

MODEL

LONG TERM CARE

ASSESSMENT TOOL

Division of Community Services
Wisconsin Department of Health and Social Services

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THE MODEL ASSESSMENT TOOL

The Assessment: Assessment is a structured process of interviews which is used to identify the participant's abilities, needs, preferences and supports; determine eligibility for programs and services; and provide a sound basis for developing the care plan. A secondary purpose of the assessment is to provide the participant with a good understanding of the program and the services that can be provided and of what is expected of him/her. Assessments are conducted in partnership with the participant and his/her family, guardian, or other supports as appropriate.

Purpose of the Assessment Tool: This assessment tool is designed to be a comprehensive examination of an individual's life situation which includes their deficits and their strengths. This tool is part of the assessment process that is on-going throughout the period of time that an individual receives long term care services. The assessment process includes constant re-evaluation of the person's situation in order to change services provided to meet changing needs.

This assessment tool was developed to enable care managers to perform a thorough assessment that will result in a comprehensive care plan that is individualized and considers the participant's preferences. The objective of this tool is to learn enough about the individual to create with the participant a comprehensive plan, meeting his/her needs and enhancing his/her life.

Part of the assessment process is the inclusion of addendum tools which have more in depth questions to determine additional services or to prompt the referral to professionals outside of the care management team. These addenda are used on an individual basis and will provide a greater amount of information.

Completing the Tool: It is recommended that a social worker and a nurse complete the assessment as a team. Due to the length of this inquiry, it may be advisable to conduct the assessment in two separate sessions. If a county has limited staff time and cannot perform this assessment in two separate sessions, it is suggested that the nurse and social worker divide the survey and conduct their sessions separately. If the tool is used in this manner, it is recommended that a meeting take place in order for the two assessors to discuss the findings and any follow-up that is necessary.

Please note that specific instructions for each page are printed on the facing page.

ASSESSMENT FACE SHEET

The assessment face sheet is designed to gather pertinent information and keep it within easy reach of the care manager for quick reference. It is also designed to provide a short review of information about the participant if it is needed and the care manager is not available.

Much of the information on the face sheet could/should have been obtained in the initial intake procedure.

Participant Information

Record the participant information as completely as possible. If information is unknown, write unknown. Do not leave any spaces blank. The emergency contact person and the guardian may be the same person. Write "same" in the second line.

Person's Disability(ies)

Check **all** that apply.

Program(s)

Check all that apply. If the person is not currently on a program but will be applying to one or more programs, check those that are anticipated to be providing services to the participant.

Formal Supports

Complete as accurately as possible with complete addresses and phone numbers. Complete addresses and phone numbers do not need to be obtained at the time of the assessment but do need to be filled in later. If the individual has no dentist, etc. write "none" and note that this may be an area to pursue.

LONG TERM SUPPORT ASSESSMENT

Complete the first section with an explanation of the reason for the referral. If others are present at the assessment please indicate who they are and their relationship to the participant. When asking the assessment questions, direct them to the participant. If someone other than the participant answers the question, re-direct the question to the participant (unless they are physically incapable) and politely request that the individual answer the question.

Note where you receive conflicting information or if the participant is unable to answer a question.

Advance Directives: Be sure the participant understands what an advance directive is and understands the difference between living wills, power of attorneys, and durable power of attorney for health care.

PHYSICAL HEALTH

It is important to obtain as complete a physical assessment as possible. This will help you to involve medical professionals in the care plan if it is indicated. You will also become knowledgeable about areas to focus prevention efforts. It is recommended that this section be completed by a nurse. If the individual is in the hospital or has had a recent examination by a physician, medical records may be used in addition to the information obtained in this section. Do not use any medical information in lieu of asking the participant the questions directly.

Part of a good health assessment is determining if the individual is happy with their health care provider and what preferences they may have. If a participant is unhappy with his/her provider or feel she/he doesn't have choices in his/her health care, it may lead to non-compliance with health care recommendations.

