functions and there is great variability of the need for this assistance, based on the kinds and frequency of assistance. The two tasks of *Medical Accompaniment* and *Accompaniment to Alternative Resources* were excluded because the needed time is a function of distance from consumers' homes to health care practitioners. More remote counties are likely to need to authorize more time. The two tasks of *Removal of Grass and Weeds* and *Snow Removal* are rarely authorized and, when appropriate, are reflective of the environment, so they are not good candidates for guidelines. Guidelines were not developed for *Teaching and Demonstration* because, if authorized, it covers one of many tasks. *Protective Supervision* was excluded because, by definition, the need is 168 hours per week (24 hours per day, 7 days a week). *Paramedical Services* were excluded because the authorization based on the time and frequency specified by the doctor who completes the SOC 321 Paramedical Authorization form.

Hourly Task Guidelines were developed for the remaining twelve tasks (the letters in front of the tasks are the letters of the fields on the SOC 293, Service Authorization grid where staff authorize services:

- BB Meal Preparation
- CC Meal Cleanup
- II Bowel and Bladder
- JJ Feeding
- KK Bed Baths
- LL Dressing
- MM Menstrual Care
- NN Ambulation
- OO Transfer
- PP Bathing
- QQ Rubbing Skin and Repositioning
- RR Care and Assistance with Prosthesis and Self Administration of Medications

Task Tool

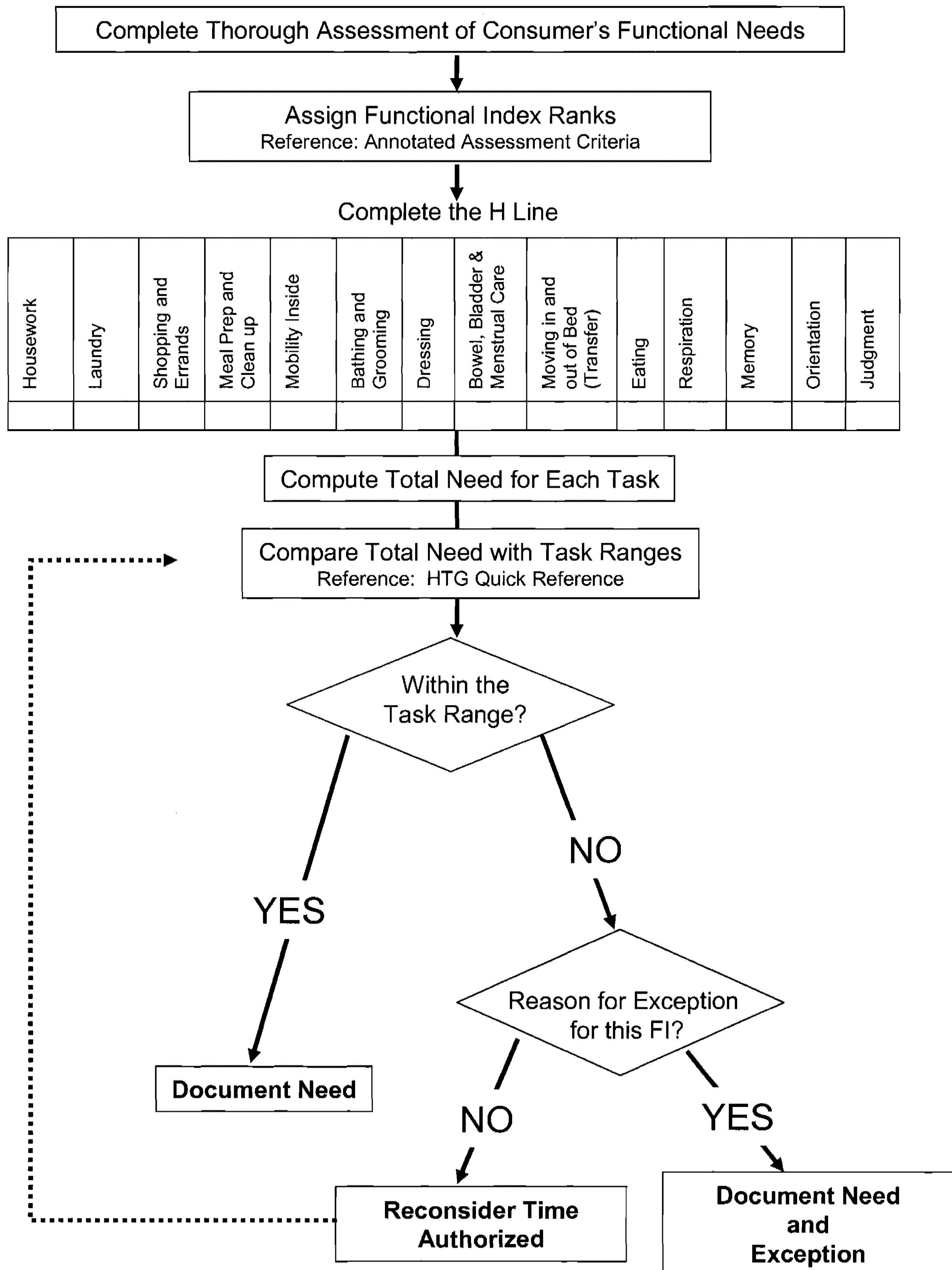
The County Welfare Directors Association coordinated efforts to develop the Task Tool. IHSS staff of many counties throughout the State participated in efforts to clarify task definitions and task components. The first step in assuring statewide uniformity is to assure that all workers throughout the State are defining tasks consistently. Current regulations contain overlap of tasks. For example, getting to and from the bathroom for the task of *Bowel and Bladder* is currently listed both within the task of *Bowel and Bladder* and *Ambulation*. It was moved to *Ambulation*. Wheelchair maintenance and battery charging is part of *Domestic* in the PCSP regulations, but is not mentioned in the IHSS regulations; many staff have been authorizing that assistance as part of *Care and Assistance with Prosthesis*. It is being moved into *Domestic*. *Bowel and Bladder* was revised to clarify the portions of the task that are Paramedical. The definition of *Bed Bath* was revised to include all sponge bathing because there is no reason to separate the task, assigning it to *Bathing* when done in a chair or other site, retaining *Bed Bath* for that function performed in a bed. *Rubbing Skin and Repositioning* was revised, moving getting on and off seats and wheelchairs to *Transferring.*

HTG Time Ranges

Statute required that the HTG be a range of time that reflects the normal amount of time to complete the tasks. Standards from all 50 states were reviewed; none were applicable to California's efforts because only 11 states had guidelines and none of those that did was as generous as California's. There were two series of intensive interviews with consumers and providers: one was conducted by Public Authorities and the other by CDSS and County staff. None of these efforts gave useful information for building

HTGs. The conclusion was that the only reliable information that in developing the HTGs was CMIPS data. The Total Needs of all 360,000 active consumers statewide were used. Many statistical tests were applied to CMIPS data. Many of the standard statistical tests could not be used in determining data trends because authorizations are not statistically "normal." By that we mean that if the authorization hours were graphed by frequency of authorization, it's not a bell-shaped curve. The best statistical measurement that reflects the most common values when data is skewed in the way CMIPS data is is the Interquartile. The Interquartile is the central half of the values when arraying all values in order from the smallest to the largest. Half of the values are below and half are above the central value. Because some values occur frequently, the Interquartile includes 61% of all authorizations in the 12 HTG tasks.

Utilization of HTGs – Process



2006 CHANGES TO CATEGORIES

ACTIVITY	CATEGORY	
	PREVIOUS	*CURRENT*
Moving to and from bathroom	Bowel and Bladder **AND** Ambulation	Ambulation
Wheelchair maintenance and battery charging	PCSP – Domestic *often* Care and Assistance with Prosthesis	Domestic
Getting on and off seats and wheelchairs	Rubbing Skin and Repositioning	Transfer
Getting in and out of vehicles	Rubbing Skin and Repositioning	Ambulation
Sponge bathing in chair	Bathing	Bed Baths

Other Changes:

- All Sponge Bathing is now under Bed Baths.
- Bowel and Bladder has been revised to clarify the portions of the task that are Paramedical.

11: Variable Assessment
Internals

VARIABLE ASSESSMENTS

Overview of Criteria for Extension of 6 Months

[MPP 30-761.215(a – h); MPP 30-761.216]

Recipient must meet the following criteria:

- ❑ At least 1 reassessment since the initial intake
- ❑ No change in living arrangements since last annual assessment
  - Must live with others *or* have regular meaningful contact with persons interested in his/her well being that are not the provider
- ❑ Able to satisfactorily direct his/her care
  - If minor this would be by his/her parent or legal guardian; or if incompetent, this would by his/her conservator
- ❑ No known change in supportive services needs in previous 24 months
- ❑ No reports to, or involvements of, an APS agency or other agencies responsible for addressing the health and safety of individuals documented in the case record since the last assessment
- ❑ No change in provider(s) in last 6 months
- ❑ No reported change in supportive services needs that require reassessment
- ❑ No hospitalization in previous 3 months

If some, but not all, are met:

- ❑ There is involvement of SW CM such as MSSP, regional center, county mental health.
- ❑ Health care professional states in writing that the recipient's medical condition is not likely to change.

In Home Supportive Services
VARIABLE ASSESSMENT CHECKLIST

Client Name:__________________________________ Case #:____________________

Original Assessment Date: _____________ Assessment Extension Date:_____________

Criteria	Initials
Client does **not** receive any of the following: *Advance Pay, Restaurant Meal Allowance, Parent Provider, Spouse Provider* *Source: Client file*	
Client has had at least one face-to-face reassessment since the initial program intake assessment. *Source: Client file*	
Client's living arrangement has not changed since the last annual reassessment **and** the client lives with others or has regular meaningful contact with other people other than the client's IHSS/PCSP provider. *Source: Client report/Client file*	
Client, parent or legal guardian (if minor), or conservator is able to satisfactorily direct the client's care. *Source: Social Worker determination*	
There has been no change in the client's supportive service needs within the previous 24 months. *Source: SOC 293*	
No reports have been made to and there has been no involvement of Adult Protective Services since the county last assessed the client. *Source: APS Database search*	
Client has had the same provider(s) for six months. *Source: CMIPS search/Client file*	
Client has not reported a change in his or her need for supportive services that requires a reassessment and did not indicate any opposition to extending the assessment interval for an additional 6 months. *Source: Client report*	
Client has not been hospitalized within the last three months. *Source: Client report*	
A phone call to the client has been documented in the comment sheet.	

If the client doesn't meet all of the above criteria but the social worker determines that an extended assessment interval is appropriate, please indicate the factors that justify extending the assessment:____

____

____

If all of the above criteria are met and the social worker determines that it is appropriate to extend the reassessment from 12 months to 18 months, the case file and this checklist should be submitted to a supervisor for review.	
Social Worker Signature:	Date:
Supervisor Signature:	Date:

In Home Supportive Services
VARIABLE ASSESSMENT CHECKLIST
Procedure

Purpose

To identify the criteria used to assess those IHSS clients that are eligible to have their annual renewal visit extended from 12 months to 18 months.

Procedure

1. The Social Worker will review the renewals for a given month prior to the month they are due.

2. The Social Worker will identify those clients that appear to meet the Variable Assessment Criteria.

3. The Social Worker will complete a Variable Assessment Checklist on the clients that were identified.

4. For those clients that do not meet all of the criteria, the social worker will discard the Variable Assessment Checklist and proceed with scheduling the renewal. *(EXCEPTION: If the client doesn't meet all of the criteria, but the social worker determines that an assessment extension would be appropriate, the checklist may be submitted to the supervisor for further consideration.)*

5. If the client does meet all of the criteria, the social worker will submit the Variable Assessment Checklist with the client file for approval to extend the renewal date to 18 months. **(This must be approved by the supervisor no later than the 15th of the month for which the renewal is currently due.)**

6. If the supervisor approves the extension, the case file will be given back to the social worker. The original of the signed Variable Assessment Checklist will be filed in the case file.

7. The SW will modify the SOC 293 to reflect the new assessment end date. County Use only section will state "6 MO RENEW" to indicate this is a variable assessment. White copy of SOC 293 will be sent to payroll.

8. The assessment date in CMIPS will be modified by Payroll to reflect the new assessment date indicated on the SOC 293.

9. The completed Variable Assessment Checklist will be filed on the top left section of the chart during the extended assessment period. When the extended renewal date arrives, the Variable Assessment Checklist will be filed on the bottom right section of the chart.

HEPATITIS FACTS

Hepatitis A

Hepatitis A is one of the most common strains of Hepatitis, and is found in the feces of an infected person. It is spread as a result of poor personal hygiene and/or proper sanitation. One can become contract the Hepatitis A by eating food that has been prepared by one infected with the virus or by drinking Hepatitis A contaminated water. One can also contract Hepatitis A through close physical contact (i.e. sexual intercourse). Although some people do not experience symptoms, things to look out for are:

· A High Fever
· Nausea
· Fatigue
· Jaundice or Yellowing of Eyes and Skin
· Loss of Appetite
· Diarrhea
· Abdominal Pain
· Dark Urine

Symptoms usually last around six weeks, although there are those who remain ill for up to six months. A blood test should be taken to know for sure if one is infected. Hepatitis A has an average incubation period of 28 days.

A combination vaccine for prevention of both Hepatitis A and B is now available to the public for those aged 18 years or older (Twinrix). Otherwise, a Hepatitis A vaccine may be administered, or for short-term protection, an immune globulin injection may be given.

Hepatitis B

Hepatitis B is contracted through direct contact with infected blood or bodily fluids of an infected person. The routes of transmission are quite similar to those of Hepatitis C, EXCEPT for the fact that one can also contract Hepatitis B through sexual intercourse as well as by sharing needles, razors, and toothbrushes. Sadly, an infant can also contract the virus during childbirth from an infected mother. Hepatitis B is not spread through food, water, or casual contact. The symptoms of Hepatitis B Virus include:

· Loss of Appetite
· Jaundice or Yellowing of Eyes or Skin
· Nausea, Vomiting, Fever, Stomach and/or Joint Pain
· Extreme Fatigue

There are people with Hepatitis B who experience no symptoms at all. A blood test is the only concrete evidence of infection.

Once infected with Hepatitis B, there is no immediate cure. Treatment for Hepatitis B is used for chronic infection, and usually involves interferon injections combined with oral anti-viral medication; Lamivudine, Dipivoxil, and Adefovir are the names of some of the medications used. Treatment usually lasts anywhere from 16 to 48 weeks. Unfortunately, those with Hepatitis B virus will always be carriers of the virus.

Hepatitis C

Hepatitis C is a blood borne virus that attacks liver cells. The virus is contracted through contact with infected blood and has an incubation period of anywhere from 10 to 30 years. Routes of transmission include:

· Blood Transfusions
· IV Drug Use
· Sharing Razors or Toothbrushes
· Tattoos and body Piercings.

Hepatitis C was identified in 1989, and in 1990 a Hepatitis C antibody test became commercially available. Rarely do infected patients experience acute symptoms from Hepatitis C, but instead suffer from other ailments related to the disease such as:

· Extreme Fatigue,
· Mental Cloudiness,
· Digestive Problems and Loss of Appetite.

As the disease progresses, it can lead to various levels of fibrosis (scar tissue), then cirrhosis of the liver, and over time liver cancer. There is as of yet, no known vaccine nor cure. The treatments for Hepatitis C include injections of a synthetic form of interferon (a protein that helps the body's cells resist the virus), usually accompanied by Ribavirn, an anti-viral pill. Most experience debilitating side effects. Chinese medicine, including acupuncture and herbal remedies, is often used to treat Hepatitis C. Some patients even integrate both Eastern and Western therapies. Approximately 20% of patients with chronic Hepatitis C will die from liver failure due to advanced liver disease. Others will be forced to undergo a liver transplant. Still, many others, if they take proper care of themselves, can live out a normal life span.

http://www.silenceisdeadly.com/

HEPATITIS B FREQUENTLY ASKED QUESTIONS

What is hepatitis B?
Hepatitis B is caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

How do you know if you have hepatitis B?
Only a blood test can tell for sure.

How is HBV spread?
HBV is spread when blood from an infected person enters the body of a person who is not infected. For example, HBV is spread through having sex with an infected person without using a condom (the efficacy of latex condoms in preventing infection with HBV is unknown, but their proper use might reduce transmission), by sharing drugs, needles, or "works" when "shooting" drugs, through needlesticks or sharps exposures on the job, or from an infected mother to her baby during birth.

Hepatitis B is not spread through food or water, sharing eating utensils, breastfeeding, hugging, kissing, coughing, sneezing or by casual contact.

How long does it take for a blood test, such as HBsAg, to be positive after exposure to hepatitis B virus?
HBsAg will be detected in an infected person's blood on the average of 4 weeks (range 1-9 weeks) after exposure to the virus. About 1 out of 2 patients will no longer be infectious by 7 weeks after onset of symptoms and all patients, who do not remain chronically infected, will be HBsAg-negative by 15 weeks after onset of symptoms.

If a person has symptoms, how long does it take for symptoms to occur after exposure to hepatitis B virus?
If symptoms occur, they occur on the average of 12 weeks (range 9-21 weeks) after exposure to hepatitis B virus. Symptoms occur in about 70% of patients. Symptoms are more likely to occur in adults than in children.

What are the symptoms of hepatitis B?
Sometimes a person with HBV infection has no symptoms at all. The older you are, the more apt you are to have symptoms. You might be infected with HBV (and be spreading the virus) and not know it.

If you have symptoms, they might include:

- yellow skin or yellowing of the whites of your eyes (jaundice)
- tiredness
- loss of appetite
- nausea
- abdominal discomfort
- dark urine
- clay-colored bowel movements
- joint pain

What are the risk factors for hepatitis B?
You are at increased risk of HBV infection if you:

- have sex with someone infected with HBV
- have sex with more than one partner
- shoot drugs
- are a man and have sex with a man
- live in the same house with someone who has chronic (long-term) HBV infection
- have a job that involves contact with human blood
- are a client in a home for the developmentally disabled
- have hemophilia
- travel to areas where hepatitis B is common (country listing)

One out of 20 people in the United States will get infected with HBV some time during their lives. Your risk is higher if your parents were born in Southeast Asia, Africa, the Amazon Basin in South America, the Pacific Islands, or the Middle East.

