Appendix B

Home Visitation Program Model Guide

1. Home Visit Preparation with HDM Initial Malnutrition Assessment

Home Visit Preparation

1. Review past patient records (medical, AAA, HH)
2. Discuss, when appropriate, with other providers
3. Call to remind patient you are coming
4. Review “Home Visitation” power point presentation

| Name: ______________________________ | Assessment Date: ________ | DOB: ________ | Age: ________ | Sex: ________ | M/F ________ |
| Address: ____________________________ | apt# ________ | City: ________ | Zip: ________ | County: ________ |
| Phone: (___) _____ - _______ | Email: ____________________________ |
| Referred by: ____________________________ |

HDM Initial Malnutrition Assessment

Demographic/Social

Marital status: Married □ Single □ Widowed □ Divorced □ Other □ ____________
Caregiver/Contact Person: ____________________________ Relation: ____________ Phone: (___) _____ - _______
Household Composition:
   □ Alone □ Spouse/partner □ Spouse and children □ Child/children □ Relative □ Non-relative □ Other □ ____________
Medical benefits:
   □ Medicare □ Medicaid □ None □ Other □ ____________
Finances: Below national poverty level? Yes □ No □
   □ Independently manages all finances and money
☐ Independently manages daily purchases but needs assistance with paying bills/ banking/ large transactions
☐ Unable to manage finances

Currently receiving the following services:
- Food stamps ☐ Weatherization ☐ Lifeline ☐ Food Bank/Pantry ☐ Medicaid Waiver ☐
- Subsidized Housing ☐ Homemaker program ☐ Veteran ☐ Spouse of Veteran ☐ Home Health Aide ☐
- Nursing Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Senior Companion ☐
- Other ☐

Race or ethnic background:
- Caucasian ☐ Asian, Pacific Islander ☐ African American ☐ Hispanic ☐ American Indian/native Alaskan ☐
- Other ☐

Legal Guardian? Yes ☐ No ☐ Name: ___________________________ Phone: (___) ___ - ________

Pets? Yes ☐ No ☐ If yes describe: ________________________________

Pets provided with: Pet food ☐ Table scraps ☐ Both ☐

Perceived Wellbeing

Would you say your physical health over the past year has: Improved ☐ Stayed same ☐ Become worse ☐
   Explain why:________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Would you say your mental health or emotional state over the past year has: Improved ☐ Stayed same ☐ Become worse ☐
   Explain why:________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Would you say your ability to get around and take care of yourself, and to do things for yourself and other people over the past year has: Improved ☐ Stayed same ☐ Become worse ☐
   Explain why:________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Medical/Physical
Primary Doctor: Name: ____________________________ Phone: (____) ____ - ________

Recent hospital discharge date: ________ Admission Diagnosis: ____________________________________________

History of hospitalization (past 3 years):
Admission date: ________ Admission Diagnosis: __________________________________________________________________________
Admission date: ________ Admission Diagnosis: __________________________________________________________________________
Admission date: ________ Admission Diagnosis: __________________________________________________________________________

Current medical diagnosis: __________________________________________________________________________________________

Self-assessed pain scale: Are you dealing with any pain? Yes ☐ No ☐ Location: _____________________________________________

If yes rate your pain on a scale 1-10 (1 no pain, 10 worst pain)

1…………2…………3…………4…………5…………6…………7…………8…………9…………10

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics</td>
<td>Diuretics</td>
</tr>
<tr>
<td>Antacids</td>
<td>Insulin/hypoglycemic Agents</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>H₂ Blockers</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Laxatives</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Lipid Lowering</td>
</tr>
<tr>
<td>Antihypertensive</td>
<td>Non-Steroidal</td>
</tr>
<tr>
<td>Anti-Parkinsonian</td>
<td>Psychotherapeutic Drugs</td>
</tr>
<tr>
<td>Cardiac Glycosides</td>
<td>Steroids</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietary Supplements/Herbs</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin/Mineral</td>
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</table>

