Meals on Wheels Expanded Assessment Implementation Manual

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Introduction

In Maine, 17% of older adults experience food insecurity. According to the Maine State Plan on Aging, a quarter of Mainers over the age of 50 worry about not having enough food and 11% report skipping meals, or purposefully eating less due to financial reasons.

Older adults who are food insecure are:

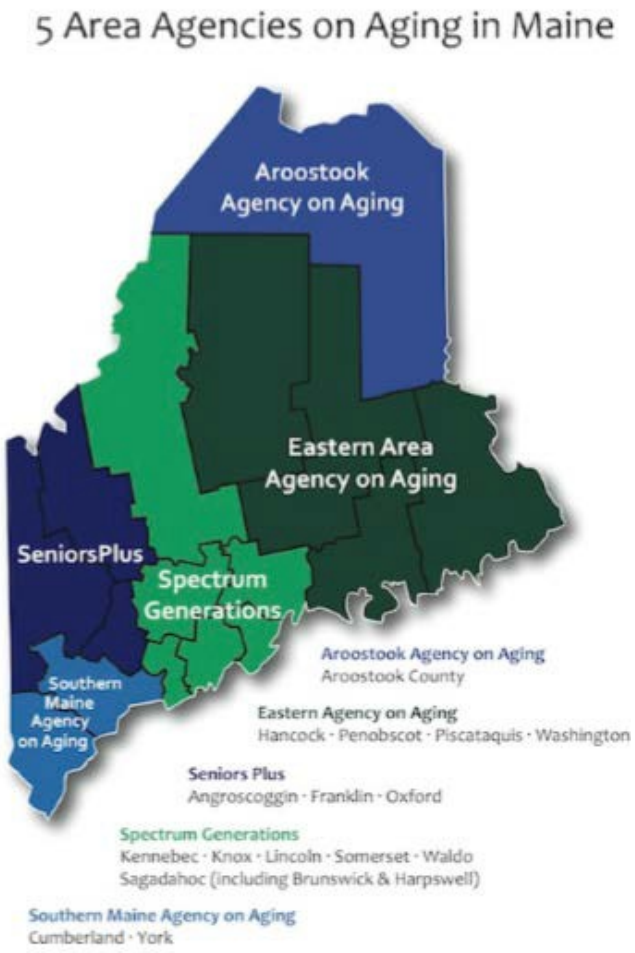
- 50% more likely to be diabetic
- 60% more likely to suffer from congestive heart failure
- 3 times more likely to suffer from depression

Meals on Wheels

Adequate and nutritious meals become a challenge for those with Dementia. The senses decline with age which impacts appetite and desire to eat. Studies have shown that older Americans prefer to remain in their homes for as long as possible as they age; however, as they age, they may lose the ability to cook or drive to the grocery store. A great solution to this is home-delivered meals, which, for many, is the key to living independently. Maine provides these meals through five Area Agencies on Aging in the state. In 2015, a total of more than 800,000 meals were delivered.

History of the Assessment

Meals on Wheels volunteers do much more than deliver a meal; they are there to offer a friendly smile, check in, and look out for red flags; however, the assessment required by the state of Maine for these home visits solely determines eligibility for the service when it has the potential to do so much more. The Southern Maine Agency on Aging (SMAA) is one of the five Maine Area Agencies on Aging. Serving Cumberland and York Counties, SMAA offers many programs and services to older Mainers, including their Meals-on-Wheels program, which has been running for more than four decades. In 2014, as part of a grant, they created the expanded assessment with the vision of identifying people living alone with dementia without adequate support and connecting them to other services.



This expanded assessment stresses the importance of screening for cognitive impairment. It aims to identify people who need certain resources and connect them to those resources. It addresses the social determinants of health, isolation, transportation, falls, and more.

Implementation & Evaluation

Pilot Program

Initially, SMAA needed to determine the applicability and effectiveness of the expanded assessment by launching a pilot program in two sites (Kittery and Sanford). It was not implemented by seasoned, trained assessors. During this time, the expanded assessment was separated from the state-mandated assessment. The data flowed into the Crisis to Thriving Scale used by Community Support Programs (CSP) to monitor client progress. Any additional questions added to the assessment had to be approved by the state.

During the pilot period, the expanded assessment was monitored closely to see if it was working as intended, and to identify potential logistical issues. Assessors kept track of the time it took to complete the assessment, how the clients were responding to certain questions, whether the assessment was increasing referrals to CSP, and what questions were most effective at promoting these referrals. As issues arose, the assessment was refined accordingly.

Implementation

After the pilot program, the protocol that was established for the assessment was:

- Initial Assessment (face to face 30-60 minutes)
- Annual assessment (face to face 30-60 minutes)
- Every 6 months phone check in

Implementation was conducted by MOW assessors with supervision from the Nutrition Services manager. The assessors work out of 8 local MOW sites in York and Cumberland counties. Consistency and training were essential for successful implementation of the expanded assessment. This included training the assessors on their approach when conducting the assessment and ongoing fidelity monitoring to ensure that all the assessors were conducting the assessment in a consistent way. Currently, SMAA has 8-9 assessors: one at each site.

Successful implementation of the expanded assessment required cooperation between departments at the agency, specifically nutrition services and the community support program team. SMAA had a program manager for ADI grant to facilitate this culture change.

Barriers

As the expanded assessment was used more and more during the pilot period, some problems arose. Because the expanded assessment is much more comprehensive than the traditional, state-mandated assessment, assessors reported a drastic increase in the length of their home visits. While the state-mandated assessment only took about 20 minutes, the new questions in the expanded assessment increased that time by 40 minutes. Additionally, after a certain point, the clients refused to answer the questions. This prompted the team to find a way to reduce the time. This was accomplished through training and more experience with the tool.