Is there a cure for hepatitis B?
There are no medications available for recently acquired (acute) HBV infection. Hepatitis B vaccine is available for the prevention of HBV infection. There are antiviral drugs available for the treatment of chronic HBV infection.

How common is HBV infection in the U.S.?
In 2003, an estimated 73,000 people were infected with HBV. People of all ages get hepatitis B and about 5,000 die per year of sickness caused by HBV.

If you are pregnant, should you worry about hepatitis B?
Yes, you should get a blood test to check for HBV infection early in your pregnancy. This test is called hepatitis B surface antigen (HBsAg). If you test HBsAg-negative early in pregnancy, but continue behaviors that put you at risk for HBV infection (e.g., multiple sex partners, injection drug use), you should be retested for HBsAg close to delivery. If your HBsAg test is positive, this means you are infected with HBV and can give the virus to your baby. Babies who get HBV at birth might develop chronic HBV infection that can lead to cirrhosis of the liver or liver cancer.

If your blood test is positive, your baby should receive the first dose of hepatitis B vaccine, along with another shot, hepatitis B immune globulin (called HBIG), at birth. The second dose of vaccine should be given at aged 1-2 months and the third dose at aged 6 months (but not before aged 24 weeks).

Can I donate blood if I have had any type of viral hepatitis?
If you had any type of viral hepatitis since aged 11 years, you are not eligible to donate blood. In addition, if you ever tested positive for hepatitis B or hepatitis C, at any age, you are not eligible to donate, even if you were never sick or jaundiced from the infection.

How long can HBV survive outside the body?
HBV can survive outside the body at least 7 days and still be capable of causing infection.

What do you use to remove HBV from environmental surfaces?
You should clean up any blood spills - including dried blood, which can still be infectious - using 1:10 dilution of one part household bleach to 10 parts of water for disinfecting the area. Use gloves when cleaning up any blood spills.

http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm#general

HIV FACTS

HIV Facts is a comprehensive online resource for information about the Human Immunodeficiency Virus.

We offer information on dozens of topics including The immune system, Transmission and spread of HIV, HIV Testing, Books, Community Dicussions and much more.

Introduction

The human immunodeficiency virus (HIV) is a frequently mutating retrovirus that attacks the human immune system and which has been shown to cause acquired immune deficiency syndrome (AIDS).

HIV was discovered and identified as the agent for AIDS by Luc Montagnier of France.

A minority of scientists continue to question the connection between HIV and AIDS and even the very existence of HIV.

As of 27 November 2003, there were an estimated 54,862,417 worldwide HIV infections, 30% of which were in Southern Africa.

HIV causes disease by infecting the CD4+ T cells. These are a subset of leukocytes (white blood cells) that normally coordinate the immune response to infection. By using CD4+ T cells to replicate itself, HIV spreads throughout the body and at the same time depletes the very cells that the body needs to fight the virus.

Once an HIV-positive individual's CD4+ T cell count has decreased to a certain threshold, they are prone to a range of diseases that the body can normally control. These opportunistic infections are usually the cause of death.

There are several reasons why HIV is so hard to fight. First, the virus is an RNA virus, using the reverse transcriptase enzyme to convert its RNA into DNA.

During that process there is a large chance of mutation.

Therefore, the virus becomes quickly resistant to therapy. Second, the common notion that HIV is a killer feasting on T cells is not true.

If HIV were a killer virus, it would have died out soon because there would be too little time for new infections. Now, HIV stays in the body for years, infecting people through unsafe sex, blood transfusions and breastfeeding of infants while the patient sometimes doesn't know.

HIV can survive even when drugs eliminate all detectable virons in the blood. It integrates itself into the DNA of the host cell and can stay there for years, lying dormant, immune to all kinds of therapy because it is just DNA.

When the cell divides and the DNA is copied, the virus is copied too. After years, the virus can become active again, seize the cell's machinery and replicate.

In recent years, the notion that the CD4+ T cells decrease because of direct HIV infection has become doubted as well. The HIV coating protein readily detaches from virus particles.

The blood becomes filled with these proteins, which can stick to the CD4+ T cells, gluing them together. In addition, they are recognized by the immune system, causing the immune cells to attack their own CD4+ cells. In summary, HIV is a guerrilla terrorist, keeping low and seeking shelter when threatened, but always ready to hit where it hurts.

Transmission and Spread

HIV infection is spread through the exchange of infected blood, semen, vaginal fluid, and breast milk. Other fluids, such as cerebral spinal fluid, can also transmit the virus. But the average person does not come in contact with cerebral spinal fluid.

HIV is a blood-borne pathogen (something that causes disease), which means it needs blood to survive. HIV dies quickly on contact with air) The body fluids that can carry the virus all have blood in them. More specifically, they have white blood cells (CD4 cells) in them. Vaginal fluid may contain white blood cells from vaginal infections.

White blood cells are the cells that become infected with HIV, so the more white blood cells in the fluid, the more risky the fluid is for transmission. These fluids can be placed in risk order based on the amount of white blood cells they contain. From most risky to least risky, the order is blood, semen, vaginal fluid, and breast milk.

Intact skin is an excellent barrier to HIV infection. HIV infected blood, however, does have the potential of getting into an open cut or sore of another person. This has rarely occurred, but the potential is there.

For this reason, it is important to always follow universal precautions.

Other body fluids that do not have blood in them do not spread HIV You cannot get HIV from tears, sweat, urine, feces, saliva, mucus, vomit, or earwax.

Some of these fluids may carry other diseases, but not HIV If, however, these fluids do have visible blood in them, they can be infectious from unkilled HIV or other diseases.

The Centers for Disease Control and Prevention (CDC) have established a simple rule for urine, vomit, or other fluids: If you can see blood (red) in it, treat it as if it were blood, and infected. If you cannot see red, the amount of blood is too small to be of real concern for HIV But remember, you can get other diseases from these fluids.

Therefore always follow universal precautions. Use gloves for cleaning of blood, urine, or feces and disinfect floors or furniture with a 1 to 10 solution of bleach (or Lysol spray on fabric that would be stained by bleach). Never put dirty hands in your mouth or eyes. After you take off the gloves, wash your hands with warm water and soap.

How HIV Is Not Spread

You do not catch HIV the way you catch a cold or the flu. HIV is not spread from hugging, kissing, shaking hands, dancing, sharing food, drinking from a fountain, sitting on a toilet seat, or swimming in a pool or hot tub. You cannot get it in a restaurant, even if the waitress or cook is infected. You do not get HIV from someone coughing, sneezing, or spitting on you.

Touching

You do not get HIV from massage, tickling, or other contact with healthy skin. The skin is an excellent barrier for germs, including HIV. Any exposure to HIV on the skin is destroyed by exposure to air or mild disinfectants, such as soap and warm water, or other mild cleansers.

Kissing

As far as we know, no one has ever gotten HIV from kissing. Theoretically you could get HIV from French-kissing (open-mouth, deep, or tongue kissing) someone who is HIV infected. Here, both people would have to have open sores on their mouth, lips, or gums. Blood from the bleeding infected person would have to get into the mouth sores of the other person.

Regular kissing is not a risk, even if saliva is exchanged. Saliva is a poor transmitter of HIV It does not contain white blood cells, and it has a natural antibiotic substance that kills HIV Any HIV found in saliva is few in number and short lived.

Researchers agree that kissing poses a very small risk. Scientists from the National Institute of Dental Research (NIDR) have discovered the protein believed to be responsible for saliva's anti-HIV properties. It is called secretory leukocyte protease inhibitor, or SLPI (pronounced "slippy").

SLPI works by interacting with white blood cells, not HIV Although researchers aren't sure how, SLPI seems to keep HIV out. They hope this may help them find a way of protecting people exposed to HIV infected blood.

Giving Blood

You cannot get HIV from giving blood. When you donate blood, a brand new needle is used to take the blood. The needle is destroyed when you are finished giving blood. You are a blood donor, not a blood recipient, so you're not getting blood or any germs from another person. Don't be afraid to give blood. It is an important way to help others.

Mosquitoes

You cannot get HIV from mosquitoes. When you are bitten by a mosquito, you are a blood donor, not a blood recipient. What happens when a mosquito bites you? It lands on your skin and sticks its mouth into your skin. It regurgitates saliva into your skin to keep your blood from coagulating. This is what makes your skin itch after the bite. Then the mosquito sucks blood out.

This blood goes into its stomach, where it is digested. When the mosquito is hungry again, the process is repeated. No blood from the first person gets into you. You cannot get HIV from other biting or stinging insects such as fleas, lice, or flies.

How HIV Is Spread

HIV is spread in three ways: from the exchange of infected fluids during sexual intercourse, from an infected mother to her child, and from the sharing of infected needles.

Sexual Transmission

The primary way HIV is transmitted throughout the world is through sexual contact. Through June 1996, 59 percent of Americans who were diagnosed with AIDS contracted the disease from having sex with an infected person.

Among adolescents and young adults (13-24), through June 1996, 67 percent who were diagnosed with AIDS contracted the disease from having sex with an infected person. An addition al 11 percent of the cases had multiple risks, including sex.

There are three types of sexual intercourse: oral, vaginal, and anal. HIV can be transmitted during sexual intercourse if the virus in the blood, semen, or vaginal fluid of the infected person comes in contact with and gets into the body of the other person.

Blood includes menstrual blood, blood from cuts or sores, and bleeding from rough sex. Anal sex is particularly dangerous because it can easily cause rectal bleeding. Here, feces might be infected because of the infected blood they contain. Semen, a mixture of sperm and male sexual fluids, is released when a man ejaculates, or comes.

A drop of this fluid often comes out of the penis when a man is sexually aroused, or turned on. Even this pre-ejaculatory fluid can contain the virus in an infected male. Vaginal fluid is produced by glands inside the vagina and keeps the tissues moist and lubricated during sex. It can carry HIV in an infected woman.

Transmission takes place when these infected body fluids find an opening in the skin. If white blood cells carrying the virus from these fluids get into those openings, the person becomes infected.

Openings do not necessarily mean cuts or tears in the skin. Moist tissue in body openings, like the vaginal canal, the urinary opening at the tip of the penis, the rectum, or even the moist tissue inside the eye or at the back of the throat has microscopic openings for the virus to get in. Actually, the anus, urethra, vaginal canal, and back of the throat have columnar epithelial tissue, to which the virus binds. This is why mucous membranes are considered a problem for transmission.

When there are open sores or rashes on the penis or vagina, finding an entrance into the body is even easier for the virus.

For these reasons, all forms of sexual intercourse with an infected partner can place a person at risk for HIV infection.

The risks, however, are not equal. We can rank order the risk.

From high to low they are anal, vaginal, then oral intercourse. Anal intercourse is the riskiest form of intercourse.

It involves the male placing his penis in the rectum of his partner. Anal sex is practiced by both heterosexual (opposite sex) and homosexual (same sex) couples. Anal intercourse is risky for two reasons. First, the rectum was not designed for sexual intercourse. It does not stretch like the vaginal canal.

It is, therefore, susceptible to tearing and bleeding. These tears provide a natural opening for the virus to get in. In addition, the large intestine is a nonsterile environment. To prevent this nonsterile environment from infecting the body, the intestine contains a layer of white blood cells to fight off infection. These white blood cells are the very CD4 cells that pick up HIV These cells then transport the virus into the body. This can happen even if there is no tearing and bleeding during anal intercourse.

Vaginal intercourse with an infected person is a definite risk. This is the most common form of sexual intercourse. The man puts his penis inside the vagina of the woman. Semen coming out of the man's penis or vaginal fluid produced by the woman can carry HIV Even when there are no irritations or breaks in the vaginal wall, microscopic openings in the mucous membrane and the lining of epithelial cells can allow the virus into the body. The virus can also infect men through the urethra of the penis.

Oral intercourse is the least risky form of intercourse for HIV transmission. Also known as oral-genital sex, it involves using the mouth or tongue to stimulate the other person's sex organs. Both heterosexual and homosexual males and females practice this form of intercourse. The risk of HIV infection is low from oral sex for two reasons.

First there is a large amount of saliva in the mouth. The antibiotic action of the saliva helps kill or inactivate HIV before it can get into the body. Second, if infected fluids (semen or vaginal fluid) are swallowed, the strong stomach acid in an adult will kill the virus. It seems that the most vulnerable spots are the columnar epithelial cells of the mucous membrane at the back of the throat or open sores in the gums or mouth. There have not been any well-documented cases of HIV transmission via the mouth, but it is not risk free. More research needs to be done in this area.

It is important to remember that both men and women are at risk. During heterosexual sex, the woman is at greater risk. This is because there are more openings in the mucous membrane of the vaginal canal than in the urethra of the penis. What is more important, semen stays in the vaginal canal for many hours providing longer exposure.

The vaginal canal and the cervix can then have more time to act as a receptor for HIV In addition, infected semen usually contains more virus than infected vaginal fluid. During intercourse the semen is deposited in the vaginal canal and remains there long enough to cause infection. Infected vaginal fluid may not stay on the penis very long.

After intercourse, when the penis is withdrawn from the vagina, it is exposed to the air that will kill any virus on the outside. HIV can remain active as long as it is moist. When infected vaginal fluid, semen, or blood is thoroughly dry, exposed to the air, HIV is no longer active.

Some partners of infected individuals have been infected after having intercourse only once. Others, in spite of repeated exposure, have not become infected. The reason for this is somewhat of a mystery, but we do have some clues.

The higher the level of virus (high viral load) in the infected person's blood, the greater the risk of infection. As with other germs, some people are more resistant than others. Research has found that tobacco, alcohol, and other drugs weaken the immune system. Use of these substances seems to make a person more susceptible.

The more often a person has intercourse and the more sexual partners a person has, the greater the chances are of becoming infected. If one partner has another sexually transmitted disease (STD), the chances of HIV transmission go up. Other STDs, such as gonorrhea or syphilis, cause sores that provide openings for the virus to get in.

Several studies have shown that uncircumcised men have a higher risk of getting HIV and transmitting it to their partners. Circumcision is the removal of the foreskin of the penis. The operation is usually done during the first week after a baby boy is born. If the foreskin has not been removed, the chances are greater that dirt, bacteria, viruses, and infection will accumulate under the foreskin. Some men even have small sores under the foreskin that provide openings for the virus to get in or out.

Sexual intercourse during a woman's period may increase the chances of transmission. Increased blood in the vaginal area can make transmission to the male easier. Openings in the vaginal canal from menstrual bleeding leave the woman with more areas for the virus to enter her body. Studies have shown that women who have HIV positive partners and use oral contraceptives are less likely to become infected. Oral contraceptives tend to thicken the cervical mucus.

This may slow the passage of infected cells in semen once they encounter the cervix. Oral contraceptives, however, are not a substitute for the barrier methods of HIV prevention, such as using condoms. Use of an intrauterine device (IUD) has been associated with an increased risk of transmission. The IUD may cause inflammation of the uterine mucosa. The inflammation causes white blood cells to pool in that area. These cells are highly susceptible to HIV infection.

Women who have sex with women are at risk of HIV infection. The level of risk depends on their sexual practices. Use of sex toys, sexual activity around the menstrual cycle, and pre-existing STDs influences the risk.

New research has shown that some people-perhaps one in 100 whites-have a mutated gene that might protect them from HIV infection. This may explain why some people have repeated risky sex and still do not become infected.

The gene controls CCR5, which normally helps CD4 act as a docking station for HIV When the gene is defective, the docking between CD4 and HIV is slowed or prevented. Some people have one defective gene (getting it from one parent) and some have two (getting them from both parents).

The effects of having only one is still unclear, but researchers believe it may make people less likely to be infected. People with two of these genes seem to get no infection. How long this protection will last is still unknown. As this research continues, it may open possibilities for treatment and prevention.

Mother-to-Child Transmission

As of July 1996, 90 percent of the pediatric cases of AIDS in the United States were diagnosed in babies born to HIV-positive mothers. The remainder were infected by other means, such as infected needles, child abuse, or infected blood products.

The World Health Organization (WHO) estimates that 5 percent to 10 percent of the current global total HIV infections were transmitted from mother to infant during pregnancy, or about 1.5 million children. These transmissions seem to occur in about 25 percent of completed pregnancies in HIV infected women.

Several studies have tried to learn or predict what pregnancy risk factors might influence transmission. Whether the mother seroconverted before or during pregnancy; birth order of twins; proximity of a lower-lying twin to the cervix; fetal position; and natural vs. cesarean birth are risk factors that have been considered. No definite conclusions have resulted from the research.

HIV has been detected in breast milk of HIV infected women. Transmission after birth has been documented in breast-fed babies of infected mothers. There is much disagreement, however, whether transmission occurs from the milk. Some research has shown that the HIV level is higher in colostrum, the milky substance secreted from the breast before and just after birth, than in breast milk.

The frequency of transmission is also under question. There is also a question of whether transmission is more likely from mothers infected before delivery as opposed to those infected after delivery.

A mathematically predictive breast-feeding study was done using the numbers of infected mothers in New York City. It predicted that if all HIV-infected mothers did not breast-feed their infants, 5 fewer babies would die, but 58 more infants would die if all the uninfected mothers did not breast-feed. This is because breast-feeding helps prevent infection and disease in children. Because of this uncertainty, many countries still encourage women to breast feed.

Transmission in Drug Users

Worldwide, injecting drug use is the second largest cause of HIV transmission. In the United States, in 1995, it was responsible for 85 percent of the cases among heterosexual men.; Sixty-six percent of the cases among women in 1995 were transmitted either by sharing needles or through sexual contact with a drug user.

Sharing needles is a high-risk activity for blood-to-blood transmission. The risk of transmission increases with the frequency of injection, frequency of using shared needles, and injecting in shooting galleries (places people go to shoot drugs and where needles are often shared).

Drug users, especially crack users, tend to also be sexually active. A crack high often produces an enhanced sexual drive, and sex is a common way to get money to buy drugs.

Therefore, crack users and other drug users-even those who do not inject needles-are at greater risk of HIV. In addition, drug and alcohol use tends to impair judgment.

