WELCOME TO THE
IHSS TRAINING ACADEMY

CORE: ASSESSMENT AND AUTHORIZATION

On behalf of the California Department of Social Services (CDSS), we are pleased to offer ***Core: Assessment and Authorization***. This two-day training has been designed to promote consistent assessment and assignment of functional levels and of authorization for needed IHSS services.

Topics will include:

- Uniformity and Functional Index Scales
- Annotated Assessment Criteria
- Gathering Information from Consumers
- Assessment Challenges
- Documentation
- Authorizing Services
- Hourly Task Guidelines
- Determining Exceptions and Documenting
- Variable Assessment Intervals
- Universal Precautions
- Medi-Cal Information, Supplies, and DME
- Cultural Resources

Objectives

At the end of the program, the participants will be able to:

- Identify successful techniques in interviewing and communicating with consumers, families, and providers in difficult situations.
- Identify best practices in dealing with challenging cases.
- Understand the importance of documentation in creating a clear picture of a consumer's needs and in substantiation of the authorization process.
- Demonstrate understanding of the authorization process using the Hourly Task Guidelines.
- Demonstrate the ability to think critically, authorizing appropriate amounts of services.
- Document the basis of service need and authorization.
- Document HTG exceptions when appropriate.
- Explain the importance of differentiation between consumer needs and preferences when authorizing services.

IHSS TRAINING ACADEMY
CORE: ASSESSMENT AND AUTHORIZATION

TABLE OF CONTENTS

IHSS TRAINING ACADEMY
CORE: ASSESSMENT AND AUTHORIZATION

TABLE OF CONTENTS (Continued)

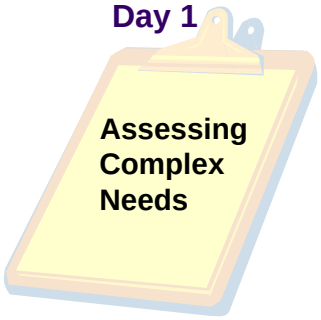
Tab

Welcome to the In-Home Supportive Services Training Academy

A partnership between…

- California Department of Social Services
- California Welfare Directors' Association
- California State University, Sacramento
  - College of Continuing Education
  - Institute for Social Research

Assessment and Authorization: Day 1

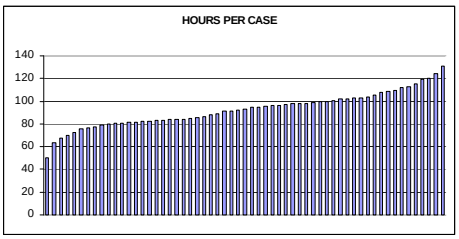


Assessing Complex Needs

Why IHSS Training?

- Need for consistency in authorization practices
- Increasing complexities of IHSS with three programs – PCSP, Waiver and IHSS Residual
- Need for standardized training for staff performing assessments
- Legislative mandate SB 1104

Variance in Statewide Authorization of Hours



The monthly average statewide is approx. 85 hrs. State data, 7/05.

SB 1104 – Quality Assurance

- Statewide social worker training to improve and standardize assessment process.
- Develop hourly task guidelines.
- Workgroup currently addressing regulations through revision process and creating emergency regulations.
- Enhance state and local fraud and data evaluation activities.
- Establishment of dedicated QA function at county level with state monitoring.

Prerequisites for Uniformity

- Consumer's needs are evaluated the same way.
- Workers all over the state apply the same standards when assessing function.
- The rankings of the scales are applied the same.

Outcomes

- When consumers with similar needs receive similar services, ***all consumers have an equal opportunity to experience independence and safety.***
- Assessment standards ***promote consistency and fairness*** – across the state and within counties.

Functional Index Scale
[MPP 30-756]

1. **Independent**
2. **Verbal Assistance**
3. **Some Human Help Needed**
4. **Lots of Human Help Needed**
5. **Cannot Perform**

Functional Index Scales Include

- Housework
- Laundry
- Shopping and Errands
- Meal Preparation/ Cleanup
- Ambulation
- Bathing, Oral Hygiene, and Grooming/ Routine Bed Bath
- Dressing/Prosthetic Devices
- Bowel, Bladder, and Menstrual Care
- Transfer
- Eating
- Respiration
- Memory
- Orientation
- Judgment

Clarification: FI Rank 2

- Service authorization decisions differ.
- For all other ranks, consumers should have a "Total Need" in the associated task.
- For FI 2, need may take an inconsequential amount of service ***or*** take an extreme amount of time.

Clarification: FI Rank 2

If Consumer

- needs simple reminding
- is compliant
- reminding can be given while the provider is completing other tasks

Then

- no time would be authorized.

Clarification: FI Rank 2

If Consumer

- prompting takes the undivided attention of the provider

Then

- time should be authorized.

Note: When continual prompting is no longer effective, then a reassessment to a higher FI Rank may be necessary.

Clarification: FI Rank 2

- If no time is authorized for a rank of 2:
  - Even though 0 hours is below the HTG ranges, there is no reason to document an exception.
- If time is authorized for a rank of 2:
  - The HTG ranges are the basis for documenting exceptions.

Gathering Information from Consumers





Performance Based Assessment

Observe consumer for assessment data related to:

- Safety
- Independence
- Abilities
- Performance in key functional areas

Interview Success in a Complex Assessment

- Avoiding Bias –
  - Don't express your own opinions – consumers will change their answers to make you happy.
  - Don't suggest answers if consumer wants your help – repeat the question, pause and let them take a moment.
  - Avoid leading probes that might suggest an answer.

From "Doing the Interview: how to really ask those questions and enjoy it"

Interview Success in a Complex Assessment

- Use Probes for Clarity and Completeness
  - "*You said…. What do you mean by that?"*
  - *"I'm not sure I understand. Could you give me more information?"*
  - *"Could you explain, tell me more about that?"*

From "Doing the Interview: how to really ask those questions and enjoy it"

Interview Success in a Complex Assessment

- Tread Carefully – but don't avoid embarrassing subjects
  - Build rapport at beginning of interview.
  - Reassure consumer you are not embarrassed.
  - Ask questions straight-forwardly and without hesitation.
  - Explain these are questions you ask everyone.

From "Doing the Interview: how to really ask those questions and enjoy it"

Other Assessment Cues

Verbal

- Tone/inflection of voice
- Discrepancies between what consumers say and what they do

Environmental Observations

- Discrepancies between the way the environment looks and what consumer reports as service needs

Sensory Cues

- Smell
- Tactile information – sticky floors, surfaces

Your Body Speaks Your Mind

Between 60-80% of our message is communicated through our Body Language, only 7-10% is attributable to the actual words of a conversation.

Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

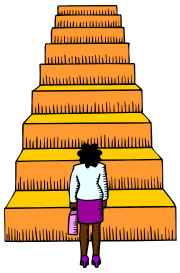
Other Resources for Assessment Information

- Family Members
- Providers
- Informal Support System
- MSSP, Linkages
- Day Programs
- Medical Verification
- Regional Centers
- Senior Centers
- Senior Apartment
  - Staff
- Other Sources

Key Points to Remember

- Habits may differ from actual ***abilities.***
- Focus on ***functioning***, rather than on a medical diagnosis.
- Assistive devices often promote ***independence*** – don't necessarily indicate additional impairment.
- Authorization of services is based on the consumer's ***individual level of need***.
- Assessment should focus on ***needs versus wants*** of the consumer.

Assessment Challenges



Assistive Devices
Durable Medical Equipment (DME)

- Importance of DME:
  - Promotes the consumer's independence.
  - Improves quality of life and satisfaction.
  - Can greatly affect the consumer's functional ability.
- Assess the consumer's use of and possible need for DME.
- Must have medical prescription for payment of DME.
- Document DME and how it affects the consumer's independence when assigning functional scores and authorizing services.

H Line Exercise: Consumer with Assistive Devices

- Using the scenario provided, determine the H Line for the areas identified:
  - Domestic
  - Meal Preparation and Clean-up
  - Bathing and Grooming
  - Dressing
- Record your answers and report out

Assessment Challenges

1. Providers or family that want to speak for the consumer.
2. Consumers who understate their need.
3. Consumers who overstate their need.

Assessment Challenges

- Angry consumers
- Hostile consumers
- Emotionally distraught consumers

Assessment Challenges

- People dealing with grief/loss issues
- Consumers dealing with impact of chronic illness

H Line Exercise

- Using the scenario provided, determine the H Line for the areas identified:

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

  Alice
  - Domestic
  - Meal Preparation
  - Ambulation
  - Bathing and Grooming

- Record your answers and report out

Assessment Challenges

- Hearing impairments
- Visual impairments
- Cultural issues

Alzheimer's

- The most common form of dementia
- Three stages – early, middle and late
- Progressive nature is variable

Importance of Good Documentation

Good Documentation

- Provides historical record.
- Provides continuity for case transfers.
- Substantiates authorization at state hearings.
- Shows adherence to laws, regulations and policies.
- Aids in the investigation of potential fraud.

Create a Clear Picture of the Situation

- Avoid documenting unnecessary information.
- Record the facts and avoid judging statements.
- Keep to the point and purpose of the visit.
- The files are open – all information may be read by the consumer.
- Do not document mental illness diagnosis unless it has been confirmed.

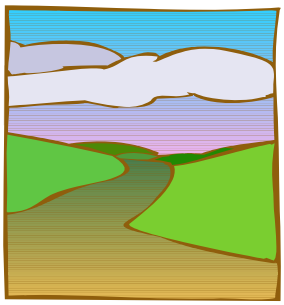
Exercise

Assessing Needs

Emily

Exercise: Assessing Needs

- Read scenario – share roles
- Complete SOC 293 H Line *ONLY*
- Put H Line FI scores on flipchart for report out
- Be prepared to discuss the assessment data you have to support FI scores identified



End of Day 1

Thanks for your participation!

