This document shows a picture of where in PHL to enter each part of the old (REDCap) Assessment.

SASH Assessment

Date Assessment Completed

Name of SASH staff completing assessment

Participant's First Name

Participant's Middle Initial

Participant's Last Name

Has signed Use and Disclosure: Yes No

Date of most recently signed Use and Disclosure

Participant's Date of Birth

Social Security Number

Participant Gender: Male, Female, Transgender,

Self-Identified Gender Participant's Race:

White

African American or Black

Asian

Hispanic or Latino (White Race only)

Address Line 1_____

Address Line 2 _____

City _____

State _____

Zip Code _____

Is the participant living in the community at large?

Yes No

Phone

Cell Phone

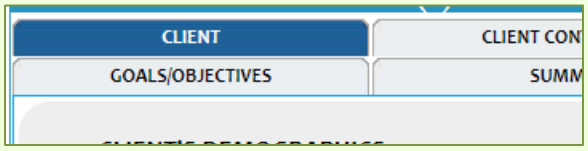
Email

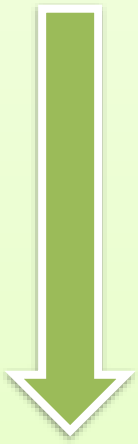
Primary Support Contact Information

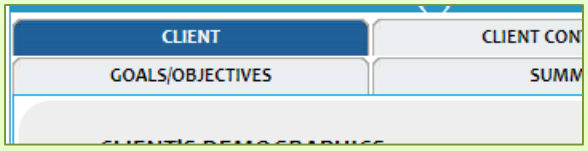
Secondary Support Contact Information

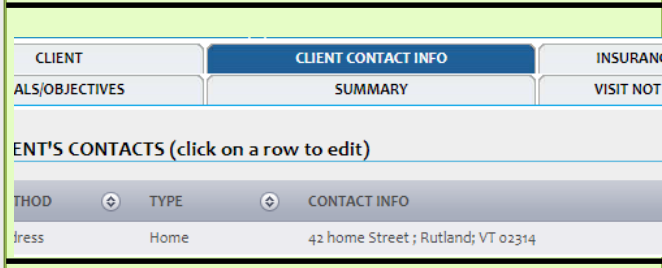
PHL Location

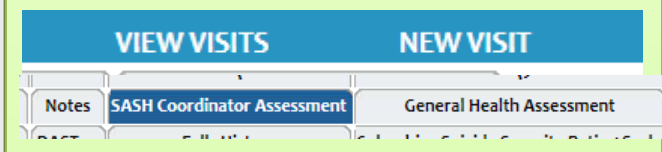
Will AutoFill

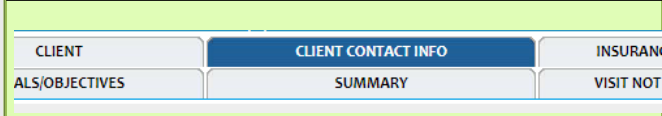


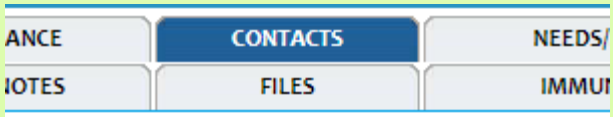












Insurer: (circle all that apply)

AETNA

APEX

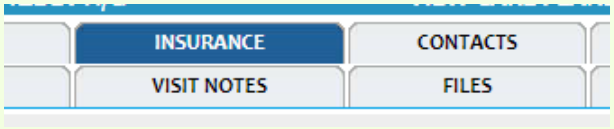
BCBS

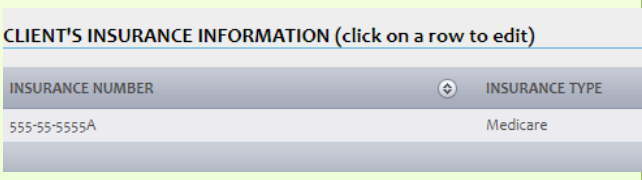
CHAMPUS

Cigna

Fidelis

Medicaid





Insurance ID number

Does participant have documented Advanced Directives?

Yes No

Advance Directive Agent's contact information

Where is Advanced Directive stored?

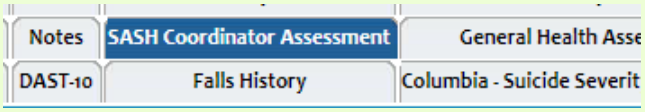
Family Member

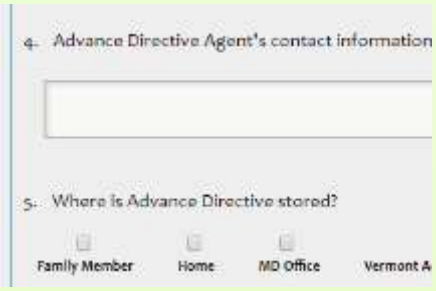
Home

MD Office

Vermont Advanced Directives Registry

Other





Does participant have a legal guardian?