This puts them at greater risk of contracting HIV from sex or just wanting to try a new drug. People can also black out from alcohol or drug use, meaning that they do not remember what they did and with whom. They have no memory of their risks. For all these reasons, having sex with a person who has used drugs, especially needles, can be very risky.

Needle sharing for any reason is dangerous.

If a diabetic shared needles to take insulin, this is risky. Athletes who share needles when taking steroids are at risk of HIV. Never share needles for any reason.

The injected drug does not spread HIV, it is the sharing of the needles or works-syringes, eye droppers, needles, spoons or other items used to prepare the drug-that does. When a person injects or shoots drugs, blood is drawn back into the needle and syringe. Some blood from the first person may remain in the needle.

If the person is HIV-infected, the virus will be in the blood. The next person or persons who use the equipment can get HIV. Old needles that have not been used for a long time may still be infected because HIV can survive a long time inside needles. This is because blood remains in the hollow of the needle, where there is often no air.

Once people start using drugs, they can become addicted. This is especially true for injection drugs. Because you need a prescription in some states, needles are often expensive or hard to get. In some states and countries, needles are legal to possess without a prescription. Where they are available for purchase at pharmacies, there is a significantly lower rate of HIV infection among needle users, women, and children.

Some places have needle exchange programs, where addicts can bring in old needles and exchange them for new ones.' Addicts may start to feel sick if they go too long without the drug. When they finally get the drug, they often need a fix so badly that they do not take the time to sterilize the needle. They also may not have anything to sterilize it with.

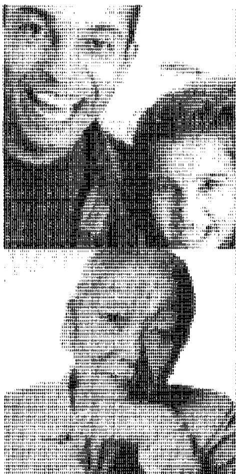
Drug users may not think clearly. Needle users often believe that only someone else will get HIV. They may not bother cleaning the needles or works. Users often shoot up with friends. It is a group activity. For some, cleaning needles is an insult. It implies that the friend is not clean or is infected.

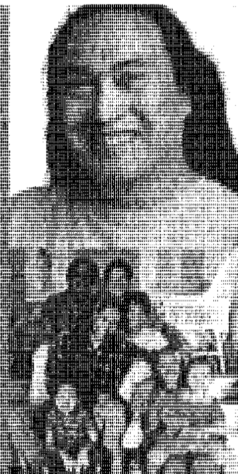
Many drug users go to shooting galleries to get drugs. These are often in abandoned buildings or unclean locations. Equipment or supplies for sterilizing works are often not available there. At shooting galleries, people often rent out or share works. They may be used by many people each day. The HIV infection rate is very high among those who frequent shooting galleries.

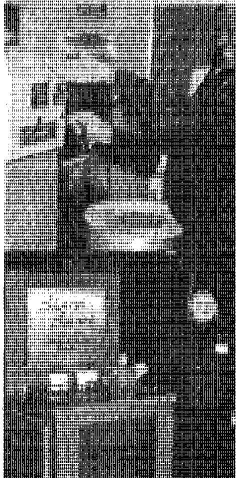
A common practice in many cities is for addicts to sell repackaged needles. These are sold as clean needles but are really not clean. Addicts are selling their old needles to make money to buy more drugs. Never trust a needle bought on the street.

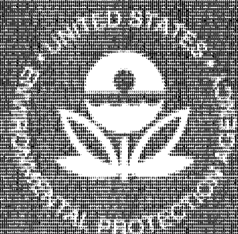
http://www.hiv-facts.com/

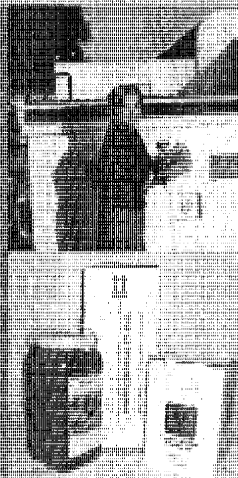
Community Options for Safe Needle Disposal

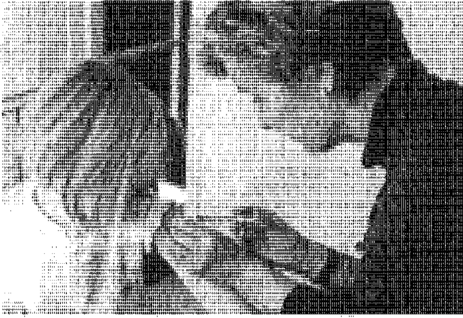


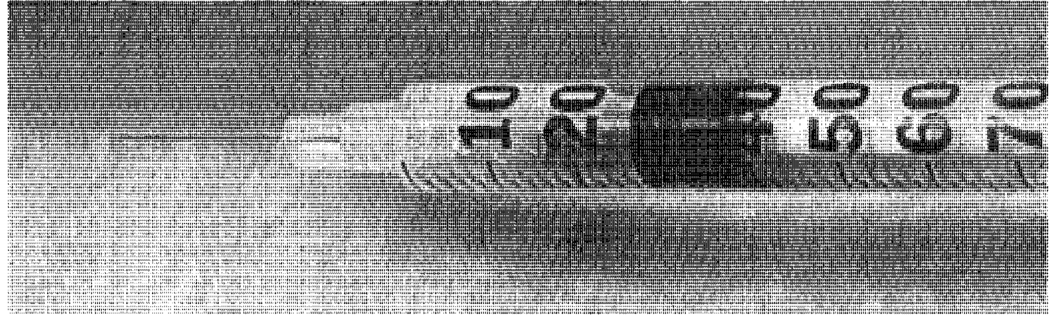












Each year, 8 million people across the country use more than 3 billion needles, syringes, and lancets—also called sharps—to manage medical conditions at home.

Sharps disposal by self-injectors is not typically regulated, and self-injectors do not always know the safest disposal methods. This situation could lead to haphazard disposal habits and increased community exposure to sharps. People at the greatest risk of being stuck by used sharps include sanitation and sewage treatment workers, janitors and housekeepers, and children.

Due to the hazards that unsafe disposal practices present, many states and municipalities are choosing to offer safe, convenient disposal options to sharps users.

What Are Sharps Used For?

People use sharps to treat all sorts of medical conditions in the home, and the number of conditions treated at home with injectable medicines continues to rise. Sharps users may use lancets and/or needles and syringes to deliver medicine for conditions such as:

- Allergies
- Arthritis
- Cancer
- Diabetes
- Hepatitis
- HIV/AIDS
- Infertility
- Migraines
- Multiple Sclerosis
- Osteoporosis
- Psoriasis

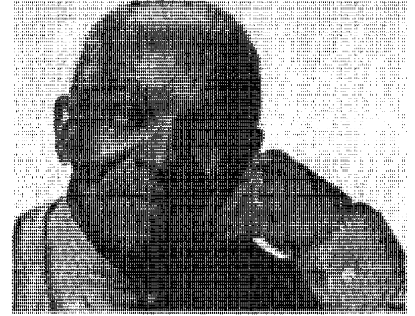
What are the dangers of used sharps?

Some sharps users throw their used needles in the trash or flush them down the toilet. Used sharps left loose among other waste can hurt sanitation workers during collection rounds, at sorting and recycling facilities, and at landfills, or become lodged in equipment, forcing workers to remove them by hand. Children, adults, and even pets are also at risk for needle-stick injuries when sharps are disposed improperly at home or in public settings.

Loose needles at a municipal solid waste location.

People exposed to sharps face not only the risk of a painful stick, but also the risk of contracting a life-altering disease such as HIV/AIDS or Hepatitis B or C. All needle-stick injuries are treated as if the needle were infected with a disease. Victims of sharps-related injuries face the cost of post-injury testing, disease prevention measures, and counseling, even if no infection or disease was spread. Some diseases can take a long time to appear on test results, leading to months of testing and apprehension.

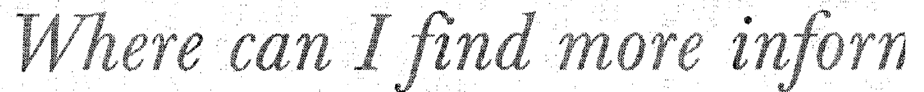
Needle-stick injuries are a preventable health risk, and states and municipalities can take specific actions to protect their residents from this risk.



Safe Disposal Options

- **Drop-off collection sites:** Sharps users can take their filled sharps container to appropriate collection sites, which may include doctors' offices, hospitals, health clinics, pharmacies, health departments, community organizations, police and fire stations, and medical waste facilities. These programs often give self-injectors the option of continuing to use empty household containers to collect sharps, but prevent the sharps from entering the household waste stream.
- **Household hazardous waste collection sites:** Self-injectors can place their used sharps in a special sharps container or, in some cases, an approved household container, take them to municipal household hazardous waste collection sites, and place them in the sharps collection bins. These sites also commonly accept hazardous materials such as household cleaners, paints, and motor oil.
- **Residential special waste pickup services:** Self-injectors can place their used sharps in a special container, similar to a recycling container, and put it outside their home for collection by trained special waste handlers. Some programs require customers to call for pickup, while others offer regular pickup schedules.
- **Mail-back programs:** Used sharps are placed in special containers, which are mailed (in accordance with U.S. Postal Service requirements) to a collection site for proper disposal. Mail-back programs are available for individual use by sharps users, and can also serve as a disposal method for community collection sites. These programs work especially well for rural communities, communities that don't already have a medical waste pickup service (e.g., school systems, retail outlets, sporting arenas, casinos), and individuals who wish to protect their privacy.
- **Syringe exchange programs:** Sharps users can exchange their used needles for new needles. Exchange programs are usually operated by community organizations, which properly dispose of the used needles collected at exchange sites.
- **Home needle destruction devices:** A variety of products are available that clip, melt, or burn the needle and allow the sharps user to throw the syringe or plunger in the garbage. These devices can reduce or eliminate the danger of sharps entering the waste stream.

A household hazardous waste disposal center in San Bernardino, California.



A variety of resources are available for states and municipalities that want to improve the safe options for sharps disposal available to their residents.

Program Assistance Information

You can contact the Coalition for Safe Community Needle Disposal by phone at (800) 643-1643 or online at <www.safeneedledisposal.org>. The coalition can assist in implementing a safe sharps disposal program in your area.

If your state or municipality wishes to establish a syringe exchange program, contact the North American Syringe Exchange Network at (253) 272-4857 or <www.nasen.org>.

Government Resources

The Internet is a valuable resource for researching the steps other states and municipalities have taken to inform their citizens and ensure safe sharps disposal.

The Centers for Disease Control (CDC) Web site, located at <www.cdc.gov/needledisposal>, provides state-by-state information on sharps-related laws and regulations, safe community disposal programs, published guidance, and contact information.

Some states that use the Internet to publicize their sharps disposal programs and regulations include:

- **California**

  www.ciwmb.ca.gov/wpie/healthcare/ppcp.htm

- **Florida**

  www.doh.state.fl.us/environment/facility/biomed/hmesharp.htm

- **New Hampshire**

  www.des.nh.gov/factsheets/sw/sw-31.htm

- **New Jersey**

  www.state.nj.us/health/eoh/phss/syringe.pdf

nation about sharps disposal?

- **New York**

  www.health.state.ny.us/nysdoh/hivaids/esap/housesharps.htm

  www.health.state.ny.us/nysdoh/hivaids/esap/regover.htm#emergency

- **Rhode Island**

  www.health.ri.gov/environment/risk/medwaste.htm

- **Washington (Seattle/King County)**

  www.metrokc.gov/health/apu/resources/disposal.htm

- **Wisconsin**

  www.dnr.wi.gov/org/aw/wm/medinf

Mail-back Program Providers

Mail-back programs, which allow home sharps users to mail their used sharps to a licensed disposal facility, present a safe, viable sharps disposal option for every community. For a list of providers, visit the Coalition for Safe Community Needle Disposal Web site at <www.safeneedledisposal.org>.

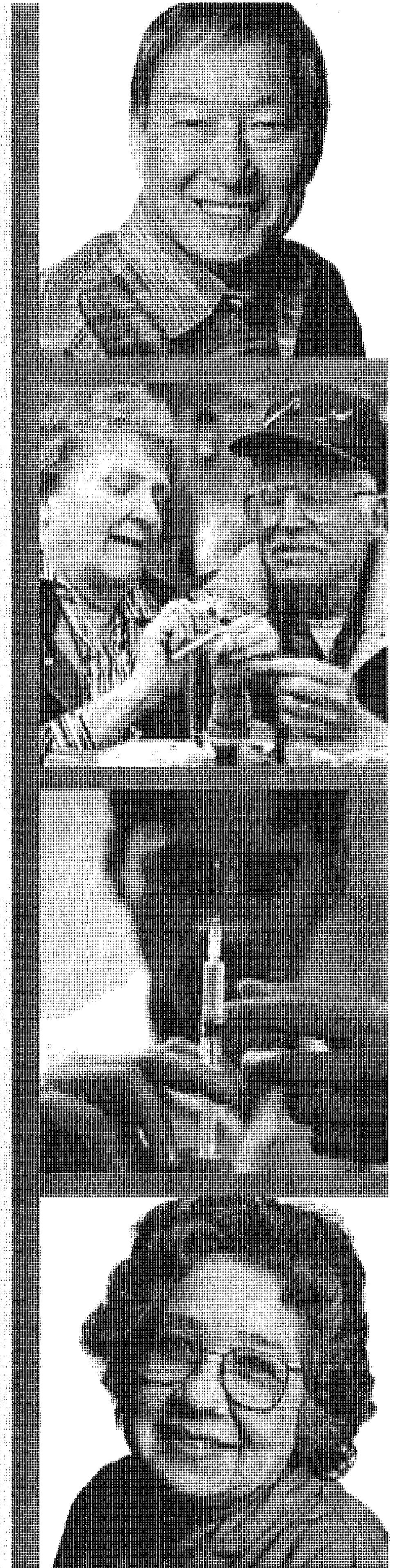
Home Needle Destruction Devices

These devices sever, melt, or burn the needle, allowing sharps users to throw the syringe or plunger in the garbage. For a list of vendors, visit the Coalition for Safe Community Needle Disposal Web site at <www.safeneedledisposal.org>.

Other Relevant Information

To learn more about regulations concerning medical waste disposal, consult EPA's Medical Waste Web site at <www.epa.gov/epaoswer/other/medical>.

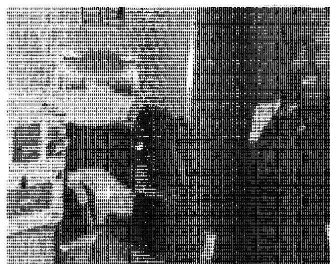
The Household Hazardous Waste section of the Earth 911 Web site, <www.earth911.org>, allows users to enter their ZIP code and view a list of sharps disposal programs available in their area.



As home use of injectable medicines continues to rise, communities throughout the United States are implementing safe disposal programs to reduce the public health hazards that used sharps present when improperly disposed. Currently, hundreds of collection or disposal programs exist across the country. Active states include: California, Florida, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Washington, and Wisconsin.

Drop-Off Collection:

Low-cost Solution Protects Employees Houston, Texas

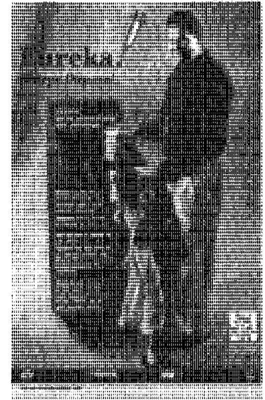


To better serve sharps users while guarding against needle-stick injuries, the Houston Airport System (HAS) installed wall-mounted sharps disposal units in all 69 of its public and employee restrooms at a cost of $300 per year and a startup cost of $2,000. HAS financed the disposal program. **For more information on the program, contact Bush Intercontinental Airport at (281) 230-3017.**

Drop-Off Collection:

Statewide Partnership Reduces Needle Sticks Rhode Island

Rhode Island formed a state coalition, headed by the Diabetes Foundation of Rhode Island, to address an increase in needle-stick injuries at the state's landfill and materials recovery facility. The program placed sharps disposal kiosks at 42 locations statewide, including pharmacies, doctors' offices, and fire and police stations. Home sharps users bring their filled sharps containers for disposal and receive a new sharps container in return, all free of charge. The annual average cost to maintain a kiosk is $1,500, which includes the cost of the sharps containers provided to users, literature, kiosk maintenance, and proper waste disposal. In addition, the program now assists other states in designing similar programs and identifying potential funding sources. **For more information, contact the Diabetes Foundation of Rhode Island at (401) 725-7800.**



Drop-Off Collection:

24-Hour Low-cost Community Solution Wisconsin Rapids, Wisconsin

Riverview Hospital in Wisconsin Rapids, Wisconsin, began its own sharps disposal program. *Sharps Smart* was implemented to help sharps users follow the state law that keeps used sharps out of the waste stream. The program allows self-injectors to bring their filled commercial sharps containers or sealed household containers to the hospital, where users mark the container with an orange biohazard label and drop it into the *Sharps Smart* cart for free disposal. Maintaining the program costs about $2,500 per year. The collection cart, located in the entryway of the hospital, is always available to residents. **For more information, contact Riverview Hospital Environmental Services at (715) 421-7443.**

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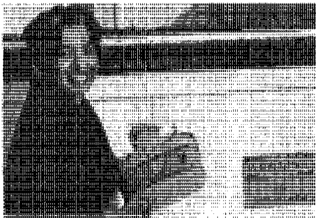
Household Hazardous Waste Collection:

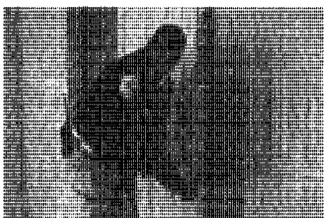
State-funded Collection Program San Bernardino, California



When the city of San Bernardino's hospital stopped accepting used sharps from community members, sanitation workers began to notice an increase in needle sightings—despite a city ordinance that prohibits disposing of used sharps in household trash. The city implemented a sharps disposal program that allows sharps users to drop off sharps containers at the city's existing household hazardous waste collection facilities. The program is successful largely due to the fact that it is convenient and free. The California Integrated Waste Management Board funded the program for the first two years at an annual cost of $5,900. The city of San Bernardino now funds it at an annual cost of $6,000. To publicize the program, the city offers a point-of-sale display to pharmacies and includes information about the program in the city newsletter. **To learn more, contact the city of San Bernardino at (909) 384-5549.**

Residential Special Waste Pickup:

Door-to-Door Disposal Service Columbus, Georgia

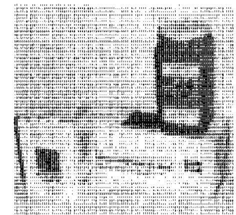


The city of Columbus, Georgia, took a personal approach to its sharps disposal program after sanitation workers suffered needle-stick injuries from sharps discarded in household garbage. Residents now collect their sharps in their own hard plastic container and call the city's waste management agency when their sharps container is full. A waste supervisor is then dispatched to their home to take the container for safe disposal.

