# Assessment Basics Part 2

Louisiana Department of Health

Office of Behavioral Health

Summer Chaves, LPC-S

March 31, 2022

A “good assessment” is not an end in itself.
The assessment process provides the care manager an opportunity to begin to engage on a human level with the client and the family and is a first step in establishing the relationship that will be instrumental in helping the older adult and the family to navigate the aging process.

Theme of Person Centered Planning sheds light on the goal of the PASRR Level II Evaluation:

**“Nothing about us without us”**

# PASRR Level II Documentation

- Psychiatric Evaluation and Completed Psychiatric History
- Psychosocial Assessment that includes history of IP and OP Mental Health and SUD treatment
- Medication History/ Medication Administration Record/Medication List
- Comprehensive Medical History and Physical
- Current MDS (for continued stays only)
- Dementia proof (see Legal memo from 2018)
- Any Additional documentation to support presence of SMI such as progress notes, social worker notes, physician notes, etc…
- Any additional documentation to support presence of functional needs that necessitate NF placement such as ADL notes, PT, OT, SP notes, assessments, etc…

# History Taking in Reverse: Beginning With the Social History

*BARRY J. WU, MD, FACP*
*Yale University*

## Physician-Centered

- *"Do you smoke?"*
- *"Do you drink?"*
- *"Do you use illicit drugs?"*

## Person-Centered

- *"Let me start at the beginning. Tell me . . ."*
- *"Where were you born?"*
- *"What level of schooling have you completed?"*
- *"What is a typical day like for you—what time do you wake up, what do you have for breakfast, then what do you do, what do you have for lunch, then what do you do, what you have for dinner, then what do you do, when do you go to bed?"*
- *"How much do you smoke?"*
- *"How much do you drink?"*
- *"What recreational drugs have you tried before?"*

# History Taking in Reverse: Beginning With the Social History, continued

*BARRY J. WU, MD, FACP*
*Yale University*

## Physician-Centered

- *"Do you have any family history of heart attack, stroke, cancer, diabetes, hypertension, or hyperlipidemia?"*

## Person-Centered

- *"Tell me about your mother."*
- *"How old is she?"*
- *"What medical problems does she have?"*

# History Taking in Reverse: Beginning With the Social History, continued

*BARRY J. WU, MD, FACP*
*Yale University*

## Physician-Centered

- *"Do you have diabetes?"*
- *"Did the pain begin today?"*
- *"Did the pain get better or worse with walking?"*
- *"Is it a pressure pain?"*
- *"Does the pain go to down your left arm?"*
- *"Is the pain the worst you have ever felt?"*
- *"Did you have this pain before?"*

- *"Any problems with weight loss?"*
- *"Is there anything else I should know?"*

## Patient-Centered

- *"What medical problems do you have?"*
- *"When did the pain start?"*
- *"What makes it better?*
- *"What makes it worse?"*
- *"How would you describe the pain?"*
- *"Where does the pain go?"*
- *"On a scale of 1 to 10, with 10 being the worst pain, how would you rate this pain?"*
- *"What were you doing when you experienced this pain?"*
- *"Tell me about your weight."*
- ***"What else should I know?"***

# Psychiatric Decline in Status

- Timeframe is defined (3 – 6 months)
- Capture a clear **picture** of what these behaviors and the decline in status looks like (one word responses are not telling)
  - What could they do before the decline that they cannot do now?
  - What where they doing/saying that indicated a decline in status?
  - When did this occur?
  - What were the precipitating events?
  - What was the intervention to reduce the behaviors? How was it successful or unsuccessful?
  - What was the result of these behaviors?

**Within the last three (3) to six (6) months, has the individual had an episode of significant decline to their psychiatric status resulting in one of the following**: □ legal/judicial involvement □ loss of housing □ crisis intervention □ bizarre behavior (ex: hallucinations, delusions, excessive spending, aggressive behavior) □ other (please describe):

# Additional Questions to Consider in Assessing a Decline in Psychiatric Status

- Describe functioning prior to the decline in mental status and functioning.
  - Always ask for examples
  - Ask for time frames
  - Ask for clarification, do not assume you understand what is meant if it is not specific
- What could individual do then that they cannot do now?
- What behaviors were not present then that are present now?
- What behaviors were present then that are not present now?
- What other changes do you notice now that were not present in the past when the individual was “doing better” but are present now and are a concern? –social, mood, hobbies, ability to manage emotions…

# Substance Use History & Current Services

**VI. SUBSTANCE USE/DEPENDENCE** (Past use of primary, secondary & tertiary current substance, incl. type, frequency, method & age of first use.)