One of SMAA's goals is to match referrals to CSP and other services to the questions asked in the expanded MOW assessment. Due to an initial lack of communication between the various program areas at SMAA, a lot of this was a manual effort. Initially the influx of referrals led to a short-term waitlist for CSP. Cooperation between departments was essential. Moreover, although there was a recorded increase in referrals, efforts also need to be made to close the gap and follow through with how many of those referrals lead to acceptance. Nutrition services are currently working on how to follow through to see how the referrals to CSP has impacted WBAS scores and connection to services.

Early in the process, sustainability plans needed to be made to determine how this work would continue after the grant. This was a critical piece of the rollout. Timing was also essential. It was

found that rolling out the new assessment protocol required a transition period. For SMAA this was especially important because there were a lot of other interagency changes occurring simultaneously.

Outcomes

- 75% increase in referrals to CSP
- Greater collaboration and improved relationship between different teams at the organization.
- Improved collaboration led to better workflows for both teams.
- Improved collaboration reduced the number of contacts to clients, creating a single point of entry for services.

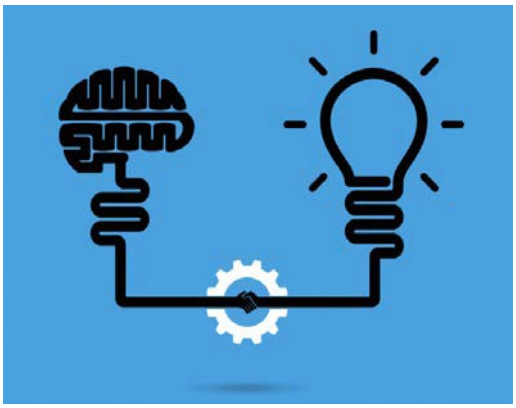
> "I can't imagine that there was a time when we spent 15 minutes in a home to only determine eligibility for Meals-on-Wheels. This is second nature now."
>
> —Renee Longarini, SMAA

Reasons for Success

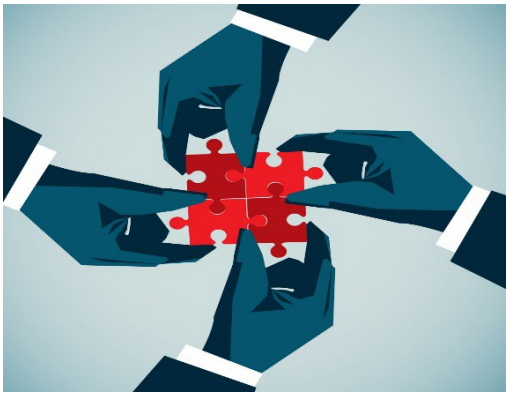
SMAA was able to implement the expanded MOW assessment successfully because they eased into it, allowing a transition period. They provided comprehensive training to their assessors, and continuously monitored them, providing ongoing support. When barriers arose, they were able to successfully navigate them by increasing the communication and collaboration within the organization. A culture of innovation, collaboration, excellence, and

data-driven decision making was crucial to successful implementation.

Innovation



Collaboration



Excellence

Data-driven decision making

Volunteers and Assessors

Volunteers and assessors are incredibly important to any Meals on Wheels program. Volunteers drive and deliver meals to homebound individuals, and assessors are paid staff who visit their home to conduct the assessment and make follow-up calls. With the implementation of the MOW expanded assessment, comprehensive trainings with assessors had to be done to ensure consistency and make sure everyone is on the same page.

> "Meals on Wheels assessors are the eyes on the ground."
>
> —Renee Longarini, SMAA

Training

Trainings for the assessors covered all the required fields of the assessment, regulations for MOW eligibility, a day in the life of an assessor, and instructions for conducting mobile assessments directly into Nutrition services software, Harmony. Trainings also brought in speakers from various SMAA programs to educate the assessors about other services that their client may qualify for.

When a new client referral is provided to the site, the initial client assessment must occur within 9 business days of the referral at the client's home. Assessors are instructed to complete the assessment to the best of their ability using the information provided by the client. The client may feel uncomfortable with a seemingly never-ending string of questions directed towards them. If the volunteer takes a more casual approach, oftentimes clients provide needed information without any prompting. Assessors are also trained to ask the client certain questions to obtain more information. These include questions about what they eat on the weekend, if they go to the food pantry, groceries, and driving.

Assessors are instructed to keep a pen handy to take occasional notes, and treat the client with respect and dignity. All clients have a right to self-determination in their plan of care, and all information must be kept confidential. Before inputting a referral into the system, the volunteer must ask for permission from the client. One of the volunteer's priorities must be to always keep the client as comfortable as possible.

Assessors are also trained to check for signs of medical emergencies such as:

- ☐ Chest pain
- ☐ Choking
- ☐ Confusion or change in mental status, unusual behavior, difficulty waking
- ☐ Coughing or vomiting blood
- ☐ Difficulty speaking
- ☐ Fainting or loss of consciousness
- ☐ Head or spine injury
- ☐ Severe or persistent vomiting or diarrhea
- ☐ Sudden injury due to a motor vehicle accident, burns or smoke inhalation, near drowning, deep or large wound

☐Sudden or severe pain anywhere in the body
☐Sudden dizziness, weakness or change in vision
☐Swallowing a poisonous substance
☐Severe or unusual abdominal pain or pressure
☐Suicidal or homicidal feelings
☐Uncontrolled bleeding

In such cases, they must call for emergency help and wait with the client until help arrives. They must not provide any medical assistance unless they are trained to do so.