By having waste collection supervisors—who are already in the field on their regular rounds—pick up sharps from residents, Columbus has provided a safe disposal option that costs the city virtually nothing. **For more information, contact the city of Columbus at (706) 653-4161.**

Mail-back Program:

Flexibility and Accessibility by Mail Alameda County, California



Some municipalities are recognizing the flexible benefits of mail-back programs and are beginning to offer them to their residents. Restaurant chains, department stores, stadiums, and school districts are also beginning to use mail-back programs as a viable disposal option for their collected sharps. Mailback programs complement existing needle collection programs by offering disposal solutions for rural or homebound residents.

Alameda County, California, is conducting a pilot program by distributing mail-back containers free of charge to medically under-served populations. The county's large size and diverse demographics have presented problems in adopting more traditional methods of safe sharps disposal, such as drop-off sites or residential collection. By contracting with a vendor for mail-back service, Alameda hopes to reach a greater percentage of its self-injecting population—if residents have a mailbox, they have access to the service. **For more information, contact the Alameda County Sharps Coalition at (510) 532-1930.**

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MRSA INFECTION

Introduction

Methicilllin-resistant Staphylococcus aureus (MRSA) infection may be one of the most frightening illnesses you've never heard of. Unlike more galvanizing diseases such as smallpox and bird flu, MRSA infection has quietly been killing and maiming hundreds of thousands of vulnerable people, including children, without grabbing a single headline.

One reason may be that staphylococcus aureus bacteria, often simply called staph, are common — they're found on the skin or in the nose of about one-third of the population. The bacteria are generally harmless unless they enter the body through a cut or other wound, and even then they often cause only minor skin problems in healthy people. But in older adults and people who are ill or have weakened immune systems, ordinary staph infections can be deadly.

Decades ago, a strain of staph emerged in hospitals that was resistant to the broad-spectrum antibiotics commonly used to treat it. Dubbed methicillin-resistant Staphylococcus aureus (MRSA), it was one of the first germs to outwit all but the most powerful drugs. Since then, MRSA infection has flourished in hospitals and care facilities worldwide, where it can cause massive infections in bones, joints, the bloodstream and surgical wounds. When not treated properly, MRSA infection is fatal.

In the 1990s, a type of MRSA began showing up in the wider community. Today, that form of staph, known as community-associated MRSA, or CA-MRSA, is responsible for most serious skin and soft tissue infections and for a lethal form of pneumonia.

Vancomycin is one of the few antibiotics still effective against hospital strains of MRSA infection, although the drug is no longer effective in every case. Several drugs continue to work against CA-MRSA, but CA-MRSA is a dangerous and rapidly evolving bacterium, and it may simply be a matter of time before it, too, becomes resistant to most antibiotics.

Signs and Symptoms

Staph infections, including MRSA, generally start as small red bumps that resemble pimples, boils or spider bites. These can quickly turn into deep, painful abscesses that require surgical draining. Sometimes the bacteria remain confined to the skin. But they can also burrow deep into the body, causing potentially life-threatening infections in bones, joints, surgical wounds, the bloodstream, heart valves and lungs.

Unlike hospital-associated MRSA, CA-MRSA produces a deadly toxin (Panton-Valentine leukocidin) that destroys white blood cells and living tissue. The toxin can cause severe, often fatal skin infections (necrotizing, or "flesh-eating," fasciitis) and pneumonia.

Causes

Although the survival tactics of bacteria contribute to antibiotic resistance, humans bear most of the responsibility for the problem. Leading causes of antibiotic resistance include:

- **Unnecessary antibiotic use in humans.** Like other superbugs, MRSA is the result of decades of excessive and unnecessary antibiotic use. For years, antibiotics have been prescribed for colds, flu and other viral infections that don't respond to these drugs, as well as for simple bacterial infections that normally clear on their own.

- **Antibiotics in food and water.** Prescription drugs aren't the only source of antibiotics. In the United States, about 70 percent of all antibiotics wind up not in people but in beef cattle, pigs and chickens. For the most part, these drugs aren't used to treat disease but to fatten the animals quickly and to prevent illnesses that are common in the unhygienic conditions in which animals are raised. The same antibiotics then find their way into municipal water systems when the runoff from feedlots contaminates streams and groundwater. Routine feeding of antibiotics to animals has become such a threat to public health that the practice is banned in the European Union and many other industrialized countries. Antibiotics given in the proper doses to animals who are actually sick don't seem to produce resistant bacteria.
- **Germ mutation.** Even when antibiotics are used appropriately, they contribute to the rise of drug-resistant bacteria because they don't destroy every germ they target. Bacteria live on an evolutionary fast track, so germs that survive treatment with one antibiotic soon learn to resist others. And because bacteria mutate much more quickly than new drugs can be produced, some germs end up resistant to just about everything. That's why only a handful of drugs are now effective against most forms of staph.

Hospitals: Germ incubators

MRSA first emerged in hospitals in the 1960s and since then has been nearly unstoppable. It travels from person to person on clothing, cart handles, bedrails and catheters, and even breeds in the water in floral arrangements, leading hospitals in the United Kingdom to ban flowers in critical care units. Evading every effort to control it, MRSA accounts for half of the major complications in hospitalized people and for tens of thousands of deaths every year.

Scientists think hospital-acquired MRSA is particularly virulent and tenacious because it hides and replicates in a common type of amoeba — a single-celled organism that's present on most surfaces. Amoebas can spread in the air, which means that MRSA may be transmitted without human contact. What's more, germs that breed in amoebas are stronger and more drug-resistant than other pathogens are.

CA-MRSA: Right under your nose

MRSA was confined to healthcare settings until the late 1990s, when four previously healthy children in the Midwest died suddenly of massive MRSA infections. Around the same time, athletes began showing up with hard-to-treat boils, and inmates in some U.S. prisons developed deep abscesses that didn't respond to antibiotic treatment. MRSA also turned up among military recruits and some gay men.

It's likely that what is now called community-associated MRSA (CA-MRSA) entered the wider world in the nostrils of people who picked up the bacteria in hospitals. The Centers for Disease Control and Prevention estimates that at least 1 percent of the population, or 2 million people, now carry CA-MSRA in their noses. Carriers may not be sick, but they can spread the infection and run the risk of becoming ill themselves.

The bacteria spread mainly through skin-to-skin contact and through small cuts and abrasions. Overcrowding and poor hygiene also encourage the spread of staph. Once CA-MRSA enters the body, it causes boils and abscesses and, like hospital strains, sometimes sparks massive infections in the bone, blood or lungs.

Risk Factors

Because hospital and community strains of MRSA generally occur in different settings, the risk factors for the two strains differ.

Risk factors for hospital-acquired MRSA include:

- **A current or recent hospitalization.** Despite attempts to eradicate it, MRSA remains the scourge of hospitals, where it attacks the most vulnerable — older adults and people with weakened immune systems, burns, surgical wounds or serious underlying health problems.
- **Residing in a long-term care facility.** MRSA is far more prevalent in these facilities than it is in hospitals. Most people admitted to a care facility are likely to carry MRSA and have the ability to spread it, even if they're not sick themselves.
- **Invasive devices.** People who are on dialysis, are catheterized, or have feeding tubes or other invasive devices are at especially high risk.

These are the main risk factors for CA-MRSA:

- **Young age.** CA-MRSA can be particularly deadly in children, sometimes ravaging their bodies in a matter of hours. The bacteria usually enter through a cut or scrape but can quickly cause a massive systemic infection. Children and young adults are also much more likely to develop necrotizing pneumonia than older people are. Children may be susceptible because their immune systems aren't fully developed or they don't yet have antibodies to common germs.
- **Participating in contact sports.** CA-MRSA has crept into both amateur and professional sports teams. The bacteria spread easily through cuts and abrasions and skin-to-skin contact.
- **Sharing towels or athletic equipment.** Although few outbreaks have been reported in public gyms, CA-MRSA has spread among athletes sharing razors, towels, uniforms or equipment.
- **Having a weakened immune system.** People with weakened immune systems, including those living with HIV/AIDS, are more likely to have severe CA-MRSA infections.
- **Living in crowded or unsanitary conditions.** Outbreaks of CA-MRSA have occurred in military training camps and in dozens of American and European prisons, killing some inmates and infecting guards and other staff.
- **Recent hospitalization or antibiotic use.** A recent hospital stay or treatment with fluoroquinolones (ciprofloxacin, ofloxacin or levofloxacin) or cephalosporin antibiotics can increase the risk of CA-MRSA.
- **Association with health care workers.** People who are in close contact with health care workers are at increased risk of serious staph infections. MRSA can travel through families, passing between parents and children on shared clothing, towels and other personal items.

When to Seek Medical Advice

Keep an eye on minor skin problems — pimples, insect bites, cuts and scrapes — especially in children. If wounds become infected, see your doctor. Ask to have any skin infection tested for MRSA before starting antibiotic therapy. Drugs that treat ordinary staph aren't effective against MRSA, and their use could lead to serious illness and more resistant bacteria.

Screening and Diagnosis

Most often, doctors diagnose MRSA by checking a tissue sample or nasal secretions for signs of drug-resistant bacteria. The sample is sent to a lab where it's placed in a dish of nutrients that encourage bacterial growth (culture). But because it takes about 48 hours for the bacteria to grow, infected people may continue to spread MRSA while awaiting test results, and those who are already ill can become worse or, in the most serious cases, die. Newer tests that can detect staph DNA in a matter of hours are available, but they're more expensive than culture tests, and most hospitals don't yet use them.

Treatment

Although resistant to many common antibiotics, both hospital and community strains of MRSA still respond to certain medications. In hospitals and care facilities, doctors generally rely on the last-ditch antibiotic vancomycin to treat resistant germs. CA-MRSA may be treated with vancomycin or other antibiotics that have proved effective against particular strains. Although vancomycin saves lives, its constant use makes it more likely that germs will soon grow resistant to it as well; some hospitals are already seeing outbreaks of vancomycin-resistant MRSA. To help reduce that threat, doctors often drain abscesses caused by MRSA rather than treat the infection with drugs.

Prevention

Every year, about 2 million Americans develop hospital-acquired infections and 90,000 die of them. Many of these are the result of MRSA, one of the most virulent and tenacious of the antibiotic-resistant germs. Hospitals are fighting back by instituting surveillance systems that track bacterial outbreaks and by investing in products such as antibiotic-coated catheters and gloves that release disinfectants. Still, the best way to prevent the spread of germs is for health care workers to wash their hands frequently, to properly disinfect hospital surfaces and to take other precautions such as wearing a mask when working with people with weakened immune systems.

Here's what you can do to protect yourself, family members or friends from hospital-acquired infections.

- Ask all hospital staff to wash their hands before touching you — every time.
- Wash your own hands frequently.
- Make sure that stethoscopes and other instruments are wiped with alcohol before use.
- Ask to be bathed with disposable cloths treated with a disinfectant rather than with soap and water.
- Make sure that intravenous tubes and catheters are inserted and removed under sterile conditions; some hospitals have dramatically reduced MRSA blood infections simply by sterilizing patients' skin before using catheters. Better yet, avoid having a urinary tract catheter whenever possible.

Preventing CA-MRSA

Protecting yourself from CA-MRSA — which might be just about anywhere — may seem daunting, but these common-sense precautions can help reduce your risk:

- **Keep personal items personal.** Avoid sharing personal items such as towels, sheets, razors, clothing and athletic equipment. MRSA spreads on contaminated objects as well as through direct contact.
- **Keep wounds covered.** Keep cuts and abrasions clean and covered with sterile, dry bandages until they heal. The pus from infected sores often contains MRSA, and keeping wounds covered will help keep the bacteria from spreading.

- **Sanitize linens.** If you have a cut or sore, wash towels and bed linens in hot water with added bleach and dry them in a hot dryer. Wash gym and athletic clothes after each wearing.
- **Wash your hands.** In or out of the hospital, careful hand washing remains your best defense against germs. Scrub hands briskly for at least 15 seconds, then dry them with a disposable towel and use another towel to turn off the faucet. Carry a small bottle of hand sanitizer containing at least 62 percent alcohol for times when you don't have access to soap and water.
- **Get tested.** If you have a skin infection that requires treatment, ask your doctor to test for MRSA. Many doctors prescribe drugs that aren't effective against antibiotic-resistant staph, which delays treatment and creates more resistant germs. If you're having surgery, ask to be tested for MRSA one week before you enter the hospital.

By Mayo Clinic Staff
May 30, 2006
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Original Article: http://www.mayoclinic.com/health/mrsa/DS00735

13: Scenarios

Case Scenario – Jason
Consumer with DME

Jason is a 20-year-old male who is a paraplegic as a result of an automobile accident two years earlier. He lives with his parents and has a bedroom and bathroom that have been adapted to meet his needs. He has a roll-in shower in the bathroom and a lightweight wheelchair that he uses to move around the house and participate in wheelchair sports such as basketball and track events. Jason's mother and father are employed and up to this point have had insurance which has covered all of the medical expenses and home care. The insurance has paid for someone to come in during the day and help Jason with his personal care (bathing and grooming and dressing), clean his room, and cook meals while his parents are out of the home. As the policy dollar limits have been reached, private insurance is not available and Jason's parents have applied for IHSS for their son and have indicated that they would like to have a provider come in and provide the same services that the private insurance covered.

At the time of the home visit, Jason is at home with his mother. Jason is observed to be a well-nourished, young adult who is able to move around the house with agility. He has one portion of his room set up for weight lifting which he states that he does for approximately two hours per day to maintain his upper extremity strength. Jason indicates that he is able to perform most ADLs and IADLs without help from another person. He indicates that he does not have time to clean his own room because he is busy with other activities. He states he has never had to clean his own room, even before the accident. Jason's mother indicates that he needs to have someone cook his meals during the day because he will just eat junk food all day if no one cooks for him and will not clean up the kitchen after he cooks. She also states he needs to have range of motion exercises performed two times per day. Jason's mother states that he is able to dress himself, but does not always dress appropriately for the occasion, so he needs reminding regarding clothing selection. She states as an example he wears t-shirts and shorts to church. You observe him to be neatly and appropriately dressed.

Group Tasks:

How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation and Cleanup
- Bathing, Oral Hygiene and Grooming
- Dressing

Case Scenario – Kimberly
Assessing FI Score for Consumers with Variable Functioning

Kimberly is a 39-year-old female who has a diagnosis of Fibromyalgia. She receives SSI and has applied for IHSS. During the initial interview, Kimberly states that she needs help with most ADLs and IADLs on a daily basis due to her intense back pain. Kimberly has lived with her mother off and on for the last ten years, and she states that when she lived at home, her mother helped her. Kimberly has recently moved into a one-bedroom duplex with her boyfriend, Jeff, who is a tow truck driver. Jeff is willing to help Kimberly when he is home, but since he is on call 24 hours a day, he is gone for a large portion of the day and night. This is the second time that you have scheduled an interview with Kimberly. No one answered the door when you arrived for the first visit.

At the time of the 3:00 p.m. interview, Kimberly greets you at the door. She is able to walk back to the living room and seat herself in a recliner without any apparent stress or pain, although she ambulates slowly. Kimberly is dressed in sweats and appears somewhat disheveled. Kimberly states that she just got up a half hour earlier because she didn't sleep well the night before. The house is cluttered and looks like it has not been cleaned in a long period of time. There are many dirty dishes in the sink, dirty pots on the stove and piles of clothes everywhere. Kimberly begins by apologizing for not answering the door when the first interview was scheduled. She said she was experiencing so much pain that day that she could not get out of bed.

Kimberly states that she wants IHSS because she primarily needs someone to clean her house and cook her meals, but she also needs help with some personal care when Jeff is not at home. She states that on average he is gone about 16 hours per day. She states that in her Fibromyalgia support group, there are several people who get IHSS and she learned about the program from them.

During the interview, Kimberly states that on bad days, Jeff helps her get in and out of bed, getting to and from the bathroom, and on and off the toilet when he is home. When asked about what type of help he gives her, she said that he gives her a boost and steadies her because she must move very slowly. He must be careful when getting her out of bed to prevent her back from twisting. She states that he will come by and check on her and help her with personal care or fixing a snack if needed during the day when he is between calls, but cannot do this when he has a really busy day. She states that this is why she needs someone else who she can call to help with her personal care on bad days. She states that when Jeff is not there, she tries to limit the trips to the bathroom because getting in and out of bed and on and off the toilet causes her intense pain. She states that on bad days, because her pain is so severe, she limits her intake of liquids to minimize the frequency that she must go to the bathroom so she can wait until she can get help. She

states that the lady who lives next door helps her occasionally, but she doesn't like to bother her. She says that if the lady were paid by IHSS for helping her, she would not be so hesitant about calling her.

Kimberly states that she takes multiple medications and lives on Vicodin and sleep medications prescribed by her doctor.

When asked about good days and bad days, Kimberly states that a good day is one in which she can sit in the living room and watch TV all day. She states that on good days, she probably could do a little around the house or cook a meal or wash the dishes. On a bad day, she is not able to get out of bed without assistance and she must wait until Jeff or the neighbor comes in to help her with all activities. Kimberly says that she has on average three or four good days per week. She states that she is having a good day on the day of the interview even though she did not sleep well the night before.

