Health Home Program
Washington

Assessment Screening Tools

Required Screenings

Patient, Parent or Caregiver Activation Measure – PAM® from Insignia

PHQ-9: Patient Health Questionnaire with nine questions to screen for depression and suicide (age 18 & older)

PSC-17: Pediatric Symptoms Checklist for children (age 4 – 17)

Katz ADL: activities of daily living to take care of themselves (age 18 & older)

BMI: Body Mass Index to determine if they are a healthy weight (age 2 and above)

Note: the client reserves the right to decline to complete any of these screenings

Health Action Plan – Required Screenings

Initial / Annual HAP Required Screenings			
SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

Value Ranges

- **PAM, CAM, PPAM**
  - Score 0.0-100.0
  - Level 1-4
- **Katz ADL** 0-6
- **PHQ=9** 0-27
- **PSC-17** 0-34
- **BMI** 0.0-125.9

The Patient Activation Measure®

Insignia's Patient, Caregiver and Parent of Patient Activation Measures

Level 1: Disengaged and overwhelmed

Level 2: Becoming aware, but still struggling

Level 3: Taking action

Level 4: Maintaining behaviors and pushing further

Review

- Utilize Insignia's website and Coaching for Activation
- Complete the PAM/CAM/PPAM with every HAP visit
- Document if client declines to complete
- Tailor goal setting and action planning based level of activation
- Insignia offers training – check with your supervisor or Lead
- Multiple languages available – visit Insignia's website

Depression Screening for Children and Adults

Depression Screenings

- The Care Coordinator’s role is to screen for possible behavioral health issues
- Care Coordinators do not diagnose, counsel, or treat; they refer to qualified professionals and behavioral health resources for further assessment and treatment

Pediatric Symptom Checklist - 17

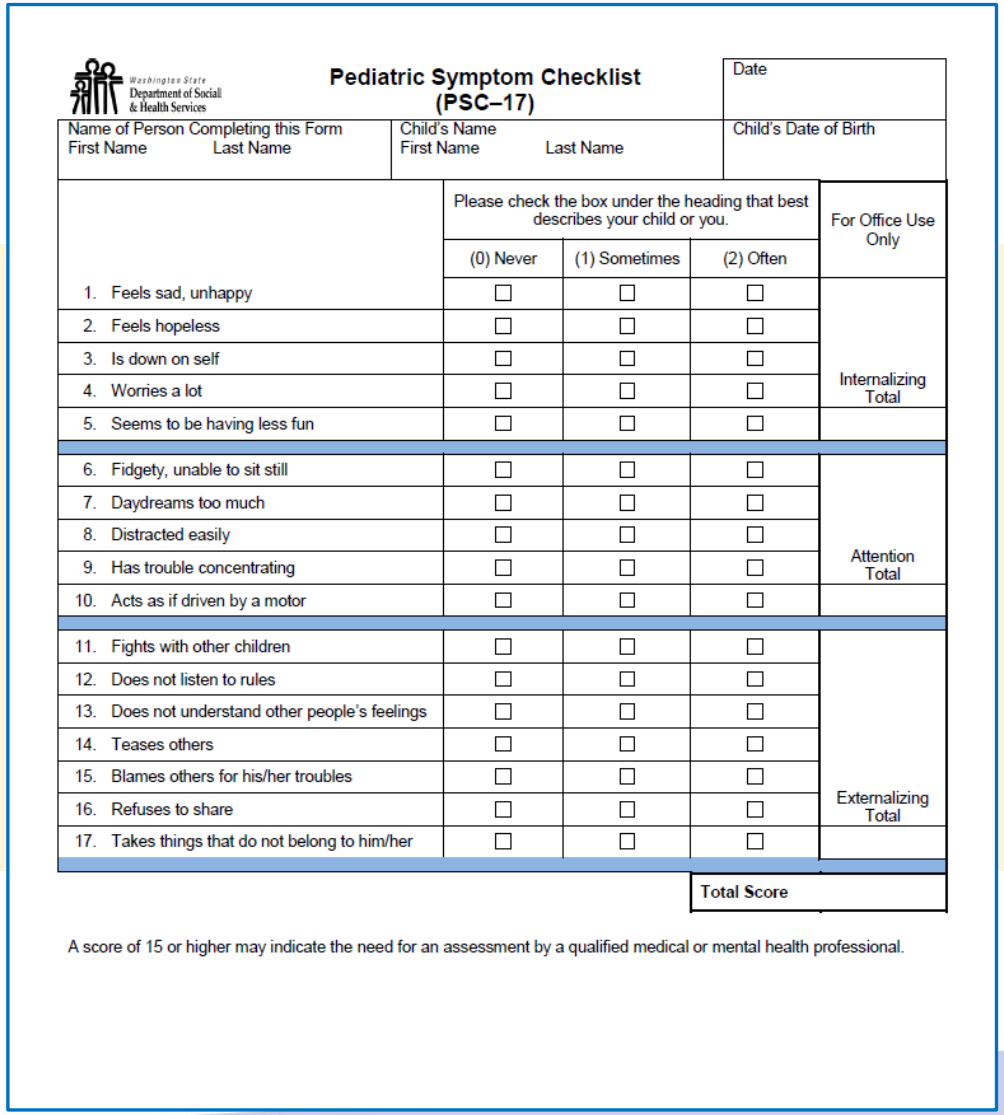
Pediatric Symptom Checklist – 17

- The PSC-17 must be completed for children ages 4 to 17 years of age
- The screening is completed by the parent or guardian
  - Scoring is based on the parent's report of current behaviors
- A child aged 13 and over may self-administer the screening
- Note in the comment section the name of the person who completed the screening and their relationship to the child. Enter the score in the HAP and note in the case narrative
- The screening tool should not be used for diagnosing

The PSC-17 is a Required Screening

You may find a copy of the form and instructions in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



Washington State Department of Social & Health Services

Pediatric Symptom Checklist (PSC–17)

Name of Person Completing this Form First Name Last Name	Child's Name First Name Last Name	Date Child's Date of Birth

	Please check the box under the heading that best describes your child or you.			For Office Use Only
	(0) Never	(1) Sometimes	(2) Often	
1. Feels sad, unhappy	☐	☐	☐	
2. Feels hopeless	☐	☐	☐	
3. Is down on self	☐	☐	☐	
4. Worries a lot	☐	☐	☐	Internalizing Total
5. Seems to be having less fun	☐	☐	☐	
6. Fidgety, unable to sit still	☐	☐	☐	
7. Daydreams too much	☐	☐	☐	
8. Distracted easily	☐	☐	☐	
9. Has trouble concentrating	☐	☐	☐	Attention Total
10. Acts as if driven by a motor	☐	☐	☐	
11. Fights with other children	☐	☐	☐	
12. Does not listen to rules	☐	☐	☐	
13. Does not understand other people's feelings	☐	☐	☐	
14. Teases others	☐	☐	☐	
15. Blames others for his/her troubles	☐	☐	☐	
16. Refuses to share	☐	☐	☐	Externalizing Total
17. Takes things that do not belong to him/her	☐	☐	☐	
			Total Score	

A score of 15 or higher may indicate the need for an assessment by a qualified medical or mental health professional.

PSC-17 Scoring

	Please check the box under the heading that best describes your child or you.			For Office Use Only
	(0) Never	(1) Sometimes	(2) Often	
1. Feels sad, unhappy	☐	☐	☐	
2. Feels hopeless	☐	☐	☐	
3. Is down on self	☐	☐	☐	
4. Worries a lot	☐	☐	☐	Internalizing Total
5. Seems to be having less fun	☐	☐	☐	
6. Fidgety, unable to sit still	☐	☐	☐	
7. Daydreams too much	☐	☐	☐	
8. Distracted easily	☐	☐	☐	
9. Has trouble concentrating	☐	☐	☐	Attention Total
10. Acts as if driven by a motor	☐	☐	☐	
11. Fights with other children	☐	☐	☐	
12. Does not listen to rules	☐	☐	☐	
13. Does not understand other people's feelings	☐	☐	☐	
14. Teases others	☐	☐	☐	
15. Blames others for his/her troubles	☐	☐	☐	
16. Refuses to share	☐	☐	☐	Externalizing Total
17. Takes things that do not belong to him/her	☐	☐	☐	

Total Score

Pediatric Symptom Checklist – 17 Scoring

- Includes 17 questions – a total score of 15 or higher suggests significant behavior or emotional problems and should lead to the recommendation that the child be seen by their PCP or a mental health specialist
- The 17 questions are divided into 3 subscales which also have cut-off scores for referral:
  - Internalizing- anxiety and mood disorder, cut-off score of 5
  - Attention- hyperactivity, attention deficit, cut-off score of 7
  - Externalizing – conduct problems, oppositional behavior, cut-off score of 7

Pediatric Symptom Checklist – 17 cont.

- The PCP may have additional screenings they will complete. They may choose to provide counseling in the office, or they might refer out to a mental health provider. They might prescribe psychiatric medication or may refer to psychiatry or to a behavioral pediatrician
- A parent can access Behavioral Health services directly without a referral from the PCP
- For more information go to the HCA Child and Youth Behavioral Health Services website at **https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/child-and-youth-behavioral-health#are-there-resources**

Consider Vignette From 2-Day Training

What would you do if Luchita scored 12 on the PSC-17 – with 7 points on the attention scale?