ATTACHMENT B

ANNOTATED ASSESSMENT CRITERIA

Annotated Assessment Criteria is designed to assist you in the application of rankings specified in Manual of Policies and Procedures (MPP) Section 30-756 which are applied to evaluate a recipient's capacity to perform certain In-Home Supportive Services (IHSS) tasks safely. The Annotated Assessment Criteria describes each functional rank in more detail as it applies to an individual's capacity to perform certain types of tasks specified in MPP Section 30-757, and it provides sample observations you might make for each ranking, characteristics of a recipient who might be ranked at each level, and questions which might elicit the information needed to determine the appropriate rank. These samples are lists of possible indicators, not definitive standards.

General

Following are general questions that may be asked of applicants to help determine whether need exists:

- How frequently have you been seen by a doctor?
- Has the doctor limited your activities?
- When does your family come to see you and how do they feel about your condition?
- What can family/friends/neighbors do to help you?
- Who has been helping you up to this point?
- Why are you asking for help now?
- How have circumstances changed?
- How long have you been having difficulty?
- What is limiting your activities?
- How do you feel about the status of your health?
- How long do you think you will need this service?
- How would you manage if your provider called in sick one day?

Information to be given and reinforced periodically:

- A clear explanation of the recipient's responsibilities in the county's delivery system.
- IHSS is a program which provides only those services necessary for the recipient's safety which the recipient is unable to perform.

Observations

A number of observations are applicable to all functions. These involve observing the recipient getting up from a chair, ambulating, standing, reaching, grasping, bending, and carrying; and observing the recipient's endurance and mental activity. In the following text, the first eight observable behaviors above are referred to as "movement." All of these functions can usually be

observed by noting how the recipient admitted you into the housing unit and shaking his/her hand when arriving; asking the recipient to show you the housing unit; asking the recipient to show you all his/her medications; asking him/her to get his/her Medi-Cal card for you; and asking him/her to sign the application. If the above-listed functions have not been adequately demonstrated in the course of the interview, it is sometimes helpful to ask the recipient for a glass of water. Since the ranking of functioning is hierarchical, observations and questions in a lower rank are likely to apply to a higher one. Observations lead to a general assumption as to the appropriate level of functioning, and follow-up questions elicit information as to what assistance is necessary for the level of functioning observed. This listing is not all-inclusive, nor does the presence of one behavior on the list necessarily create the basis for the ranking. All your senses are involved in gaining cues to determine the recipient's functioning as a whole. Quite often, it is important to get a medical report to verify that there is a basis for observed behaviors.

General

The following are general regulatory standards that apply to all functions. The standards for each function are defined in more detail in individual scales that follow.

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/her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

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

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

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

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

Rank 6: Paramedical Services needed.

Variable Functioning

If the recipient's functioning varies throughout the month, the functional rank should reflect the functioning on reoccurring bad days. It is not solely based on a "worst" day scenario (e.g., a recipient who suffers from arthritis will have days when pain is significant and days when pain is mild; therefore, in this case you would rank a recipient based on the reoccurring days where the frequency of pain is significant).

ATTACHMENT B

DEFINITION OF SERVICES LISTED ON THE SOC 293 "H" LINE

Domestic Services

Sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs; and wheelchair cleaning and changing/recharging wheelchair batteries.

The following is the application of functional rank specific to Domestic services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all domestic chores without a risk to health or safety. Recipient is able to do all chores though s/he might have to do a few things every day so that s/he doesn't overexert her/himself.

- **Observations:** Observe if the home is neat and tidy. Observe if the recipient's movement is unimpaired.
- **Example:** Recipient with no signs of impairment moves easily about a neat room, bending to pick up items and reaching to take items from shelves.
- **Question:** Are you able to do all the household chores yourself, including taking out the garbage?

Rank 2: Able to perform tasks but needs direction or encouragement from another person. Recipient is able to perform chores if someone makes him/her a list or reminds him/her.

- **Observations**: Observe if the recipient seems confused or forgetful and has no observable physical impairment severe enough to seem to limit his/her ability to do housework; if there is incongruity in what you observe, such as dirty dishes in cupboard.
- **Example:** Young man apparently physically healthy, but obviously confused and forgetful, is being reminded that it is time for him to sweep and vacuum.
- **Questions**: How do you manage to keep your apartment clean? Has anyone been helping you up to this time?

Rank 3: Requires physical assistance from another person for some chores (e.g., has a limited endurance or limitations in bending, stooping, reaching, etc.).

- **Observations:** Observe if the recipient has some movement problems as described above; has limited endurance; is easily fatigued; or has severely limited eyesight. Observe if the home is generally tidy, but needs a good cleaning; if it is apparent that the recipient has made attempts to clean it, but was unable to.
- **Example:** Small frail woman answers apartment door. Apartment has some debris scattered on carpet and quite-full trashcan is sitting in kitchen area. The remainder of apartment is neat.

- **Questions:** Have you been doing the housework yourself? What have you been doing about getting your housework done up until now?

Rank 4: Although able to perform a few chores (e.g., dust furniture or wipe counters) help from another person is needed for most chores.

- **Observations:** Observe if the recipient has limited strength and impaired range of motion. Observe if the house needs heavy cleaning.
- **Example:** Recipient walking with a cane is breathing heavily in cluttered living room. The bathtub and toilet are in need of cleansing. The recipient's activities are limited because of shortness of breath and dizziness.
- **Questions:** What household tasks are you able to perform? Has your doctor limited your activities?

Rank 5: Totally dependent upon others for all domestic chores.

- **Observations:** Observe if dust/debris is apparent; if there is garbage can odor; if the bathroom needs scouring; if household chores have obviously been unattended for some time. Observe if the recipient has obvious limited mobility or mental capacity.
- **Examples:** Bed-bound recipient is able to respond to questions and has no movement in arms or legs. Frail elderly man is recovering from heart surgery and forbidden by doctor to perform any household chores.
- **Questions:** Are there any household tasks you are able to perform? What is limiting your activities? Who has been helping you to this point?

Laundry

Gaining access to machines, sorting laundry, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and sorting laundry, mending and ironing. (Note: Ranks 2 and 3 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Laundry services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all chores.

- **Observations:** Observe if the recipient's movement seems unimpaired; if s/he seems able to ambulate, grasp, bend, lift, and stand adequately; if s/he is wearing clean clothes.
- **Example:** Recipient is apparently physically fit. The recipient's movements during interview indicate that s/he has no difficulty with reaching, bending, or lifting.
- **Questions:** Are you able to wash and dry your own clothes? Are you also able to fold and put them away?

Rank 4: Requires assistance with most tasks. May be able to do some laundry tasks (e.g., hand wash underwear, fold and/or store clothing by self or under supervision).

- **Observations:** Observe if the recipient has some impairment in movement, is nodding, displays forgetfulness, or has severely limited eyesight; if the recipient's clothing is stained or spotted.
- **Example:** Frail woman is unable to transfer wet wash to the dryer, particularly, sheets and towels. Housemate encourages her to help with sorting and folding, etc.
- **Questions:** Are you able to lift and transfer wet articles in the laundry? How have you handled this laundry up to now? Who has been doing your laundry for you up to this time? Has the doctor suggested that you do some simple tasks with your arms and hands?

Rank 5: Cannot perform any task, is totally dependent on assistance from another person.

- **Observations:** Observe if there are severe restrictions of movement**.**
- **Example:** Quadriplegic recipient is seated in wheelchair, obviously unable to perform laundry activities**.**
- **Questions:** Who does your laundry now? What has changed in your circumstances that resulted in your asking for help now?

Shopping and Errands

Compiling list; bending, reaching, lifting, and managing cart or basket; identifying items needed; transferring items to home and putting items away; telephoning in and picking up prescriptions; and buying clothing. (Note: Ranks 2 and 4 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Shopping and Errands with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can perform all tasks without assistance.

- **Observations:** Observe if movement seems unimpaired and the recipient seems oriented**.**
- **Example:** Social worker questions elderly man whose responses indicate that he is able to do his own shopping and can put groceries and other items away**.** Although his movements are a little slow, it is evident that he is capable of performing this task.
- **Question:** How do you take care of your shopping and errands?

Rank 3: Requires the assistance of another person for some tasks (e.g., recipient needs help with major shopping needed but can go to nearby store for small items, or the recipient needs direction or guidance).

- **Observations:** Observe if the recipient's movement is somewhat impaired; if the recipient has poor endurance or is unable to lift heavy items; if s/he seems easily confused or has severely limited eyesight; if there is limited food on hand in refrigerator and cupboard.
- **Example:** Recipient goes to corner market daily to get a few small items. Someone else makes a shopping list.

- **Questions:** Do you have difficultly shopping? What are the heaviest items you are able to lift? Do you usually buy the items you planned to purchase? Do you have any difficulty remembering what you wanted to purchase or making decisions on what to buy? (Ask recipient's significant other whether the recipient has difficulty making decision on what to buy or if recipient's mental functioning seems impaired.)

Rank 5: Unable to perform any tasks for self.

- **Observations:** Observe if movement or mental functioning is severely limited.
- **Example:** Neighbors help when they can. Teenaged boy comes to recipient's door and receives money and list from recipient to purchase a few groceries.
- **Questions:** Has someone been shopping for you? How do you get your medications?

Meal Preparation/Meal Cleanup

Meal Preparation includes such tasks as planning menus; removing food from 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 stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.

Meal Cleanup 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.

Note: Meal Cleanup does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under Domestic services.

The following is the application of functional rank specific to Meal Preparation/Meal Cleanup with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can plan, prepare, serve, and cleanup meals.

- **Observations:** Observe if the recipient's movement seems unimpaired.
- **Example:** Recipient cooks and freezes leftovers for reheating.
- **Questions:** Are you able to cook your own meals and cleanup afterwards? Are you on a special diet? If yes, describe.

Rank 2: Needs only reminding or guidance in menu planning, meal preparation, and/or cleanup.

