Comprehensive Assessment for Aging Network Community-Based Long Term Care Services

COMPASS

Instructions

April 2014

New York State Office for the Aging

CONTENTS

INSTRUCTIONS
Comprehensive Assessment for Aging Network
Community-Based Long Term Care Services

INTRODUCTION

The Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) is designed to be a useful client assessment instrument that will inform and guide comprehensive care planning. It provides the basis to determine the need for AAA-funded services, as well as referrals to other programs and providers when appropriate. The COMPASS is intended to reflect the critical role informal caregivers play in the client's plan of care and to gather information to develop a care plan that focuses on goals and objectives to address identified problems or needs.

This version of the COMPASS contains the Minimum Data Set (MDS) that all assessment instruments for aging-funded community-based long term care are required to include as of April 1, 2014.

The person being assessed has certain rights in regards to the assessment process. It is important that the assessor and the person know these rights. The assessor has the responsibility to inform the person of their rights. The person being assessed must be told:

- Why the assessment is being conducted;
- Why the information is being requested;
- How the information will be used; and
- That he/she has a right to refuse to provide information.

If a person refuses to provide some information in response to a question asked by the assessor, he/she must be told:

- It may be possible to provide services to him/her based on the information that is provided, but
- Failure to provide all the information requested could result in the person not receiving the services he/she wants or those services most appropriate to meet his/her needs.

If the inability to provide services to a person is due to the person failing to provide adequate information, the person should be notified of that fact.

All information gathered during the assessment process, including that contained in the assessment document, is confidential. This information should be shared with others only as needed. The person must be informed that information will be shared with others as necessary to implement the care plan and to comply with program requirements, including but not limited to monitoring, research and evaluation.

GENERAL CONCEPTS

USE THESE INSTRUCTIONS --- Read these instructions before completing the COMPASS. Keep them with the COMPASS as assessments are completed. ***Frequent reference to these instructions will aid in accurately completing the COMPASS.***

USE ONLY THE DEFINITIONS WITHIN THESE INSTRUCTIONS --- Different types of assessment instruments are used for specific reasons and programs. Consequently, they often require different definitions. ***In all cases, use the definitions supplied on the COMPASS, in these instructions, the Reporting Guide, Consolidated Area Agency Reporting System (CAARS) and Client Data Systems or by this office as part of the Standard Service Definitions. Do not use definitions used on other assessment forms.*** Our ability to achieve consistency in assessment from assessor to assessor depends on a common understanding of all the terms.

HOW TO ANSWER QUESTIONS --- completing questions having ranges of responses will be easier by beginning with the first descriptor if the person is relatively independent, and the last if the person tends to be heavily dependent. ***Descriptors that are obviously not applicable to the person should be eliminated immediately.*** Attention can then be focused on the remaining descriptors to determine which best describes the individual.

USE YOUR BEST JUDGMENT --- At times it may be difficult to choose between two responses to describe a person. ***Do not leave the question blank, but use your best judgment to select the most appropriate response. It may be possible to use other available information to provide a response.***

EXAMPLES --- ***Examples given in these instructions are just that -- examples.*** They suggest types of conditions that pertain but are not to be taken as the only ones that apply.

MEASURE THE PERSON'S STATUS --- ***a person's functional status fluctuates from day to day and even within the day.*** To determine at what level a person will be assessed, use the following four CRITERIA:

- **TIME PERIOD** --- Use the person's average status over the past ***four weeks*** (unless a question specifically uses a different time period). If the assessor's information about the person covers less than four weeks, use that lesser time period in assessment of the person for the COMPASS.

- **60% RULE** --- Measure what the person generally does. Generally means ***what the person did 60% or more of the time*** during the past four weeks or appropriate time period. If the person's care plan is or will be governed by a behavior that took place less than 60% of the time, base the assessment on this behavior since it is influencing the plan of care.

- **CHANGE OF CONDITION RULE** --- If the person has improved or deteriorated during the past 28 days and is expected to remain at the new level or continue to

change in the same direction, ***record on the assessment instrument the response that best reflects the person's new functional status***.

- **MEASURE WHAT THE PERSON ACTUALLY DOES** --- Measure the person's actual performance, not what the person might be able to do. This applies even when someone else performs a task that the person can do.

- **OBSERVED VS. RECORDED** --- If a medical or other record for the person is not consistent with the person's actual functional status or the care being provided, ***use the actual rather than recorded.***

- **SHARE WITH THE PERSON BEING ASSESSED –**

  - That you want to ask some questions about themselves, because you don't want to sit there and make assumptions about them; you want to get to know them accurately. And a lot of people have identities that people can't necessarily see.
    - Also, that you don't want to make assumptions about the kind of relationships they have, or how they see themselves. You want them to let you know, so that you can really get to know them and understand what's going on in their life.

  - Tell them that everyone is asked the same questions, so no one is being singled out. Note too that medical and health information must remain private and is federally protected against intrusion and unlawful sharing under State and Federal law. [If possible, you can provide materials on the federal Privacy Rule and how medical and health information is kept private. For more information, visit www.hhs.gov/ocr/privacy/]

  - Let them know that the information collected is shared only on a need to know basis. This will include the people involved in developing, overseeing or monitoring the assessment and care plan process (e,g, case manager, supervisor). If someone else needs to see your information, you will be notified. You can also say that some data is anonymously reported to the state but will not include your name or address or other information that would identify the client as an individual (e.g. number of units of service or total number of clients by age).

  - Make it clear that the person being assessed is the primary focus of the assessment. Make every effort to understand and act on his/her point of view. At times, these instructions emphasize the involvement of appropriate family members and other informal caregivers whenever possible. However, this involvement should occur only with the consent of the person being assessed. Also, if there are differing and competing wishes, those of the older person who is being assessed should come first whenever possible.

SOURCES OF INFORMATION --- the information requested may be available from the person, informal supports, and/or available agency records (those of the completing agency and others). However, the person her/himself should be the first and primary source of information unless the person is unable to provide information.

NEED TO MAKE A REFERRAL TO A HEALTH OR MENTAL HEALTH PROFESSIONAL -- See Appendix "Indicators for Referral", at the end of the Instructions. The assessment interview provides the assessor with an opportunity to observe and learn many things about the person. Some of these may be beyond the scope, training and/or purview of the assessor and some may require follow-up. The Appendix provides guidance in evaluating some of these conditions, in determining when to consider them to be emergencies, and in deciding on appropriate follow-up. Become familiar with the material in this appendix so that it is available during the assessment and care planning processes.

INTAKE INFORMATION

This is a stand-alone section that is completed only at the time of the initial contact.

A. **Person's Name:** Self-explanatory.

B. **Address:** Specify the person's current address. If this is temporary indicate this. Also, if any further contact will be at a different location this should be noted and the additional information provided.

C. **Phone # and E-mail:** Enter all phone numbers at which person can be reached. If this is temporary indicate this. If further contact will be at a location with a different phone number this should be noted and the additional information provided. If none, write "none." Enter the client's e-mail address if one's available and used.

D. **Date of Referral:** Enter the date that the referral came in to your office using two digits each for the month, and day and four for the year. For example, April 15, 1997 would be entered as 04/15/1997.

E. **Referral Source:** Identify the person by name who made the referral and the agency he/she is affiliated with, if there is one (for example: Mary Smith, receptionist at Doctor Jones' office); or the connection the referrer has to the person (for example: Edith Noble, next door neighbor). Also include a phone number in case it is necessary to follow up with the person who made the referral.

If it is a self-referral, this would be so noted.

F. **Presenting Problem/Person's Concern(s):** Summarize the statements made by the referral source that explains why the referral is being made.

G. **Does The Person Know That A Referral Has Been Made?** Find out if the person is aware of the referral being made on his/her behalf and if not, why not, as this information has implications for how the assessor may approach the person in order to continue with the assessment process.

H. **Intake Worker's Name and E-mail:** Self-explanatory.

CASE IDENTIFICATION

Client Case #: This is the unique identifying number generally completed by the software system being used to meet the 10 digit numeric client record/number key requirement.

Assessment Date: Enter the date that the assessment is being conducted using two digits each for the month and day and four for the year. For example, April 15, 2012 would be entered as 04/15/2012.

Assessor Name: Self-explanatory.

Assessment Agency: Self-explanatory.

Reason for COMPASS Completion: Check the one item which best explains the reason for the assessment. "Initial" refers to the first assessment done for a person who has not previously been assessed for any of the community based long term care services covered by this assessment/reassessment process. "Reassessment" is an assessment done after the initial assessment or a subsequent reassessment, according to the required timeframes or because of a change in the person's situation that indicates the need to conduct a complete event-based reassessment.

Next Assessment Date: Enter the projected date for the next assessment using two digits each for the month and day and four for the year. For example, April 15, 2013 would be entered as 04/15/2013.

I. CLIENT INFORMATION

A. Person's Name: Self-explanatory.

B. Address: Specify the person's address, ***where services will be provided***. Be sure to include the zip code.

If the mailing address is different from the person's home address, this should be noted and the mailing address included in the case file.

C. E-mail: Enter the client's e-mail address if one's available and used.

D. Telephone No.: Enter all phone numbers including cell at which person can be reached. If none, write "none."

E. Social Security No.: Use only the number assigned by the federal Social Security Administration to the person, not one assigned to the person's spouse. If the person has no Social Security Number, write in "none." If a person refuses to give you this information write "refused" and continue on with the assessment. You can ask if they will provide the last four digits of the social security number. This is being used for research purposes with grants provided by our Federal funding agencies.

F. **Marital Status:** Check the appropriate answer.
Note to interviewer: "Domestic partner" is a legal relationship recognition status available to some same-sex and opposite-sex couples in some states and cities. Some couples also may define themselves as "domestic partners" or "significant others" even if they have no legal relationship to each other. It is important to recognize that for some, the most important person in their lives is someone to whom they have no legally recognized relationship. If a client checks this category, you should consider asking the client who is the domestic partner/significant other so as to better inform your care plan for the individual. Please note that Domestic Partnership is not the same as a legally recognized marriage in New York State.

G. **Sex:** Self-explanatory. Check the appropriate answer.
Note to interviewer: If a client asks what you mean, you can clarify and say "when you were born, did the doctors say you were a boy or a girl?"

H. **Transgender** - Gender Identity or Expression

Note to interviewer: This question may draw some questions from your client. If the client asks what you mean, you may provide further guidance by saying, "Your gender is the way you experience yourself – for many people that's either male or female, and for some people it might be something else."

I. **Birth Date:** Enter the date that the person was born using two digits each for month and day and four for the year. For example, November 4, 1923 would be entered as 11/04/1923.

Age: Self-explanatory

J. **Race/Ethnicity:** Self-explanatory.

K. Sexual Orientation --- *Note to interviewer: If a client asks why you need to know that, you might say:*

These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.

L. Creed: Enter the person's creed, a formal statement of religious belief; a confession of faith or a system of belief, principles using one of the available responses including did not answer or other.

M. National Origin: Enter the person's national origin which includes the birthplace of the individual or their ancestors as self-identified by the client.

N. **Primary Language:** Answer all parts of this question by checking the appropriate boxes. Specify the primary language. ***Note that this question is designed to allow for different languages to be entered for the three language skills***.

O. Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are considered to be limited English proficient, or "LEP." This can affect their ability to receive needed services and require the provision of interpretation services.

P. **Living Arrangement:** Identify who the person lives with. This information should be collected for the residence where the person will be receiving formal services.

Q. **Has the person experienced any of the listed forms of abuse within the last six months** and were they referred to one of the listed agencies. If the issues are ongoing review what steps can be taken to provide assistance.

These types of abuse are defined as:

Domestic Violence

Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV), is broadly defined as a pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, or cohabitation. Domestic violence, so defined, has many forms, including physical aggression or assault (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

Elder Abuse*

- **Physical abuse:** Non-accidental use of force that results in bodily injury, pain, or impairment. This includes, but is not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
- **Sexual abuse:** Non-consensual sexual contact of any kind. This includes, but is not limited to, forcing sexual contact with self or forcing sexual contact with a third person.
- **Emotional abuse:** Willful infliction of anguish, pain, or distress through verbal or non-verbal acts. This includes, but is not limited to, isolating or frightening an adult.
- **Financial exploitation:** Improper use of an adult's funds, property, or resources by another individual. This includes, but is not limited

to, fraud, embezzlement, forgery, falsifying records, coerced property transfers, or denial of access to assets.