6yr girl who began living with her mother 3 months ago after being placed in foster care. Her medical issues include gastrostomy, developmental delay, conduct disorder and immune system disorder

PSC-17 Website

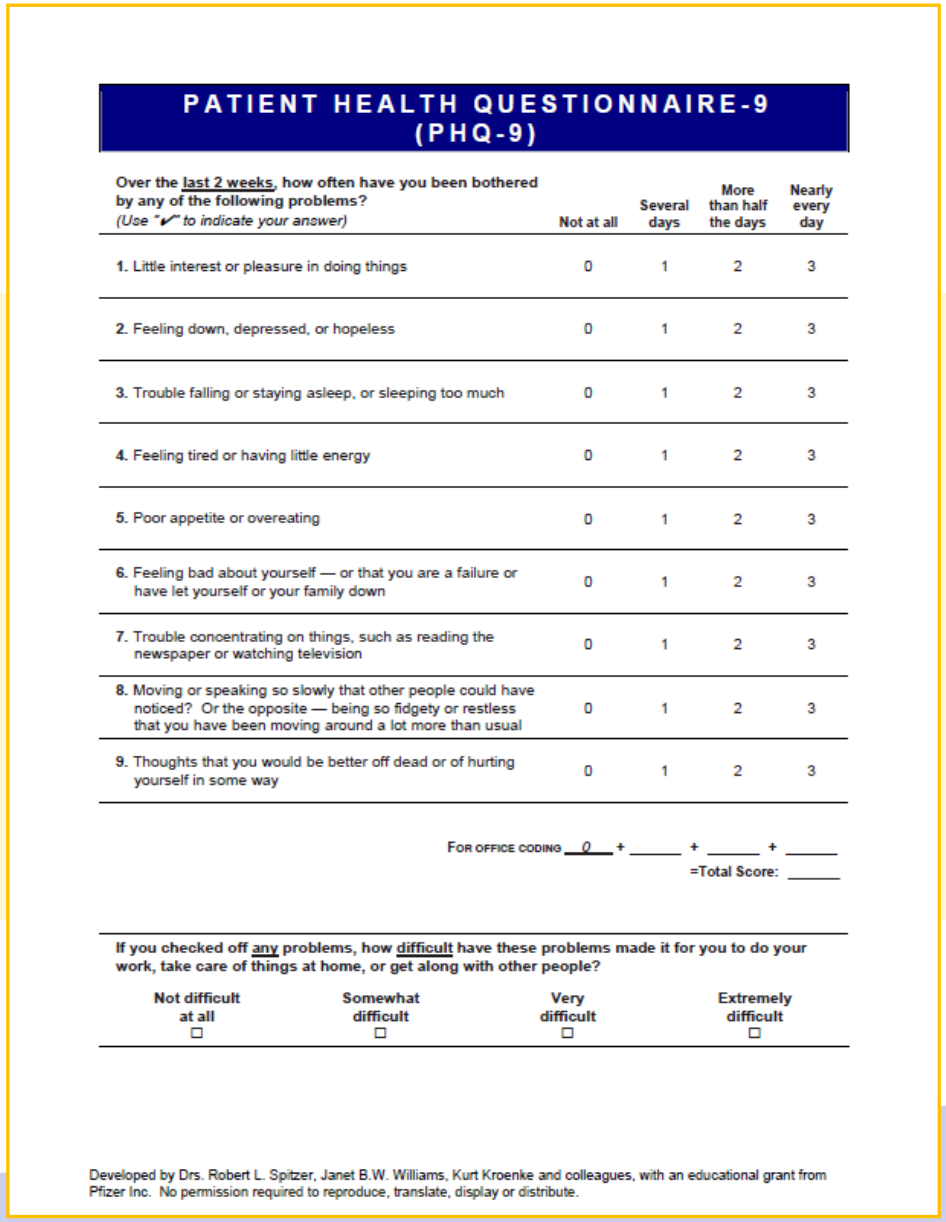
For translations visit the Massachusetts General Hospital website located at: https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist/

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a Required Screening

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

PSC-17 continued

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PHQ-9 Screening Tips

- Normalize the screening; don’t make it a big deal
- Some people respond better to terms like “stress” when talking about their anxiety or “sadness” rather than depression
- Remember the power that stigma holds - many people do not want to self-identify
- Treatment for depression can be very effective

PHQ-9 Administration

- Start with general question:
  - In general, how do you feel about life?
- Ask more specific question:
  - How have you been feeling over the past 2 weeks?
  - Over the last two weeks, how many days were you… (then continue with the question)
- If the individual can read, give them the questionnaire and ask to fill it out. If necessary, ask the questions yourself or work with caregiver (with client’s permission)

PHQ-9 Scoring and Follow-Up

- A score of 10 or more indicates possible depression
- Discuss with client that they may be suffering from depression
- If needed, reassure that depression is a treatable illness, not a moral weakness
- Offer referral for diagnosis and treatment
- If not engaged with PCP or BH provider, offer to help connect to provider(s)
- Follow up within 2 weeks

Question #9 - Suicide

Question 9: “Thoughts that you would be better off dead, or of hurting yourself”

- This question screens for suicidal thoughts
- Your role is to reassure and help connect the client to immediate help if needed or make a referral to crisis or mental health services
- If you *deem* immediate suicide risk, stay with the person until help arrives

Question #9 - Suicide cont.

If the answer to question # 9 is anything **other than a score of 1 or "Not at All":**

- Follow your agency's suicide screening and protocol
- Offer crisis resources and help client call the crisis line
- If a client expresses that they have thought about suicide, have a plan, and have the means seek help immediately
- If you *deem* immediate suicide risk, stay with the person until help arrives

Question #9 - Suicide cont.

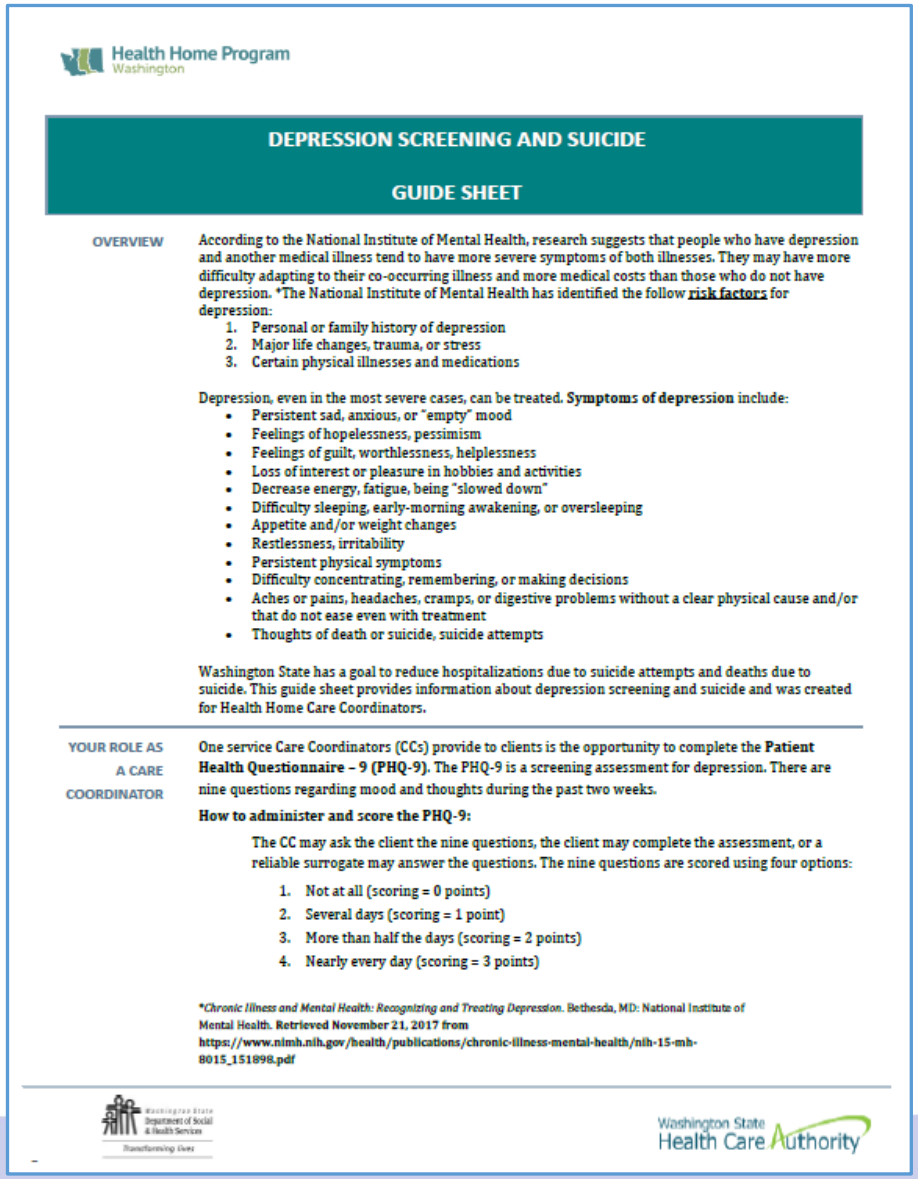
- If the client answers Yes: SAMHSA recommends asking these four questions about suicidal ideation:

1. Past Suicide Attempt: “Have you ever attempted to harm yourself in the past?”
2. Suicide Plan: “Have you had thoughts about how you might actually hurt yourself? If yes, “Do you have the means to follow it through?”
3. Probability (Perceived): “How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?”
4. Preventive (Protective) Factors: “Is there anything that would prevent or keep you from harming yourself?”

Suicide Question - Follow-Up

- If a client says that they have thoughts of suicide, have a plan, and have the means, seek help immediately
- For immediate crisis intervention call 9-1-1. Have the client's address and phone number available for your report
- Stay with the client until a family member, client representative, Designated Crisis Responder (DCR), emergency responder, or law enforcement arrives
- Consult with your supervisor either on the phone for emergencies or in person for non-emergencies

Guide Sheet on Depression Screening and Suicide



Health Home Program
Washington

DEPRESSION SCREENING AND SUICIDE

GUIDE SHEET

OVERVIEW

According to the National Institute of Mental Health, research suggests that people who have depression and another medical illness tend to have more severe symptoms of both illnesses. They may have more difficulty adapting to their co-occurring illness and more medical costs than those who do not have depression. *The National Institute of Mental Health has identified the follow **risk factors** for depression:

1. Personal or family history of depression
2. Major life changes, trauma, or stress
3. Certain physical illnesses and medications

Depression, even in the most severe cases, can be treated. **Symptoms of depression** include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decrease energy, fatigue, being "slowed down"
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Restlessness, irritability
- Persistent physical symptoms
- Difficulty concentrating, remembering, or making decisions
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment
- Thoughts of death or suicide, suicide attempts

Washington State has a goal to reduce hospitalizations due to suicide attempts and deaths due to suicide. This guide sheet provides information about depression screening and suicide and was created for Health Home Care Coordinators.

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) provide to clients is the opportunity to complete the **Patient Health Questionnaire – 9 (PHQ-9).** The PHQ-9 is a screening assessment for depression. There are nine questions regarding mood and thoughts during the past two weeks.