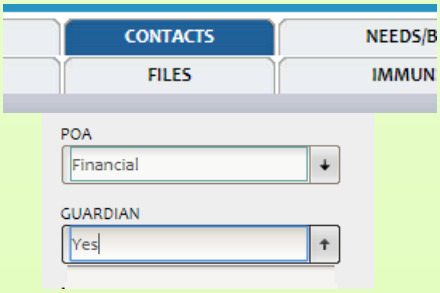
Yes No

Legal guardian's contact information

Does participant have a Power of Attorney for finances?

Yes No

Power of Attorney for finances contact information



In the past year, has the participant received any of the following services (select all that apply.)

Area Agency on Aging (AAA)

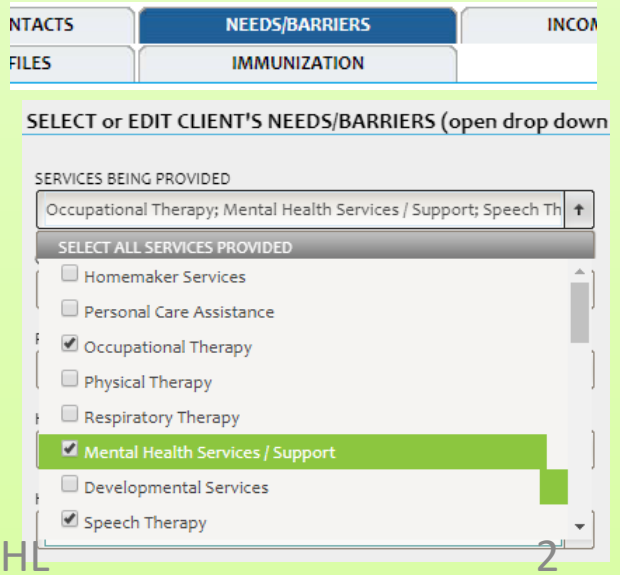
Home Health/Visiting Nurse Association (VNA)

Case Management

Homemaker (assistance w/ cleaning/household duties)

Personal Care (assistance with bathing/dressing)

Physical Therapy



SASH Assessment

Does participant need a referral for additional services? Yes

Reason for referral?

Asthma
Case Mgt.
Dental Health
Diabetes
Employment Assist.
Family Wellness
Financial Assist.
Food Assist.
Health Edu.
Health Maintenance
Healthier Living Workshop
Home Care Service
Housing Assist.
HTN Mgmt.
Insurance Assist.
Med. Assist.
Mental Health
Nutrition Clinician

Specify "other" reason for referral

Agency referred to:

Area Agency on Aging
Community Heath Team
Community Mental Health Agency
Home Health Agency
Transportation Agency
Vermont Quit Network
Other

Specify "other" agency referred to_____

Do you have a transition of care to document? Yes No

Date of transition

Type of transition occurred

Home to ED
Home to Inpatient/Hospital
Hospital to Rehab
Home to Long Term Care

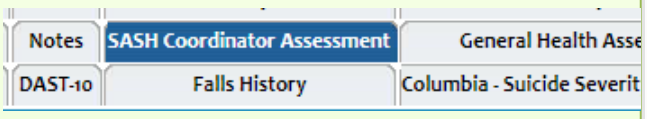
Specify "other" type of transition

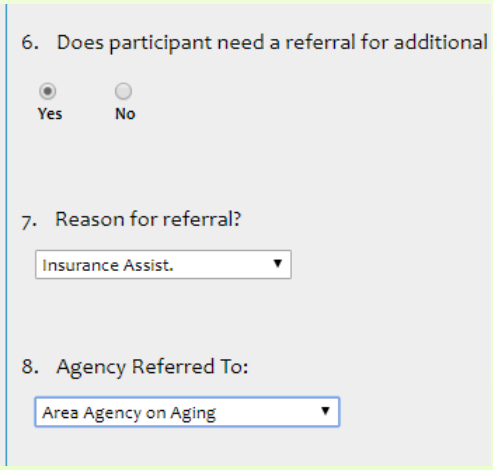
Type of care coordination for transition

Med Reconciliation
Coordination of Home Health Services
Coordination of Mental Health Services
Coordination of Substance Abuse Services

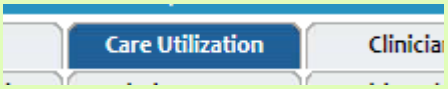
Specify "other" type of care coordination for transition

PHL Location

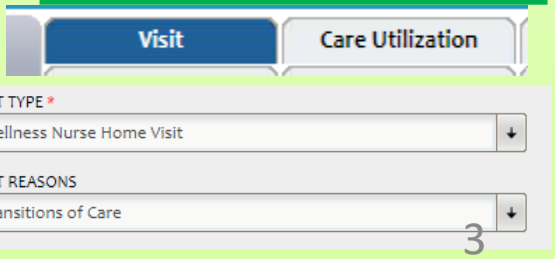




These will auto populate from PatientPing soon. You can enter manually at location below.



