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

<table>
<thead>
<tr>
<th>SCREEN</th>
<th>DATE</th>
<th>SCORE / LEVEL</th>
<th>IF NOT COMPLETE, EXPLAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAM</td>
<td></td>
<td>/</td>
<td></td>
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<tr>
<td>CAM</td>
<td></td>
<td>/</td>
<td></td>
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<tr>
<td>PPAM</td>
<td></td>
<td>/</td>
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<tr>
<td>Katz ADL</td>
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<tr>
<td>PHQ-9</td>
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<tr>
<td>PSC-17</td>
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</tr>
<tr>
<td>BMI</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## 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
# PSC-17 Scoring

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Feels sad, unhappy</td>
<td>Never</td>
<td>Sometimes</td>
</tr>
<tr>
<td>2.</td>
<td>Feels hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Is down on self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Worries a lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Seems to be having less fun</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internalizing Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Fidgety, unable to sit still</td>
<td></td>
<td></td>
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<tr>
<td>7.</td>
<td>Daydreams too much</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>Distracted easily</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>Has trouble concentrating</td>
<td></td>
<td></td>
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<tr>
<td>10.</td>
<td>Acts as if driven by a motor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attention Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Fights with other children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Does not listen to rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Does not understand other people’s feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Teases others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Blames others for his/her troubles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Refuses to share</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Takes things that do not belong to him/her</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Externalizing Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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/](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
### Mood and Activity Changes-Self-Rated Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**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
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

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](http://www.warecoveryhelpline.org)

• **Teen Link Help Line** for teens: 866-833-6546 or [https://www.teenlink.org/](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
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

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.phqscreens.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 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.
Using PRISM – Case Manager

<table>
<thead>
<tr>
<th>Events</th>
<th>AD</th>
<th>Elig</th>
<th>Risk</th>
<th>IP Score</th>
<th>Claims</th>
<th>OP</th>
<th>IP</th>
<th>Rx</th>
<th>ER</th>
<th>AOD</th>
<th>MH</th>
<th>LTC</th>
<th>Labs</th>
<th>Providers</th>
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<tbody>
<tr>
<td>DEMOGRAPHICS(...)</td>
<td></td>
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<tr>
<td>Name: KNUIT, SACHA</td>
<td>DOB: 1951-03-05</td>
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</tr>
<tr>
<td>Gender: F</td>
<td>Age: 69</td>
<td></td>
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<tr>
<td>PI ID (ACES): 11111111111</td>
<td>Phone: (855) 256-1654</td>
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</table>

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

<table>
<thead>
<tr>
<th>Risk Score: 4.08</th>
<th>IP Admit Risk Score: 95.0%</th>
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<tbody>
<tr>
<td>Primary Risk: Cardiovascular, medium</td>
<td></td>
</tr>
<tr>
<td>Secondary Risk: Renal, very high</td>
<td></td>
</tr>
<tr>
<td>Mental Illness: Psychiatric, medium low</td>
<td></td>
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<tr>
<td>Substance Abuse: No</td>
<td></td>
</tr>
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</table>

**Avatars(4)** Fall(1) Pain(2) Limitations(38) Client Worker

Details of Long Term Care Assessment 577553B on 2020-10-19 (Annual) for CARE client named KNUIT, SACH.

<table>
<thead>
<tr>
<th>ACL Score [0 to 29]:</th>
<th>Depression Score:</th>
<th>CPS Score [0 to 6]:</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

**Overall Self-Sufficiency:** DETERIORATED

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane, Lois</td>
<td>508-749-1331 Ext. 321</td>
</tr>
<tr>
<td>ACTIVITIES</td>
<td>INDEPENDENCE: (1 POINT)</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>POINTS (1 OR 0)</td>
<td>NO supervision, direction or personal assistance</td>
</tr>
<tr>
<td><strong>BATHING</strong></td>
<td>(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.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
<tr>
<td><strong>DRESSING</strong></td>
<td>(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
<tr>
<td><strong>TOILETING</strong></td>
<td>(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSFERRING</strong></td>
<td>(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
<tr>
<td><strong>CONTINENCE</strong></td>
<td>(1 POINT) Exercises complete self control over urination and defecation.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
<tr>
<td><strong>FEEDING</strong></td>
<td>(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
</tr>
<tr>
<td>POINTS:_________</td>
<td></td>
</tr>
</tbody>
</table>
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