- **Observations:** Recipient seems forgetful. There is rotten food, no food in refrigerator, or a stockpile of Twinkies®, only. Recipient's clothes are too large, indicating probable weight loss. There are no signs of cooking.

- **Example:** Elderly recipient is unable to plan balanced meals, has trouble knowing what to eat so eats a lot of desserts and snacks, sends granddaughter to purchase fast foods. Recipient leaves dishes near the sofa where s/he eats; s/he reuses dirty dishes if not reminded to wash and dry them.
- **Question:** Are you able to prepare and cleanup your own meals?

Rank 3: Requires another person to prepare and cleanup main meal(s) on less than a daily basis (e.g., recipient can reheat food prepared by someone else, can prepare simple meals, and/or needs some help with cleanup but requires another person to prepare and cleanup with more complex meals which involve, peeling, cutting, etc., on less than a daily basis).

- **Observations:** Observe if the recipient's movement is impaired; if s/he has poor strength and endurance or severely limited eyesight; if s/he appears adequately nourished and hydrated.
- **Example:** Recipient can reheat meals, make a sandwich, and get snacks from the package. Recipient has arthritis that impairs her/his grasp; s/he is unable to wash dishes because s/he cannot hold on to dishes.
- **Questions:** What type of meals are you able to prepare for yourself? Can you lift casserole dishes and pans? Can you reheat meals that were prepared for you ahead of time? Are you able to wash dishes? Can you wipe the counter and stove?

Rank 4: Requires another person to prepare and cleanup main meal(s) on a daily basis.

- **Observations:** Recipient has movement and endurance problems and has very limited strength of grip.
- **Example:** Recipient is unable to stand for long periods of time. Recipient can get snacks from the refrigerator like fruit and cold drinks, can get cereal, or make toast for breakfast, etc.
- **Questions:** Can you stand long enough to operate your stove, wash, dry, and put away dishes and/or load/unload the dishwasher?

Rank 5: Totally dependent on another person to prepare and cleanup all meals.

- **Observations:** Observe if the recipient has severe movement problems or is totally disoriented and unsafe around the stove.
- **Example:** Recipient has schizophrenia. Recipient believes that when s/he gets wet the water has the power to enable people to read her/his mind. Provider cuts up food in bite-sized portions and carries tray to bed-bound recipient.
- **Questions:** Are you able to prepare anything to eat for yourself? Does your food and drink need to be handled in any special way? Can you wash dishes?

*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. (MPP 30-756.41)

ATTACHMENT B

Ambulation

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.

The following is the application of functional rank specific to Ambulation with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Requires no physical assistance though recipient may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety.

- **Observations:** Observe if the recipient is steady on feet, able to maneuver around furniture, etc. Observe if the recipient needs to grab furniture or walls for support. Have the recipient show you the home and observe ambulation.
- **Questions:** Do you ever have any difficulty moving around? Have you ever had to use a cane or walker? Do you feel safe walking alone in your home?

Rank 2: Can move independently with only reminding or encouragement (e.g., needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker).

- **Observations:** Observe if the recipient can use his/her walker or cane of his/her own volition; if recipient can rely appropriately on an appliance; if there is an assistive device visible in a corner rather than right beside the recipient when s/he is sitting; how well the recipient is able to move about with an assistive device; if there is any modifications observable in the home such as grab bars, etc.
- **Questions:** Do you ever have trouble handling your device? Are there times when you forget and get somewhere and need help getting back or do not wish to use your device? What happens then? Have you experienced any falls lately? Describe.

Rank 3: Requires physical assistance from another person for specific maneuvers (e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces).

- **Observations:** Observe if the recipient needs to ask you for assistance; if the recipient appears to be struggling with a maneuver that could put her/him at risk if unattended; if recipient appears strong enough to handle the device; if there are architectural barriers in the home.
- **Questions:** Are there times when you need to rely on someone else to help you get around the house? What kind of help do you need and when? What happens when there is no one to help you? Are there certain times of day or night when movement is more difficult for you? Are all areas of your home accessible to you?

Rank 4: Requires assistance from another person most of the time. Is at risk if unassisted.

- ∗ **Observations:** Observe if the recipient is able to answer the door; get back safely to his/her seat; if there is clutter on the floor, scattered rugs, or stairs; if there is obvious fatigue or labored breathing; if there are bruises, scabs, bumps, or burns (signs of falls) on the recipient.
- ∗ **Questions:** Is there someone in the home helping you now? If so, what is the level of assistance?

Rank 5: Totally dependent upon others for movement. Must be carried, lifted, or assisted into a wheelchair or gurney at all times.

- ∗ **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if s/he makes needs known.
- ∗ **Questions:** Who is available to help you when you need to be moved? Do you feel s/he is able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Bathing, Oral Hygiene, and Grooming/Routine Bed Bath

Bathing (Bath/Shower) 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.

Oral Hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

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

Note: Bathing, Oral Hygiene, and Grooming does not include getting to/from the bathroom. These tasks are assessed as mobility under Ambulation services.

Routine Bed Bath 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**.**

The following is the application of functional rank specific to Bathing, Oral Hygiene, and Grooming/Routine Bed Baths with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to bathe, brush teeth, and groom self safely without help from another person.

- ∗ **Observations:** Observe if the recipient's mobility is unimpaired; if the recipient is clean and well groomed; if there is assistive equipment in the bathroom.
- ∗ **Questions:** Do you ever require any assistance with Bathing, Oral Hygiene, or Grooming? Are you able to get in and out of the tub or shower safely? Have you ever fallen?

ATTACHMENT B

Rank 2: Able to bathe, brush teeth, and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

- **Observations:** Observe if the recipient has body odors, unwashed hair, dirt or grime on body, un-manicured fingernails; if the recipient is unshaven, displays a lack of oral hygiene or general poor grooming habits; if the recipient is unaware of his/her appearance.
- **Questions:** Are there times when you forget to bathe, brush your teeth, and groom yourself, or it seems just too much bother? Does anyone help you organize your bath or shower?

Rank 3: Generally able to bathe and groom self, but needs assistance with some areas of body care (e.g., getting in and out of shower or tub, shampooing hair, or brushing teeth).

- **Observations:** Observe if the recipient has weakness or pain in limbs or joints; difficulty raising arms over head, frailty, general weakness, unsteady gait indicating a safety risk; if the bathroom is not set up to meet the recipient's safety needs (e.g., grab bars, tub bench); if recipient's grooming indicates an unaddressed need.
- **Example:** Recipient has fear associated with lack of movement.
- **Questions:** Are there areas of bathing, oral hygiene, or grooming that you feel you need help with? What? When? How do you get into the shower or tub? Do you ever feel unsafe in the bathroom? Have you ever had an accident when bathing? What would you do if you did fall?

Rank 4: Requires direct assistance with most aspects of bathing, oral hygiene, and grooming. Would be at risk if left alone.

- **Observations:** Observe if the recipient requires assistance with transfer; has poor range of motion, weakness, poor balance, fatigue; skin problems (e.g., indications of a safety risk). Determine how accessible and modified the bathroom is to meet the recipient's needs.
- **Questions:** How much help do you need in taking a bath and washing your hair? If there were no one to help you, what would be left undone? Do you experience any loss of sensation to your body? Do you have any fears related to bathing? Have you fallen when getting into or out of the tub or shower? What would you do if you did fall?

Rank 5: Totally dependent on others for bathing, oral hygiene, and grooming.

- **Observations:** Observe if there is any voluntary movement and where; if the recipient exhibits good skin color, healthy, clean skin and hair; if bathing schedules/activities are appropriate for the recipient's specific disability/limitations.
- **Questions:** Are you satisfied with your bathing, oral hygiene, and grooming routines? Does anything frighten or scare you when you are bathed?

ATTACHMENT B

Dressing/Prosthetic Devices:

Dressing/Prosthetic Devices: Putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings, braces, and prosthetic devices; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

The following is the application of functional rank specific to Dressing/Prosthetic Devices with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to put on, fasten, and remove all clothing. Clothes self appropriately for health and safety.

- **Observations:** Observe if the recipient is appropriately dressed; if clothing is buttoned, zipped, laced; if the recipient has no difficulty with small hand movements as demonstrated by his/her ability to sign the application.
- **Questions:** Do you ever have any difficulty getting dressed (e.g., buttoning or zipping clothing, etc.).

Rank 2: Able to dress self; but requires reminding or direction.

- **Observations:** Observe the appropriateness of the recipient's dress for room temperature or if the recipient's clothing is bizarre (e.g., wearing underwear outside of clothing); if the clothing is buttoned, zipped, laced; if the clothing is relatively clean, is mended if necessary, is the correct size for recipient; if the recipient is blind; if the recipient is alert and aware of his/her appearance.
- **Questions:** Are there times when it seems just too much of a bother to get dressed for the day? Does anyone ever comment to you on how you are dressed? Are you warm enough or too warm? Could you use some help in getting your clothes organized for the day?

Rank 3: Unable to dress self completely without the help of another person (e.g., tying shoes, buttoning, zipping, putting on hose, brace, etc.).

- **Observations:** Observe if the recipient's clothes are correctly fastened; if the recipient apologizes or seems embarrassed about the state of his/her dress; if the recipient asks you for any assistance; if the recipient is disabled in his/her dominant hand; if the recipient has impaired range of motion, grasping, small hand movement; if the recipient needs special clothing.
- **Questions:** Are there any articles of clothing you have difficulty putting on or fastening? Do you need help with clothing items before you feel properly dressed? Do you need to use a special device in order to get dressed? Do you use Velcro® fastening?

Rank 4: Unable to put on most clothing items by self. Without assistance the recipient would be inappropriately or inadequately clothed.

- **Observations:** Observe if the recipient's range of motion and other movements are

impaired. Observe if the recipient is dressed in bed clothes, robe, and slippers rather than street clothes; if the recipient appears too cold or too warm for the room temperature; if the recipient seems willing to try to adapt to alternate methods of dressing.