PHYSICAL HEALTH

It is recommended that a nurse complete this section along with the section on ADLs and IADLs. If completed by the care manager, no need to duplicate top section

Name: (Last, First, M.I.) _____ Birthdate: ____/____/____

Address: _____ Zip: _____ Telephone: _____ County: _____

Physicians name: _____ Clinic: _____ Hospital: _____

Interviewer name _____ Sections completed: (circle) Physical health ADLs IADLs

List previous, present or potential health problems	Under Treatment		Comments:
	Yes	No	

When did you last see your doctor? _____ What was this for? _____

How often do you see your physician? _____

Are you happy or unhappy with your medical care? (circle) If unhappy, explain _____

Have you been hospitalized in the last year? yes no If yes, how many times? _____

What was this for? _____

What hospital do you go to? _____

Have you ever been admitted to a nursing home, CBRF, AFH, other? yes no When? _____

Where? _____ Why were you there? _____

Medications/Treatments/Services/Supplies

When listing the medications, it is helpful to ask to see the medications and where they are kept. Take each medication individually and ask the participant the accompanying questions. Be sure to include over-the-counter medications. Note any indications that the person does not understand or is not taking the medication properly. If the individual does not administer their own medications, be sure to ask these questions of the provider.

If you are able to look at the medication bottles, check the expiration dates. Follow-up with the physician and/or home health providers to double check the accuracy of the medications being taken.

MEDICATIONS (including over-the-counter)/TREATMENT/SERVICES/SUPPLIES

For each medication ask the person: What is the medication for? What are the side effects of this medication? How and when do you take this medication?

Name	Dosage/Frequency	Client's Understanding/Compliance

Nurse: If medications indicate the need for blood levels, are blood levels being done as needed? yes no

Are you allergic to any medications? yes no What?

How do you obtain your medications?

Do you use a pillbox or other reminder? yes no

What? _____

Do you use tobacco? yes no Do you drink caffeine? yes no

Do you currently drink or have you ever drank alcohol? currently: yes no in the past: yes no

How much do you drink each day _____ week _____

Do you use or have you ever used street drugs? yes no

Which ones and how much?

Assessor: If this information or other info indicates a need for more complete AODA data, see addendum tool

Are you currently receiving any services? (HHA, PT, OT, ST, etc.) yes no If yes, describe what those are and who provides these services: _____

Do you routinely purchase any medical supplies? yes no What? _____

Question: In general, how would you say your health is?

Record the participant's response to this question. This question provides a good insight into the participant's own view of their health and is a key to how the person views their current ability to manage their health. If the participant is currently in the hospital, record how she/he would have responded before admission and how she/he responds now.

Physical Systems Breakdown

Ask the participant each of the accompanying questions, i.e. "How is your eyesight?"

Allow the participant to answer the question and use the prompts that follow if the answer is not complete enough to provide you with the information requested.

Question and note any instances in which your observation differs from the participant's response. For example, The participant responds that their eyesight is fine and you observe the participant wearing glasses. If the participant is blind in one eye - note which eye. Do the same with ears.

If the participant (particularly an elderly person) has not had a vision, hearing or dental exam in the past two years it is an indication that they may need to be examined. (A younger person may not need a vision or hearing exam.)

In general, how would you say your health is? _____

What is your height? _____ What is your weight? _____

Has your weight gone up or down in the past year? yes no

Assessor: if yes, please complete nutritional assessment and/or depression screen

Vision – How is your eyesight?

- Client has no problem Impairment is not corrected
- Client is blind: (circle) one eye both eyes Can you see to read? yes no
- Client wears corrective lens: glasses: yes no contacts: yes no
- Date of last exam: _____ Client needs exam

Comments: _____

Hearing – How is your hearing?

- Client has no problem Client wears hearing aid: yes no
- Impairment is not corrected Client experiences ringing in the ears
- Client is deaf: (circle) one ear both ears
- Date of last exam: _____ Client needs exam

Comments: _____

Dental – Do you have any dental concerns?

