COMPASSIONATE RELEASE CRITERIA FOR MEDICAL CIRCUMSTANCES

Federal Bureau of Prisons

Clinical Guidance

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1. PURPOSE

The Federal Bureau of Prisons (BOP) *Clinical Guidance on Compassionate Release Criteria for Medical Circumstances* provides updated guidance to BOP employees to apply the policies and regulations in *Program Statement Compassionate Release/Reduction in Sentence Procedures*. Specifically, this guidance will assist institutions with making appropriate patient referrals for reduction in sentence (RIS) per the following sections of the policy: terminal medical conditions (*Section 4(a))*, debilitated medical conditions (*Section 4(b))*, elderly inmates with medical conditions (*Section 4(c)),* infectious disease (*Section 4(d))*, and other extraordinary medical circumstances (*Section 4(e)).* This guidance also provides a clearer understanding of how Health Services Division (HSD) reviewers will evaluate reduction in sentence requests under these categories.

RIS qualification relies on clinical judgment regarding the usual course of an illness and recognizes that making medical prognostications of life expectancy or debilitation is imprecise. The physician's clinical judgment must be supported by objective clinical information and documentation sufficient to justify a RIS based on medical criteria. The amount and detail of documentation will vary by diagnosis. For example, a patient with metastatic solid organ cancer may be demonstrated to be terminal with less documentation than one with chronic lung disease, owing to the prognostic calculators often available for oncologic conditions.

- *This guidance is meant to be a guide for medical providers to assess, determine and document their patient's eligibility for RIS but each patient will be evaluated individually and may have additional conditions, disabilities, or risk factors not described specifically in this guidance which may affect their eligibility for RIS.*

2. PROCESS FOR ASSESSING REQUESTS FOR REDUCTION IN SENTENCE

1. The Clinical Director will be notified by the institution RIS coordinator. (i.e., Social Work, Case Management Coordinator, Unit Team, etc.) that a RIS has been requested.
2. Once notified, the Clinical Director must ensure the following documents are fully completed:
    a. **Reduction in Sentence Eligibility Review** – form available in *Appendix 1. Reduction in Sentence Eligibility Review.*
        i. If it is determined the inmate does not qualify for a RIS no further evaluation is required.
        ii. If it is determined the inmate meets the basic medical criteria then move to b. below to complete a Comprehensive Medical Review.
    b. **Reduction in Sentence Comprehensive Medical Review** to include the Instrumental Activities of Daily Living (IADL) and Physical Self-Maintenance Scale (PSMS) – forms available in *Appendix 2. Comprehensive Medical Review*, *Appendix 3. IADL*, *and Appendix 4. PSMS*
        i. All questions in the medical review summary must be completed in detail.
        ii. Ensure BEMR is updated with outside medical documentation to include any consultations.
    c. Return completed form(s) to the RIS coordinator.

- *If assistance is needed to complete these forms, contact the institution or regional social worker.*

3. MEDICAL CRITERIA FOR TERMINAL MEDICAL CONDITIONS

The certification of a terminal RIS will be based on the physician's clinical judgment regarding the usual course of the individual's illness. To be eligible for consideration under this medical category, a patient must have a serious and advanced condition that is progressive, irreversible, and associated with an end-of-life trajectory (even if the specific timeframe of survival is uncertain), when fully compliant with treatment recommendations. Normally, a terminal diagnosis is determined by a survival rate of less than 50% within 5 years. A patient is considered to have a terminal and incurable disease with an end-of-life trajectory if there is documented evidence of major decline in their clinical and functional status that is not considered to be reversible. Since determination of this decline requires assessment of the patient's status over time, it is essential that both baseline and follow-up evaluations be reported where appropriate.

DEFINITION

A **TERMINAL ILLNESS** is a serious and advanced condition that is progressive, irreversible and associated with an end-of-life trajectory when fully compliant with treatment recommendations, even if the specific timeframe of survival is uncertain.

EXAMPLES OF QUALIFYING DIAGNOSES

- Metastatic solid tumors (incurable and non-responsive to treatment)
- Amyotrophic Lateral Sclerosis (ALS) or comparable neurodegenerative diseases
- End-stage organ disease
- NYHA Class IV Heart Failure
- Advanced COPD (oxygen dependence, frequent hospitalizations)
- End-stage renal disease (not benefitting from dialysis)
- Decompensated cirrhosis with complications (e.g., bleeding varices, encephalopathy)
- Advanced dementia with profound cognitive/functional loss and frequent infections

GENERAL INDICATORS OF TERMINAL DECLINE

- Progressive loss of mobility of ADLs (e.g., eating, dressing, hygiene)
- Unintentional weight loss > 10% in 6 months
- Multiple Hospitalizations within a 6-12 month period
- Recurrent or severe infections
- Refractory symptom burden (e.g., shortness of breath, pain, fatigue) despite treatment
- Shift toward palliative rather than curative care
- Failure of or ineligibility for further curative therapy

EXCLUSIONS

A condition should *not* be classified as terminal if:

- The clinical decline is reversible with available treatment or due to acute illness
- The patient is responding to curative treatment
- The condition is stable or slowly progressive without indications of end-of-life trajectory
- There is no evidence of significant functional decline

REQUIRED DOCUMENTATION

When determining terminal illness, the provider must:

- Specify the diagnosis and stage/severity
- Describe the functional and clinical decline
- Document relevant clinical findings, labs and imaging
- Note any transition to palliative goals of care
- Provide estimated statement of life expectancy in months and years

DETERMINING END OF LIFE TRAJECTORY: CLINICAL CRITERIA

The following criteria are not specific to any disease state and can be used to determine an end-of-life trajectory by worsening clinical status, symptoms, signs, and laboratory results.

- Recurrent or intractable serious infections such as pneumonia, sepsis, or pyelonephritis
- Progressive inanition as documented by the following and not due to reversible causes such as depression or use of diuretics:
  - Weight loss of at least 10% body weight in the prior six months
  - Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth)
  - Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without a current documented weight
  - Decreasing serum albumin
  - Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption
- Dyspnea with increasing respiratory rate
- Intractable cough, nausea, vomiting, or diarrhea not responsive to treatment
- Pain requiring increasing doses of major analgesics more than briefly
- Decline in systolic blood pressure to below 90 or progressive postural hypotension
- Worsening ascites, or edema
- Venous, arterial, or lymphatic obstruction due to local progression or metastatic disease
- Pleural/pericardial effusion
- Change in level of consciousness
- Laboratory changes (laboratory testing is not required to establish eligibility):
  - Increasing calcium, creatinine, or liver function studies
  - Increasing tumor markers (e.g. CEA, PSA)
  - Progressively decreasing or increasing serum sodium or increasing serum potassium

Determining End of Life Trajectory: Functional Status

These criteria are not specific to any disease state and can be used to support an end-of-life trajectory by worsening functional and cognitive status.