- **Questions:** Do you feel unable to get out or have people visit because you are unable to get adequately dressed? Do you ever feel too hot or too cold because you cannot put on or take off the necessary clothing to make you feel more comfortable? Has your health ever been affected because you have not been able to dress appropriately for the weather or temperature?

Rank 5: Unable to dress self at all, requires complete assistance from another.

- **Observations:** Observe if the recipient is capable of voluntary movement? If the recipient's clothing appears comfortable and clean; if the recipient appears satisfied with the degree of dress. Determine if the recipient would prefer a dress and shoes rather than a robe and slippers all of the time.
- **Questions:** How do you change your clothing? Do you ever feel too warmly or too coolly dressed? Is your clothing comfortable and clean enough? Do you get changed as often as you feel necessary?

Bowel, Bladder, and Menstrual Care

Bowel, Bladder, and Menstrual Care: Assisting with using, emptying, and cleaning bedpans/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 gloves; wiping and cleaning recipient; assisting with getting on/off commode or toilet; and washing/drying hands. Menstrual care is limited to the external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping, cleaning, and washing/drying hands.

Note: This task 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. In assessing Menstrual care, it may be necessary to assess additional time in other service categories such as Laundry, Dressing, Domestic, Bathing, Oral Hygiene, and Grooming. Also, if a recipient wears diapers, time for menstrual care should not be necessary

The following is the application of functional rank specific to Bowel, Bladder, and Menstrual care with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to manage Bowel, Bladder, and Menstrual care with no assistance from another person.

- **Observations:** Observe if recipient's movement is unimpaired and odor of urine present; if the recipient has had colon cancer, observe if the recipient wears a colostomy or ostomy bag or if there are ostomy or colostomy bags present.
- **Questions:** Do you need any help when you have to use the toilet? Do you also use a bedside commode, urinal, or bedpan? Do you have any problems getting to the bathroom on time?

Rank 2: Requires reminding or direction only.

- **Observations:** Observe if the recipient seems disoriented or confused; if urine smells are detectable; if furniture is covered with barrier pads or plastic; if adult diapers are in the recipient's bedroom or bathroom; if the recipient takes diuretics such as Lasix®; if the recipient's clothing is stained, indicating that there is an incontinence problem.
- **Questions:** In the past month, have you had difficulty getting to the toilet/commode on time? If yes, how often? Does someone remind you?

Rank 3: Requires minimal assistance with some activities but the constant presence of the provider is not necessary.

- **Observations:** Observe if there are moderate movement impairments; if there is severe limitation of use of the recipient's hands; if the recipient needs a boost to transfer.
- **Questions:** Do you have any problems using the bathroom or managing your clothes? Does anyone help you? If yes, what kind of assistance do you need and how often? Are you able to empty your urinal/commode (if used)? Do you have accidents? How often do the accidents occur? Are you able to cleanup after them?

Rank 4: Unable to carry out most activities without assistance.

- **Observations:** Observe the severity of the recipient's movement problems; if the recipient is unable to transfer unassisted; the recipient's or provider's statement as to the quantity or frequency of daily laundry and any indication that hand laundry is done daily. Observe if there is a large amount of unwashed laundry with the odor of urine or fecal matter. Observe if there are meds such as stool softeners visible.
- **Questions:** Who helps you? How? Is s/he available every time you need help? Do you need more help at certain times of the day/night?

Rank 5: Requires physical assistance in all areas of care.

- **Observations:** Observe if the recipient has any voluntary movement; if the recipient is bedfast or chair bound; if the recipient is able to make her/his needs known.
- **Questions:** Who helps you? What is your daily routine? Do you also need assistance with activities we classify as Paramedical Services?

Transfer

Transfer: 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.

Note: Transfer does not include assistance on/off toilet. This task is assessed as part of Bowel, Bladder, and Menstrual Care. Care of pressure sores (skin and wound care). This task is assessed as part of Paramedical services.

ATTACHMENT B

The following is the application of functional rank specific to Transfer with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to do all transfers safely without assistance from another person though recipient may experience some difficulty or discomfort. Completion of task poses no risk to his/her safety.

- **Observations:** Observe if the recipient's movement is unimpaired; if s/he is able to get out of a chair unassisted when s/he shows you the house; if s/he shifts weight while sitting.
- **Questions:** Do you ever need a boost to get out of bed or out of the chair? When? How often? Do you ever have difficulty moving around?

Rank 2: Able to transfer, but needs encouragement or direction.

- **Observations:** Observe if the recipient seems confused and has trouble getting out of a chair (probably more problematic in getting out of bed). Determine if the recipient is bed bound on bad days.
- **Questions:** Does anyone help you get out of bed in the morning? How does s/he help you?

Rank 3: Requires some help from another person (e.g., routinely requires a boost).

- **Observations:** Observe the length of time it takes the recipient to answer door; the sounds heard as the recipient comes to door; if the recipient asks you for a boost when s/he gets up to get medications, or is shaky when using assistive device; if the recipient is obese and has a great deal of difficulty getting up.
- **Questions:** Do you always have difficulty getting out of a chair? Who helps you? How? How often? Do you also have trouble getting out of bed? What kind of help do you need? (Expressing interest in how the recipient has solved one problem usually encourages her/him to tell you ways s/he have solved other problems.)

Rank 4: Unable to complete most transfers without physical assistance. Would be at risk if unassisted.

- **Observations:** Observe if the recipient uses an assistive device for mobility; if the recipient's joints are deformed from arthritis or some other disease; if the recipient is wearing a cast or brace; if someone in house assists the recipient to get up if s/he uses a walker or is in a wheelchair; if there are bruises, scabs, or bumps or burns on the recipient.
- **Questions:** Who helps you? How? How often? Both in getting into and out of bed, in and out of chair/wheelchair? Do you need more help at certain times of the day/night?

Rank 5: Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.

- **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if the recipient makes needs known.

- **Questions:** Who is available to help you when you need to be moved? Do you feel they are able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Eating

Assisting with consumption of food and assurance of adequate fluid intake consisting of eating 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. Eating task includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning face and hands; and washing/drying provider's hands.

Note: This does not include cutting food into bite-sized pieces or puréeing food, as these tasks are assessed in Meal Preparation services.

The following is the application of functional rank specific to Eating with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to feed self.

- **Observations:** Observe if there is no impairment in grasp indicated when the recipient signs the application or handles medicine bottles; if there is a cup or glass next to the recipient's chair; observe how the recipient takes a drink.
- **Questions:** Do you need any help eating? (Since deterioration usually occurs in a hierarchical manner and feeding oneself is the last function to lose, questions may not be necessary if the recipient is able to dress self and scores 1 in Bowel and Bladder Care except in cases where the recipient seems mentally impaired.)

Rank 2: Able to feed self, but needs verbal assistance such as reminding or encouragement to eat.

- **Observations:** Observe if the recipient appears depressed, despondent, or disoriented; if the recipient's clothes seem large for the recipient, indicating possible recent weight loss; if there is rotten food, no food in refrigerator, or a stockpile or Twinkies®, only; if there are not any signs of cooking.
- **Questions:** What have you eaten today? How many meals do you eat each day? Do you have trouble with a poor appetite? What is the difficulty? Are there times you forget to eat? Does it sometimes seem like it takes too much effort to eat? Do you have trouble deciding what to eat?

Rank 3: Assistance needed during the meal (e.g., to apply assistive device, fetch beverage or push more food within reach, etc.), but constant presence of another person is not required.

- **Observations:** Observe if manual dexterity is impaired, particularly of dominant hand; if there are straws or cups with spill-proof lids; if the recipient has difficulty shaking hands; if s/he has severely limited eyesight.

- **Questions:** Do you need help in feeding yourself? Do you need to use special utensils to feed yourself? Do you feel that you get enough to eat? Do you have difficulty reaching food on your plate or reaching your glass?

Rank 4: Able to feed self some foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person.

- **Observations:** Food stains on clothing; shakiness of hands; deformity of hands with limitation in ability to grasp or hold trays, towels, bibs.
- **Questions:** Does someone help you eat? How? How often? Do you eat with the rest of the family? Can you feed yourself finger foods? Are you able to use a fork or spoon? Do you have difficulty chewing or swallowing? If so, how do you deal with the problem?

Rank 5: Unable to feed self at all and is totally dependent upon assistance from another person.

- **Observations:** Observe if the recipient has no use of upper extremities; if there are trays, towels, bibs, etc., near the recipient.
- **Questions:** What is your daily routine for eating meals?

*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. (MPP 30-756.41)

Respiration

Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

The following is the application of functional rank specific to Respiration with suggestions that may help inform the determination as to rank:

Rank 1: Does not use respirator or other oxygen equipment or is able to use and clean independently.

- **Observations:** Observe the oxygen equipment present; if the recipient coughs or wheezes excessively or if breathing is labored.
- **Question:** Are you able to clean and take care of the equipment yourself?

Rank 5: Needs help with self-administration and/or cleaning.

- **Observations:** Observe the same things above and if when the recipient ambulates if s/he has difficulty with breathing or breathing is laborious. Observe the recipient's meds; if the recipient has weakness or immobility in conjunction with breathing problems; if there is a referral from an oxygen supplier indicating the recipient is not taking care of the equipment properly.

ATTACHMENT B

- **Questions:** Are you able to clean and take care of the equipment yourself? If not, how does it get done? How often do you use the equipment? Have you had difficulty administering your own oxygen or using your breathing machine? (If yes, refer for Paramedical service.) Who cleans equipment after you use it?

*If all the recipient's needs for human assistance in Respiration are met with Paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is Paramedical service rather than Respiration. (MPP 30-756.42).

ATTACHMENT B

MENTAL FUNCTIONING

Memory

Recalling learned behaviors and information from distant and recent past.

The following is the application of functional rank specific to Memory with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Memory is clear. Recipient is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events. The recipient is able to give you detailed information in response to your questions.

