applicable requirements described in §§ 574.310, 574.320, 574.330, and 574.340, HOPWA funds may be used to assist all forms of housing designed to prevent hopelessness including emergency housing, shared housing arrangements, apartments, single room occupancy (SRO) dwellings, and community residences. Appropriate supportive services, as required by § 574.310(a), must be provided as part of any HOPWA assisted housing, but HOPWA funds may also be used to provide services independently of any housing activity.

(b) *Activities.* The following activities may be carried out with HOPWA funds:

(1) Housing information services including, but not limited to, counseling, information, and referral services to assist an eligible person to locate, acquire, finance and maintain housing. This may also include fair housing counseling for eligible persons who may encounter discrimination on the basis of race, color, religion, sex, age, national origin, familial status, or handicap;

(2) Resource identification to establish, coordinate and develop housing assistance resources for eligible persons (including conducting preliminary research and making expenditures necessary to determine the feasibility of specific housing-related initiatives);

(3) Acquisition, rehabilitation, conversion, lease, and repair of facilities to provide housing and services;

(4) New construction (for single room occupancy (SRO) dwellings and community residences only).

(5) Project- or tenant-based rental assistance, including assistance for shared housing arrangements;

(6) Short-term rent, mortgage, and utility payments to prevent the homelessness of the tenant or mortgagor of a dwelling;

(7) Supportive services including, but not limited to, health, mental health, assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, day care, nutritional services, intensive care when required, and assistance in gaining access to local, State, and Federal government benefits and services, except that health services may only be provided to individuals with acquired immunodeficiency syndrome or related diseases and not to family members of these individuals;

(8) Operating costs for housing including maintenance, security, operation, insurance, utilities, furnishings, equipment, supplies, and other incidental costs;

(9) Technical assistance in establishing and operating a community residence, including planning and other pre-development or pre-construction expenses and including, but not limited to, costs relating to community outreach and educational activities regarding AIDS or related diseases for persons residing in proximity to the community residence;

(10) Administrative expenses:

(i) Each grantee may use not more than 3 percent of the grant amount for its own administrative costs relating to administering grant amounts and allocating such amounts to project sponsors; and

(ii) Each project sponsor receiving amounts from grants made under this program may use not more than 7 percent of the amounts received for its own administrative costs relating to carrying out eligible activities under this section, including costs of staff necessary to carry out eligible activities.

(11) For competitive grants only, any other activity proposed by the applicant and approved by HUD.

(c) *Limitations of assistance to primarily religious organizations—(1) Provision of assistance.* (i) Assistance may be provided under this part by a grantee to a project sponsor that is a primarily religious organization if the primarily religious organization agrees to provide all eligible activities under this program in a manner that is free from religious influences and in accordance with the following principles:

(A) It will not discriminate against any employee or applicant for employment on the basis of religion and will not limit employment or give preference in employment to persons on the basis of religion.

(B) It will not discriminate against any person applying for any of the eligible activities under this part on the basis of religion and will not limit such housing or other eligible activities or give preference to persons on the basis of religion.

(C) It will provide no religious instruction or counseling, conduct no religious services or worship (which term does not include voluntary nondenominational prayer before meetings), engage in no religious proselytizing, and exert no other religious influence in the provision of eligible activities under this part.

(ii) Assistance will not be provided to a project sponsor that is a primarily religious organization to construct or acquire a structure. Assistance may be provided to a project sponsor that is a primarily religious organization to rehabilitate or convert a structure owned by the organization, only as described in paragraph (c)(2) of this section.

(2) *Rehabilitation or conversion of structures owned by primarily religious organizations.* Grant amounts may be used to rehabilitate or convert a structure that is owned by a primarily religious organization, only if:

(i) The structure (or portion thereof) that is to be rehabilitated or converted with HUD assistance has been leased to an existing or newly established wholly secular organization (which may be established by the religious organization under the provisions of paragraph (c)(3) of this section).

(ii) The HUD assistance is provided to the secular organization (and not the religious organization) to make the improvements.

(iii) The leased structure will be used exclusively for secular purposes available to all persons regardless of religion.

(iv) The lease payments paid to the primarily religious organization do not exceed the fair market rent for the structure before the rehabilitation or conversion was done.

(v) The portion of the cost of any improvements that benefit any unleased portion of the structure will be allocated to, and paid for by, the religious organization.

(vi) The primarily religious organization agrees that if the secular organization does not retain the use of the leased premises for wholly secular purposes for the useful life of the improvements, the primarily religious organization will pay an amount equal to the residual value of the improvements to the original grantee from which the amounts used to rehabilitate or convert the building were derived. While the original grantee is expected to use this amount for eligible HOPWA activities, there is no requirement that funds received after the close of the grant period be used in accordance with the requirements of this part.

(3) *Assistance to a wholly secular private nonprofit organization established by a primarily religious organization.*

(i) A primarily religious organization may establish a wholly secular private nonprofit organization to serve as a project sponsor. The secular organization may be eligible to receive all forms of assistance available under this part.

(ii) The secular organization must agree to provide eligible activities under this part in a manner that is free from religious influences and in accordance with the principles set forth in paragraph (c)(1)(i) of this section.

(iii) The secular organization may enter into a contract with the religious organization to operate the housing assistance, supportive services and other eligible activities for the project. In such a case, the religious organization must agree in the contract to carry out its contractual responsibilities in a manner free from religious influences and in accordance with the principles set forth in paragraph (c)(1)(i) of this section.

(iv) The rehabilitation or conversion of structures are subject to the requirements of paragraph (c)(2) of this section.

§ 574.310 General standards for eligible housing activities.

All grantees using grant funds to provide housing must adhere to the following standards:

(a) *Supportive services.* The grantee shall ensure that qualified service providers in the area make available appropriate supportive services to the individuals assisted with housing under this subpart. Supportive services are described in § 574.300(b)(7). For any individual with acquired immunodeficiency syndrome or a related disease who requires more intensive care than can be provided in housing assisted under this subpart, the grantee shall provide for locating a care provider who can appropriately care for the individual and for referring the individual to the care provider.

(b) *Housing quality standards.* All housing assisted under § 574.300(b) (3), (4), (5), and (8) must meet the applicable housing quality standards outlined below.

(1) *State and local requirements.* Each recipient of assistance under this part must provide safe and sanitary housing that is in compliance with all applicable State and local housing codes, licensing requirements, and any other requirements in the jurisdiction in which the housing is located regarding the condition of the structure and the operation of the housing.

(2) *Habitability standards.* Except for such variations as are proposed by the locality and approved by HUD, recipients must meet the following requirements:

(i) *Structure and materials.* The structures must be structurally sound so as not to pose any threat to the health and safety of the occupants and so as to protect the residents from hazards.

