Adult Core 2.0

Total Questions : **100**

Member Details :

Name: **Altruista ID:**

Date Of Birth: **Home Phone:**

1 **Do you agree to Case Management services?**

- Yes
- No

2 **Do you agree to discuss your health information with me today?**

- Yes
- No

3 **Would it be ok if we share the information we discuss today with your doctor/primary care provider and others who may be involved in your care?**

- Yes
- No

4 **PROMPT: Verify and update race, ethnicity and language in member details**

Use Quick Links to navigate to Member Details

5 **How would you describe your health?**

- Excellent
- Good
- Fair
- Poor

6 **What concerns do you have regarding your health?**

Enter Concerns

7 **Does your health keep you from doing the things you want?**

- Yes
- No

8 **Do you have a primary care provider/PCP?**

- Yes

Enter Name of PCP

- No
- NA

9 **In the past 12 months, have you seen your primary care provider/PCP for any reason?**

- Yes
- No

10 **Do you have difficulties (such as transportation, making appointments) that keep you from seeing your PCP or other type of needed provider as frequently as you would like to?**

- Yes
- No

11 **If yes, why?**

- Transportation
- Difficulty making or getting an appointment
- Cannot afford copay
- No PCP

- Language barrier
- Other

Describe Other Barrier

12 How often do you worry that you don't have enough food for yourself or your family?

- Never
- Sometimes
- Always
- Declined to answer

13 Do you feel safe at home and in your neighborhood?

- Never
- Sometimes
- Always
- Declined to answer

14 Do you get help from agencies (e.g.. Meals on Wheels, Food Bank, Church) in your neighborhood?

- Yes
- No

15 Within the past 30 days, where have you been living?

- Owned or rented home (e.g., house, apartment, room)
- Stayed at someone else's home
- Homeless (shelter, street, vacant building, outdoors, park)
- Group home setting
- Transitional living facility or a temporary or emergency shelter (e.g., halfway house)
- Correctional facility (e.g., detention center, jail, prison)
- Hotel
- Other

Describe Other

16 Who do you live with?

- Lives Alone
- Spouse/Significant Other
- Family
- Relatives
- Caregiver
- Other

Describe Other

17 What is your employment Status?

- Employed - Full Time
- Employed - Part Time
- Leave of Absence
- Disabled
- Retired
- Student
- Unemployed
- Other

Describe Other

18 Are you currently seeking Employment Assistance?

- ○ Yes
- ○ No
- ○ Don't Know

19 Have you ever served in the military?

- ○ Yes
- ○ No

20 Are you deaf or do you have serious difficulty hearing?

- ○ Yes
- ○ No

21 Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ○ Yes
- ○ No

22 Do you have serious difficulty concentrating, remembering, or making decisions

- ○ Yes
- ○ No

23 Are you currently receiving or have you received any of the following services in the last 6 months?

- ☐ Adult Day Care
- ☐ Hemodialysis
- ☐ Home Health Nurses
- ☐ Home Physical Therapy
- ☐ Home Occupational Therapy
- ☐ Home Speech Therapy
- ☐ Mental Health Services
- ☐ Home Delivered Meals
- ☐ Personal Care Aid
- ☐ Private Duty Nursing
- ☐ Physical, Speech or Occupational Therapy in an Outpatient Setting
- ☐ Overnight Care/Services
- ☐ Social Worker
- ☐ Transportation Service
- ☐ Other (Specify):

Define Other ____

- ☐ None

24 Do you currently use any of the following medical equipment?

- ☐ Cane/Walker
- ☐ Wheelchair
- ☐ Oxygen
- ☐ C-pap/Bi-pap
- ☐ Blood Sugar Monitor
- ☐ Ventilator
- ☐ Nebulizer
- ☐ Other (Specify):

Define Other ____

- [ ] None

25 Describe your ability to get around.

- ( ) Must stay in bed all or most of the time
- ( ) Must stay in the house all or most of the time
- ( ) Need the help of another person getting around inside or outside the house
- ( ) Need the help of some special aid, like a cane or wheelchair, to get around inside or outside the house
- ( ) Do not need the help or another person or a special aid but have trouble getting around freely
- ( ) Not limited in any of these ways
- ( ) Doesn't know

26 Do you have serious difficulty walking or climbing stairs?

- ( ) Yes
- ( ) No

27 Have you had 2 or more falls or any fall with an injury in the past year?

- ( ) Yes

  Describe Falls [ ]
- ( ) No
- ( ) Unknown

28 Are you afraid of falling in the future?

- ( ) Yes
- ( ) No
- ( ) Unknown

29 Do you need help with any of the following activities?

- [ ] Bathing
- [ ] Toileting
- [ ] Dressing
- [ ] Eating
- [ ] Getting in/out of bed or chair
- [ ] Housekeeping
- [ ] Preparing Meals
- [ ] Shopping
- [ ] Running Errands
- [ ] Paying Bills
- [ ] Managing Money
- [ ] Getting Transportation
- [ ] Using Telephone
- [ ] Taking Medications
- [ ] Independent in all of the above