- Physiologic impairment of functional status as demonstrated by Karnofsky Performance Status (KPS) (see *Appendix 5*) or Palliative Performance Score (PPS) < 70% (see *Appendix 6*)
  OR
- Progressive decline in Functional Assessment Staging (FAST) for dementia (see *Appendix 7*)
  OR
- Current inability or progression to inability to perform activities of daily living (ADL) or instrumental activities of daily living (IADL) independently as demonstrated by poor or worsening Instrumental Activities of Daily Living (*Appendix 3*) and Physical Self-Maintenance (*Appendix 4*) scores.

Determining End of Life Trajectory: Disease-Specific Clinical Criteria

The below guidance is specific to disease states and can be used to determine an end-of-life trajectory by worsening clinical status, symptoms, signs, and laboratory results.

Metastatic solid tumor malignancy

- Disease with metastases at presentation
  OR
- Progression from an earlier stage of disease to metastatic disease with a continued decline despite therapy.

Amyotrophic Lateral Sclerosis (ALS)

Progression of disease differs markedly from patient to patient and no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS. Some patients decline rapidly, and others progress more slowly. For this reason, the patient's history of the rate of progression is important to obtain to predict prognosis. In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. Patients with ALS can be considered to have an end-of-life trajectory when more than 1 of the following are present:

- Critically impaired respiratory function defined by FVC < 40% predicted (seated or supine) and/or more than 1 of the following:
- Dyspnea at rest
- Orthopnea
- Use of accessory respiratory musculature; Paradoxical abdominal motion
- Respiratory rate > 20
- Reduced speech / vocal volume
- Weakened cough
- Severe nutritional deficiency defined by dysphagia with progressive weight loss of at least five percent of body weight with or without election for gastrostomy tube insertion.

DEMENTIA DUE TO ALZHEIMER'S DISEASE AND OTHER RELATED DEMENTIA DISORDERS

Patients have an end-of-life trajectory with dementia if they meet any of the following criteria.

- Stage ≥ 7 according to the Functional Assessment Staging (FAST) Scale (*Appendix 7*)
- Unable to ambulate, dress or bathe without assistance
- Urinary and fecal incontinence, intermittent or constant
- No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words
- Aspiration pneumonia
- Pyelonephritis
- Septicemia
- Decubitus ulcers, multiple, stage 3-4
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl

HEART DISEASE

Patients are in the terminal stage of heart disease if they meet the following two criteria:

- Optimally treated for heart disease or not candidates for surgical procedures. If the patient is not prescribed a vasodilator, a documented medical reason is required (e.g., hypotension or renal disease.)
- *New York Heart Association Classification of Heart Failure* Class IV (i.e., symptoms occur even at rest and any physical activity increases discomfort).

Documentation of the following factors will support the RIS request but is not required to establish eligibility:

- Treatment-resistant symptomatic supraventricular or ventricular arrhythmias
- History of cardiac arrest or resuscitation
- History of unexplained syncope
- Brain embolism of cardiac origin
- Concomitant HIV disease

HIV DISEASE

Patients with HIV are considered in an end-of-life trajectory if they display any of the following criteria when fully compliant with treatment recommendations:

- CD4+ count < 25 cells/uL or persistent (2 or more assays at least one month apart) HIV viral load >100,000 copies/ml
- CNS lymphoma
- Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass)
- Mycobacterium avium complex (MAC) bacteremia, untreated or unresponsive to treatment
- Progressive multifocal leukoencephalopathy
- Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
- Visceral Kaposi's sarcoma unresponsive to therapy

- Cryptosporidium infection
- Toxoplasmosis, unresponsive to therapy

Documentation of the following factors will support the RIS request but are not required to establish eligibility:

- Chronic persistent diarrhea
- Persistent serum albumin < 2
- Age > 50 years
- Advanced AIDS dementia complex
- Toxoplasmosis
- Congestive heart failure NYHA Class IV (i.e., symptomatic at rest)
- Advanced liver or renal disease

LIVER DISEASE

Patients are considered in the terminal stage of liver disease when the following two criteria are met:

- Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5
- Serum albumin < 2.5 gm/dl

End stage liver disease is considered to be in an end-of-life trajectory when at least one of the following is present:

- Ascites, refractory to treatment
- Spontaneous bacterial peritonitis, despite prophylaxis
- Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 mEq/l)
- Hepatic encephalopathy, refractory to treatment
- Recurrent variceal bleeding, despite intensive therapy

Documentation of the following factors will support the RIS request but are not required to establish eligibility:

- Progressive malnutrition
- Muscle wasting with reduced strength and endurance
- HBsAg (Hepatitis B) positivity
- Hepatitis C refractory to treatment

PULMONARY DISEASE

Patients are in the terminal stage of pulmonary disease if they meet the following criteria:

- Severe chronic lung disease as documented by either:
  - Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, and resulting in decreased functional capacity (e.g., bed to chair existence, fatigue, and cough.)
    - *Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea but is not necessary to obtain.*
  - Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory distress.
    - *Documentation of serial decrease of FEV1 > 40 ml over a year is objective evidence for disease progression but is not necessary to obtain.*
- Hypoxemia at rest on room air, as evidenced by oxygen saturation ≤ 88% (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO2 greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)

Documentation of the following factors will support the RIS request but are not required to establish eligibility:

- Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy)
- Resting tachycardia > 100/min

4. MEDICAL CRITERIA FOR DEBILITATED MEDICAL CONDITIONS

To be eligible for consideration under this medical category, a patient must be suffering from an incurable, progressive cognitive or medical illness, that causes substantial functional impairment and diminishes their ability to function in a correctional environment with no reasonable expectation of recovery. Although chronic conditions may affect a patient's functional capabilities temporarily, appropriate treatment of these conditions often results in improved function or even a return to normal function. Assessment of this criterion is based on functional limitations that remain after maximum medical improvement has been achieved to the extent possible through treatments that are optimized in accordance with established clinical guidelines and standards of care**.** Treatments may include, but are not limited to, medications, surgery, occupational and physical therapy, and durable medical equipment.

While a patient may be diagnosed with a condition that is permanent, progressive, and deteriorating, medical staff must also determine that the condition has substantially diminished the patient's ability to function in a correctional facility. Functional capacity is commonly described in terms of a person's ability to accomplish a variety of ADLs and IADLs.

DEFINITION

A patient is considered **DEBILITATED** if they experience significant physical, functional or cognitive decline, resulting in substantial impairment in performing self-care within the correctional environment, with no reasonable expectation of recovery when fully compliant with treatment recommendations.

EXAMPLES OF QUALIFYING DIAGNOSES:

- Advanced Parkinson's disease
- Stroke with residual paralysis
- Inflammatory arthritis causing immobility
- Advanced frailty (per clinical assessment)
- Moderate-to-severe dementia

GENERAL INDICATORS OF DEBILITATION

- Documented history of progressive functional loss
- Functional decline requiring total or near-total assistance with basic Activities of Daily Living (ADL) such as bathing, dressing, eating, toileting, and mobility
- Inability to navigate the facility without assistive devices and help
- Repeated falls, admission to nursing care center
- Failure to benefit from rehabilitation efforts when fully compliant
- Decline in ability to perform Independent Activities of Daily Living (e.g., cleaning their living spaces, managing commissary accounts, using commissary, food, and laundry services appropriately, making telephone calls, using the computer, medication management, and reporting to scheduled activities appropriately such as doing laundry or standing count, etc.)