<table>
<thead>
<tr>
<th>Nutrition/Herbal Supplement</th>
<th>Dose</th>
</tr>
</thead>
</table>

| OTC                        |      |

Additional details / notes

(Check most appropriate box)
☐ Independently takes medications as prescribed (correct dose and times)
☐ Ability to take medications independently from prefilled daily pill dispenser
☐ Unable to take medications independently

Risk factors for fall and injury, i.e., identify any conditions about this patient that increase his/her risk of falling or injury (check all that apply)

☐ Orthostatic hypotension
☐ osteoporosis
☐ gait problem
☐ impaired balance
☐ confusion
☐ Parkinsonism
☐ pain
☐ inadequate assistive device(s)
☐ other

Additional details / notes

History of falls, trip, and/or stumble? Yes ☐ No ☐ ______ # in the past 6 months ______ # GLF (explain)

Bone fractures in the past 6 months? Yes ☐ No ☐ ______ # in the past 6 months (explain/location)

Sensory impairments affecting functioning (check all that apply)

Hearing: Conversation difficulties ☐ deaf ☐ uses corrective aid ☐ Vision: ☐ Uses corrective lenses ☐ Blind ☐

Additional details / notes

Cognitive/Behavioral

Mini-Cognitive Test

a. Ask patient to repeat three unrelated nouns. Then tell them you will be asking them to repeat the words later.

b. Instruct patient to draw a clock. Have patient perform task after each instruction item.
   i. Draw clock face
   ii. Place numbers on face
   iii. Place hands on clock to read 11:10
   iv. Repeat the three nouns.

c. Interpretation:
   i. Give one point for each recalled word after the clock draw distracter
   ii. A score of zero indicates positive screen for dementia
   iii. A score of one or two with an abnormal CDT* indicates positive screen for dementia
   iv. A score of one or two with a normal CDT* indicates negative screen for dementia
   v. A score of three indicates negative screen for dementia

   (*CDT – clock drawing test)

   Date: ________________ Score: _______

d. Past Scores
   Date: ________________ Score: _______
   Date: ________________ Score: _______
Anxiety  □ Yes □ No  How long? ____(Days/Weeks/ Months/Years)

Depression: □ Yes □ No  How long? ____(Days/Weeks/Months/Years)

Mood changes: □ Yes □ No  How long? ____(Days/Weeks/Months/Years)

Patient Health Questionnaire (PHQ-2):

Over the past two weeks, how often has the patient been bothered by any of the following problems?

e. Little interest or pleasure in doing things
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly every day

f. Feeling down, depressed, or hopeless
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly every day

   Date: ___________  Score: ______

Functional

Shopping:
Grocery shopping provided by:  Spouse/Family □ Friend □ Other □ _________________________________
Frequency: ___________per (Week/Month)

Food Preparation:
   (Check most appropriate box)
   □ Able to plan, prepare, and serve balanced meals if supplied with ingredients
   □ Able to heat and serve pre-made meals
   □ Unable to prepare, heat or serve meals

Cooking Facilities (check all that apply): Stove □ Microwave □ Refrigeration □ Plumbing/water □

Kitchen stocked with adequate food preparation equipment/tools? Yes □ No □ _________________________________

Able to independently use all food preparation equipment/tools? Yes □ No □ _________________________________

Kitchen is clean and tidy? Yes □ No □ _________________________________

Fridge is well stocked? Yes □ No □ _________________________________

Pantry is well stocked? Yes □ No □ _________________________________

Foods in kitchen are within expiration dates? Yes □ No □ _________________________________

Safely reaches items on low and high shelves? Yes □ No □ _________________________________

Meal preparation: Self (times/week____) □ Other person (times/week____) □ Nutrition services (times/week____) □

Additional details / notes


Home environment

Living room:

☐ Cluttered

☐ Couch/chair - patient able to stand from:

☐ Rugs

☐ Adequate Lighting

Bedroom:

Patient able to get on and off of bed? Yes ☐ No ☐

Bathroom: (check all that apply)

☐ Shower handles ☐ Hand held shower ☐ Shower chair ☐ Commode ☐ Raised toilet seat

☐ Floor condition good ☐ Rugs ☐ Shower/ Tub ☐ Walk-in

Additional details / notes

Safety considerations:

Physical Self-Maintenance Scale (PSMS)

Activities of Daily Living

Descending numbered items represent worsening states of function. Choose the item that best describes the resident’s functional status. Scores in all categories should then be totaled. The higher the final score, the greater the degree of impairment.

A. Toileting

1. ☐ Cares for self at toilet completely, no incontinence.

2. ☐ Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents.

3. ☐ Soiling or wetting while asleep more than once a week.

4. ☐ Soiling or wetting while awake more than once a week.

5. ☐ No control of bowels or bladder.

Score:


B. Feeding

1. ☐ Eats without assistance.

2. ☐ Eats with minor assistance at mealtimes and/or with special preparation of food, or help in cleaning up after meals.

3. ☐ Feeds self with moderate assistance and is untidy.

4. ☐ Requires extensive assistance for all meals.

5. ☐ Does not feed self at all and resists efforts of others to feed him/her.

Score:

C. Dressing

1. ☐ Dresses, undresses, and selects close from own wardrobe.
2  ☐ Dresses and undresses self with minor assistance.
3  ☐ Needs moderate assistance in dressing or selection of clothes.
4  ☐ Needs major assistance in dressing, but cooperates with efforts of others to help.
5  ☐ Completely unable to dress self and resists efforts of others to help.

Score: 

D. Grooming
1  ☐ Always neatly dressed, well groomed, without assistance.
2  ☐ Grooms self adequately with occasional minor assistance, e.g., shaving.
3  ☐ Needs moderate and regular assistance or supervision in grooming.
4.  ☐ Needs total grooming care, but remain well-groomed after help from others.
5.  ☐ Actively negates all efforts of others to maintain grooming.

Score: 

E. Physical Ambulation
1  ☐ Goes about grounds and surrounding area (e.g., town or city) on their own.
2  ☐ Ambulates within residence or about one block distances.
3  ☐ Ambulates with assistance of (check one)
   ☐ Another person ☐ railing ☐ cane ☐ walker
   ☐ Wheelchair – gets in and out without help
   ☐ Wheelchair – needs help getting in and out
4  ☐ Sits unsupported in chair or wheelchair, but cannot propel self without help.
5  ☐ Bedridden more than half the time.

Score: 

F. Bathing
1  ☐ Bathes self (tub, shower, sponge bath) without help.
2  ☐ Bathes self with help in getting in and out of tub.
3  ☐ Washes face and hands only, but cannot bathe rest of body.
4  ☐ Does not wash self but is cooperative with those who bathe him/her.
5  ☐ Does not try to wash self, and resists efforts to keep him/her clean.

Score: 

Total of all scores: 

The higher the final score, the greater the degree of impairment with a total score of seven representing the lowest level of impairment, and a total score of 30 representing the highest level of impairment.

Additional details / notes

Nutrition

Weight: ___________ Height: ___________

(a) Any unintentional weight change in the past six months?  Yes ☐ No ☐ Loss ☐ Gain ☐
(b) How much weight change? ___________ lbs/kg in the past ___________ weeks/months
(c) Appetite: Good ☐ Fair ☐ Poor ☐ ____________________________

Estimated Requirements:
<table>
<thead>
<tr>
<th>Meal</th>
<th>Food Item</th>
<th>Quantity</th>
<th>Calories</th>
<th>Protein</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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<tr>
<td>AM Snack</td>
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<tr>
<td>Lunch</td>
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<tr>
<td>PM snack</td>
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<td></td>
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<tr>
<td>Dinner</td>
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</tbody>
</table>
Are you following any specific diet at home? Yes ☐ No ☐ (if yes explain)___________________________