You can log a “visit” for Transition of Care and note what was done (vitals, med rec, etc) in visit tab.

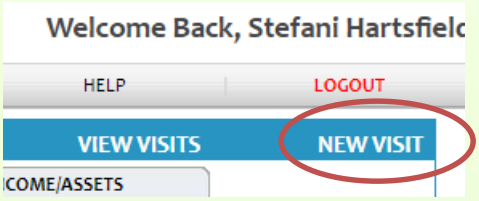


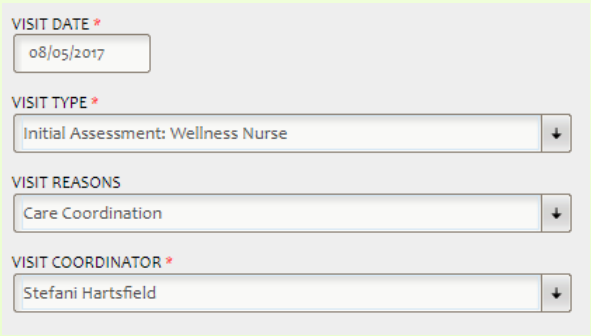
General Health Assessment

Date assessment completed

Name of SASH staff completing assessment

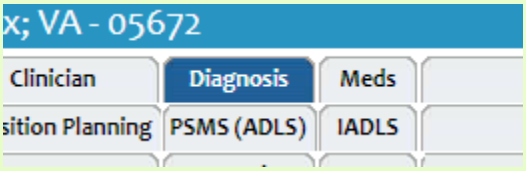
Majority of assessment information is in "Visit" section.

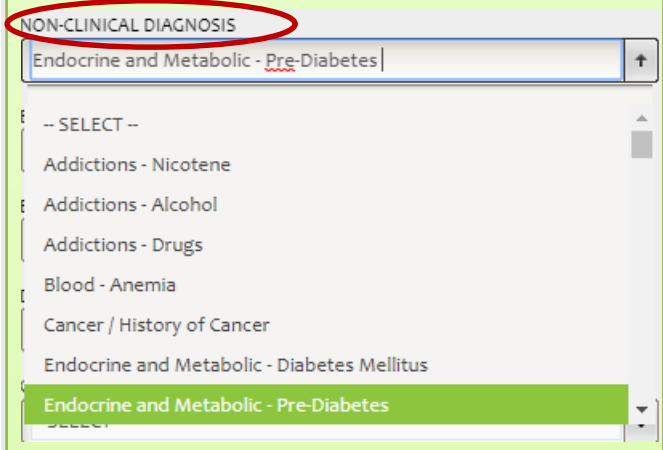




Do you have Chronic Conditions to report?

Addictions - Nicotine Addictions - Alcohol Abuse Addictions - Drugs
Blood- Anemia
Cancer/ History of Cancer Chronic Pain
Endocrine - Diabetes Endocrine - Pre-Diabetes Endocrine - Thyroid Disease
Gastrointestinal - GERD/Acid Reflux Gastrointestinal Diverticulitis Gastrointestinal - Liver Disease
Gastrointestinal Ulcerative Colitis/Crohn's Disease





Medical History:

Please put in Notes for now. Working on a better location.

How does the participant rate their health?

Excellent

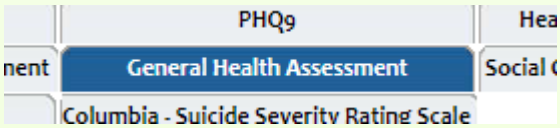
Very Good

Good

Fair

Poor

Not Done



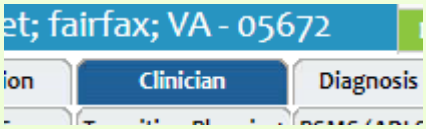
Does participant have a primary care provider? Yes No

County of Primary Care Provider

Primary Care Site

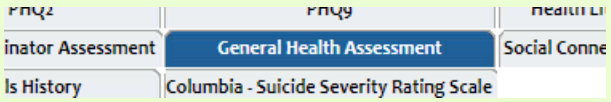
Provider Name

Provider Contact Information



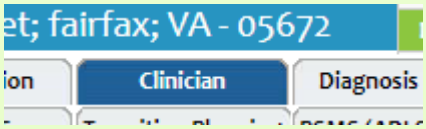
Does the participant routinely have annual exams?

Yes No



Does participant routinely receive care from any specialty prov

Specialty provider contact information



Immunizations

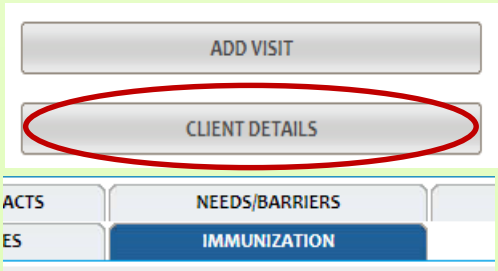
Pneumococcal Polysaccharide Vaccine	Yes	No
Influenza Vaccine	Yes	No
Shingles Vaccine	Yes	No

Need to go back to "client details" section for Immunizations. Will get fixed in next phase.