Assessors are trained to look out for the following:

Family dynamic	Inadequate heat or cooling	Unsanitary living conditions
Attention span/signs of dementia or unexplained symptomology	Fire hazards	Pests
Tripping hazards	Pathway and/or steps	Hoarding
Access to doorways	Lighting	Food spoiled
Need for grab bars, railings, ramps	Uncared for pets/pet health and safety	Food not stored properly

The assessors must provide a heart packet if the client presents with any of the following:

Arrhythmia	Heart Attacks	Congenital heart disease
Coronary artery disease	Stroke	Heart valve problems

High blood pressure	Cardiovascular disease	

Finally, it is the responsibility of the assessor to complete a follow-up phone assessment six months after the initial assessment. This call should focus on eligibility, dietary restrictions, health concerns, emergency contact information, and other services they might need. A year later, they must go back for the annual assessment, which is to be performed in the same manner as the initial assessment.

Fidelity Monitoring

Fidelity monitoring included a training for all new assessors on the assessment protocol. There was also a training follow-up. The purpose of this follow-up was to check in and address barriers. Additionally, there was ongoing monitoring and support for the assessors. There was continuous improvement; data was collected to identify which questions were not being asked or answered regularly and plans were made to address those discrepancies.

Helpful Resources

Southern Maine Agency on Aging

Address:

136 U.S. Route One
Scarborough, ME 04074

Contact Information:

Toll-free • 1-800-427-7411
Local • 207-396-6500
Fax • 207-883-8249

Renee Longarini
Southern Maine Agency on Aging Nutrition Manager

Email: rlongarini@SMAA.org

Summary

Conclusion

This manual outlined the implementation and success of an expanded Meals on Wheels assessment at the Southern Maine Agency on Aging. This expanded assessment proved to be a huge step up from the previous state mandated assessment that was used. It is much more comprehensive and can help identify clients in need of more support and connect them to services that may help them.

Implementation of the expanded assessment has proved to be sustainable and worth it in the long run. As seen in the Southern Maine Agency on Aging, once implemented, it was hard to imagine going back to only the state mandated assessment.

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Appendix

This appendix includes the full Meals on Wheels expanded assessment as developed by the Southern Maine Agency on Aging. It also includes the previous assessment that SMAA used, which only included questions that were mandated by the state of Maine.

ExpandedMOWAssessment:

MoW Assessment

General

Assessment Information

Date Assessment Completed:

_____/_____/_____

Specify the type of assessment, or the reason for the assessment.

- ☐ Initial assessment (In person)
- ☐ Annual assessment (In person)
- ☐ Follow-up assessment (Phone)

Referred by:

- ☐ Adult Day Care
- ☐ Adult Protective Services
- ☐ Anonymous
- ☐ Area Agency on Aging (other than SMAA)
- ☐ Assisted Living / Residential Care Facility
- ☐ Caregiver
- ☐ Case Manager
- ☐ Clergy / Religious Organization
- ☐ CMS (Medicare/Medicaid)
- ☐ County
- ☐ DHHS (not APS)
- ☐ EIM / Home & Community Care Org
- ☐ Family
- ☐ Fire Deptartment / EMT / Rescue
- ☐ Friend
- ☐ Hospice (home based)
- ☐ Hospice (facility based)
- ☐ Home Health (not Hospice Program)
- ☐ Hospital / Acute Care Facility
- ☐ Housing Authority
- ☐ Information & Referral Service
- ☐ Insurance Company
- ☐ Law Enforcement
- ☐ Legal Rep
- ☐ Neighbor
- ☐ Nursing Home
- ☐ Ombudsman
- ☐ Other
- ☐ Other Federal Agency
- ☐ Other Nonprofit Organization
- ☐ Other Service Provider
- ☐ Other State Agency
- ☐ Personal Care / Homemaking Agency
- ☐ Pharmacy
- ☐ Physician / Medical Provider
- ☐ Self
- ☐ Senior Center
- ☐ Skilled Nursing Facility (Rehab)
- ☐ SMAA (internal referral or repeat client)
- ☐ Social Security
- ☐ Unknown
- ☐ Veterans' Administration
- ☐ Volunteer (Outside SMAA)

Identifying Client Information

What is the client's first name?

What is the client's middle initial?

What is the client's last name?

Enter the client's residential street address or Post Office box.

Enter the second line of the client's street address.

Enter the client's residential city or town.

Enter the client's telephone number.

What is the client's gender?

- ☐ Declined to Disclose
- ☐ Female
- ☐ Male
- ☐ Other
- ☐ Transgendered
- ☐ Unknown

If gender is other, what does the client identify as gender?

What is the client's date of birth?

_____/_____/_____

Emergency Contacts - List POA/Guardian first

First emergency contact - Is legally appointed guardian?

- [ ] No
- [ ] Yes

First emergency contact - name:

First emergency contact - relationship to client:

First emergency contact - home phone:

First emergency contact - cell phone:

First emergency contact - work phone:

First emergency contact - physical address:

Second emergency contact - name:

Second emergency contact - relationship to client:

Second emergency contact - home phone:

Second emergency contact - cell phone:

Second emergency contact - work phone:

Second emergency contact - address:

Changes Since Last Assessment

Medical problems / health information / changes since last home-delivered meals assessment:

Meals Eligibility - Must Meet all Sections

Section 1 - Eligibility Group

Select the Title IIIc eligibility group that applied to client

- [ ] 60+ years old and client of Adult Protective
- [ ] 60+ years old and in greatest socio-economic need
- [ ] Spouse (any age) of a current Home Delivered Meals participant. ELIGIBLE
- [ ] Under 60 years old, disabled, and living with a current HDM participant
- [ ] None of the above

Select the SSBG eligibility group that applies to client (subject to funding ability)

- [ ] Under 60 years old and client of Adult Protective Services
- [ ] 60+ years old, and at risk of NF placement or with LTC needs
- [ ] Under 60 years old, blind, or disabled
- [ ] None of the above

Section 2 - Meal Preparation

Ability to prepare meals - at least 2 items needed to meet test

- [ ] Doesn't understand how to prepare well-balanced meals
- [ ] Can't access items in cupboard, stove or refrigerator
- [ ] Endurance too low to prepare well-balanced meal and then eat
- [ ] Can't turn stove/oven on/off due to physical limitations
- [ ] Can't shop/obtain food adequate for preparing well-balanced meals
- [ ] None of the above (NOT ELIGIBLE)

Supports are available to assist with meal preparation.