How to administer and score the PHQ-9:

The CC may ask the client the nine questions, the client may complete the assessment, or a reliable surrogate may answer the questions. The nine questions are scored using four options:

1. Not at all (scoring = 0 points)
2. Several days (scoring = 1 point)
3. More than half the days (scoring = 2 points)
4. Nearly every day (scoring = 3 points)

**Chronic Illness and Mental Health: Recognizing and Treating Depression.* Bethesda, MD: National Institute of Mental Health. Retrieved November 21, 2017 from https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/nih-15-mh-8015_151898.pdf

Washington State Department of Social & Health Services

Washington State Health Care Authority

You may find a copy in the Care Coordinator Toolkit at https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit

* Please note these are guidelines

** Your agency may have their own policies, procedures, and reporting requirements

Follow-Up

- Find out if your organization requires you to follow the Columbia Suicide Severity Rating Scale (C-SSRS)
- Find out if your organization provides training for helping the client create a “Safety Plan”
- Document the results of the screening and all actions taken
- Follow up with phone calls or face-to-face visits with the client, family members, or client representative to discuss outcomes from hospitalizations and/or treatment and counseling

Crisis Services

- National Suicide Prevention Lifeline: 1-800 273-8255 (TALK)
  - https://suicidepreventionlifeline.org/
- Each county maintains a crisis line – Available to everyone
  - Visit the HCA Behavioral Health Administration website for a list by county: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines
- Face-to-face crisis intervention
  - When a person cannot manage safely within the community, hospitalization may be sought
  - Hospitalization can be voluntary or involuntary
  - Involuntary hospitalization can only occur if directed by a "Designated Crisis Responder" (DCR) invokes the Involuntary Treatment Act- often called "ITA"
- Connect with 211

Help Lines

- For referral to services in your county, contact the **Washington Recovery Help Line** at 1-866-789-1511 or www.warecoveryhelpline.org
- **Teen Link Help Line** for teens: 866-833-6546 or https://www.teenlink.org/

Depression Intervention in the Health Action Plan (HAP)

- Incorporate PHQ-9 score into HAP
- Use the responses to stimulate discussion on developing goals/action steps
- High PHQ-9 score might lead to a discussion on MH referrals
- HAP goal/action steps could focus on connecting client to Mental Health resources or crisis services
- If depression is related to a chronic disease, HAP goal/actions steps could be focused on chronic disease management

Consider Vignette From 2-Day Training

What would you do if Tom scored high on the PHQ-9 - above 15 - with a Zero on Question #9 (no suicide ideation)?

54yr old homeless man. Has major medical risk factors, has behavioral health risk factors, Alcohol abuse, High ED use, no PCP, 2-3 BH service visits a month

Consider Vignette From 2-Day Training

Carmella

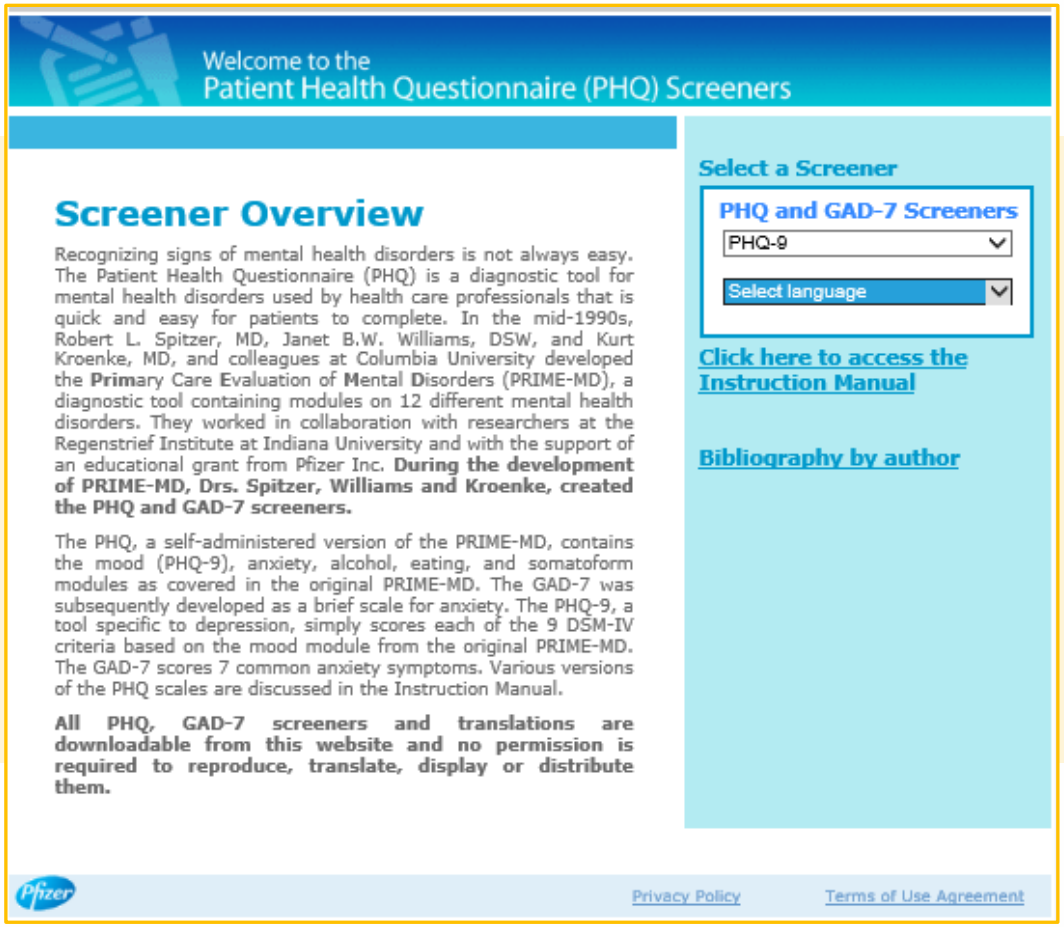
How would you help Carmella if she scored very high on the PHQ-9 with a positive answer on Question #9?

25yr old living at home. Has major medical risk factors, major BH factors, 8 IP admissions in 15 months (one for OD and one for MH), high ED use – past visits include BH issues & adult sexual abuse, frequent therapy visits & crisis interventions, No PCP

Translations of PHQ-9 and GAD-7

The website sponsored by Pfizer is located at:

https://www.phqscreeners.com/select-screener

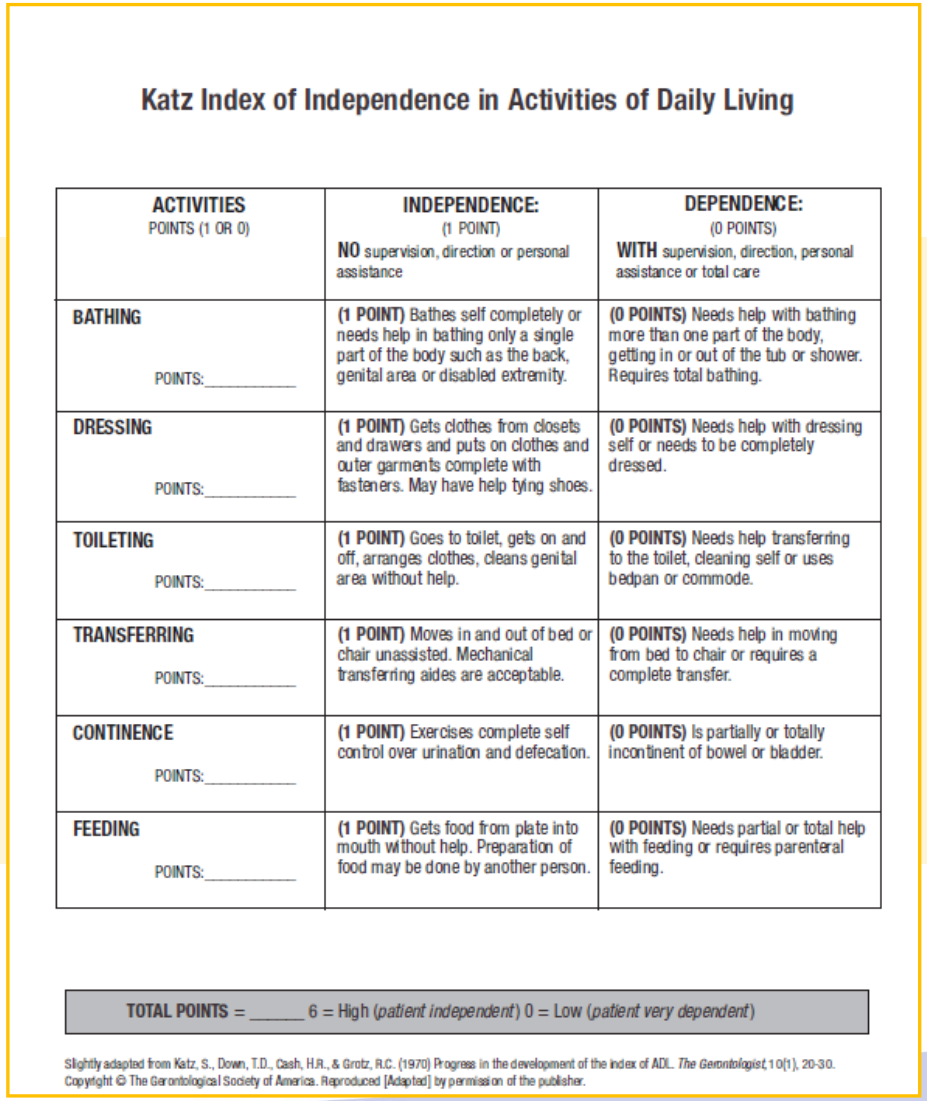


Katz Index of Independence in Activities of Daily Living (ADL)

The Katz ADL

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:_____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:_____	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS:_____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS:_____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS:_____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS:_____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (*patient independent*) 0 = Low (*patient very dependent*)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.

Katz ADL

- The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate tool to assess functional status as a measurement of the client's ability to perform activities of daily living independently
- This assessment is easily understood across many professionals and disciplines
- Required for clients 18 years of age and older
- This assessment only measures basic ADLs, but can be used as a tool to indicate if a referral for Long Term Services and Supports is needed

Using PRISM to Assess

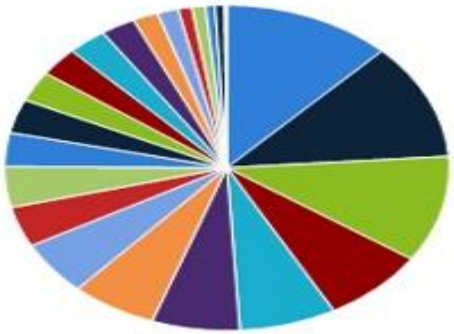
Prior to engaging with a Health Homes client, you can view their PRISM information to see if a CARE Assessment has ever been done

Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1951-03-05
Gender:	F	Age:	69
P1 ID (ACES):	1111111111WA (1111111111)	Phone:	(855) 256-1654



RISK PROFILE FOR SERVICE DATE RANGE FROM 2020-11-11 TO 2019-08-17

Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Long Term Care Assessments

ID	Type	Status	Date	Problem Description
5775319	Annual	Current	2020-10-19	Annual Review to determine continued elligibility.
5688454	Significant Change	History	2020-06-18	Significant Change review due to client's fall and fracture of leg.
5535221	Annual	History	2019-12-26	Annual review to determine continued eligibility.

Using PRISM – Case Manager

Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1951-03-05
Gender:	F	Age:	69
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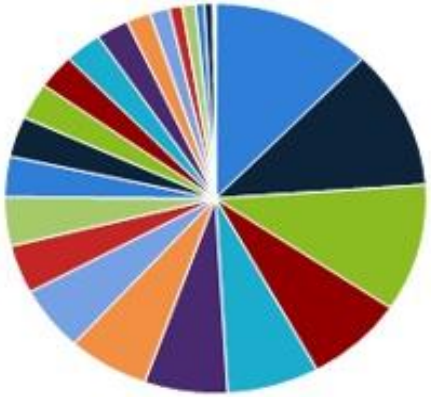

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Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

aviors(4) Fall(1) Pain(2) Limitations(38) Client Worker

Details of Long Term Care Assessment 5775319 on 2020-10-19 (Annual) for CARE client named KNUT,SACH.