(ii) *Access.* The housing must be accessible and capable of being utilized without unauthorized use of other private properties. Structures must provide alternate means of egress in case of fire.

(iii) *Space and security.* Each resident must be afforded adequate space and security for themselves and their belongings. An acceptable place to sleep must be provided for each resident.

(iv) *Interior air quality.* Every room or space must be provided with natural or mechanical ventilation. Structures must be free of pollutants in the air at levels that threaten the health of residents.

(v) *Water supply.* The water supply must be free from contamination at levels that threaten the health of individuals.

(vi) *Thermal environment.* The housing must have adequate heating and/or cooling facilities in proper operating condition.

(vii) *Illumination and electricity.* The housing must have adequate natural or artificial illumination to permit normal indoor activities and to support the health and safety of residents. Sufficient electrical sources must be provided to permit use of essential electrical appliance while assuring safety from fire.

(viii) *Food preparation and refuse disposal.* All food preparation areas must contain suitable space and equipment to store, prepare, and serve food in a sanitary manner.

(ix) *Sanitary condition.* The housing and any equipment must be maintained in sanitary condition.

(c) *Minimum use period for structures.* (1) Any building or structure assisted with amounts under this part

must be maintained as a facility to provide housing or assistance for individuals with acquired immunodeficiency syndrome or related diseases:

(i) For a period of not less than 10 years, in the case of assistance provided under an activity eligible under § 574.300(b) (3) and (4) involving new construction, substantial rehabilitation or acquisition of a building or structure; or

(ii) For a period of not less than 3 years in the cases involving non-substantial rehabilitation or repair of a building or structure.

(2) Waiver of minimum use period. HUD may waive the minimum use period of a building or structure as stipulated in paragraph (c)(1) of this section if the grantee can demonstrate, to the satisfaction of HUD, that:

(i) The assisted structure is no longer needed to provide supported housing or assistance, or the continued operation of the structure for such purposes is no longer feasible; and

(ii) The structure will be used to benefit individuals or families whose incomes do not exceed 80 percent of the median income for the area, as determined by HUD with adjustments for smaller and larger families, if the Secretary finds that such variations are necessary because of construction costs or unusually high or low family incomes.

(d) *Resident rent payment.* Each person receiving rental assistance under this program or residing in any rental housing assisted under this program must pay as rent, including utilities, an amount determined in accordance with section 3(a) of the United States Housing Act of 1937 and 24 CFR 813.106. Under these authorities, each resident must pay as rent the higher of:

(1) 30 percent of the family's monthly adjusted income (adjustment factors include the age of the individual, medical expenses, size of family and child care expenses and are described in detail in 24 CFR 813.102);

(2) 10 percent of the family's monthly gross income; or

(3) If the family is receiving payments for welfare assistance from a public agency and a part of the payments, adjusted in accordance with the family's actual housing costs, is specifically designated by the agency to meet the family's housing costs, the portion of the payments that is designated.

(e) *Termination of assistance.* Assistance to participants who reside in housing programs under this grant may be terminated if the participant violates program requirements or conditions of occupancy. Grantees must ensure that supportive services are provided, so that a participant's assistance is terminated only in the most severe cases. In terminating assistance to any program participant, grantees must provide a formal process that recognizes the rights of individuals receiving assistance to due process of law. This process at a minimum, must consist of:

(1) Serving the participant with a written notice containing a clear statement of the reasons for termination;

(2) Permitting the participant to have a review of the decision, in which the participant is given the opportunity to present written objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision; and

(3) Providing prompt written notification of the final decision to the participant.

(Paragraph (c) approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.320 Additional standards for rental assistance.

(a) If grant funds are used to provide rental assistance, the following additional standards apply:

(1) *Maximum subsidy.* The amount of grant funds used to pay monthly assistance for an eligible person may not exceed the difference between:

(i) The lower of the rent standard or reasonable rent for the unit; and

(ii) The resident's rent payment calculated under § 574.310(d).

(2) *Rent standard.* The rent standard shall be established by the grantee and shall be no more than the published section 8 fair market rent (FMR) or the HUD-approved community-wide exception rent for the unit size. However, on a unit by unit basis, the grantee may increase that amount by up to 10 percent for up to 20 percent of the units assisted.

(3) *Rent reasonableness.* The rent charged for a unit must be reasonable in relation to rents currently being charged for comparable units in the private unassisted market and must not be in excess of rents currently being charged by the owner for comparable unassisted units.

(b) With respect to shared housing arrangements, the provisions of subpart C of 24 CFR part 882 shall be followed.

§ 574.330 Additional standards for short-term supported housing.

Short-term supported housing includes facilities to provide temporary shelter to eligible individuals as well as rent, mortgage, or utilities payments to enable eligible individuals to remain in their own dwellings. If grant funds are used to provide such short-term supported housing assistance, the following additional standards apply:

(a) *Time limits.* (1) A short-term supported housing facility may not provide residence to any individual for more than 60 days during any six month period. Rent, mortgage, or utilities payments to prevent the homelessness of the tenant or mortgagor of a dwelling may not be provided to such an individual for these costs accruing over a period of more than 21 weeks in any 52 week period. These limitations do not apply to rental assistance provided under § 574.300(b)(5).

(2) *Waiver of time limitations.* HUD may waive, as it determines appropriate, the limitations of paragraph (a)(1) and will favorably consider a waiver based on the good faith effort of a project sponsor to provide permanent housing under subsection (c).

(b) *Residency limitations*—(1) *Residency.* A short-term supported facility may not provide shelter or housing at any single time for more than 50 families or individuals;

(2) *Waiver of residency limitations.* HUD may waive, as it determines appropriate, the limitations of paragraph (b)(1) of this section.

(c) *Placement.* A short-term supported housing facility assisted under this part must, to the maximum extent practicable, provide each individual living in such housing the opportunity for placement in permanent housing or in a living environment appropriate to his or her health and social needs.

(d) *Assistance to continue independent living.* In addition to the supportive services provided when an individual is relocated to a short-term supported housing facility, supportive services may be provided to individuals when they remain in their residence because the residence is appropriate to the needs of the individual. In the latter case, a rent, mortgage or utilities payments program assisted under this part shall provide, when reasonable, supportive services specifically designed to maintain the individual in such residence.

(e) *Case management services.* A program assisted under this section shall provide each assisted individual with an opportunity, if eligible, to receive case management services from the appropriate social service agencies.

(Paragraph (b) approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.340 Additional standards for community residences.