  ➔ *Appendices 3 and 4 are helpful tools for assessing and documenting a patient's ADLs and IADLs, respectively.*

DOCUMENTATION REQUIREMENTS

All requests should include:

- Primary diagnosis with clinical severity and progression
- Determination of functional and/or cognitive impairments using validated clinical scales (see below)
- Summary of relevant labs, imaging, specialist consultations
- Description of care needs and inability to function in the correctional environment and limitations evidenced by the patient's inability to perform ADLs and IADLs.
- Physical Therapy and Occupational Therapy assessment outlining the patient's level of functioning, rehab potential, whether the patient is at their baseline level of functioning, and the patient's compliance with rehabilitation services. (If there is no PT on site, please consult Regional Physical Therapy)
- Current summary of adaptive devices prescribed to include participation in inmate companion program or wheelchair pusher program.
- Consideration for RIS will include assessment of the primary disease, impact of other serious medical conditions of the individual, and degree of functional impairment.

DETERMINING DEBILITATION: FUNCTIONAL STATUS

The following validated clinical support tools may be used to support the determination that the patient suffers from an incurable, progressive medical illness that causes substantial functional impairment and diminishes their ability to function in a correctional environment.

- Functionally debilitated over a 6-month period as defined by the following:
  - A score of ≥ 40 on the Modified Barthel Index (SHAH Version): Self-care assessment (*Appendix 8*) OR
  - A score of 4 or less on the IADL adapted for the use in the correctional environment. (*Appendix 3*) AND
  - A score of 2 or less on the PSMS adapted for the use in the correctional environment (A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment) (*Appendix 4*)

DETERMINING DEBILITATION: COGNITIVE STATUS

The following validated clinical support tools may be used to support the determination that the patient suffers from an incurable, progressive cognitive illness that causes substantial functional impairment and diminishes their ability to function in a correctional environment.

- Cognitively debilitated over a 6-month period as defined by one of the following:
  - <4 on Mini-Cog (*Appendix 9*)
  - <5 on the General Practitioner assessment of Cognition (GPCOG) (*Appendix 10*)
  - <20 on the St. Louis University Mental Status Examination (SLUMS) (*Appendix 11*)

5. MEDICAL CRITERIA FOR ELDERLY INMATES

To be eligible for consideration under this medical category, an individual must be 65 and older, have served the lesser of 10 years or 75 percent of their term of imprisonment, and be experiencing a serious deterioration in physical or cognitive health because of the aging process. Assessment of this criterion is based on functional limitations that remain after maximum medical improvement has been achieved to the extent possible through treatments that are optimized in accordance with established clinical guidelines and standards of care. Treatments may include, but are not limited to, medications, surgery, occupational and physical therapy, and durable medical equipment.

DEFINITION

An inmate is considered **ELDERLY** under this category if they are age 65 or older, have served the lesser of 10 years or 75% of their sentence, and have serious deterioration in physical or cognitive health due to the aging process without substantial improvement despite optimal medical care.

EXAMPLES OF QUALIFYING DIAGNOSES

- Cardiovascular: Atherosclerotic cardiovascular disease
- Pulmonary: Obstructive or restrictive lung disease
- Hepatic: Chronic liver failure with recurring ascites

- Neurological: Dementias (Alzheimer's, Lewy body, frontotemporal), ALS, Parkinson's, Huntington's, advanced MS, stroke with residual deficits
- Infectious disease complications: HIV-related dementia, progressive multifocal leukoencephalopathy
- Rheumatologic: Advanced rheumatoid arthritis, gout, ankylosing spondylitis
- Diabetes with complications (retinopathy, nephropathy, neuropathy)
- Severe musculoskeletal degeneration (e.g., end-stage osteoarthritis)

GENERAL INDICATORS OF DETERIORATION

- Need for transfer to a medical or mental health unit that provides a higher level of nursing care or increased intensity of service.
- Designated permanently to a medical or mental health unit for medical treatment or treatment for cognitive impairment.
- Needing to be reoriented to person, place, or time.
- Requires staff or companion assistance with ADLs (bathing, grooming, toileting, eating, mobility)
- Requires staff or companion assistance with IADLs (medication management, hygiene, laundry, commissary, attending meals/pill line, reorientation to person/place/time)

DOCUMENTATION REQUIREMENTS

- Primary diagnosis with severity and progression
- Functional/cognitive assessments (validated scales)
- Summary of relevant labs, imaging, consultations
- Current care needs and ability to function in correctional environment
- Current summary of adaptive devices prescribed to include participation in inmate companion program or wheelchair pusher program.

DETERMINING ELDERLY WITH DEBILITATION: FUNCTIONAL STATUS

The following validated clinical support tools may be used to support the determination that an elderly patient is experiencing a serious deterioration of physical health due to the aging process without substantial improvement despite optimal medical care.

- Functionally Debilitated over a 3-month period as defined by the following:
  - A score of ≥ 40 on the Modified Barthel Index (SHAH Version): Self-care assessment (*Appendix 8*) OR
  - A score of 4 or less on the IADL (*Appendix 3*) AND
  - A score of 2 or less on the PSMS (A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment) (*Appendix 4*)

DETERMINING ELDERLY WITH DEBILITATION: COGNITIVE STATUS

The following validated clinical support tools may be used to support the determination that an elderly patient is experiencing a serious deterioration of cognitive health due to the aging process without substantial improvement despite optimal medical care.

- Cognitively Debilitated over a 3-month period as defined by one of the following:
  - <4 on Mini-Cog (*Appendix 9*)
  - <5 on the General Practitioner assessment of Cognition (GPCOG) (*Appendix 10*)
  - <20 on the St. Louis University Mental Status Examination (SLUMS) (*Appendix 11*)

6. MEDICAL CRITERIA FOR INFECTIOUS DISEASE

DEFINITION

The patient is at increased risk of suffering severe medical complications or death (*risk criteria is determined based on guidance from public health authorities and published clinical data*) due to current personal medical risk factors specific to the patient's medical condition as a result of the exposure to the ongoing outbreak of infectious disease and such risk cannot be mitigated in a timely or adequate manner.

INDICATORS FOR CONSIDERATION

To be eligible for consideration under this medical category, a patient **MUST** be housed at a correctional facility affected or at imminent risk of being affected by an ongoing and extraordinary outbreak of infectious disease, or a public health emergency declared by an appropriate federal, state, or local authority and such risk cannot be mitigated in a timely or adequate manner.