- **Intentional Neglect:** Failure to meet the needs of the dependent elderly person by, for example, willfully withholding food or medications or refusing to take the elder to seek medical care.
- **Unintentional Neglect:** Neglect that involves ignorance or from genuine inability to provide care.
- **Self-Neglect:** This is the adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself.
- **Abandonment:** Desertion of a vulnerable elder by anyone who has assumed care or custody of that person.

* Social Services Law. § 473 and NY Codes, Rules and Regulations, 18 NYCRR § 457.1.

R. **Emergency Contact Person:** Enter the name, address, relationship to the person, phone number(s) at home and work of the primary individual the person wishes to be contacted in case of an emergency. There is room to provide this information for a secondary emergency contact person, if two individuals have been identified. If none, print "none."

S. Use these definitions for determining frail and disabled status:

a. Frail - A person with one or more functional deficits in the following areas:

- Physical functions
- Mental functions
- Activities of Daily Living [ADL] (eating, bed/chair transfer, dressing, bathing, toileting and continence).
- Instrumental Activities of Daily Living [IADL] (meal preparation, housekeeping, shopping, medications, telephone, travel and money management).

b. Disabled - Any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. This includes alcoholism and drug addiction. Note, all EISEP clients are considered to be frail/disabled.

II. HOUSING STATUS

A. **Type of Housing:** Check the type of housing that applies.

Single Family Home: a detached living unit housing one household. Trailers/mobile homes, elder or echo cottages and accessory apartments are considered single-family homes.

Multi-unit Housing: more than one living unit such as two, three or four family dwellings, duplexes, triplexes, condominiums, cooperatives, or multi-unit apartment buildings/complexes.

If other, specify.

The assessor should describe under the Comments any special living conditions associated with the person's type of housing that affects the person's informal support system. For example, an elder cottage may be located on property containing the home of a family member, which would have a direct impact on the person's supportive environment.

B. **Person Owns, Rents, Other:** Check the appropriate answer. If other, specify. For example, a person may live with a family member or friend, but pay no rent.

C. **Home Safety Checklist:** Check each condition that applies. The checklist will help the assessor identify situations that may cause problems to the person's or providers' health and safety or the person's capacity to stay at home.

The following guidelines should be used to evaluate the conditions that are included in this section:

Accumulated Garbage: Assessor should check both inside and outside to determine if there is an unusual amount of accumulated garbage which may affect the person's general health and safety.

Bad Odors: These are odors which appear unusual such as strong smell of urine, rotting garbage, animal waste.

Carbon Monoxide (CO)/Detectors Not Present/Not Working: Check/Recommend installation.

Doorway Widths Are Inadequate: When applicable to the person's situation, doorways should be wide enough to accommodate a wheelchair or other special equipment, such as a walker.

Floors and Stairways Dirty and Cluttered: Self- explanatory.

Loose Scatter Rugs Present in One or More Rooms: Self-explanatory.

No Lights in the Bathroom or in the Hallway: Self- explanatory.

No Handrails on the Stairway: Check the condition of the handrails.

No Lamp or Light Switch Within Easy Reach of Bed: Fixtures should be at a height that is comfortable and possible for the person to reach. For example, if a person is in a wheelchair, fixtures might have to be lowered or if a person is bedridden and cannot reach a wall switch, a new arrangement such as extension cords or new lights may be needed.

No Locks on Doors or Not Working: Self-explanatory.

No Grab Bar in Tub or Shower: Self-explanatory.

No Rubber Mat or Non-Slip Decals in the Tub or Shower: Self-explanatory.

Smoke Detectors Not Present/Not Working: Check Battery/ Recommend installation.

Stairs Not Lit: Check for inadequate lighting.

Stairways Not in Good Condition: Check for dirt, clutter and condition of stair treads. Stairs should be firm and strong.

Telephone and Appliance Cords Strung Across Areas Where People Walk: Self-explanatory.

Traffic Lane from the Bedroom to the Bathroom Is not Clear of Obstacles: Self-explanatory.

Other: Specify any other home environment condition that might be problematic to the person's health or safety. For example, exposed or hazardous wiring, pest or vermin infestation.

Under Comments include all changes that must be made to accommodate person's current condition. For example, a commode installed and bath arrangement made downstairs if the only house bathroom is upstairs and the person cannot climb stairs; the installation of a bed downstairs; or bed with rails because the person needs such protection at night. Include any other factors which might affect the care plan, such as availability of space for a sleep-in care giver.

D. **Neighborhood Safety:** Check yes or no. Check yes if environmental conditions outside the person's residence affect the safety of the person or of informal or formal caregivers. For example, high crime rate in the neighborhood, and describe under the Comments.

III. HEALTH STATUS

As you go through the Health Status section, keep in mind that a referral may be necessary for the person based on information provided to the assessor. Referral information is located in the Care Plan section; you should note the possible need for a referral in the comments portion at the end of this section.

A. Primary Physician, Clinic, HMO, Hospital:
Name/Address/Phone

Complete the Appropriate Line:

- Physician if person has an individual private practitioner as primary medical provider;
- Clinic/HMO if a clinic or HMO;
- Hospital if the person uses the emergency room as his/her primary medical provider.
- Other: specify health practitioners other than the primary provider regularly involved in the person's care, including specialists.

Print name, address, and phone number of health practitioner who monitors person's health and provides health care services. If applicable, specify the type of primary care provider and title (e.g., doctor of medicine - M.D.; physician assistant - P.A.; nurse practitioner - N.P., etc.)

A person may not have a physician, clinic or HMO who serves as primary provider. ***Under no circumstances may an assessor force a person to choose a particular provider, or force a person to seek a provider.*** A person without a primary medical provider should be assisted in finding one, and encouraged to do so. Depending on instructions from the local AAA, assistance in finding a primary medical provider may be the responsibility of the assessor or another staff person.

Services cannot be withheld if the person refuses to seek a primary medical provider, except if you determine that services cannot safely be provided.

B. Date of last visit to Primary Medical Provider: Note the month and year of most recent visit to primary medical provider. Specify whom the person saw on most recent visit, reason for contact, and specify location of visit in the comments portion of this section, if applicable.

C. Does the person have a self-declared chronic illness and/or disability? Check all that apply from the list provided. If the person indicates a condition not listed, check 'other' and specify. Under the Comments, include diagnoses and impairments that may affect the Care Plan. Definitions for items in the list are included at the end of the instructions for item III.C.

To answer this item, use all available sources: the person her/himself and, with the person's consent, informal caregivers, the person's physician if necessary, and informed formal service providers. The purposes of recording this information are to have available data which assist in:

- Making a Care Plan which is appropriately responsive to the person's needs;

- Enabling the assessor or other designated person to participate in the coordination of other services if necessary; and

- Identifying indicators for referral for medical assessment and/or treatment if needed.

The assessor should ask the person to describe known health conditions, and to state whether the condition has been diagnosed by a health professional and a course of treatment prescribed. Note if the person seems to have a good awareness of his/her health condition. Note especially if your observation suggests the possibility of other health conditions not named by the person.

Some persons may not have a well-organized perception of their health condition. In those cases, you may have to undertake a more focused interview with the person or by interviewing others.

Any of the health conditions may require action by the case manager, including discussing with the person what current treatment or remedy is being used or considered. Some conditions should be brought to the attention of a Nutrition Program for the Elderly as they may indicate need for assessment by a nutritionist or dietitian. These conditions are:

- alcoholism
- cancer
- dental problems
- diabetes
- digestive problems
- heart disease
- high blood pressure
- hypoglycemia
- smelling impairment
- swallowing difficulties
- taste impairment

Health Status Checklist Definitions

The purpose of these definitions is to help the assessor understand and clarify the meaning of conditions that may affect the client. If the person has a condition, indicates the possible presence of a condition, or the assessor observes the possible presence of a condition, the definitions should help the assessor clarify the condition and consider whether follow-up should be pursued.

Alcoholism: A disorder manifested by complete absorption with and loss of control over consumption of alcohol and characterized by chronicity, intoxication, and tendency toward relapse. Excessive drinking causes physical disability, leading to impaired emotional, occupational, and social adjustments.

> Symptoms and Signs: There may be motor instability; reduced mental function; increased pulse rate; decreased blood pressure; dilated pupils; flushing of skin; drowsiness or stupor.

Alzheimer's Disease: A severe neurological disorder marked by progressive dementia and cerebral cortical atrophy. The disease has a relentless and irreversible course but may take from a few months to four or five years to go to the stage of complete helplessness.

Arthritis: Inflammation of a joint, usually accompanied by pain and, frequently, changes in structure.

Cancer: Any of various malignant tumors or neoplasms that manifest invasiveness and a tendency to spread (metastasize) to new sites. It spreads directly into surrounding tissues and also may be disseminated through the lymphatic and circulatory system.

Constipation: Difficult defecation; infrequent defecation with unduly hard and dry fecal material; sluggish action of the bowels.

Colitis: Inflammation of the mucus membrane of the colon.

Colostomy: Incision of the colon for the purpose of making a more or less permanent duct (fistula) between the bowel and the abdominal wall. The location is usually indicated as groin area (inguinal colostomy) or back and sides between lowest ribs and pelvis (lumbar colostomy), etc.

Congestive Heart Failure: Condition, characterized by weakness, breathlessness, abdominal discomfort, edema in lower portions of body, resulting from venous stasis and reduced outflow of blood.

Dehydration: Occurs when output of water exceeds water intake. May result from deprivation of water, excessive loss of water, reduction in total quantity of electrolytes, or injection of hypertonic solutions.

Dental Problems: Pertaining to the teeth.

Diabetes: A disorder characterized by an abnormally high concentration of glucose in the blood (hyperglycemia) and excretion of abnormal quantities of sugar in the urine (glycosuria).

Diabetes mellitus is a disease of pancreatic origin, characterized by insulin deficiency, subsequent inability to use carbohydrates, excess sugar in the blood and urine, excessive thirst, hunger and urination, weakness, emaciation, imperfect combustion of fats resulting in abnormal increase in acidity in body's fluids (acidosis), and, without injection of insulin, eventual coma and death.

Diarrhea: Frequent passage of watery bowel movements. It is a frequent symptom of gastrointestinal disturbances and is primarily the result of increased wave-like muscle contractions that propel contained matter along tubular organs (peristalsis).

Digestive Problems: Problems with digestion, the process by which food is broken down mechanically and chemically in the digestive tract and converted into absorbable forms.

Diverticulitis: Inflammation of a diverticulum or of diverticula in the intestinal tract, especially in the colon, causing stagnation of feces in little distended sacs of the colon.

Fractures (Recent): A sudden breaking of a bone, or a broken bone. A recent fracture is one that has occurred within the past two years or so.

Frequent Falls: Has the person experienced 2 or more falls during the prior one year period?

Gall Bladder Disease: Any pathological disorder affecting the gall bladder and/or bile ducts.

Hearing Impairment: Difficulty perceiving sound.

Heart Disease: Any pathological disorder of the heart.

Hiatal Hernia: Protrusion of the stomach upward into the mediastinal cavity, through the esophageal hiatus of the diaphragm.

High Blood Pressure: A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

High Cholesterol: Having levels of LDL (low-density lipoprotein cholesterol, also called "bad" cholesterol) in excess of 160.

Hypoglycemia: Deficiency of sugar in the blood. A condition in which glucose is abnormally low.

Liver Disease: Any of several ailments affecting the liver. The liver receives blood from the portal vein and thus is the first organ to receive blood from the intestines where the blood has absorbed the final products of digestion and decomposition products.

Low Blood Pressure: A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

Osteoporosis: Increased porosity (small openings) of bone, leads to frequent fractures, falls, humpback, and/or loss of height. This frequently occurs in women due to a calcium deficiency.

Parkinson's: A chronic disease affecting the central nervous system characterized by a fine slowly-spreading tremor, muscular weakness and rigidity.

Renal Disease: Disease of the kidney.