30 Do you have the help you need to meet your needs?

- ( ) Yes
- ( ) No

31 Do you take prescription medications?

- ( ) Yes
- ( ) No

32 Do you take your medications as your doctor has prescribed?

- Yes
- No

33 What keeps you from taking your medications as prescribed?

- Can't get to pharmacy
- Can't get approved for coverage or excluded in their plan
- Can't afford
- Experiencing side effects or don't like the way it makes me feel
- Forgets to take almost every day
- Lack of understanding/knowledge
- Hard to keep tracks of multiple medications
- Other

Describe Other Reasons for not taking medications

34 How many times in the past 12 months have you stayed overnight as a patient in a hospital?

- None
- 1-3 times
- 4 or more times

35 Was the hospitalization for mental health or substance abuse?

- Yes
- No
- Declined to answer

36 How many times in the past 12 months have you gone to the Emergency Room for care and were not admitted to the hospital?

- None
- 1-3 times
- 4 or more times

37 Was there an ER visit for mental health or substance abuse?

- Yes
- No

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

Select one option from each of the following questions

39 Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

40 Feeling down, depressed or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

41 Trouble falling asleep, staying asleep, or sleeping too much

- Not at all
- Several days
- More than half the days
- Nearly every day

42 **Feeling tired or having little energy**

- Not at all
- Several days
- More than half the days
- Nearly every day

43 **Poor appetite or overeating**

- Not at all
- Several days
- More than half the days
- Nearly every day

44 **Feeling bad about yourself – or that you're a failure or have let yourself or your family down**

- Not at all
- Several days
- More than half the days
- Nearly every day

45 **Trouble concentrating on things, such as reading the newspaper or watching television**

- Not at all
- Several days
- More than half the days
- Nearly every day

46 **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**

- Not at all
- Several days
- More than half the days
- Nearly every day

47 **Thoughts that you would be better off dead or of hurting yourself in some way**

- Not at all
- Several days
- More than half the days
- Nearly every day

48 **Over the last two weeks, how often have you been bothered by any of the following problems? [GAD-7]**

Select one option from each of the following questions

49 **Feeling nervous or on edge**

- Not at all
- Several days
- More than half the days
- Nearly every day

50 **Not being able to stop or control worrying**

- Not at all
- Several days
- More than half the days
- Nearly every day

51 **Worrying too much about different things**

- Not at all
- Several days
- More than half the days
- Nearly every day

52 Trouble relaxing

- Not at all
- Several days
- More than half the days
- Nearly every day

53 Being so restless that it is hard to sit still

- Not at all
- Several days
- More than half the days
- Nearly every day

54 Becoming easily annoyed or irritable

- Not at all
- Several days
- More than half the days
- Nearly every day

55 Feeling afraid as if something awful might happen

- Not at all
- Several days
- More than half the days
- Nearly every day

56 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

57 Are you experiencing any pain other than the usual aches and pain that are typical for you?

- Yes

  Describe pain [ ]
- No
- Doesn't Know
- Refused to Answer

58 Describe the pain in the last 3 days

- None
- Mild
- Moderate
- Severe
- Unable to Respond

59 During the last 4 weeks how much did pain interfere with your normal routine?

- Not at all
- Several days

- More than half the time
- Nearly every day
- Doesn't Know

60 What eases your pain?

- Medication
- Relaxation Techniques
- Visualization
- Other

Describe Other

61 Are you pregnant?

- Yes
- No
- N/A

62 Have you ever been told you have one or more of the following medical conditions?

- Coronary Artery Disease
- Heart Failure or enlarged heart
- High Blood Pressure
- Asthma
- COPD, or other breathing problems
- ESRD or currently on dialysis
- Sickle Cell Disease
- HIV/AIDS
- Hemophilia
- Diabetes or sugar problems
- Hepatitis C
- Obesity/Overweight
- Depression OR Major Depression
- Significant Memory Loss or Dementia
- Bi-Polar Disorder
- Schizophrenia or other psychotic disorders
- Anxiety Disorder
- SUD (Substance Use Disorder)
- Other Conditions
- None
- Doesn't know

63 Do you have an Intellectual/Developmental Disability?

- Yes

Type of Intellectual/Developmental Disability

- Autism Spectrum Disorder
- Cerebral Palsy
- Down Syndrome
- Fetal Alcohol Syndrome
- Neurodevelopmental Disorder
- Other
- Prader Willi Syndrome
- Spina Bifida
- Tourette Syndrome

- No

64 Do you have a care manager or support coordinator from another agency?

- Yes

Enter Information in Care Team

- No

65 **Have you had a dental exam in the last year?**

- Yes
- No
- Doesn't know

66 **Do you have any dental concerns?**

- Yes

  What are your dental concerns?

