Health Module

Key
Bold Blue Highlight: Module narrative and directions- assessment level instructions and/or help
Orange: Items, responses, and other language specifically for participants 0-17 unless otherwise indicated
Green: Skip patterns
Red: Additional instructions for assessors- item level help
Purple: Section level help
Teal: Notes for automation and/or configuration
S **Denotes a shared question with another module (one way only unless otherwise indicated)**
Gray Highlight: Responses/Text Boxes to pull forward to Assessment Output
Yellow Highlight: populate and/or pull forward to the support plan from another module or section within the support plan itself
Green Highlight: Populate and/or pull forward from the member record to an assessment or from an assessment to the member record
Denotes mandatory item
Item populates forward for Reassessment
Teal Highlight: Items only for Revision and CSR -Support Plan only
Italics: Items from FASI (CARE) – for Department use only

The purpose of the Health module is to identify health needs and risks to the participant's safety as a result of health issues and identify additional services and supports that should be addressed during support planning.

Assessors should not be using the Health module to diagnose conditions. Items in this module should only be used to document existing health issues and provide follow-up for health concerns. Assessors should look for health conditions or issues that place the participant's health or safety at risk, represent an unmet health need, or involve information that may be important to share with support providers (with consent of the participant).

Notes/Comments are present at the end of each section. These are used to: 1) Document additional information that was discussed or observed during the assessment process and was not adequately captured. 2) Document unique behavioral, cognitive or medical issues that were not captured in the assessment items that may increase the need for supervision or support. This narrative can provide additional justification in the event of a case review

Commented [SL1]: The module document is a reference for automation. If the CCM tool provides a different method to improve user efficiency (e.g. navigation, workflow, layout) this should be reviewed with the Department for optimization within the CCM platform. This document is a not intended to be automated as is.

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1. MEDICAL SERVICES

1. In the last 6 months, has the participant received services at any of the following facilities?

- ☐ Hospital emergency department
- ☐ Short-stay acute hospital (IPPS)
- ☐ Long-term care facility
- ☐ Skilled Nursing facility (SNF)
- ☐ Long-term care hospital (LTCH)
- ☐ In-patient rehabilitation hospital or unit (IRF)
- ☐ Psychiatric hospital or unit
- ☐ Home health agency (HHA)
- ☐ Hospice
- ☐ Outpatient services
- ☐ IID Facility (ICF-IID)
- ☐ Urgent Care
- ☐ Other

  Describe other medical services received in the last 6 months: ___________________
- ☐ None

2. Notes/Comments: Medical Services

2. HEALTH CARE PROVIDER INFORMATION

Health Care Provider Information is maintained in the Member record and will populate to this section. Any updates need to be made in the Member record. Primary Care Physician/Pediatrician and Dentist must be documented in the Member record. If Member does not have a PCP/Pediatrician or Dentist, assessor must select "Needs Referral to Obtain." Only if the Member has a provider in the Member record, should the assessor select "Would Like to Change Provider" if applicable.

1A. Primary and Dental Care Providers:

Health Care Provider Type	Name/Clinic	Contact Information	Would Like to Change Provider	Needs Referral to Obtain	Comments
Primary Care Physician/ Pediatrician			❍ Yes ❍ No	❍ Yes ❍ No	

Commented [SL2]: Within the CCM tool numbering for sections and questions does not need to match document, however format needs to be determined by the Department based on CCM design.

Commented [SL7]: Automation: Columns 1,2 and 3, 4, 5 and 6 will populate from the Member record if applicable.

Column "Would Like to change Provider" only shows if column 2 or 3 has a response

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Dentist			❍ Yes ❍ No	❍ Yes ❍ No	

1B. Other Health Care Providers

Health Care Providers	Name/Clinic	Contact Information	Would Like to Change Provider	Needs Referral to Obtain	Comments
Psychiatrist			Yes No	Yes No	
Psychologist/Therapist			Yes No	Yes No	
Optometrist/Vision Specialist			Yes No	Yes No	
Pharmacy (Primary)			Yes No	Yes No	
Pharmacy (Other)			Yes No	Yes No	
Home Health Agency			Yes No	Yes No	
Medical Case Manager			Yes No	Yes No	
RAE Care Coordinator			Yes No	Yes No	
Specialty Clinic/ Specialist			Yes No	Yes No	
Other, Identify healthcare provider: ________			Yes No	Yes No	

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3. GENERAL HEALTH

1. **Overall, how does the participant rate his/her health?**
   - ❍ Excellent
   - ❍ Good
   - ❍ Fair
   - ❍ Poor
   - ❍ Choose not to answer

2. **Are there any immediate health concerns?**
   - ❍ No
   - ❍ Choose not to answer
   - ❍ Yes,
     Describe immediate health concerns: ______________________________

3. **Known allergies or any adverse drug reactions:** (Allergy information is maintained in the Member record and will populate to this section. Any updates need to be made in the Member record.)

Commented [SL10]: Automation: Column 1,2,3,4 and 5 from the Member Record if applicable.

Allergy (Searchable text field)	Type of Allergy (Drop Down)	Reactions (Drop Down)	Information Source (Drop Down)	Notes/ Comments
Identified allergy to populate	➢ Environmental ➢ Food ➢ Medication ➢ Other	➢ Abdominal pain ➢ Anaphylaxis ➢ Dizziness ➢ Hives ➢ Itching ➢ Nausea/vomiting ➢ Rash ➢ Swelling ➢ Trouble breathing ➢ Unknown ➢ Wheezing ➢ Other	➢ Self-Report ➢ Proxy ➢ Provider	Text

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4. Height, Weight and BMI (Height, Weight and BMI are maintained in the Member record and pulls forward to this item. Any updates need to be made in the Member record.)