Respiratory Problems: Trouble with breathing.

Smelling Impairment: A decrease in the person's sense of smell. Smell and taste are closely aligned, and impairment in smell may affect ability to determine flavors, etc.

Speech Problems: Trouble with oral expressions of one's thought.

Stroke: Sudden onset of paralysis resulting from injury to brain or spinal cord.

Swallowing Difficulties: Difficulties in passing food from the mouth through the throat and esophagus into the stomach.

Taste Impairment: Difficulty determining the flavor of a substance in the mouth.

Ulcer: An open sore or lesion of the skin or mucous membrane of the body.

Urinary Tract Infection: An infection in the organs and ducts participating in secretion and elimination of urine.

Visual Impairment: Of or relating to difficulty viewing external objects.

Source: Taber's Cyclopedic Medical Dictionary (1979: F.A. Davis Company, Philadelphia) with modifications

D. **Does the person have an assistive device?** Check yes or no. If yes, check all that apply. If the person has dentures, check whether they are full or partial.

Other should be checked if assistive devices not listed are used. Examples include prosthesis, flashing lights for telephone or doorbell, telephone for persons with hearing impairments, and "grabber" to reach items on floor or overhead. Specify the device and its use where appropriate (e.g., limb which is replaced).

E. **Does the person need assistive device?** On the basis of your observations, the person's comments, or statements from the informal or formal caregivers, identify any assistive device(s) or additional assistive device(s) the person may need.

Check yes or no. If yes, specify the type of device the person needs.

F. **Does person and/or caregiver need training on use?** Check yes or no. If yes, describe the training needs or instructions required by the person and/or the informal caregiver. Specify if the person, the person and the primary caregiver, or just the primary caregiver need training on use.

G. **Has the person been hospitalized within the last 6 months?** Check yes or no. If yes, specify month/year of most recent visit. Specify the reason for stay in hospital and note month and year of discharge date.

Consider this information when developing the care plan. Service need may be affected by medical condition and should be noted. Potential referral may be necessary, depending on indicators, such as the person being frequently hospitalized.

H. **Has the person been taken to the emergency room within the last 6 months?** Check yes or no. If yes, specify month/year of most recent emergency room visit. Describe the reason for most recent ER visit and whether this led to a hospital admission.

I. **Has PRI and/or DMS-1 been completed in the past 6 months?** Check yes or no. Specify month and year of most recent assessment completed. It is possible that the person will be unfamiliar with specific names of assessment processes and instruments. The person may, however, know that a nurse or other professional has been to see her/him recently, and that she or he has been asked questions about her or his health, etc. An informal caregiver may also be helpful with this information. Find out the name of the individual and/or agency that may have performed an

assessment, for further inquiry as to the specific instrument and the details such as completion date and score.

This information is valuable for several reasons. It provides additional information and insight about the person and his/her circumstances. It indicates the involvement of other professionals who you may need or want to contact at some point. It provides information that may be useful or needed in the future. Lastly, it helps the assessor in building a more complete client record.

The Patient Review Instrument (PRI) is generally performed by a nurse and is completed for purposes of nursing home placement in New York State.

A Long Term Care Placement Form (more commonly referred to as the DMS-1) is generally completed by a nurse or doctor and may have been completed for purposes of the Long Term Home Health Care Program or Program for All-Inclusive Care for the Elderly (PACE, a demonstration program operational in some locations in New York.)

Comments: The assessor should use the comments portion of this section to note any additional information about health status not covered in the items in this section, and information based on the items that the assessor would like to specify. This is especially important as items relate to the care plan.

J. Alcohol Screening Test - The CAGE Questionnaire

The CAGE test is a straightforward alcohol screening test, used by many professionals in the alcohol addiction field that simplifies the process of identifying those with alcohol issues.

It is a VERY SIMPLE 4 question self-test where you have the person answer yes or no to the questions.

It is important that they note that when answering the questions they take into account their behavior and feelings over their whole lifetime NOT just now.

Let them know that just because they may have answered yes to 2 or more questions **does not mean they are alcoholic**.

What it does mean is that their drinking should be investigated further

What do the Answers mean?

Answering yes to 1 question.
Then the probability of an alcohol problem is about 25%
Answering yes to 2 questions.
Then the probability of having an alcohol problem is about 50%

Answering yes to 3 questions.
Then the probability of having an alcohol problem is about 75%
Answering yes to 4 questions.
Then the probability of having an alcohol problem is about 95%

You can advise them that:

If you have answered yes to any of the questions in the CAGE questionnaire, or they are worried about alcohol consumption, it is strongly advisable to consult an alcohol specialist.

Usually this means making an appointment with an **alcohol/addiction counselor** and so that they can discuss their alcohol consumption with him/her.

If they feel more comfortable with their **family doctor** then they should go to them by all means. Most doctors have a good knowledge of alcoholism and its signs. If they think there is a problem they can refer to a counselor/treatment center. Medicare also now pays for screening and behavioral counseling in primary care to reduce alcohol misuse. There are no copayments, coinsurance or deductibles.

THE ASSESSOR SHOULD NOTE THE POSSIBLE NEED FOR A REFERRAL IN THIS PART OF THIS SECTION. THIS WILL BE USEFUL FOR CARE PLANNING PURPOSES.

IV: NUTRITION

Data taken in this section, together with other information on the COMPASS, will identify the need for Home Delivered Meal service and/or potential interventions by a registered dietitian.

Eligibility and/or need for Home Delivered Meal service is based on information gathered from the following sections: Health Status, Nutrition, IADLs, ADLs and Informal Support Status. This cumulative information will help the assessor in developing the person's care plan.

To be eligible for Home Delivered Meal service, the person must meet all three of the following criteria:

- Person is incapacitated due to accident, illness, or frailty; and
- Person lacks the support of family, friends, or neighbors; and
- Person is unable to prepare meals because of lack/inadequacy of facilities, inability to shop and cook for self, inability to prepare meals or lack of knowledge or skill.

Referral to a registered dietitian: Factors that should be considered include person's Body Mass Index (BMI), Nutritional Risk Score, Modified/Therapeutic Diet needs, Nutritional Supplements, and Health status.

A&B **Height and Weight:** Enter person's height and weight. Assessor should note the source used to document the person's height and weight. For example, the person may have been weighed measured by a health professional during his/her last doctor's visit. ***Height and weight are simple but important ways of monitoring nutritional status.***

C. **Body Mass Index (BMI):** The BMI can be used to assess quickly whether the person is over or underweight. Healthy older adults should have a BMI between 22 AND 27. A BMI outside of this range may indicate the need for a referral to a dietician.

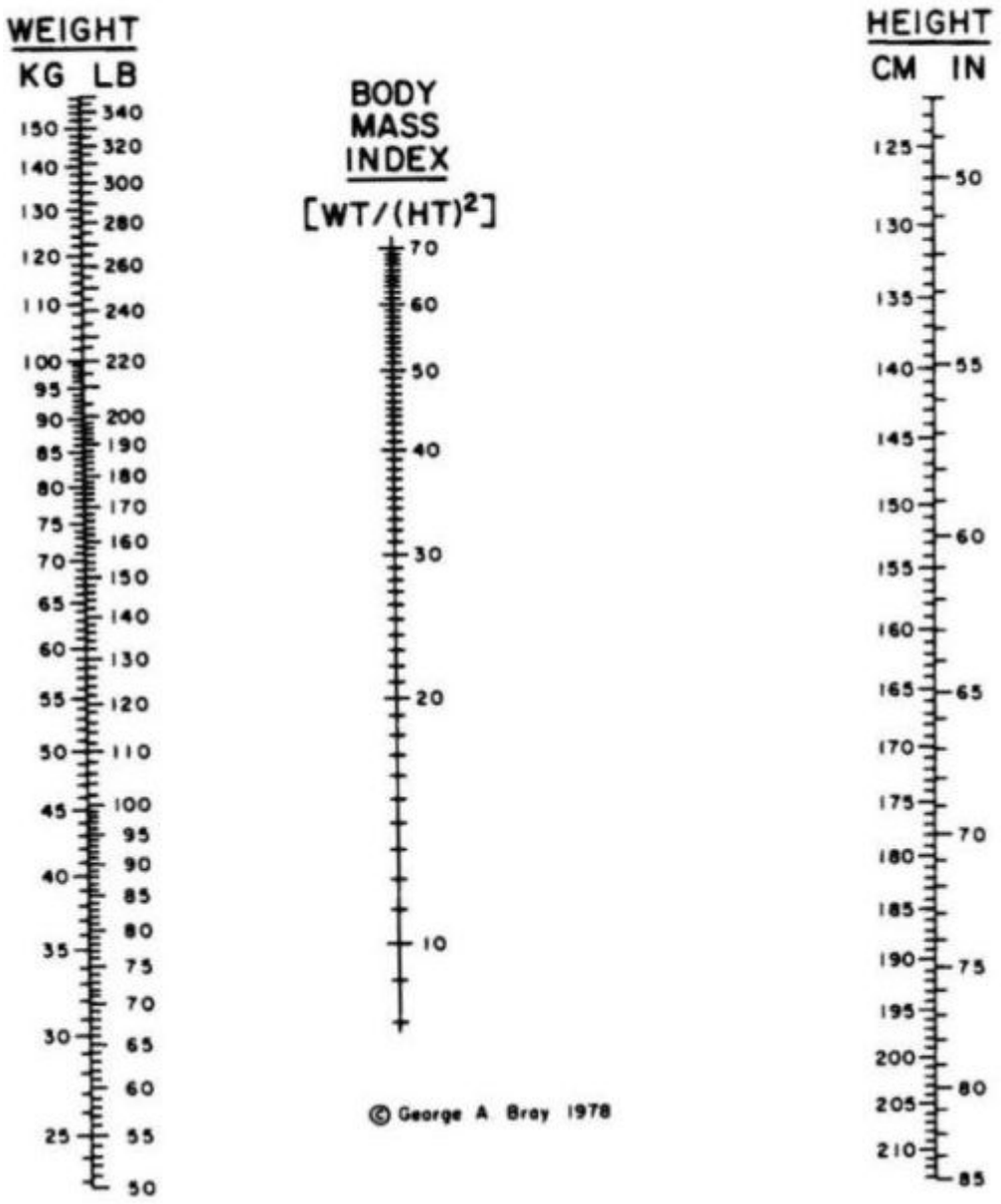
BMI is calculated from the person's height (converted to inches) and weight by using the following formula: weight in pounds x 703; divide this number by height in inches; then divide this number by height in inches again. For example: Person is 5 ft. 4 inches and weighs 140 pounds. 140 X 703 = 98,700; 98,700 divided by 64 inches = 1542; 1542 divided by 64 inches = 24 (BMI). The BMI is within normal range.
Assessor may also use the Nomogram chart (shown below) to calculate the person's Body Mass Index as follows:

- Record the person's height (convert into inches) and weight on the appropriate scale.
- Use a straight edge to connect the two points and circle the spot where this straight line crosses the center line.
- This is the person's Body Mass Index.

D. **Are the Person's Refrigerator/Freezer & Cooking Facilities Adequate?** Check yes or no. Facilities are not adequate if the person cannot safely store, cook, heat/reheat food or meals.

E. **Is the Person Able to Open Containers/Cartons & Cut Up Food?** Check yes or no. If person is unable to perform these functions, check "no". The assessor should include specific information about person's physical disability (such as arthritis, paralysis) or other reason(s) which limit the person's ability and the person's need for adaptive utensils or food containers.

F. **Does the Person Have a Physician Prescribed Modified/-Therapeutic Diet?** Check yes or no. ***Check yes only if diet has been prescribed by a physician.*** If possible, the assessor should determine if the person has a copy of his/her prescribed diet.



A modified/therapeutic diet is designed to meet the requirements of a given situation. It may be modified in individual nutrients, caloric value, consistency, flavor, content of specific foods or a combination of these factors.

If yes, check which type of modified/therapeutic diet the person's physician has prescribed. Types of modified/therapeutic diets include the following:

Texture Modified: A diet designed to minimize the amount of chewing or aid in swallowing. It may be used for dental problems, postoperative patients of head, neck, and mouth surgery, and stroke. For example: chopped diet.