(a) A community residence is a multiunit residence designed for eligible

persons to provide a lower cost residential alternative to institutional care; to prevent or delay the need for such care; to provide a permanent or transitional residential setting with appropriate services to enhance the quality of life for those who are unable to live independently; and to enable such persons to participate as fully as possible in community life.

(b) If grant funds are used to provide a community residence, except for planning and other expenses preliminary to construction or other physical improvement for the development of a community residence, the grantee must, prior to the expenditure of such funds, obtain and keep on file certifications that:

(1) The grantee has entered into a written agreement with service providers to provide, or the grantee will itself provide, services as required by § 574.310(a) to eligible persons assisted by the community residence;

(2) The grantee has acquired sufficient funding for these services, or has on file an analysis of the service level needed for each community residence and a statement of which agencies will provide the needed services and how the services will be funded, and the service providers are qualified to assist eligible persons; and

(3) Any construction or physical improvements carried out with amounts received from the grant will comply with any applicable State and local housing codes and licensing requirements in the jurisdiction in which the community residence is located.

Subpart E—Special Responsibilities of Grantees and Project Sponsors

§ 574.400 Prohibition of substitution of funds.

Amounts received from grants under this part may not be used to replace other amounts made available or designated by State or local governments through appropriations for use for the purposes of this part.

§ 574.410 Capacity.

The grantee shall ensure that any project sponsor with which the grantee contracts to carry out an activity under this part has the capacity and capability to effectively administer the activity.

§ 574.420 Cooperation.

(a) The grantee shall agree, and shall ensure that each project sponsor agrees, to cooperate and coordinate in providing assistance under this part with the agencies of the relevant State and local governments responsible for services in the area served by the grantee for eligible persons and other public and private organizations and agencies providing services for such eligible persons.

(b) A grantee that is a State shall obtain the approval of the unit of general local government in which a project is to be located before entering into a contract with a project sponsor to carry out an activity authorized under this part.

(c) A grantee that is a city receiving a formula allocation for an EMSA shall coordinate with other units of general local government located within the metropolitan statistical area to address needs within that area.

§ 574.430 Fee prohibitions.

The grantee shall agree, and shall ensure that each project sponsor agrees, that no fee, except rent, will be charged of any eligible person for any housing or services provided with amounts from a grant under this part.

§ 574.440 Confidentiality.

The grantee shall agree, and shall ensure that each project sponsor agrees, to ensure the confidentiality of the name of any individual assisted under this part and any other information regarding individuals receiving assistance.

§ 574.450 Financial records.

The grantee shall agree, and shall ensure that each project sponsor agrees, to maintain and make available to HUD for inspection financial records sufficient, in HUD's determination, to ensure proper accounting and disbursing of amounts received from a grant under this part.

Subpart F—Grant Administration

§ 574.500 Responsibility for grant administration.

(a) *General.* Grantees are responsible for ensuring that grants are administered in accordance with the requirements of this part and other applicable laws. Grantees are responsible for ensuring that their respective project sponsors carry out activities in compliance with all applicable requirements.

(b) *Grant agreement.* The grant agreement will provide that the grantee agrees, and will ensure that each project sponsor agrees, to:

(1) Operate the program in accordance with the provisions of these regulations and other applicable HUD regulations;

(2) Conduct an ongoing assessment of the housing assistance and supportive services required by the participants in the program;

(3) Assure the adequate provision of supportive services to the participants in the program; and

(4) Comply with such other terms and conditions, including recordkeeping and reports (which must include racial and ethnic data on participants) for program monitoring and evaluation purposes, as HUD may establish for purposes of carrying out the program in an effective and efficient manner.

(c) *Enforcement.* HUD will enforce the obligations in the grant agreement in accordance with the provisions of 24 CFR 85.43. A grantee will be provided an opportunity for informal consultation before HUD will exercise any remedies authorized in paragraph (a) of that section.

§ 574.510 Environmental procedures and standards.

(a) Before any amounts under this program are used to acquire, rehabilitate, convert, lease, repair or construct properties to provide housing, HUD shall perform a review in accord with 24 CFR part 50, which implements the National Environmental Policy Act and the related Federal environmental laws and authorities listed under 24 CFR 50.4. In performing its environmental review, HUD may use previously issued environmental reviews prepared by other local, State, or federal agencies for the proposed property. The grantee will cooperate in providing these documents. HUD must, however, conduct the environmental analysis and prepare the environmental review and be responsible for the required environmental findings.

(b) HUD shall determine whether an environmental assessment under NEPA is required. HUD also shall determine whether the proposed property triggers thresholds for the applicable federal environmental laws and authorities listed under 24 CFR 50.4. These may apply when the property:

(1) Is located within designated coastal barriers;

(2) Is listed on, or eligible for listing on, the National Register of Historic Places; located within, or adjacent to, an historic district, or is a property whose area of potential effects includes a historic district or property;

(3) Is located near hazardous industrial operations handling fuels or chemicals of an explosive or flammable nature;

(4) Is contaminated by toxic chemicals or radioactive materials;

(5) Is located within a runway clear zone at a civil airport or within a clear zone or accident potential zone at a military airfield;

(6) Is located within certain flood hazard areas or a designated wetland;

(7) Is located within an area requiring flood insurance protection;

(8) Is located within a high noise area;

(9) Is located within a coastal management zone;

(10) Is located on a sole source aquifer; or

(11) Would affect an endangered species.

(c) A grantee or project sponsor shall refer the property to HUD for threshold review and shall submit all available, relevant information to HUD to permit HUD to make the review.

(d) If HUD determines that one or more of the thresholds are exceeded, HUD shall conduct an environmental review of the issue and, if appropriate, establish mitigating measures that the grantee and/or project sponsor shall carry out for the property unless it decides to select an alternate property.

(e) HUD will issue a notice specifying applicable threshold and documentation requirements.

(Approved by the Office of Management and Budget under OMB control number 2506.0133)

§ 574.520 Performance reports.

A grantee shall submit to HUD annually a report describing the use of the amounts received, including the number of individuals assisted, the types of assistance provided, and any other information that HUD may require. Annual reports are required until all grant funds are expended.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.530 Recordkeeping.

Each grantee must ensure that records are maintained for a three-year period to document compliance with the provisions of this part. Grantees must maintain current and accurate data on the race and ethnicity of program participants.

§ 574.540 Obligation and deobligation of funds.

Selection of an application for funding and notification of the applicant constitutes the obligation of funds by HUD to cover the amount of the approved assistance. HUD may deobligate all or a portion of the amounts approved for eligible activities if such amounts are not expended in a timely manner, or the proposed activity for which funding was approved is not provided in accordance with the approved application and the requirements of this regulation. HUD may deobligate any amount of grant funds that have not been expended within a three-year period from the date of the signing of the grant agreement. The grant agreement may set forth other circumstances under which funds may be deobligated or sanctions imposed.