ADL Score [0 to 28]:	14	Depression Score:	17	CPS Score [0 to 6]:
Overall Self-Sufficiency:	DETERIORATED	Self Rated Health Status:	POOR	Residential Group:

Name	Phone
Lane, Lois	508-749-1831 Ext: 321

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:_____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:_____	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
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FEEDING POINTS:_____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

Katz ADL – Administration and Follow-Up

- Score one point for each of the ADLs that the client reports they can perform Independently; without supervision, direction, or personal assistance
- The KATZ ADL Assessment will not affect any of the clients current services or CARE scores
- If a client indicates that they are dependent with two or more ADLs, consider a discussion about a referral for Long-Term Services & Supports (LTSS)
- If the client is already on LTSS, the KATZ ADL could determine if the client had a recent significant change in their function. This would be communicated to the Long-Term Care Case Manager

Katz ADL - Other Steps

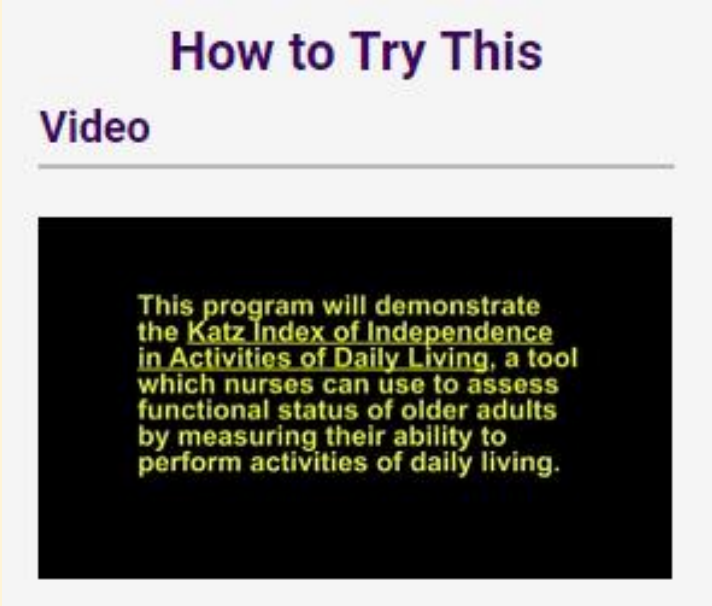
- Other options are available if a client needs assistance with ADLs and isn't interested in LTSS
  - DME, Family support, MAC/TSOA referral, Evaluate living situation, discuss how the client can remain independent
- Share KATZ ADLS results with the clients PCP if client consents
- Help coach the client into making unmet needs into Goals and Action Steps within the HAP
- To find information on who to contact for local services for HCS/DDA please visit **https://www.dshs.wa.gov/altsa/home-and-community-services/who-contact-find-local-services**

Consider Vignette From 2-Day Training

How could you use the Katz ADL with Sacha?

69 yr old living at home with 4 hours of personal care per day through Community First Choice Program. Care assessment shows moderate ADL needs

Katz ADL - Additional Training



https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl

Body Mass Index (BMI)

What is BMI?

According to the CDC, BMI:

- Is a number calculated from a person's height and weight
- Can be an indicator of risk for certain medical conditions
- Can be used as a inexpensive screening tool, but it is not diagnostic of the health of an individual
- BMI = 703 x (weight ÷ (height in inches x height in inches))
  - Do multiplication in brackets first

BMI Categories

Weight Status Category	Child/Teen (BMI Percentile)	Adult (BMI)
Underweight	Less than the 5th percentile	Below 18.5
Normal or Healthy Weight	5th percentile to less than the 85th percentile	18.5-24.9
Overweight	85th to less than 95th percentile	25.0-29.9
Obese	Equal to or greater than the 95th percentile	30.0 and above

BMI in Care Coordination

- An example of an open ended question- “If you decided to try and achieve a healthier weight, how would you go about doing it? What are the three most important benefits you see in making this change?” [1]

- Acknowledging the clients PAM activation level is an important step in effective care coordination
- BMIs that fall in the underweight category need to be communicated with the client’s providers as much as the overweight or obese categories

Consider Vignettes From 2-Day Training

- How could you use the BMI score?

More Information

BMI Calculator for Children and Teens (2-19)
https://www.cdc.gov/healthyweight/bmi/calculator.html

BMI Calculator for Adults
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

For more information visit the CDC's website at:
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Additional Screenings

AUDIT: Alcohol Use Disorders Identification Test

DAST: Drug Abuse Screening Test

Falls Risk: My Falls Free Plan

GAD-7: Generalized Anxiety Disorder

Pain Scales: Numeric, Wong-Baker or FLACC

Note: the client reserves the right to decline to complete any of these screenings

When to Complete an Additional Screening

Use your clinical judgment to determine the need and frequency for offering additional screenings

Examples:

- If a client identifies a goal related to pain: one of the three pain screenings
- If a client voices concerns about their use of alcohol or drugs: the AUDIT or DAST
- If a client reports falls or fractures: falls risk
- If a client identifies a goal to reduce stress or anxiety: GAD-7

If the Health Action Plan (HAP) includes goals or action steps related to one of the additional screenings then the screening must be completed and documented on the HAP

Alcohol Use Disorder Identification Test (AUDIT) and Drug Abuse Screening Test 10 (DAST-10)

Talking About Drugs and Alcohol

Your Comfort Zone

Confidence is the key to asking drug/alcohol questions successfully

If you don’t feel comfortable asking the questions, they might not feel comfortable answering them

- **Confidence**
- **Compassion**
- **Nonjudgmental**
- **Listen**
- **Use simple reflections**
- **Normalize the experience**
- **Don’t down-play the questions**

The Screening Process

- The first step in the screening process is to ask the brief prescreen questions first
- If the client reports “no” to all the prescreen questions you’re done
- If the client answers yes to any of the questions, continue with the full screen

Prescreening Questions

ONE DRINK EQUALS

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

Please answer the questions below.	None (0)	1 or More
1. How many times in the past year have you had **4 or more drinks in a day**?	○	○
2. How many times in the past year have you used a **recreational drug** or used a **prescription medication for non-medical reasons**?	○	○

- Two questions
- Determine if further screening is necessary
- Does not determine if there is a problem
- If “yes” on either prescreen question an AUDIT or DAST should be administered

Full Screenings

Alcohol Use Disorder Identification Test (AUDIT)

- Patients with a positive alcohol prescreen are given the AUDIT
- Developed by the World Health Organization
- 10 multiple choice questions for alcohol only
- 95% accurate in classifying people into risk categories for SUDs
- Accurate across many cultures/nations

Drug Abuse Screening Test 10 (DAST-10)

- Patients with a positive drug prescreen are given the DAST
- 10 Yes/No Questions for poly drug use
- Abstinence based screening tool-meaning there is no safe level for any drug use
- Validated for screening adults
- Places individual in a risk category for Substance Use Disorders (SUDs)

AUDIT - Administration

One drink equals	 12 oz. Beer	 5 oz. Wine	 1.5 oz. Liquor (one shot)

In the past 12 months…

Place an X in one box that best describes your answer to each question.

AU1. How often do you have a drink containing alcohol?	○ Never 0	○ Monthly or less 1	○ 2-4 times a month 2	○ 2-3 times a week 3	○ 4 or more times a week 4
AU2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○ 1 or 2 0	○ 3 or 4 1	○ 5 or 6 2	○ 7 to 9 3	○ 10 or more 4
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
AU3. How often do you have 5 or more drinks on one occasion?	○ 0	○ 1	○ 2	○ 3	○ 4
AU4. How often during the last year have you found that you were not able to stop drinking once you had started?	○ 0	○ 1	○ 2	○ 3	○ 4
AU5. How often during the last year have you failed to do what was normally expected from you because of drinking?	○ 0	○ 1	○ 2	○ 3	○ 4
AU6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	○ 0	○ 1	○ 2	○ 3	○ 4
AU7. How often during the last year have you had a feeling of guilt or remorse after drinking?	○ 0	○ 1	○ 2	○ 3	○ 4
AU8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	○ 0	○ 1	○ 2	○ 3	○ 4
AU9. Have you or someone else been injured because of your drinking?	○ No 0		○ Yes, but not in the last year 2		○ Yes, during the last year 4
AU10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	○ No 0		○ Yes, but not in the last year 2		○ Yes, during the last year 4
Add scores by column, then across row.					

AUDIT Answer Visual

#1 Never Monthly or less 2-4 times a month

2-3 times per week 4 or more times a week

#2 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

#3-8 Never Less than monthly Monthly Weekly

Daily or almost daily

#9-10 No Yes, but not in the last year Yes, during the last year

One drink equals	 12 oz. Beer	 5 oz. Wine	 1.5 oz. Liquor (one shot)

In the past 12 months…

Place an X in one box that best describes your answer to each question.

AU1. How often do you have a drink containing alcohol?	○ Never 0	○ Monthly or less 1	○ 2-4 times a month 2	● 2-3 times a week 3 +3	○ 4 or more times a week 4
AU2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○ 1 or 2 0 +1	● 3 or 4 1	○ 5 or 6 2	○ 7 to 9 3	○ 10 or more 4
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
AU3. How often do you have 5 or more drinks on one occasion?	○ 0	○ 1	● 2 +2	○ 3	○ 4
AU4. How often during the last year have you found that you were not able to stop drinking once you had started?	○ 0 +1	● 1	○ 2	○ 3	○ 4
AU5. How often during the last year have you failed to do what was normally expected from you because of drinking?	○ 0 +1	● 1	○ 2	○ 3	○ 4
AU6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	○ 0 +1	● 1	○ 2	○ 3	○ 4
AU7. How often during the last year have you had a feeling of guilt or remorse after drinking?	○ 0	○ 1	● 2 +2	○ 3	○ 4
AU8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	○ 0	○ 1	● 2 +2	○ 3	○ 4
AU9. Have you or someone else been injured because of your drinking?	○ No 0		○ Yes, but not in the last year 2	+4	● Yes, during the last year 4
AU10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	● No 0		○ Yes, but not in the last year 2		○ Yes, during the last year 4
Add scores by column, then across row.	**0**	**4**	**6**	**3**	**4**

Add subtotals for total score

=17

Sum Columns

Washington State Department of Social & Health Services
BHSIA Behavioral Health and Service Integration Administration

AUDIT - Scoring

SCORING:

Each response from the AUDIT has a score ranging from 0 to 4. The top of each column has a number. That number equals the score value for responses in that column. After a patient has completed the AUDIT, add up each column score, and then sum all five columns for the patient's score. Below are the scoring guidelines for the AUDIT.