Commented [SL11]: Automation: Column 1 and 2 will pull forward from Member record if applicable. This is uni-directional, user cannot update in the Health module.

Current Height	________Feet
Current Height	________Inches
Current Weight	________Pounds
BMI	**[Auto calculate]**

5. Has the participant lost 5% or more weight in the last month?
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes, on physician prescribed weight loss regimen
- ❍ Yes, not on physician prescribed weight loss regimen

6. Notes/Comments: General Health

4. RISK SCREEN

This section is used to identify whether the participant experiences health-related circumstances that may put him/her at risk. The purpose of this section is to inform support planning and allow risk mitigation strategies to be developed.

1. In the past year, participant has been seen by his/her primary care provider.
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes

Number of times seen by Primary Care Provider/Pediatrician in the past year: _______
Reason(s) for being seen by Primary Care Provider/Pediatrician in the past year:
- ☐ Physical examination
- ☐ Other

Describe other reason(s) for being seen by Primary Care Provider/Pediatrician: _______

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2. In the past year, participant has called 911.
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes
  Number of times called 911 in the past year:_____
  Reason(s) called 911: ________________________________

3. In the past year, participant has called behavioral and/or mental health crisis services line.
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes
  Number of times called crisis services line in past year: _____
  Reason(s) called crisis services line: ______________________________

4. Participant has received crisis or urgent behavioral or mental health support in the last 90 days.
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes
  Number of times received crisis or urgent behavioral or mental health support in the last 90 days: _________________________
  Describe crisis or urgent behavioral or mental health support received in last 90 days: ____________________________

5. In the past year, participant has gone to a hospital emergency room (not counting overnight stay).
- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes,
  Number of times gone to emergency room in the past year: _____
  Reason(s) for going to emergency room: ________________________________

6. In the past year, participant has stayed overnight or longer in a hospital.
- ❍ No [Skip to Item 7- Nursing Facility Stays]
- ❍ Choose not to answer [Skip to Item 7- Nursing Facility stays]
- ❍ Unknown [Skip to Item 7- Nursing Facility stays]

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❍ Yes

Number of times stayed overnight or longer in hospital in the past year: _____
Reason(s) stayed overnight or longer in hospital: ______________________________

6A. Were any of these admissions planned?

❍ No
❍ Choose not to answer
❍ Unknown
❍ Yes

Number of planned admissions: _____
Reason(s) for planned admissions: ______________________________

7. In the past year, participant has had nursing facility stay(s).

❍ No
❍ Choose not to answer
❍ Unknown
❍ Yes

Number of times has nursing facility stay in the past year: _____
Reason(s) for nursing facility stay: ______________________________

8. In the past year, participant has had two or more falls or any fall with injury.

❍ No [Skip to Item 9- Afraid of falling when home]
❍ Choose not to answer [Skip to Item 9- Afraid of falling when home]
❍ Unknown [Skip to Item 9- Afraid of falling when home]
❍ Yes (Only show for ages 18 and older)
❍ Yes, age appropriate falls (Only show for ages 17 and under) [Skip to Item 9- Afraid of falling when home]
❍ Yes, falls related to a disability and/or health condition (Only show for ages 17 and under)

8A. Fall(s) that resulted in an injury.

No
Yes, type:
☐ Fracture
☐ Head Injury
☐ Other,
Describe other falls that resulted in injury: ____________________

9. Are you afraid of falling when at home?

❍ No **(Skip to Item 12: Infant Health)**
❍ Yes
❍ Maybe, not sure

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- ❍ Don't know **(Skip to Item 12: Infant Health)**
- ❍ Unclear response (**Skip to Item 12: Infant Health)**
- ❍ Refused/no response **(Skip to Item 12: Infant Health)**

Commented [SL22]: Q9-12 responses are NCI-AD and need to remain as they are, also applies to the items/responses in the safety and self- preservation module

10. Has somebody worked with you to reduce your risk or fear of falling?

- ❍ No
- ❍ Yes
- ❍ Maybe, not sure
- ❍ Don't know
- ❍ Unclear response
- ❍ Refused/no response

11. Fear of falling keeps him/her from doing things.

- ❍ No
- ❍ Yes, explain why and what things fear of falling prevents: ________________
- ❍ Maybe, not sure
- ❍ Don't know
- ❍ Unclear response
- ❍ Refused/no response

12. Infant health- Has the participant had any of the following issues? Check all that apply.

- ☐ Born prematurely
- ☐ Low birth weight
- ☐ Experienced health problems due to issues with the mother's health during pregnancy
- ☐ Other,
  Describe issues with infant health: ________________________
- ☐ None apply
- ☐ Unknown

13. In the past year, has the participant missed over 25 percent of work or classes because of a disability related issue?

- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes, why:
  - ☐ Physical health issues
  - ☐ Behavioral health issues
  - ☐ Issues with attention or stamina
  - ☐ Other reason(s) for missing over 25 percent of work/classes because of a disability related issue,

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Describe reason(s) for missing over 25 percent of work/classes because of a disability related issue: ______________________

14. Notes/Comments: Risk Screen

5. MEDICATIONS

Medication information, if present, will populate from the Medication section of the Member record including prescription and/or over the counter medications. Updates to medication information are bi-directional: Adding and/or editing medications in this section will be reflected in the Member record and adding and/or editing medications in the Member record will be reflected in this section.