- [ ] No
- [ ] Yes (NOT ELIGIBLE)

Section 3 - Isolation

Client is homebound or otherwise isloted

- [ ] No (NOT ELIGIBLE)
- [ ] Yes

Section 4 - Meal Availability

Lives in assisted housing where meal preparation is available/provided?

- [ ] No
- [ ] Yes (NOT ELIGIBLE)

Eligibility Determination

Meal Eligibility: 1=Eligible, 0=Not Eligible, -1=UK, Answer all Questions

Based on the score above, is the client eligible for home delivered meals?

- [ ] No (Skip to Additional Needs Screening section)
- [ ] Yes

Meal Delivery

Enter meal delivery needs

Number of months client is anticipated to need home delivered meals (6 maximum)

Describe any special diet or meal-prop needs the client has.

Select all days that meal delivery is being requested/needed

- [ ] Monday
- [ ] Tuesday
- [ ] Wednesday
- [ ] Thursday
- [ ] Friday
- [ ] Saturday
- [ ] Sunday

Are Home Delivered Meals hot or frozen?

- [ ] Don't Know
- [ ] Frozen
- [ ] Hot

Number of hot meals per week needed:

Number of frozen meals per week needed:

Nutrition Screening Initiative - Determine Your Nutritional Health

Screening Required?

Is this 1) an in-person assessment, 2) with a client who is at least 60 years old, AND 3) client has met eligibility criteria above?

- [ ] No (skip to the next section)
- [ ] Yes (answer screening questions below)

Screening Questions

How much do you currently weigh?

What is your height in Inches (4'=48", 5'=60", 6'=72")?

Has illness or condition made the client change the kind and/or amount of food eaten?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client eat fewer than 2 meals per day?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client eat few (less than 5) vegetables or fruits, or milk products per day?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client have 3 or more drinks of beer, liquor or wine almost every day?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client have tooth or mouth problems that make it hard to eat?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client sometimes not have enough money to buy food?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client eat alone most of the time?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- [ ] Don't know
- [ ] No
- [ ] Yes

Without wanting to, has the client lost or gained 10 pounds in the past 6 months?

- [ ] Don't know
- [ ] No
- [ ] Yes

Is the client not always physically able to shop, cook and/ or feed themselves (or to get someone to do it for them)?

- [ ] Don't know
- [ ] No
- [ ] Yes

Nutritional Risk

Client's Nutritional Risk Score

Is the nutritional risk score above 6 or more?

- [ ] Don't know
- [ ] No - (0-2: Good/Low Risk, 3-5: Moderate Risk)
- [ ] Yes - Client is at High Nutritional Risk

Additional NAPIS Questions - Required for Title IIIc Funding

Ability to Perform Acitivities of Daily Living (ADLs) in the last 7 days

Eating performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Dressing performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Bathing performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Toilet use performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Transfering performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Walking (in home) performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

What is the client's ADL count?

ASSESSOR. Please indicate any UNMET ADL needs, including areas where client has services that are not fully meeting the need.

Ability to Perform Instrumental Activities of Daily Living (IA DLs) in the last 7 days

Meal preparation performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Shopping performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Medication management performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Money management performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Telephone use performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Heavy housework performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Light housekeeping performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

Transportation performance:

- [ ] Independent
- [ ] Assistance Needed
- [ ] Unknown

What is the client's IADL count?

ASSESSOR. Please indicate any UNMET IADL needs, including areas where client has services that are not fully meeting the need.

Ethnicity and Race

Ethnicity:

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Unknown

Race:

- [ ] American Indian/Native Alaskan
- [ ] Asian
- [ ] Black/African American
- [ ] Hispanic
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Non-Minority (White, non-Hispanic)
- [ ] Other
- [ ] Two or More Races
- [ ] Unknown
- [ ] White-Hispanic

Nutrition Education

Nutrition Information Left with Client

- [ ] No
- [ ] Yes

Additional Needs Screening

Demographics

Select the client's current marital status.

- [ ] Civil union
- [ ] Divorced
- [ ] Legally Separated
- [ ] Married
- [ ] Significant Other
- [ ] Single
- [ ] Widowed

Does the Client live alone?

- [ ] Declined to Disclose
- [ ] No
- [ ] Unknown
- [ ] Yes

Client lives with:

- [ ] Don't Know
- [ ] Family other then Spouse
- [ ] Friend
- [ ] Homeless / Temporary Housing
- [ ] Other
- [ ] Spouse

Type of housing:

- [ ] Acute/hospital
- [ ] Apartment - private
- [ ] Apartment - Subsidized/low income
- [ ] Assisted Living
- [ ] Group Home
- [ ] Homeless
- [ ] Nursing home
- [ ] Own home or condo
- [ ] Private home (not client's)
- [ ] Single room occupancy (SRO)
- [ ] Other

Number and types of pets in home:

Client is a veteran:

- [ ] Declined to Disclose
- [ ] No
- [ ] Spouse of a Veteren
- [ ] Yes

Sevice-Connected Disability:

- [ ] Don't know
- [ ] No
- [ ] Yes

Served during wartime:

- [ ] No
- [ ] Yes

Veteran status comments:

Financial

Is client willing and able to share household income information?

- [ ] Don't Know
- [ ] No (skip to next sub-section)
- [ ] Yes

How many people are there in the client's household?