Sodium Restricted: The goal of sodium (Na, salt) restriction is to control hypertension, promote the loss of excess fluids and/or manage impaired liver function, cardiovascular disease and renal disease. Foods containing large amounts of natural sodium or commercially processed foods to which sodium has been added are restricted in amount (e.g., salted snack foods, sauerkraut, seasoning salts.) For example: No Added Salt diet, 2 gm. Sodium.

High Calorie, High Protein: A diet designed to meet the need for increased nutrition during certain illnesses such as cancer and HIV. Nutritional supplements may be included as part of an overall nutritional care plan.

Calorie Controlled Diet: The goal is to aid in the management of Diabetes and/or in weight control. In cases of Diabetes, daily dietary intake is controlled carefully for calories, protein, carbohydrates, and fat. Diet may require simple menu substitutions such as in desserts high in concentrated sugar: cakes, cookies, pies, canned fruit in heavy syrup. For example: 1200 ADA calorie diet, or 1200 calorie weight reducing diet.

Fat Restricted: A diet designed to limit fat intake and/or reduce fat in the blood (serum lipid levels). These lipids include cholesterol and triglycerides. A fat controlled diet is used in the management of conditions where fat is not tolerated (hyperlipo-proteinemias or for biliary tract, pancreas, and malabsorptive syndromes). For example: 40 gm Fat.

Renal: A diet designed to maintain optimal nutritional status in persons with impaired renal function who may be on hemodialysis. Protein, sodium, potassium, phosphorus, and fluid are controlled.

Other: If the person has a physician-prescribed diet that is not included in the list of Modified/Therapeutic Diets, assessor should check other and specify.

If no, ask if the person follows a regular diet or a special diet. A regular diet is designed to maintain a healthy person in a nutritional status sufficient to meet the needs of a particular stage of a life cycle. It satisfies the requirements of the recommended dietary allowances. A special diet includes or substitutes foods to meet a particular need or choice. Check all diets which apply. Types of Special Diets include the following:

Ethnic/Religious: A regular or modified diet that also considers preferences of a nationality, race, ethnic group and/or religious community. If a client has an ethnic/religious diet specify. For example: Kosher/Jewish.

Vegetarian: There are three major classifications within the term vegetarian diet: plant foods with dairy products and eggs (lacto-ovovegetarian), plant foods with dairy products (lactovegetarian), and plant foods only (vegan).

G. **Does the Person Have a Physician-Diagnosed Food Allergy?** Check yes or no. Check yes ***only if allergy has been diagnosed by physician***. Allergies produce definable physiological reactions, including but not limited to indigestion, diarrhea, hives, intestinal cramps, and choking. ***Do not enter food dislikes.*** If yes, describe which food produces an allergic reaction.

H. **Does the Person Use Nutritional Supplements?** Check yes or no. If person uses food or beverage supplements, including vitamin/mineral supplements, answer yes. If yes, specify who prescribed and describe the type of supplement(s) person is currently taking.

I. **Nutritional Risk Status (NSI):** The purpose of questions in this section is to determine the person's Nutritional Risk Status based on the person's responses.

The person's nutritional risk score will help the assessor make appropriate referrals to a registered dietitian.

Check all appropriate risk indicators that apply and circle corresponding numbers at the right. All "yes" answers have a score assigned.
The NSI score is obtained by adding the number of those factors that were answered yes. Check the appropriate level of nutritional risk.

Score of 6 or more indicates "high" nutritional risk: Refer to registered dietitian.
Score of 3-5 indicates "moderate" nutritional risk.
Score of 2 or less indicates "low" nutritional risk.

1. **Person Has Illness or Condition that Changes the Kind and/or Amount of Food Eaten:** Any disease, illness or chronic condition may affect the way a person eats. Also confusion, memory loss, loneliness, or depression can cause changes in a person's appetite and/or digestion. Energy level may have an effect. The assessor may want to cross reference the person's response to this question with Section III. Health Status, Item C and Section V. Psycho-Social Status, Item A.

2. **Eats Fewer than Two Meals/Day:** Self-explanatory.

3. **Eats Fewer than Two Daily Servings of the Following Food Groups:** A serving from each food group constitutes the following:

Fruits: One half cup cooked, fresh or juice; or portion as normally served.
Vegetables: One half cup cooked or fresh; or portion as normally served.
Milk Products: One cup of milk or yogurt, one ounce of cheese, one half cup of ice cream or cottage cheese.

If person answers yes to any of these, circle the 2 points. For example, if a person eats fewer than two daily servings from fruits, vegetables, and milk products, you would ***add only 2 points***. If the person eats fewer than two daily servings from the fruit group, but indicates he/she is eating more than two daily servings from vegetable or milk group, you would still ***add only 2 points***.

4. **Has Three or More Drinks of Beer, Liquor or Wine Almost Every Day:** Self-explanatory.

5. **Has Tooth or Mouth Problems that Make It Hard to Eat:** Refers to problems person may have with loose, missing, or rotten teeth, poor gums, or dentures which don't fit well or cause mouth sores making it hard to eat.

6. **Does Not Always Have Enough Money to Buy Food that Is Needed:** Self-explanatory.

7. **Eats Alone Most of the Time:** Self-explanatory.

8. **Takes Three or More <u>Prescribed or Over-the-Counter Drugs a Day:</u>** ***This question should be asked and cross-referenced with Section VIII-Medications currently taken.***

9. **Without Wanting To, Lost or Gained 10 Pounds in the Past Six Months:** Self-explanatory.

10. **Not Always Physically Able to Shop, Cook and/or Feed Self:** Self-explanatory.

Comments: Specify any special considerations which have been noted in the Nutrition Section or elsewhere on the COMPASS and that have an impact on the person's nutritional needs or indicates the need for a referral to a dietitian. These include:

- Health related factors (Section III, item C): The assessor should be aware that the majority of health conditions listed there have implications for nutrition intervention.
- Impaired in IADLs (Section VII): Shopping (item B); Prepare and Cook meals (item E)
- Impaired in ADLs (Section VIII): Mobility (item D); Eating (item G).
- Informal Support Status (Section X).

V. PSYCHO-SOCIAL STATUS

For each of the questions, assess the presence of the behavior as exhibited by the person, or reported by his/her formal and/or informal caregivers.

Your capacity to provide details in response to these questions will depend not only on your interviewing skills but also the amount of experience you have with the person and his/her formal and/or informal caregivers. When the behavior or condition exists, describe to the extent possible in the space provided. The person's psycho-social status must be considered during the development of the Care Plan. Insofar as you can, any comments you make concerning a problem behavior should include the following factors:

Frequency: How often does this behavior occur? Describe the behavior as occurring monthly if it happens one to three times every four weeks; weekly if it happens at least weekly but not daily; and daily if it happens every day.

Predictability: Is the behavior predictable or unpredictable? For predictable behavior, the caregiver can discern when a person will exhibit the behavioral problem and plan appropriate responses in advance. The behavioral problem may occur during ADL routines (e.g., bathing), specific treatments (e.g., ambulation exercises) or for a logical reason, such as being wrongly criticized, bumped into, etc. The behavior is unpredictable when the caregiver cannot foretell when or under what circumstances the person will exhibit the behavioral problem since there is no evident pattern.

Origin of Condition: When measuring the person's condition, do not consider the origin of this disability, i.e., physical, mental and/or social problems. The concern for measurement is what the person's condition is. Origin of condition is not relevant to the assessment:

A. Does the Person Appear, Demonstrate and/or Report, Any of the Following? Check all that apply.

Checklist Definitions

Alert: The person is mentally responsive and perceptive. Able to appropriately communicate and provide feedback.

Cooperative: The person willingly works with others that are acting on his/her behalf.

Dementia: The person demonstrates distorted comprehension and expression. Exhibits inaccurate or unwise decision making and unsafe self-direction.

Depressed: The person appears melancholy and/or withdrawn. Expresses feelings of sadness and/or guilt. For example, the person often refuses to participate in social activities.

Disruptive Socially: Through verbal and/or physical actions, the person interferes with others. This interference requires immediate attention to control the situation. Without intervention, the disruption would persist or a problem would occur.

Hallucinations: The person demonstrates false or distorted perception of objects or events with a compelling sense of their reality. For example, the person may claim to see people or objects that are not there.

Hoarding: Pathological or compulsive hoarding is a specific type of behavior characterized by:

- acquiring and failing to throw out a large number of items that would appear to have little or no value to others (e.g., papers, notes, flyers, newspapers, clothes)
- severe cluttering of the person's home so that it is no longer able to function as a viable living space
- significant distress or impairment of work or social life

Impaired Decision-Making: The person makes decisions which put themselves and/or others at risk of illness, injury, and/or death. The person creates financial risk due to inappropriate expenditures. This is not due to lack of knowledge.

Lonely: The person expresses feelings of loneliness. States for example, that he/she does not see his/her family and friends enough and/or indicates that he/she misses contact with other people.

Memory Deficit: The person demonstrates forgetful behavior which is dangerous to self or others. For example, fails to shut off burners on stove, fails to put out cigarettes, does not watch food that is cooking and/or burns food, etc.

Physical Aggression: The person is assaultive or combative to self or others with intent for injury. For example, the person hits self, throws objects, punches or hits others, and/or makes dangerous maneuvers with wheelchair.

Self-Neglect: is a behavioral condition in which an individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to any medical conditions they have. Extreme self-neglect can be known as Diogenes syndrome.

Sleeping Problems: The person exhibits increased activity, restlessness, anxiety, fear, and/or tension that occurs during the night.

Suicidal Thoughts: The person expresses feelings of despondency, self-destruction or suicide. For example, the person states he/she would like to end it all.

Suicidal Behavior: The term is understood to mean both suicidal equivalents not recognized as such (accidents, repeated risk-taking) and repeated suicide attempts whose chronic and unsuccessful nature certainly constitutes a real risk, but which are also acts of essentially relational significance.

Verbal Disruption: The person routinely yells, baits, and/or threatens other individuals.

Worried or Anxious: The person appears uneasy, distressed and/or troubled. Demonstrates apprehension, fear, nervousness and/or agitation.

Other (specify): Do not include behaviors or conditions otherwise noted in this section or elsewhere on the COMPASS. Indicate behaviors not included on the list that may affect the safety of the person and/or caregivers. In the space provided, enter the problem behavior.

B. **Evidence of Substance Abuse Problems:** Check yes or no. If the person demonstrates behaviors such as abuse of drugs and/or alcohol (there are clear patterns, levels and strength of the evidence that indicate such abuse), check yes and describe in the space provided.

C: **Problem Behavior Reported:** Check yes or no. Although not demonstrated during your observations and/or through your interactions directly with the person, check yes, if the person's formal and/or informal caregivers report problem behavior. This situation will require further investigation and assessment to verify. Describe in the space provided.

D. **Diagnosed Mental Health Problem:** Check yes or no. If the person has a professionally diagnosed mental health problem and/or an active treatment plan, check yes and describe in the space provided.

E. **History of Mental Health Treatment:** Check yes or no. If the person has a history of receiving professional services or any other type service for a mental health condition, but not now receiving such services, check yes and describe in the space provided.

F. **Does It Appear That A Mental Health Evaluation Is Needed?** Check yes or no. On the basis of a past mental health assessment and the observation of current behavior problems, the person should be referred to treatment services. The services can be provided in any appropriate setting. ***Note Section E, Problems to be referred, in the Care Plan Section, XIII.*** Also see Appendix, Indicators for Referral.

VI. PRESCRIBED AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN

In care planning, medication use patterns may need to be addressed. You should assess potential problems in drug use, such as history of non-compliance or abuse of specific medications or with all medications. Observe indicators for possible problem behaviors, such as use of outdated medications, similar medications from several physicians, and use of medications (over-the-counter and prescription) which may be antagonistic or which may exaggerate each other's effects. For example, use of aspirin and blood thinners (anti-coagulants).

A. Medications: Name, Dose, Frequency, Reason Taken

Determine medications used and purposes as stated by the person or by another informed source. A useful technique in the home is to ask to see containers of all medications used. If assessor believes there is a problem, you should check with person's pharmacist or physician (if person has one).