- Client has own teeth Client wears dentures
- Client needs dentures
- Client has a dental disease: describe _____
- Date of last exam: _____ Client needs exam

Comments: _____

Respiratory – Do you have any difficulty breathing?

- Client has no difficulty Client experiences sinus problems
- Client reports experiencing shortness of breath (SOB) Client has frequent cough
- Client is currently on oxygen Client is observed experiencing SOB
- Usage/number of liters per minute _____
- Where is it obtained? _____

Comments: _____

Cardiovascular – Have you experienced any heart problems?

- Client has no difficulty
- Client experiences chest pain
- Client experiences edema (swelling)
- Client experiences leg pain (intermittent claudication)

Pulse _____ Blood Pressure _____

Comments: _____

Skin – Do you have any open sores or skin problems?

- Client has no difficulty
- Client wears hearing aid: yes no

Client has ulcers, open wounds or bruises Where: _____

Client has a rash or skin disease(s). Describe: _____

Comments: _____

Nutrition – Are there certain foods that your doctor says you should or should not eat? (i.e., no salt, diabetic)?

What? _____

- Client has no difficulty
- Client is unwilling or unable to follow diet
- Client requires nutritional supplements
- Client's food or fluid intake must be monitored

How would you describe your appetite: excellent good fair poor

Comments: _____

Assessor: additional nutrition assessment is found in addendum section

Elimination – Do you have any problems with your bowels or bladder?

- Client has no difficulty
- Client experiences bladder incontinence. When? _____ How often? _____
- Client experiences bowel incontinence. When? _____ How often? _____
- Client has colostomy or ileostomy Client wears protective pads
- Client has recently experienced a change in elimination; Describe: _____

Are any of the following a problem to you?

- constipation diarrhea frequent urination at night

Do you need or use any of the following?

- commode urinal toilet railings bed pan catheter elevated toilet seat other

Comments: _____

Reproductive Health – What is the date of your last physical exam? _____

Female: Date of last pelvic exam _____ pap smear _____
 Date of last breast exam _____ monthly self breast exam yes no

Male: Date of last prostate exam _____
 Date of last testicular exam _____ monthly self testicular exam yes no

Comments: _____

Musculo Skeletal – Do you have any problems with the following:

- muscle weakness swelling joint stiffness pain muscle cramps

Comments: _____

What is your activity/exercise level?

Assessor: please record participant's perception

- bed bound inactive or sits most of the time moderately active very active

Comments: _____

Central Nervous System – Do you experience any of the following?

- tremors headaches seizures trouble speaking abnormal muscle movements loss of sensation/feeling
 other:

Comments: _____

Miscellaneous

	yes	no	Explain:
Do you have any problems with your feet?			
Do you experience weakness, fatigue or dizziness?			
Have you experienced a fall within the last year?			
Do you have a history of stroke?			

Physical Health (con 't)

Note any difficulty in communicating needs and what services, supports, etc. may help the person become more independent.

The last question in this section about follow-up required, is designed to prompt the assessor to think about ways to improve the health and independence of the person being assessed. Anything noted in this section should be included on the care plan.

If the client has identified visual and/or auditory impairments, or communication problems, please describe how they make their needs known: (i.e., gestures, sign language, interpreter, communication board, etc.) _____

What does the individual require in the area of health teaching about their illness, disability, medications or treatments? Describe what is needed and follow-up required:

ACTIVITIES OF DAILY LIVING

Completing this section will help the care manager get a good picture of what the participant is able to do for themselves and what assistance is needed or provided. Follow the code guide as to what the participant either needs or has and define the code in the comment section. The comment section is designed to specifically state what the participant needs and/or has in the way of services. Any line that has a code other than A should have a comment. Note any areas that the assistance is not enough to maintain the participant in the environment they choose to be in. This should then be a part of the care planning process.