Date of Pneumococcal Polysaccharide Vaccine

Date of Influenza vaccine (injectable)

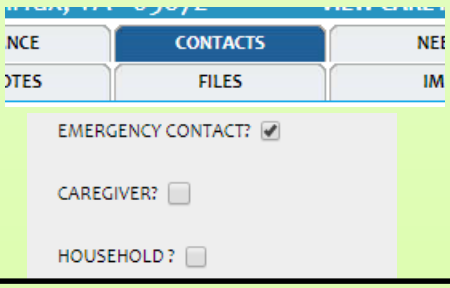
Date of shingles vaccine



Does participant have a caregiver? Yes No

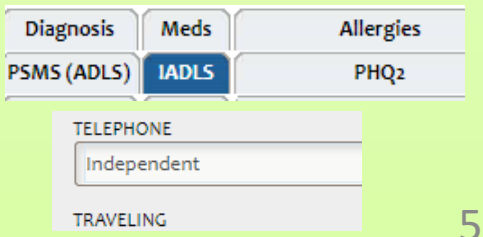
Does caregiver live with participant? Yes No

Caregiver name and phone number



In the past 7 days, did you need help from others to take care of things such as

laundry	Yes	No
housekeeping	Yes	No



In the past 7 days, did you need help from others to perform everyday activities such as:

Eating	Yes	No
Getting dressed	Yes	No
Grooming	Yes	No

Does the participant use an assistive device for ambulation? Y

Select assistive devices used:

- cane
- walker
- crutches
- wheelchair
- motorized scooter

Does the participant need any of the following devices

- Ramp
- doorways widened
- assistive eating devices
- assistive dressing devices

Does participant need assistance in obtaining any of the follow

- eyeglasses
- hearing aids
- dentures
- other

Does the participant have a Personal Emergency Response Sys

(PERS) such as Lifeline or Link to Life? Yes No

Does the participant need assistance managing medications?

Where does participant store medications?

How does participant dispose of unused or expired medicatio

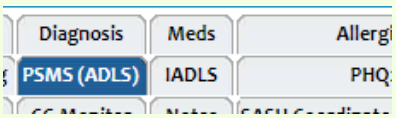
General medication comments?

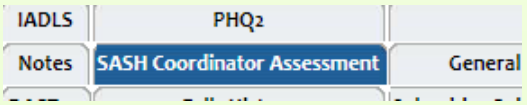
Participant's Primary Pharmacy

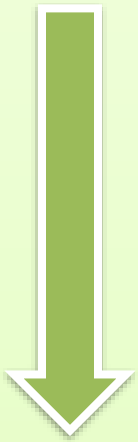
Cognitive Health Screen:

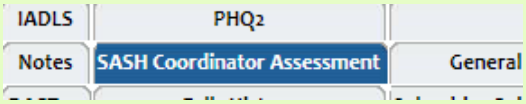
Clock Drawing total score

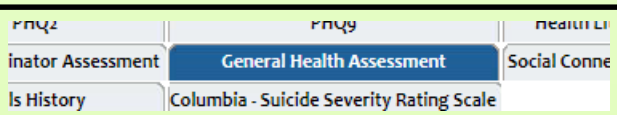
- pass (greater than 4)
- borderline (equal to 4)
- fail (less than 4)

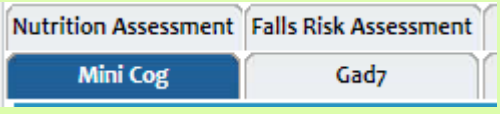












Three Word Recall total score

Pass (greater than 2)

Borderline (equal to 2)

Fail (less than 2)

Category Fluency Total Score

Pass (greater than 15)

Borderline (equal to 15)

Fail (less than 15)

Total Cognitive Ability Score: Pass Fail

2 passes= pass

2 fails= fail

1 pass, 1 fail, and 1 borderline= fail

Participant is unable to perform the Cognitive Screen:

Yes No

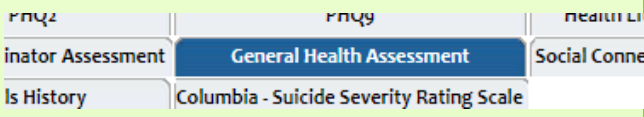
Additional information about cognitive assessment

Has the participant suffered a personal loss or misfortune in the last year?