Subpart G—Other Federal Requirements

§ 574.600 Nondiscrimination and equal opportunity.

Grantees and project sponsors must, within the eligible population, comply with the following requirements for nondiscrimination on the basis of race, color, religion, sex, national origin, age, familial status and handicap:

(a) *Fair housing requirements.* The requirements of the Fair Housing Act (42 U.S.C. 3601–19) and implementing regulations at 24 CFR part 100; Executive Order 11063 and implementing regulations at 24 CFR part 107; and title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) (Nondiscrimination in Federally Assisted Programs) and implementing regulations issued at 24 CFR part 1;

(b) *Discrimination on the basis of age or handicap.* The prohibitions against discrimination based on age under the Age Discrimination Act of 1975 (42 U.S.C. 6101–07) and implementing regulations at 24 CFR part 146; the prohibitions against discrimination against handicapped individuals under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and implementing regulations at 24 CFR part 8; and applicable provisions of the Americans with Disabilities Act (42 U.S.C. 12101–12213) and implementing regulations at 28 CFR part 35 (States and local government grantees) and part 36 (public accommodations requirements for certain types of short-term housing assistance).

(c) *Employment opportunities.* The requirements of section 3 of the Housing and Urban Development Act of 1968, (12 U.S.C. 1701(u)) (Employment Opportunities for Lower Income Persons in Connection with Assisted Projects).

(d) *Minority and women's business enterprises.* The requirements of Executive Orders 11625, 12432, and 12138 apply to grants under this part. Consistent with HUD's responsibilities under these Orders, the grantee and project sponsor must make efforts to encourage the use of minority and women's business enterprises in connection with funded activities.

(e) *Affirmative outreach.* A grantee or project sponsor must adopt procedures to ensure that all persons who qualify for the assistance, regardless of their race, color, religion, sex, age, national origin, familial status, or handicap, know of the availability of the HOPWA program, including facilities and services accessible to persons with a handicap, and maintain evidence of implementation of the procedures.

(f) *Disability requirements.* The grantee and project sponsor must not discriminate against persons with AIDS or related diseases based on an additional handicap of such persons in violation of the Fair Housing Act or section 504 of the Rehabilitation Act of 1973. In addition, the grantee and project sponsor must comply with the reasonable modification requirement of the Fair Housing Act, the reasonable accommodation requirements of the Fair Housing Act and section 504 of the Rehabilitation Act of 1973, and the accessibility requirements of the Fair Housing Act, section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act, and implementing regulations. See 42 U.S.C. 3604(f) and 24 CFR 100.203–100.205; 29 U.S.C. 794 and 24 CFR part 8; and 28 CFR parts 35 and 36.

§ 574.605 Applicability of OMB circulars.

The policies, guidelines, and requirements of 24 CFR part 85 (codified pursuant to OMB Circular No. A–102) and OMB Circular No. A–87 apply with respect to the acceptance and use of funds under the program by States and units of general local government, including public agencies, and Circulars Nos. A–110 and A–122 apply with respect to the acceptance and use of funds under the program by private non-profit entities. (Copies of OMB Circulars may be obtained from E.O.P. Publications, room 2200, New Executive Office Building, Washington, DC 20503, telephone (202) 395–7332. (This is not a toll-free number.) There is a limit of two free copies.

§ 574.610 Drug-free workplace.

Grantees are subject to the requirements of sections 5151–5180 of the Drug-Free Workplace Act of 1988 and HUD's implementing regulations at 24 CFR part 24, subpart F.

§ 574.615 Anti-lobbying certification.

Recipients of Federal contracts, grants, and loans are prohibited from using appropriated funds for lobbying the Executive or Legislative Branches of the Federal Government. The rule is found at 24 CFR part 87. It requires applicants, grantees, and project sponsors of assistance exceeding $100,000 to certify that no Federal funds have been or will be spent on lobbying activities in connection with the assistance. The rule also requires

disclosures from applicants, grantees, and project sponsors if nonappropriated funds have been spent or committed for lobbying activities if those activities would be prohibited if paid with appropriated funds. Substantial monetary penalties may be imposed for failure to file the required certification or disclosure.

§ 574.620 Debarred or suspended contractors.

The provisions of 24 CFR part 24 relating to the employment, engagement of services, awarding of contracts, or funding of any contractors or subcontractors during any period of debarment, suspension, placement in ineligibility status are applicable to grantees and project sponsors under this part.

§ 574.625 Conflict of interest.

(a) In addition to the conflict of interest requirements in OMB Circular A–102 and 24 CFR 85.36(b)(3), no person who is an employee, agent, consultant, officer, or elected or appointed official of the grantee or project sponsor and who exercises or has exercised any functions or responsibilities with respect to assisted activities, or who is in a position to participate in a decision making process or gain inside information with regard to such activities, may obtain a financial interest or benefit from the activity, or have an interest in any contract, subcontract, or agreement with respect thereto, or the proceeds thereunder, either for himself or herself or for those with whom he or she has family or business ties, during his or her tenure or for one year thereafter.

(b) *Exceptions: Threshold requirements.* Upon the written request of the recipient, HUD may grant an exception to the provisions of paragraph (a) of this section when it determines that the exception will serve to further the purposes of the HOPWA program and the effective and efficient administration of the recipient's program or project. An exception may be considered only after the recipient has provided the following:

(1) A disclosure of the nature of the conflict, accompanied by an assurance that there has been public disclosure of the conflict and a description of how the public disclosure was made; and

(2) An opinion of the recipient's attorney that the interest for which the exception is sought would not violate State or local law.

(c) *Factors to be considered for exceptions.* In determining whether to grant a requested exception after the recipient has satisfactorily met the requirements of paragraph (b) of this section, HUD will consider the cumulative effect of the following factors, where applicable:

(1) Whether the exception would provide a significant cost benefit or an essential degree of expertise to the program or project that would otherwise not be available;

(2) Whether the person affected is a member of a group or class of eligible persons and the exception will permit such person to receive generally the same interests or benefits as are being made available or provided to the group or class;

(3) Whether the affected person has withdrawn from his or her functions or responsibilities, or the decisionmaking process with respect to the specific assisted activity in question;

(4) Whether the interest or benefit was present before the affected person was in a position as described in paragraph (a) of this section;

(5) Whether undue hardship will result either to the recipient or the person affected when weighed against the public interest served by avoiding the prohibited conflict; and

(6) Any other relevant considerations.