(Medication list pulls from medication section of the Member record)

Columns will contain drop down options that include:

Route:

- oral route: swallowed by mouth as a pill, liquid, tablet or lozenge
- rectal route: suppository inserted into the rectum
- intravenous route: injected into vein with a syringe or into intravenous (IV) line

- infusion: injected into a vein with an IV line and slowly dripped in over time
- intramuscular route: injected into muscle through skin with a syringe
- topical route: applied to skin
- enteric: delivered directly into the stomach with a G-tube or J-tube
- nasal: sprays or pumps that deliver drug into the nose
- inhaled: inhaled through a tube or mask (e.g. lung medications)
- otic: drops into the ear
- ophthalmic: drops, gel or ointment for the eye
- sublingual: under the tongue

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- buccal: held inside the cheek
- transdermal: a patch on the skin
- subcutaneous: injected just under the skin
- Other, describe in notes

Frequency:

- After meals- p.c.
- Before meals- a.c.
- Twice a day- b.i.d.
- Three times a day- t.i.d.
- Four times a day- q.i.d.
- Every other day- q.o.d.
- In the morning- qam
- Every four hours- q4h
- At bedtime- h.s.
- As desired- ad lib.
- As needed- prn
- Other, describe in notes

Information Source:

- Self-Reported
- Proxy Reported
- Professional Medical Information Page (PMIP)
- Hospital Discharge Records
- Claims
- Other, describe in notes

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Current Medications:

Name of Medication (to include Dose & Unit)	Route (Drop Down)	Frequency (Drop Down)	Taken for psychotropic reason	Understand why participant/ child taking med.	Prescribing Physician	Pharmacy	End Date	Information Source (Drop Down)	Taking as prescribed
			❍ Yes ❍ No	❍ Yes ❍ No					
			❍ Yes ❍ No	❍ Yes ❍ No					
			❍ Yes ❍ No	❍ Yes ❍ No					

4. Has issues with getting prescription(s) and/or over the counter medication(s) filled or refilled regularly.

No
Choose not to answer
Unknown
Yes,
Describe issues with getting prescription(s) and/or over the counter medication filled: ______________________________

I. MEDICATION MANAGEMENT

This is used to identify the ability to prepare and take all prescribed medications reliably and safely.

5A. Indicate the type(s) of medication the participant currently takes: [(Preference would be to show items 5B "oral medications," 5C "inhalant/mist medications," 5D "injectable medications," 5E "intravenous medications," and 5F "other type(s) of medication" based on "Current Medications" route (column 2)]

- ☐ Oral medications
- ☐ Inhalant/mist medications
- ☐ Injectable medications (includes subcutaneous, intradermal and intramuscular)
- ☐ Intravenous medications (includes IV push/injection and infusion)
- ☐ Other type(s) of medication
- ☐ None (Skip to 5G- Level of support varied past 30 days)

5B. Medication management-oral medication: *The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.*

Last 3 Days	***Performance Level***
❍	***Independent -*** *Participant completes the activity by him/herself with no assistance from helper.*
❍	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age.*
❍	***Setup or clean-up assistance -*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity.*

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❍	***Supervision or touching assistance -*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently.*
❍	***Partial/moderate assistance -*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
❍	***Substantial/maximal assistance -*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*
❍	***Dependent -*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity.*
❍	***Activity not Attempted-*** *Participant refused*
❍	***Activity not attempted*** *due to short-term medical condition or safety concern*
❍	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

5C. Medication management-inhalant/mist medications: *The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.*

Last 3 Days	*Performance Level*
❍	***Independent -*** *Participant completes the activity by him/herself with no assistance from helper.*
❍	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age.*
❍	***Setup or clean-up assistance -*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity.*
❍	***Supervision or touching assistance -*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently.*
❍	***Partial/moderate assistance -*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
❍	***Substantial/maximal assistance -*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*
❍	***Dependent -*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity.*
❍	***Activity not Attempted-*** *Participant refused*
❍	***Activity not attempted*** *due to short-term medical condition or safety concern*
❍	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

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5D. Medication management-injectable medications: *The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.*

Last 3 Days	***Performance Level***
○	***Independent -*** *Participant completes the activity by him/herself with no assistance from helper.*
○	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age.*
○	***Setup or clean-up assistance -*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity.*
○	***Supervision or touching assistance -*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently.*
○	***Partial/moderate assistance -*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
○	***Substantial/maximal assistance -*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*
○	***Dependent -*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity.*
○	***Activity not Attempted-*** *Participant refused*
○	***Activity not attempted*** *due to short-term medical condition or safety concern*
○	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

5E. Medication management-intravenous: The ability to prepare and take all prescribed intravenous medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Last 3 Days	***Performance Level***
○	***Independent -*** *Participant completes the activity by him/herself with no assistance from helper.*
○	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age.*
○	***Setup or clean-up assistance -*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity.*
○	***Supervision or touching assistance -*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently.*
○	***Partial/moderate assistance -*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
○	***Substantial/maximal assistance -*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*

❍	***Dependent -*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity.*
❍	***Activity not Attempted-*** *Participant refused*
❍	***Activity not attempted*** *due to short-term medical condition or safety concern*
❍	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

5F. Medication management-other type(s) of medication: The ability to prepare and take all prescribed other type(s) of medication reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Last 3 Days	***Performance Level***
❍	***Independent -*** *Participant completes the activity by him/herself with no assistance from helper.*
❍	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age.*
❍	***Setup or clean-up assistance -*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity.*
❍	***Supervision or touching assistance -*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently.*
❍	***Partial/moderate assistance -*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
❍	***Substantial/maximal assistance -*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*
❍	***Dependent -*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity.*
❍	***Activity not Attempted-*** *Participant refused*
❍	***Activity not attempted*** *due to short-term medical condition or safety concern*
❍	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

5G. Has the level of support the participant needs for medication management varied over the last 30 days?