No

Yes, one serious loss

Yes, two or more serious losses



PHQ-2 - In the last 2 weeks, how often have you been bothered by... (if total is 3 or greater complete PHQ-9 su

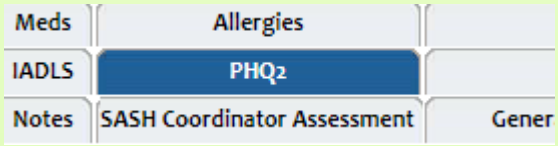
a. little interest or pleasure
b. in doing things

1. not at all
2. several days
3. more than half the days
4. nearly every day

b. feeling down, depressed, or hopeless

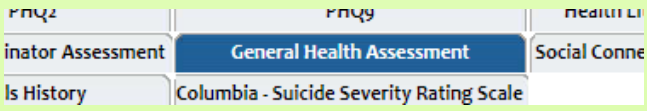
1. not at all
2. several days
3. more than half the days
4. nearly every day

PHQ-2 Total



Have you wished you were dead or wished you could go to sleep and not wake up?

Yes No



GAD-2, Anxiety Screen: Over the past two weeks how often ha

been bothered by..(if total is 3 or greater complete GAD-7 su

1. feeling nervous, anxious, or on edge
   - 0 not at all
   - 1 several days
   - 2 over half the days
   - 3 nearly every day

2. not being able to stop or control worrying
   - 0 not at all
   - 1 several days
   - 2 over half the days
   - 3 nearly every day

GAD-2 Total _____

How many times in the past year have you had 4 or more drinks in a day?

- 1 time
- 2 times
- 3 or more times

How many times in the past year have you used an

illegal drug or used a prescription medication for non-medical

- 0 times
- 1 time
- 2 times
- 3 or more times

Within the past 12 months, we worried whether our food

would run out before we got money to buy more.

Yes No

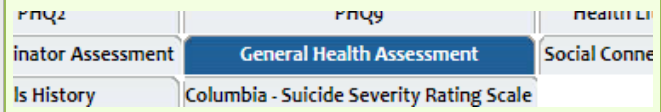
Within the past 12 months, the food we bought just didn't

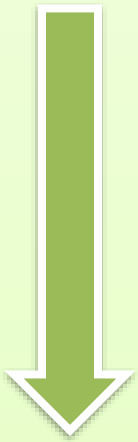
last and we didn't have money to buy more.

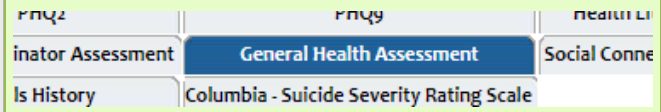
Yes No

What is your current relationship with tobacco use?

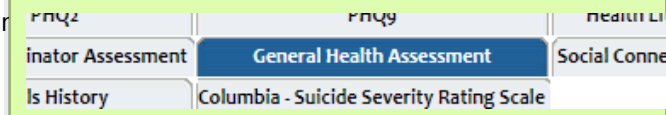
- Never
- former
- current tobacco user
- current exposure to secondhand sr
- no for medical reasons
- not performed







Food Insecurity Questions are no longer being asked in SASH Assessment. Optional: Put answers in a note. Food insecurity covered in Nutrition assessment.



Vitals

Date Assessment Completed

Name of SASH staff completing the assessment

Height (inch)

Weight (lb)

BP SBP

BP DBP

Temperature

Pulse Rate

Home Blood Glucose

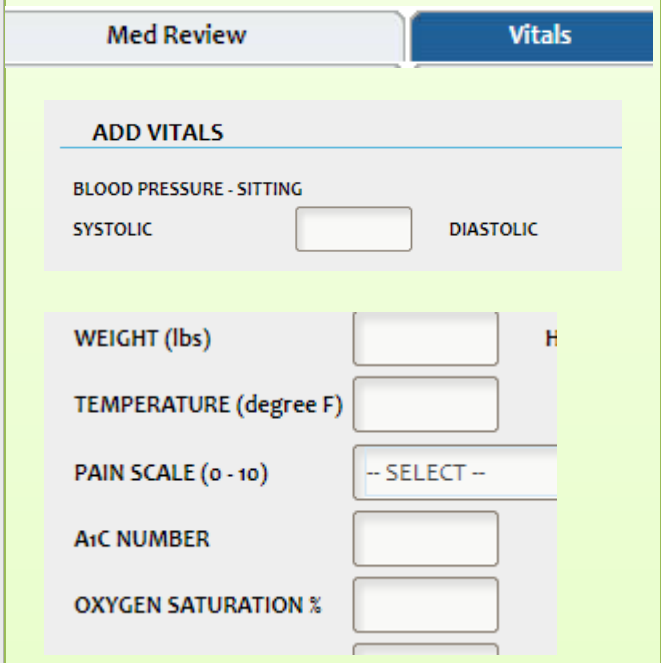
Oxygen Saturation %

Pain Scale (please add comments to encounter notes)

0 1 2 3 4 5 6 7 8 9 10

Edema Absent (please add comments to encounter notes)

+1 +2 +3 +4



Falls assessment

Has participant fallen in the past year? Yes No

Approximate date of most recent fall?