The questions in this section are designed to elicit a narrative response by the participant. The assessor may need to prompt with additional questions to obtain the information required. It is also helpful if this information can be corroborated by either a care provider or individual knowledgeable about the participants abilities.

Again, be thinking about ways in which this individual may become more independent by receiving teaching, therapy or assistive devices. You need not complete this section immediately but may wish to make notes so as not to forget to provide any follow-up that is required.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

This section will also provide you with a picture of the participant's abilities. Be thinking of adaptive aids the individual could benefit from and/or consultation with physical therapists, occupational therapists, etc.

If a participant answers a question by stating that they are unable to do that particular activity any longer, be sure to ask if they would like to be involved in that activity and make a note to discuss that particular area when determining the services the participant will receive. For example, if the participant responds that they can no longer participate in grocery shopping because they can't see the labels well enough, but would like to continue with this activity, you may want to pursue a vision exam or providing a support worker to go shopping with the individual.

DECLARATION OF INCOME AND ASSETS

This form is the same as the form which may have been completed to determine initial eligibility for services. If a form has been completed, you may need to update it only and/or complete any missing information. If a form has previously been completed and signed, this form does not need to be signed.

If the individual is applying for the Medicaid-Waiver, it is important to obtain complete information on the monthly medical expenses to put on the medical/remedial expenses part of the cost sharing form. Also, your county may allow some or all of these expenses to apply to an individual's cost share for Community Options Program services.

If the participant does not have an irrevocable funeral trust fund and needs to spend down to qualify for services. this area should be pursued.

DECLARATION OF INCOME & ASSETS

Name: _____

MONTHLY EARNED INCOME

1. Before tax wages or salary

CLIENT

SPOUSE

2. Before tax income from

self-employment

ALL OTHER INCOME

1. Social Security

2. SSI/SSI-E

3. Veteran's Pension

4. Pensions/Annuities

5. Interest/Dividend Income

6. Other: (i.e., estates/trusts,
net rental income,
workman's compensation,
unemployment compensation,
alimony, etc.

TOTAL ALL OTHER INCOME

COMBINED ASSETS OF CLIENT AND SPOUSE

Consider assets over the protected limits. Do not count

your home, furnishings, or car.

1. Cash on hand

2. Savings

3. Checking

4. IRA

5. Certificates of deposit

6. Money Market

7. Other: (i.e., stocks, bonds, trusts-excluding funeral trusts under \$2,000, money owed to you and any property not used for any of the following: the person's homestead, a business, farming operation or rental income, a vehicle to go to work, to medical providers or for normal participation in community living.)

8. Life ins. cash value if face value is more than \$1500

TOTAL ASSETS

Income received for children in the home (i.e., child support, soc. security, SSI, etc.) _____

EXPENSES

Child support or family support ordered to be paid monthly: Yours _____ Spouse's _____

Maintenance or alimony court ordered to be paid monthly: Yours _____ Spouse's _____

List **average monthly** out-of-pocket expenses which could be considered medically related to the person's condition. Medically related expenses should be interpreted broadly. The following are examples of what should be counted, but the list is not complete: medications, medical supplies, equipment, payments on outstanding medical bills, caregivers, excess energy costs related to a medical condition, health insurance premiums, doctor/dentist/hospital bills (not covered by a third party), MA co-payments, hearing aids, wheelchair expenses, diapers, bed pads, etc.

Do you have an irrevocable funeral trust fund? _____

Have you or your spouse sold or given away property (such as land, stocks, bonds, cash, etc.) within the last thirty months including transfers of property to children, relatives or other persons? YES NO

I have tried to give true and accurate information. I understand that the agency may request more detailed and documented information later.

Date: _____ Signature: _____

Relationship to participant

SOCIAL HISTORY/RESOURCES

It is very important to obtain complete information about the informal supports available to the participant as it is the goal of community programs to support and enhance services to individuals, not supplant what is currently being provided. It is also important to learn if informal supports will continue and/or need to be increased. Be aware of indications of caregiver stress and burden. You may wish to complete the addendum “Family Screen” or additional caregiver burden screen.