- **Observations:** Observe if recipient's responses to your questions indicate that s/he has good recall; knows his/her doctors' names; knows his/her own telephone number or the number of a close friend; is clear about sources of income and assets; knows who close relatives are and where they live. Observe if the recipient is mentally capable of following through on activities of daily living; if s/he has good social skills; if recipient's thought process seems clear and s/he is able to keep track during a conversation.
- **Example:** An elderly women living alone in her home responds quickly and confidently to your questions to establish her eligibility for IHSS and determine her need for services. The recipient is reasonably organized. His/her medications are in place. There are stamped bills in the mailbox. The trash appears to be picked up regularly. There is a grocery list ready for the IHSS provider.
- **Questions:** Who is your doctor? What medicine do you take regularly? What is your address and telephone number? When were you born? Where were you born? What is the date today? How long have you lived in this house? Where did you live before you lived here? What serious illnesses or surgeries have you had? How long ago was each illness or surgery?

Rank 2: Memory loss is moderate or intermittent: Recipient shows evidence of some memory impairment, but not to the extent where s/he is at risk. Recipient needs occasional reminding to do routine tasks or help recalling past events.

- **Observations:** Observe if the recipient appears forgetful and has some difficulty remembering names, dates, addresses, and telephone numbers; if the recipient's attention span and concentration are faulty; if the recipient fidgets, frowns, etc., possibly indicating a struggle to recall; if the recipient repeats statements and asks repetitive questions; if recipient occasionally forgets to take medication or cannot recall when s/he last took medication and if the problem is corrected with the use of a Medi-Set (pill distribution box) set up by someone else. Observe if the recipient may become bewildered or appears overwhelmed when asked about details; if the recipient's recall process aggravates mental confusion or causes intermittent memory loss; if the recipient becomes moderately confused when daily routine is altered.
- **Example:** Elderly man has to be prompted occasionally by his wife when he tries to respond to your questions. He apologizes for or tries to conceal memory lapses.

- **Questions:** What year were you born? How old are you now? How old were you when your first child was born? What medicines do you take? Tell me what you usually do during the day. Who telephones or comes to see you often? What do you have to eat for dinner tonight?

Rank 5: Severe memory deficit: Recipient forgets to start or finish activities of daily living that are important to his/her health and/or safety. Recipient cannot maintain much continuity of thought in conversation with you.

- **Observations:** Observe if the recipient has a blank or benign look on her/his face most of the time; if s/he is continually placing and replacing objects in the room to avoid answering your questions; if s/he gives inappropriate responses to questions; if the recipient's voice and/or train of thought trails off in middle of conversations; if s/he starts an activity and forgets to finish it; if the recipient consistently forgets to take medications or takes them inappropriately, even with a Medi-Set. Determine if the recipient has a history of leaving stove burners on or the water running in the sink and/or tub causing overflows. Observe if the recipient cannot remember when s/he ate last or what s/he ate; if s/he is unable to remember names of close relatives; has loss of verbal ability; is impaired intellectually; displays abnormal and potentially dangerous behavior.
- **Example:** Middle-aged man suffering from Alzheimer's disease is totally unable to respond to your questions. He becomes very agitated for no good reason; arises from chair as if to leave room and stares in bewilderment; needs to be led back to his chair. He seems unconcerned with events in daily life and cannot articulate his need for services. His daily routine follows a set, rigid pattern. He relates to the situation on a superficial basis.
- **Questions:** What are the names and relationships of your closest relatives? Did you eat breakfast today? What did you eat? Can you tell me what I'm holding in my hand? How old are you? What is your birth date? Ask housemate: What happens when the recipient is left alone? Does s/he remember any events from the previous day, hour, or minute? Does s/he remember who you are? Does s/he remember how to operate the stove, shave self, or perform other tasks safely?

Orientation

Awareness of time, place, self, and other individuals in one's environment.

The following is the application of functional rank specific to Orientation with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Orientation is clear. Recipient is aware of where s/he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day.

- **Observations:** Observe if the recipient appears comfortable and familiar with his/her surroundings. Recipient makes and keeps good eye contact with you. His/her facial expression is alert and is appropriate to the situation. The recipient is spontaneous and direct. The recipient shows interest in maintaining a good personal appearance. The

recipient is obviously in touch with reality; is aware of time and place; readily responds to questions about his/her living arrangement, family, etc.; is fully aware of the reason for your visit. Determine if the recipient is physically able to leave home unassisted and if the recipient can find his/her way back without getting lost and can get around using public transportation.

- **Example:** Recipient is ready and waiting for your visit. S/he initiates social amenities such as offering coffee, a chair to sit on, etc. The recipient introduces family members and/or is able to identify family pictures when asked and has the documents ready that you asked him/her to locate.
- **Questions:** Do you have relatives living close by? Why are you asking for help at this time? How have you managed to care for yourself until now? Do you have someone who helps around the home?

Rank 2: Occasional disorientation and confusion is apparent but recipient does not put self at risk: Recipient has general awareness of time of day; is able to provide limited information about family, friends, age, daily routine, etc.

- **Observations:** Observe if the recipient appears disheveled and the surroundings are chaotic. Observe if objects are misplaced or located in inappropriate places; if there is moldy food in and out of kitchen; if the recipient does not notice that the home is over heated or under heated until you mention it; if the recipient appears to be less confused in familiar surroundings and with a few close friends; if the recipient is able to maintain only marginal or intermittent levels of social interaction; if the recipient is able to provide some information but is occasionally confused and vague; if the recipient is not always aware of time, surroundings and people; if the recipient is able to respond when redirected or reminded.
- **Example:** Twice in the past year the recipient has called her daughter at 2:00 a.m. and was not aware that it was the middle of the night. When told what time it was, the recipient apologized and went back to bed. When you enter the recipient's apartment, the elderly woman asks, "Why are you here today? You said you'd be here Tuesday." You respond, "This is Tuesday." The recipient seems unprepared for your visit and has difficulty settling down for the interview. She participates with some difficulty. She is not comfortable outside of her immediate environment and rarely ventures out. Her mail is left unopened occasionally, and her clothing and some perishable food items are not properly stored.
- **Questions:** What day is today? How many rooms do you have in your home? Where is the closest grocery store? Do you know who I am and why I am here? Do you go out alone? Do you ever get lost when you go out of the house alone? Do you know the name of the bus you take when you go to the store and where the bus stop is to go home? What month, year, season, holiday, etc.?

Rank 5: Severe disorientation which puts recipient at risk: Recipient wanders off; lacks awareness or concern for safety or well being; is unable to identify significant others or relate safely to environment or situation; has no sense of time of day.

- **Observations:** Observe if the recipient shuffles aimlessly throughout house; if s/he

exhibits inappropriate behaviors such as giggling or making comments that are irrelevant to the conservation; if s/he handles objects carelessly; appears unkempt, displays poor personal hygiene; has a manner of dress that is inappropriate or bizarre; if when the social worker attempted to shake the recipient's hand, s/he tried to bite social worker's hand. Observe if the recipient is very confused, unaware of time, place, and/or individuals; goes to the mailbox and cannot find her/his way back to the apartment; does not recognize the apartment manager when the manager tries to help the recipient find her/his way back to the apartment and the recipient becomes highly agitated. Observe if the recipient appears to be disoriented and experiences hallucinations and displays a dazed and confused state of mind; is unable to answer simple questions appropriately; if the recipient's sleep-wake cycle may be abnormal; if the recipient confuses immediate living relatives (son/daughter) with dead relatives (husband, etc); if emotional instability is present.

- **Example:** Family member or friend must answer door, as recipient is unable to maneuver in home without wandering. The recipient must be directed to chair. The recipient exhibits no awareness of the purpose of the social worker's visit. The recipient is unable to concentrate; s/he either does not respond to questions or speaks unintelligibly.
- **Questions:** What is your name? Where do you live? What is the date today? What year is it? Where are you? Where are you going? If the recipient is unable to respond or responds inappropriately, ask housemate: What is the nature of ___'s mental problem? What can the recipient do for self? What does the recipient do if left alone?

Judgment

Making decisions so as not to put self or property in danger. Recipient demonstrates safety around stove. Recipient has capacity to respond to changes in the environment (e.g., fire, cold house). Recipient understands alternatives and risks involved and accepts consequences of decisions.

The following is the application of functional rank specific to Judgment with suggestions that may help inform the determination as to rank:

Rank 1: Judgment unimpaired: Able to evaluate environmental cues and respond appropriately.

- **Observations:** Observe if home is properly maintained, and in safe repair; if recipient's responses show decision-making ability is intact; if recipient dresses appropriately for the weather; if recipient is able to form correct conclusions from knowledge acquired through experience; if recipient is capable of making independent decisions and is able to interact with others.
- **Example:** Recipient takes pride in managing his/her own affairs and does so appropriately. The recipient has a list of numbers to call in case of emergency; takes measures to guard safety such as locking doors at night, not allowing strangers into home, etc.
- **Questions:** Do you have a list of numbers to call in case of an emergency? Do you have friends or family who could help out in a crisis situation? What would you do if your provider were unable to come to work one day?

ATTACHMENT B

Rank 2: Judgment mildly impaired: Shows lack of ability to plan for self; has difficulty deciding between alternatives, but is amenable to advice; social judgment is poor.

- **Observations:** Observe if the home is in disrepair (leaking faucets, broken appliances, inadequate lighting, etc.); if debris has been allowed to accumulate in walk-way areas; if food in the home is of poor nutritional value; if the recipient is unable to recognize that there are alternatives or unable to select between them and is unable to plan or foresee consequences of decisions. Observe if the recipient is not capable of making decisions without advice from another, is able to understand options when explained, makes correct choices; knows enough to turn stove and heat on and off.
- **Example:** Recipient wastes money on useless items while allowing needed repairs to go unattended. The recipient "makes do" with the condition of home even if it is inconvenient for the recipient. The recipient appears to be a "collector," has difficulty throwing anything out even though access through home is limited. The recipient can't decide which provider s/he wants. The grocery list to provider contains mostly junk food. The recipient stopped homebound meals when s/he decided they weren't tasty rather than add salt. S/he refuses to use walker or cane.
- **Questions:** Who would you call in case of emergency? If someone you did not know came to your door at night, what would you do? What are you able to do for yourself? Do you need anyone to help you? Who would you depend on to assist you if you needed a household repair done such as if your heater did not work?