Cause of most recent fall?

Disposition of most recent fall?

ED visit

Hospital Stay

Other

NA

Does participant feel unsteady when standing or walking? Ye

Does the participant worry about falling? Yes No

MACH-10 Assessment

Participant is 65+ Y

Participant has 3+ co-existing conditions Y

Participant has a history of falls Y

Participant suffers from incontinence

Participant has visual impairment Y

Participant has impaired functional mobility Y

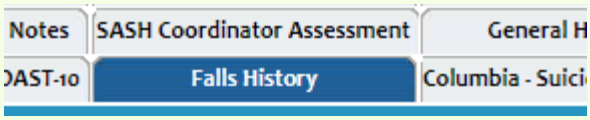
Participant has environmental hazards Participant has Poly Y

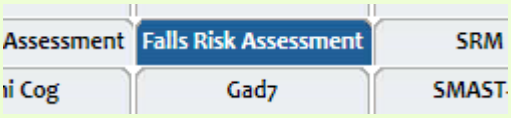
Pharmacy (4 or more prescriptions) Y

Participant has pain affecting level of functioning Y

Participant has cognitive impairment Y

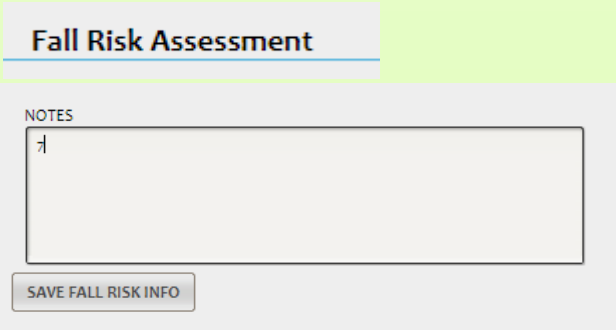
Fall Risk Total Score (4+ = at risk for falling)





We are switching from MAHC-10 to the STEADI. You do not need to enter each MAHC-10 question answer. They do not match.

Please put the
Fall Risk Total Score
In the Fall Risk Assessment Notes Box:



Lubben Social Network Scale

How many relatives do you see or hear from at least once a month?

1. None
2. One
3. Two
4. Three or four
5. Five through eight
6. Nine or more

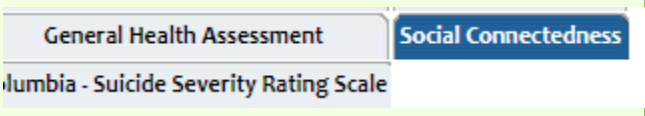
How many relatives do you feel at ease with that you can talk about private matters?

1. None
2. One
3. Two
4. Three or four
5. Five through eight
6. Nine or more

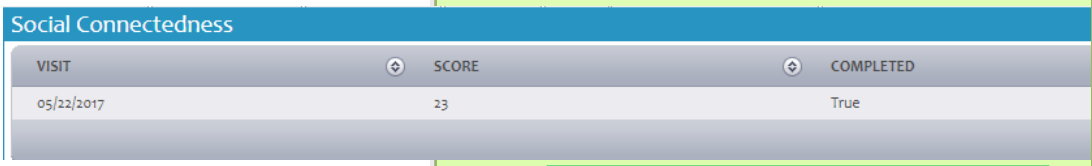
How many relatives do you feel close to such that you could call on them for help?

1. None
2. One
3. Two
4. Three or four
5. Five through eight
6. Nine or more

LSNS-6 Total Score_____
(Score of < 12 suggestive of social isolation)
(total points from above)



There are now 2 screens in here:
Lubben Social Network
And
UCLA Loneliness Scale



Lubben Total Score shown in table at top of page

Phq9

In the last 2 weeks, how often have you been bothered by... (a and b answered previously)

c. trouble staying or falling sleep, or sleeping too much

0- not at all

1several days

2more than half of the days 3-

nearly every day

d. feeling tired or little energy

1not at all

2 several days

3more than half of the days 3-

nearly every day

e. poor appetite or overeating

0- not at all

1several days

2more than half of the days 3-

nearly every day

f. feeling bad about yourself, feeling that you are a failure or feeling that you have let your family down

0- not at all

1several days

2more than half of the days 3-

nearly every day

If you checked any problem on this questionnaire, how difficu
you to do your work, take care of things at home, or get alon

not difficult at all

somewhat difficult

very difficult

extremely difficult

PHQ2 | PHQ9

dinator Assessment | General Health Assessment

CLIENT'S PHQ9 DETAILS (click on a row to edit)

VISIT	PHQ9
05/15/2017	21
08/03/2017	17

Total Score shown in table at top of page

These question answer choices do not match in PHL. Known issue to be fixed. Match as closely as possible.

Gad7

Anxiety Screen: Over the past two weeks how often have you been bothered by...