Name: List all medications that are prescribed and/or purchased over-the-counter. Medications include laxatives, antacids, heart medication, etc.

Dose/Frequency: For each medication listed, identify the amount/quantity to be taken at each time (e.g., three teaspoons, 1 250 mg tablet). Also state the frequency which is the number of times the medication is to be taken per day, week or as needed.

Reason Taken: State the reason for taking the medication as expressed by the person. Record the person's statement of the reason for taking the medication. To the extent possible, you should attempt to have an explanation provided to the person when she/he cannot remember the reason for the medication, or if the reason does not match your personal understanding of the purpose of the medication. It is important to note if the person is not taking medications properly (knowingly or unknowingly.)

B. Primary Pharmacy and Phone Number:

Specify the name and phone number of the primary pharmacy used by the person for prescriptions and other drug/personal items. This should be asked of the person and may be confirmed by the labels on the prescription medication.

C. Does the Person State Any Problems With Medication(s)?

Adverse Reactions/Allergies/Sensitivities:

Check yes or no. If yes, describe any demonstrable physiological reactions produced by any substance. Include substances that cause an allergy (allergens) such as medications and/or environmental factors. Food allergies should ***not*** be included here, as they are recorded in Section VI., Nutrition.

Cost of Medication

Check yes or no. If yes, describe any problem the person states that he/she has with cost of medication. This is important for potential referral.

Obtaining Medications

Check yes or no. If yes, briefly explain whether person can get own medications (refill prescriptions), whether it can be done by an informal caregiver, whether pharmacy can deliver, or whether a formal service is needed to obtain medications. This may be important for care planning.

Other: Self-explanatory.

VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Use the following qualifiers in answering each IADL question:

Time period: Past four weeks.

Frequency: Assess how the person completed each IADL 60% or more of time it was performed ***(IADL status may fluctuate during the day or over the past four weeks)***.

Changed Condition Rule: When a person's capacity to perform IADLs with or without an adaptive/assistive device has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the IADL according to its status during the past seven days.

Changes in Functional Capacity: Consider whether the degree to which the person can no longer perform the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with shopping because he/she is recovering from an operation or broken limb, but the level of assistance would diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the IADL, or how much the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

Is Need Met: At the time of the assessment are the needs for these activities being met?

Activity Status: What Can the Person Do? The IADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. They involve handling equipment, tools or systems outside the body. Consider the person's abilities such as bending, stretching, lifting, pulling, walking a specific distance, etc. By breaking tasks into simple steps, the assessor will be able to determine what aspects of each task are most challenging. For each IADL

question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the IADL in the box provided.

Check if Assistance Is/Will be Provided by Informal and/or Formal Supports: If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver, such as in the administration of medications, or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. State the name of the informal caregiver and the specific days/hours the assistance is required. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

Comments: Describe any specific limitations or needs there might be for each activity, parts of tasks to be done and responsibilities of informal and formal services, and/or other factors that may be important for developing and/or implementing the Care Plan. For example, in the activity of shopping, you have the opportunity to indicate to what degree the person needs assistance. In the example of telephone, you can assess whether the person needs some type of assistive device, perhaps even the telephone itself, to satisfy the IADL need. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

Definitions of Activities

A. **Housework/Cleaning:** To be able to dust, sweep, wash dishes, vacuum, move small pieces of furniture to clean, rinse out bath - to handle the normal range of housekeeping chores.

Status #1: Able to perform almost all household tasks - light and heavy work. Person is totally able.

Status #2: Able to perform light housework (e.g., dusting, dishes, trash disposal). Cannot do most heavy housework (e.g., vacuuming, washing floors, cleaning kitchen). Person needs some assistance.

Status #3: Unable to do any housework. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

B. **Shopping:** To select, order, or purchase items in a store (groceries, clothes, drugs, etc.) and to carry them home or be able to have them sent.

Status #1: Able to go by self to shop, including carrying packages. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to go by self to shop or order items, but needs someone to carry packages.
- Able to do by self only light shopping and carry small packages, but needs someone to do occasional major shopping.
- Unable to go shopping alone, but can go with someone to assist.

Status #3: Needs someone to do all shopping and errands. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

C. **Laundry:** To carry laundry to and from washing machine, to get to laundry facilities, to use washer and dryer, to wash small items by hand.

Status #1: Able to take care of all laundry and can get to laundry facilities. Person is totally able.

Status #2: Able to do light laundry, such as minor hand wash or light washer loads. Needs help with heavy laundry such as getting to laundry facility, carrying large loads of laundry, or supervision. Person needs some assistance.

Status #3: Unable to do any laundry physically or needs continual supervision and assistance (if confused or judgment impaired). Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

D. **Transportation:** Ability to use transportation such as a car, van, taxi, or public transportation to go to a place farther than person can walk. For example, to go to a medical appointment. To do this, it implies that the person has the cognitive and physical ability to travel.

Status #1: Able to drive a car or arrange and use a van, taxi or public transportation. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Can arrange necessary transportation, but needs help in and out of vehicle.
- Must have someone else arrange for and provide the transportation, person can use transportation.
- Does not have access to transportation --- appropriate mode of transportation unavailable.

Status #3: Person needs maximum assistance. Specify degree of assistance required:

- Person can not leave home.
- Person requires maximum assistance to arrange, help in and out of the vehicle and provide the transportation.

Status #4: Does not perform the activity due to unwillingness.

E. **Prepare and Cook Meals:** To be able to chop, cut, measure foods to prepare a recipe, to know how long food should cook to be edible. Person is able to use the stove or oven, be able to lift and move pots and pans, be able to boil water, etc.

Status #1: Able to plan and prepare all meals for self. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to fix main meals but not on a regular basis.
- Able to fix light meals (e.g., cereal, sandwich) or reheat but not on a regular basis.

Status #3: Unable to prepare any meals, even reheat. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

F. **Self-Administration of Medications:** To be able to perform all tasks involved with the use of medications, whether prescribed or over the counter. Includes tasks such as being able to follow the schedule for taking medications, identifying container having proper medication, opening the container, counting out or measuring the medication, doing any procedures

to prepare the medication for use, and the acts of ingesting, applying or injecting the medication.

Status #1: Able to self-administer medication without any assistance or supervision. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Requires supervision to keep track of which medications must be taken, or to take medications at the proper time. Otherwise capable of taking medication as directed by others.

- Requires assistance in identifying the proper medication, opening the container, counting out pills or preparing for applying, ingesting or injecting medications; otherwise capable of taking medication prepared by others.

Status #3: Totally incapable of managing self-administration of medication, and completely dependent on others for supervision and assistance.

Status #4: Does not perform the activity due to unwillingness.

G. Handle Personal Business/Finances: To understand how to pay bills; balance a checkbook; keep accounts; answer correspondence; write and keep track of when to pay which bills; handle money, understand the cost of items and count change.

Status #1: Able to pay bills (on time and for correct amount), balance checkbook/handle bank account and make contracts independently. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- May need to be reminded to pay bills or take care of other personal business.

- May need assistance in getting materials needed (e.g., checkbook, stamps) or assistance in writing checks, letters, and balancing checkbook.

- May need assistance or guidance in handling financial matters (home mortgage, investments).

Status #3: Needs someone to write checks, pay bills and handle personal business. Person does not participate in decisions. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

H. **Telephone:** To be able to use phone book or know numbers of parties desired to be reached, or to actually be able to dial and use telephone regardless if person has a telephone.

Status #1: Able to look up phone numbers, dial number and receive phone calls. Person is totally able.

Status #2: Person needs some assistance. Specify degree of assistance required:

- Able to use the phone as needed, but needs some help to get to the phone.
- Able to use phone with assistance and/or supervision (look up numbers, dialing).

Status #3: Unable to use phone. Person needs maximum assistance.

Status #4: Does not perform the activity due to unwillingness.

Are changes in IADL functional capacity expected in the next 6 months?
Self-explanatory.

VIII: ACTIVITIES OF DAILY LIVING (ADLS)

Use the following qualifiers in answering each ADL question:

Time period: Past four weeks.

Frequency: Assess how the person completed each ADL, with or without an adaptive/assistive device, 60% or more of time it was performed (ADL status may fluctuate during the day or over the past four weeks).

Changed Condition Rule: When a person's capacity to perform ADLs has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.

Changes in Functional Capacity: Consider whether the degree to which the person can no longer do the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with bathing because he/she is recovering from an operation or broken limb, but the level of assistance may diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the ADL, or the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

Is Need Met: At the time of the assessment are the needs for these activities being met?

Activity Status: What Can the Person Do? The ADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. For each ADL question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the ADL in the box provided.

Check if Assistance Is/Will be Provided by Informal and/or Formal Supports: If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. State the name of the informal caregiver and the specific days/hours the person is required. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

Comments: Describe any specific limitations or needs there might be for each activity, parts of tasks to be done and responsibilities of informal and formal services and/or any other factor important for developing and/or implementing the Care Plan. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

General Definitions:

A. **Intermittent:** A caregiver (informal or formal) does not have to be present during the entire activity.

B. **Supervision:** Verbal encouragement and observation, not physical hands-on care, is needed by the person.

C. **Assistance:** Physical hands-on care is needed by the person.

D. **Continual:** One to one care is needed by the person; if a provider is not present the person will not complete the activity.

Definitions of Activities

A. **Bathing:** To wash the body or body parts, whether tub, shower, or basin, including getting to the bath, obtaining the bath water, and getting into the tub or shower.

Status #1: Requires no human supervision or support. May use adaptive equipment.

Status #2: Requires intermittent checking and observing. May require assistance for minor parts of the task, such as transferring in and out of the bath and bathing back and feet.

Status #3: Requires continual help (supervision or physical assistance) with most parts of bathing.

Status #4: Person does not participate. Person is bathed in bath, shower or bed by another.

B. **Personal Hygiene:** Grooming, including combing hair, washing face, shaving and brushing teeth.

Status #1: Responsible for self, and receives no human supervision or assistance with personal grooming.

Status #2: Requires intermittent verbal cuing or observation, and/or requires assistance with difficult parts of grooming.

Status #3: Requires continual help (supervision and/or physical assistance) with most or all of personal grooming.

Status #4: Person does not participate; another person performs all aspects of personal hygiene.

C. **Dressing:** Putting on, fastening and taking off all items of clothing (including braces or artificial limbs worn daily) and obtaining and replacing these items in their usual storage places.

Status #1: Needs no human supervision or physical assistance.

Status #2: May need intermittent supervision (verbal encouragement and/or minimal physical assistance) for the proper arrangement and retrieval of clothing.

Status #3: Requires continual help (encouragement, teaching, and/or physical assistance) with difficult parts of dressing.

Status #4: Specify degree of assistance required:

- Has to be completely dressed by another: person does not participate.

- Bed gown is generally worn due to condition of person.

D. **Mobility:** How the person moves about from place to place with adaptive equipment, wheelchair, or by self.

Status #1: Walks with no supervision or human assistance. May require mechanical device (for example, a walker) but not a wheelchair.

Status #2: Walks with intermittent supervision (that is, verbal cuing and observation.) May require human assistance for difficult parts of walking (for example, negotiating stairs or ramps.)

Status #3: Walks with constant one-to-one supervision and/or constant physical assistance.

Status #4: Specify degree of assistance required:

- Wheels with no supervision or assistance, except for difficult maneuvers (for example, using elevator or wheeling over ramps.) May actually be able to walk, but generally does not move.

- Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

E. **Transfer:** Moving between the bed and chair, getting in and out of bed or a chair or wheelchair.

Status #1: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings or a trapeze.

Status #2: Requires intermittent supervision (that is, verbal cuing/guidance) and/or physical assistance for difficult maneuvers only.

Status #3: Requires one person to provide constant guidance, steadiness and/or physical assistance. Person participates in transfer.

Status #4: Specify degree of assistance required:

- Requires lifting equipment and at least one person to provide constant supervision and/or physically lift.

- Cannot transfer and is not taken out of bed.

F. **Toileting:** Getting to and from the toilet, transferring on and off the toilet (commode, bedpan), cleaning self after elimination, adjusting clothing, and continence.