§ 574.630 Displacement, relocation and real property acquisition.

(a) *Minimizing displacement.* Consistent with the other goals and objectives of this part, grantees and project sponsors must assure that they have taken all reasonable steps to minimize the displacement of persons (families, individuals, businesses, nonprofit organizations, and farms) as a result of a project assisted under this part.

(b) *Relocation assistance for displaced persons.* A displaced person (defined in paragraph (f) of this section) must be provided relocation assistance at the levels described in, and in accordance with the requirements of, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (URA) (42 U.S.C. 4601–4655) and implementing regulations at 49 CFR part 24.

(c) *Real property acquisition requirements.* The acquisition of real property for a project is subject to the URA and the requirements described in 49 CFR part 24, subpart B.

(d) *Appeals.* A person who disagrees with the grantee's or project sponsor's determination concerning whether the person qualifies as a "displaced person," or the amount of relocation assistance for which the person is eligible, may file a written appeal of that determination with the grantee. A low-income person who is dissatisfied with the grantee's determination on his or her appeal may submit a written request for review of that determination to the HUD Field Office.

(e) *Responsibility of grantee.* (1) Each grantee shall certify (i.e., provide assurance of compliance as required by 49 CFR part 24) that it will comply with the URA, the regulations at 49 CFR part 24, and the requirements of this section, and shall ensure such compliance notwithstanding any third party's contractual obligation to the grantee to comply with these provisions.

(2) The cost of required relocation assistance is an eligible project cost in the same manner and to the same extent as other project costs. Such costs also may be paid for with funds available from other sources.

(3) The grantee shall maintain records in sufficient detail to demonstrate compliance with these provisions.

(f) *Definition of displaced person.* (1) For purposes of this section, the term "displaced person" means a person (family, individual, business, nonprofit organization, or farm) that moves from real property, or moves personal property from real property, permanently, as a direct result of acquisition, rehabilitation, or demolition for a project assisted under this part. This includes any permanent, involuntary move for an assisted project including any permanent move for an assisted project, including any permanent move from the real property that is made:

(i) After notice by the grantee, project sponsor, or property owner to move permanently from the property, if the move occurs on or after the date that the grantee submits to HUD an application for assistance that is later approved and funded;

(ii) Before the submission of the application to HUD, if the grantee, project sponsor, or HUD determines that the displacement resulted directly from acquisition, rehabilitation, or demolition for the assisted project; or

(iii) By a tenant-occupant of a dwelling unit, if any one of the following three situations occurs:

(A) The tenant moves after the "initiation of negotiations" and the move occurs before the tenant has been provided written notice offering him or her the opportunity to lease and occupy a suitable, decent, safe and sanitary dwelling in the same building/complex, under reasonable terms and conditions, upon completion of the project. Such reasonable terms and conditions include a monthly rent and estimated average monthly utility costs that do not exceed the greater of:

(1) The tenant's monthly rent before the initiation of negotiations and estimated average utility costs, or

(2) 30 percent of gross household income; or

(B) The tenant is required to relocate temporarily, does not return to the building/complex and either:

(1) The tenant is not offered payment for all reasonable out-of-pocket expenses incurred in connection with the temporary relocation, or

(2) Other conditions of the temporary relocation are not reasonable; or

(C) The tenant is required to move to another unit in the same building/complex but is not offered reimbursement for all reasonable out-of-pocket expenses incurred in connection with the move, or other conditions of the move are not reasonable.

(2) Notwithstanding the provisions of paragraph (f)(1) of this section, a person does not qualify as a "displaced person" (and is not eligible for relocation assistance under the URA or this section), if:

(i) The person has been evicted for serious or repeated violation of the terms and conditions of the lease or occupancy agreement, violation or applicable Federal, State or local law, or other good cause, and HUD determines that the eviction was not undertaken for the purposes of evading the obligation to provide relocation assistance;

(ii) The person moved into the property after the submission of the application and, before signing a lease and commencing occupancy, was provided written notice of the project, its possible impact on the person (e.g., the person may be displaced, temporarily relocated, or suffer a rent increase) and the fact that the person would not qualify as a "displaced person" (or for any assistance provided under this section), if the project is approved;

(iii) The person is ineligible under 49 CFR 24.2(g)(2); or

(iv) HUD determines that the person was not displaced as a direct result of acquisition, rehabilitation, or demolition for the project.

(3) The grantee or project sponsor may request, at any time, HUD's determination of whether a displacement is or would be covered under this section.

(g) *Definition of initiation of negotiations.* For purposes of determining the formula for computing the replacement housing assistance to be provided to a residential tenant displaced as a direct result of privately undertaken rehabilitation, demolition, or acquisition of the real property, the term "initiation of negotiations" means the execution of the agreement between the grantee and the project sponsor.

§ 574.635 Lead-based paint.

The grantee and project sponsor must comply with the requirements of the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. 4821–4846) and implementing regulations at 24 CFR part 35, as applicable. In addition, the grantee and project sponsor must also meet the following requirements relating to inspection and abatement of defective lead-based paint surfaces:

(a) Treatment of defective paint surfaces must be performed before final inspection and approval of the renovation, rehabilitation or conversion activity under this part; and

(b) Appropriate action must be taken to protect facility occupants from the hazards associated with lead-based paint abatement procedures.

(Approved by the Office of Management and Budget under OMB control number 2506–0133)

§ 574.640 Flood insurance protection.

No property to be assisted under this part may be located in an area that has been identified by the Federal Emergency Management Agency (FEMA) as having special flood hazards, unless:

(a)(1) The community in which the area is situated is participating in the National Flood Insurance Program and the regulations thereunder (44 CFR parts 59 through 79); or

(2) Less than a year has passed since FEMA notification regarding such hazards; and

(b) The grantee will ensure that flood insurance on the structure is obtained in compliance with section 102(a) of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4001 et seq.).

§ 574.645 Coastal barriers.

In accordance with the Coastal Barrier Resources Act, 16 U.S.C. 3501, no financial assistance under this part may be made available within the Coastal Barrier Resources System.

§ 574.650 Audit.

The financial management system used by a State or unit of general local government that is a grantee must provide for audits in accordance with 24 CFR part 44. A nonprofit organization that is a grantee or a project sponsor is subject to the audit requirements set forth in 24 CFR part 45.

Dated: December 2, 1992.

Jack Kemp,

Secretary.