❍ No **(Skip to Item 5K- Medication Management Equipment)**
❍ Yes, identify the highest level of support needed in the past 30 days:

Last 30 Days	***Performance Level***
❍	***Independent –*** *Participant completes the activity by him/herself with no assistance from helper*
❍	***Age appropriate dependence-*** *The participant requires a level of support consistent with his/her age*

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❍	***Setup or clean-up assistance –*** *Helper sets up or cleans up; participant completes activity. Helper assists only prior to or following the activity*
❍	***Supervision or touching assistance –*** *Helper provides verbal cues or touching/steadying assistance as participant completes activity. Assistance may be provided throughout the activity or intermittently*
❍	***Partial/moderate assistance –*** *Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort*
❍	***Substantial/maximal assistance –*** *Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort*
❍	***Dependent –*** *Helper does all of the effort. Participant does none of the effort to complete the task OR the assistance of 2 or more helpers is required for the participant to complete the activity*
❍	***Activity not Attempted-*** *Participant refused*
❍	***Activity not attempted*** *due to short-term medical condition or safety concern*
❍	***Not applicable-*** *Participant does not usually do this activity*

Scoring based on:
☐ Observation ☐ Self-report ☐ Proxy

5H. How frequently has this enhanced support for medication management been needed in the past 30 days? ❗

- ❍ 2 or more times per day
- ❍ Daily
- ❍ 4-6 times per week
- ❍ 1-3 times per week
- ❍ 3-4 times per month
- ❍ 1-2 times per month
- ❍ Other, Specify frequency of enhanced support for medication management: ________________

5I. Approximately how long does each instance of enhanced medication management support last? ❗

- ❍ 0-15 minutes
- ❍ 16-30 minutes
- ❍ 31-45 minutes
- ❍ 46-60 minutes
- ❍ Greater than 60 minutes

5J. Describe the circumstances that result in this additional need for medication management support. ❗

5K. Does the participant have or need any adaptive equipment to assist with medication management? ❗

- ❍ No **(Skip equipment table) follow automation instructions in teal after the table**
- ❍ Yes

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II. MEDICATION EQUIPMENT

Medication Equipment Table:

In Use of device column use the following responses:

- ***Assistive device needed and available-*** *Participant needs this device to complete daily activities and has the device in the home*
- ***Assistive device needed but current device unsuitable-*** *Devices is in home but no longer meets participant's needs*
- ***Assistive device needed but not available-*** *Participant needs the device but it is not available in the home*
- ***Participant refused-*** *Participant chooses not to use needed device*

Type of Assistive Device	Use of Device (Drop down)	Comments/Supplier
CompuMed	Drop Down	
Medi-minder	Drop Down	
Medi-set	Drop Down	
Pill crusher	Drop Down	
Pill cutter	Drop Down	
Specialized medical equipment	Drop Down	
Syringe	Drop Down	
Other medication equipment (1), Describe other medication equipment (1): __________	Drop Down	
Other medication equipment (2), Describe other medication equipment (2): ______	Drop Down	

If the participant responded to 5B, C, D, E AND F as "Independent", "Age Appropriate Dependence", AND/OR "Not Applicable" AND 5G as "No" skip to Notes/Comments: Medication

II. MEDICATION MANAGEMENT - PREFERENCES AND GUIDANCE FOR WORKERS

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5K. Preferences and Guidance for Workers – Identify the participant's preferences and what he/she wants workers to know when supporting him/her with medication management. **Consider age appropriate factors.**

- ☐ Able to manage multiple medications
- ☐ Able to put medications in mouth
- ☐ Able to use/give own injections
- ☐ Aware of frequency and dosages
- ☐ Aware of potential side effects
- ☐ Behavioral issues
- ☐ Cannot crush pills
- ☐ Cannot open containers
- ☐ Cannot fill syringe
- ☐ Cannot swallow whole pills
- ☐ Cue to swallow medications
- ☐ Disease/symptoms interfere with performing task
- ☐ Doesn't take medications due to cost
- ☐ Does not use correct dosage
- ☐ Forgets to refill medications
- ☐ Forgets to take medication
- ☐ Has multiple prescriptions
- ☐ Inform participant of each medication given
- ☐ Medications delivered
- ☐ Organize/Label medications
- ☐ Place medication in participant's hand/mouth
- ☐ Pre-filled syringe
- ☐ Prefers to keep meds in room
- ☐ Put medications in lock box
- ☐ Read labels to participant
- ☐ Reorder medication
- ☐ Resistive to medication
- ☐ Requires special handling
  - Describe special handling: ________
- ☐ Takes medications as prescribed
- ☐ Takes outdated or expired medications
- ☐ Unable to read labels
- ☐ Understands purpose of medication
- ☐ Use a pill box
- ☐ Uses multiple pharmacies
- ☐ Other

Describe preferences for support with medication management: ______

- ☐ None

5L. Is training/skill building needed to increase independence with medication management?

- ❍ No
- ❍ Yes,
  - Describe training needed around medication management: ____________________

5M. Notes/Comments: Medication Management

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6. DIAGNOSES

Diagnoses information, if present, will populate from the Diagnoses section of the Member record. All Diagnoses information needs to be verified and updated prior to completing the assessment. Updates to diagnoses information are bi-directional: Adding and/or editing diagnoses in this section will be reflected in the Member record and adding and/or editing diagnoses in the Member record will be reflected in this section.

1. **Diagnoses** **(ICD.10/Diagnosis information populates from Diagnosis Section in Member Record)**

ICD.10 Code/ Diagnosis	Health Care Provider has diagnosed participant	Diagnosis active in past year	Affects functioning	Receiving treatment for condition	Requires follow-up or referral
Searchable Field of ICD code or diagnosis	☐	☐	☐	☐	☐

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7. HEALTH CONDITIONS, DIAGNOSES AND SURGERIES

1. **Does the participant have a diagnosis of paralysis or a missing limb? (Shared with LOC Screen Module)**
   - ❍ No
   - ❍ Yes
     - ☐ Paralysis, describe presentation of paralysis: ____________
     - ☐ Missing limb, identify limb: _________

2. **Does the participant have a diagnosis of any of the following <u>mental health conditions</u> that have been active in the past year?**
   - ☐ Attention deficit hyperactivity disorder (ADHD or ADD)
   - ☐ Autism Spectrum Disorder
   - ☐ Bipolar Disorder
   - ☐ Depressive Disorders
   - ☐ Disruptive, Impulse Control, and Conduct disorders
   - ☐ Mood Disorder
   - ☐ Obsessive Compulsive Disorder (OCD)
   - ☐ Paranoid Disorders
   - ☐ Trauma and Stressor Related disorders (e.g., PTSD, Reactive Attachment disorder, Acute Stress disorder)
   - ☐ Schizophrenia Spectrum and Other Psychotic Disorders
   - ☐ Other
     Specify other Mental Health Diagnosis: _________
   - ☐ None

3. **Does the participant have a diagnosis of any of the following <u>brain injury conditions</u>?**
   - ☐ Reported brain injury, need to identify specific diagnosis
   - ☐ Nonpsychotic mental disorders due to brain damage
   - ☐ Toxic encephalopathy
   - ☐ Subarachnoid and/or intracerebral hemorrhage
   - ☐ Occlusion and stenosis of precerebral arteries
   - ☐ Acute, but ill-defined cerebrovascular disease
   - ☐ Other and ill-defined cerebrovascular disease
   - ☐ Late effects of cerebrovascular disease
   - ☐ Fracture of the skull or face
   - ☐ Concussion resulting in an ongoing need for assistance with activities of daily living
   - ☐ Cerebral laceration and contusion
   - ☐ Subarachnoid, subdural, and extradural hemorrhage, following injury

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- ☐ Other unspecified intracranial hemorrhage following injury
- ☐ Intracranial injury
- ☐ Late effects of musculoskeletal and connective tissue injuries
- ☐ Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living
- ☐ None

4. Does the participant have a diagnosis of any of the following <u>spinal cord injury</u> conditions?

- ☐ Spinal cord injury unspecified
- ☐ Complete lesion of spinal cord
- ☐ Anterior cord syndrome
- ☐ Central cord syndrome
- ☐ Other specified spinal cord injury
- ☐ Lumbar spinal cord injury without spinal bone injury
- ☐ Sacral spinal cord injury without spinal bone injury
- ☐ Cauda equina spinal cord injury without spinal bone injury
- ☐ Multiple sites of spinal cord injury without spinal bone injury
- ☐ Unspecified site of spinal cord injury without spinal bone injury
- ☐ Injury to cervical nerve root
- ☐ Injury to dorsal nerve root
- ☐ Injury to lumbar nerve root
- ☐ Injury to sacral nerve root
- ☐ Injury to brachial plexus
- ☐ Injury to lumbosacral plexus
- ☐ Injury to multiple sites of nerve roots and spinal plexus
- ☐ Injury to unspecified site of nerve roots and spinal plexus
- ☐ Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles
- ☐ Injury to other sympathetic nerve excluding shoulder and pelvic girdles
- ☐ Injury to other sympathetic nerve excluding shoulder and pelvic girdles
- ☐ Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles
- ☐ Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles
- ☐ Paraplegia
- ☐ Paraplegia, Unspecified
- ☐ Paraplegia, Complete
- ☐ Paraplegia, Incomplete
- ☐ Quadriplegia/Tetraplegia/Incomplete – unspecified
- ☐ Quadriplegia – C1-C4/Complete
- ☐ Quadriplegia – C1-C4/Incomplete
- ☐ Quadriplegia – C5-C7/Complete
- ☐ Quadriplegia – C5-C7/Incomplete
- ☐ None

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4A. Does the diagnosis impact the participant's functioning? (Show if any response EXCEPT "None" was slected in item 3 "Does the participant have of any of the following spinal cord injury diagnoses")

- ❍ No
- ❍ Yes

5. Has the participant been diagnosed with a life limiting illness by a medical professional? Note: Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the client reaches adulthood. (Shared with LOC) (Only show for ages 19 and under)

Commented [SL30]: Note-will need to determine age cut-off (e.g. 18 years and 364 days, DOB minus 1 day)

- ❍ No
- ❍ Yes

6. Has the participant been diagnosed with a life limiting illness by a medical professional? Note: The definition of a life limiting illness for adults (18+) is a prognosis of death within the next year due to a medical condition. (Only show for ages 19 and older)

- ❍ No
- ❍ Yes

7. Is the participant at risk of developing pressure ulcers?

- ❍ No
- ❍ Yes, indicated by professional judgment (e.g., participant has paralysis/limited mobility, is incontinent)
- ❍ Yes, indicated in home health plan or clinical record (e.g., on Braden or Norton tools)

8. Does the participant have any wounds and/or skin conditions?

- ❍ No (Skip to Section 9: **Participant has had surgery(ies) that affects current functioning or quality of life.**)
- ❍ Chose not to answer (Skip to Section 9: **Participant has had surgery(ies) that affects current functioning or quality of life.**)
- ❍ Unknown (Skip to Section 9: **Participant has had surgery(ies) that affects current functioning or quality of life.**)
- ❍ Yes

8a. Check all that apply:

- ☐ Bruises
- ☐ Burns – 2 degree or greater

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- ☐ Chronic irritation
- ☐ Diabetic foot ulcer
- ☐ Delayed healing of surgical wound
- ☐ Dry skin
- ☐ Epidermis Bullosa (EB)
- ☐ Open lesions, abrasions, cuts or skin tears
- ☐ Rash
- ☐ Skin desensitized to pain/pressure
- ☐ Skin disease
- ☐ Stasis ulcers
- ☐ Surgical site
- ☐ Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)
- ☐ Trauma-related wound
- ☐ Wounds
- ☐ Other,
  Specify other type of wound and/or skin condition: __________

8b. How long have wounds and/or skin conditions been a problem?

8c. Have you received treatment for the wound and/or skin conditions identified?

- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes,
  Describe the treatment(s) received for the wound and/or skin conditions identified:
  ____

9.Participant has had surgery(ies) that affects current functioning or quality of life.

No [Skip to Section 10: Notes/Comments: Health Conditions, Diagnoses and Surgeries]
Choose not to answer [Skip to Section 10: Notes/Comments: Health Conditions, Diagnoses and Surgeries]
Unknown [Skip to Section 10: Notes/Comments: Health Conditions, Diagnoses and Surgeries]
Yes

- ☐ Surgeries that negatively affect current functioning or quality of life
- ☐ Surgeries that positively affect current functioning or quality of life

9A. Describe the surgeries that impact functioning or quality of life:

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10. Notes/Comments: Health Conditions, Diagnoses and Surgeries

8.TREATMENTS AND MONITORING

1. On average the participant requires intervention greater than verbal redirection at least once every two hours during the day AND on average once every three hours at night across all behavioral and/or medical issues OR exhibits constant vocalization

(Shared from Psychosocial module: Bi-directional) This item is to help determine if participant meets targeting criteria for the Children's Extensive Services (CES) waiver. If "yes" is selected for "Due to medical issues," the documentation must include for each treatment and monitoring- status, who performs, status of caregiver, frequency and description.

- ❍ No
- ❍ Yes
  - ☐ Yes- Due to behavioral issues (Interventions for behavioral issues are documented in the Psychosocial Module)
  - ☐ Yes-Due to medical issues (Interventions for medical issues are documented in the Health Module)
  - ☐ Yes-Due to constant vocalization (Interventions for constant vocalization are documented in the Psychosocial Module)

2. Participant is in danger of being admitted to an institution/out of home placement because of a medical issue(s).

- ❍ No
- ❍ Yes

3.Treatments and Monitoring

Identify treatments and monitoring the participant receives and/or needs.

- ☐ Bowel program
- ☐ Bladder program
- ☐ Chemotherapy
- ☐ Catheter changes
- ☐ CPAP/ Sleep Apnea treatment
- ☐ Colostomy or Ileostomy

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- ☐ Glucometer
- ☐ Hemodialysis or Peritoneal Dialysis
- ☐ Insulin pump
- ☐ Intravenous (IV) care and/or medication administration
- ☐ Nasogastric tube (NG), Gastrostomy tube (GT), Jejunostomy tube (JT) care and/or medication administration
- ☐ Nebulizer treatment
- ☐ Oxygen concentrator
- ☐ Seizure monitoring
- ☐ Suctioning treatments (e.g., Nasopharyngeal or tracheostomy)
- ☐ Telemedicine
- ☐ Turning/repositioning program
- ☐ Vital sign monitoring
- ☐ Vascular access device (e.g., central line, PICC, Portacath) care and/or medication administration
- ☐ Ventilator
- ☐ Wound care (e.g., dressings or drainage tubes)
- ☐ Other (1)
  - Specify other (1) type of treatment/monitoring
- ☐ Other (2)
  - Specify other (2) type of treatment/monitoring

Show "Treatment/Monitoring Status" (column 1) for each if applicable therapy selected in item 3 (treatments and monitoring)
Then

Show "Performed by", "Caregiver Status", and "Frequency" (columns 2-4) ONLY if response selected in "Treatment/Monitoring Status" (column 1) is: "Treatment/monitoring needed and available" OR "Treatment/monitoring needed but no longer meets participant's needs." If these columns show, responses are mandatory.

Show item "Briefly describe …" for each applicable therapy selected in item 1, responses are mandatory.

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Treatment/monitoring Status	**Performed By:**	**Caregiver Status:**	**Frequency:**
• **Treatment/ monitoring needed and available-** Participant needs this treatment/monitoring for health and safety and/or to complete daily activities and has the device in the home • **Treatment/ monitoring needed but no longer meets participant's needs-** Treatment/monitoring is performed but no longer meets participant's needs • **Treatment/ monitoring needed but is not being received-** Participant needs the treatment/monitoring but it is not currently receiving. • **Participant refused-** Participant refuses the treatment/monitoring.	☐ **Caregiver** ☐ **Nurse** ☐ **Parent** ☐ **Self** ☐ **Relevant Mental Health Care Professional** ☐ **Other** **Identify person who performed treatment______**	Can an existing caregiver (excluding those provided through an agency) provide the treatment or monitoring? ❍ Yes ❍ No Identify which caregiver(s) can perform the task. If some or all caregivers cannot perform the task, describe the reasons and identify training or other supportive service that would allow the caregiver to perform the task. If the caregiver is not interested in providing the support or additional training, document this: _____	❍ Less than monthly to once per month ❍ More than once per month and up to weekly ❍ More than once per week and up to daily ❍ 2+ times per day (at least 5 days per week)
Briefly describe 1) the reason for the treatment or monitoring 2) the participant's strengths, preferences and challenges related to the treatment or monitoring including any other information, such as planned end dates: ____			

4. Notes/Comments: Treatments and Monitoring

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9. THERAPIES - SKILLED/SPECIALIZED THERAPIES

1. Therapy – Skilled/Specialized Therapies (Non-Behavioral/Mental Health)

Identify therapies the participant receives and/or needs.

- ☐ Alternative/ Integrated Therapies (e.g., acupuncture, dry needling, cupping)
- ☐ Hippotherapy/ Equine Therapy
- ☐ Massage Therapy
- ☐ Music Therapy
- ☐ Occupational Therapy
- ☐ Pain Management
- ☐ Physical Therapy
- ☐ Range of Motion Exercise
- ☐ Respiratory Therapy
- ☐ Speech Therapy
- ☐ Other,
  Specify other therapy type: __________
- ☐ None

Show "Therapy Status" (column 1) for each if applicable therapy selected in item 3

Then

Show "Performed by", Caregiver Status", and Frequency (columns 2-4) ONLY if the response selected in "Therapy Status" (column 1) is: "Therapy needed and available" OR "Therapy needed but no longer meets participant's needs." If these columns show, responses are mandatory.

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Show item "Briefly describe …" for each applicable therapy selected in item 1, responses are mandatory.

Therapy Status:	**Performed By:**	**Caregiver Status:**	**Frequency:**
• **Therapy needed and available-** Participant needs and is currently receiving this therapy • **Therapy needed but no longer meets participant's needs-** Participant needs the therapy but no longer meet's participant's needs. • **Therapy needed but is not being received-** Participant needs the therapy but is not currently receiving. • **Participant refused-** Participant chooses not to receive this therapy	☐ **Caregiver** ☐ **Nurse** ☐ **Parent** ☐ **Self** ☐ **Relevant Mental Health Care Professional** ☐ **Other** **Identify person who performed treatment______** ___________	Can an existing caregiver (excluding those provided through an agency) provide the treatment or monitoring? ❍ Yes ❍ No Identify which caregiver(s) can perform the task. If some or all caregivers cannot perform the task, describe the reasons and identify training or other supportive service that would allow the caregiver to perform the task. If the caregiver is not interested in providing the support or additional training, document this: _________	❍ Less than monthly to once per month ❍ More than once per month and up to weekly ❍ More than once per week and up to daily ❍ 2+ times per day (at least 5 days per week)

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Briefly describe 1) the reason for the therapy 2) the participant's strengths, preferences and challenges related to the therapy and other information, such planned end dates of the therapy:

2. Notes/Comments: Skilled/Specialized Therapies

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10. ASSESSMENT OF FEET

1. Participant has conditions related to his/her feet such as bunions, diabetes related, etc.

- ❍ No [Skip to Section 11- Assessment of Pain]
- ❍ Yes
- ❍ Choose not to answer [Skip to Section 11- Assessment of Pain]

2. Conditions and/or Current Status of Feet: **(Columns 2-4 only show if the condition is checked in column 1)**

Conditions	Problematic	Comments
☐ Bunions	○	
☐ Calluses	○	
☐ Corns	○	
☐ Diabetic foot care	○	
☐ Fungus	○	
☐ Hammer Toes	○	
☐ Infection (Cellulitis, Drainage)	○	
☐ Neuropathy	○	
☐ Open Lesions	○	
☐ Overlapping toes	○	
☐ Other (1), Describe other (1) condition and current status of feet _____	○	
☐ Other (2), Describe other (2) condition and current status of feet _____	○	

3. Participant has had a foot exam conducted by a medical professional.

- ❍ No
- ❍ Yes
  Approximate Month/Year of the last foot exam: ___________
- ❍ Unknown
- ❍ Choose not to answer

4. Participant had surgeries or medical procedures on his/her feet.

- ❍ No
- ❍ Yes,
  Describe surgeries or medical procedures on feet: __________
- ❍ Choose not to answer

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5. Foot Care Needs

- ☐ Apply ointments/ lotions
- ☐ Diabetic foot care
- ☐ Dry bandage change
- ☐ Foot soaks
- ☐ Healing Inserts
- ☐ Nails trimmed in last 9 days
- ☐ Pads
- ☐ Protective booties
- ☐ Special Shoes
- ☐ Toenails need trimming
- ☐ Toe separators
- ☐ Other,