3. Worrying too much about different things

1Not At All

2 Several Days

3Over Half the Days

3- Nearly Every Day

4. Trouble relaxing

1Not At All

2 Several Days

3Over Half the Days

3- Nearly Every Day

5. Being so restless that it's hard to sit still

1Not At All

2 Several Days

3Over Half the Days

3- Nearly Every Day

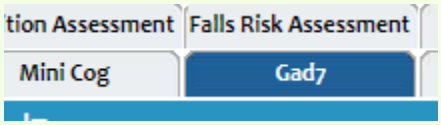
If you checked of any problems, how difficult have these made care of things at home, or get along with other people?

not difficult at all

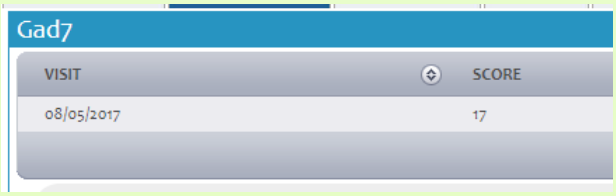
somewhat difficult

very difficult

Extremely difficult



All 7 GAD questions need to be answered in GAD7 survey. GAD2 answers do not carry over...yet.



Total Score shown in table at top of page

Nutrition Assessment

Do you eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day? (yes= 1 point)

Yes No

Do you have fewer than 2 servings of dairy products or tofu every day? (yes= 1 point)

Yes No

Do you have problems biting, chewing, or swallowing that make it difficult for you to eat?

Check all that apply

biting

chewing

swallowing

Are there times when you do not have enough money to buy the food you need? (yes= 4 points)

Yes No

Do you eat most meals alone? (yes= 1 point)

Yes No

Do you take 3 or more prescribed or OTC medications each day? (yes= 1 point)

Yes No

Have you lost or gained 10 pounds or more in the last 6 months without trying? (yes= 2 points)

Yes No

Are there times when you are not physically able to: (check all

shop for food

cook

eat on your own

Do you have 3 or more drinks of beer, wine or liquor almost every day? (yes= 2 points)

Yes No

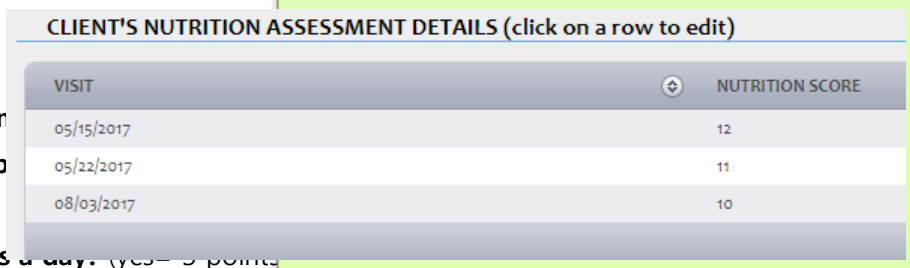
Have you made changes in lifelong eatin
because of health problems such as diab

Yes No

Do you eat fewer than 2 complete meals a day? (yes= 3 points)

Yes No

Nutritional Checklist Total Score _____



Total Score shown in table at top of page

S-MAST-G

When talking to others, do you ever understate how much you actually drink?

Yes No

When drinking, have you sometimes skipped a meal because you did not feel hungry?

Yes No

Does having a few drinks help reduce shakiness or tremors?

Yes No

Does alcohol sometimes make it hard for you to remember parts of a day or night?

Yes No

Do you usually take a drink to relax or calm your nerves?

Yes No

Do you drink to take your mind off problems like feeling alone or being in physical or emotional pain?

Yes No

Have you increased your drinking after experiencing a loss in your life?

Yes No

Has a doctor, nurse, or other health care provider ever said that they were concerned about your drinking?

Yes No

Have you tried to reduce your drinking from your own concern or to try to manage the amount of your drinking?

Yes No

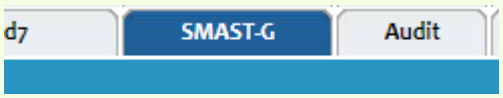
When you feel lonely, does having a drink help you feel bette

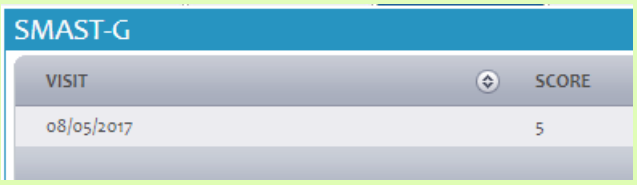
Yes No

S-MAST-G total Score _____

Do you drink alcohol and at the same time use mood or mind altering drugs,?

Yes No





Audit

1.How often do you have a drink containing alcohol?

1 never
2 monthly or less
3 2 to 4 times a month
4 2 to 3 times a week
5 4 or more times a week

2.How many drinks containing alcohol do you have on a typical day when you are drinking?

1 never
2 monthly or less
3 2 to 4 times a month
4 2 to 3 times a week
5 4 or more times a week

3.How often do you have 5 or more drinks on one occasion?