**NFPE Checklist**

<table>
<thead>
<tr>
<th>Region</th>
<th>Location</th>
<th>Task</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skin</strong></td>
<td>Globally</td>
<td>• Dermatitis, rashes, petechiae, ecchymosis, scaliness, dryness.</td>
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<td></td>
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<tr>
<td><strong>Head</strong></td>
<td>Hair</td>
<td>• Touch and observe for the following: thinness, dullness, dryness, brittleness, patchy growth and easily pluck able.</td>
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<tr>
<td></td>
<td></td>
<td>• Palpate temporal muscles. Check for fullness and firmness. Observe for depression, hollowing.</td>
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<tr>
<td><strong>Eyes</strong></td>
<td></td>
<td>• Orbital pads: Gently palpate area below eyes. Observe for darkness, hollowness, and/or loose skin.</td>
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<tr>
<td></td>
<td></td>
<td>• Observe for cracked or reddened corners of eyes, foamy (Bitot’s Spots) areas on sclera; dull, dry or rough sclera; dull, milky, opaque cornea.</td>
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<tr>
<td><strong>Mouth</strong></td>
<td></td>
<td>Have patient open mouth and shine penlight into oral cavity. Next, have patient stick out tongue. Observe:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mucosa: pallor, dryness, decreased salivary flow, ulcerations (mucositis)</td>
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<td></td>
<td></td>
<td>• Tongue: magenta or beefy red color; smooth, slick appearance (glossitis) (Swallowing Impaired? Yes ☐ No ☐) (Chewing Impaired? Yes ☐ No ☐)</td>
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<td></td>
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</tr>
<tr>
<td><strong>Teeth</strong></td>
<td></td>
<td>• Observe for tooth decay, missing teeth. (Dentition: Teeth ☐ Edentulous ☐) (Dentures: Upper ☐ Lower ☐)</td>
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<tr>
<td><strong>Gums</strong></td>
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<td>• Observe for sponginess, bleeding; swollen, red, receding gums.</td>
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<tr>
<td><strong>Lips</strong></td>
<td></td>
<td>• Observe for bilateral cracks at corners of mouth, redness (angular stomatitis/cheilosis).</td>
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<td></td>
</tr>
<tr>
<td><strong>Upper Body</strong></td>
<td><strong>Deltoid</strong></td>
<td>• Palpate muscles around the shoulders (deltoid muscles) for fullness and firmness. Observe for squaring of shoulders.</td>
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</tbody>
</table>
Clavicle
• Gently palpate above and below the clavicle for fullness and firmness. Observe for prominence of clavicle.

Ribs
• Have patient sit forward and palpate ribs.

Triceps Skinfold
• Have patient bend arm at 90 degree angle with upper arm perpendicular to body; if patient unable to cooperate, bend elbow at 90 degrees and place forearm horizontally across body if possible; grasp upper arm midway between shoulder and elbow with palm and fingers and gradually pull skin away from arm with fingers while wiggling slightly to separate fat from muscle.

Interosseous
• Have patient make okay sign with thumb and first finger and while palpating interosseous muscle between thumb and first finger and the interosseous muscles between remaining fingers. Check for fullness and firmness. Observe for depression.
• Observe fingernails for missing, misshapen (spoon shaped), splintered, transverse ridging, discoloration, dullness, lackluster appearance, mottling.

Grip Strength

<table>
<thead>
<tr>
<th>Dominant Hand: Right ☐ Left ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Hand:</td>
</tr>
<tr>
<td>_______</td>
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<tr>
<td>_______</td>
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<tr>
<td>_______</td>
</tr>
</tbody>
</table>

Avg.    Avg.

Nutrition Diagnosis:
________________________________________________________

Functional Deficits:
________________________________________________________

Care Plan:
________________________________________________________
Goals:

1) ___________________________________________________________

2) ___________________________________________________________

3) ___________________________________________________________
References


