KEY BEHAVIORAL HEALTH ASSESSMENT TOOLS

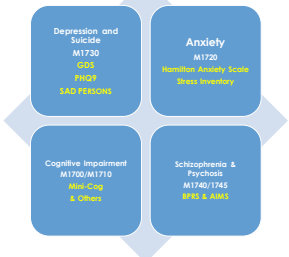
FOR USE IN BEHAVIORAL HEALTH HOME CARE

C&V Senior Care Specialists,Inc.

Benefits of Using Evidenced Based Tools

- 1-Determine specific symptoms
- 2-Diagnosis individual Conditions
  - Serve as checklists
- 3-Assess improvement and deterioration
- 4-Highlight potential side effects of Treatment
- 5-Provides consistency
- 6. Evidence based practice
- 7-Provide outcomes
- 8-Increases access to funding

Assessments: Which Ones To Use?



C&V Senior Care Specialists,Inc.

Assessment - Let's Look More Carefully

Cognitive Function:
M1700- score of "2" or > requires Mini-Cog
and M1710 – Helpful to Ask Others – Patient May not Recognize own Confusion – same as above-
score of "2" or > requires Mini-Cog &/or FAST and Comments
IF patient had Alzheimer's & /or a dementia dx do not have to do Mini-Cog

C&V Senior Care Specialists, Inc.

MINI-COG

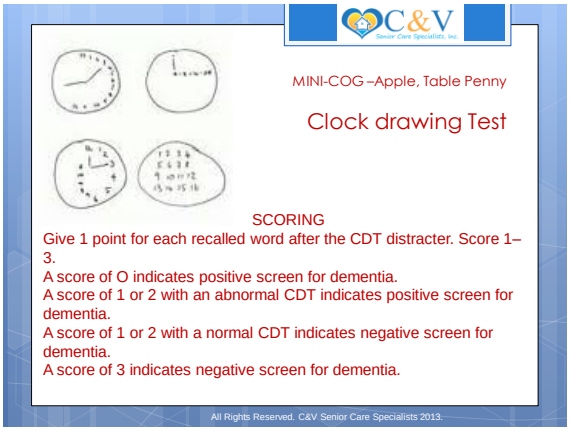
1. THREE Word RE-CALL
2. CLOCK DRAWING TEST

Inc.

Mini-Cog Assessment Tool

- Valid instrument for screening cognitive impairment
- Consists of 3-item recall test and a clock drawing task
- Two-part test of executive function(ability to plan, manage time, organize activities)
- Simple, effective, easy to use
  - Uncovers cognitive impairment in its earliest stages
- 3-5 Minutes
- Great for use in Primary Care
- http://vimeo.com/4361918

C&V Senior Care Specialists, Inc.



MINI-COG –Apple, Table Penny

Clock drawing Test

SCORING

Give 1 point for each recalled word after the CDT distracter. Score 1–3.

A score of O indicates positive screen for dementia.

A score of 1 or 2 with an abnormal CDT indicates positive screen for dementia.

A score of 1 or 2 with a normal CDT indicates negative screen for dementia.

A score of 3 indicates negative screen for dementia.

Assessment - Let's Look More Carefully

DEPRESSION:

A score of 3 on PHQ-2 or higher should trigger a complete Depression Assessment using a Standardized Tool such as PHQ-9 or Geriatric Depression Scale (short version)

Also important to assess: flat facial expression, lack of eye contact, slumped posture, unkempt appearance, slow response to questions, tendency to become teary and irritability – IMPORTANT TO OBSERVE THESE BEHAVIORS AND DOCUMENT – CAN'T INFER DEPRESSION FROM THESE OBSERVATIONS ALONE!!

C&V Senior Care Specialists,Inc.

Assessment - Let's Look More Carefully

DEPRESSION- (Continued)

USE ONE OF ADDITIONAL ASSESSMENTS/INVENTORIES

1. PHQ9
2. Geriatric Depression Scale

DOCUMENT SCORE

(If patient is elderly and confused – complete Depression Scale + Mini-Cog

C&V Senior Care Specialists,Inc.

Geriatric Depression Scale

Choose the best answer for how you felt this past week:

Are you basically satisfied with your life?	Yes / **No**
Have you dropped many of your activities and interests?	**Yes** / No
Do you feel that your life is empty?	**Yes** / No
Do you often get bored?	**Yes** / No
Are you in good spirits most of the time?	Yes / **No**
Are you afraid that something bad is going to happen to you?	**Yes** / No
Do you feel happy most of the time?	Yes / **No**
Do you often feel helpless?	**Yes** / No
Do you prefer to stay at home, rather than going out and doing new things?	**Yes** / No
Do you feel you have more problems with memory than most?	**Yes** / No
Do you think it is wonderful to be alive now?	Yes / **No**
Do you feel pretty worthless the way you are now?	**Yes** / No
Do you feel full of energy?	Yes / **No**
Do you feel that your situation is hopeless?	**Yes** / No
Do you think that most people are better off than you are?	**Yes** / No

Scoring Key: **Score: _____ (number of depressed" answers –all bolded answers)**
Normal **0-4**
Mildly depressed **>5 points suggestive of depression**
Severely depressed **≥ 10 points is almost always indicative of depression**
A score of >5 points should warrant a follow-up comprehensive assessment.