When asking the participant to tell you about their personal history, allow them to freely share what they choose. You may wish to prompt them with the examples provided. Help the individual to focus on positive life experiences. Help them to see where they have struggled and coped with difficult situations in the past.

Social History/Resources (con 't)

When asking questions about social activities be sure to identify barriers to participation and address those issues in the care plan.

Please describe what a typical day is like for you now: _____

How is this different from what it used to be? _____

What do you enjoy doing around your home? (i.e., gardening, pets, crafts, cooking, t.v., reading, etc.) _____

What activities do you enjoy outside of your home? (i.e., church, sporting events, concerts, dining, movies, etc.)

Are you currently employed either paid or volunteer? yes no If no, would you like to be? yes no

What activities have you always wanted to try but have not been able to? _____

Do you now or have you in the past, belonged to any groups? yes no If yes, what? _____

What do you usually do for holidays? _____

Do you regularly visit anyone? yes no If no, is there a transportation problem? yes no _____

Assessor: please determine the transportation problem

Do other people regularly visit you? yes no If yes, who? _____

Assessor: determine connection and importance of visitor(s)

Is there anyone who routinely checks on you to be sure you are okay? yes no If no, is there someone you would like to check on you routinely? yes no Who? _____

Do you regularly talk to anyone over the phone? yes no If yes, who? _____

How would you describe your social activity level?

isolated socially active uninvolved by choice

Would you like to increase the amount of your social activity? yes no

If yes, a) what would you like to do? _____

b) what is stopping you from doing this? _____

When you have a decision to make, do you make it yourself or do you often have someone help you? _____

What aspect of your life are you most proud of? _____

What other information would you like to share with me that will help me to know you better? _____

PHYSICAL ENVIRONMENT

When completing this section of the assessment it is helpful to compare your observations with what the participant says. It may help to look around the home with the participant's permission or even have the participant show you around. This will give you an opportunity to observe the participant's mobility as well as how they have adapted to their environment.

Be aware of your own personal biases. If the house looks run down and you may not want to live in it, it doesn't mean the participant does not want to live there.

PHYSICAL ENVIRONMENT

How long have you lived in your current residence? _____ Are you happy here? _____ If not, why not? _____

Do you own or rent? _____ Landlord (if applicable) _____

Do you feel safe living here? _____

Check which items are currently a problem for you		Describe the Problem/Repair Plan
Upkeep of building		
Hot water		
Comfortable temperature		
Stove/Refrigerator		
Telephone		
TV/Radio		
Washer/Dryer		
Trouble with neighbors/roommate		
Isolated location		
Access barriers inside home		
Access barriers outside home		
Substantial repairs needed		
Lack of space		
Housing too expensive		
Client must move		
Tub/Shower		
Difficulty with landlord		
Plumbing		
Other		

Additional Comments: _____

EMOTIONAL FUNCTIONING

This section is often difficult to talk about with a participant because of the emotion involved. Participants may not be completely honest with you about their feelings. Be sure to note differences between what the participant states he/she feels and the affect they show. It is important for the assessor to feel comfortable with questions in this section. If you don't feel comfortable, the participant won't feel comfortable. You may wish to try them out on a co-worker before actually going through the interview. If the participant does become emotional, give him/her time to compose himself/herself and let them know it is all right to express emotions. Don't rush through the questions or ignore the emotion or the participant may feel they have done something wrong.