[FR Doc. 92–30977 Filed 12–24–92; 8:45 am]

BILLING CODE 4210–32–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Community Planning and Development

[Docket No. N–92–3440; FR–3294–N–01]

Announcement of Allocations for Housing Opportunities for Persons With AIDS

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This notice contains a listing of formula allocations for Fiscal Year 1993 under the Housing Opportunities for Persons With AIDS (HOPWA) program and information on how eligible applicants may apply for the formula grants to which they are entitled. An Interim Rule for the Fiscal Year 1993 program containing the requirements and other programmatic information for HOPWA is published elsewhere in this issue of the **Federal Register.**

DATES: Application packages will be available beginning December 28, 1992, from the HUD field offices listed at the end of this announcement. Applications may be submitted any time before the deadline date and will be processed as soon as they are received. Applicants are encouraged to submit their applications as soon as possible.

The original copy of the application must be received at the HUD Field Office serving the jurisdiction of the applicant no later than 4 p.m. local time on March 15, 1993. An additional copy of the application must also be sent to the following address: Department of Housing and Urban Development, Office of Special Needs Assistance Programs, room 7262, 451 Seventh Street, SW., Washington, DC 20410, Attention: James N. Forsberg, Director. However, a determination that an application was received on time will be made solely on receipt of the original application at the Field Office. Additional information regarding the submission of applications is included in the package.

FOR FURTHER INFORMATION CONTACT: The HUD Field Office serving the jurisdiction of the applicant. See the listing at the end of the announcement.

Program Authority

The $90,000,000 in assistance made available in this announcement is authorized by the AIDS Housing Opportunity Act (42 U.S.C. 12901), as amended by the Housing and Community Development Act of 1992 (Pub. L. 102–550, approved October 28, 1992), and was appropriated by the Department's appropriation act for fiscal year 1993 (Pub. L. 102–389, approved October 6, 1992). An additional $10,000,000 in appropriated funds, to be awarded by competitive grants, will be announced in a Notice of Funding Availability (NOFA) to be published later.

Eligibility

Under the Act, entitlement grants are to be awarded to eligible States and to qualifying cities in eligible metropolitan statistical areas (EMSAs), as they are defined in § 574.3 of the Interim Rule published elsewhere in this issue of the **Federal Register,** in accordance with an allocation formula described in § 574.130 of that rule. Eligible States must have more than 1,500 cumulative cases of persons with AIDS in that portion of the State outside of any eligible metropolitan statistical area, and they must have an approved Comprehensive Housing Affordability Strategy (CHAS). In the case of a city applicant, the city must be the most populous unit of general local government in the eligible metropolitan statistical area and must have an approved CHAS. In addition, the EMSA must have more than 1,500 cumulative cases of persons with AIDS and a population of more than 500,000.

For the fiscal year 1993 awards, the number of cumulative cases of AIDS used to determine if the 1,500 threshold has been met is as of March 31, 1992 and is from data collected by the U.S. Department of Health and Human Services, Centers for Disease Control. The Department has used 1990 U.S. Census data to determine the populations of metropolitan statistical areas and the city that is the most populous unit of general local government in each eligible metropolitan statistical area.

Recipient Disclosures: HUD Reform Act

States and units of general local government receiving assistance under this NOFA must make all applicant disclosure reports available to the public for three years. Required update reports must be made available along with the applicant disclosure reports, but in no case for a period less than three years. Each State and unit of general local government may use HUD Form 2880 to collect the applicant disclosure and update reports, or it may develop its own form. (See CFR part 12, subpart C, and the notice published in the **Federal Register** on January 16, 1992 (57 FR 1942) for further information on these disclosure requirements.)

Efforts to influence HUD's decisions with respect to financial assistance under these allocations are subject to disclosure requirements imposed by section 13 of the Department of Housing and Urban Development Act. That Act contains two provisions dealing with efforts to influence HUD's decisions with respect to financial assistance. The first imposes disclosure requirements on those who are typically involved in these efforts—those who pay others to influence the award of assistance or the taking of a management action by the Department and those who are paid to provide the influence. The second restricts the payment of fees to those who are paid to influence the award of HUD assistance or management of the award, if the fees are tied to the number of housing units received or are based on the amount of assistance received, or if they are contingent upon the receipt of assistance.

Section 13 was implemented by final rule published in the **Federal Register** on May 17, 1991 (56 FR 22912). If readers are involved in any efforts to influence the Department in these ways, they are urged to read the final rule, particularly the examples contained in Appendix A of the rule.

Listing of Eligible Metropolitan Statistical Areas and States With Projected Awards

Chart 1, below, provides the Department's determination of the States entitled to formula grants from the 1993 appropriation and their formula allocations. Chart 2, below, provides the Department's determination of the eligible metropolitan statistical areas that are entitled to formula grants from the 1993 appropriation, the city that is the most populous unit of general local government in an eligible metropolitan statistical area, and the formula allocation.

CHART 1.—STATES THAT QUALIFY FOR THE HOPWA PROGRAM AND FISCAL YEAR 1993 AWARDS

State	1993 award
Arizona	$571,000
California	1,801,000
Connecticut	882,000
Florida	2,205,000
Missouri	925,000
New Jersey	1,166,000
New York	1,312,000
North Carolina	822,000
Ohio	1,086,000
Pennsylvania	693,000
Puerto Rico	904,000
South Carolina	519,000
Tennessee	542,000

CHART 1.—STATES THAT QUALIFY FOR THE HOPWA PROGRAM AND FISCAL YEAR 1993 AWARDS—Continued

State	1993 award
Texas	1,827,000
Virginia	630,000

CHART 2. ELIGIBLE METROPOLITAN STATISTICAL AREAS THAT QUALIFY FOR THE HOPWA PROGRAM, FISCAL YEAR 1993 AWARDS, AND THE CITY WITHIN EACH EMSA THAT IS THE ELIGIBLE APPLICANT

Name of EMSA and applicant city	1993 award
**Anaheim-Santa Ana, CA Santa Ana	$1,017,000
**Atlanta, GA Atlanta	2,341,000
**Baltimore, MD Baltimore	1,091,000
**Bergen-Passaic, NJ Paterson	631,000
**Boston, MA Boston	1,188,000
**Chicago, IL Chicago	2,292,000
**Dallas, TX Dallas	1,767,000
**Denver, CO Denver	709,000
**Detroit, MI Detroit	729,000
**Fort Lauderdale-Hollywood, FL Fort Lauderdale	2,308,000
**Houston, TX Houston	3,016,000
**Jersey City, NJ Jersey City	1,277,000
**Los Angeles-Long Beach, CA Los Angeles	7,219,000
**Miami-Hialeah, FL Miami	4,697,000
**Nassau-Suffolk, NY Islip Town	709,000
**New Orleans, LA New Orleans	1,082,000
**New York, NY New York	20,796,000
**Newark, NJ Newark	2,838,000
**Oakland, CA Oakland	1,072,000
**Philadelphia, PA–NJ Philadelphia	1,607,000
**Riverside-San Bernardino, CA Riverside	522,000
**San Diego, CA San Diego	1,245,000
**San Francisco, CA San Francisco	6,647,000
**San Juan, PR San Juan Municipio	2,220,000
**Seattle, WA Seattle	825,000
**Tampa-St. Petersburg-Clearwater, FL Tampa	950,000
**Washington, DC-MD-VA Washington	2,292,000
**West Palm Beach-Boca Raton-Delray, FL West Palm Beach	1,028,000
Total grants allocated for 1993 in charts 1 and 2	$90,000,000

HUD Field Offices

Telephone numbers for Telecommunications Devices for the Deaf (TDD machines) are listed for field offices; all HUD numbers, including those noted *, may be reached via TDD by dialing the Federal Information Relay Service on 1–800–877–TDDY or (1–800–877–8339) or (202) 708–9300.

Arizona

Diane Domzalski, 400 N. 5th St., Suite 1600, Arizona Center, Phoenix, AZ 85004; (602) 379–4754; TDD (602) 379–4461.

California (Southern)

Herbert L. Roberts, 1615 W. Olympic Blvd., Los Angeles, CA 90015–3801; (213) 251–7235; TDD (213) 251–7038.

(Northern)

Gordon H. McKay, 450 Golden Gate Ave., P.O. Box 36003, San Francisco, CA 94102–3448; (415) 556–5576; TDD (415) 556–8357.

Colorado

Barbara Richards, Exec. Tower Bldg., 1405 Curtis St., Denver, CO 80202–2349; (303) 844–3811; TDD (303) 844–6158.

Connecticut

Daniel Kolesar, 330 Main St., Hartford, CT 06106–1860; (203) 240–4508; TDD (203) 240–4522.

District of Columbia

James H. McDaniel, 820 First St., NE, Washington, DC 20002; (202) 275–0994; TDD (202) 275–0967.

Florida

James N. Nichol, 325 W. Adams St., Jacksonville, FL 32202–4303; (904) 232–3587; TDD (904) 232–1291.

Georgia

Charles N. Straub, Russell Fed. Bldg., Room 688, 75 Spring St., SW, Atlanta, GA 30303–3388; (404) 331–5139; TDD (404) 730–2654.

Illinois

Richard Wilson, 77 W. Jackson Blvd., Chicago, IL 60606–5760; (312) 353–1696; TDD (312) 353–7143.

Louisiana

Greg Hamilton, P.O. Box 70288, 1661 Canal St., New Orleans, LA 70112–2887; (504) 589–7212; TDD (504) 589–7237.

Maryland

Harold Young, Equitable Bldg., 3rd Floor, 10 N. Calvert St., Baltimore, MD 21202–1865; (301) 962–2417; TDD (301) 962–0106.

Massachusetts

Frank Del Vecchio, Thomas P. O'Neill, Jr., Fed. Bldg., 10 Causeway St., Boston, MA 02222–1092; (617) 565–5343; TDD (617) 565–5453.

Michigan

Richard Paul, Patrick McNamara Bldg., 477 Michigan Ave., Detroit, MI 48226–2592; (313) 226–4343; TDD * via 1–800–877–8339.

Missouri

Miguel Madrigal, Gateway Towers 2, 400 State Ave., Kansas City, KS 66101–2406; (913) 236–2184; TDD (913) 236–3972.

New Jersey

Frank Sagarese, Military Park Bldg., 60 Park Pl., Newark, NJ 07102–5504; (201) 877–1776; TDD * via 1–800–877–8339.

New York

Joan Dabelko, 26 Federal Plaza, New York, NY 10278–0068; (212) 264–2885; TDD (212) 264–0927.

North Carolina

Charles T. Ferebee, 415 N. Edgeworth St., Greensboro, NC 27401–2107; (919) 333–5711; TDD (919) 333–5518.

Ohio

Jack E. Riordan, 200 North High St., Columbus, OH 43215–2499; (614) 469–6743; TDD (614) 469–6694.

Pennsylvania

John Kane, Liberty Sq. Bldg., 105 S. 7th St., Philadelphia, PA 19106–3392; (215) 597–2665; TDD (215) 597–5564.

Puerto Rico

Carmen R. Cabrera, 159 Carlos Chardon Ave., San Juan, PR 00918–1804; (809) 766–5576; TDD (809) 766–5909.

South Carolina

Louis E. Bradley, Fed. Bldg., 1835 Assembly St., Columbia, SC 29201–2480; (803) 765–5564; TDD * via 1–800–877–8339.

Tennessee

Virginia Peck, 710 Locust St., Knoxville, TN 37902–2526; (615) 549–9422; TDD 549–9372.

Texas

R.D. Smith, 1600 Throckmorton, P.O. Box 2905, Fort Worth, TX 76113–2905; (817) 885–5483; TDD (817) 885–5447.

Virginia

Joseph Aversano, Fed. Bldg., 400 N. 8th St., P.O. Box 10170, Richmond, VA 23240–9998; (804) 771–2624; TDD (804) 771–2820.

Washington

John Peters, Arcade Plaza Bldg., 1321 2nd Ave., Seattle, WA 98101–2054; (206) 553–0374; TDD (206) 553–4351.

Dated: December 2, 1992.

Denise R. Alexander,

Deputy Assistant Secretary for Operations.

[FR Doc. 92–30976 Filed 12–24–92; 8:45 am]

BILLING CODE 4210–29–M

federal register

Monday
December 28, 1992

Part IV

The President

Proclamation 6517—To Amend the Generalized System of Preferences

Federal Register
Vol. 57, No. 249
Monday, December 28, 1992

Presidential Documents

Title 3—

The President

Proclamation 6517 of December 23, 1992

To Amend the Generalized System of Preferences

By the President of the United States of America

A Proclamation

1. Pursuant to sections 501 and 502 of the Trade Act of 1974, Public Law 93–618, as amended (19 U.S.C. 2461 and 2462) ("Trade Act"), and having due regard for the eligibility criteria set forth therein, I have determined that it is appropriate to designate Ethiopia as a beneficiary developing country for purposes of the Generalized System of Preferences ("GSP").

2. Pursuant to section 504(a)(1) of the Trade Act (19 U.S.C. 2464(a)(1)), the President may withdraw, suspend, or limit the application of the duty-free treatment accorded under the GSP with respect to any article or any country after considering the factors set forth in sections 501 and 502(c) of the Trade Act (19 U.S.C. 2461 and 2462(c)). Accordingly, after taking into account the factors set forth in sections 501 and 502(c) of the Trade Act, I have determined that it is appropriate to withdraw the duty-free treatment accorded under the GSP to imports of sulfanilic acid provided for in subheading 2921.42.24 of the Harmonized Tariff Schedule of the United States ("HTS").