Guidelines for Interpretation for AUDIT

Score	Risk Level	Intervention
0-6 (Female) 0-7 (Male)	Zone I	Feedback and alcohol education
7-15 (Female) 8-15 (Male)	Zone II	Brief intervention
16-19	Zone III	Brief intervention plus brief therapy
20-40	Zone IV	Brief intervention plus referral to chemical dependency treatment

Babor TF, Higgins-Biddle JC , Saunders JB, Monteiro MG. *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd Edition.* World Health Organization. 2001

DAST-10 Administration

DRUG USE QUESTIONS (DAST-10)

Using drugs can affect your health and your daily life. Please help us assist you by answering the questions below.

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months…	**1**	**0**
1. Have you used drugs other than those required for medical reasons?	○ Yes	○ No
2. Do you abuse more than one drug at a time?	○ Yes	○ No
3. Are you unable to stop using drugs when you want to?	○ Yes	○ No
4. Have you ever had blackouts or flashbacks as a result of drug use?	○ Yes	○ No
5. Do you ever feel bad or guilty about your drug use?	○ Yes	○ No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	○ Yes	○ No
7. Have you neglected your family because of your use of drugs?	○ Yes	○ No
8. Have you engaged in illegal activities in order to obtain drugs?	○ Yes	○ No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	○ Yes	○ No
10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	○ Yes	○ No
TOTAL		

Date_____

DAST-10

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months…	Yes	No	
DA1. Have you used drugs other than those required for medical reasons?	● 1	○ 0	+1
DA2. Do you abuse more than one drug at a time?	● 1	○ 0	+1
DA3. Are you unable to stop using drugs when you want to?	○ 1	● 0	+0
DA4. Have you ever had blackouts or flashbacks as a result of drug use?	○ 1	● 0	+0
DA5. Do you ever feel bad or guilty about your drug use?	○ 1	● 0	+0
DA6. Does your spouse (or parents) ever complain about your involvement with drugs?	● 1	○ 0	+1
DA7. Have you neglected your family because of your use of drugs?	● 1	○ 0	+1
DA8. Have you engaged in illegal activities in order to obtain drugs?	● 1	○ 0	+1
DA9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	○ 1	● 0	+0
DA10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	○ 1	● 0	+0
TOTAL	**5**	**0**	

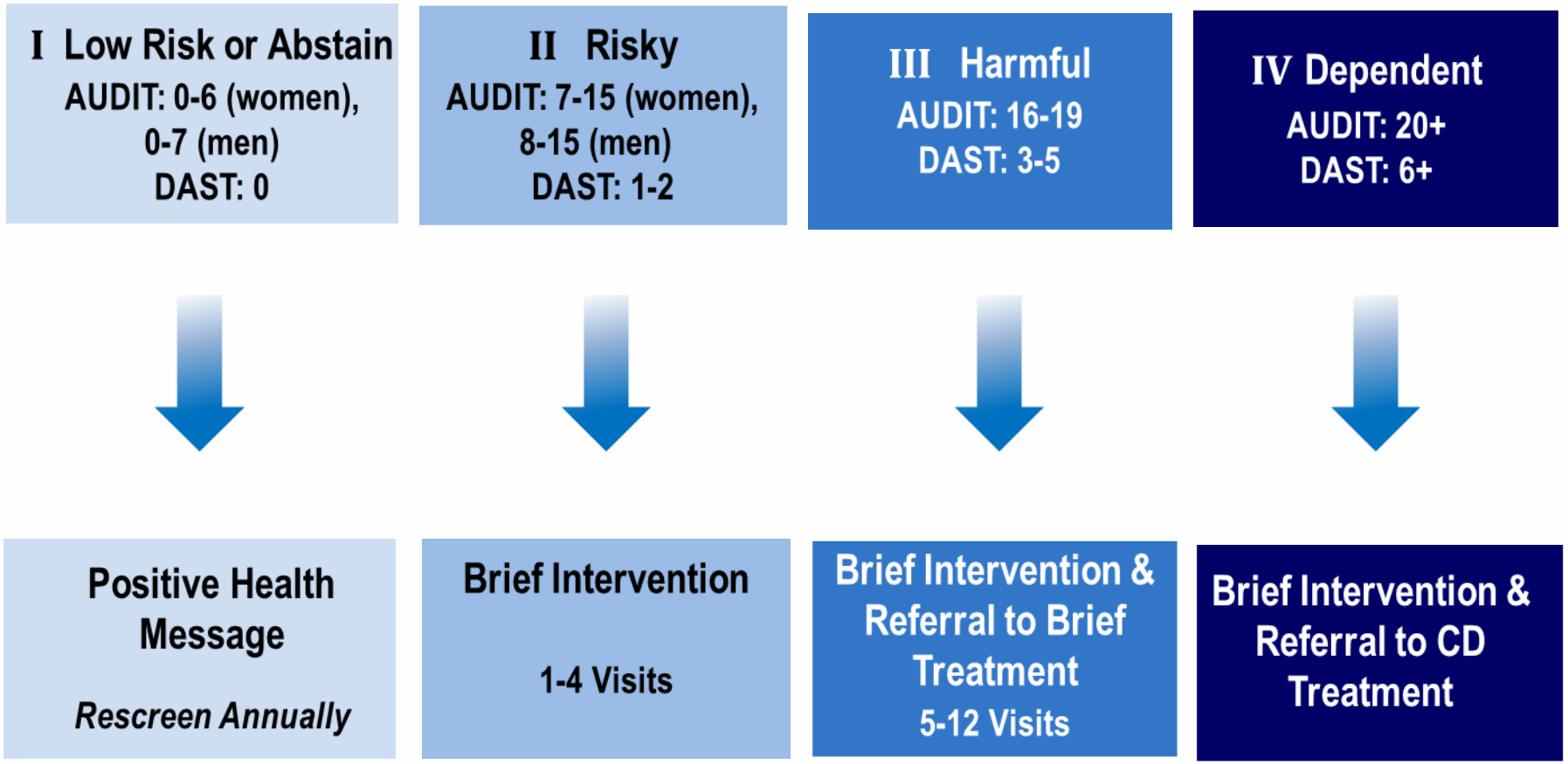
Sum of "Yes" Column is Total Score

DAST-10 – Scoring Interpretation

Guidelines for Interpretation of DAST-10 Scores

Score	Risk Level	Suggested Action
0	No problems reported	Encouragement and education
1-2	Moderate level	Brief intervention
3-5	High level	Brief intervention plus brief therapy
6-10	Substantial level	Brief intervention plus referral to chemical dependency treatment

Full Screen Scores



Resources

Please visit https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/substance-use-treatment#type-of-services for information on SUD referrals, providers and services as well as resources to help someone

DAST: https://sbirt.publichealthcloud.com/resources/links/DAST-10%20Revised.pdf

Spanish (some differences including 6 month lookback & 4 more items https://elcentro.sonhs.miami.edu/research/measures-library/dast-10/dast-10_spa.pdf

AUDIT: Multiple languages available https://auditscreen.org/translations

Consider Vignette From 2-Day Training

What would you do if Tom scored high on the AUDIT?

54yr old homeless man. Has major medical risk factors, has behavioral health risk factors, Alcohol abuse, High ED use, no PCP, 2-3 BH service visits a month

Falls

Falls Are a Serious Problem

According to the CDC

- More than 1 out of 4 older adults fall each year but less than half tell their doctor
- Falling once doubles the chances of falling again
- 1 out of every 5 falls result in a serious injury
- Each year, 3 million older adults are treated in the emergency department due to falls
- Over 800,000 patients per year in the hospital most often have a head injury or hip fracture
- Total medical costs due to falls totals more than $50 billion

Leading Risk Factors for Falls

- Previous falls, especially with injury*
- Decreased leg strength
- Vitamin D Deficiency
- Decreased balance
- Taking more than four medications
- Unsafe home environment
- Vision problems
- Chronic Conditions*
- Fear of falling
- Decreased sensation in feet
- Advanced age*