The following medical conditions are examples that may place a patient at increased risk if exposed to an ongoing outbreak of infectious disease or an ongoing public health emergency:

- Advanced age
- Cancer
- Advanced kidney disease on dialysis
- Placement in a long term care facility or skilled nursing unit
- Obstructive and restrictive lung diseases
- Advanced heart or liver disease
- Primary immunodeficiencies
- Dementia

EXCLUSIONS & RISK MITIGATION STRATEGIES

The following risk mitigation strategies or procedures are examples that institutions may initiate to mitigate infectious disease risk in a timely and adequate manner:

- Increased availability and use of PPE specific to the infectious agent for all employees and patients
- Identifying specific medical isolation or quarantine housing units in the institution to remove potentially infectious patients from the general population

- Requiring facial PPE for all employees and inmates in skilled nursing or long-term care units
- Screening and testing all incoming inmates for infectious disease
- Instituting mandatory quarantine for symptomatic patients or incoming inmates from outside the BOP
- Increasing disinfection and cleaning of housing units
- Creating modified movement schedules to further decrease contact with inmates in other parts of the facility

7. OTHER EXTRAORDINARY MEDICAL CIRCUMSTANCES

To be eligible for consideration under this category, a patient must have a major medical condition that requires specialized medical care that is unique, rare or unusual which cannot be provided in the BOP and without which, the patient is at major risk of serious deterioration in health or death. With recent medical advancements and new, emerging technologies, patients may present with investigational study devices that are only available for treatment and monitoring in non-BOP hospitals or be eligible for placement in life-saving clinical trials in locations outside the BOP service area. In addition, a patient may need a stem cell or solid organ transplant that cannot be effectuated by the BOP prior to the patient's release date and must be performed urgently to avoid clinical deterioration or a delay in care.

DEFINITION

An inmate is considered in this category if they are suffering from a medical condition that requires long-term or specialized medical care that cannot be provided in the BOP without undue hardship, prohibitive costs, or significant disruption to the safe and orderly running of the institution, and without which the inmate is at risk of serious deterioration in health or death.

EXAMPLES OF QUALIFYING DIAGNOSES

- Leukemia/lymphoma requiring stem cell transplant which the BOP cannot effectuate prior to release date
- Presence of an investigational or study device which is not eligible for continuance within a BOP facility
- Participation in a life-saving research trial or investigation that is only available outside of the BOP
- Major illness such as pulmonary hypertension requiring medication infusion systems not compatible with law enforcement radio or other necessary institutional technology

EXCLUSIONS

A condition should not be classified as extraordinary if:

- There are alternative community standard treatments available within the BOP
- The patient is not eligible for the research trial or investigational device due to other mitigating circumstances such as age or sex
- There are alternative medication delivery systems or infusion devices which are clinically comparable and compatible with BOP and/or law enforcement technologies

DOCUMENTATION REQUIREMENTS

When determining extraordinary circumstances, the provider must:

- Specify the diagnosis and stage/severity
- Describe the specialized medical care that the patient requires
- Explain in detail why the treatment is not available in the BOP – unavailable, undue hardship, prohibitive costs or significant disruption of the safe and orderly running of the institution
- Provide evidence for why this treatment is medically necessary to prevent serious clinical deterioration or death

REFERENCES

1. Anderson, F., Downing, G. M., Hill, J., Casorso, L., & Lerch, N. (1996). Palliative Performance Scale (PPS): A new tool. Journal of Palliative Care, 12(1), 5–11. https://doi.org/10.1177/082585979601200102
2. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451–1454.
3. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
4. Brodaty, H., Pond, D., Kemp, N. M., Luscombe, G., Harding, L., Berman, K., & Huppert, F. A. (2002). The GPCOG: A new screening test for dementia designed for general practice. Journal of the American Geriatrics Society, 50(3), 530–534. *https://doi.org/10.1046/j.1532-5415.2002.50122.x*
5. Centers for Medicare & Medicaid Services (2024). *Medicare Hospice Benefits (CMS Product No. 02154).* Medicare.gov (CMS).
6. Centers for Medicare & Medicaid Services (Medicare Administrative Contractor LCD) (2023). *Local Coverage Determination (LCD): Hospice - Determining Terminal Status (L33393).* CMS Medicare Coverage Database.
7. Farris, C. (2020). Prognostic tools in hospice and Palliative Medicine. *Physician Assistant Clinics*, *5*(3), 331–340. https://doi.org/10.1016/j.cpha.2020.02.005
8. Guo, H. J. (2022, November 14). Instrumental activity of Daily Living. StatPearls [Internet]. *https://www.ncbi.nlm.nih.gov/books/NBK553126/*
9. Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of Daily Living. The Gerontologist, 9(3 Part 1), 179–186. *https://doi.org/10.1093/geront/9.3_part_1.179*
10. Mahoney FI, Barthel D. Functional evaluation: the Barthel Index. *Maryland State Med Journal* 165;14:56-61. Used with permission.
11. Sclan, S. G., & Reisberg, B. (1992). Functional assessment staging (FAST) in alzheimer's disease: Reliability, validity, and ordinality. International Psychogeriatrics, 4(3), 55–69. https://doi.org/10.1017/s1041610292001157
12. Shah, S., Vanclay, F., & Cooper, B. (1989a). Improving the sensitivity of the Barthel Index for stroke rehabilitation. Journal of Clinical Epidemiology, 42, 703 - 709.
13. Tariq, S. H., Tumosa, N., Chibnall, J. T., Perry, M. H., & Morley, J. E. (2006). Comparison of the Saint Louis University Mental Status Examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder—a pilot study. The American Journal of Geriatric Psychiatry, 14(11), 900–910. *https://doi.org/10.1097/01.jgp.0000221510.33817.86*
14. Tate, R. L., & Cameron, I. D. (2016). A compendium of tests, Scales and questionnaires: The Practitioner's Guide to Measuring Outcomes after acquired Brain Impairment. Routledge, Taylor & Francis Group.

APPENDIX 1. REDUCTION IN SENTENCE ELIGIBILITY REVIEW

Before completing this review, refer to Program Statement **Compassionate Release/Reduction In Sentence Procedures.**

INMATE INFORMATION			
Inmate Name	**Reg. No.**	**Inmate Age**	**Institution**

Category of Reduction in Sentence Request:

Terminal Medical Condition	☐	Debilitated Medical Condition	☐
Elderly Inmate with Medical Conditions	☐	Infectious Disease	☐
Other Extraordinary Circumstances	☐		

Complete applicable section below

TERMINAL MEDICAL CONDITION	
1. Does the inmate have a serious and advanced condition that is progressive, irreversible, and associated with an end-of-life trajectory?	☐ Yes ☐ No
2. AND/OR, does the inmate have a life expectancy of less than 50% in 5 years, or documented evidence of major decline in their clinical and functional status that is not considered reversable?	☐ Yes ☐ No
If "No" is checked for BOTH items, the inmate does not qualify under this category.	

DEBILITATED MEDICAL CONDITION	
1. Does the inmate have an incurable, progressive cognitive or medical illness, that causes substantial functional impairment and diminishes their ability to function in a correctional environment with no reasonable expectation of recovery when fully compliant with medical treatment?	☐ Yes ☐ No
2. AND, do the functional limitations remain after maximum medical improvement has been achieved to the extent possible through treatments that are optimized in accordance with established clinical guidelines and standards of care?	☐ Yes ☐ No
If "No" is checked for EITHER of these items, the inmate does not qualify under this category.	