**How to Try This**

Video

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

This program will demonstrate the Katz Index of Independence in Activities of Daily Living, a tool which nurses can use to assess functional status of older adults by measuring their ability to perform activities of daily living.
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 an inexpensive screening tool, but it is not diagnostic of the health of an individual

\[ \text{BMI} = 703 \times \left( \frac{\text{weight}}{\text{height in inches} \times \text{height in inches}} \right) \]

• Do multiplication in brackets first
## BMI Categories

<table>
<thead>
<tr>
<th>Weight Status Category</th>
<th>Child/Teen (BMI Percentile)</th>
<th>Adult (BMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>Less than the 5&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>Below 18.5</td>
</tr>
<tr>
<td>Normal or Healthy Weight</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; percentile to less than the 85&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>18.5-24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>85&lt;sup&gt;th&lt;/sup&gt; to less than 95&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>25.0-29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>Equal to or greater than the 95&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>30.0 and above</td>
</tr>
</tbody>
</table>
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?”

- 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?

Sacha  Carmella  Luchita  Tom  Jacob
More Information

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

BMI Calculator for Adults

For more information visit the CDC’s website at:
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

AUDIT and DAST Screening Tools
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

<table>
<thead>
<tr>
<th>ONE DRINK EQUALS</th>
<th>12 oz. beer</th>
<th>5 oz. wine</th>
<th>1.5 oz. liquor (one shot)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Please answer the questions below.</th>
<th>None (0)</th>
<th>1 or More</th>
</tr>
</thead>
</table>

1. How many times in the past year have you had 4 or more drinks in a day? | ₀ | ₀ |

2. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? | ₀ | ₀ |

- 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AU1. How often do you have a drink containing alcohol?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU2. How many drinks containing alcohol do you have on a typical day when you are drinking?</strong></td>
<td>☐ 1 or 2</td>
<td>☐ 3 or 4</td>
<td>☐ 5 or 6</td>
<td>☐ 7 to 9</td>
<td>☐ 10 or more</td>
</tr>
<tr>
<td><strong>AU3. How often do you have 5 or more drinks on one occasion?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU4. How often during the last year have you found that you were not able to stop drinking once you had started?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU5. How often during the last year have you failed to do what was normally expected from you because of drinking?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>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?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU7. How often during the last year have you had a feeling of guilt or remorse after drinking?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU9. Have you or someone else been injured because of your drinking?</strong></td>
<td>☐ No</td>
<td>☐ Yes, but not in the last year</td>
<td>☐ Yes, during the last year</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>AU10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?</strong></td>
<td>☐ No</td>
<td>☐ Yes, but not in the last year</td>
<td>☐ Yes, during the last year</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Add scores by column, then across row.
<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times a month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2-3 times per week</td>
<td>4 or more times a week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
</tr>
<tr>
<td>#3-8</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Daily or almost daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#9-10</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
</tr>
</tbody>
</table>
### One drink equals

<table>
<thead>
<tr>
<th>12 oz. Beer</th>
<th>5 oz. Wine</th>
<th>1.5 oz. Liquor (one shot)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### In the past 12 months...