Status #1: Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

Status #2: Requires intermittent supervision for safety or encouragement, or minor physical assistance (for example, clothes adjustment or washing hands.)

Status #3: Requires constant supervision and/or physical assistance with major/all parts of task, including appliances (for example, colostomy, ileostomy, or urinary catheter.) Continent of bowel and bladder.

Status #4: Incontinent of bowel and/or bladder, whether or not taken to a toilet. (Incontinent: 60% or more of the time the person loses control of his/her bowel or bladder functions with or without equipment.)

G. **Eating:** Getting food by any means from the receptacle (plate, cup, etc.) into the body and to swallow the food served.

Status #1: Feeds self without supervision or physical assistance. May use adaptive equipment.

Status #2: Requires intermittent supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread, or opening milk carton.

Status #3: Requires continual help (encouragement, teaching, physical assistance) with eating or meal will not be completed.

Status #4: Specify degree of assistance required:

- Totally fed by hand. Person does not manually participate.
- Tube or parenteral feeding for primary intake of food, not just for supplemental nourishments.

Are Changes in ADL Functional Capacity Expected in the Next 6 Months?
Self-explanatory.

IX. SERVICES CLIENT CURRENTLY IS RECEIVING

Check all formal services currently being provided. Indicate provider name, address, telephone number and contact person. Exclude assistance provided by informal caregivers as this information is recorded elsewhere.

X. INFORMAL SUPPORT STATUS

Unless otherwise stated, the questions in this section apply to the entire informal support system. Several questions in this section assess the capacity and needs of the informal caregivers. When possible they should be directed to both the informal caregiver(s) and the person during the assessment interview(s). When this is not possible, the question(s) should be directed to the person and the responses recorded. The assessor should contact the informal caregiver(s) directly, but only after receiving the person's permission to do so, to verify the information and get additional information as may be necessary. If permission is denied by the person, then contact should not be made with the informal caregivers that have been identified.

Space has been provided to record information for two (primary and secondary) informal caregivers if appropriate.

A. Does the Person Have Family, Friends and/or Neighbors That Could Help with Care? Check yes or no as appropriate.

If no informal supports are present, skip to question D. Of this section.

1&2 Primary and Secondary Informal Supports: Identify those who provide care for the person. Include their name, address, relationship to the person, email addresses and telephone number(s). Under "involvement", include the specific types of assistance and tasks, and specify the times they are done.

For each informal support noted, check the following questions.

a. **Does the Person Appear to Have a Good Relationship with This Person?** Check yes or no as appropriate. Clarify the response in the space provided. Do not "lead" the person to a particular answer; however, it may be necessary to help the person describe the relationship by asking probing questions or giving examples. ***For example: you might ask questions like -- How are things between you and your daughter? When you speak to your daughter what are the kinds of things you talk about -- Does she talk things over with you?***

b. **Would the Person Accept Help or More Help from this Person to Stay at Home and/or Maintain Independence?** Check the appropriate answer based on the information provided. Ascertain

from the person to what extent she/he is willing to accept help from informal supports. It may help to provide examples. Listen to what is said as well as how things are said. Assessor observations and comments should be carefully noted as such and distinguished from what the person says. Explain in the space provided.

c. **Are There Any Factors that May Limit this Person's Involvement?** Check all of the appropriate answers based on the information provided. Ask this question in a neutral and understanding manner. ***For example: Are there other things that take a lot of your daughter's attention, or that make it hard for her to see you more often?***

d. **Would this person be considered to be a caregiver?** A caregiver is a traditional or non-traditional family member, friend or neighbor who is helping another person they are concerned about with the everyday tasks of living. The caregiver and care receiver may live together, near each other or far away from one another.

e. Is Caregiver respite needed? Check Yes or No. If yes, check all that apply.

f. If respite is needed select from the list of possible non-institutional respite services, the ones that could be provided to the client that will provide respite to the caregiver.

g. Ask if the caregiver would like information about other caregiver services.

B. Can Other Informal Supports Provide Temporary Care to Relieve the Caregiver(s)? Check yes or no as appropriate. If yes, include the detail in the space provided to explain who might be available, when they might be available and what they may be able to do. Before considering the options available in the formal system, review the capacity of the person's family, friends and neighbors to determine their potential for providing a break to the primary informal supports. ***Additional follow up with these other individuals may be necessary to further explore their capacity.***

C. Does the Person Have Any Community/Neighborhood/ Religious Affiliations that Could Provide Assistance? Check yes or no as appropriate. If yes, provide the necessary detail in the space provided. Before exploring the options that are available in the formal system, seek out all low cost/no cost options for addressing the person's needs. Since various organizations sometimes provide community services, explore what might be available in the community.

XI. MONTHLY INCOME

The information requested in this section pertains to the monthly income of the person being assessed, their spouse and includes other family/household income. This information will help the assessor in determining the person's appropriateness for benefit and entitlement programs, such as those found in the next section. A person is under no obligation to disclose income information. However, if during care planning, EISEP or CSE EISEP-like services are identified as needed services, the person who refuses to disclose financial information will be required to pay the full cost of services in order to receive these services.

A. Monthly Income: Determine the monthly amount received from each source of income for the individual being assessed, their spouse, and other family/household members. Use the net income, after expenses incurred in producing the income, --- as well as after federal, state and local income taxes --- have been deducted. Net income cannot be less than $0.00. Be sure to use the most up-to-date income information that is available. In the last column enter the total family/household income. This amount is used to determine poverty status.

1. **Social Security (net):** The person's monthly income from Social Security. Enter the net amount, which is the amount after the Medicare Part B premium has been deducted.

2. **Supplemental Security Income: (SSI)** The person's amount of SSI received each month. If the person receives SSI, he/she is automatically Medicaid certified. If the person has not received a Medicaid card, contact LDSS. If the person receiving SSI needs Personal Care, refer him/her to the Local Department of Social Services (LDSS) for Personal Care.

3. **Pension/Retirement Income:** The amount of the person's pension/retirement benefit each month. The sources may be from private/government pensions, veteran's benefits, annuities, IRAs, etc.

4. **Interest:** The amount of interest the person regularly receives each month from monies held in accounts such as savings, checking, Certificates of Deposit, etc.

5. **Dividends:** The amount of money received each month from stocks, bonds, and other sources.

6. **Salary/Wages:** The monthly income the person derives from employment.

7. **Other:**

Other income must include any:

- net income from farm and non-farm self employment,
- net income from buying and selling real or personal property which produces income, i.e., capital gains,
- net income from roomers, boarders, or from the rental of property, and
- all other regular sources of income not listed or explicitly excluded below.

Do not include income from the following sources:

- German War Reparations (or reparations from any country)
- Earned income from wages, salary, or stipends received under:
  - Title V
  - JTPA
  - Foster Grandparents
  - Other programs established to foster employment of lower income elderly, such as the Green Thumb Employment Program;
- Unearned income from:
  - One time lump sum payments such as insurance benefits (however, interest or other regular income subsequently received from one-time lump sum payment will be counted as income)
  - Occasional gifts, IT-214, Property Tax Credit/Rebate; and
  - Income from home equity conversion plans, i.e., "Reverse Mortgages" (funds received from such plans are debts that must be paid in future).

Do not use the value of goods, services or benefits received in-kind when you calculate monthly income. The value of Food Stamps, HEAP benefits and all other goods, services or benefits received in-kind are not considered income.

B. Number of people in household. Used with total family/household income to determine poverty status.

C. Is client a veteran? Used in determining other services which may be available.

D. Person will provide no financial information.

Check the box if person will not provide any financial information. Describe why.

Please continue on to XII. Benefits/Entitlements. Even though the person has refused to provide income information, he/she may be willing to provide other information regarding benefits and entitlements.

Note: Additional information is required from persons who will be receiving EISEP services or CSE-funded EISEP-like services. To gather this information, use the EISEP "Financial Information & Client Agreement" form, or a locally developed form that includes all of the required information.

XII. BENEFITS AND ENTITLEMENTS

Information obtained in this section will assist the assessor in determining if a person is currently receiving any one of a variety of benefit/entitlement programs. For each of the benefits listed, ascertain and record A, B, C or D under the Benefit Status Code column using the following:

A. Has the benefit/entitlement;
B. Does not have the benefit/entitlement;
C. May be eligible and is willing to pursue the benefit/ entitlement; or
D. Refuses to provide information.

Also assess whether the person needs information and/or counseling on benefits and entitlement programs.

As you go through the list, it is important to determine if the person was in receipt of a benefit in the past and is no longer in receipt. For example, the person received HEAP benefits in the past, but now the person no longer is receiving HEAP, the assessor can ascertain the reason and may be instrumental in assisting this person to receive the benefit again.

Entitlements and Benefit Categories

Income Related Benefits

Social Security (SS): Self Explanatory

Supplemental Security Income (SSI): A federal program that pays monthly checks to people in need who are 65 years of age or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide

sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets. A person in receipt of SSI is categorically eligible for Medicaid and should have a Medicaid card.

Railroad Retirement: Persons who worked for a railroad company are entitled to the benefits at retirement (includes Medicare).

Social Security Disability (SSD): A worker who is permanently disabled or has a disability that is expected to last one year or longer may be entitled to the payment of monthly Social Security Disability Insurance benefits if they are covered under Social Security guidelines.

Veteran Benefits: The person may be eligible for veteran benefits if any of the following conditions exist: the person is a veteran, the person's spouse is/was a veteran, or the person has a deceased child who was a veteran. If any of these criteria are met and the person does not have the benefit, refer the person to the veteran's service agency serving the locality.

Other: Specify.

Entitlements

Medicaid Number: Specify the person's Medicaid number. Medicaid is a government assistance program which pays for a comprehensive range of medical services for persons with low income and assets. There are a number of community based services that a Medicaid eligible individual can receive, such as in-home personal care, Personal Emergency Response Systems (PERS) and transportation, administered by the local Department of Social Services. For persons requiring nursing home care, a separate Medicaid application must be pursued to ensure coverage of the person's nursing home bills. This must be pursued irrespective of the person's current eligibility for "community" Medicaid.

Food Stamps: Coupons that are issued monthly which may be used at any participating store or supermarket to purchase food. Elderly participants may also be qualified to use their food stamps at USDA-approved restaurants. Food stamp eligibility is based upon the person's income and assets.

Public Assistance: A cash benefit that is furnished to individuals or families to provide for essential shelter, food and clothing needs. Public Assistance is divided into two categories, Aid to Families with Dependant Children (AFDC) and Home Relief (HR). Public Assistance (PA) recipients receive semi-monthly cash grants based on financial need, living arrangement and household size. All PA recipients automatically receive Medicaid and most receive Food Stamps.

Other: Specify.

Health Related Benefits

Medicare Number: Specify the person's Medicare number. Medicare is the federal health insurance program for people 65 or older and certain disabled people. Medicare has two parts. Part A, known as Hospital Insurance, covers hospital, skilled nursing facility, home health and hospice care. Part A has deductibles and coinsurance. Part B, known as Medical Insurance, primarily covers doctor's fees, most outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A. There is a monthly premium for Part B coverage, which is automatically deducted from the person's Social Security check. Part B also has an annual deductible and coinsurance amounts.

Qualified Medicare Beneficiary (QMB): A federal program requiring states to pay the Medicare premiums, deductibles and co-payments for Medicare beneficiaries who qualify based on income and resources.

Specified Low Income Medicare Beneficiary (SLMB): A program that pays a person's Medicare Part B premiums. This program is based on income and assets, however income can be somewhat higher than the income limit for the QMB described above.

Elderly Pharmaceutical Insurance Coverage (EPIC): A program that assists a person with paying for prescription costs. To be eligible, the person must be 65 years of age or older and meet certain financial criteria.

Medigap Insurance/HMO: Medigap insurance is designed to supplement Medicare's benefits by providing specific coverage that helps to fill the gaps in a person's Medicare coverage. There are ten standard medigap plans.

Medicare beneficiaries have a choice in how they may receive their Medicare benefits -- either through traditional, fee-for-service Medicare or through a Medicare managed care plan or HMO. One choice to fill Medicare gaps is enrollment in a Medicare managed care plan or HMO. A Medicare HMO must provide all Medicare-covered services and benefits and most offer additional benefits such as preventive services, prescription coverage, dental care, hearing and or eyeglasses. The person must continue to pay the Medicare Part B premium, some plans charge an additional monthly premium. The HMO usually offers all regular Medicare benefits and may add extra benefits such as preventive care services and prescriptions.