ELDERLY INMATE WITH MEDICAL CONDITIONS	
1. Is the inmate age 65 or older and has the inmate served lesser than 10 years or 75% of their sentence (verify with unit team)? *If no, inmate does not qualify under this category.*	☐ Yes ☐ No
2. Does the inmate suffer from a documented chronic or serious medical condition related to the aging process?	☐ Yes ☐ No
3. Has the inmate experienced deteriorating mental or physical health conditions that substantially diminishes his/her ability to function in a correctional environment?	☐ Yes ☐ No
Page 1 of 2. Table continues on next page.	

ELDERLY INMATE WITH MEDICAL CONDITIONS (continued)	
4. Will conventional treatment provide a substantial improvement to the inmate's mental or physical condition? *If yes, inmate does not qualify under this category.*	☐ Yes ☐ No
Items 1, 2 & 3 must be checked "Yes" for the inmate to qualify under this category.	

INFECTIOUS DISEASE	
1. Is the institution at imminent risk of being affected by an extraordinary outbreak of infectious disease or has a public health emergency been declared by an appropriate federal, state or local authority?	☐ Yes ☐ No
2. Is the inmate at increased risk at suffering severe medical complications or death due to the current personal medical risk factors specific to the inmate's medical condition as the result of the exposure to the ongoing outbreak of infectious disease?	☐ Yes ☐ No
3. Can the risk be mitigated in a timely or adequate manner? *If yes, inmate does not qualify under this category.*	☐ Yes ☐ No
Items 1 & 2 must be checked "Yes" for the inmate to qualify under this category.	

OTHER EXTRAORDINARY CIRCUMSTANCES	
Does the inmate suffer from a medical condition that requires long-term or specialized medical care that cannot be provided in the BOP without undue hardship, prohibitive costs, or significant disruption to the safe and orderly running of the institution, and without which the inmate is at risk of serious deterioration in health or death?	☐ Yes ☐ No
If "No" is checked for BOTH items, the inmate does not qualify under this category.	

ELIGIBILITY DETERMINATION			
Inmate may qualify for RIS under the following category:			
Terminal Medical Condition	☐	Debilitated Medical Condition	☐
Elderly Inmate with Medical Conditions	☐	Infectious Disease	☐
Other Extraordinary Circumstances	☐		
Inmate does not qualify for RIS	☐		

REVIEWER INFORMATION		
Name of staff person completing this review	**Position**	**Screening Date**
A physician, APP, or other medical professional will be consulted for review of all RIS requests based on medical circumstances.		
Clinical Director Signature		**Date**
Page 2 of 2		

APPENDIX 2. REDUCTION IN SENTENCE COMPREHENSIVE MEDICAL REVIEW

Institution	**Completed By**	**Date**
Inmate Name	**Reg. No.**	**Inmate Age**

Select RIS Category (choose only one category)

Terminal Medical Condition	☐	Debilitated Medical Condition	☐
Elderly Inmate with Medical Conditions	☐	Infectious Disease	☐
Other Extraordinary Circumstances	☐		

RIS Qualifying Medical and Surgical Summary – *Must include the following, attach supporting documentation as necessary.*

- Diagnosis and stage/severity
- Relevant clinical findings, labs, and imaging results
- Summary of specialty consultation reports and relevant hospitalizations
- End of life trajectory indicators
- Current treatment plan
- Note any transition to palliative goals of care

Assessment of Access to Care

- Does the patient's care currently meet community standards?
- Are there potential delays in care due to scheduling or staffing?
- Is the institution capable of providing for the inmate's medical needs?

Assessment of Functional and Clinical Decline *(include scores where applicable)*

- Describe ability to function in a correctional environment
- For RIS for terminal, debilitated, or elderly conditions:
  - At a minimum, must include scores from Appendix 3. Instrumental Activities of Daily Living or Appendix 4. Physical Self Maintenance Scale
  - Include appropriate score from Appendix 5. Karnofsky Performance Status Scale, Appendix 6. Palliative Performance Scale, Appendix 7. Functional Assessment Staging Scale, *or* Appendix 8. Modified Barthel Index Self Care Assessment.
- For RIS for dementia or similar cognitive diagnosis:
  - Must include at least 1 score from Appendix 9. MINICOG, Appendix 10. General Practitioner Assessment of Cognition Screening Test, *or* Appendix 11. Saint Louis University Mental Status Examination.

Assistive Devices/Equipment

History of Treatment Compliance *(include any signed refusals of care)*

Page 1 of 2. Table continues on next page.

Estimated prognosis and life expectancy (*supported by survival statistics, prognostic calculators, specialist opinion, etc.)*
Infectious Disease RIS - additional information • Define ongoing outbreak of infectious disease • Specify personal medical risk factors
RIS for Extraordinary Circumstances – additional information • Describe the unique, rare, or unusual specialized medical care that cannot be provided in the BOP • Specify the major risk of serious deterioration in health or death without the treatment
RIS Review Completed by (APP or physician) **Printed Name:** **Signature:** **Date review completed:**
Page 2 of 2

Completion of this RIS Comprehensive Medical Review must also include the IADL and/or PSMS forms, available n the following pages.

APPENDIX 3. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

For each task area (A–I), circle the score (1 or 0) for the statement that **most closely corresponds** to the inmate's current functional ability. Then, add together the task scores to arrive at the total. The examiner should complete the scale based on information about the inmate from the inmate him/herself, cellmates, inmate care companions/nursing assistants, staff, and recent records. This tool is useful for indicating specifically how a person is performing at the present time.

Inmate Name	**Reg. No**

A. Ability to Use the Telephone	**Score**
1. Operates telephone on own initiative; looks up and dials numbers, etc.	1
2. Dials a few well-known numbers	1
3. Unable to use telephone without human assistance	0

B. Ability to Use the Computer	**Score**
1. Uses the computer to communicate with staff and family via email	1
2. Needs assistance to use the computer	1
3. Unable to use the computer at all	0

C. Shopping	**Score**
1. Able to complete commissary list and manage commissary independently	1
2. Needs assistance to complete commissary list and managing commissary	0
3. Needs to be accompanied to commissary for full assistance	0
4. Completely unable to shop	0

D. Food Preparation/Nutrition	**Score**
1. Able to independently plan and prepare snacks/meals outside of food services	1
2. Needs assistance to plan and prepare snacks/meals outside of food services	1
3. Does not maintain adequate diet by eating snacks or going to food service	0
4. Needs complete assistance in obtaining meals	0

E. Housekeeping	**Score**
1. Maintains cell independently according to BOP Policy	1
2. Performs light daily tasks such as dishwashing, bed making	1
3. Performs light daily tasks but cannot maintain acceptable levels of cleanliness	0
4. Needs help with all housekeeping tasks	0
5. Does not participate in any housekeeping tasks	0

F. Laundry	**Score**
1. Does personal laundry completely	1
2. Launders small items; rinses socks, etc.	1
3. All laundry must be done by others	0

G. Mode of Transportation if Released	**Score**
1. Able to travel independently on public transportation or drive own car	1
2. Able to arrange own travel via taxi, but would not otherwise be able use public transportation	1
3. Able to travel on public transportation when assisted or accompanied by another	0
4. Travel would be limited to taxi or automobile with assistance of another	0
5. Would not travel at all	0

H. Responsibility for Own Medications	**Score**
1. Is responsible for taking medication in correct dosages at correct time	1
2. Takes responsibility if medication is prepared in advance in separate doses	0
3. Is not capable of managing own medication	0

Page 1 of 2. Table continues on next page.

I. Ability to Handle Finances	Score
1. Manages TRULINCS account independently	1
2. Needs help managing account	1
3. Incapable of managing account	0

Scoring: The inmate receives a score of 1 for each section labeled A thru I if his or her competence is rated at some minimal level or higher. Add the total points circled for A thru I. The total score may range from 0 to 9. **A lower score indicates a higher level of dependence.**	
Total Score for Section A thru I	
IADL Assessment Completed by **Printed Name:** **Signature:** **Date review completed:**	
Page 2 of 2	

Adapted for use in the correctional environment from: Lawton MP, Brody EM, Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. Gerontologist 9(1969):179-186.

APPENDIX 4. PHYSICAL SELF-MAINTENANCE SCALE (PSMS)

Circle the scoring point for the statement that **most closely corresponds** to the inmate's current functional ability for each task. Add each section number circled to arrive at the final score. The examiner should complete the scale based on information about the inmate from the inmate, cellmates, care companion/nursing assistant, staff, and recent records. This tool is useful for indicating specifically how a person is performing at the present time.

Inmate Name	**Reg. No**

A. Toilet	**Score**
1. Care for self at toilet completely; no incontinence	1
2. Needs to be reminded, or needs help in cleaning self, or has rare (weekly at most) accidents	0
3. Soiling or wetting while asleep more than once a week	0
4. Soiling or wetting while awake more than once a week	0
5. No control of bowels or bladder	0

B. Feeding	**Score**
1. Eats without assistance	1
2. Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals	0
3. Feeds self with moderate assistance and is untidy	0
4. Requires extensive assistance for all meals	0
5. Does not feed self at all and resists efforts of others to feed him or her	0

C. Dressing	**Score**
1. Dresses, undresses, and wears uniform according to BOP Policy	1
2. Dresses and undresses self, with adaptive equipment	1
3. Needs moderate assistance in dressing	0
4. Needs major assistance in dressing, but cooperates with efforts of others to help	0
5. Completely unable to dress self and resists efforts of others to help	0

D. Grooming	**Score**
1. Always neatly dressed, well-groomed, without assistance	1
2. Needs moderate and regular assistance or supervision with grooming	0
3. Needs total grooming care, but can remain well-groomed after help from others	0

E. Physical Ambulation	**Score**
1. Moves about the unit and institution independently	1
2. Ambulates only short distances	0
3. Ambulates with assistance of (circle one) a. Another person b. Railing c. Cane d. Walker e. Wheelchair, transfers without help f. Wheelchair, needs help to transfer	0
4. Sits unsupported in chair or wheelchair, but cannot propel self without help	0
5. Bedridden more than half the time	0

F. Bathing	**Score**
1. Bathes self (tub, shower, sponge bath) without human assistance	1
2. Bathes self with help getting in and out of tub	0
3. Washes face and hands only, but cannot bathe rest of body	0
4. Does not wash self, but is cooperative with those who bathe him or her	0
5. Does not try to wash self and resists efforts to keep him or her clean	0

Page 1 of 2. Table continues on next page.

Scoring: The inmate receives a score of 1 for each section labeled A thru F if his or her competence is rated at some minimal level or higher. Add the total points circled for A thru F. The total score may range from 0 to 6. **A lower score indicates a higher level of dependence.**	
Total Score for Section A thru F	
PSMS Assessment Completed by **Printed Name:** **Signature:** **Date review completed:**	
Page 2 of 2	

Adapted for use in the correctional environment from: Lawton MP, Brody EM, Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. Gerontologist 9(1969):179-186.

APPENDIX 5. KARNOFSKY PERFORMANCE STATUS SCALE

The Karnofsky Performance Scale (KPS) is an assessment tool for functional impairment. It is used to improve understanding of patient needs, ability to carry out daily activities and to assess patient prognosis.

Condition	Value (%)	Level of functional capacity
Able to carry on normal activity and to work. No special care needed.	100%	**No complaints; no evidence of disease**
	90%	**Able to carry on normal activity; minor signs or symptoms of disease**
	80%	**Normal activity with effort; some signs or symptoms of disease**
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70%	**Cares for self; unable to carry on normal activity or to do active work**
	60%	**Requires occasional assistance but is able to care for most personal needs**
	50%	**Requires considerable assistance and frequent medical care**
Unable to care for self; requires equivalent of institutional or hospital care; diseases may be progressing rapidly.	40%	**Disabled; requires special care and assistance**
	30%	**Severely disabled; hospital admission indicated although death not imminent**
	20%	**Very sick; hospital admission necessary; active supportive treatment necessary**
	10%	**Moribund; fatal processes progressing rapidly**
	0%	**Dead**

APPENDIX 6. PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some house work, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
Death	- - - -	- - - -	- - - -	- - - -	- - - -

APPENDIX 7. FUNCTIONAL ASSESSMENT STAGING (FAST) SCALE

Stage	Stage Name	Functional Assessment
1	**Normal Aging**	No deficits whatsoever
2	**Possible Mild Cognitive Impairment**	Complains of forgetting location of objects. Subjective word finding difficulties
3	**Mild Cognitive Impairment**	Decreased job function evident to co- workers; difficulty in traveling to new locations; decreased organizational capacity
4	**Mild Dementia**	IADLs become affected such as bill paying, cooking, cleaning, traveling, handling personal finances
5	**Moderate Dementia**	Requires assistance in choosing proper clothing to wear for the day, season, and occasion.
6a	**Moderately Severe Dementia**	Difficulty putting on clothes without assistance
6b		Unable to bathe properly. E.g., difficulty adjusting bath water temp occasionally or more frequently over the past weeks
6c		Inability to handle the mechanics of toileting (forgets to flush, does not wipe properly, or dispose of toilet paper) occasionally or more frequently over past weeks
6d		Urinary incontinence (occasional or more frequent)
6e		Fecal incontinence (occasional or more frequent over the past week)
7a	**Severe Dementia**	Speaks 5-6 words during the day.
7b		Speech limited to use of single intelligible word in an average day or over the course of interview (the person may repeat the word over and over)
7c		Ambulatory ability lost (can't walk without personal assistance)
7d		Ability to sit up without assistance lost (will fall over without lateral supports)
7e		Can no longer smile
7f		Can no longer hold head up

The FAST Scale for Dementia is also known as the Reisberg Functional Assessment Staging Scale. Copyright 1984 by Barry Reisberg, M.D.