Kimberly requests that someone cook meals, do the entire meal cleanup, clean the house, and help her with personal care when Jeff is not at home.

Group Tasks:

How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation and Cleanup
- Transfer
- Bowel and Bladder

Case Scenario – Alice
Consumers that Understate Need

Alice is a 94-year-old lady who lives independently in a three-room apartment in a senior apartment complex. She had been performing all ADLs and IADLs without assistance until recently when she was hospitalized following a fall. Her diagnoses include hypertension and congestive heart failure. She is quite thin. She says she was 5'6" before she started losing height. When she was admitted to the hospital, she weighed 97 lbs. She also has mild tremors in her hands from early stages of Parkinson's disease. The hospital discharge planner has made an IHSS referral indicating she needs assistance with Domestic and Related services, Bathing and Grooming, and Dressing. During the initial IHSS evaluation, Alice reports that she has lived for 94 years without any help and does not need any help now. Alice indicates that she feels that her main problem is dizziness which contributed to the recent fall. She stated that when she feels dizzy, she holds onto the walls when she ambulates around the home.

At the time of the visit, the apartment is neat and tidy. Alice reports that although she feels tired all of the time and it often takes her all day, she does manage to do all of the housework herself. She states that her daughter vacuums once per week. She states that she does all of her personal laundry by hand and hangs it on a clothes rack to dry inside. Her daughter comes over once a week and takes the other laundry to her house. Alice indicates that her daughter or neighbor shop for her. She states that she eats toast and coffee for breakfast if she is hungry, makes a sandwich for lunch, and can prepare a light dinner herself. She states that if she is feeling dizzy, she will use the walls for support to go into the kitchen and heat up a can of soup for dinner. Her daughter brings dinner to her three times per week. She denies that she needs any assistance with personal care.

<u>Group Tasks:</u>
How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation
- Ambulation
- Bathing, Oral Hygiene and Grooming

Case Scenario – Emily
Assessing Need

Emily

Emily is a 38-year-old consumer who lives with her husband Bobby and their two children (13-year-old Jill and 8-year-old Jordan). Emily was diagnosed with Multiple Sclerosis approximately two years ago, and her disease has progressed rapidly. Bobby works during the day and provides some of Emily's care during the evenings and weekends, but he chooses not to be paid. Her 18-year-old daughter Amy, who does not live in the home, provides the rest of her care. In addition to Multiple Sclerosis, Emily has high blood pressure and Type I diabetes, which requires two daily insulin injections and periodic blood sugar testing. She takes multiple pills for her blood pressure and MS twice daily. Emily has an electric wheelchair which she is able to use independently to get around the home. When she goes out for her medical appointments, she requires assistance getting from the house to the car and from the car into the doctor's office. She also requires assistance transferring from the wheelchair to the car and from the car to the wheelchair. The home is equipped with a Hoyer lift, which is used to move her in and out of bed. Emily requires assistance with all Domestic and Related services, and with personal care including bowel and bladder care. Emily is completely unable to bathe herself. Her daughter Amy states that it is difficult to hold her mother up in the shower, requiring a longer time than usual to perform this task. Emily is also at risk of choking because she is unable to chew solid food. For this reason, Amy must puree her mother's food. Emily has no strength in her hands and is unable to grasp utensils. Every Saturday, Emily's mother, Bertha, comes over to dress and bathe her and to make a day's worth of meals for Emily and her family. Emily's husband, Bob, is afraid to leave his wife unattended at any time. He states that Emily requires 24-hour care and supervision. He is afraid that, if left unattended, she could be harmed by an intruder or could choke on something. He is requesting Protective Supervision.

Bob

Bob is 40 years old and has been married to Emily for 19 years. She is his one and only true love, but her illness has been hard on him over the last two years, and at times, he just does not know if he can take it anymore. Bob wants the maximum of 283 hours of care for Emily. Bob does not understand that service hours are based on assessed needs. He believes that someone needs to be with his wife at least 8 hours per day, 7 days per week, which is why he is requesting Protective Supervision. Bob can get pretty upset when speaking with the social worker because he believes no one understands the situation and that IHSS is not providing his wife with the hours she needs.

Doctor
Emily has numerous doctors, including a neurologist who is optimistic about Emily's health status. On the medical evaluation form he states: "not at risk of placement … does require assistance with housekeeping, meals, dishes, laundry, shopping … all personal care ... Diagnosis: MS, HTN, and Diabetes." He also completed the SOC 321, stating: "needs assistance with insulin injections and blood sugar checks … length of time: 99 months."

Amy
Amy is Emily's 18-year-old daughter, who recently graduated from high school. She had been accepted at Stanford University, but decided to give up school to take care of her mother. Amy feels guilty that she resents her mother at times, but knows that one day she will be able to go off to school. Amy knows that the situation is hard on the whole family, but she wants to be able to move on with her life. Amy made the comment, "I want to be my mom's little princess again." Amy lives in a small studio apartment a few doors from her parents' home. Amy claims that it was nice that her father fixed up the apartment for her, but that she does not have any freedom. She is out of the main house, but she spends all day taking care of her mother, and then she runs her younger brother and sister around. By the time Saturday arrives, she is so tired physically and mentally that all she does is sleep. Amy speaks about the dreams she had of becoming a teacher, and about traveling to Europe this summer with her friends, which she will not be able to do. Amy talks about the many nights she and her mother spent talking about those dreams, but that was before her mother became sick. For Amy, life is not about dreams anymore, but making it through one more day.

Group Tasks
Identify the functional rankings on the H line provided.

Housework	*Laundry*	*Shopping & errands*	*Meal prep and clean up*	*Mobility Inside*	*Bathing and grooming*	*Dressing*	*Bowel, bladder & menstrual care*	*Moving in and out of bed (Transfer)*	*Eating*	*Respiration*	*Memory*	*Orientation*	*Judgment*

Case Scenario – Mary
Documenting Need

Initial Assessment

Mary is a 72-year-old female who lives with her daughter, Rebecca, in a two-bedroom, one-bath apartment. Rebecca indicates during the assessment that she quit her job when her mother moved in with her to receive IHSS. Rebecca indicates that Mary was living independently until approximately one year ago when she had a stroke which left her paralyzed on her right (dominant) side and unable to speak. Rebecca indicates that her mother had been fiercely independent before the stroke and that she has seen a marked decrease in her overall condition since the stroke. Rebecca believes that her mother has "given up" and further indicates that on most days, her mother does not want to get out of bed. Rebecca states that she must do "everything" for her mother and that she is exhausted from what she indicates is 24-hour care. She states that since her mother will not get up to use the bathroom, she must continuously monitor her skin condition. She indicates that although her mother wears diapers and has pads on the bed, she must change the bedding every day because it still gets soiled and wet. Rebecca indicates that a neighbor does all of the food shopping and errands for her and her mother and does not wish to be compensated.

Rebecca's sister comes over and stays with her mother when she goes out once a week to do the laundry. She states that she does her mother's laundry separately from hers because of incontinence issues and must take the laundry to a laundry facility about three miles from her home. Rebecca explains that the laundry machines in the apartment complex are frequently broken, and people steal things when laundry is left unattended. Rebecca states that she appreciates her sister staying with her mother while she does the laundry, and recognizes that her sister is limited in her ability to care for her mother due to her own family obligations. However, she states that she still feels some resentment because she has given up her career to care for her mother.

<u>Group Tasks:</u>

Based on the information above and utilizing the Task Tool, Annotated Assessment Criteria, and IHSS Regulations, the group should discuss their answers to the following questions:

1. What factors would you take into consideration in assessing the need for Housework, Laundry, and Food Shopping?
2. Please indicate your reasons and what you would need to document in the case file.
3. What other actions would you take?

Critique the following *Narrative Summary* for Mary's Reassessment:

1. What do you like about this documentation sample?
2. What is missing or should not be included?

(You may want to reference the Narrative Guide in Tab 8.)

2-1-06 – Home visit with Mary and daughter/provider, Rebecca, for reassessment. Rebecca provided all responses to questions as Mary has been unable to speak since a stroke about one year previously. Mary moved in with Rebecca to receive care following the stroke. Rebecca indicates that she believes her mother's condition has continued to deteriorate since the stroke and feels her mother has "given up." She states that her mother usually does not want to get out of bed and that she must do everything for her. The apartment was neat and clean at the time of the HV. Mary appeared to be sleeping in her bed at the time of the HV, although she seemed to open her eyes and recognize me when I spoke her name. There was a large pile of laundry in Mary's bedroom. There continues to be alternative resources available as the neighbor does all of the food shopping and errands. A SOC 450 was obtained from the neighbor at the initial visit and is in the case file. Mary's laundry is done separately by Rebecca at a facility about three miles away. One of Mary's other daughter's comes over and stays with her while Rebecca does the laundry. I asked Rebecca if her sister provided services to her mother when she comes over and she stated that her sister just sits there like a bump on a log and does not lift a finger. Rebecca seemed overwhelmed during the HV and appeared exhausted. During the HV, I discussed with Rebecca her feelings regarding her sister's inability to help with her mother's care. Rebecca indicated that although she sometimes resented the fact that she gave up her career and at times feels like her sister could do more, she is generally able to cope with the situation. She indicated that although her sister does not provide much physical help, she is always willing to talk to her and provide emotional support. I provided Rebecca with information on how to hire another provider and how to access the PA Registry. I also provided her with information regarding community resources which may assist her, including MSSP and ADHC. I reviewed the current FI Rankings and determined that the rankings for Bathing and Grooming and Bowel and Bladder Care should be changed based on the increased amount of assistance needed in these areas. I also increased the amount of time assessed for these services to reflect the current need. The hours for Domestic include only the room used exclusively by Mary which I assessed at 1.00 hour per month, which was increased to 2.00 hours to reflect extra bed linen changes. Out of home laundry authorization assessed at 1.50 hours as laundry facilities on premises cannot be utilized. No proration of laundry as it is done separately due to incontinence.

Case Scenario – Albert
Documenting Need

Initial Assessment

Albert is a 78-year-old man who lives independently in a one-bedroom apartment. Albert uses a walker to move around within his house and indicates that he has been disabled for 20 years due to an accident he had while working. He states that he had lung surgery due to cancer but continues to smoke. When you walk into the apartment, you note a heavy smoke odor. Albert indicates that he uses oxygen at night, but does not need it during the day. He keeps the oxygen set up in his bedroom and is able to hook it up without assistance. The oxygen supplier services the equipment.

Albert's provider comes in four days per week to help him. When questioned regarding his need for Meal Preparation, Albert indicates that he has had toast and coffee for breakfast everyday for the last 20 years and would not want to eat anything else. He indicates that he gets lunch from Meals on Wheels (MOW) five days per week, which he eats for his main meal. On the days that he does not receive MOW, his provider prepares the main meal for him. Albert says that he cannot prepare the main meals because he cannot stand for longer than five minutes at a time. Albert states that the type of meal his provider prepares varies, but it usually takes about one half hour to prepare each meal. Albert is able to make a sandwich or soup for himself which he has for lunch or his evening meal. Albert indicates that the provider cleans up after preparing the main meal, which usually takes her about 15 minutes. She also washes any accumulated dishes when she gets there each day and that it usually takes her about 10 minutes. Albert admits that he could probably wash the few dishes that accumulate from his breakfast, lunch, and dinner, but he leaves them for his provider because he thinks she enjoys washing them.

Albert indicates that he is unable to get into the bathroom at night so he uses a bedside commode which the provider empties and cleans. Albert indicates that he does not need any help with toileting at any other time, but you note a strong urine smell in the apartment.

<u>Group Tasks:</u>

Based on the information above and utilizing the Task Tool, Annotated Assessment Criteria, and IHSS Regulations, the group should discuss their answers to the following questions:

1. What factors would you take into consideration in assessing the need for Meal Preparation, Meal Cleanup, and Bowel and Bladder Care?
2. Indicate how you would address the issue of the urine odor with Albert.
3. Indicate any other issues you feel need to be addressed.

Critique the following *Narrative Summary* for Albert's Reassessment:

1. What do you like about this documentation sample?
2. What is missing or should not be included?

(You may want to reference the Narrative Guide in Tab 8.)

2-1-06 – Home visit with Albert for reassessment. Albert has been diagnosed with lung cancer and has had lung surgery. It was noted during the prior assessment that Albert uses oxygen, but continues to smoke. A heavy smoke odor was present in the apartment. When Albert opened the door, I observed him ambulating with the use of a walker. This appeared to be safe for him. Albert indicated that he uses oxygen only at night and that he has it set up in his bedroom. Albert indicated he could do some minor housework but that his provider did most of it for him. He indicates his provider comes four days per week. Albert indicated that the services he needs assistance with are meal prep and cleanup, laundry, shopping, and emptying the commode which he uses at night. I noted that there was a urine odor in the entire apartment. I reviewed Albert's need for services with him and obtained the following information: He has only toast and coffee for breakfast which he prefers and has been his habit for 20 years. He gets MOW five days per week for lunch. His provider prepares his main meal on the four days that she is there which he reheats in the microwave. When she is not there, he prepares a sandwich or soup for his evening meal. Although Albert states he can do any breakfast, lunch or other cleanup, he states that he leaves them for his provider because she likes to do them. I am changing the assessment for Meal Prep from 7.00 hours per week to reflect availability of MOW and provider preparing main meal 2 x per week. I am also changing assessed need for Meal Cleanup to reflect Meal Cleanup for main meal on days provider prepares, as Albert is capable of doing small amount of dishes from meals. I explained this to Albert and he said he understood. Albert states he cannot get to the bathroom at night due to oxygen use so he uses a bedside commode which his provider empties and cleans. Albert states that he showers once per week and sits on a bath bench. He has appropriate rails in his bathroom. I discussed the urine odor with Albert and he said he didn't understand why there would be an odor. He thinks that maybe his provider hadn't cleaned the commode correctly the last time she was there. I told him that he should make sure that if he did require additional assistance with B/B care or other personal care, he should be sure to call me so that we can make sure that needed services are authorized. He said he would do this. Authorization for B/B care will continue as indicated in prior assessment.

Case Scenario – George
HTG

George is a 68-year-old male whose diagnoses include hypertension and renal failure. He goes to dialysis three times per week. George was recently diagnosed with emphysema. He moved in with his daughter, Marie, two months prior to the home visit. His daughter has applied for IHSS on his behalf. Prior to moving in with his daughter, he lived alone in an upstairs apartment. During the home visit, George's daughter states that she wanted him to move in with her because of her concern over his increasing shortness of breath and the fear that he would not be able to negotiate the stairs by himself, in the near future. The current residence is a small three-bedroom, one-bathroom, ranch-style house. The residents are George, Marie and her husband, and their three children – ages 4, 10, and 16. George sleeps on the couch in the living room.

At the time of the home visit, George is lying on the couch. Marie states that her father returned from dialysis shortly before your arrival. George appears to be alert, although you occasionally have to repeat questions and note that he appears to doze off a couple of times during the interview. George states that, in his view, Marie exaggerates his condition and that he is generally able to take care of all of his own needs. He states that he misses the independence and privacy he had in his own apartment. He does admit that on dialysis days, he requires some assistance from Marie, including assistance off of the couch, ambulation to and from the bathroom, and assistance to and from the kitchen for meals.

During the interview, Marie frequently interrupts and contradicts what her father says. She states that he needs help on all days. She says that after dialysis he cannot do anything for himself. She states that she must help him to put on his pajamas and to manage his clothing when he uses the bathroom. She states that she always assists him with bathing also because she is afraid he will fall. She indicates that even when George goes for a short walk outside, she always accompanies him because she is afraid that he will fall: he is unsteady when walking outside the house.

Marie states that she must frequently encourage her father to eat because he does not have any appetite. She states that she left him alone on a couple of occasions on non-dialysis days, and that he did not eat dinner on those days. She says she prepares George's meals separately because he is on a high-protein, restricted salt, phosphorous and potassium diet. She states that he usually eats a poached egg and a piece of toast for breakfast. She indicates that he probably could fix his own breakfast on non-dialysis days, but it would take him too long. She also agrees that he could make his own breakfast on dialysis days because he doesn't leave the house until 9:00 a.m. She says it takes her a half hour to make his breakfast and serve it, and that she prepares his lunch

(usually cottage cheese and canned fruit or yogurt) because that is what daughters do for their fathers. She says that this meal takes about 10 minutes to make. She says that a typical dinner for George is meat, a small amount of starch, and some vegetables, which takes her about a half hour to prepare.

You ask Marie if you can speak to her father without her present as you have some personal questions you need to ask him, and that you believe he will be more comfortable if you can ask those questions in private. Marie reluctantly agrees.

After Marie leaves, George states that he is unhappy with his current living arrangement and misses his friends from the apartment complex. He states that he spent much of his time playing cards with his friends prior to moving in with Marie. He states that his grandchildren are in and out of the living room at all hours of the day and night and that the TV is constantly on with kids shows. He states that there is not much to do even when he is feeling well and that Marie will not let him do anything. When you ask him about other activities he enjoys, he states that when he had his own house he enjoyed working in the garden. He says Marie will not let him help with the garden because she thinks he will fall. George states he currently feels useless.

George states that on his non-dialysis days he can ambulate without assistance and sometimes goes for short walks to get out of the house. He does, however, need a boost from the chair or couch, even on non-dialysis days. He states that on non-dialysis days he would be able to fix meals for himself, but Marie does not want him to do this. He states that at his apartment he did all meal preparation and cleanup, but admits that on his dialysis days, he frequently did not eat dinner because it was too much work for him. He states that when he lived at his apartment, he would bathe about once or twice a week and that he continues this habit. He states that he bathes on non-dialysis days and that Marie does not assist or monitor him. He admits that he requires assistance off of the couch on dialysis days and that his daughter helps him walk to and from the bathroom, and to and from the kitchen for meals, because he is unsteady on his feet. He also states that Marie helps him put on his pajamas when he gets home on dialysis days and that she also manages his clothes after he uses the bathroom. When you ask George about the time Marie spends helping him with these activities, he replies that you will have to ask Marie because he does not have any idea. He states that Marie drives him to and from the dialysis clinic. When he lived in his apartment a van would pick him up and bring him home. The van personnel would assist him from his apartment to the van, then from the van to the clinic and back again after dialysis. George states that he would still be able to use the van, but Marie prefers to drive him.

When Marie returns to the room, she states that she thinks she spends about 15 minutes per day helping George to and from the bathroom for a bowel movement. While conducting the interview you observe her helping George up from the couch and steadying him while he ambulates the short distance to the bathroom. You note that George is slow getting up from the couch and returning to a seated position and that it takes approximately 1 minute for Marie to help him get up, another minute gaining balance before walking, and another minute for him to return to a seated position. You note that Marie provides elbow support when George walks and that it takes approximately five minutes from the time that he starts to get up from the couch until he is seated again. Marie states that on non-dialysis days she assists him with transfers about ten times per day and that it takes 5 minutes to get him to a standing position and 5 minutes to return to a seated position. You observe that it is about the same distance from the couch to the bathroom as the couch to the kitchen. You ask her to think of how much help he needs on dialysis days. She says that she needs to do just about everything for him on those days; it is hard because she is worried about how frail he has gotten and she also has her own kids and husband to take care of. Luckily – Marie tells you – her youngest is in preschool, it is not so bad, and she is glad to be able to help her father. When he was living alone, she was so worried about him.

You ask her to be specific about the help she provides him. She states that on dialysis days she helps him up 3 times a day to go to the kitchen table and back to the couch for meals, and once a day to go to the bathroom and back to the couch for his bowel movement. He does not urinate because of the dialysis. When she takes him to the dialysis clinic she has to do the following:

- assistance getting him up from the couch;
- elbow support while he walks from the couch to the car;
- assistance into the car for the trip to the dialysis center;
- assistance out of the car, once they arrive at the dialysis center;
- elbow support while he walks from the car to the dialysis clinic;
- all of the above steps (in reverse order) after his dialysis treatment is finished.

Marie states that George has two different doctors – his primary physician and his nephrologist. He sees each of them every other month, alternating between the two, for an average of one trip per month. Marie states that the dialysis clinic and his two doctors are located in the same medical complex and that it takes her 10 minutes to help George from the front door of the house to the car and about 12 minutes to help him from the car to the clinic.

Marie states that – one or two times a week on non-dialysis days – she sets up the shower bench, helps her father in and out of the shower, and gives him the hand-held shower head. She says that, once seated, he can manage his own shower, but she has to be within ear-shot to hear him in case he needs her while he showers. According to Marie, if George bends over to dry his legs and feet, he gets dizzy when he sits up again. For this reason, she helps him to dry his legs and feet when he has finished showering. This whole process takes about a half hour each time.

Group Tasks:

1. Using the Annotated Assessment Criteria/Task Tools document, discuss why the following FI rankings are appropriate for George.

   Mobility Inside – 4
   Meal Preparation – 4
   Transfer – 3
   Eating – 2
   Bathing – 3

2. Use the available information to determine the assessed need for Transfer, Ambulation, Meal Preparation and Bathing. Complete the Documentation Worksheet to show how you calculated the need.

3. Use the HTG documents to determine if the assessed need for Transfer, Ambulation, Meal Preparation and Bathing is within the HTG. If it is not within the guidelines, indicate how you would document the exception(s) on the Documentation Worksheet.

George – Documentation Worksheet

Meal Preparation

FI Rank (Enter)		
	Low	**High**
Rank 2	3.02	7.00
Rank 3	3.50	7.00
Rank 4	5.25	7.00
Rank 5	7.00	7.00

Note: Compare Total Need with above range.

Needs help with ☐ Breakfast ☐ Lunch ☐ Dinner

Meal	Example of Typical Meal	Need Per Meal	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				

Reason for assistance:

Shared living exceptions (required when services not prorated):

Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:

Ambulation

FI Rank (Enter)		
	Low	**High**
Rank 2	0.58	1.75
Rank 3	1.00	2.10
Rank 4	1.75	3.50
Rank 5	1.75	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Walking inside home				
Retrieving assistive devices				
Assistance from house to car & in/out of car for medical appt. and to Alt. Resource				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Transfer

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance from standing, sitting, or prone position to another, or transfer from one piece of equipment or furniture to another				
Reason for assistance: Additional information to document exceptions to guidelines and identification of Alt. Resources:				

Bathing, Oral Hygiene, and Grooming

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting in/out of tub/shower				
Oral hygiene				
Grooming				
Reason for assistance: Additional information to document exceptions to guidelines and identification of Alt. Resources:				

Fibromyalgia

Definition

Fibromyalgia is a chronic syndrome (constellation of signs and symptoms) characterized by diffuse or specific muscle, joint, or bone pain, fatigue, and a wide range of other symptoms.

Characteristics

The defining symptoms of Fibromyalgia are chronic, widespread pain and tenderness to light touch, and usually moderate to severe fatigue.

In addition to pain and fatigue, people who have Fibromyalgia may experience:

- sleep disturbances,
- morning stiffness,
- headaches,
- irritable bowel syndrome,
- painful menstrual periods,
- numbness or tingling of the extremities,
- restless legs syndrome,
- temperature sensitivity,
- cognitive and memory problems (sometimes referred to as "fibro fog"), or
- a variety of other symptoms.

Fibromyalgia is often referred to as an **"invisible" illness** or disability due to the fact that generally there are no outward indications of the illness or its resulting disabilities.

Functional Considerations

- Fibromyalgia can affect every aspect of a person's life due to pervasive and persistent chronic pain.
- Expect that the consumer may have cycles of good days and bad days.
- Individuals suffering from invisible illnesses in general often face disbelief or accusations of malingering or laziness from others that are unfamiliar with the syndrome and therefore may be defensive during the assessment.
- Fibromyalgia is a chronic condition, but is not progressive.

The information is presented to inform IHSS social workers about medical conditions. It is not meant to contradict any information the consumer may receive from their personal physician. **All IHSS assessments should be individualized and are not diagnosis specific.**

14: Regulations

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30-700 PROGRAM DEFINITION 30-700

.1 The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care. Eligibility and services are limited by the availability of funds.

.2 The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code Section 14132.95 and Title 22, California Code of Regulations, Division 3 and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Division 30.

.3 The IHSS Plus Waiver program provides IHSS Plus Waiver services, to eligible Medi-Cal beneficiaries, subject to Medi-Cal provisions, statutes and regulations, pursuant to Welfare and Institutions Code Section 14132.951 and Title 22, California Code of Regulations, Division 3, and is operated pursuant to Division 30.

.31 These services are available as described in MPP Section 30-757, when services are provided by a parent of a minor child recipient or a spouse; and/or when the recipient receives a Restaurant Meal Allowance; and/or when the recipient receives Advance Payment for in-home care services.

.32 Recipients in any one of the categories described in Section 30-700.31, who have been determined eligible for Medi-Cal, qualify for the IHSS Plus Waiver program.

.33 The IHSS Plus Waiver Program is a "Section 1115 Demonstation Project" as defined in 42 USC, Section 1315. This demonstration project has been approved for 5 years, beginning August 1, 2004. Eligibility and services are limited to the availability of funds and potential extensions to the demonstration.

.4 Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP.

.5 All civil rights laws, rules, and regulations of Division 21 shall be complied with in administering IHSS program regulations.

NOTE: Authority cited: Sections 10553, 10554, 12300, 14142.95, and 14132.951, Welfare and Institutions Code; Chapter 939, Statutes of 1992; and 42 USC, Section 1315(a) of the Social Security Act. Reference: Sections 12300, 14132.95, and 14132.91, Welfare and Institutions Code.

30-701 SPECIAL DEFINITIONS 30-701

(a) (1) Administrative costs are those costs necessary for the proper and efficient administration of the county IHSS program as defined below. Activities considered administrative in nature include, but are not limited to:

(A) Determine eligibility;

(B) Conduct needs assessments;

(C) Give information and referrals;

(D) Establish case files;

(E) Process Notices of Action;

(F) Arrange for services;

(G) Compute shares of cost;

(H) Monitor and evaluate contractor performance;

(I) Respond to inquiries;

(J) Audit recipient and individual provider timesheets;

(K) Enter case and payroll information into the CMIPS;

(L) Screen potential providers and maintain a registry or list.

(2) Administrative activities for PCSP are those activities necessary for the proper and efficient administration of the county PCSP. In addition to all activities listed in Section 30-753(a)(1) as administrative activities for IHSS except Section 30-753(a)(1)(G), the following activities are considered administrative in nature, subject to PCSP funding:

(A) Nursing supervision;

(B) Clerical staff directly supporting nursing supervision of PCSP cases;

(C) Physician certification of medical necessity when such certification is completed by a licensed health care professional who is a county employee;

(D) Provider enrollment certification.

30-701 SPECIAL DEFINITIONS 30-701
(Continued)

(3) Allocation means federal, state, and county monies which are identified for a county by the Department for the purchase of services in the IHSS Program.

(b) (1) Base Allocation means all federal, state and county monies identified for counties by the Department for the purchase of services in the IHSS Program, exclusive of any provider COLA allocation, but including recipient COLA.

(2) Base Rate means the amount of payment per unit of work before any premium is applied for overtime or related extraordinary payments.

(c) (1) Certified Long-Term Care Insurance Policy or Certificate or certified policy or certificate means any long-term care insurance policy or certificate, or any health care service plan contract covering long-term care services, which is certified by the California Department of Health Services as meeting the requirements of Welfare and Institutions Code Section 22005.

(2) Compensable services are only those services for which a provider could legally be paid under the statutes.

(3) Consumer means an individual who is a current or past user of personal care services, as defined by Section 30-757.14, paid for through public or private funds or a recipient of IHSS or PCSP.

(4) County Plan means the annual plan submitted to the California Department of Social Services specifying how the county will provide IHSS and PCSP.

(5) CRT or Cathode Ray Tube means a device commonly referred to as a terminal which is used to enter data into the IHSS payrolling system.

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30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(6) CRT County means a county in which one or more CRTs have been located allowing the county to enter its data directly into the payrolling system.

(d) (1) Deeming means procedures by which the income and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost.

(2) Designated county department means the department designated by the county board of supervisors to administer the IHSS program.

(3) Direct advance payment means a payment to be used for the purchase of authorized IHSS which is sent directly to the recipient in advance of the service actually being provided.

(e) (1) Employee means the provider of IHSS under the individual delivery method as defined in Section 30-767.13.

(2) Employer means the recipient of IHSS when such services are purchased under the individual delivery method as defined in Section 30-767.13.

(3) Equity Value means a resource's current market value after subtracting the value of any liens or encumbrances against the resources which are held by someone other than the recipient or his/her spouse.

(f) (Reserved)

(g) Gatekeeper Client means a person eligible for, but not placed in a skilled or intermediate care facility as a result of preadmission screening.

(h) (1) Hours Worked means the time during which the provider is subject to the control of the recipient, and includes all the time the provider is required or permitted to work, exclusive of time spent by the provider traveling to and from work.

(2) Housemate means a person who shares a living unit with a recipient. An able and available spouse or a live-in provider is not considered a housemate.

(i) (1) "Intercounty Transfer" means a transfer of responsibility for the provision of IHSS services from one county to another when the recipient moves to a new county and continues to be eligible for IHSS:

(A) "Transferring County" means the county currently authorizing IHSS services.

(B) "Receiving County" means the county to which the recipient moves to make his/her home.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(C) "Transfer Period" means the period during which the transferring county remains responsible for payment of IHSS services, after which the receiving county will be responsible for payment. The transfer period starts when the transferring county sends *the* documentation, including the notice of transfer form, and records to the receiving county.

(D) "Expiration of Transfer Period" means the end of the transfer period. The transfer period shall end as soon as administratively possible but no later than the first day of the month following 30 calendar days after the notification of transfer form is sent to the receiving county or as allowed in Section 30-759.96.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

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(E) Example: The transferring county sends a notification of transfer form along with documents to the receiving county on January 20th.

The receiving county has 30 calendar days to return the transfer form. The receiving county returns the transfer form on February 19th, stating that they will assume responsibility effective March 1st.

- The transfer period begins January 20th.

- The transfer period ends on March 1st. IHSS payment is terminated by the transferring county.

- The receiving county begins IHSS payment effective March 1st and the transfer is complete.

HANDBOOK ENDS HERE

(j) (Reserved)

(k) (Reserved)

(l) (1) Landlord/Tenant Living Arrangement means a shared living arrangement considered to exist when one housemate, the landlord, allows another, the tenant, to share housing facilities in return for a monetary or in-kind payment for the purpose of augmenting the landlord's income. A landlord/tenant arrangement is not considered to exist between a recipient and his/her live-in provider. Where housemates share living quarters for the purpose of sharing mortgage, rental, and other expenses, a landlord tenant relationship does not exist, though one housemate may customarily collect the payment(s) of the other housemate(s) in order to pay mortgage/rental payments in a lump sum.

(2) Licensed Health Care Professional means a person who is a physician as defined and authorized to practice in this state in accordance with the California Business and Professions Code.

(3) Live-In Provider means a provider who is not related to the recipient and who lives in the recipient's home expressly for the purpose of providing IHSS-funded services.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(4) A list means any informal or formal listing or registry of written name(s) of prospective In-Home Support Services providers maintained by the county agency, county social services staff, a contractor as defined under Welfare and Institutions Code Section 12302.1, or any public or private agency for purposes of referring the prospective providers for employment.

(m) Minor means any person under the age of eighteen who is not emancipated by marriage or other legal action.

(n) (1) Net Nonexempt Income means income remaining after allowing all applicable income disregards and exemptions.

(2) Nonprofit consortium means an association that has a tax-exempt status and produces a tax exempt status certificate and meets the definition of a nonprofit organization as contained in OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980.

HANDBOOK BEGINS HERE

(A) OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980, defines a nonprofit organization as one which:

(1) Operates in the public interest for scientific, educational, service or charitable purposes;

(2) Is not organized for profit making purposes;

(3) Is not controlled by or affiliated with an entity organized or operated for profit making purposes; and

(4) Uses its net proceeds to maintain, improve or expand its operations.

HANDBOOK ENDS HERE

(o) (1) Out-of-Home Care Facility means a housing unit other than the recipient's own home, as defined in (o) (2) below. Medical out-of-home care facilities include acute care hospitals, skilled nursing facilities, and intermediate care facilities. Nonmedical out-of-home care facilities include community care facilities and homes of relatives which are exempt from licensure, as specified in Section 46-325.5, where recipients are certified to receive board and care payment level from SSP.

(2) Own Home means the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her home.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(p) (1) Paper County means a county which sends its data in paper document form for entry into the payrolling system to the IHSS payrolling contractor.

(2) Payment Period means the time period for which wages are paid. There are two payment periods per month corresponding to the first of the month through the fifteenth of the month and the sixteenth of the month through the end of the month.

(3) Payrolling System means a service contracted for by the state with a vendor to calculate paychecks to individual providers of IHSS; to withhold the appropriate employee taxes from the provider's wages; to calculate the employer's taxes; and to prepare and file the appropriate tax return.

(4) Personal Attendant means a provider who is employed by the recipient and, as defined by 29 CFR 552.6, who spends at least eighty percent of his/her time in the recipient's employ performing the following services:

(A) Preparation of meals, as provided in Section 30-757.131.

(B) Meal clean-up, as provided in Section 30-757.132.

(C) Planning of menus, as provided in Section 30-757.133.

(D) Consumption of food, as provided in Section 30-757.14(c).

(E) Routine bed baths, as provided in Section 30-757.14(d).

(F) Bathing, oral hygiene and grooming, as provided in Section 30-757.14(e).

(G) Dressing, as provided in Section 30-757.14(f).

(H) Protective supervision, as provided in Section 30-757.17.

(5) Preadmission Screening means personal assessment of an applicant for placement in a skilled or intermediate care facility, prior to admission to determine the individual's ability to remain in the community with the support of community-based services.

(6) Provider Cost-of-Living Adjustment (COLA) means all federal, state and county monies identified for counties by SDSS for the payment of wage and/or benefit increases for service providers in the IHSS program.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(7) Public Authority means:

(A) An entity established by the board of supervisors by ordinance, separate from the county, which has filed the statement required by Section 53051 of the Government Code, and

(B) A corporate public body, exercising public and essential governmental functions and that has all powers necessary and convenient to carry out the delivery of in-home supportive services, including the power to contract for services and make or provide for direct payment to a provider chosen by a recipient for the purchase of services.

(q) (Reserved)

(r) (1) Recipient means a person receiving IHSS, including applicants for IHSS when clearly implied by the context of the regulations.

(2) Reduced payment means any payment less than full payment that may be due.

(s) (1) Severely Impaired Individual means a recipient with a total assessed need, as specified in Section 30-763.5, for 20 hours or more per week of service in one or more of the following areas:

(A) Any personal care service listed in Section 30-757.14.

(B) Preparation of meals.

(C) Meal cleanup when preparation of meals and consumption of food (feeding) are required.

(D) Paramedical services.

(2) Shared Living Arrangement means a situation in which one or more recipients reside in the same living unit with one or more persons. A shared living arrangement does not exist if a recipient is residing only with his/her able and available spouse.

(3) Share of cost means an individual's net non-exempt income in excess of the applicable SSI/SSP benefit level which must be paid toward the cost of IHSS authorized by the county.

(4) Spouse means a member of a married couple or a person considered to be a member of a married couple for SSI/SSP purposes. For purposes of Section 30-756.11 for determining PCSP eligibility, spouse means legally married under the laws of the state of the couple's permanent home at the time they lived together.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(5) SSI/SSP means the Supplemental Security Income and State Supplementary Program administered by the Social Security Administration of the United States Department of Health and Human Services in California.

(6) State Allocation Plan means that process whereby individual county IHSS program allocations are developed in a manner consistent with a) Welfare and Institutions Code Sections 10102 and 12300 et seq., and b) funding levels appropriated and any control provision contained in the Annual Budget Act.

(7) State-mandated program cost means those county costs incurred for the provision of IHSS to recipients, as specified in Section 30-757, in compliance with a state approved county plan. Costs caused by factors beyond county control such as caseload growth and increased hours of service based on individually assessed need, shall also be considered state-mandated.