1 never
2 monthly or less
3 2 to 4 times a month
4 2 to 3 times a week
5 4 or more times a week

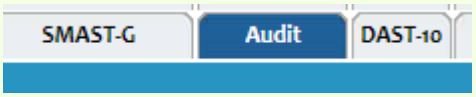
4.How often during the last year have you found that you were not able to stop drinking once you had started?

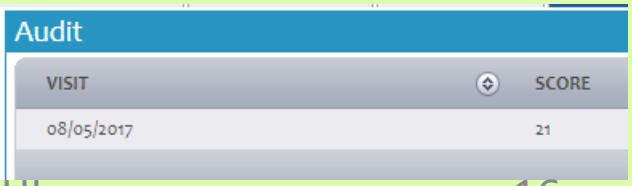
1 never
2 monthly or less
3 2 to 4 times a month
4 2 to 3 times a week
5 4 or more times a week

5.How often during the last year have you failed to do what was normally expected of you because of drinking?

1 never
2 monthly or less
3 2 to 4 times a month
4 2 to 3 times a week
5 4 or more times a week

AUDIT Total Score_____
(total points from above)





Healthy Living Plan

What are participant's self-reported health and Education wellness

- Employment
- Medication Medical
- Equipment Legal assistance
- Transportation
- Housing
- Provider Relationship
- Management of health conditions
- Improved Social support
- Food and Nutrition
- Financial stability
- Recreation
- Alcohol / drug use
- Mental Health
- Benefits and programs
- Volunteer
- Parenting

Specify "other" type of goal_____

What are participant's self-reported obstacles to Access to care meeting health and wellness goals?

- Eligibility
- Communication among providers
- Needed support resource is at capacity
- Physical health
- Mental Health
- Medical diagnosis is unclear
- Symptoms are not well managed
- Literacy
- Hearing deficit
- Visual deficit
- Lack of computer/internet access
- Caregiver support
- Financial
- Past or present abuse/trauma
- Addiction
- Transportation
- Interpersonal relationships

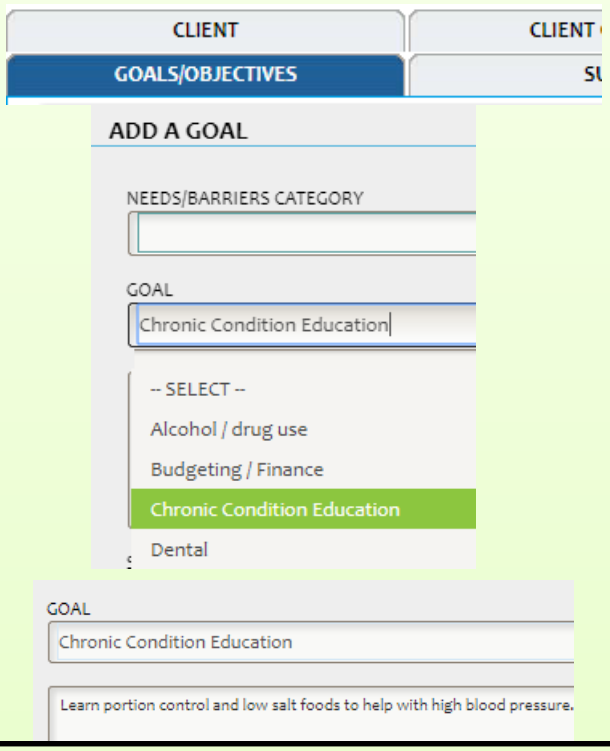
specify "other" obstacles_____

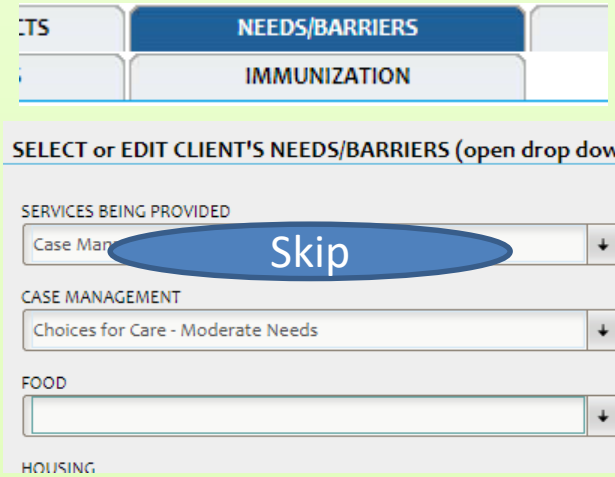
Participant's current stage of change

- Pre-contemplation
- contemplation
- preparation
- action
- maintenance

Self-Management Goal Assessment

- no effort
- some effort
- successful effort
- not assessed





Find category in dropdowns above with matching Need or Barrier to goal.

Stage of change not capture. Can used "notes"
Goal Assessment = Goal Status