APPENDIX 8. MODIFIED BARTHEL INDEX (SHAH VERSION): SELF CARE ASSESSMENT (MBI)

INDEX ITEM	SCORE	DESCRIPTION
Chair/Bed Transfers	0	Unable to participate in a transfer. Two attendants are required to transfer the patient with or without a mechanical device.
	3	Able to participate but maximum assistance of one other person is require in all aspects of the transfer.
	8	The transfer requires the assistance of one other person. Assistance may be required in any aspect of the transfer.
	12	The presence of another person is required either as a confidence measure, or to provide supervision for safety.
	15	The patient can safely approach the bed walking or in a wheelchair, lock brakes, lift footrests, or position walking aid, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, transfer back into it safely and/or grasp aid and stand. The patient must be independent in all phases of this activity.
Ambulation	0	Dependent in ambulation.
	3	Constant presence of one or more assistant is required during ambulation.
	8	Assistance is required with reaching aids and/or their manipulation. One person is required to offer assistance.
	12	The patient is independent in ambulation but unable to walk 50 meters without help, or supervision is needed for confidence or safety in hazardous situations.
	15	The patient must be able to wear braces if required, lock and unlock these braces, assume standing position, sit down, and place the necessary aids into position for use. The patient must be able to crutches, canes, or a walker, and walk 50 meters without help or supervision.
Ambulation/Wheelchair ***** (If unable to walk.) *Only use this item if patient is rated "0" for Ambulation, and then only if the patient has been trained in wheelchair management.*	0	Dependent in wheelchair ambulation.
	1	Patient can propel self short distances on flat surface, but assistance is required for all other steps of wheelchair management.
	3	Presence of one person is necessary and constant assistance is required to manipulate chair to table, bed, etc.
	4	The patient can propel self for a reasonable duration over regularly encountered terrain. Minimal assistance may still be required in "tight corners" or to negotiate a curb ≥ 100mm high.
	5	To propel wheelchair independently, the patient must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. The patient must b able to push a chair at least 50 meter and negotiate a curb.

(Table continues on the following page)

MODIFIED BARTHEL INDEX (SHAH VERSION): SELF CARE ASSESSMENT (continued)		
INDEX ITEM	**SCORE**	**DESCRIPTION**
Stair Climbing	0	The patient is unable to climb stairs.
	2	Assistance is required in all aspects of chair climbing, including assistance with walking aids.
	5	The patient is able to ascend/descend but is unable to carry walking aids and needs supervision and assistance.
	8	Generally, no assistance is required. At times supervision is required for safety due to morning stiffness, shortness of breath, etc.
	10	The patient is able to go up and down a flight of stairs safely without help or supervision. The patient is able to use handrails, cane or crutches when needed and is able to carry these devices as he/she ascends or descends.
Toilet Transfers	0	Fully dependent in toileting.
	2	Assistance required in all aspects of toileting.
	5	Assistance may be required with management of clothing, transferring, or washing hands.
	8	Supervision may be required for safety with normal toilet. A commode may be used at night but assistance is required for emptying and cleaning.
	10	The patient is able to get on/off the toilet, fasten clothing and use toilet paper without help. If necessary, the patient may use a bed pan, commode, urinal at night, but must be able to empty it and clean it.
Bowel Control	0	The patient is bowel incontinent.
	2	The patient needs help to assume appropriate position, and with bowel movement facilitatory techniques.
	5	The patient can assume appropriate position but cannot use facilitatory techniques or clean self without assistance and has frequent accidents. Assistance is required with incontinence aids such as pad, etc.
	8	The patient may require supervision with the use of suppository or enema and has occasional accidents.
	10	The patient can control bowels and has no accidents, can use suppository, or take an enema when necessary.
Bladder Control	0	The patient is dependent in bladder management, is incontinent, or has indwelling catheter.
	2	The patient is incontinent but is able to assist with the application of an internal or external device.
	5	The patient is generally dry by day, but not at night and needs some assistance with the devices.
	8	The patient is generally dry by day and night, but may have an occasional accident or need minimal assistance with internal or external devices.
	10	The patient is able to control bladder day and night, and/or is independent with internal or external devices.

(Table continues on the following page)

MODIFIED BARTHEL INDEX (SHAH VERSION): SELF CARE ASSESSMENT (continued)		
INDEX ITEM	**SCORE**	**DESCRIPTION**
Bathing	0	Total dependence in bathing self.
	1	Assistance is required in all aspects of bathing, but patient is able to make some contribution.
	3	Assistance is required with either transfer to shower/bath or with washing or drying; including inability to complete a task because of condition or disease, etc.
	4	Supervision is required for safety in adjusting the water temperature, or in the transfer.
	5	The patient may use a bathtub, a shower, or take a complete sponge bath. The patient must be able to do all the steps of whichever method is employed without another person being present.
Dressing	0	The patient is dependent in all aspects of dressing and is unable to participate in the activity.
	2	The patient is able to participate to some degree but is dependent in all aspects of dressing.
	5	Assistance is needed in putting on, and/or removing any clothing.
	8	Only minimal assistance is required with fastening clothing such as buttons, zips, bra, shoes, etc.
	10	The patient is able to put on, remove, corset, braces, as prescribed.
Personal Hygiene (Grooming)	0	The patient is unable to attend to personal hygiene and is dependent in all aspects.
	1	Assistance is required in all steps of personal hygiene, but patient able to make some contribution.
	3	Some assistance is required in one or more steps of personal hygiene.
	4	Patient is able to conduct his/her own personal hygiene but requires minimal assistance before and/or after the operation.
	5	The patient can wash his/her hands and face, comb hair, clean teeth and shave. A male patient may use any kind of razor but must insert the blade, or plug in the razor without help, as well as retrieve it from the drawer or cabinet. A female patient must apply her own make-up, if used, but need not braid or style her hair.
Feeding	0	Dependent in all aspects and needs to be fed, nasogastric needs to be administered.
	2	Can manipulate an eating device, usually a spoon, but someone must provide active assistance during the meal.
	5	Able to feed self with supervision. Assistance is required with associated tasks such as putting milk/sugar into tea, salt, pepper, spreading butter, turning a plate or other “set up” activities.
	8	Independence in feeding with prepared tray, except may need meat cut, milk carton opened or jar lid etc. The presence of another person is not required.
	10	The patient can feed self from a tray or table when someone puts the food within reach. The patient must put on an assistive device if needed, cut food, and if desired use salt and pepper, spread butter, etc.

MODIFIED BARTHEL INDEX (SHAH VERSION): SELF CARE ASSESSMENT INTERPRETATION

SCORE	INTERPRETATION
0 – 20	Total Dependence
21 - 60	Severe Dependence
61 – 90	Moderate Dependence
91 – 99	Slight Dependence
≥ 100	Independence

SCORE	PREDICTION
Less than 40	Unlikely to go home • Dependent in Mobility • Dependent in Self Care
60	Pivotal score where patients move from dependency to assisted independence.
60 – 80	If living alone will probably need a number of community services to cope.
More than 85	Likely to be discharged to community living • Independent in transfers and able to walk or use wheelchair independently.