3. Section 604 of the Trade Act (19 U.S.C. 2483) authorizes the President to embody in the HTS the substance of the provisions of that Act, and of other acts affecting import treatment, and actions thereunder.

NOW, THEREFORE, I, GEORGE BUSH, President of the United States of America, acting under the authority vested in me by the Constitution and the laws of the United States of America, including but not limited to sections 501, 502(c), 504(a)(1), and 604 of the Trade Act, do proclaim that:

(1) General note 3(c)(ii)(A) to the HTS, listing those countries whose products are eligible for benefits of the GSP, is modified by inserting "Ethiopia" in alphabetical order in the enumeration of independent countries.

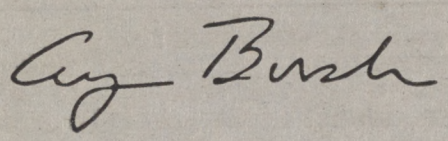
(2) In order to withdraw the duty-free treatment accorded under the GSP to sulfanilic acid, the HTS is modified as provided in the Annex to this proclamation.

(3) For HTS subheadings 2921.42.26 and 2921.42.28, effective with respect to goods originating in the territory of Canada which are entered, or withdrawn from warehouse for consumption, on or after January 1, 1993, in the Rates of Duty 1-Special subcolumn of the HTS, the HTS is modified by deleting the symbol "(CA)" and the duty rate preceding it, and inserting in the parentheses following the "Free" rate the symbol "CA," in alphabetical order.

(4) Any provisions of previous proclamations and Executive orders inconsistent with the provisions of this proclamation are hereby superseded to the extent of such inconsistency.

(5) The modifications to the HTS made by paragraphs (1) and (2) of this proclamation shall be effective with respect to articles that are: (i) imported on or after January 1, 1976, and (ii) entered, or withdrawn from warehouse for consumption, on or after 15 days after the date of publication of this proclamation in the **Federal Register**.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-third day of December, in the year of our Lord nineteen hundred and ninety-two, and of the Independence of the United States of America the two hundred and seventeenth.



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ANNEX

The Harmonized Tariff Schedule ("HTS") is modified as provided below, with bracketed matter included to assist in the understanding of proclaimed modifications. The following supersedes matter in the HTS. The subheadings and superior text are set forth in columnar format, and material in such columns is inserted in the columns of the HTS designated "Heading/Subheading", "Article Description", "Rates of Duty 1-General", "Rates of Duty 1-Special", and "Rates of Duty 2", respectively.

Subheading 2921.42.24 is superseded by:

	[Amine-function compounds:]			
	[Aromatic monoamines ...:]			
	[Aniline derivatives ...:]			
"2921.42.26	Metanilic acid.....	2.4¢/kg + 18.8%	Free (A*,E,IL,J) 0.4¢/kg + 3.7% (CA)	15.4¢/kg + 60%
2921.42.28	Sulfanilic acid.....	2.4¢/kg + 18.8%	Free (E,IL,J) 0.4¢/kg + 3.7% (CA)	15.4¢/kg + 60%"

Conforming change: General note 3(c)(ii)(D) to the HTS is modified by deleting "2921.42.24 India" and inserting, in numerical sequence, "2921.42.26 India" in lieu thereof.

[FR Doc. 92-31624
Filed 12-23-92; 4:13 pm]
Billing code 3190-01-C

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An asterisk (*) precedes each entry that has been issued since last week and which is now available for sale at the Government Printing Office.

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1, 2 (2 Reserved)	(869–017–00001–9)	$13.00	Jan. 1, 1992
3 (1991 Compilation and Parts 100 and 101)	(869–017–00002–7)	17.00\1\	Jan. 1, 1992
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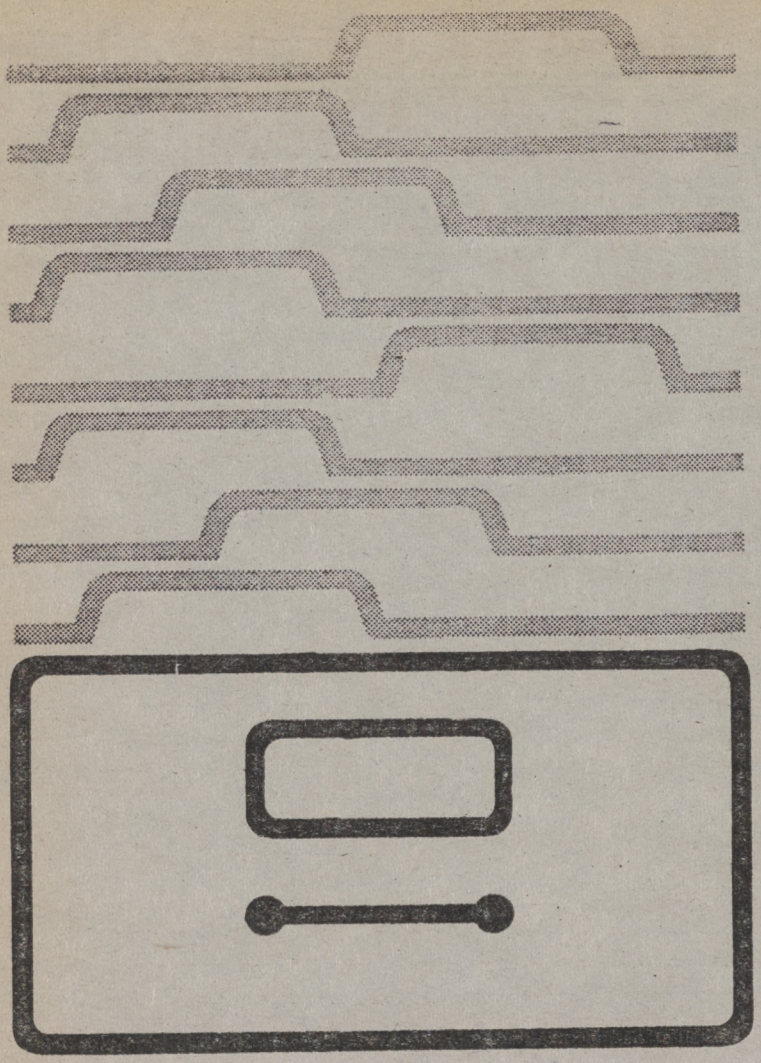

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in the Code of Federal Regulations (CFR)

GUIDE: Revised January 1, 1992

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