If the person has the benefit, specify the Medigap insurance or HMO.

Long Term Care Insurance: A policy designed to help cover some of the costs associated with long-term care. Policies covering long term care services currently being sold in New York State are indemnity policies. They pay a specific dollar amount for each day you spend in a nursing facility or for each home health or home care visit. ***New York has established minimum standards for four***

classifications of insurance policies: long term care insurance, nursing home and home care insurance, nursing home insurance only and home care insurance only. An additional form of LTC insurance is the NYS Partnership for Long Term Care. The Partnership program allows those persons who purchase a Partnership policy to qualify for Medicaid without spending down their assets once the benefits under the long term care policy are exhausted. One must contribute their income toward the cost of their care. If person has the benefit, specify the type of LTC insurance.

Other Health Insurance: Person has additional insurance that provides health coverage, such as an employer-sponsored retiree plan, hospital indemnity or specific disease insurance. If the person has the benefit, specify the type of other insurance.

Housing Related Benefits

Senior Citizen Rent Increase Exemption (SCRIE): Tenants aged 62 and over who live in rent controlled or rent stabilized apartments ***in New York City and in several municipalities in Nassau and Westchester Counties*** may qualify for an exemption to rental incomes if their incomes and proportion of their incomes spent on rent meet eligibility guidelines.

Section 8: Federal rental vouchers and rent certificates to provide financial assistance for very low income elderly and families in rental housing, enabling those residents to pay no more than 30% of their incomes on rent.

IT 214: Also known as the Circuit Breaker Program, provides income tax credits or rebates to older homeowners and renters who are paying a disproportionate amount on housing expenses in relation to their household income. A person may qualify for a rebate even if he pays no income tax.

Veteran Tax Exemption: A reduction in property taxes may be available to the veteran or spouse of a veteran. Since there are various options under the Veteran's Tax Exemption, refer the person to the Veteran's Service Agency serving the locality.

Reverse Mortgage: Community banks and financial lenders offer various financial options which allow an older homeowner to use the equity he/she has built up in his/her home as additional sources of regular income. These loans may specify a specific pay-back date for the principal and interest, but most are repayable upon the death of the homeowner or sale of the home.

Real Property Tax Exemption: New York State allows up to 50% exemption in local real property taxes for older homeowners, with each locality allowed to set its own maximum income eligibility standard.

Home Energy Assistance Program (HEAP): A federally funded program to provide financial assistance to low income persons 60 years of age or older to help pay heating bills.

Weatherization Referral and Packaging Program (WRAP): This program uses special energy case management to provide safe, affordable, energy efficient housing to low income, vulnerable elderly.

Other: Specify.

XIII. CARE PLAN

The Care Plan section aggregates the key information from the rest of this assessment instrument. Through the assessment process, the assessor has identified (1) the person's situation: home environment; health; nutritional status; mental health; functional ability; (2) the person's needs including needs for referrals; and (3) implications for the involvement of formal and informal caregivers to be defined and described in the Care Plan. The Care Plan section of the assessment should be used to bring all the assessment information together and to develop and implement a coordinated plan of care.

While the Care Plan is developed to reflect the person's current situation, the individual developing the Care Plan needs to be sensitive to person's evolving situation. This means that**,** where indicated, the person developing the Care Plan should note areas to be watchful for because of an unstable or a potentially changing situation (e.g., potential change in caregiver situation, or change in service requirements due to level of need).

The Care Plan should be developed when the assessor completes the assessment. A delay increases the likelihood of changes in the person's condition, resulting in the need to conduct a reassessment. ***If the care plan includes EISEP-funded services or CSE-funded EISEP-like services, it is necessary to complete a Financial Information and Client Agreement or equivalent form.***

Assessors should not be limited to brokering or authorizing existing services. The assessor should strive to challenge the paid formal service system to be more flexible and to accommodate consumer values and preferences, to expand the range of service options available, and to cover new and/or traditional services.

To implement the Care Plan, the assessor should build on the strengths of the person, be familiar with current community resources, be able to maximize informal supports, be knowledgeable about financing of services, and understand cost arrangements to obtain services.

COMPLETE ALL ITEMS

Date: Enter the date the Care Plan was completed using two digits each for month, day and four for the year. For example, March 12, 2013 would be entered as 03/12/2013.

Prepared by: Self-explanatory.

Person's Name: Self-explanatory.

Person's Phone: Self-explanatory.

Address: Specify the address, where services will be provided.

A. Is the person self-directing/able to direct care?

Check yes or no. Determine the person's capacity to make choices about his/her care and ability to understand the impact of those choices. In addition, determine if the person understands the tasks required for his or her care and whether he/she can supervise the staff who will perform the tasks. If the person is not able to direct home care staff, specify who will provide direction.

B. Problems to be Addressed, Goals, Care Plan Objectives, Proposed Time Frame:

Problem(s) to be Addressed: List the problems identified during the assessment that will be addressed in the care plan through the authorization/arrangement of service(s).

Goal(s): The assessor, in consultation with the person and, with the consent of the person, his/her informal caregivers, should prepare goal statements for each problem/need identified through the assessment process that will be addressed. Specify goals only for problems for which some type of service or care is indicated. Do not list activities that the person can do alone or for which the person has compensated and requires no additional intervention. (***See example, below.***)

Goal statements should be concise and specific. Whenever possible, they should be stated in functional terms that are observable or measurable so that the person, informal caregiver(s) and assessor can tell whether the person has reached goals and related objectives.

For each goal, it will become possible to identify desired outcomes that the person, informal caregiver, and assessor expect will result from the service intervention. At the point when a service or the care plan is being terminated, it will be possible to compare the stated goal(s) to client outcomes to determine if the goal(s) have been reached.

Care Plan Objectives: The objective(s) are steps toward reaching a stated goal. Objectives should be concise and specific. (***See example, below***.)

Proposed Time Frame: For all goal statements, a reasonable time frame/limit for achievement of the goal should be specified. This applies to persons where the goal relates to maintenance of function, intervention to help with person's declining ability, as well as goals for improvement. (***See example, below***.)

An example of client problems, goals, objectives and proposed time frames follows. In this example, the client is expected to improve with the service intervention in terms of ability to manage at home, and maintain this status over time:

Example: Problems: Person has difficulty preparing food, and with bathing and dressing due to arthritis limiting use of hands.

Goals: Nutrition - Stable nutritional status. Bathing - Self-manage bathing with caregiver assistance. Dressing - Independent dressing with fastening assistance from caregiver.	
1. Objectives: (1) Train person in content of modified diet so can select appropriate groceries and plan menus. (2) Supply utensils so person can prepare nutritious meals at home. (3) Supplement with home delivered meals.	Proposed time frame: (1) 12 weeks (2) 4 weeks (3) on-going
2. Objective: Bathing: Have home care worker sponge bathe client and teach client and caregiver how to do properly.	Proposed time frame: 3 weeks
3. Objectives: Dressing: (1) Develop skills of client and informal caregiver to help the client with dressing. (2) Discuss with person availability of clothing that she can manage.	Proposed time frame: (1) 12 weeks (2) 2 Weeks

PLEASE NOTE THE FOLLOWING:

- Problems to be addressed can include inability to perform IADL or ADL tasks, psycho-behavioral condition of the person, or the person's treatment of caregivers; anything, that is, that affects the development and implementation of a plan of care for the person.

- State problems in functional terms, e.g., "cannot do . . .," "has difficulty with

- Provide the reason for each problem. These statements are important because they can imply root cause or different service requirements. For example, "cannot cook" might be due to blindness, or because the person lacks a stove or does not know how to cook.

- Group together all problems that are similar or have the same root cause or reason, and might be met by the same service. ***For example, the person cannot do household chores and shopping because he or she is blind; person cannot do bathing, dressing, toileting due to limited mobility caused by a broken hip. Be specific and brief.***

  Goal statements are different from the list of services to be provided.

C. What are the person's preferences regarding the provision of services?

Unless there are very unusual circumstances, the person and, with the person's consent, his/her informal caregiver(s) should always be present and involved in the development of the Care Plan. To the extent possible within the context of payer requirements, the Care Plan should reflect the choices, values and preferences of the person and his/her informal caregiver(s). This would include timing and frequency of services delivered, how services are to be delivered, how instructions to the care provider will be handled, and preferences concerning cultural beliefs and language.

D. Types of Services to be provided: The Care Plan should list the specific types of help the person needs to reach specified goals. Enter any service to be provided, whether it is a paid formal service or services provided by informal caregivers. Enter services by service name (i.e., case management, housekeeping/chore, homemaking/personal care, home delivered meals, social adult day care, etc.). When both a paid formal provider and an informal caregiver will provide the same type of service (e.g., personal care), list that service twice. You should specify tasks the informal and/or formal provider(s) are to do, for all services the person will be receiving, regardless of payer. The types of formal providers vary somewhat according to the county in which the person lives, but can include the Medicaid Personal Care Program, Public Health Nursing, Social Adult Day Care Program, Home Delivered Meals, Counseling Services, Friendly Visitor Program, Telephone Reassurance, and/or other formal services available in the county.

How Much: How many days per week and how many hours per day/week.

When: The specific days of the week when services are to be provided i.e. Monday AM, Wednesday PM at 1:00, etc.

Frequency: Enter the appropriate frequency for the delivery of the service (i.e. daily, every week, every other week, once a month, etc.). Specify "one time only" if the service is provided once (for example, an EISEP ancillary service, or weatherization).

Start Date for the service. Enter as ten digits, e.g., 05-09-1997. For ancillary services, enter purchase date or project starting date, as appropriate. This date may be left blank if the person is placed on a waiting list for a service.

Projected End Date (if known). Enter as ten digits, e.g., 08-09-1997. This date may be left blank if no projection of service duration can be made at the time of completion of the Care Plan.

Formal/Informal: Specify if the care will be provided by a formal service provider or through an informal caregiver such as family, friends, neighbors, and/or community/neighborhood group.

Name of the Provider who will be providing services.

E. **Problems to be Referred** to other programs: List other problems indicated in the assessment that are to be addressed by other agencies or programs. Services to which the person is to be referred must be considered in the development and implementation of the Care Plan. ***Please see the Appendix for INDICATORS FOR REFERRALS***.

Specify all services for which the person will be referred to address these assessed needs. Referrals may also be made to supplement services listed in D. above.

Referred to: Specify the name of the provider (i.e. Public Health Agency, Adult Protective Services, etc.) who will be providing services.

F. **Information/Special Instructions That Have Direct Bearing on Implementation of This Care Plan:** Include any additional information/instructions that have direct bearing on implementation of the Care Plan. For example -- person has large dog that is not friendly to others.

G. **Has the person been placed on a waiting list for any service need?** Check yes or no. If yes, indicate the name of the service, provider name, and the date the person was placed on the waiting list. As much as

possible, the Care Plan should be carried out according to the timetable set forth in the Care Plan. If too long a delay occurs, a reassessment of the person may be necessary.

H. **Plan has been discussed and accepted by client and/or informal supports:** Check yes or no to indicate whether the person and/or informal supports accept the Care Plan. We expect that in most instances the person would be involved in these discussions and decisions, and the informal supports would be involved as appropriate and necessary. If not, explain why not.

Please Note The Following: The person and his or her informal caregivers have the right to comment on the Care Plan. This includes commenting on the adequacy of the Care Plan; refusing services on any part of the Care Plan without fear of loss of other services, except if the person's safety becomes at-risk or if parts of the care plan are essential to meet program requirements. For example, case management is required to receive other EISEP-funded services.

If the Care Plan includes EISEP or CSE EISEP-like services, the assessor must complete the EISEP Cost Share Determination and Client Agreement or equivalent form. The person and his or her informal caregiver(s), as appropriate must be informed about cost-sharing responsibilities, if any.

The assessor must inform the person's informal caregiver(s) and service providers that will be involved in the person's care of relevant information from the assessment and Care Plan. At a minimum, this includes goals of care delivery, information about types of services to meet the person's needs and time frame. For some services, greater detail will be required.