**Check any/all that apply in past 12 months:**

☐ Alcohol Use; ☐ Illegal Drug Use; ☐ Injected Drug Use ; ☐ Tobacco Product Use; ☐ Prescription Drugs Abuse; ☐ Non-Prescription (OTC) abuse; ☐ Alcohol and/or Drug Overdose; ☐ Alcohol and/or Drug Withdrawal; ☐ Problems caused by gambling; ☐ Trouble stopping any substance; ☐ Denies ☐ Other/Describe:

**Substance Use Treatment History:** ☐ None; ☐ Outpatient; ☐ Intensive Outpatient; ☐ Residential/Inpatient; ☐ Detox; ☐ Other/Describe:

| SUBSTANCE TYPE Include all use in last 30 days. | AGE OF 1ST USE | YEARS IN LIFETIME | DAYS IN PAST 30 | DAYS SINCE LAST USE | AMOUNT | ROUTE OF ADMINISTRATION |
|---|---|---|---|---|---|---|
| | | | | | | ☐ Oral; ☐ Nasal; ☐ Smoking; ☐ Non-IV Injxn; ☐ IV |
| | | | | | | ☐ Oral; ☐ Nasal; ☐ Smoking; ☐ Non-IV Injxn; ☐ IV |
| | | | | | | ☐ Oral; ☐ Nasal; ☐ Smoking; ☐ Non-IV Injxn; ☐ IV |
| | | | | | | ☐ Oral; ☐ Nasal; ☐ Smoking; ☐ Non-IV Injxn; ☐ IV |

# Medical History

**PHYSICAL/MEDICAL HISTORY**

**VII. CURRENT MEDICAL CONDITIONS** (Check all that apply; supporting documentation must be attached)

Meets Medical Eligibility for NF placement as determined by the Level I Authority ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| ☐ Pregnant | Due date: | Prenatal care: | | |
| ☐ None Reported | ☐ Congestive Heart Failure<br>**Date of onset:** | ☐ Asthma<br>**Date of onset:** | ☐ Seizure<br>**Date of onset:** | ☐ Sexually Transmitted Dz<br>**Date of onset:** |
| ☐ High Blood Pressure<br>**Date of onset:** | ☐ Stroke<br>**Date of onset:** | ☐ Emphysema<br>**Date of onset:** | ☐ Cirrhosis<br>**Date of onset:** | ☐ Chronic Pain<br>**Date of onset:** |
| ☐ Heart Disease (specify):<br>**Date of onset:** | ☐ Diabetes ☐ Insulin<br>**Date of onset:** | ☐ Epilepsy<br>**Date of onset:** | ☐ Digestive Problems<br>**Date of onset:** | ☐ Thyroid Disease<br>**Date of onset:** |
| ☐ Cancer (specify type):<br>**Date of onset:**<br>Life expectancy of less than 6 months?<br>☐ Yes ☐ No | ☐ Dementia<br>☐ Early Stage<br>☐ Late Stage<br>**Date of onset:**<br>Must provide proof of dx and complete dementia addendum | ☐ Underweight<br>☐ Overweight<br>**Date of onset:** | ☐ COPD<br>☐ Oxygen<br>☐ No oxygen<br>**Date of onset:** | Chronic Kidney Disease<br>☐ Stage 1<br>☐ Stage 2<br>☐ Stage 3<br>☐ Stage 4<br>**Date of onset:** |

☐ Other/Describe:

List source of medical conditions noted above:

# Current Medications

**PASRR LEVEL II INDEPENDENT BEHAVIORAL HEALTH COMPREHENSIVE EVALUATION**

**VIII. Allergies:**

**IX. CURRENT MEDICATIONS** (Including non-psychotropic prescribed medications for last 12 months) *include additional pages as necessary*

| Medication Name | Dose | Freq. | Route | Current | COMMENTS (Reason Prescribed/Response/Side effects/Interactions, etc.) |
|---|---|---|---|---|---|
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |
| | | | | □ Yes; □ No | |

| X. PRIMARY CARE PHYSICIAN | NAME | PHONE | FAX |
|---|---|---|---|
| | | | |

# Medication Compliance & Other Therapies

**XI.** **a)** Does the individual has a history of non-compliance with medication? □ Yes □ No (if Yes describe)

**b)** Does the individual has the ability to administer his/her medication without supervision? ( provide detailed rationale for answer) □ Yes □ No ( If no describe how medication compliance can be accomplish)

**XII.** **ADDITIONAL MEDICAL HISTORY INCLUDING DATES OF ONSET** (Diagnosis, Pertinent injuries (head trauma), Illnesses; Hospitalizations, Surgery, Labs Values, Status of Conditions, Neurological Assessment reviewing motor function, gait, communication, etc.)

**a)** Does person participate in: □ Speech Therapy □ Occupational Therapy □ Physical Therapy □ Wound Care

If checked, explain:

# Family History

| SOCIAL HISTORY |
| --- |
| **XIII. FAMILY HISTORY** (relationship status with relatives, family involvement in treatment, and living status of significant relatives): |
| **Current Adverse Circumstances:** ◻ N/A; ◻ Poverty; ◻ Criminal Behavioral; ◻ Mental Illness; ◻ Substance Use; ◻ Abuse; ◻ Neglect; ◻ Domestic Violence; ◻ Violence; ◻ Trauma/Describe: _____<br>◻ Other/Describe: _____ |
| **Current Family Stress:** ◻ Low Stress; ◻ Mildly Stressful; ◻ Moderately Stressful; ◻ Highly Stressful; ◻ Extremely Stressful<br>◻ Other/Describe: _____ |
| **Current Family Supports:** ◻ Highly Supportive; ◻ Supportive; ◻ Limited Support; ◻ Minimal Support; ◻ No Support<br>◻ Other/Describe: _____ |
| **Additional Comments:** |

# Assessing Family History

- What is their relationship like with their family?
- What kind of family support do they have?
- Where do the family members live?
- What are the strengths and challenges of their support system?
- What types of contact do they have (regular visits…)?
- Are they married/widowed?
- If they're married what is their spouses health like/limitations?
- How many children, if any, do they have? Where do they live? What is their relationship like?
- Do they have grandchildren or great children? What is their relationship like?
- Who is their primary Caregiver? Does their primary Caregiver have any health related issues?

# Trauma History

| XIV. TRAUMA HISTORY | |
|---|---|
| **History of Trauma:** | ☐ None; ☐ By History ☐ Experienced; ☐ Witnessed; |
| TYPE: | ☐ Abuse; ☐ Neglect; ☐ Violence; ☐ Sexual Assault; ☐ Related to Military experience<br>☐ Other/Describe: |

# Assessing for Trauma History

- "When broaching the subject of trauma, ask the client if he/she has ever experienced any traumatic events such as witnessing or experiencing:
  - car accidents or other types of accidents,
  - natural disasters,
  - war,
  - adult/ childhood physical or sexual assault,
  - having been threatened
- Reliable reporting of events is best obtained by asking about specific event types.
- *Under-reporting of exposure tends to occur when people are asked only broad questions such as 'Have you ever experienced a traumatic event?'* [287]."

*https://cdn.fedweb.org/fed-42/2/AgingAndTrauma_FactSheet_CenterOnAgingAndTrauma_2fdbr.pdf*

# Living Situation Assessment

**XV. LIVING SITUATION** (Current status and functioning)

**a. Primary Residence:** □ Own Home; □ Apartment; □ Relative's Home; □ Group Home; □ Homeless; □ Nursing Facility
□ Other/Describe:

**How long at current residence?**

**Individuals Living in the Home:**

| **Source of meals/food:** | **Means of transportation:** |
|---|---|

**Have you ever been homeless? (**if yes give dates and describe living situation) □ Yes □ No

**Additional Comments:** (Include psychological and social adjustments made to disabilities and/or disorders as it relates to housing needs.)