**Non-modifiable*

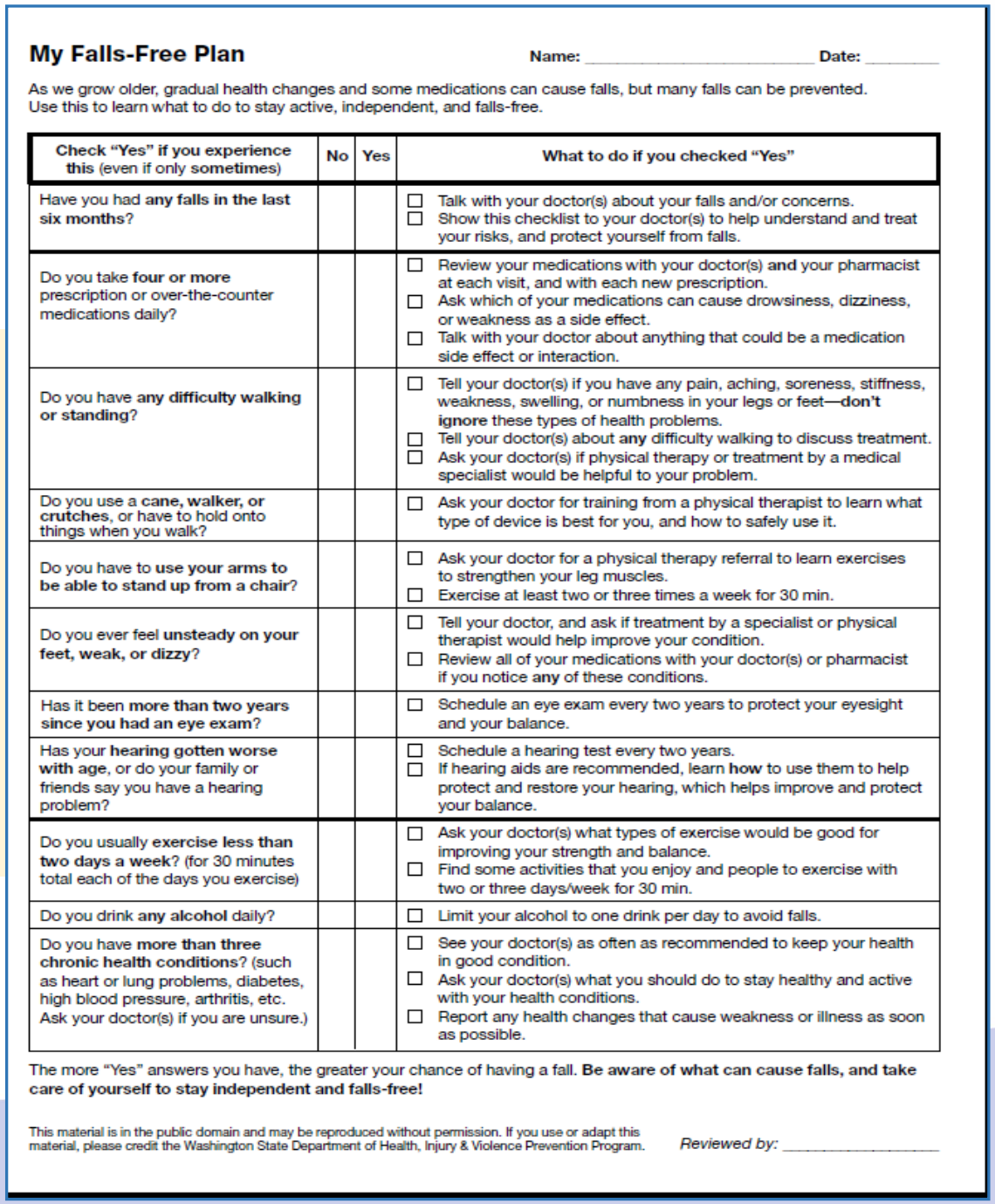
Falls Are Preventable

Risk Factor	Intervention
Decreased leg strength and balance	Physical Therapy or Exercise Program
Vitamin D Deficiency	Have doctor evaluate need for supplement
Medications	Have doctor and pharmacist review meds with client and assess meds for falls risk
Unsafe Home Environment	Remove throw rugs, install grab bars and clear clutter from walkways
Fear of falling	Discuss ways to modify risks and focus on empowerment to make a change
Vision problems	Yearly eye exam with optometrist
Decreased sensation in feet	Appointment with podiatrist

My Falls-Free Plan:
A Falls Risk Screening Tool

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



My Falls-Free Plan Name: _____ Date: _____

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

Check "Yes" if you experience this (even if only sometimes)	No	Yes	What to do if you checked "Yes"
Have you had **any falls in the last six months**?			☐ Talk with your doctor(s) about your falls and/or concerns. ☐ Show this checklist to your doctor(s) to help understand and treat your risks, and protect yourself from falls.
Do you take **four or more** prescription or over-the-counter medications daily?			☐ Review your medications with your doctor(s) **and** your pharmacist at each visit, and with each new prescription. ☐ Ask which of your medications can cause drowsiness, dizziness, or weakness as a side effect. ☐ Talk with your doctor about anything that could be a medication side effect or interaction.
Do you have **any difficulty walking or standing**?			☐ Tell your doctor(s) if you have any pain, aching, soreness, stiffness, weakness, swelling, or numbness in your legs or feet—**don't ignore** these types of health problems. ☐ Tell your doctor(s) about **any** difficulty walking to discuss treatment. ☐ Ask your doctor(s) if physical therapy or treatment by a medical specialist would be helpful to your problem.
Do you use a **cane, walker, or crutches**, or have to hold onto things when you walk?			☐ Ask your doctor for training from a physical therapist to learn what type of device is best for you, and how to safely use it.
Do you have to **use your arms to be able to stand up from a chair**?			☐ Ask your doctor for a physical therapy referral to learn exercises to strengthen your leg muscles. ☐ Exercise at least two or three times a week for 30 min.
Do you ever feel **unsteady on your feet, weak, or dizzy**?			☐ Tell your doctor, and ask if treatment by a specialist or physical therapist would help improve your condition. ☐ Review all of your medications with your doctor(s) or pharmacist if you notice **any** of these conditions.
Has it been **more than two years since you had an eye exam**?			☐ Schedule an eye exam every two years to protect your eyesight and your balance.
Has your **hearing gotten worse with age**, or do your family or friends say you have a hearing problem?			☐ Schedule a hearing test every two years. ☐ If hearing aids are recommended, learn **how** to use them to help protect and restore your hearing, which helps improve and protect your balance.
Do you usually **exercise less than two days a week**? (for 30 minutes total each of the days you exercise)			☐ Ask your doctor(s) what types of exercise would be good for improving your strength and balance. ☐ Find some activities that you enjoy and people to exercise with two or three days/week for 30 min.
Do you drink **any alcohol** daily?			☐ Limit your alcohol to one drink per day to avoid falls.
Do you have **more than three chronic health conditions**? (such as heart or lung problems, diabetes, high blood pressure, arthritis, etc. Ask your doctor(s) if you are unsure.)			☐ See your doctor(s) as often as recommended to keep your health in good condition. ☐ Ask your doctor(s) what you should do to stay healthy and active with your health conditions. ☐ Report any health changes that cause weakness or illness as soon as possible.

The more "Yes" answers you have, the greater your chance of having a fall. **Be aware of what can cause falls, and take care of yourself to stay independent and falls-free!**

Reviewed by: _____

My Falls-Free Plan – Screening and Scoring

Give the client a copy of the screening tool

- It offers ideas for clients
- It may be shared with family members and caregivers

Interpreting the score:

- 0 to 2 indicates a low risk for falls
- 2 to 4 indicates a moderate risk for falls
- 4 or more indicates a high risk for falls

**** Ask about falls every face-to-face visit***

My Falls-Free Plan – Recommendations to Ask the Client

Has it been over two years since their last eye exam?

- It may be time to schedule an appointment

Do they have glasses? Do they wear them? Are their glasses broken? Do they need a replacement?

- Suggest ideas on how to keep them handy, for example, on the nightstand by their bed

Are they having trouble hearing?

- A referral for a hearing test may be of benefit

Do they exercise two or more times per week?

- Brainstorm ideas to get your client moving more

Do they consume alcohol on a daily basis?

- Consider administering an AUDIT assessment (Alcohol Use Disorders Identification Test)
- Educate the client about safe levels of alcohol consumption

My Falls-Free Plan - Recommendations

Encourage clients to talk to their doctor if:

- They take more than 4 medications (including over-the-counter medications)
- They are experiencing dizziness or light headedness
  - This may be a sign of a blood pressure problem
- They report a loss of strength or balance
  - A referral to PT and/or OT may help them restore function
  - A prescription for durable medical equipment, such as a cane or walker, may increase safety and confidence

Falls and Health Action Planning

Develop a Short-Term Goal to reduce fall risk

Identify the client's risk factors e.g. environmental or physical

Create Action Steps (relate to risk factors)

- Make appointment with Primary Care
- Sign up for strength & balance fitness class
- Have medications reviewed for falls risk
- Appointment with Podiatrist
- Vision exam with Optometrist
- Learn how to better manage Chronic Conditions

Evidence Based Community Falls Prevention Programs

Available in the community at low or no cost

Requires physician approval to participate

Educational Programs and Exercise Classes

MANAGING CONCERNS ABOUT FALLS

Resources

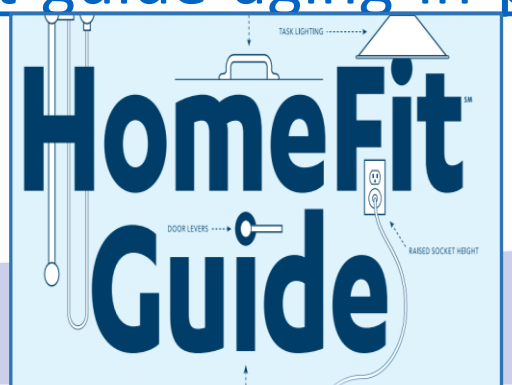
“What YOU Can Do To Prevent Falls” and “Check for Safety” are free to download from the CDC

https://www.cdc.gov/steadi/pdf/STEADI-Brochure-WhatYouCanDo-508.pdf

https://www.cdc.gov/steadi/pdf/check_for_safety_brochure-a.pdf

AARP HomeFit Guide

http://www.aarp.org/livable-communities/info-2014/aarp-home-fit-guide-aging-in-place.html



Consider Vignette From 2-Day Training

What would your follow-up be with Sacha who scored 7 on the My Falls-Free Plan?

69 yr old living at home with 4 hours of personal care per day. She recently fell in the bathroom

Generalized Anxiety Disorder (GAD-7)

Generalized Anxiety Disorder (GAD) - Definition

Generalized Anxiety Disorder (GAD) is characterized by excessive, exaggerated anxiety and worry about everyday life events with no obvious reasons for worry. People with symptoms of generalized anxiety disorder tend to always expect disaster and can't stop worrying about health, money, family, work, or school. In people with GAD, the worry is often unrealistic or out of proportion for the situation. Daily life becomes a constant state of worry, fear, and dread. Eventually, the anxiety so dominates the person's thinking that it interferes with daily functioning, including work, school, social activities, and relationships

Generalized Anxiety Disorder (GAD) - Symptoms

- Worry
- Irritability
- Mood swings
- Feeling of dread and impending danger
- Social withdrawal
- Difficulty in concentrating
- Headaches
- Nausea and vomiting
- Diarrhea or constipation
- Urge to urinate frequently and excessive thirst
- Palpitations and chest pain
- Excessive sweating and hot flushes
- Difficulty in breathing
- Difficulty in falling asleep or maintaining sleeping state throughout the night
- Dizziness or vertigo
- Tremors
- Dry mouth
- Muscle weakness
- Painful or missed menstrual periods

Generalized Anxiety Disorder (GAD)- Treatment- Co- Occurring Disorders

- Serious, chronic, or terminal illnesses
- Eating disorders
- Headaches
- Health anxiety
- Hoarding disorder
- Irritable bowel syndrome (IBS)
- Sleep disorders
- Substance use disorders
- Adult ADHD (attention deficit/hyperactive disorder)
- BDD (body dysmorphic disorder)
- Chronic pain
- Fibromyalgia

GAD-7 - When to Complete

Use your clinical judgment to determine the need and frequency for offering

Some examples to consider:

- If you observe or client reports any symptoms
- If the client identifies anxiety symptoms on the PHQ-9
- If the client is taking medication for anxiety
- If a client identifies a goal to reduce stress or anxiety
- If the client has participated in a GAD-7 screening in prior activity period

If the HAP includes goals or action steps related to one of the optional screenings then the screening must be offered and documented on the HAP