Rank 5: Judgment severely impaired: Recipient fails to make decisions or makes decisions without regard to safety or well-being.

- **Observations:** Observe if safety hazards are evident: clothing has burn holes; faulty wiring, leaking gas, burned cookware, etc. Observe if utilities may be shut off; food supply is inadequate or inedible. If the recipient is a pet owner, observe if there are animal feces in home. Observe if the recipient is obviously unaware of dangerous situations, not self-directing, mentally unable to engage in activities of daily living; goes outside with no clothing on; if neighbors saw smoke from apartment several times; if they entered and extinguished fires on stove; if someone from the community calls to report that the recipient is defecating or urinating on the front yard. Observe if the recipient cannot decide to eat, dress, or take medications; if the recipient seems preoccupied, confused, or frightened; if the recipient is unaware or too frail or feeble to make decisions to maintain self safely at home; if s/he takes a shower with clothes on; drinks spoiled milk, etc.
- **Example:** Recipient has open access to home to anyone who approaches. The recipient seems unaffected by stench or odors due to garbage, feces, urine, etc; exhibits no concern over obvious safety hazards (e.g., debris piled on stove, papers scattered near heater, etc.); lets injuries such as burns go unattended. In the past year, the recipient has recurrently started dinner and fell asleep and awoke to a smoke-filled kitchen.
- **Questions:** What would you do if you saw something on fire in your house? If you needed to get to the doctor what would you do? Ask Housemate: What happens when __ is left alone? Can s/he recognize situations that would lead to danger? Is s/he capable of making rational decisions?

SPECIAL INSERT

Doing the Interview: How to Really Ask Those Questions and Enjoy it

Colleen King

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An edited version of a presentation given at "Assessment Revisited: Practical Approaches to Assessing the Elderly." A conference presented by the University of Minnesota Long-Term Care DECISIONS Resource Center, Minneapolis, Minnesota.

Colleen King presented this paper and additional insights at "Assessment Revisited: Practical Approaches to Assessing the Elderly," the Center conference held in September in Minneapolis.

Through years of experience in both supervising and training interviewers and through my own experience as an interviewer I have developed a style of interviewing I call, *conversations with a purpose.* This style of interviewing is conversational, relaxed, but structured within the boundaries of appropriate interviewing. Even in the most open-ended type of assessment there will be boundaries of correctness that each individual administrating the tool must stay within. I have tried to develop a style that will insure that the viability of the tool will not be compromised, allow you to stay within the boundaries of the tool, and make the assessment workable and enjoyable for the individual administrating the tool.

The comprehensive assessment interview can be a valuable tool in assessing the needs of older people. If done correctly the assessment can be an enjoyable and rewarding experience for both the client and the assessor. If done incorrectly the assessment can be biased, frustrating, and a waste of everyone's valuable time. In the next few pages I would like to challenge you to an enjoyable experience. Conversations with older people are never boring. You should have confidence in the assessment tool and know the information you collect will help you provide for the needs of the individuals you desire to help.

I would like to talk about the most common mistakes and how to correct them. The most common mistakes made in any kind of assessment interview, either interviews with fixed questions or more open-ended interviews, are:

- Failure to ask the questions on the tool.
- Not spending time to develop rapport with the client.
- Bias or leading the client.
- Inappropriate probing.
- Avoiding difficult situations.

The responsibility of the assessment lies in your hands. With proper training, a better understanding of the tool, and support from peers; your job can be worth your time.

ASK THE QUESTIONS

The key to your successful comprehensive assessment of a client is knowing and understanding your assessment tool. The assessment tool was designed with the purpose of permitting a fuller and better understanding of the care needs of the older person. If your assessment is done correctly you should be able to:

- determine eligibility of the client.
- better respect the rights of the client.
- design a care plan that will fit the needs of the client.
- become more familiar with future needs of the client.
- provide information to planners that will allow them to more accurately determine the needs on a community basis.

For the client's sake, the assessment tool should be taken seriously. If it's not worth your time to ask the questions correctly, it is not worth the client's time to try to answer the questions honestly. Without the assessment tool you are not going to get accurate data. You may think you know how I feel, but unless you ask me you are only guessing. If I have recently lost a spouse and you skip the questions dealing with mood and outlook because you assume you know the answers, you have lost valuable information about me. You do not know if I am handling the situation within the normal range of grief, or if I am not facing the

situation and may need help. You just assume I am depressed. Depression, sadness and grief are very different. It is far better to learn how to talk to the grieving client and how to ask questions in difficult situations than to answer for the client. To design a care plan on guessing is not fair to the client. These tools have been developed to help you meet the needs of the client.

A common problem is not asking the questions when they are embarrassing to the assessor. The interviewer is often uncomfortable talking about incontinence or income or both. Older people don't mind describing toileting issues if discussed matter-of-factly. If questions are handled in a respectful manner people will not mind discussing these issues. If you have developed rapport with the client early on you will not feel as embarrasssed. The client will understand that what you are doing is important and you will feel confidence in the rapport established. The purpose of the comprehensive assessment is not to embarrass, but to provide a care plan. Incontinence is a common problem with older people and is not embarrassing. If an individual becomes embarrassed by questions it is your responsibility to comfort that person.. Inform them, "I talk to a variety of people in many different situations and all questions are important in determining a care plan. All questions may not be relevant to you or your situation, but they are all an important part of the assessment."

Before a comprehensive assessment is done each assessor should know:

- What each question means, and how to reword the question to adapt to odd or difficult situations.
- What are the boundaries of each question? When would I be leading or biasing; how much do I help the client understand the question? In the ADL's usually there is a definition of dressing, and eating, and you must not neglect giving the full elements of this definition. You must know what to do when the client says, "I can do everything but button the back of my dress." An example of more strict boundaries might be in the mental status questions where often you are instructed not to change or alter the questions at all.
- How to answer questions to reassure the client of the worth and value of the assessment.

If you do not have a working knowledge of the tool you should ask for help. If you do not believe in and value the tool, you should talk to someone who has confidence in the tool. There should be someone available to assist you. If you understand what you are doing and have confidence in what you are doing, your comprehensive assessments will be enjoyable and valuable. Before you use the assessment tool:

- Role play with another employee.
- Make notes of difficult questions and how to handle them.
- Be prepared to answer questions about the tool.
- Know how to handle difficult situations.

SPEND TIME TO DEVELOP RAPPORT

After you have a working knowledge and confidence in your tool the next thing to learn is developing rapport with the client. The time you spend in the beginning to develop rapport can make or break an assessment. If the client feels comfortable with you, he/she will speak more openly with you. Spending time to develop rapport can make the interview go more quickly, you will gather more valuable information, and the conversation will be more enjoyable. You develop rapport by:

- Speaking in a conversational tone.
- Spending time talking about something other than the assessment (small talk).

Reassuring clients that this is important and worth their time. The information will be used to prepare a care plan that fits their needs.

- Not being afraid to answer questions. Approach questions as an opportunity to explain further, not as an obstacle to overcome.
- Listening to the client and making a mental note of speech patterns. This will help you pace the assessment to the characteristics of the client. It is important early on to note whether the client is talkative or quiet.
- Letting clients know you are enjoying talking with them; it will help them relax.
- Observing the client's behavior in the presence of others. If there are other family members in the room, this will give you an opportunity to view how openly the client speaks in front of others.
- Spending some time talking about the assessment before you begin. Tell the client the type of questions you will be asking and why, i.e. "I will ask you some general questions about activities you may be involved in. This will help us work together to figure out your needs and how we can be helpful to you."
- Always being professional, but not being afraid to enjoy yourself. You can laugh and be relaxed while doing your job. If you are relaxed the client will know that they too can be relaxed.

The time you spend developing rapport with the client will help you better understand the client. This knowledge of the client will help you direct the conversation, know when to probe more, give you an idea of how talkative the client is and how much time the assessment will take. Social workers and nurses are trained to make people feel comfortable and are excellent interviewers. Do not become paralyzed by the assessment form or forget the skills you already have. Integrate the skills you have with the assessment tool. Do not be overwelmed by the assessment tool and forget the sensitive listening skills you have. Set the assessment tool aside when needed and listen to the client. If you have developed rapport early on, this will come naturally.

AVOIDING BIAS

This is an area where most professionals will err. You know the issues so well, and you are so familiar with the needs of older people that you are probably right more than you are wrong when you guess or assume. The problem is not when you are right, but when you are wrong. The assessment tool was not designed for the professional to guess, but for the professional to ask and find out what the client will answer. A bias is any influence that changes an answer or an opinion from what it might have been without that influence. It is important to be aware of your own bias and how that would conflict with the assessment. Once you say to the client, "so what you are trying to say is," you have given your opinion and biased the assessment.

It is important to be aware of interviewing errors. It is easy to relax your objective attitude and thus bias responses. To avoid influencing or biasing, follow these rules:

- DO NOT express your own opinions or how you think the client should respond (i.e. "I think everyone should have physical therapy"). Clients will change their answers to please you or change their answer to what you believe to be the correct answer. Try to reassure the client that we really do want their opinions. We are interested in what they experience or feel about a certain situation. The whole purpose of a comprehensive assessment is defeated when you answer for a client, lead the client or bias the client's responses.
- DO NOT suggest answers even if the client wants your help. Help the client sort out their opinions or responses; don't give them the answer. Repeat the question, read it through slowly, pause, and tell the client to "take a moment and think about it." If you

take your time and do not rush the client, you will be less likely to suggest an answer. The client will appreciate your kindness and patience.