APPENDIX 9. MINI-COG

STEP 1: THREE WORD REGISTRATION

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

STEP 2: CLOCK DRAWING

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

STEP 3: THREE WORD RECALL

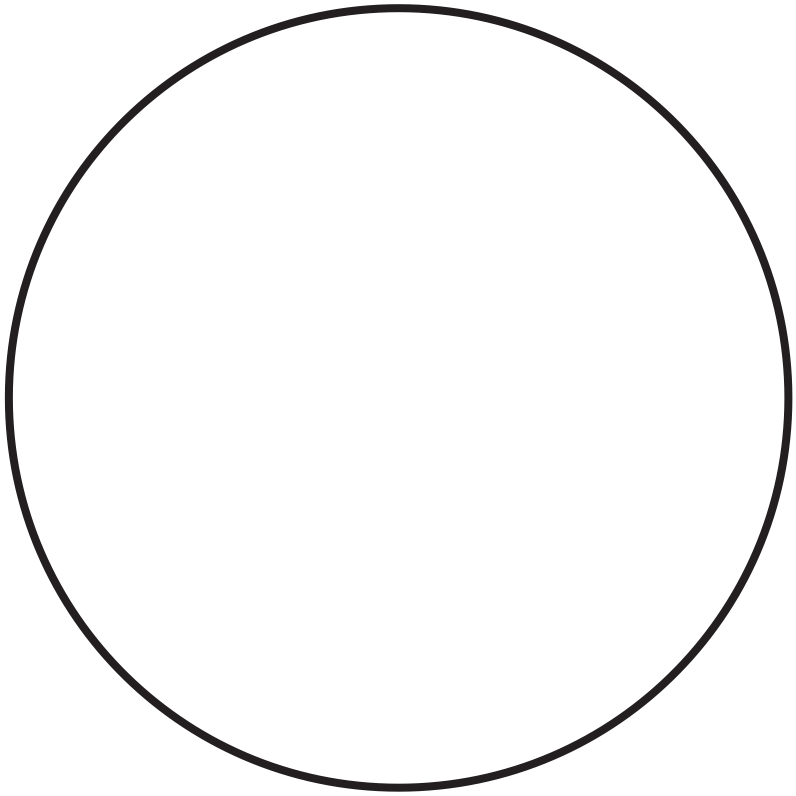
Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

SCORING

Word Recall: _____ (0-3 points)	**1 point for each word spontaneously recalled without cueing.**
Clock Draw: _____ (0 or 2 points)	**Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored.** **Inability or refusal to draw a clock (abnormal) = 0 points.**
Total Score: _____ (0-5 points)	**Total score = Word Recall score + Clock Draw score.** **A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.**

CLOCK DRAWING



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APPENDIX 10. GENERAL PRACTITIONER ASSESSMENT OF COGNITION (GPCOG) SCREENING TEST

STEP 1: PATIENT EXAMINATION

Unless specified, each question should only be asked once.

Name and Address for subsequent recall test

1."I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts).

Time Orientation	**Correct**	**Incorrect**
2. What is the date? (exact only)	☐	☐
Clock Drawing – use blank page		
3. *Please mark in all the numbers to indicate the hours of a clock* (correct spacing required)	☐	☐
4. *Please mark in hands to show 10 minutes past eleven o'clock* (11.10)	☐	☐
Information		
5. *Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).	☐	☐
Recall		
6. *What was the name and address I asked you to remember?*		
John	☐	☐
Brown	☐	☐
42	☐	☐
West (St)	☐	☐
Kensington	☐	☐

To get a total score, add the number of items answered correctly.
Total correct (score out of 9) ☐

If patient scores 9, no significant cognitive impairment and further testing not necessary.

If patient scores 5-8, more information required. Proceed with Step 2, informant section.

If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

GPCOG SCREENING TEST (CONTINUED)

INFORMANT INTERVIEW

Informant's name: _____ **Date: _____**

Informant's relationship to patient, i.e. informant is the patient's: _____

These six questions ask how the patient is compared to when they were well, say 5 to 10 years ago. Compared to a few years ago:

	Yes	No	Don't Know	N/A
• Does the patient have more trouble remembering things that have happened recently than they used to?	☐	☐	☐	☐
• Does he or she have more trouble recalling conversations a few days later?	☐	☐	☐	☐
• When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	☐	☐	☐	☐
• Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?	☐	☐	☐	☐
• Is the patient less able to manage his or her medication independently?	☐	☐	☐	☐
• Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g bad leg, tick 'no')	☐	☐	☐	☐

To get a total score, add the number of items answered 'no', 'don't know' or 'N/A'

Total score (out of 6) _____

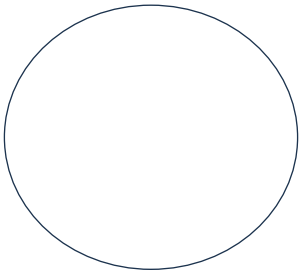
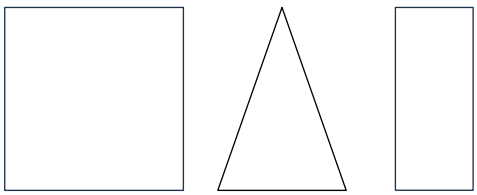
If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

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APPENDIX 11. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS) EXAMINATION FOR COGNITIVE IMPAIRMENT & DEMENTIA

Name: _____ Age: _____

Is the patient alert? _____ Level of Education: _____

Score	Points Available	Questions to ask the patient
	1	1. What day of the week is it?
	1	2. What is the year?
	1	3. What state are we in?
--	--	4. Please remember these five objects. I will ask you what they are later. *Apple Pen Tie House Car*
--	--	5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
	1	How much did you spend?
	2	How much do you have left?
	3	6. Please name as many animals as you can in 1 minute. (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15 + animals
	5	7. What were the five objects I asked you to remember? 1 point for each correct answer
	2	8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24. (0) 87 (1) 648 (1) 8537
--	--	9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock. 
	2	Hour markers okay?
	2	Time correct?
	1	10. Please place and X in the triangle 
	1	Which of the figures is the largest?
	8	11. I am going to tell you a story. Please listen carefully because afterwards I am going to ask you some questions about it. Jill was a very successful stockbroker. She made a lot of money in the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed home to bring up

		her children. When they were teenagers, she went back to work. She and Jack lived happily ever after. 2 What was the females name? 2 What work did she do? 2 When did she go back to work? 2 What state did she live in?
	30	**TOTAL SCORE**

Scoring		
High School Education		**Less than High School Education**
27-30	**Normal**	25-30
21-26	**Mild Neurocognitive disorder**	20-24
1-20	**Dementia**	1-19

_____ _____ _____

Clinicians Signature Date Time

Adapted from: SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) – A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.