**b. Preferences:** include things the individual or their family member feels will enhance his/her living situation

**c. Abilities/Interests/Strengths –**Include strengths, skills, aptitudes that might assist in maintaining or improving living situation; also list assets, service options and resources the person has to meet needs, including available housing options

**e. Where would you like to live?**

# Living Situation Assessment continued

**f.** **Prior Community Services Utilized such as:** □ Home Health; □ Sitters; □ Waiver Services; □ Adult Day Care;
□ PSH Voucher: Name of PSH Provider: _____
□ Voucher (Type)_____
□ Services through the Office of Citizens with Developmental Disabilities

**g.** **Prior Nursing Home Placement:** Date(s) and Names of Facility(ies) *include additional pages as necessary* **□ None**

**Name of Facility:**_____ **/ Date(s)**_____**/ Reason for Leaving:** _____

**Name of Facility:**_____ **/ Date(s)**_____**/ Reason for Leaving:** _____

**h.** **Needs –** From evaluator's perspective, identify the needs that will allow the individual to remain in the community (Ex. Transportation, personal care attendant day program, outpatient therapy, council on aging, home health, medication management, ACT, CPST, substance abuse treatment housing subsidy, money in savings, care-giver resource assessment, etc.)

# Living and Home Environment Items to Consider

- Who do they live with? Who are their supports?
- What is their home set up? Do they have stairs they have to navigate?
- Are they able to get around their home independently?
- Do they use medical equipment to navigate their home?
- Are they independent in their ADL's?
- If they live alone do they have someone to check on them regularly?
- Are they safe in their home?
- Where were they living before and why did they leave?
- What previous services were tried at maintaining them in the community?
  - Type
  - Duration
  - Frequency
  - What was provided
  - Why was it not successful

# Functional Status and ADLs

| XVI. LEARNING/WORKING AND FUNCTIONAL STATUS | |
|---|---|
| **a. Employment/Education/Rehabilitation Status:** | |
| **Current source of income:** | **Estimated Monthly Income Amount:** |
| **Military income**: ☐ No; ☐ Yes; | **Military Status:** |
| **Difficulties with Reading/Writing:** ☐ No; ☐ Yes; | **Estimated Literacy Level:** |
| **Employed within the last year?:** ☐ No; ☐ Yes | **Type of Work Performed?** |
| **Assistive Devices utilized/required:** ☐ No; ☐ Yes: ☐ Hearing Aid ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other (describe) | |
| **Additional Comments:** (Include psychological and social adjustments made to disabilities and/or disorders.) | |

# Functional Status and ADLs cont.

**b. Current Status & Functioning** (Assess ability to fulfill responsibilities; interact with others, capacity self-care, etc.)

| ADLs/IADLs | Explanation for how Determined | Impairment Expected to improve? | No Impairment | Supervision | Limited Assistance | Extensive Assistance | Total Assistance |
|---|---|---|---|---|---|---|---|
| Mobility | Select | Select | | | | | |
| Bathing | Select | Select | | | | | |
| Dressing | Select | Select | | | | | |
| Self-Feeding | Select | Select | | | | | |
| Personal hygiene & grooming | Select | Select | | | | | |
| Toilet hygiene | Select | Select | | | | | |
| Housework | Select | Select | | | | | |
| Meal Preparation | Select | Select | | | | | |
| Medication Management | Select | Select | | | | | |
| Managing Finances | Select | Select | | | | | |
| Shopping (groceries or clothing) | Select | Select | | | | | |
| Communication | Select | Select | | | | | |
| Transportation | Select | Select | | | | | |

**Comments –** indicate if the impairment is due to the current illness, including individual's reliance on support systems to perform activities in the community