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] Five
- [ ] Six
- [ ] Seven
- [ ] Eight
- [ ] Greater than eight
- [ ] Information unavailable

Mo income for current household size: 100% FPL

Mo income for current household size: 125% FPL

Mo income for current household size: 150% FPL

Mo income for current household size: 200% FPL

Mo income for current household size: 250% FPL

Mo income for current household size: 300% FPL

Based on the chart above, is the client's income level at or below 100% of the Federal Poverty Level?

- [ ] Don't know
- [ ] No
- [ ] Yes (skip to next subsection)

Based on the above guidelines, what is the client's income range?

- [ ] Don't know
- [ ] 101% - 125% FPL
- [ ] 126% - 150% FPL
- [ ] 151% - 200% FPL
- [ ] 201% - 250% FPL
- [ ] 251% - 300% FPL
- [ ] Over 300% FPL

Difficulty paying monthly bills:

- [ ] No - able to afford bills
- [ ] Sometimes - occassionally some bills go unpaid
- [ ] Always - some bills go unpaid every month

Most Concerning Expenses to Client:

- [ ] None
- [ ] Other - Describe in field notes
- [ ] Unable to afford food
- [ ] Unable to afford medical expenses that are not covered by insurance/Medicare
- [ ] Unable to afford medicine or medical supplies
- [ ] Unable to afford rent/utility bills

Housing

Client satisfied with current living environment:

- [ ] Don't Know
- [ ] No
- [ ] Yes

If not satisfied, reason(s):

Client receives rental assistance:

- [ ] Don't Know
- [ ] No
- [ ] Yes

Client receives Rental Subsidy:

- [ ] Don't know
- [ ] No
- [ ] Yes

Client receives Rent Rebate / Property Tax Rebate:

- [ ] Don't know
- [ ] No
- [ ] Yes

Client keeps heat turned down in winter to save money:

- [ ] No
- [ ] Yes

Client applied for Low Income Home Energy Assistance Plan (LIHEAP):

- [ ] Don't Know
- [ ] No
- [ ] Yes

Nutrition & Hunger Risk

Client receives SNAP (Food Stamps):

- [ ] Don't know
- [ ] No
- [ ] Yes

Other nutritional supports client is interested in (check all that apply):

- [ ] Commodity Supplemental Food Program
- [ ] Congregate Meals
- [ ] Farmshare
- [ ] Food Pantry
- [ ] Nutrition Counseling
- [ ] Other - Specify in Field Notes
- [ ] None at this time

In-Home Support

Adaptive equipment used by Client:

Adaptive equipment needed that client doesn't have:

- [ ] Don't know
- [ ] Bedside commode
- [ ] Cane
- [ ] Crutches
- [ ] Dentures
- [ ] Grab bars
- [ ] Hospital bed
- [ ] Hoyer Lift
- [ ] Lift Chair
- [ ] Prothesis
- [ ] Ramp access
- [ ] Shower Bench/Shower Chair
- [ ] Transfer Equipment
- [ ] Walker
- [ ] Wheelchair cushion
- [ ] Wheelchair, electric
- [ ] Wheelchair, manual
- [ ] Other - Specify in field notes
- [ ] None at this time

Memory Concerns

Client has concerns about his/her memory:

- [ ] Don't know
- [ ] No
- [ ] Yes

ASSESSOR. Does Client's perception of memory status match your observations?

- [ ] No
- [ ] Yes

ASSESSOR. Explain basis for answer:

ASSESSOR. Are you aware of any other information (eg. , caregiver concerns, known diagnoses, etc.) that Indicates there are memory concerns?

- [ ] No
- [ ] Yes

ASSESSOR. If yes, describe:

Count as Potential Person with Dementia

ASSESSOR. Count as potential person with dementia (a nswer Yes if indicator above = 1)

- [ ] No
- [ ] Yes

Managing Chronic Conditions

Client Reports Challenges with (check all the apply):

- [ ] Hearing
- [ ] Visual
- [ ] Speech or Language
- [ ] Physically disabled
- [ ] Weakness or Fatigue
- [ ] Shortness of Breath
- [ ] None

ASSESSOR. Explain checked chronic conditions reported above:

Name of Client's primary care physician:

Practice client's primary doctor is affiliated with:

Client has seen his/her doctor within:

- ☐ 0 - 6 months
- ☐ 6 - 12 months
- ☐ over 12 months
- ☐ Unknown

Name of care manager, if Client has one:

Name of additional health care provider:

Additional organization(s) that help Client:

Has Client been in hospital or emergency room in past 12 mos.?

- ☐ Don't know
- ☐ No
- ☐ Yes

If yes, describe (reason, date, location, duration, etc.):

Falls Prevention

Last time client fell:

- ☐ Never
- ☐ Don't know
- ☐ Within last year
- ☐ 1-3 years ago
- ☐ More than 3 years ago

Client worries/thinks about falling:

- ☐ Don't know
- ☐ No
- ☐ Yes

Health Insurance

Client has questions about health insurance or needs help with insurance paperwork:

- ☐ Don't Know
- ☐ No
- ☐ Yes

Prescriptions

Client has difficulty obtaining all needed prescriptions or over-the-counter medications:

- ☐ Don't Know
- ☐ N/A
- ☐ No
- ☐ Yes

If trouble obtaining medications, reason(s):

Clients largest concerns about medications:

Isolation / Socialization

The next few questions are about how you feel about different aspects of your life.

☐

How often do you feel that you lack companionship: Hardly ever, some of the time, or often?

- ☐ Don't know
- ☐ Hardly Ever
- ☐ Some of the Time
- ☐ Often

How often do you feel left out: Hardly ever, some of the time, or often?

- ☐ Don't know
- ☐ Hardly Ever
- ☐ Some of the Time
- ☐ Often

How often do you feel isolated from others? (Is it hardly ever, some of the time, or often?)