EMOTIONAL FUNCTIONING

Have you had any major changes or losses in your life in the past year? (i.e., death of a loved one, loss of job, divorce, illness, moving, retirement, change in financial status) yes no

Comments: _____

Do you ever have trouble getting to sleep or staying asleep? yes no

Assessor: If yes, determine how often and what might be the cause, i.e., sleeping during the day

Have you had a change in appetite? yes no Comments: _____

Do you get upset easily? yes no

- If yes, a) What kind of things upset you? _____
b) How often does that happen? _____
c) What do you usually do when you get upset? _____

Are you happy most of the time? yes no What kinds of things make you happy? _____

Do you sometimes find yourself feeling unhappy or depressed? yes no

- If yes, a) What kind of things depress you? _____
b) How often does that happen? _____
c) Is there a pattern to this depression (i.e., weather, increased isolation, finances, special dates, etc.)? _____

d) What do you usually do when you get depressed? _____

How often do you feel lonely? _____ What do you do when you feel lonely? _____

Do you suddenly change moods for no apparent reason? yes no Comments: _____

Are you very worried or afraid about some things? yes no

- If yes, a) What things worry you? _____
b) What things are you afraid of? _____

Do you ever feel that life isn't worth living? yes no

- If yes, a) Do you ever feel that you want to die? _____
b) Do you ever think about suicide? _____
c) When does that happen? _____
d) How often? _____

Do you sometimes have trouble getting along with people you are close to? yes no

- If yes, a) What kinds of things cause the trouble? _____
b) What do you usually do about it? _____

How would you rate your mental or emotional health at the present time?

- excellent good fair poor

Are you receiving any mental health treatment or services now? yes no If yes, what?

ADDITIONAL COMMENTS: (Is further mental health assessment needed?) _____

COGNITIVE FUNCTIONING

This section is also difficult for assessors to conduct. It is important to ask the questions in a straight forward manner so as to not bias the results. It is helpful to tell the person the test is given to all people going through the assessment process. It may also be helpful to simply ask the participant for permission to ask them questions about their memory. In most cases they will agree. If the participant should refuse to answer the questions, note their refusal and move to the next section. It is also helpful to practice this test before actually giving it to a participant.

Nurses are often trained in completing the cognitive assessment. If you have a nurse complete the physical assessment, you may also wish to have them complete this section.

COGNITIVE FUNCTIONING

**SHORT MENTAL STATUS
QUESTIONNAIRE (SPMSQ)**

E. Pfeiffer (1975)

Instructions: Ask questions 1-10 in this list and record all answers. Ask questions 4a only if patient does not have a telephone. Record total number of errors based on ten questions.

1. What is the date today? _____
2. What day of the week is it? _____
3. What is the name of this place? _____
4. What is your telephone number? _____
- 4a. What is your street address? _____
(ask only if patient doesn't have a telephone)
5. How old are you? _____
6. When were you born? _____
7. Who is the President of the U.S. now? _____
8. Who was President just before him? _____
9. What was your mother's maiden name? _____
10. Subtract 3 from 20 and keep subtracting from each new number, all the way down.

TOTAL NUMBER OF ERRORS

0 - 2 Errors =	Intact Intellectual Functioning
3 - 4 Errors =	Mild Intellectual Impairment
5 - 7 Errors =	Moderate Intellectual Impairment
8 -10 Errors =	Severe Intellectual Impairment

PERSON'S PREFERENCES

This section is meant to be a review of the information obtained from the completion of the assessment tool. As the care plan is developed it is important to know exactly what the participant's preferences are in relation to each of the categories listed.

Please be aware that this section should not be limited to what services/supports are available to the individual but rather a means to recording what is important for that person and a way of setting goals for the individual, i.e., if the individual prefers to do their own shopping but is unable to because of mobility problems, this needs to be noted as a way of setting the goal for the individual to become more independent with mobility so that they can participate in the shopping in some manner.

This form may be a helpful way to recap with the participant what was learned in the assessment interview and could be a means to clarify any issues that were not initially made clear.

PERSON'S PREFERENCES

(Describe person's preferences in the following areas)

Living Arrangement: _____

Service Arrangements: (type, who, frequency)

Medical Services:

Community Connections: (social, recreational, transportation)

Is there anything about your cultural/ethnic heritage that is important for us to know?:

Other:

