Southern Maine AGENCY On AGING Creating Better Days

Community Support Program
Dementia Crisis to Thriving Scale

CRISIS	VULNERABLE	SAFE	STABLE	THRIVING	UNABLE TO ASSESS	COMMENTS
Nutrition Status						
1-2 Unable to cook/prepare food. Does not initiate eating without prompting.	3-4 Able to use the microwave to cook/prepare food. Does not have help. Does not eat a sufficient diet.	5-6 Receives some help preparing meals. Uses only the microwave to cook/prepare food when alone. Diet is suboptimal.	7-8 Receives reliable support with meals. Uses only the microwave to cook/prepare food when alone. Diet is sufficient.	9-10 Can safely use the stove to prepare some meals, and uses the microwave 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 with shopping is unreliable or inconsistent. Food is in short supply 1-2x/week.	5-6 All food is obtained from food assistance resources. Has adequate food supply when receives shopping help.	7-8 Partially relies on food assistance resources. Has reliable help with food shopping and stable supply.	9-10 Can afford to buy desired foods. Can shop without help. No unmet food needs.		
Health Care						
1-2 Has immediate unmet health needs and no provider.	3-4 Has unstable health needs with inconsistent follow-up and/or inconsistent adherence to recommended regimen.	5-6 Major health needs are generally well managed with consistent follow-up; inconsistent adherence to recommended plan.	7-8 Most health needs are generally met with consistent follow-up; generally adheres to prescribed regimen.	9-10 Health needs met, well 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 with weekly 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, with injury, home is unsafe.	3-4 Home unsafe. Fall without injury, or no fall in past 3 months.	5-6 Home is safe. Fall within three to five months, no injury. Fall risk factors exist.	7-8 No falls in past 6 months, home is safe, 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 with 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 unwilling or unable to participate in person's care needs.	5-6 Family and friends are supportive but lack time, knowledge, ability, or resources to help.	7-8 One person is actively invested in client's day to day care needs and/or a Power of Attorney exists.	9-10 Dependable network of family and friends who provide assistance and/or a Power of Attorney exists.		

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Socialization						
1-2 Has limited or no interaction with anyone at home or in the community. Prefers to be alone and/or purposefully avoids contact when possible.	3-4 Interacts with only service providers (i.e. mail carrier, delivery person, cashier, healthcare provider). Has few opportunities to socialize; reports feeling lonely.	5-6 Evidence of sufficient contact from a non-provider by phone or in person.	7-8 Evidence of socialization inside and outside of the home. Is interested in having more contact with others.	9-10 Engages in social activities regularly and is satisfied with his/her level of socialization.		
Transportation						
1-2 No means of transportation. Still drives and is not safe.	3-4 Relies exclusively on friends or family and transportation needs not always met. Or still drives but is having increasing difficulty.	5-6 Appears safe to drive or has transportation to meet basic needs.	7-8 Most transportation needs met including non-essential needs.	9-10 Has reliable vehicle for personal use & feels confident driving locally, and/or has reliable back up plans (public transport, 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 refuses help.	5-6 Has some support, but has some financial issues that need to be addressed.	7-8 Manages own money, but may need occasional help communicating or handling issues.	9-10 Manages money independently; or has reliable financial help.		
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 with planning, environment safe	9-10 Home well maintained and affordable, safe environment.		
Personal Care/Safety						
1-2 Immediate help is needed for at least 1 ADL	3-4 Client requires limited or total assistance or cueing. Assistance is inconsistent.	5-6 Needs assistance or cuing with most ADLs, and has support, but unreliable back-up plan.	7-8 Needs assistance or cuing with most ADLs, but has assistance and stable back-up plan; OR requires limited assistance or supervision, and assistance is available.	9-10 Fully able to perform ADLs without assistance or support.		
Cognitive Function						
1-2 Memory and cognitive function deficits present immediate danger to self or others.	3-4 Memory and cognitive function deficits are a barrier to making decisions and meeting basic needs.	5-6 Memory and/or cognitive function are beginning to interfere with independently managing IADLs.	7-8 Memory and/or cognitive function prevent client from engaging in desired activities or hobbies.	9-10 Memory issues are minimally interfering with functioning. Cognitive function is mostly intact.		