Care providers, both formal and informal, should know which care providers will be participating in the person's care and the extent and timing of their help. The assessor should discuss and delineate the roles and responsibilities of the consumer in ensuring the success of the Care Plan.

The assessor should carefully discuss all reasonable care and residential housing options with the person and her/his informal caregiver(s). The assessor should discuss advantages and disadvantages of each including the risks associated with care and the costs and funding sources available. The assessor should leave the final decision to the person and, if appropriate, her/his informal caregiver(s).

I. **Plan Approved By:** If someone other than the assessor approves the Care Plan, enter name, signature and title of the person who approved the Care Plan. Enter the date the Care Plan was approved using two digits each for month and day and four for the year. For example, March 12, 2013 would be entered as 03/12/2013.

APPENDIX

A. INDICATORS FOR REFERRAL

PLEASE NOTE THE FOLLOWING: Indicators for Health Assessment and/or Mental Health Assessment Referral are gathered from Section III, Health Status and Section V, Psycho-Social Status.

BACKGROUND:

A person in need of non-medical support services may have an undiagnosed and/or untreated condition that requires attention. Or, a previously known condition may have worsened so that assessment and treatment may become necessary. The indicators for health or mental health referral discussed here identify certain observations that may suggest the need for a health or mental health professional's examination.

The indicators should be considered during any contact with the person: assessment, reassessment, home visits to assure quality of care, or in any other part of the ongoing case management process. Further, they can be used to inform any other individuals coming in contact with the person, including informal supports or formal caregivers.

PROCESS FOR IDENTIFYING INDICATORS:

1. **Observation:** Certain conditions may be identified by the case manager through observation. Use the following indicators list as a guide for things to look for. Looking closely at the person can disclose abnormalities; in general, what would look abnormal on the case manager is also abnormal when seen on an older person (e.g., swelling of an extremity or puffiness around the eyes).

2. **Ask about conditions and changes in conditions:** The case manager can ask in a general way for the person to identify any conditions or changes in conditions that the person thinks might be important for the case manager to know about. If observation shows a condition not mentioned by the person, further probing is appropriate. It is also appropriate to seek further information from other knowledgeable individuals.

3. **Discover if a physician or other health professional has diagnosed a condition.** Whether observed by the case manager or identified by the person in response to questions, ask if the condition has been diagnosed by a physician or other health professional. If the person states a condition in terms of a diagnosis or disease (i.e., "I have high blood pressure" or "I have congestive heart failure"), find out if the statement reflects a physician diagnosis.

   If the person states that the condition has been diagnosed, the assessor may, if necessary to verify the diagnosis, seek confirmation from other knowledgeable persons: family members, informal supports, etc. Confirmation can help identify circumstances in which the diagnosis has not been made by a health professional, or provide more detail on duration and incidence than remembered by the person.

On a first assessment, the only source of information about changes in condition will come from the person, informal supports, family, etc.

4. **Ask about treatments ordered:** If the condition has been diagnosed by a physician or other health professional, ask if treatment has been ordered and determine if the treatment is being followed.

REFERRAL IS NEEDED IF:

- The condition has not been diagnosed;
- The condition has changed;
- Treatment has not been ordered; or
- The treatment is not being followed.

REFERRAL ORDER:

1. Usually, referral should be to the person's primary medical provider: personal physician or usual medical provider (clinic, HMO, etc.) if any.

2. Follow the instructions of the primary provider if referral to another health professional is indicated (e.g., a physical therapist if ordered by a physician).

3. When the person has no regular medical provider, referral will be to a local public health nursing service.

   Exception: In the case of a psycho-behavioral indicator, referral may be directly to a mental health professional.

   Follow-up: After referral, determine the results of the professional assessment and the effect on the care plan.

INDICATORS:

General: With some persons, there may be a tendency to minimize the importance of a condition, especially if long lasting. The important criteria are whether diagnosis and treatment have occurred, and if change has occurred from chronic to acute distress. Acute distress usually is suggested as the condition becomes the total object of the person's attention. Another useful guide is the swiftness of onset of a condition or change. A condition that has developed over the course of a few hours to a day is more likely to be serious.

The following lists contain indicators of need for referral if the condition exists and is not under treatment, or if change has occurred. The first three are noted as indicators of need for emergency treatment to prevent serious illness, injury or death. Other items may indicate need for emergency treatment, especially if change has been abrupt or distress is acute.

THE FOLLOWING ARE INDICATORS OF PHYSICAL CONDITIONS NEEDING REFERRAL:

- Person appears to be sleeping comfortably but cannot be wakened: emergency;
- Frequent falls: if a fall is associated with severe pain or bruising, or obvious broken limb: emergency;
- Chest pain, chest pressure, pain radiating from chest down arms, or severe indigestion or vomiting: emergency;
- Swelling of a body part; report which part(s) is swollen;
- Poor skin color, especially on face or in limbs;
- Difficulty breathing, or easily winded whether with exertion or just in conversation;
- Strong odors of urine or feces;
- Frequent inebriation;
- Open sores, whether they appear infected or not, and especially if not healing promptly;
- Very dry, flaking skin;
- Frequent going to the bathroom, whether voiding urine or feces, not related to an acute condition;
- Frequent or unusual nausea, vomiting or dizziness;
- Frequent headaches;
- Several bruises, particularly if on extremities;
- Bleeding, from wound on body or into urine or feces.

THE FOLLOWING ARE INDICATORS OF PSYCHO-BEHAVIORAL CONDITIONS NEEDING MENTAL HEALTH REFERRAL:

- Memory loss;
- Hallucinations.

THE FOLLOWING TWO LISTS ARE INDICATORS OF NEED FOR REFERRAL WHEN THERE ARE <u>SIGNIFICANT CHANGES</u> IN PHYSICAL OR PSYCHO-BEHAVIORAL CONDITION:

CHANGE IN PHYSICAL CONDITIONS NEEDING REFERRAL:

- Large **INVOLUNTARY** change in weight (more than 10 pounds in six months);
- Change in capacity to perform IADLs or ADLs if such change is not directly related to an obvious cause. For example, change in capacity due to an acute respiratory infection or after surgery would not count here;
- Loss of appetite, or other major change in appetite or dietary intake;
- Change in sleep pattern, whether to much more or much less than previous normal;
- Increase in thirst;
- Change in ability to communicate verbally (oral or writing);
- Change in strength or stamina;

- Change in awareness of or interest in surroundings;
- Change in sensory ability.

CHANGE IN PSYCHO-BEHAVIORAL CONDITIONS NEEDING REFERRAL:

- Change in social interactions, reducing previously maintained contacts;
- Change in personal behavior, as in mode of dressing, aggressiveness, or ability to make judgments not related to change in physical capacity.

OTHER CONSIDERATIONS:

Follow up: While the COMPASS does not record this, the assessor or other case manager will follow up on the referral(s). The assessor or case manager will have to decide whether the assessment for non-medical services must wait for a report from the referral before a care plan can be made and put into operation. In such cases, inform the person of the need for a report of the referral.

Refusal to accept referral: A person retains the right to refuse medical treatment, including assessment. If you decide that such choice may not reflect informed decision-making or subjects the person to imminent risk of serious harm, you should employ the usual procedures to refer the case to Protective Services for Adults of the local Department of Social Services.

If referral is refused, you may have to conclude that the information to be gained from the referral is necessary to decide that the person can be maintained safely at home. If you believe that the person can not be served safely at home you must make an appropriate referral, e.g., police department, fire department, Protective Services for Adults.

B. Assistance With Questions Regarding Sexual Orientation and Transgender Status - Provided by Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders, (SAGE)

Transgender - If the client is confused or put off by this, you can say something like this: I understand that this issue might be very clear for you, but some people have an experience of their gender that is unique to them, and that other people might not be able to see. I want to give all my clients the respect and freedom of defining themselves.

If a person seems confused by the wording of the question but is struggling because they may indeed identify as transgender but not with that term, you could clarify by saying: If a client needs help with this idea: For some people, their body is a male body but inside they feel like a woman. Or they have a female body, but inside, they feel like a man. Have you ever had feelings like that?

If the client says they are transgender, say:
I'm glad you told me that.
What would you like me to call you?
What pronoun would you like me to use?

If the client identifies their gender or sexuality by using a word you're not familiar with; say OK, that's a new word for me. But I want to support you and I want to understand you, so, what does that mean to you? Is that a word that would be appropriate for me to use too, or is that a word that only someone who sees themselves as [genderqueer] would use?

Sexual Orientation – These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.

Emphasize that a client's sexual orientation or gender identity will not be discussed with his/her family or friends without the client's specific permission.

If a client does not understand what some of the terms may mean, consider the following definitions:

Heterosexual or straight: Used to describe people whose primary physical, romantic, and/or emotional attraction is to people of the opposite sex.

Lesbian: A woman whose primary physical, romantic, and or/emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

Gay: A word used to describe anyone, mainly men, who have primary physical, romantic, and/or emotional attraction to someone of the same sex, e.g., gay man, gay people. Many gay people prefer this term over "homosexual" which retains negative connotations.

Bisexual: An individual who is physically, romantically, and/or emotionally attracted to both men and women. "Bisexual" does not suggest having equal sexual experience with both men and women.

Not sure: If a client says "not sure," attempt to clarify if the person is unsure of their own sexual orientation (perhaps because they are questioning it themselves) or if they are unclear of what the question means. If the latter, attempt to clarify the question and answers. If the former, consider making a note in the client's chart so as to consider this when developing the care plan.

Did not answer: If a client does not answer because they feel the question is intrusive, attempt to remind the person of the level of confidentiality they can expect, as well as why all of the questions are being asked. If the person still does not want to answer, do not force them to give you this information and check this box instead.

Other: There may be other categories that a person considers, such as "asexual." If the category the person suggests is not one of the options, "other" is the appropriate box to check.

SERVICE/CARE PLAN TERMINATION

This section is completed only when service(s) that the client is currently receiving is/are being discontinued or the Care Plan is being terminated. Its purpose is to document when and why Service(s) or the Care Plan is/are being discontinued and to identify the outcome(s) from the service(s) provided.

A. **What is being terminated?** Check service when service(s) will no longer be provided. ***Note that this does not apply to a change in the amount or frequency of a particular service.*** Specify which service(s) will be discontinued.

Check Care Plan if <u>all</u> services the client currently is receiving are being discontinued.

B. **Termination Date**: Enter the date that the service(s) or Care Plan is/are being terminated using two digits for the month and day and four for the year. For example, June 19, 1998 would be entered as 06/10/1998.

C. **Reason for Termination**: Check the reason which best describes why the service(s) or care plan is/are being discontinued.

1. **Goal Met:** The Goal(s) listed in the Care Plan has/have been met and therefore service(s) is/are no longer needed. Specify which goal(s) has/have been met as indicated in the Care Plan.

2. **Independence:** The client has regained enough capacity so that he/she no longer requires the service(s).

3. **Client Request:** The client asks that the service(s) be discontinued.

4. **Client Relocated:** Self explanatory.

5. **Hospitalization**: Self explanatory.

6. **Nursing Home or Assisted Living Facility Placement:** Self explanatory

7. **Death**: Self explanatory

8. **Other**: If service(s) is/are being discontinued for another reason, check and specify the reason. For example, when a service is being replaced by another, such as Home Delivered Meals being replaced by a home care worker who will prepare a meal.

D. **Service or Care Plan Related Client Outcome Statements**:
Client outcome statements should be concise and specific showing whether the person has reached goals and related objectives for each problem addressed by the particular service or care plan as appropriate, in the targeted time

frame**(**s**)**. For example, if problem was "difficulty with preparing food" (due to arthritis limiting use of hands), and a desired goal was "Stable Nutrition Status," state whether the service(s) helped the person reach this goal, and if not, explain why not, if appropriate.

E. **Plan Terminated By**: ***Complete this only when the care plan is being terminated*****.** The person terminating the care plan must sign on the appropriate line. Enter the title of the person and his/her phone number. Enter the date using two digits for the month and day and four for the year. For example, July 20, 2013 would be entered as 07/20/2013.