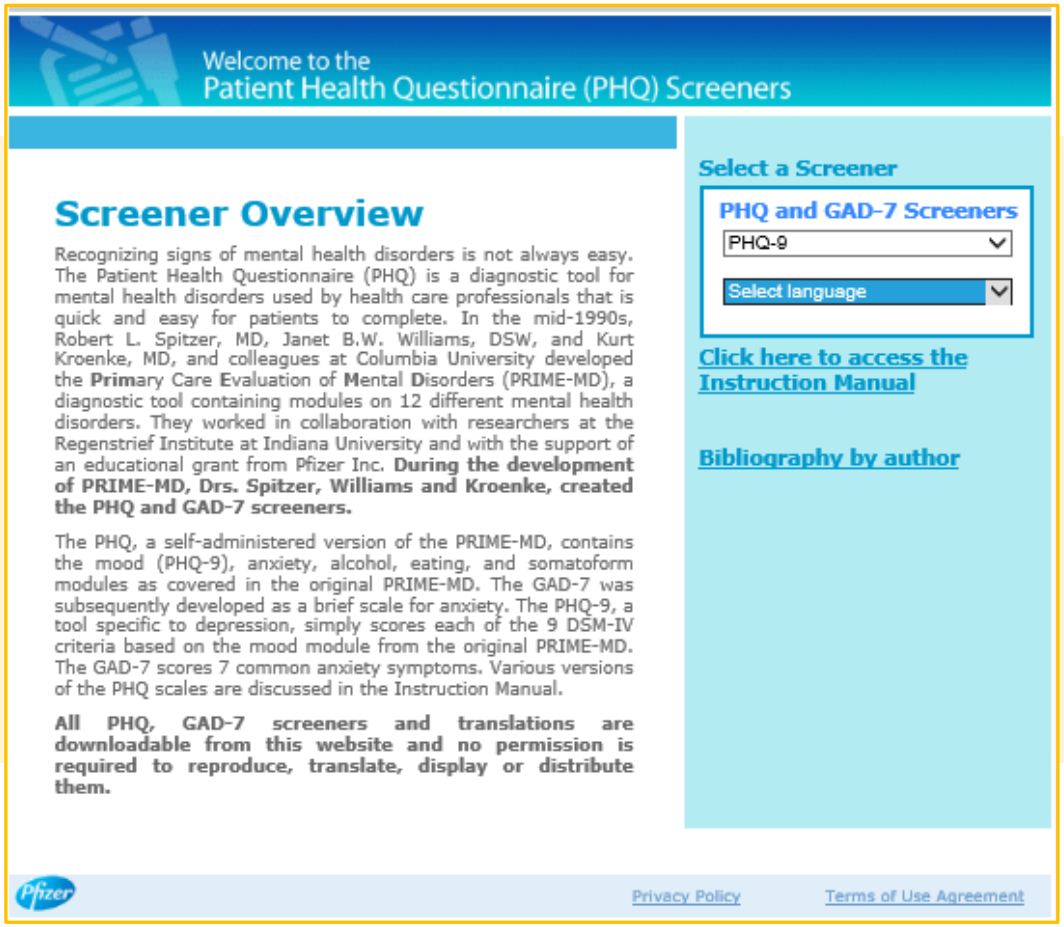
GAD-7 - Screening

- May be used for ages 12 and older
- Normalize the screening; don’t make it a big deal
- Some people respond better to terms like “stress” when talking about their anxiety or “sadness” rather than depression
- Remember the power that stigma holds - many people do not want to self-identify
- Treatment can be very effective and have a positive impact on symptom management and improved daily functioning

Translations of PHQ-9 and GAD-7

The website sponsored by Pfizer is located at:

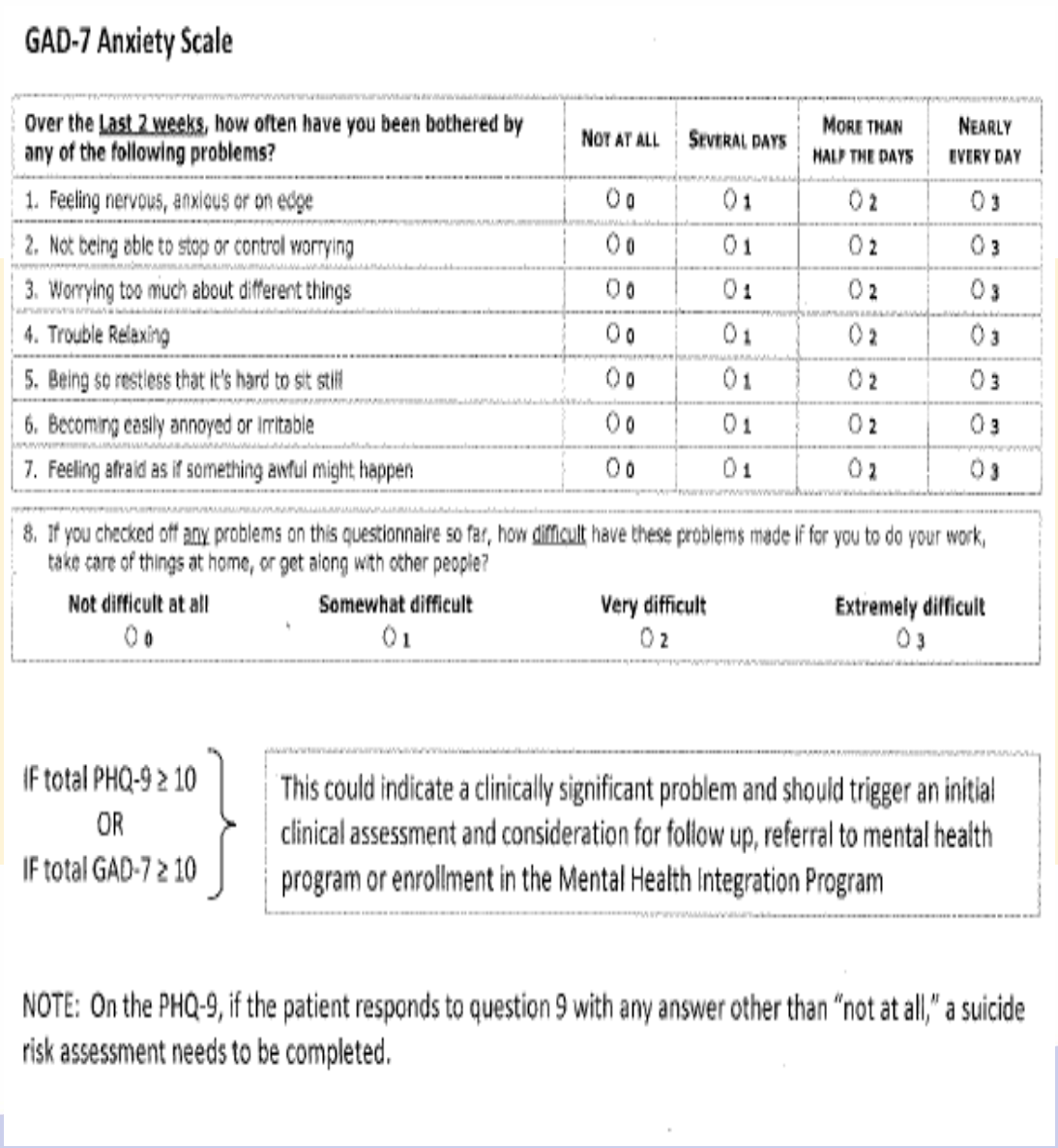
http://www.phqscreeners.com/select-screener



GAD-7

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



GAD-7 Anxiety Scale

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble Relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

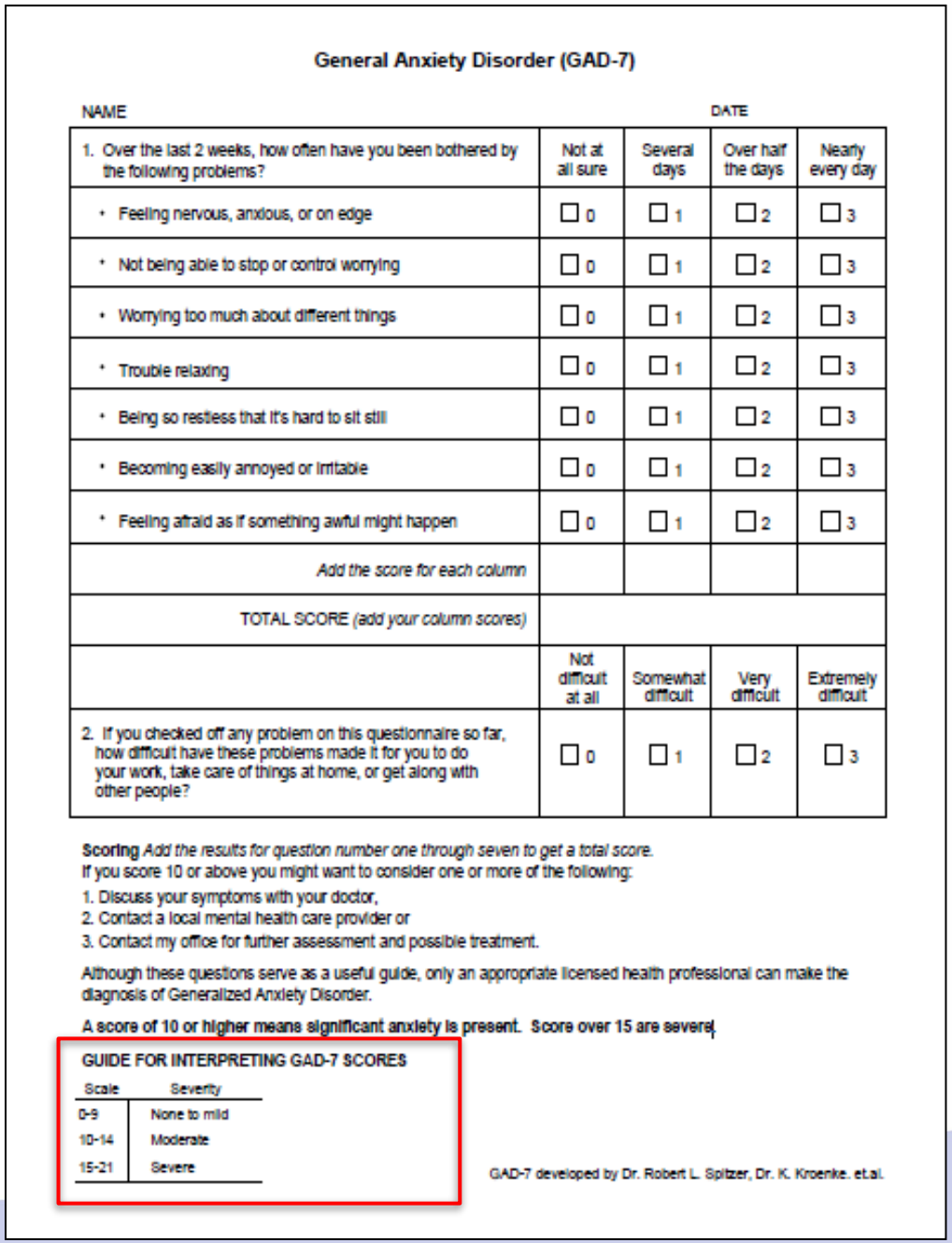
IF total PHQ-9 ≥ 10
OR
IF total GAD-7 ≥ 10

This could indicate a clinically significant problem and should trigger an initial clinical assessment and consideration for follow up, referral to mental health program or enrollment in the Mental Health Integration Program

NOTE: On the PHQ-9, if the patient responds to question 9 with any answer other than "not at all," a suicide risk assessment needs to be completed.