- ☐ Don't know
- ☐ Hardly Ever
- ☐ Some of the Time
- ☐ Often

What is your degree of satisfaction with your ability to spend time with others?

- ☐ Don't know
- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Not too Satisfied
- ☐ Not at all Satisfied

Transportation

Client able to get to the places he/she needs to go:

- ☐ Don't know
- ☐ No
- ☐ Yes

If no, type(s) of transportation needed:

- ☐ Shopping/errands
- ☐ Medical Appointments
- ☐ Social/Recreational
- ☐ Other - Indicate in field notes

Client knows how to access transportation resources in the area:

- ☐ Don't know
- ☐ No
- ☐ Yes

Abuse / Neglect / Exploitation

Client feels safe in home and community:

- ☐ No
- ☐ No response
- ☐ Not applicable - explain in field notes
- ☐ Sometimes
- ☐ Unclear response - explain in field notes
- ☐ Yes

If not, what makes client feel unsafe:

ASSESSOR. Signs or risk factors of abuse, neglect, or exploitation were observed during assessment:

- ☐ Unsure
- ☐ No
- ☐ Yes

If yes, describe:

Home Safety

ASSESSOR. Home safety concerns observed during assessment (check all that apply):

- ☐ Aggressive or Neglected Animals
- ☐ Fire Hazards / Lack of Smoke Alarms
- ☐ Hoarding
- ☐ Inaccessible exits / entrances
- ☐ Inadequate heating or cooling
- ☐ Insects/Rodents Present
- ☐ Insufficient lighting
- ☐ Maintenance/repair needs
- ☐ Neighborhood concerns
- ☐ Unsanitary living conditions
- ☐ Parking Issues
- ☐ Plumbing problems
- ☐ Rancid/improperly stored food
- ☐ Safety modifications needed (grab bars, railings, ramp)
- ☐ Tripping Hazards (rugs, cords, clutter)
- ☐ Weapons
- ☐ Yard maintenance (snow removal, lawn care)
- ☐ Other - Specify in field notes
- ☐ No home safety concerns noted

Legal

ASSESSOR. Client expressed legal concerns:

- ☐ Don't Know
- ☐ No
- ☐ Yes

Caregiver Concerns

ASSESSOR. Describe any concerns reported by Caregiver:

ASSESSOR. Caregiver interested hearing from Family Caregiver Support Program about:

- [ ] Don't know
- [ ] Adult Day Services
- [ ] Classes
- [ ] Finding Resources
- [ ] Help with Problem Solving
- [ ] Options Counseling
- [ ] Respite
- [ ] Setting up LTC Services and Supports
- [ ] Other - Specify in field notes
- [ ] None at this time

Volunteer

Interested in volunteer opportunities:

- [ ] Don't know
- [ ] No
- [ ] Yes

If yes, volunteer activies client is interested in:

Other

ASSESSOR. Pertinent Social History (childhood, occupation, hobbies):

ASSESSOR. Other concerns not already described in assessment:

Outcome

ASSESSOR. Based on this Assessment, will you be completing an internal referral to SMAA Community Services?

- [ ] No
- [ ] Yes

ASSESSOR. Based on this assessment have you or will you be making a referral to:

- [ ] Adult Protective
- [ ] Commodity Supplemental Food Program
- [ ] None

ASSESSOR. If no referral to be made, indicate reason:

- [ ] Client Declined Referral
- [ ] No Referral Needs Identified
- [ ] Identified Referral Need(s) already addressed by CS on intake

ASSESSOR. If client declined referral, indicate any reason given:

Title :

Date

Title :

Date

StateMandated Assessment

SOUTHERN MAINE Agency on Aging

Consumer ID #_____ **Site:** _____

Initial assessment: Referral date_____ Referred by _____ (name / organization)

Assessment date_____ Start date of meals _____

OR

Re-assessment: Date_____ Check One: Telephone____ In-person_____

Name	**Emergency Contact**
Address	Relationship Telephone # Address Circle if: POA / Guardian
Town of Residence	**Contact #2**
Telephone # (circle one) Male / Female	Relationship Telephone # Address Circle if: POA / Guardian
DOB Social Security # **(optional)**	
Medical problems / health information / changes since last home-delivered meals assessment	

ELIGIBILITY – The consumer must meet the criteria in each section to be eligible for meals:

Section 1 (1 needed to meet criteria)

OAA Title III Funding:

- ☐ **Age 60 or older client of Adult Protective Services**
- ☐ **Age 60 or older in greatest social or economic need**
- ☐ **Spouse (of any age) of participating older person; AAA has determined that receipt of meal by the spouse is in the best interest of the older person – NO NEED TO COMPLETE SECTION 2, 3, 4.**
- ☐ **Under age 60 with a disability residing with older person receiving home-delivered meals**

***Subject to availability of* Social Services Block Grant (SSBG) Funding:**

- ☐ **Under age 60 clients of Adult Protective Services**
- ☐ **Age 60 or older; AAA has determined that person is at risk of nursing facility placement or has long-term care needs.**
- ☐ **Under age 60, deaf, blind or with a disability**

Section 2 Check all that apply

- ___Does not understand how to prepare well-balanced meals
- ___Cannot access items in the cupboard, stove or refrigerator
- ___Endurance too low to prepare well-balanced meal and then eat
- ___Cannot turn stove/oven on/off due to physical limitations
- ___Cannot shop or obtain food adequate for preparing well-balanced meals

☐ **Unable to prepare meals**

(2 items above checked to meet criteria)

STOP HERE IF LESS THAN 2 ITEMS. CONSUMER IS NOT ELIGIBLE FOR MEALS

If unable to prepare meals:

☐ Has no support system to prepare meals. (MUST ALSO BE CHECKED FOR ELIGIBILITY)