C&V Senior Care Specialists,Inc.

PHQ-9

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

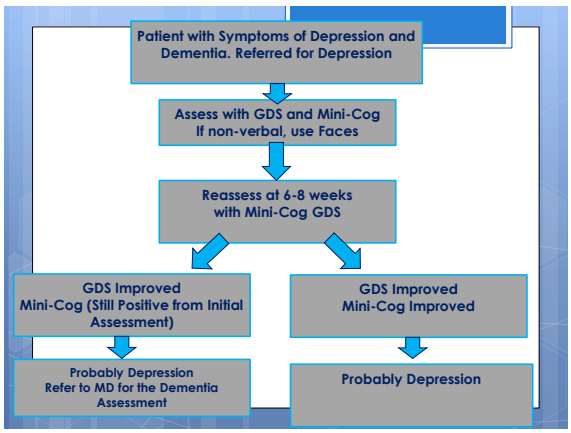
FOR OFFICE CODING: 0 _____ + _____ + _____ = _____
**Total Score: _____

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.

Senior Care Specialists,Inc.



Assessment - Let's Look More Carefully

SUICIDALITY:

M1730 a Score of 3 on PHQ2 should trigger additional Depression assessment tool – PHQ9 or GDS. Also, to assess suicide risk

HISTORY – SUICIDAL ATTEMPT?? CURRENT PLAN? METHOD TO CARRY OUT PLAN?

These items MUST be explored – Remember that YOU WILL NOT MAKE SOMEONE COMMIT SUICIDE IF YOU ASK THEM ABOUT IT – TO THE CONTRARY – TALKING ABOUT IT DECREASES THE DESIRE TO FOLLOW THROUGH WITH IT-

COMPLETE "SAD PERSONS" Suicide Assessment Tool –

IMPLEMENT PSYCHIATRIC EMERGENCY POLICY IF NECESSARY

C&V Senior Care Specialists, Inc.

Assessment - Let's Look More Carefully

SUICIDALITY

M1740:#2-Impaired Decision-making

#4- Physical Aggression

6-Delusional, hallucinatory, or paranoid

HISTORY – SUICIDAL ATTEMPT??

USE COMMENT SECTION – COMPLETE "SAD PERSONS" Suicide Assessment Tool

Many items on SAD Persons are asked as part of OASIS-C

IMPLEMENT PSYCHIATRIC EMERGENCY POLICY IF NECESSARY

C&V Senior Care Specialists, Inc.

Assessment - Let's Look More Carefully

ANXIETY :

Item M1720

Frequently Accompanies Depression BUT May Also Exist By Itself

A rating of **daily** may indicate serious anxiety. Ask how Anxiety Affects Patient's life – Does it interfere with Sleep; from Going Out of House; From Engaging in Physical Care or Activities. Document in Comments Section What Patient Says About Impact of Anxiety on Life and Follow up with Anxiety Specific Assessment Anxiety/Stress Inventory or Hamilton Anxiety Scale

Necessary to Directly Inquire About Presence and Extent of Anxiety.

C&V Senior Care Specialists, Inc.

Assessment - Let's Look More Carefully

A rating of daily may indicate serious anxiety. Ask how Anxiety Affects Patient's life – Does it interfere with Sleep; from Going Out of House; From Engaging in Physical Care or Activities. Document in Comments Section What Patient Says About Impact of Anxiety on Life and Follow up with Anxiety Specific Assessment Anxiety/Stress Inventory or Hamilton Anxiety Scale

WHAT MEDICAL CONDITIONS COMMONLY INCLUDE ANXIETY AS A CO-MORBID DX?

C&V Senior Care Specialists, 2012

ANXIETY RATING TOOLS

Hamilton Anxiety Rating Scale(HAM-A)

-Assess frequency, durations of 14 anxiety symptoms.

-Can use script

-See attached

Anxiety/Stress Inventory

-Can use as self rated tool or ask questions

C&V Senior Care Specialists,Inc.

Assessment - Let's Look More Carefully

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS:

OASIS LESS HELPFUL IN ASSESSING BEHAVIORS ASSOCIATED WITH SCHIZOPHRENIA OR OTHER PSYCHOTIC DISORDERS.

M1740 – Most important item –choices 2, 3,4, 5, and/or 6 could point to psychotic behavior or behavior that is motivated by internal stimuli and experienced only by the patient. The nurse may observe the behaviors or they may be reported by family member, significant other or another health care provider – source of information should be documented .

C&V Senior Care Specialists,Inc.

ASSESSMENT REMINDER

ON ADMISSION

- GDS or PHQ-9 (if PHQ-2+ or referred for Depression)
- Mini-Cog
- Hamilton Anxiety (if daily anxiety or referred for Anxiety)

(Week 8 & 9)RECERT

- GDS or PHQ-9 Anxiety (if + at admission)
- Mini-Cog (If + on admission)
- Hamilton Anxiety (if + at admission)

C&V Senior Care Specialists,Inc.

DOCUMENTATION

- Document the results of scales in notes
- Communicate findings to MDs, NPs involved in patient's care
- Useful in assessing progress and medication effectiveness

C&V Senior Care Specialists,Inc.

QUESTIONS

C&V Senior Care Specialists,Inc.