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

<table>
<thead>
<tr>
<th>AU1. How often do you have a drink containing alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 2-4 times a month</td>
</tr>
<tr>
<td>○ 3 or more times a week</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>AU2. How many drinks containing alcohol do you have on a typical day when you are drinking?</th>
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</tr>
<tr>
<td>○ 3 or 4</td>
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<tr>
<td>○ 7 to 9</td>
</tr>
<tr>
<td>○ 10 or more</td>
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</tr>
</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
<tr>
<td>○ 2</td>
</tr>
<tr>
<td>○ 3</td>
</tr>
<tr>
<td>○ 4</td>
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</tbody>
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<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
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</tr>
<tr>
<td>○ 3</td>
</tr>
<tr>
<td>○ 4</td>
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<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
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</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
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</tr>
<tr>
<td>○ 4</td>
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</tbody>
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<tr>
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</thead>
<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
<tr>
<td>○ 2</td>
</tr>
<tr>
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</tr>
<tr>
<td>○ 4</td>
</tr>
</tbody>
</table>

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<tr>
<th>AU8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</th>
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<tbody>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ 1</td>
</tr>
<tr>
<td>○ 2</td>
</tr>
<tr>
<td>○ 3</td>
</tr>
<tr>
<td>○ 4</td>
</tr>
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<td>○ Yes, during the last year</td>
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<tr>
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</tr>
<tr>
<td>○ Yes, but not in the last year</td>
</tr>
<tr>
<td>○ Yes, during the last year</td>
</tr>
</tbody>
</table>

Add scores by column, then across row. **Sum Columns**

0 4 6 3 4

_Add subtotals for total score_

=17
**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.

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

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.

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

**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.

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

**TOTAL** 5 0

*Sum of “Yes” Column is Total Score*
## DAST-10 – Scoring Interpretation

### Guidelines for Interpretation of DAST-10 Scores

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk Level</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems reported</td>
<td>Encouragement and education</td>
</tr>
<tr>
<td>1-2</td>
<td>Moderate level</td>
<td>Brief intervention</td>
</tr>
<tr>
<td>3-5</td>
<td>High level</td>
<td>Brief intervention plus brief therapy</td>
</tr>
<tr>
<td>6-10</td>
<td>Substantial level</td>
<td>Brief intervention plus referral to chemical dependency treatment</td>
</tr>
</tbody>
</table>
Full Screen Scores

I. Low Risk or Abstain
   AUDIT: 0-6 (women), 0-7 (men)
   DAST: 0

II. Risky
   AUDIT: 7-15 (women), 8-15 (men)
   DAST: 1-2

III. Harmful
    AUDIT: 16-19
    DAST: 3-5

IV. Dependent
    AUDIT: 20+
    DAST: 6+

- Positive Health Message
  Rescreen Annually

- Brief Intervention
  1-4 Visits

- Brief Intervention & Referral to Brief Treatment
  5-12 Visits

- Brief Intervention & Referral to CD Treatment
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
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

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

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


AARP HomeFit Guide

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) 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.phqsscreeners.com/select-screener

### GAD-7 Anxiety Scale

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

**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
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:

Consider Vignette From 2-Day Training

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 person’s 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
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/
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.

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grin or frown; withdrawn; distracted</td>
<td>Frequent to constant frown; clenched jaw; quavering chin</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy; restless; tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arching or rigid, holding</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Means or whimpering, occasional complaint</td>
<td>Crying steadily, screams or sob; frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or being talked to; distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

How to Use the FLACC

In patients who are awake: observe for 1 to 5 minutes or longer. Observe legs and body uncovered. If possible, report the patient. Inspect the body and assess for tanniness and tone.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, report the patient. Inspect the body and assess for tanniness 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 the patient has increased tone, rigidity, or tension.
  - Score 2 if the patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, terrors.

- **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 face, pressure on a body part.
  - Score 2 if the patient is in a fixed position, rocking; demonstrates side-to-side head movement or rocking 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, whimpering, 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.

Wherever 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 = Mild discomfort
- 2 = Moderate pain
- 3 = Severe discomfort or pain or both

From Markel, S. L., Vaghasia, L., Sheynitz, J. J., & Maloney, 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 Markel, MS, RN, Forn Vaghasia, MS, RN, and Sheila Maloney, MS, RN, at Children’s Hospital of Eastern Ontario, Ottawa, ON, Canada. 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]
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