GAD-7 - Scoring

0-9 None to Mild
10-14 Moderate
15-21 Severe



General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring *Add the results for question number one through seven to get a total score.*
If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke, et.al.

Generalized Anxiety Disorder (GAD)- Treatment and Follow-Up

Treatment involves two main approaches with most clients benefiting from a combination of the two

- Psychological therapy
- Medications

Follow-up to a positive screening

- Refer to a behavioral health provider or PCP depending upon client preference

Visit DBHR at:

- https://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-and-recovery

Consider Vignette From 2-Day Training

Carmella

How would you help Carmella if she expresses being anxious however declines to take the GAD-7 screening?

25yr old living at home. Has major medical risk factors, major BH factors, 8 IP admissions in 15 months (one for OD and one for MH), high ED use – past visits include BH issues & adult sexual abuse, frequent therapy visits & crisis interventions, No PCP

Pain

Ways Pain Can Affect Everyday Life

- Inability to leave home
- Inability to do basic ADL'S
- Increase in depression
- Decrease or increase in appetite
- Withdrawal from family and loved ones
- Increase risk in addiction

Pain and Relationships

- Pain can interfere with even the most basic part of a persons relationship without them even realizing it
- Observing a person with chronic pain during your visit and the way they interact with those around them can give you insight as to how they are doing with pain control
- The better the pain control, the better the relationship

0-10 Numeric Rating Scale

You may find a copy in the Care Coordinator Toolkit at

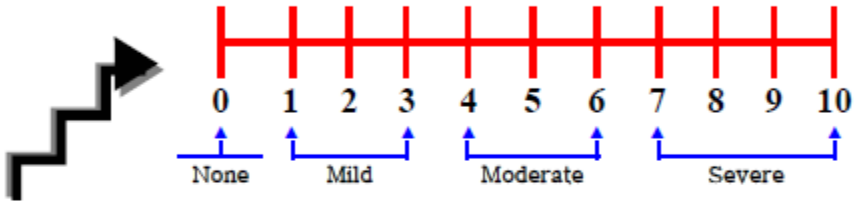
https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit

Use with adults and children 9 years and older

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER

PAIN INTENSITY INSTRUMENTS
JULY 2003

0 – 10 Numeric Rating Scale (page 1 of 1)



Indications: Adults and children (> 9 years old) in all patient care settings who are able to use numbers to rate the intensity of their pain.

Instructions:

1. The patient is asked any one of the following questions:
   - What number would you give your pain right now?
   - What number on a 0 to 10 scale would you give your pain when it is the worst that it gets and when it is the best that it gets?
   - At what number is the pain at an acceptable level for you?
2. When the explanation suggested in #1 above is not sufficient for the patient, it is sometimes helpful to further explain or conceptualize the Numeric Rating Scale in the following manner:
   - 0 = No Pain
   - 1-3 = Mild Pain (nagging, annoying, interfering little with ADLs)
   - 4–6 = Moderate Pain (interferes significantly with ADLs)
   - 7-10 = Severe Pain (disabling; unable to perform ADLs)
3. The interdisciplinary team in collaboration with the patient/family (if appropriate), can determine appropriate interventions in response to Numeric Pain Ratings.

Reference

McCaffery, M., & Beebe, A. (1993). Pain: Clinical Manual for Nursing Practice. Baltimore: V.V. Mosby Company.

Wong-Baker Faces Pain Rating Scale

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit

Use with adults and children 3 years and older

Multiple languages available
http://www.wongbakerfaces.org/faces-download/

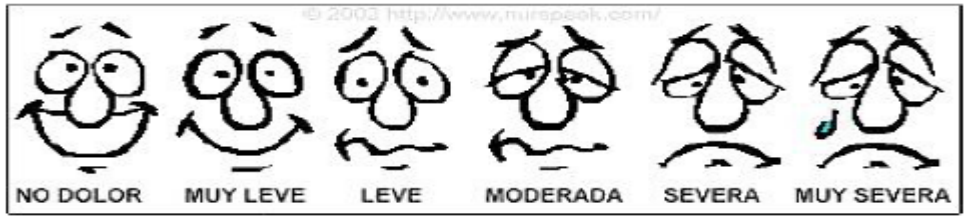
NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER

PAIN INTENSITY INSTRUMENTS
JULY 2003

Wong–Baker Faces Pain Rating Scale (page 1 of 1)

English

Español



Indications: Adults and children (> 3 years old) in all patient care settings.

Instructions:

1. Explain to the patient that each face is for a person who feels happy because he has no pain (hurt c whatever word the patient uses) or feels sad because he has some or a lot of pain.
2. Point to the appropriate face and state, "This face is . . . "
   - 0 -1 – "very happy because he doesn't hurt at all."
   - 2 - 3 – "hurts just a little bit."
   - 4 - 5 – "hurts a little more."
   - 6 - 7 – "hurts even more."
   - 8 - 9 – "hurts a whole lot."
   - 10 – "hurts as much as you can imagine, although you don't have to be crying to feel this bad."
3. Ask the patient to choose the face that best describes how he feels. Be specific about the pain location and at what time pain occurred (now or earlier during a procedure?).
4. The interdisciplinary team in collaboration with the patient/family (if appropriate), can determine appropriate interventions in response to Faces Pain Ratings.

Reference

Wong, D. and Whaley, L. (1986). Clinical handbook of pediatric nursing, ed., 2, p. 373. St. Louis: C.V. Mosby Company.

FLACC Behavioral Pain Assessment Scale

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit

Use when self report not possible. For ages 2 months to 7 years or if an individual is not able to communicate their pain level

FLACC Behavioral Pain Assessment Scale

CATEGORIES	SCORING 0	1	2
Face	No particular expression or smile	Occasional grimace or frown; withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs; frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractable	Difficult to console or comfort

How to Use the FLACC

In patients who are awake: observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

Face

- Score 0 if the patient has a relaxed face, makes eye contact, shows interest in surroundings.
- Score 1 if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed.
- Score 2 if the patient has deep furrows in the forehead, closed eyes, an open mouth, deep lines around nose and lips.

Legs

- Score 0 if the muscle tone and motion in the limbs are normal.
- Score 1 if patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of the limbs.
- Score 2 if patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, tremors.

Activity

- Score 0 if the patient moves easily and freely, normal activity or restrictions.
- Score 1 if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, pressure on a body part.
- Score 2 if the patient is in a fixed position, rocking; demonstrates side-to-side head movement or rubbing of a body part.

Cry

- Score 0 if the patient has no cry or moan, awake or asleep.
- Score 1 if the patient has occasional moans, cries, whimpers, sighs.
- Score 2 if the patient has frequent or continuous moans, cries, grunts.

Consolability

- Score 0 if the patient is calm and does not require consoling.
- Score 1 if the patient responds to comfort by touching or talking in 30 seconds to 1 minute.
- Score 2 if the patient requires constant comforting or is inconsolable.

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decisions regarding treatment of pain require careful consideration of the context in which the pain behaviors are observed.

Interpreting the Behavioral Score

Each category is scored on the 0–2 scale, which results in a total score of 0–10.

0 = Relaxed and comfortable
1–3 = Mild discomfort
4–6 = Moderate pain
7–10 = Severe discomfort or pain or both

From Merkel, S. I., Voepel-Lewis, T., Shayevitz, J. R., & Malviya, S. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3), 293–297. The FLACC scale was developed by Sandra Merkel, MS, RN, Terri Voepel-Lewis, MS, RN, and Shobha Malviya, MD, at C. S. Mott Children's Hospital, University of Michigan Health System, Ann Arbor, MI. Used with permission.

Pain Screenings - Considerations

Best practice for asking about pain at every face to face regardless of condition

- If they say yes, ask more questions
  - Have they talked with their doctor about the pain?
  - Are they receiving treatment for the pain?
  - If they are receiving treatment, do they have full control? Partial control?
  - Does the pain limit their daily functioning in any way?

Where they are at and set goals

Involve medical professional

Pain - Treatments

Treatments available for chronic pain need to be discussed with the client's PCP

- Pain clinic
- Heat
- Medications
- Physical Therapy and exercise
- Chiropractic manipulation
- Yoga or Tai Chi
- Massage
- Relaxation therapy
- Psychotherapy
- Acupuncture

Some treatments may not be covered by insurance

Pain Control

- Ask the client what they would like to have happen for their pain control. Be sure that the client is involved in the process. Often clients are not included in discussions when it comes to their own pain and they are given what the PCP or policy allows
- Is client's PCP prescribing medication? Is it adequate?

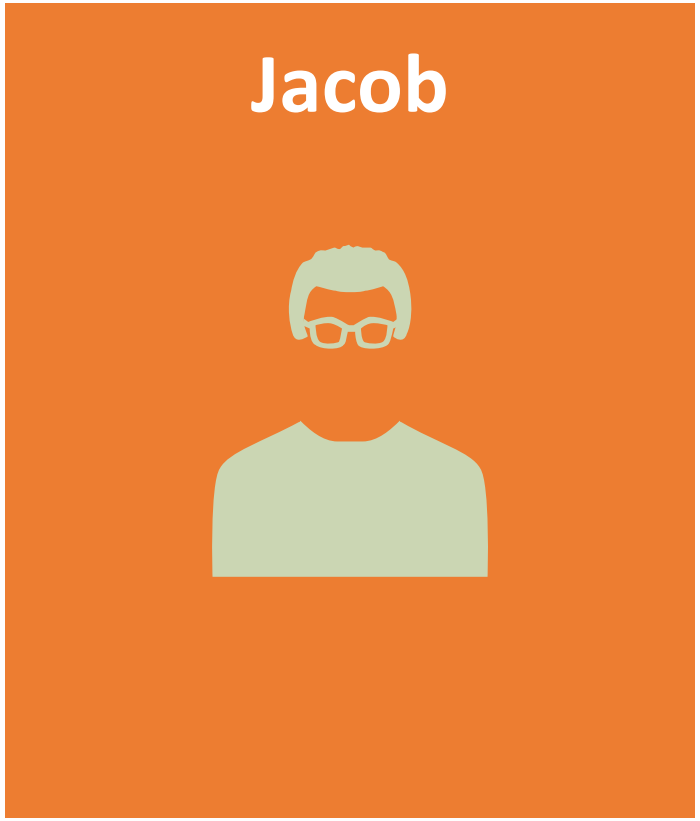
Pain Management Resources

- American Chronic Pain Association https://www.theacpa.org/
- Practical Pain Management www.practicalpainmanagement.com/patient/resources

Consider Vignette From 2-Day Training

What would you do if Jacob scored 7 on the 0-10 Numeric Rating Scale?

21yr old man living at home with parents. Has major medical risk factors with no indication of stable PCP relationship and may take medication for pain



The End