(8) Substantial Gainful Activity means work activity that is considered to be substantial gainful activity under the applicable regulations of the Social Security Administration, 20 CFR 416.932 through 416.934. Substantial work activity involves the performance of significant physical or mental duties, or a combination of both, productive in nature. Gainful work activity is activity for remuneration of profit, or intended for profit, whether or not profit is realized, to the individual performing it or to the persons, if any, for whom it is performed, or of a nature generally performed for remuneration or profit.

(9) Substitute Payee means an individual who acts as an agent for the recipient.

(t) Turnaround Timesheet means a three-part document issued by the state consisting of the paycheck, the statement of earnings, and the timesheet to be submitted for the next pay period.

(u) (Reserved)

(v) (1) Voluntary Services Certification is the form numbered SOC 450 (10/98) which is incorporated by reference and which is to be used statewide by person(s) providing voluntary services without compensation.

(w) (Reserved)

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Sections 10553, 10554, 12301.1, and 22009(b), Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 11102, 12300(c), 12301, 12301.6, 12304, 12306, 12308, 13302, 14132.95, 14132.95(e), 14132.95(f), and 22004, Welfare and Institutions Code.

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702

.1 Each county shall establish a Quality Assurance (QA) unit or function which, at a minimum, will be required to perform the following tasks:

.11 Develop and regularly review policies and procedures, implementation timelines, and instructions under which county QA and Quality Improvement (QI) programs will function.

.12 Perform routine, scheduled reviews of supportive services cases which include reviewing a sample of case files and other documents.

.121 The county shall define routine, scheduled reviews in their QA procedures.

.122 The county's QA case sample shall:

(a) Include cases from all district offices and all workers involved in the assessment process.

(b) Include a minimum number of cases determined by CDSS based on the county's caseload and QA staffing allocation.

.123 If the county is unable to meet the requirements of Section 30-702.122, the county shall submit a written alternative proposal to CDSS outlining the reason as well as an alternative sample method. CDSS shall review the proposal and determine if it is acceptable for compliance with Section 30-702.122.

.124 The county's routine, scheduled reviews shall consist of desk reviews and home visits.

.125 The review process shall be a standardized process, including standard forms for completing desk reviews of cases and for completing home visits.

(a) The desk reviews must include:

(1) A sample of denied cases.

(2) Validation of case file information by recipient contact using a sub-sample of cases.

(3) A process to verify:

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

(A) Required forms are present, completed, and contain appropriate signatures.

(B) There is a dated Notice of Action in the case file for the current assessment period.

(C) The need for each service and hours authorized is documented.

(b) The county shall conduct home visits using a sub-sample of their desk reviews to confirm that the assessment is consistent with the recipient's needs for services and the applicable federal and state laws and policies have been followed in the assessment process. When conducting home visits the county shall:

(1) Notify the recipient prior to the home visit.

(2) Verify the recipient's identity.

(3) Verify the need for any IHSS service tasks, not just the task currently authorized.

(4) Verify all data on the G-Line of the SOC 293 (1/91), which includes specific information that may impact the assessment of need.

(5) Verify the recipient understands which services have been authorized and the amount of time authorized for each.

(6) Discuss with the recipient, the recipient's health issues and physical limitations to assist in identifying the recipient's functional limitations.

(7) Discuss any changes in the recipient's condition or functional limitations since the last assessment.

(8) Discuss the quality of services provided by the county with the recipient, including addressing the recipient's awareness of, and the ability to, contact and communicate with his/her worker.

(9) Verify that the recipient understands his/her ability to request a fair hearing.

(10) Ensure a completed back-up plan, that indicates the steps the recipient must take in the event of an emergency, is in the recipient's file and a copy has been provided to the recipient to use as a future resource.

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

.126 The county's QA review process shall also identify any optional county special requirements.

.127 When the county QA staff is prevented from completing a review on a specific case, this information shall be conveyed to the appropriate staff and an alternative case shall be selected.

.13 Develop procedures to report QA findings to county and State management and to ensure that deficiencies identified are appropriately reported and corrected.

.131 The county's reporting procedures shall identify a standardized process for communicating results of routine, scheduled reviews to management, line staff, and the immediate supervisors of line staff. The process shall include:

(a) A specified time frame for response to QA findings and a follow-up process.

(b) Protocols for identifying and responding to a need for immediate action.

(c) Measures to ensure that corrective actions address problems that are systematic in nature.

.14 Review and respond to information provided as a result of data matches conducted by the State with other agencies that provide services to program recipients or State control agencies.

.141 In performing data match activities, counties shall ensure that confidentiality requirements are adhered to.

.15 Develop procedures to detect and prevent potential fraud by providers, recipients, and others, which include informing providers, recipients, and others that suspected fraud of supportive services can be reported by using the toll-free Medi-Cal fraud telephone hotline and/or internet web site.

.16 Conduct appropriate follow-up of suspected fraud and seek recovery of any overpayments, as appropriate.

.17 Identify potential sources of third-party liability and make appropriate referrals. Potential sources of third-party liability include but are not limited to:

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

.171 Long-Term Care Insurance.

.172 Worker's Compensation Insurance.

.173 Victim Compensation Program Payments.

.174 Civil Judgment/Pending Litigations.

.18 Conduct joint case review activities with State QA staff.

.19 Develop a plan for and perform targeted QA/QI studies based on:

.191 Analysis of data acquired through the county's quality assurance program; or

.192 Analysis of data available through Case Management Information Payrolling System (CMIPS), county systems; or

.193 Other information, including but not limited to:

(a) Data from QA case review findings; or

(b) Input from Public Authorities and other consumer groups.

.194 The county shall submit a quarterly report of their QA/QI activities to CDSS on the SOC 824 (3/06) form fifteen days after the report quarter ends. (Quarters end on March 31, June 30th, September 30th, and December 31st).

.2 Each county shall develop and submit an annual QA/QI Plan to CDSS no later than June 1 of each year.

.21 The QA/QI Plan shall identify how the county will use the information gathered through QA activities to improve the quality of the IHSS program at the local level.

NOTE: Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Section 12305.71, Welfare and Institutions Code.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM 30-755

.1 Eligibility

.11 A person is eligible for IHSS who is a California resident living in his/her own home, and who meets one of the following conditions:

.111 Currently receives SSI/SSP benefits.

.112 Meets all SSI/SSP eligibility criteria including income, but does not receive SSI/SSP benefits.

.113 Meets all SSI/SSP eligibility criteria, except for income in excess of SSI/SSP eligibility standards or immigration criteria, and meets applicable share of cost obligations.

(a) A person must meet immigration status criteria as provided in 20 CFR Part 416, subpart P, or must meet the state program noncitizen status criteria as provided in MPP Section 30-770.51.

.114 Was once eligible for SSI/SSP benefits, but became ineligible because of engaging in substantial gainful activity, and meets all of the following conditions:

(a) The individual was once determined to be disabled in accordance with Title XVI of the Social Security Act (SSI/SSP).

(b) The individual continues to have the physical or mental impairments which were the basis of the disability determination.

(c) The individual requires assistance in one or more of the areas specified under the definition of "severely impaired individual" in Section 30-753.

(d) The individual meets applicable share of cost obligations.

.12 Otherwise eligible applicants, currently institutionalized, who wish to live in their own homes and who are capable of safely doing so if IHSS is provided, shall upon application receive IHSS based upon a needs assessment.

.121 Service delivery shall commence upon the applicant's return home, except that authorized services as specified in Section 30-757.12 may be used to prepare for the applicant's return home.

.2 Eligibility Determination

.21 Eligibility shall be determined by county social service staff at the time of application, at subsequent 12-month intervals, and when required based on information received about changes in the individual's situation.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.22 Eligibility for current recipients of SSI/SSP shall be determined by verifying receipt of SSI/SSP. This can be done in any of the following ways:

.221 Seeing the current SSI/SSP Notice of Determination.

.222 Seeing the current SSI/SSP benefit check.

.223 Contacting the Social Security District Office.

.224 Checking the Medi-Cal Eligibility Data System (MEDS) or the State Data Exchange (SDX) screens.

.23 Eligibility for those persons described in Sections 30-755.112, .113, and .114 above shall be determined as follows:

.231 Age, blindness, and disability shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

(a) Age, blindness or disability may be established by looking at the third and fourth digits of the Medi-Cal number. If the number is 10, the recipient is aged; if 20, the recipient is blind; and if 60, the recipient is disabled. However, if the third and fourth digits of the number are not 20 or 60, a new determination of blindness or disability may be required.

.232 Residence, property, and net nonexempt income shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

.233 Net nonexempt income in excess of the applicable SSI/SSP benefit level shall be applied to the cost of IHSS.

(a) Payment of the entire obligated share of cost is a condition of eligibility for IHSS.

(b) Providers shall have the primary responsibility for collecting any share of cost owed to them.

(1) The county may collect the share of cost.

(2) Counties shall have the responsibility for collection of any share of cost which must be paid against the provider's tax liability.

(c) If a recipient fails to pay his/her entire obligated share of cost within the month for which it is obligated, IHSS shall be terminated.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

(1) Termination will be effective the last day of the month following the month of discovery of the recipient's failure to pay his/her entire obligated share of cost.

(d) If an applicant/recipient states verbally or in writing that he/she will not pay his/her share of cost, the applicant/recipient shall not be eligible for IHSS services.

.24 Notwithstanding Section 30-755.232 above, net nonexempt income for persons specified in Section 30-755.113 above shall be determined, depending on the aid category to which the individual was linked in December, 1973, according to the Old Age Security (OAS), Aid to the Blind (AB) and Aid to the Totally Disabled (ATD) income regulations which would have been applicable in the individual's case in June, 1973, if it is to the person's advantage and either of the following conditions is met:

.241 In December 1973 the person was receiving only homemaker/chore services or was receiving an OAS, AB or ATD cash grant solely for attendant care, and has received IHSS services continuously since that date.

.242 In December 1973 the person had applied for attendant care of homemaker/chore service, met all eligibility requirements in that month, and has received IHSS services continuously since that date.

.25 The case record for persons specified in .111 above shall indicate the information used to determine receipt of SSI/SSP benefits.

.26 The case record for persons specified in Sections 30-755.112, .113, and .114 above shall include:

.261 The information used by the county to determine age, blindness or disability.

.262 The information regarding the recipient's property, income, and living situation used by the county in determining eligibility. Such information shall be recorded on a statement of facts form which shall be signed by the recipient or his/her authorized representative under penalty of perjury, and shall be dated. The county shall verify income. The county may verify other information if necessary to insure a correct eligibility determination.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.263 For persons eligible under .114 above, the information used to decide that the recipient was once determined to be eligible for SSI/SSP, was once determined to be disabled as provided in .114(a) above, and was discontinued from SSI/SSP because of engaging in substantial gainful activity.

.264 The computation of the amount the recipient must pay toward the cost of in-home supportive services.

.3 Medi-Cal

.31 Recipients of services under .112, .113, and .114 above are eligible for Medi-Cal, provided that any net nonexempt income in excess of the SSI/SSP benefit level shall be applied to the cost of in-home supportive services.

NOTE: Authority cited: Sections 10553, 10554, and 12150, Welfare and Institutions Code; Chapter 939, Statutes of 1992; and Senate Bill 1569 (Chapter 672, Statutes of 2006). Reference: Sections 10554, 12304.5, 12305, 12305.6, 13283, 14132.95, and 18945 Welfare and Institutions Code.

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30-756 NEED 30-756

.1 Staff of the designated county department shall determine the recipient's level of ability and dependence upon verbal or physical assistance by another for each of the functions listed in Section 30-756.2. This assessment shall evaluate the effect of the recipient's physical, cognitive and emotional impairment on functioning. Staff shall quantify the recipient's level of functioning using the following hierarchical five-point scale:

.11 Rank 1: Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

.12 Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.

.13 Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

.14 Rank 4: Can perform a function but only with substantial human assistance.

.15 Rank 5: Cannot perform the function, with or without human assistance.

.2 Staff of the designated county department shall rank the recipient's functioning in each of the following functions.

(a) Housework;

(b) Laundry;

(c) Shopping and errands;

(d) Meal preparation and cleanup;

(e) Mobility inside;

30-756 **NEED** (Continued) **30-756**

(f) Bathing and grooming;

(g) Dressing;

(h) Bowel, bladder and menstrual;

(i) Repositioning;

(j) Eating;

(k) Respiration;

(l) Memory;

(m) Orientation; and

(n) Judgment.

.3 Staff of the designated county department shall use the following criteria to support the determination of functional impairment:

.31 The recipient's diagnosis may provide information to substantiate demonstrated functional impairments, but the recipient's functioning is an evaluation of the recipient's capacity to perform self-care and daily chores.

.32 Need may be distinct from current practice. The assessment of need shall identify the recipient's capacity to perform functions safely. The assessment of need shall identify the recipient's capacity rather than level of dependence.

.33 The recipient's needs shall be assessed within his/her environment, considering the mechanical aids or durable medical appliances the recipient uses.

.34 The scales are hierarchical. The higher the score, the more dependent the recipient is upon another person to perform IHSS services activities.

.35 Most functions are evaluated on a five-point scale. However, the functions of memory, orientation and judgment contain only three ranks. The function of respiration contains only ranks 1 and 5. These inconsistencies in the ranking patterns exist because differing functional ability in these areas does not result in significantly different need for human assistance.

30-756 NEED (Continued) **30-756**

.36 The order in which the physical functions are listed in Sections 30-756.2(a) through (k) is hierarchical.

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.361 In 95 percent of any impaired population, people tend to lose functioning in the inverse order of normal infant development. Therefore, it would be unlikely for a recipient to score higher ranks in the functions listed at the bottom of the list than those at the top. This listing should assist in the assessment process.

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.37 Mental functioning shall be evaluated as follows:

.371 The extent to which the recipient's cognitive and emotional impairment (if any) impacts his/her functioning in the 11 physical functions listed in Sections 30-756.2(a) through (k) is ranked in each of those functions. The level and type of human intervention needed shall be reflected in the rank for each function.

.372 The recipient's mental function shall be evaluated on a three-point scale (Ranks 1, 2, and 5) in the functions of memory, orientation and judgment. This scale is used to determine the need for protective supervision.

.4 Notwithstanding Section 30-756.11, staff shall rank a recipient the rank of "1" if the recipient's needs for a particular function are met entirely with paramedical services as described in Section 30-757.19 in lieu of the correlated task.

.41 If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both meal preparation and eating because tube feeding is a paramedical service.

.42 If all the recipient's needs for human assistance in respiration are met with the paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is paramedical service rather than respiration.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 12309, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

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30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757

.1 Only those services specified in Sections 30-757.11 through .19 shall be authorized through IHSS. A person who is eligible for a personal care service provided pursuant to the PCSP shall not be eligible for that personal care service through IHSS. A service provided by IHSS shall be equal to the level of the same service provided by PCSP.

(a) For services in this section where time guidelines are specified, the services shall be subject to the specified time guideline unless the recipient's needs require an exception to the guideline. When assessing time for services (both within and outside the time guidelines), the time authorized shall be based on the recipient's individual level of need necessary to ensure his/her health, safety, and independence based on the scope of tasks identified for service. In accordance with Welfare and Institutions Code Section 12301.2, the dual purpose of the guidelines is to provide counties with a tool for both consistently and accurately assessing service needs and authorizing time.

(1) In determining the amount of time per task, the recipient's ability to perform the tasks based on his/her functional index ranking shall be a contributing factor, but not the sole factor. Other factors could include the recipient's living environment, and/or the recipient's fluctuation in needs due to daily variances in the recipient's functional capacity (e.g., "good days" and " bad days").

(A) In determining the amount of time per task, universal precautions should be considered.

1. Universal precautions are protective practices necessary to ensure safety and prevent the spread of the infectious diseases. Universal precautions should be followed by anyone providing a service, which may include contact with blood or body fluids such as saliva, mucus, vaginal secretions, semen, or other internal body fluids such as urine or feces. Universal precautions include the use of protective barriers such as gloves or facemask depending on the type and amount of exposure expected, and always washing hands before and after performing tasks. More information regarding universal precautions can be obtained by contacting the National Center for Disease Control.

(2) An exception to the time guideline may result in receiving more or less time based on the recipient's need for each supportive service and the amount of time needed to complete the task.

(3) Exceptions to the hourly task guidelines identified in this section shall be made when necessary to enable the recipient to establish and maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing and shall be considered a normal part of the authorization process.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(4) No exception shall result in the recipient's hours exceeding the maximum limits of 195 hours per month as specified at Section 30-765.121 for nonseverely impaired cases or 283 hours per month for severely impaired cases as specified in Section 30-765.111. No exception shall result in the recipient's hours exceeding the maximum limit for PCSP cases as specified at Section 30-780.2(b).

(5) No exceptions to hourly task guidelines shall be made due to inefficiency or incompetence of the provider.

(6) When an exception to an hourly task guideline is made in a recipient's case, the reason for the exception shall be documented in the case file.

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(A) Documentation of the reason for the exception will provide necessary data to audit the effectiveness of each guideline in terms of:
1. Achieving equity in service authorizations; and
2. Evaluating program costs.

(B) In documenting an exception, the county worker can record the circumstances requiring more or less time than the range recommends. Examples of written documentation may include:

1. Writing a few words, phrases, or sentences (e.g., more time needed due to frequent urination, etc.); or

2. Citing the regulation that identifies the exception reason when the reason is listed as one of the exception criteria provided in regulation for that particular service (e.g., under "bowel and bladder" care, frequent urination per Section 30-757.14(a)(4)(A)).

(C) The worker's supervisor should review the documentation of the worker in accordance with current county procedures and current program regulations. The purpose of supervisory case review is to assure that service hours authorized by workers accurately reflect the individual's care needs and that these needs have been appropriately documented in the case file by the worker.

(D) Consistent with current practice, if the supervisor determines that the worker's documentation is not sufficient, the supervisor should discuss the case with the worker and identify any additional items needed to see if the worker can substantiate the exception prior to the supervisor making any changes.