Section 3

☐ **Homebound or otherwise isolated**

Section 4

☐ **Not residing in assisted housing where meals are available.**

Is consumer eligible for home-delivered meals? Circle one: YES NO* *follow Right of Appeal procedure

Expected length of time to receive meals (cannot be more than six months) _____

Special dietary/nutritional needs_____

Days of meal delivery (circle days) M T W TH F number/week: Hot_____ Frozen_____

Complete the 'Determine Checklist' form for consumers age 60+ at the initial assessment and yearly thereafter.
Was the **Determine Your Nutritional Health** checklist completed? YES NO If YES, Score ____

Southern Maine Agency on Aging

HOME-DELIVERED MEALS ASSESSMENT

Additional National Aging Program Information System (NAPIS) Requirements:

Does the consumer live alone? YES NO Rural? YES NO Low income? YES NO

Does the consumer need help with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)? Check if help is needed:		**Ethnicity** Check one:
☐ **Eating** ☐ **Dressing** ☐ **Bathing** ☐ **Toileting** ☐ **Transferring** ☐ **Walking**	☐ **Meal Preparation** ☐ **Shopping** ☐ **Managing medications** ☐ **Managing money** ☐ **Using the telephone** ☐ **Heavy housework** ☐ **Light housework** ☐ **Using available transportation**	☐ **African American** ☐ **Hispanic / Latino** ☐ **American Indian / Alaskan Native** ☐ **Asian** ☐ **Pacific Islander / Native Hawaiian** ☐ **Non-minority** ☐ **Other**
Total number ADLs checked_____	**Total number IADLs checked_____**	

I request home-delivered meals and confirm that the information above is correct.
I understand that my eligibility for home-delivered meals will be re-assessed every 6 months.

_____ _____

Consumer Signature **Date**

_____ _____

Area Agency on Aging Staff Date

Additional Space for agency use

May 25, 2005, HDM_assessform_05
Bureau of Elder and Adult Services

Crisis to ThrivingScale

CRISIS	VULNERABLE	SAFE	STABLE	THRIVING	UNABLE TO ASSESS
Nutrition Status					
1-2 Unable to cook/prepare food. Does not initiate eating w ithout prompting.	3-4 Able to use the microw ave to cook/prepare food. Does not have help. Does not eat a sufficient diet.	5-6 Receives some help preparing meals. Uses only the microw ave to cook/prepare food w hen alone. Diet is suboptimal.	7-8 Receives reliable support w ith meals. Uses only the microw ave to cook/prepare food w hen alone. Diet is sufficient.	9-10 Can saf ely use the stove to prepare some meals, and uses the microw ave for others. May occasionally eat out. Diet is sufficient.	
Food Security					
1-2 No means to access food. Has less than a day of food on hand.	3-4 Help w ith shopping is unreliable or inconsistent. Food is in short supply 1-2x/w eek.	5-6 All food is obtained from food assistance resources. Has adequate food supply w hen receives shopping help.	7-8 Partially relies on food assistance resources. Has reliable help w ith food shopping and stable supply.	9-10 Can afford to buy desired foods. Can shop w ithout help. No unmet food needs.	
Health Care					
1-2 Has immediate unmet health needs and no provider.	3-4 Has unstable health needs w ith inconsistent follow -up and/or inconsistent adherence to recommended regimen.	5-6 Major health needs are generally w ell managed w ith consistent follow -up; inconsistent adherence to recommended plan.	7-8 Most health needs are generally met w ith consistent follow -up; generally adheres to prescribed regimen.	9-10 Health needs met, w ell connected to healthcare resources, and solid adherence.	
Medications					
1-2 Unsure of medications, has no supervision & no list, evidence of missed doses and/or poor access.	3-4 Unable to manage meds independently, only sporadic supervision, takes more than 5 meds, has no med list.	5-6 Has list of meds from PCP and tries to follow it w ith w eekly supervision, no back-up plan.	7-8 Medications taken match list, inclusive of OTC, does not know reason for taking meds but takes as prescribed.	9-10 Has list of meds from PCP and tries to follow it, able to manage medications independently.	
Falls Risk					
1-2 Falls 2 or more times in past month, w ith injury, home is unsaf e.	3-4 Fall w ith or w ithout injury in past 3 months, home unsaf e.	5-6 Fall w ithin last 3 months, no injury. Home is saf e. Fall risk factors exist.	7-8 No falls in past 6 months, home is saf e, no fall risk factors.	9-10 No falls in past 12 months, gait stable, active, safe home.	
In-Home Care					
1-2 Needs paid assistance but no service in area or poor staffing; OR care available but cannot afford.	3-4 Needs paid assistance, care available, but client declines help.	5-6 In-home health care is available but staffing inconsistent and no backup; OR could use more help.	7-8 In-home health care is available, fully staffed, and reliable; client is satisfied w ith services.	9-10 No in-home care is needed at this time.	
Caregiver Engagement (Family/Friend/Other)					
1-2 Signs of abuse, neglect (other than self-neglect), or exploitation. No friends or family involved.	3-4 Family and friends unw illing or unable to participate in person's care needs.	5-6 Family and friends are supportive but lack time, know ledge, ability, or resources to help.	7-8 One person is actively invested in client's day to day care needs and/or a Pow er of Attorney exists.	9-10 Dependable netw ork of family and friends w ho provide assistance and/or a Pow er of Attorney exists.	