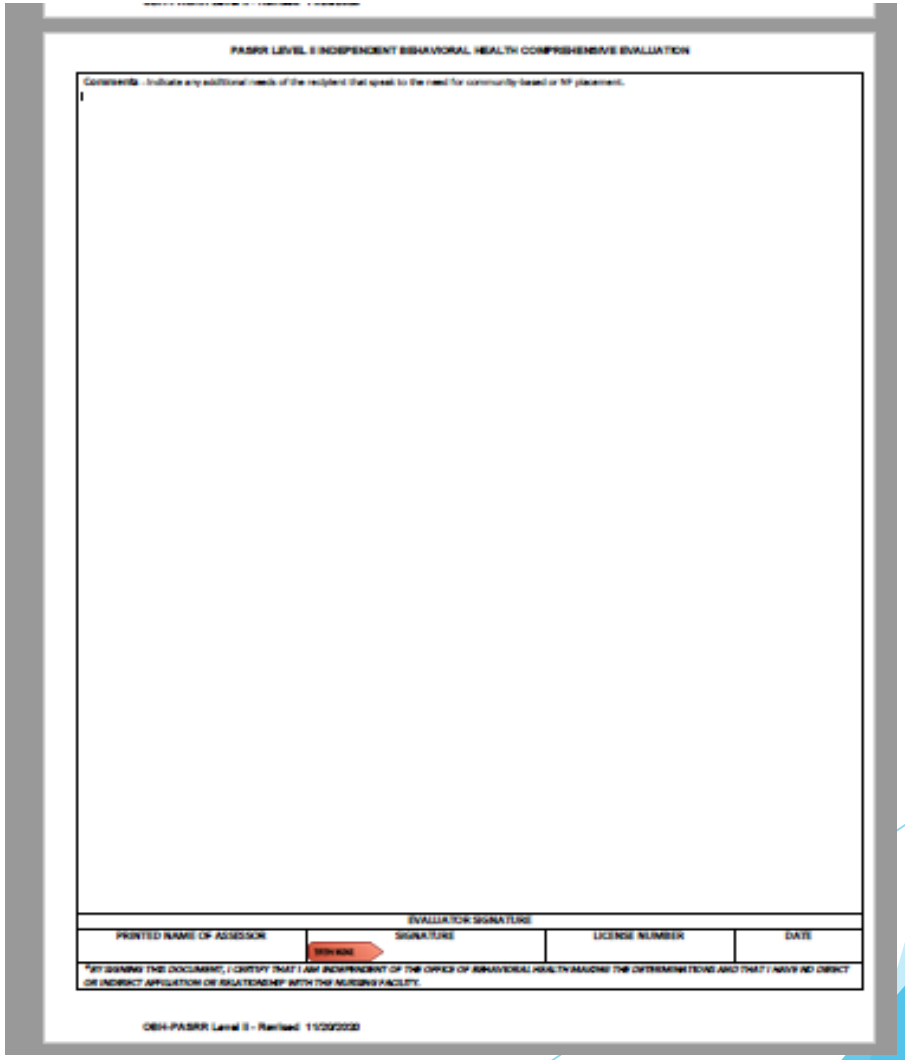
**Functional Abilities -** Include recipient reported strengths, skills, aptitudes that may help maintain or improve the current level of functioning

# Functioning: ADLs and IADLs

- Understanding an older patient's usual level of functioning and knowing about any recent significant changes are fundamental to providing appropriate health care. They also influence which treatment regimens are suitable. The ability to perform basic activities of daily living (ADLs) reflects and affects a patient's health.
- Depending on the patient's status, ask about ADLs such as eating, bathing, and dressing and more **complex instrumental activities of daily living** (IADLs) such as cooking, shopping, and managing finances. There are standardized ADL assessments that can be done quickly and in the office.
- Sudden changes in ADLs or IADLs are valuable diagnostic clues. If your older patient stops eating, becomes confused or incontinent, or stops getting out of bed, look for underlying medical problems. Keep in mind the possibility that the problem may be acute.

# Impressions, Assessment, and Recommendations

- Clinical Summary
  - Impression
  - Assessment
- Recommendations
  - Placement
  - Specialized Services
  - Nursing Facility Services
  - Community Services


PASRR LEVEL II INDEPENDENT BEHAVIORAL HEALTH COMPREHENSIVE EVALUATION

Comments - Indicate any additional needs of the recipient that speak to the need for community based or NF placement.

EVALUATOR SIGNATURE

| PRINTED NAME OF ASSESSOR | SIGNATURE | LICENSE NUMBER | DATE |
|---|---|---|---|
| | | | |

"BY SIGNING THIS DOCUMENT, I CERTIFY THAT I AM INDEPENDENT OF THE OFFICE OF BEHAVIORAL HEALTH MAKING THE DETERMINATIONS AND THAT I HAVE NO DIRECT OR INDIRECT AFFILIATION OR RELATIONSHIP WITH THE NURSING FACILITY.