- DO NOT use leading probes. Any probe which suggests an answer is a leading probe and can bias the interview. Do not make the assumption that you know what the client is talking about; let the client explain. Don't lead the client to an answer or response you think seems right or fits their situation.
- DO NOT rush the client. Some people need time to sort out their responses. If the clients are not answering, do not take this as if they are objecting to the assessment, but allow them a moment to think through their answers. If you jump in too soon, you will try to answer for them. You may think the client does not understand or does not like the question when he/she is just trying to think of the answers. Do not appear impatient; appear interested. You can acknowledge that "it is sometimes difficult to decide these answers."

The obvious and most unfair way to bias the assessment is not to ask the questions. ASK THE QUESTIONS: give the clients the opportunity to tell you their opinion, responses, and what type of care they do want or don't want. The only way you will find this out is if you let the client tell you. The last ten people you talked to might have felt a certain way, but this next person is different. If you don't ask the questions you will never know. It is like voting. If fifteen individuals voted "yes" they want their taxes increased, you would hardly assume I too would vote "yes" and not even ask me? Ask me; I have a right to my opinions!

HOW TO PROBE

One of the most common mistakes in probing is to use an inappropriate probe, that is, a probe that either leads or would bias the interview. Correct probing is probably the most difficult part of the comprehensive assessment. Inappropriate probing will occur when the assessor is having difficulty obtaining a response from the client or when a question is asked and the assessor does not know how to answer it. A correct probe is a prompt which encourages further conversation without biasing the response. The probes you would use most often are:

- Probing for correctness.
- Probing for clarity.
- Probing for completeness.

Probing for correctness is used where you want the client to answer within a category or within set responses. The best way to probe for correctness is:

- Repeat the question and the responses. When doing this, change your tone or where you pause, and it may sound different; speak slowly; and look up at the client. Try to add small talk before you repeat the question.
- Explain to the client that you are restricted by these responses. Use probes like, "if you had to choose, which one would you choose," or, "taking everything into consideration, which one would be closest to you." Always avoid probes that lead to a positive or negative end of the scale. If the client has been very ill and you ask, "Is your health excellent, good, fair or poor?" You would never probe with, "So is your health fair or poor?" Always give the client the opportunity to reflect on the full range of answers. It would be better to say, "Let me read the choices again, they are: excellent, good, fair, or poor."

If you probe in a pleasant, conversational manner your probes will not seem repetitive or obtrusive. Keep telling the client how important it is to get their views and what they feel are their needs.

Probing for clarity often entails asking the clients for a more specific response or an explanation to their answers. The client has answered your question, but you need to clarify what is meant by that answer. Always try to help the client when probing for clarity; let the client know what you don't understand and what you need clarified. The most common probes for clarity are:

- "What do you mean by that? You said that you were tired a lot; tell me what that means to you." You want the client to open up and talk to you. Does tired mean bored or sleepy, or you can't get out of the chair to answer the telephone when it rings. If the client doesn't explain tired to you, it is left to your interpretation of what tired means to you. It is much better to find out what it means to that client.
- "Could you explain that, tell me more about that?" If you are interested in what the client is saying and the conversation is going smoothly, asking the client to explain or tell you more will seem natural.
- "I'm not sure I understand." . Simply direct the client's comments by letting him/her know what you do not understand.

On many mental health batteries, the answers do require probing. For example, you ask, "Do you see things that others don't see?" and the client answers, "Yes." Before deciding to refer to a mental health specialist, a probe "Can you tell me more about what you see?" would be helpful. The client might say, "I've always been intuitive and perceptive, and people say I understand their feelings when others don't." That's very different from a hallucination.

DIFFICULT SITUATIONS

Most of the time you will find clients will want to talk about their situation. They will be as anxious as you for a care plan. There are, however, times when the situation is extreme and the client could be overcome with grief or anger. Do not shy away from these situations. You will probably feel more uncomfortable than the client. As a trained professional, you should be able to handle a social interaction which requires attention. Personally, anger is easier for me to handle than grief and extreme sadness. I find the sad situations take a lot more out of me than dealing with anger. If the client becomes overcome with sorrow or begins to cry, handle the situation no matter how difficult it is for you. By following a few guidelines you will find that these situations are not as difficult as you might imagine them to be.

First: Don't ignore the client. Don't pretend they are not crying. Simply be direct, polite and sensitive. Put down your pencil and acknowledge the situation. Use Comments like: "I'm sure that is very difficult for you", or "I'm so sorry." Try reassuring them it is safe to express their grief, loneliness, pain or sadness with you. Even a comment like, "It's O.K. to cry; we all cry," or, "I understand," is effective. Try to remember a time when your eyes swelled up and you could not hold back the tears. Those moments often are most embarrassing. Try to make the client feel comfortable and at ease with their embarrassment.

Second: Don't pity the client. Grief, pain, loneliness and sadness are a part of all of us. The client does not need or want pity. Be respectful, sensitive and handle the situation. If possible personalize it: "My grandmother felt the same way," "That was very difficult for my grandfather too," or, "I understand your fear; my grandmother was very frightened of a nursing home." Don't make up stories, but if you have some understanding of the situation, this would be the time to express it to the client. React to this situation the way you would want someone to react if it was your grandparents or parents. You do not have to indulge the situation, but a brief moment of compassion and understanding is expected.

Third: If at all possible continue on with the assessment. The situation would have to be extreme not to be able to continue. I strongly urge you not to abandon the client or the comprehensive assessment. It leaves the client with a feeling of failure of unfinished business. Comments like, "I hope I didn't upset you?" will help. If you handled the situation correctly, most clients will respond by saying, "No you've been very kind," and you might say, "May we continue with the conversation?" Most clients will be happy to go on and appreciate your kindness and patience. Remember that even though the client may seem sad while talking to you, it still can be a comfort to express feelings. Often the assessor is the one who feels uncomfortable and tries to rush or terminate the interview. Be tolerant of pauses while the client is upset. A good neutral remark is "I know this is difficult and we do appreciate your help."

When dealing with the angry client, it is best to handle the anger before you attempt the interview. If the anger isn't dealt with, it will continue throughout the interview and you will be in constant battle. Handling the angry client in the beginning gives you control and sets the pace of the interview. Handle anger or the angry client with the following techniques:

- Gently confront the client, "You seem to be very upset and I am not sure why. If I have done something to upset you please tell me." If you haven't done anything to upset the client (which is most likely) then say, "I think it is best if we talk about why you are upset before we continue." The client may not be feeling well, or may have a very good reason for being upset. Whatever the situation may be you must get the anger out in the open for you to control the conversation.
- If you are just dealing with an angry person and can not get them to open up, explain what you are doing and that your only purpose is to gather information to help design a care plan. You wish them no harm and would appreciate their cooperation. If said in a calm and pleasant manner most people will cooperate.

COMMON PROBLEMS

GETTING THE CLIENT TO TAKE THE MENTAL STATUS QUESTIONS SERIOUSLY: Although this group of questions are, for the most part, easy to ask and record, they may be inherently difficult because some people will think you are testing their mental capabilities. Again, treat these questions with respect and a straightforward attitude and do not make the client think that answering them is a pass/fail type of situation. If they have trouble with this and it bothers them, try to reassure them that they're doing fine and you're almost done. This is a common problem that will occur over and over. If you are going to take the comprehensive assessment seriously you will have to learn how to handle these situations. People will reject the mental status questions for these reasons:

- They do not know the answers and are behaving defensively.
- They know the answers and feel foolish.
- They are unsure why you are asking them these questions. Is there supposed to be a problem, or do you think that there is something wrong with them?

Handle these situations with care and respect. Reassure the client by saying, "You are being very helpful, I certainly do not want to make you feel uncomfortable. These are questions that are commonly asked of people in your situation. I talk to a lot of different people in many situations. Some questions may seem too easy and some may seem too difficult. I will write down whatever you say. We are almost done and can move quickly through this section if you like." Or else say, "I'm so sorry you feel like I am testing you. I really am not. This portion of our discussion is asked to everyone I talk to. I ask the same questions in the same order to everyone. There is no pass/fail, I write down what you say. Surely you must understand that I talk to a lot of different people in different situations.

This portion of the assessment was designed to reach a large population of people in similiar situations as yours. Some questions may seem too easy, but some questions may seem too hard. Regardless of your situation, these questions are important and I would appreciate your help. I will go quickly through this section."

Do not let the client believe you think these questions are silly, ridiculous, not necessary, or a formality that you are forced to use. All questions must be taken seriously to be effective. It is very important that the assessor never lose respect for the comprehensive assessment, and you should never allow the client to lose respect for it. If you establish the ground rules the client will follow.

The assessment is important and so are <u>all</u> the questions. The same respect should be given these questions and you should handle them the same way you would handle questions that are embarrassing to you.

<u>THE TALKATIVE CLIENT:</u> Every question you ask gives talkative clients an opportunity to tell you a story about their life, their children or events in the world. When you are spending time to develop rapport you will obviously spot the talkative client. Knowing that, the best strategy is to set ground rules. Tell the client what you are going to do, how long it will take and what you need from her. "I have about an hour and a half for this discussion. I will ask you some general questions about your daily life and some more specific questions. It would be very helpful for the consistency of this discussion to stick to this form and ask the questions in the order they appear. I will also be the person working with you when services begin." Or, if more accurate, "my job is to work with you at the beginning to identify your problems and concerns, but another worker will work with you later." This will help establish ground rules, influence the client in letting him/her know what to expect in a future relationship with the case manager, and decide how much bonding is desirable.