Crisis to Thriving Draft Definitions

Crisis: immediate help is needed; emergent risk of injury to self or others; immediate risk for hospitalization and/or APS referral

Vulnerable: at significant risk for emergent harm

Safe: basic needs are met but unstable back-up plan

Stable: needs met with adequate back-up

Thriving: independent and/or has a strong network to meet needs

Outcome Measure Draft Definitions

Nutritional Status assesses client's ability to safely prepare food and maintain a sufficient intake

- ☐ **Suboptimal:** Under representation of basic food groups, eats fewer than 3 meals/day.
- ☐ **Sufficient:** eats 3 meals/day with variety of food from 5 food groups protein, fruits, vegetables, dairy, and grains

Food Security assesses the adequacy of available food to client and `ability to obtain food

- ☐ **Adequate supply:** Enough food to meet basic metabolic requirements, basic food groups may be underrepresented on 1-2x per week.
- ☐ **Stable supply:** Supply meets minimal requirements of food group representation on a daily basis.

Health Care assess extent of unmet health care needs of client (physical or mental), access to provider and adherence with medical regimen.

Medications assesses for ability to access medications, take as prescribed, and take action for adverse effects.

- ☐ **Poor access:** Unreliable transportation to pharmacy, unable to afford medications.
- ☐ **Sporadic supervision:** Supervision less than once per week.

Falls Risk assesses for fall risk, frequency of falls, and injury associated with falls

- ☐ **Unsafe home:** structurally unsafe, fall hazards (clutter, poor lighting, no handrails, throw rugs).
- ☐ **Safe home:** Home structurally intact, absence of fall hazards (clutter, poor lighting, no handrails, throw rugs).

Fall risk factors: Unsteady gait, misuse or unavailable assistive devices (walker, cane, etc.), poor footwear, fall hazards (defined above), medications that interfere with cognitive arousal (benzodiazepines, non-benzo sleep aids, trazodone, anticholinergics, etc.).

CRISIS	VULNERABLE	SAFE	STABLE	THRIVING	UNABLE TO ASSESS
Socialization					
1-2 Has limited or no interaction w ith anyone at home or in the community. Pref ers to be alone and/or purposef ully avoids contact w hen possible.	3-4 Interacts w ith only service providers (i.e. mail carrier, delivery person, cashier, healthcare provider). Has few opportunities to socialize; reports feeling lonely.	5-6 Occasionally interacts w ith people socially (1-2x/w eek). Speaks to at least 1 friend or family member by phone each w eek. Enjoys social contact.	7-8 Often interacts w ith people in person or by phone (3-5x/w eek). Is interested in having more contact with others.	9-10 Engages in social activities regularly (5-7x/w eek or more) and is satisfied w ith level of socialization.	
Transportation					
1-2 No means of transportation. Still drives and no longer feels safe doing so or has been in an at-fault driving accident.	3-4 Relies exclusively on friends or family and transportation needs not alw ays met. Or needs to stop driving as soon as possible.	5-6 Still drives for essential reasons but is having increasing difficulty (e.g. getting confused or lost). No back up plan.	7-8 Mainly relies primarily on friends or family, and they are often able to meet the needs.	9-10 Has reliable vehicle for personal use & feels confident driving locally, and/or has reliable back up plans (public transportation, friends/family).	
Money Management					
1-2 Help is needed but not available. Evidence of financial exploitation.	3-4 Needs help from others, but help is sporadic or unreliable; or client ref uses help.	5-6 Has some support, but has some financial issues that need to be addressed.	7-8 Manages ow n money, but may need occasional help communicating or handling issues.	9-10 Manages money independently; or has a financial PoA handling all matters.	
Housing					
1-2 Literally homeless or in temporary housing/shelter.	3-4 Home poorly maintained; and/or at risk for foreclosure or eviction; and/or unsafe environment.	5-6 Some maintenance issues need to be addressed, client struggling to cover costs, environment less than desirable.	7-8 Minor non-urgent repairs needed, can cover costs w ith planning, environment safe	9-10 Home w ell maintained and affordable, safe environment.	
Personal Care/Safety					
1-2 Client has significant ADL deficit impacting self-care.	3-4 Client has requires limited or total assistance or cueing. Assistance is unavailable or inconsistent.	5-6 Needs assistance or cuing w ith most ADLs, and has support, but unreliable back-up plan.	7-8 Needs assistance or cuing w ith most ADLs, but has assistance and a stable back-up plan; OR requires limited assistance or supervision, and assistance is available.	9-10 Fully able to perform ADLs w ithout assistance or support.	
Cognitive Function					
1-2 Memory and executive function deficits present immediate danger to self or others.	3-4 Memory and executive function deficits are a barrier to making decisions and meeting basic needs.	5-6 Memory and/or executive function are beginning to interfere w ith independently managing IADLs.	7-8 Memory and/or executive function prevent client from engaging in desired activities or hobbies.	9-10 Memory issues are minimally interfering w ith functioning. Executive function is mostly intact.	

In-Home Care assesses the need for in-home care and adequacy of staffing

Caregiver Engagement (Family/Friend/POA/Other) assesses caregiver involvement, evidence of mistreatment, and reliability of engagement

Socialization assesses frequency of contact/interaction with others in the home (in person, phone or on-line), or in the community and client satisfaction with amount of socialization

Transportation assesses client's has access to safe and reliable transportation

Money Management assesses client's ability to manage own finances and/or reliance on reputable and dependable person for assistance

Housing assesses the client's current housing situation

- ☐ **Poorly Maintained:** Structure is in disrepair, grounds unkempt, interior of home is unclean, appliances and utilities may be unsafe or dysfunctional.
- ☐ **Unsafe environment:** Structure may not meet safety codes (no smoke detectors, CO detectors, disrepair, water access, heat access, safe electricity access, etc.), fall hazards exist, unclean, appliances are visibly damaged or not functioning properly.
- ☐ **Safe environment:** Neighborhood is safe, can leave home without feel of being in danger from external sources

Personal Care/Safety assesses client's independence to safely meet ADL needs

- ☐ **ADL assistance:** Difficulty with maintaining personal hygiene, preparing meals/feeding self, dressing self, toilet use, functional mobility.

Memory and Executive Function assesses degree of risk and dependence associated with memory and executive function loss