OBH-PASRR Level II - Revised: 11/20/2020

# Clinical Summary Definition

- **Clinical Summary** means a written description of a clinician's formulation of
  1. ***the cause of the client's mental health symptoms***,
  2. ***the client's prognosis***, and
  3. ***the likely consequences of the symptoms***;
  4. how the client meets the criteria for the diagnosis by ***describing the client's symptoms***, the ***duration of symptoms***, and ***functional impairment***;
  5. an ***analysis of the client's other symptoms***, ***strengths***, ***relationships***, ***life situations***, ***cultural/community influences***, and ***health concerns*** and
  6. their ***potential interaction with the diagnosis*** and ***formulation of the client's mental health condition***; and
  7. alternative diagnoses that were considered and ruled out

# Clinical Impression

- An impression is a clinical summation of information and/or an opinion formed, which is the **outcome of the clinical assessment process**. The Clinical Impression may lead to a statement of a Condition about a patient.
- Clinical Impression is **a record of a clinical assessment performed** to determine
  - **what problem(s) may affect the patient** and
  - before planning the **treatments or management strategies that are best to manage a patient's condition**
- This is NOT a diagnosis
  - **Impression is the *initial* opinion of a doctor/clinician by examining the patient.**
  - **Diagnosis is the *final* opinion of a doctor/clinician about the disease**.

# Clinical Impression and Summary: Brief Template

- First, give a brief, 3-5 sentence summary of what you have written in the assessment.
  - Identifying info (age/sex/diagnosis/where they currently live)
  - Summary of how individual appeared/presented in interview
    - Overview of dress, mood, speech, affect, memory, judgment
- Second, give your impression of the problems and attempts that have been made to address them.
  - ID Primary Problem/Need/or concern that would impact the individual's ability to live in the community. This should be directly related to any **functional impairments-physical, behavioral, and community**-identified during the assessment.
  - ID attempts (previous and current) to address Problems/Needs or concerns **(physical, behavioral, and community**) and how it was successful or unsuccessful at maintaining the individual in the community.
    - This would include current and past treatments/interventions, as well as any
    - in home/community services utilized

# Clinical Impression and Summary: Brief Template, continued

- Third, provide your recommendations for placement and addressing the functional needs you've clearly identified above.
  - What is the least restrictive setting for this individual?
    - In the community with supports?
    - In the nursing facility for a short period of time?
    - In a more restrictive setting due to medical/behavioral conditions that may be dangerous to individual or others?
  - What additional services would address the functional needs you've identified?
    - Severe mental illness present-what specialized services would adequately address these issues?
    - Problems with physical health present-are supportive therapies, evaluations, devices, etc needed to adequately address these issues?
    - Problems with ADLs-are there skills or training this individual may need to adequately address these areas?
    - Community Support issues-what is needed to support and enhance in this area (housing, crisis plans, transportation, socialization opportunities, meals support, hobbies, guardianship…)

# When Specialized Behavioral Health Services are Needed

- The patient is showing depressive symptoms, especially a decline in the ability to experience pleasure or prolonged sadness t
- Any suicidal or homicidal gestures (immediate referral)
- Any dangerous behaviors such as self-harming behavior (e.g., cutting)
- Excessive anxiety (e.g., panic attacks, irrational fears, phobias)
- Intrusive thoughts
- Periods of euphoria associated with a reduced need for sleep or impulsive or risk-taking behavior (e.g., an increase in promiscuous sex, excessive drug or alcohol use, or spending sprees)
- Severe irritability or outbursts of anger (e.g., argumentative, easily annoyed, easily upset)
- Psychosis (e.g., hallucinations, delusions, paranoia)
- Addictive behaviors (e.g., drug use, excessive alcohol use, excessive overeating)
- Signs and symptoms of abuse (physical, emotional, or sexual)

Patients who may benefit from Psychotherapy by a Licensed Mental Health Professional may include those with:

- Non-compliance with medical treatment
- Unresolved grief
- Parenting or family issues
- Struggles with adjustment to major life changes (e.g., death, move, divorce, going into a nursing facility)
- Self-sabotaging behavior (e.g., drug or alcohol abuse, binge-eating)
- Anger issues or impulse control
- Significant relationship problems (e.g., dependency, manipulation, infidelity)
- Identity confusion (e.g., gender, race, sexual orientation)
- Trouble getting along with others (roommates, staff at facilities)

# Questions

End of Part 2