  - Dental Caries
  - Periodontal or gum disease
  - Missing teeth or tooth loss
  - Other

- No Concerns
- Other

  Describe other

67 **Have you had any surgery in the past?**

- Yes

  Describe Surgery and Date

- No
- Unknown

68 **Are you planning or are you scheduled for surgery in the future?**

- Yes

  Describe Surgery and Date

- No
- Unknown

69 **Has the member received any of these preventive services in the last year? Instructions: For each service, indicate yes member has completed, no member has not completed or N/A based on member age and gender.**

- Cervical Cancer Screening - Recommended every 3 years for women ages 21 to 65

  Select

  - Yes
  - No
  - N/A

- Colon Cancer Screening - Recommend Fecal occult blood test, sigmoidoscopy or colonoscopy beginning at age 50

  Select

  - Yes
  - No
  - N/A

- Health Exam in the last year

  Select

  - Yes
  - No
  - N/A

- Mammogram Screening - Recommended screening every two years beginning at age 40

  Select

  - Yes
  - No
  - N/A

- Blood Pressure Screening - Recommend BP screening age 18 and older

  Select

  - Yes
  - No
  - N/A

- Lipid Profile / Cholesterol Screening - Recommend screening for men beginning at age 35 and women at age 45

  Select

  - Yes
  - No
  - N/A

- None of the above

70 **Have you received the flu shot within the past year?**

- Yes
- No
- Doesn't know
- NA

71 Have you received the Pneumovax shot? (If the first dose received before the age of 65 and it's more than 5 year, and the Member is now 65 years or older, needs revaccination)

- Yes
- No
- Doesn't know
- NA

72 Have you had a tetanus shot in the last 10 years?

- Yes
- No
- Doesn't know
- NA

73 Do you know your height and weight?

- Yes
- No

74 What is your height in inches?

Enter height in inches

75 What is your weight in pounds?

Enter weight in pounds

76 Calculate BMI

Calculated BMI value

77 PROMPT: Enter member height, weight and BMI in health indicators

Use Quick Links to navigate to health indicator

78 Do you have a plan in place to continue your care in the event of a disaster (such as hurricane, tornado, house fire, flood or snowstorm)?

- Yes
- No

79 What is your plan?

- Will be staying home
- Have plan for escape
- Will be going to stay with family
- Have generator back up power source
- Will be going to shelter
- Other

Describe Other Plans

80 Have you completed any of the following?

- Advance Directive
- Psychiatric Advanced Directive
- Power of Attorney
- Living Will
- None of the above

81 Is this document on file with your doctor?

- Yes
- No
- Doesn't Know
- Refused to Answer

82 Do you have a health care surrogate or someone who can make decisions for you if you are unable to speak for yourself?

- Yes

  Enter Individuals Name
- No
- Doesn't Know
- Refused to Answer

83 Are you interested in receiving some information on Advance Directives to review with your family?

- Yes
- No
- Not Now

84 Do you have any beliefs or preferences that effect the care you receive? (e.g. religious or other feelings and beliefs, such as preference for natural healers)

- Yes

  Describe beliefs or preferences
- No

85 Do you have the support available to ensure your preferences are met?

- Yes
- No

86 Do you have any life or health goals you would like to discuss?

- Yes

  List member life or health goal
- No
- N/A

87 Do you know what your health plan covers for you?

- Yes
- No

88 What is the highest level of education you have completed?

- Less Than High School

  Enter Grade
- High School Graduate
- GED
- Technical School
- Some college/No Degree
- College Graduate
- Advanced/Graduate Degree
- Other

  Describe other

89 Do you find it hard to get help filling out healthcare paperwork?

- Yes
- No

90 Do you currently use tobacco or nicotine products (Cigarettes, chewing tobacco, cigars, pipes, smokeless tobacco, electronic cigarettes)?

- No, never used tobacco
- Used to, but have quit
- Yes, currently
- Declined to answer

91 How many times in the past year have you used illegal drugs or used a prescription medication for nonmedical reasons?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

92 How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

93 How many standard drinks containing alcohol do you have on a typical day?

- 0, 1, or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

94 How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly or less
- Weekly
- Daily or almost daily

95 Has your drinking or drug use negatively impacted your activities of daily living (bathing, dressing, grooming, eating, toileting, mobility), or your ability to work, maintain meaningful relationships, or accomplish goals you have set for your life?

- Yes
- No
- N/A
- Declined to Answer

96 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member can do the things they need to do to take care of their health?

- Extremely
- Quite a bit
- Somewhat
- A little bit
- Not at all

97 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member will ask their provider questions and bring up their concerns?

- Extremely
- Quite a bit
- Somewhat
- A little bit
- Not at all

98 Trigger Readiness to Change OGI

- Yes
- No

99 End of assessment

- End of Assessment

Next