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30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES (Continued) 30-757

.11 Domestic services which are limited to the following:

(a) Sweeping, vacuuming, washing and waxing of floor surfaces.

(b) Washing kitchen counters and sinks.

(c) Cleaning the bathroom.

(d) Storing food and supplies.

(e) Taking out garbage.

(f) Dusting and picking up.

(g) Cleaning oven and stove.

(h) Cleaning and defrosting refrigerator.

(i) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(j) Changing bed linen.

(k) Miscellaneous domestic services (e.g., changing light bulbs, wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the caseworker as necessary for the recipient to remain safely in his/her home.

(1) The time guideline for "domestic services" shall not exceed 6.0 hours total per month per household unless the recipient's needs require an exception.

.12 Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

.121 The county shall have the authority to authorize this service only at the time IHSS is initially granted, to enable the provider to perform continuous maintenance; or if a lapse in eligibility occurs, eligibility is reestablished, and IHSS has not been provided within the previous 12 months. The county shall also have the authority to authorize this service should the recipient's living conditions result in a threat to his/her safety and such service may be authorized where a recipient is at risk of eviction for failure to prepare his/her home or abode for fumigation as required by statute or ordinance. The caseworker shall document the circumstances, justifying any such allowance.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.13 Related services which are limited to the following:

.131 Preparation of meals, which includes planning menus; removing food from the refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating the stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.

(a) The time guidelines range for " preparation of meals" shall be as follows unless the recipient's needs require an exception:

Preparation of Meals Hours per Week Time Guidelines		
	Low	High
Rank 2	3.02	7.00
Rank 3	3.50	7.00
Rank 4	5.25	7.00
Rank 5	7.00	7.00

Note: Rank represents the recipient's level of functioning (functional index as provided in Section 30-756.1.

(b) Factors for the consideration of time include, but are not limited to:

(1) The extent to which the recipient can assist or perform tasks safely.

(2) The types of food the recipient usually eats for breakfast, lunch, dinner, and snacks and the amount of time needed to prepare the food (e.g., more cooked meals versus meals that do not require cooking).

(3) Whether the recipient is able to reheat meals prepared in advance and the types of food the recipient eats on days the provider does not work.

(4) The frequency the recipient eats.

(5) Time for universal precautions, as appropriate.

(c) Exception criteria to the time guideline range include, but are not limited to:

(1) If the recipient must have meals pureed or cut into bite-sized pieces.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(2) If the recipient has special dietary requirements that require longer preparation times or preparation of more frequent meals.

(3) If the recipient eats meals that require less preparation time (e.g., toast and coffee for breakfast).

.132 Meal clean-up, which includes loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances, and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.

(a) Meal clean up does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under "domestic services" in Section 30-757.11.

(b) The time guideline range for "meal cleanup" shall be as follows unless the recipient's needs require an exception:

Meal Cleanup Hours per Week Time Guideline		
	Low	High
Rank 2	1.17	3.50
Rank 3	1.75	3.50
Rank 4	1.75	3.50
Rank 5	2.33	3.50

(c) Factors for consideration of time include, but are not limited to:

(1) The extent to which the recipient can assist or perform tasks safely.

(A) A recipient with a Rank 3 in "meal cleanup" who has been determined able to wash breakfast/lunch dishes and utensils and only needs the provider to cleanup after dinner would require time based on the provider performing cleanup of the dinner meal only.

(B) A recipient who has less control of utensils and/or spills food frequently may require more time for cleanup.

(2) The types of meals requiring the cleanup.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

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(A) A recipient who chooses to eat eggs and bacon for breakfast would require more time for cleanup than a recipient who chooses to eat toast and coffee.

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(3) If the recipient can rinse the dishes and leave them in the sink until the provider can wash them.

(4) The frequency that meal cleanup is necessary.

(5) If there is a dishwasher appliance available.

(6) Time for universal precautions, as appropriate.

(d) Exceptions criteria to the time guideline range may include, but are not limited to:

(1) If the recipient must eat frequent meals which require additional time for cleanup.

(2) If the recipient eats light meals that require less time for cleanup.

.133 Restaurant meal allowance.

(a) An aged or disabled client who has adequate cooking facilities at home but whose disabilities prevent their use shall be advised of his/her option to receive a restaurant meal allowance in lieu of the services specified in .131 through .133, above, and shopping for food which the recipient would otherwise receive.

(1) The amount of the restaurant meal allowance shall be that specified in Welfare and Institutions Code Section 12303.7 or as otherwise provided by law.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(A) IHSS restaurant meal allowances established in accordance with Welfare and Institutions Code Section 12303.7 shall be as follows:

Allowance for an Individual	Allowance for a Couple
$62.00 per month	$124.00 per month

(2) A recipient who receives a restaurant meal allowance as part of his/her SSP grant shall not receive a restaurant meal allowance from IHSS.

(3) An aged or disabled recipient who is an SSP recipient, who requests a restaurant meal allowance, and who does not have adequate cooking facilities at home shall be referred to SSP.

.134 Laundry services which includes the tasks of washing and drying laundry, mending, ironing, folding, and storing clothes on shelves or in drawers.

(a) Laundry facilities are considered available in the home if, at a minimum, there exists a washing machine and a capability to dry clothes on the premises.

(b) The need for out-of-home laundry services exists when laundry facilities are not available on the premises and it is therefore necessary to go outside the premises to accomplish this service. Included in out-of-home laundry is the time needed to travel to/from a locally available laundromat or other laundry facility.

(c) The time guideline for laundry service where laundry facilities are available in the home shall not exceed 1.0 hours total per week per household unless the recipient's need requires an exception to exceed this limit.

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(1) In assessing time for in-home laundry services, it is expected that the provider will accomplish other tasks while clothes are washing and drying.

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(d) The time guideline for laundry services where laundry facilities are not available in the home shall not exceed 1.5 hours total per week per household unless the recipient's need requires an exception to exceed this limit.

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(Continued)

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(1) It is expected that the typical provider will use a local laundromat as necessary for efficient time utilization.

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(e) An exception to grant more time than the time guidelines specified in Sections 30-757.134(c) and (d) may be necessary for recipients who have incontinence.

.135 Food shopping which includes reasonable food shopping and other shopping/errands limited to the nearest available stores or other facilities consistent with the recipient's economy and needs.

(a) The county shall not authorize additional time for the recipient to accompany the provider.

(b) Food shopping includes the tasks of making a grocery list, travel to/from the store, shopping, loading, unloading, and storing food.

(1) The time guideline for " food shopping" shall not exceed 1.0 hour total per week per household unless the recipient's need requires an exception to exceed this limit.

(c) Other shopping/errands includes the tasks of making a shopping list, travel to/from the store, shopping, loading, unloading, and storing supplies purchased, and/or performing reasonable errands such as delivering a delinquent payment to avert an imminent utility shut-off or picking up a prescription, etc.

(1) The time guideline for "other shopping/errands" shall not exceed 0.5 hour total per week per household unless the recipient's need requires an exception to exceed this limit.

.14 Personal care services, limited to:

(a) "Bowel and bladder" care, which includes assistance with using, emptying, and cleaning bed pans/bedside commodes, urinals, ostomy, enema and/or catheter receptacles;, application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable rubber gloves; wiping and cleaning recipient; assistance with getting on/off commode or toilet; and washing/drying recipient's and providers hands.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(1) "Bowel and bladder" care does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed as "paramedical services" specified at Section 30-757.19.

(2) The time guideline range for "bowel and bladder" care shall be as follows unless the recipient's needs require an exception:

Bowel and Bladder Care Hours per Week Time Guideline		
	Low	High
Rank 2	0.58	2.00
Rank 3	1.17	3.33
Rank 4	2.91	5.83
Rank 5	4.08	8.00

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The frequency of the recipient's urination and/or bowel movements.

(C) If there are assistive devices available which result in decreased or increased need for assistance.

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1. Situation where elevated toilet seats and/or Hoyer lifts are available may result in less time needed for "bowel and bladder" care if the use of these devices results in a decreased need for assistance by the recipient.

2. Situations where a bathroom door is not wide enough to allow for easy wheelchair access may result in more time needed if its use results in an increased need.

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30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(D) Time for universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has frequent urination or bowel movements.

(B) If the recipient has frequent bowel or bladder accidents.

(C) If the recipient has occasional bowel or bladder accidents that require assistance from another person.

(D) If the recipient's morbid obesity requires more time.

(E) If the recipient has spasticity or locked limbs.

(F) If the recipient is combative.

(b) Respiration limited to nonmedical services such as assistance with self-administration of oxygen and cleaning IPPB machines.

(c) "Feeding," which includes assistance with consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids.

(1) "Feeding" tasks include assistance with reaching for, picking up, and grasping utensils and cup; cleaning recipient's face and hands; and washing/drying hands; and washing/drying hands before and after feeding.

(2) "Feeding" tasks do not include cutting food into bite-sized pieces or pureeing food, as these tasks are assessed in "preparation of meals" services specified at Section 30-757.131.

(3) The time guideline range for "feeding" shall be as follows unless the reciepient's needs require an exception:

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

Feeding Hours per Week Time Guideline		
	Low	High
Rank 2	0.70	2.30
Rank 3	1.17	3.50
Rank 4	3.50	7.00
Rank 5	5.25	9.33

(4) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The amount of time it takes the recipient to eat meals.

(C) The type of food that will be consumed.

(D) The frequency of meals/liquids.

(E) Time for universal precautions, as appropriate.

(5) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the constant presence of the provider is required due to the danger of choking or other medical issues.

(B) If the recipient is mentally impaired and only requires prompting for feeding him/herself.

(C) If the recipient requires frequent meals.

(D) If the recipient prefers to eat foods that he/she can manage without assistance.

(E) If the recipient must eat in bed.

(F) If food must be placed in the recipient's mouth in a special way due to difficulty swallowing or other reasons.

(G) If the recipient is combative.

(d) Routine bed baths, which includes cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder and deodorant; and washing/drying hands before and after bathing.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(1) The time guideline range for "bed baths" shall be as follows unless the recipient's needs require an exception:

Bed Baths Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.75
Rank 3	1.00	2.33
Rank 4	1.17	3.50
Rank 5	1.75	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient is prevented from bathing in the tub/shower.

(C) If bed baths are needed in addition to baths in the tub/shower.

(D) Time for universal precautions, as appropriate.

(3) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient is confined to bed and sweats profusely requiring frequent bed baths.

(B) If the weight of the recipient requires more or less time.

(C) If the recipient is combative.

(e) Bathing, oral hygiene and grooming:

(1) Bathing includes cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying and applying lotion, powder, deodorant; and washing/drying hands.

(2) Oral hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

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(Continued)

(3) Grooming includes hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care when these services are not assessed as "paramedical" services for the recipient; and washing/drying hands.

(4) "Bathing, oral hygiene, and grooming," does not include getting to/from the bathroom. These tasks are assessed as mobility under "ambulation" services specified at Section 30-757.14(k).

(5) The time guideline range for "bathing, oral hygiene, and grooming," shall be as follows unless the recipient's needs require an exception:

Bathing, Oral Hygiene, and Grooming Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

(6) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The number of times the recipient may need to bathe.

(C) If the recipient requires assistance in/out of tub/shower.

(D) If the recipient needs assistance with supplies.

(E) If the recipient requires assistance washing his/her body.

(F) If the provider must be present while the recipient bathes.

(G) If the recipient requires assistance drying his/her body and/or putting on lotion/powder after bathing.

(H) If the recipient showers in a wheelchair.

(I) Universal precautions, as appropriate.

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(Continued)

(7) Exceptions to the time guideline range may include, but are not limited to:

(A) If the provider's constant presence is required.

(B) If the weight of the recipient requires more or less time.

(C) If the recipient has spasticity or locked limbs.

(D) If a roll-in shower is available.

(E) If the recipient is combative.

(f) Dressing, which includes washing/drying of hands; putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

(1) The time guideline range for "dressing" shall be as follows unless the recipient's needs require an exception.

Dressing Hours per Week Time Guideline		
	Low	High
Rank 2	0.56	1.20
Rank 3	1.00	1.86
Rank 4	1.50	2.33
Rank 5	1.90	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The type of clothing/garments the recipient wears.

(C) If the recipient prefers other types of clothing/garments.

(D) The weather conditions.

(E) Universal precautions, as appropriate.

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(Continued)

(3) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient frequently leaves his/her home, requiring additional dressing/undressing.

(B) If the recipient frequently bathes and requires additional dressing or soils clothing, requiring frequent changes of clothing.

(C) If the recipient has spasticity or locked limbs.

(D) If the recipient is immobile.

(E) If the recipient is combative.

(g) Repositioning and rubbing skin, which includes rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and range of motion exercises which shall be limited to the following:

(1) General supervision of exercises which have been taught to the recipient by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse or disease.

(2) Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent with the patient's capacity and tolerance.

(A) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(3) "Repositioning and rubbing skin" does not include:

(A) Care of pressure sores (skin and wound care). This task is assessed as a part of "paramedical" services specified at Section 30-757.19.

(B) Ultraviolet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to the skin. These tasks are assessed as part of "assistance with prosthetic devices" at Section 30-757.14(i).

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(Continued)

(4) The time guideline range for "repositioning and rubbing skin" shall be as follows unless the recipient's needs require an exception:

Repositioning and Rubbing Skin Hours per Week Time Guideline		
	Low	High
* Functional ranking does not apply	0.75	2.80

(5) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient's movement is limited while in the seating position and/or in bed, and the amount of time the recipient spends in the seating position and/or in bed.

(C) If the recipient has circulatory problems.

(D) Universal precautions, as appropriate.

(6) Exceptions criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has a condition that makes him/her confined to the bed.

(B) If the recipient has spasticity or locked limbs.

(C) If the recipient has or is at risk of having decubitus ulcers which require the need to turn the recipient frequently.

(D) If the recipient is combative.

(h) "Transfer," which includes assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

(1) "Transfer" does not include:

(A) Assistance on/off toilet. This task is assessed as part of "bowel and bladder" care specified at Section 30-757.14(a).

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(Continued)

(B) Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as part of "repositioning and rubbing skin" specified at Section 30-757.14(g).

(2) The time guideline range for "transfer" shall be as follows unless the recipient's needs require an exception:

Transfer Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The amount of assistance required.

(C) The availability of equipment, such as a Hoyer lift.
(D) Universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient gets in and out of bed frequently during the day or night due to naps or use of the bathroom.

(B) If the weight of the recipient and/or condition of his/her bones requires more careful, slow transfers.

(C) If the recipient has spasticity or locked limbs.

(D) If the recipient is combative.

(i) Care of and assistance with prosthetic devices and assistance with self-administration of medications, which includes assistance with taking off/putting on and maintaining and cleaning prosthetic devices, vision/hearing aids and washing/drying hands before and after performing these tasks.

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(Continued)

(1) Assistance with self-administration of medications consists of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(2) The time guideline range for "care and assistance with prosthetic devices" shall be as follows unless the recipient's needs require an exception:

Care and Assistance with Prosthetic Devices Hours per Week Time Guideline		
	Low	High
*Functional ranking does not apply	0.47	1.12

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient is able to manage medications and/or prosthesis independently and safely.

(B) The amount of medications prescribed for the recipient.

(C) If the recipient requires special preparation to distribute medications (e.g., cutting tablets, putting medications into Medi-sets, etc.).

(D) If the recipient has cognitive difficulties that contribute to the need for assistance with medictions and/or prosthetic devices.

(E) Universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient takes medications several times a day.

(B) If the pharmacy sets up medications in bubble wraps or Medi-sets for the recipient.

(C) If the recipient has multiple prosthetic devices.

(D) If the recipient is combative.

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(Continued)

(j) Routine menstrual care which is limited to external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping and cleaning, and washing/drying hands before and after performing these tasks.

HANDBOOK BEGINS HERE

(1) In assessing "menstrual" care, it may be necessary to assess additional time in other service categories specified in this section, such as "laundry," "dressing," "domestic," "bathing, oral hygiene, and grooming."

(2) In assessing "menstrual" care, if the recipient wears diapers, time for menstrual care should not be necessary. This time would be assessed as a part of "bowel and bladder" care.

HANDBOOK ENDS HERE

(3) The time guideline range for "menstrual care" shall be as follows unless the recipient's needs require an exception:

Menstrual Care Hours per Week Time Guideline		
	Low	High
*Functional rank does not apply	0.28	0.80

(4) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient has a menstrual cycle.

(C) The duration of the recipient's menstrual cycle.

(D) If there are medical issues that necessitate additional time.

(E) Universal precautions, as appropriate.

(5) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has spasticity or locked limbs.

(B) If the recipient is combative.

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(k) Ambulation, which includes assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc. and washing/drying hands before and after performing these tasks. "Ambulation" also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel.

(1) The time guideline range for "ambulation" shall be as follows unless the recipient's needs require an exception:

Ambulation Hours per Week Time Guideline		
	Low	High
Rank 2	0.58	1.75
Rank 3	1.00	2.10
Rank 4	1.75	3.50
Rank 5	1.75	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The distance the recipient must move inside the home.

(C) The speed of the recipient's ambulation.

(D) Any barriers that impede the recipient's ambulation.

(E) Universal precautions, as appropriate.

(3) Exceptions to the time guideline range may include, but are not limited to:

(A) If the recipient's home is large or small.

(B) If the recipient requires frequent help getting to/from the bathroom.

(C) If the recipient has a mobility device, such as a wheelchair that results in a decreased need.

(D) If the recipient has spasticity or locked limbs.

(E) If the recipient is combative.

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(Continued)

.15 Assistance by the provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel, limited to:

.151 Transportation to and from appointments with physicians, dentists and other health practitioners.

.152 Transportation necessary for fitting health related appliances/devices and special clothing.

.153 Transportation under .151 and .152 above shall be authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

.154 Transportation to the site where alternative resources provide in-home supportive services to the recipient in lieu of IHSS.

.16 Yard hazard abatement is light work in the yard which may be authorized for:

.161 Removal of high grass or weeds, and rubbish when this constitutes a fire hazard.

.162 Removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

.163 Such services are limited by Sections 30.763.235(b) and .24.

.17 Protective Supervision consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.