Identify other foot care needs

- ☐ None

6. Notes/Comments: Assessment of Feet

11. ASSESSMENT OF PAIN

1. Pain presence

- ❍ No [Skip to Item 6- Intermittent Pain]
- ❍ Choose not to answer [Skip to Item 6- Intermittent Pain]
- ❍ Yes
- ❍ Unable to determine

2. Pain frequency

- ❍ Almost constantly
- ❍ Frequently
- ❍ Occasionally
- ❍ Rarely
- ❍ Choose not to answer

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3. Pain intensity

Dropdown of 0-10 and "Choose not to answer." For the 0-10 pain scale, add corresponding emojis or faces.

4. Pain effect on sleep

❍ No
❍ Choose not to answer
❍ Yes

5. Pain effect on activities

❍ No
❍ Choose not to answer
❍ Yes

6. Do you have intermittent pain, or pain that is triggered by specific events?

❍ No
❍ Choose not to answer
❍ Yes,
Describe intermittent pain or pain triggered by specific events: ___________________

7. Is there a concern that pain is affecting the participant's behaviors?

❍ No
❍ Choose not to answer
❍ Yes,
7A. Identify behaviors pain is affecting: ______________________________________

8. Pain observational assessment.

- ☐ Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ Vocal complaints of pain (e.g., "that hurts, ouch, stop")
- ☐ Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, tightening of muscles)
- ☐ None of these signs observed or documented

9. Notes/Comments: Assessment of Pain

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12. ASSESSMENT OF SLEEP

1. Concerns about sleep

- ❍ No [Skip to Item 5 -Notes/Comments for Sleep]
- ❍ Yes
- ❍ Sometimes
- ❍ Choose not to answer [Skip to Item 5- Notes/Comments for Sleep]

2. Sleep Issues:

- ☐ Agitation
- ☐ Bedwetting/incontinence
- ☐ Difficulty waking up
- ☐ Difficulty Falling (or staying) asleep
- ☐ Falling asleep when not intending to
- ☐ Insomnia
- ☐ Nightmares/Night terrors
- ☐ Repositioning
- ☐ Sleep apnea
- ☐ Sleep walking
- ☐ Snoring
- ☐ Other,

Describe other sleep issues: ____

3. Participant had a sleep study completed.

- ❍ No
- ❍ Choose not to answer
- ❍ Unknown
- ❍ Yes

5. Notes/Comments: Sleep

13. HELPS BRAIN INJURY SCREEN

"Brain injury is a common problem and many participants with a brain injury might be undiagnosed. In order to evaluate service eligibility and make appropriate referrals, I will need to ask you some questions that will help me learn more about a potential brain injury."

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1. Participant has a diagnosed brain injury.

No

Yes [Skip to Item 4-Notes/Comments for Brain Injury Screen]

H - Have you hit your head or been Hit on the head?

No

Yes

Prompt client to think about all incidents that may have occurred at any age, even those that did not seem serious: vehicle accidents, falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse, and also for service related injuries. A brain injury can also occur from violent shaking of the head, such as being shaken as a baby or child.

E - Were you ever seen in the Emergency room, hospital, or by a doctor because of an injury to your head?

No

Yes

Many people are seen for treatment. However, there are those who cannot afford treatment, or who do not think they require medical attention.

L - Did you ever Lose consciousness or experience a period of being dazed and confused because of an injury to your head?

No

Yes

People with a brain injury may not lose consciousness but experience an alteration of consciousness. This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P - Do you experience any of these Problems in your daily life since you hit your head?

- ☐ Anxiety
- ☐ Change in relationships with others
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Difficulty Performing Your Job/School Work
- ☐ Difficulty Reading, Writing, Calculating
- ☐ Difficulty Remembering
- ☐ Dizziness
- ☐ Headaches
- ☐ Poor Judgment (Being Fired from Job, Arrests, Fights)
- ☐ Poor Problem Solving

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☐ None
☐ Has not hit head

Document <u>all</u> problems the participant has had since hitting and/or injuring his/her head. If the participant does not have any problems, assessors should select "None". If the participant has never hit his/her head, assessors should select "Has not hit head".

S - Any other significant Sickness?

❍ No
❍ Yes

Traumatic brain injury implies a physical blow to the head but acquired brain injury may also be caused by medical conditions such as brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

2. HELPS Screening Results: (See "Scoring the HELPS Screening Tool" automation)

❍ Positive
❍ Negative

Scoring the HELPS Screening Tool – use to populate the positive or negative in item 2

A HELPS screening is considered "positive" for a possible brain injury when the following three items are identified:

1. An event that could have caused a brain injury (yes to H, E or S), And
2. A period of consciousness or of being dazed and confused (yes to L or E), And
3. The presence of two or more chronic problems listed under P that were not present before the injury.

3. Participant should receive a referral for further brain injury evaluation. The answer should populate if the results are "Positive" in the HEP screening question above

❍ No
❍ Yes

Positive answers to these questions are not sufficient to suggest the presence of a brain injury. Consider positive responses within the context of the participant's self-report and documentation of altered behavioral and/or cognitive functioning. This information can be used as a basis for further inquiry, e.g., referral to a physician, further evaluation, clinical observations, etc.

4. Notes/Comments: HELPS Brain injury screen

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