Then within these constraints, the worker can say, "This is interesting, I'd like to hear more detail about your reactions to home care the next time I see you because it is so important. Right now, because of our time today, I would like to continue with the assessment interview," or, "Today we need to finish this form, but when services begin another worker will work with you and that would be important information to tell her." If you do have time and, most importantly, if the information would be helpful, you should encourage further information especially when relevant to the care plan. You can say, "I've made a note of that; you like your shower in the evening," or "It's helpful to know you like to play bridge, I've made a note about that." Of course, you should never say you made a note of something unless you actually made a note of it. And you should not say it will make a difference, if nobody will ever look at it again. I have been told that a good case manager makes these notes and <u>uses</u> them often.

<u>THE CLIENT WHO WANTS TO INTERVIEW YOU:</u> Some clients will be as interested in you or your job as you are in completing the assessment. Try to handle personal questions with a sense of humor. If the question is innocent enough answer it. If the personal questions persist or interfere with the process of the assessment gently tell the client, "I appreciate your interest. However, the importance of the assessment is to better understand <u>your</u> opinions on home care and how you feel. This is your opportunity to tell me." If clients want to know if you have children, tell them. If clients want to know your opinion on health care, <u>do not</u> tell them. Remember not to bias the assessment by leading or giving your opinions. Tell the client, "It is important to determine what your needs and opinions are. We are instructed not to express our opinions because it is very important that we do not influence you. That would be unfair to you and the people we talk to."

WHEN I KNOW THE CLIENT IS EMBARRASSED I JUST CAN'T ASK.

QUESTIONS ABOUT INCONTINENCE: If the client is embarrassed, it is your responsibility to reassure the client you are not embarrassed. The purpose is to provide for the needs of the client. Do not guess at what the needs are; ask the question. In my experience it is usually the interviewer who is more embarrassed than the client. If you are the one who is embarrassed, you will have to find a way to overcome your embarrassment. If the comprehensive assessment is to be taken seriously all questions must be asked. Ask these questions straightforwardly and without hesitation. If the client is embarrassed reassure them of the importance of asking all the questions. Try saying, "I certainly did not want to make you feel uncomfortable. I talk to a lot of people with many different needs. The importance of these questions is better understanding you and your needs to provide a care plan that is right for you." If said without embarrasment or hesitation on your part the client will feel reassured.

COMMENTS FROM CLIENTS

Some clients, no matter how much time you spend with them developing rapport, will also need reassurance. They are by nature suspicious people and will not trust you. Do not shy away from them; they just need a little more time and a little more reassurance. If you answer their questions they will eventually cooperate. They may just be toying with you to see how many questions you will answer. Do not let them have control, but do answer their questions and move quickly to the assessment tool. I have tried to think of some common questions and examples of responses to those questions. Sometimes there is no right answer. Just say something to let the client know it is fine for them to question you about what you are doing, and you will be happy to answer any of their questions. For some people it will be answering one question and for the next person you may have to answer five questions. There is no magic number—each individual is different. A good rule is to answer as many questions as needed to complete the comprehensive assessment.

"THESE QUESTIONS ARE STUPID"

I am sorry you feel that way. As I explained earlier, this tool was designed to determine the needs of people in similiar situations as yourself. Not all the questions will apply to you, as I talk to a variety of people and everyone is not the same. I just don't want to answer for you and not give you the opportunity to express yourself. If we come to a question that does not apply, just tell me and we can skip that question, but it is important to get this information from you.

"HOW DO I KNOW YOU WON'T USE THE INFORMATION AGAINST ME?"

There is no way I could use any information against you. My only purpose is to better understand what your needs are and if you qualify for certain programs. I have the opportunity to get to know you and what you may want or may not want in designing a care plan for you. You have the opportunity to have input into your needs. The conversation will go quickly, and you may even find it enjoyable.

"YOU ARE GOING TO DO WHAT YOU WANT ANYWAY WHY BOTHER"

Actually that is not true. This tool was designed with you in mind. The purpose is to ask you and not assume we know what you want or need. There are of course programs that you may not qualify for, but we would like to determine what your needs are and what you want. If we were going to make decisions without you I would not be here. I would like the opportunity to spend some time with you and sort through this. I think it will be very good for you. Why don't we get started and if you have any questions please feel free to stop me.

"THAT'S A PERSONAL QUESTION"

Yes, many of the questions I ask will be personal. As I explained the purpose of this discussion is to better understand your needs and provide a care plan just for you. I appreciate you helping me out and answering these questions. I talk to a lot of people and everyone is an individual.

"MY INCOME IS NONE OF YOUR BUSINESS"

Well, income is a very important question and part of this assessment. Many programs are based on income. In deciding a care plan and your needs, I must determine if such a plan is affordable or if you are eligible for this. If you feel uncomfortable telling me, maybe you would like to write it down for me?

"JUST WHAT ARE YOU REALLLY GOING TO USE ALL THIS INFORMATION FOR?"

The information will be used to provide a care plan that fits your individual needs. This assessment will help us determine your eligibility for certain programs. I can't tell you what you need unless I first sit down and talk to you. An assessment is the fairest way to determine your needs. You have as much say in this as I do.

"JUST WHO GETS TO SEE THIS?"

I will be looking it over, and with your permission the nurse in the program will look at it and a summary of information goes to the main office at the state level of the program. We are very strict with this information and value your openess to talk to me. I keep all the forms in a locked filing cabinet.

ROLE PLAY SITUATIONS

Questions are from the GERIATARIC ASSESSMENT TESTING AND EVALUATION SYSTEM (GATES), from Florida

INTERVIEWER: I'm going to start with some general questions. Some of these questions may seem too easy and some may seem too difficult. Don't worry, just answer the questions the best you can. We will start with: what is today's date?
CLIENT: August 17th, 1990.
INTERVIEWER: What day of the week is it?
CLIENT: Well, it's Monday isn't it?
INTERVIEWER: What do you want me to write down?
CLIENT: Monday.
INTERVIEWER: What is the name of this place?
CLIENT: This is my house. This is getting ridiculous.
INTERVIEWER: We have a few more questions left in this section. What is your telephone number?
CLIENT: 884-2894
INTERVIEWER: How old are you?
CLIENT: How old are you?
INTERVIEWER: I asked you first.
CLIENT: 67 and you?
INTERVIEWER: 39. When were you born?
CLIENT: You mean my birthdate?
INTERVIEWER: Yes.
CLIENT: May 22nd,1923
INTERVIEWER: Who is the President of the United States now?
CLIENT: Are you trying to see if I am crazy?
INTERVIEWER: Absolutely not, I am sorry you feel this way. These questions are part of our standardized assessment that is asked of everyone. I ask the same questions in the same order to

everyone. We are almost done.
CLIENT: Well, it is Bush isn't it?
INTERVIEWER: What would you like me to write down?
CLIENT: I would like you to tell me ... is Bush.
INTERVIEWER: It would be inappropriate for me to answer for you. My job is to write down whatever you say. This section can be difficult, but it is an important part of the assessment. You are doing fine, we only have three questions left in this section and then we can move on to another section. Now what do you want me to write down for: who is the President of the United States right now?
CLIENT :I am sure it is Bush.
INTERVIEWER: Who was the President before him?
CLIENT: Before who?
INTERVIEWER: Before the current President.
CLIENT: I almost got you to tell me didn't I?
INTERVIEWER: You are definitely keeping me on my toes.
CLIENT: Wasn't that Carter?
INTERVIEWER: What would you like me to write down?
CLIENT: It is so frustrating when you can't remember.
INTERVIEWER: You can take a moment and think about it. I don't want you to feel rushed.
CLIENT: I just don't know.
INTERVIEWER: What was your mother's maiden name?
CLIENT: Her name was Susan.
INTERVIEWER: Her last name?
CLIENT: Same as mine.
INTERVIEWER: Last question in this section. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down.
CLIENT: All the way down to what?
INTERVIEWER: Down until you can no longer subtract 3.
CLIENT: Let me get my calculator out of the drawer.
INTERVIEWER: No calculators.
CLIENT: I did not think there would be math questions. This is getting very difficult. I am a smart man, but I never was any good at math.
INTERVIEWER: Would you like to give it a try?
CLIENT: No!
INTERVIEWER: This next set of questions I know you will enjoy. I am going to ask you some questions about how you have been feeling and you can answer "yes" or "no" to each question. This section goes real quickly.

If the interviewer keeps an attitude that is up and positive it will help the client through the difficult questions. I find being honest and straightforward always works best. Don't be afraid to tell the client, "I can't answer for you, but I will write down whatever you want me to write down." Let the client know that you have a job to do and a boss to answer to by saying, "We have been told that it is unfair for me to bias or lead you or answer for you. When we were trained to do these discussions we were told how important it is that we write down only your responses. The purpose of this is to better understand your needs and opinions. All questions may not even apply to you or your situation, but please allow me to ask them and if you would try to answer them I would appreciate it. This can really be an enjoyable conversation".

Questions are from the PREADMISSION SCREENING (PAS) ASSESSMENT FORM from Minnesota:
INTERVIEWER: I'm going to ask you some general questions about how you have been feeling in the past two months. You can answer "yes" or "no" to each of these questions and if you have any questions please feel free to stop me at any time. My first question is: Have you had continued lack of interest in most activities and/or continued low, sad or depresed moods?
CLIENT: Oh yes, I have no interests, I just sit here all day I never see anyone, no one cares, my life is just awful.
INTERVIEWER: Is there anything you are still interested in or activities you still enjoy?
CLIENT: I never miss L.A. Law, I do my jigsaw puzzles every week and my one granddaughter and I visit every Friday morning.
INTERVIEWER: Your visits with your granddaughter sound like they are very enjoyable for you.
CLIENT: Yes, I look forward every Friday to see her.
INTERVIEWER: Have you been sad or depressed in the past two months?
CLIENT: When you are old and sick life isn't good. People forget you or try to make you feel stupid like there is something wrong with you. Like you are doing with some of these questions.
INTERVIEWER: I am so sorry you feel that way. I can honestly say I was not trying to make you feel stupid. I have enjoyed this conversation, I think you are a bright and interesting person. My only objective is to design a care plan that will fit your individual needs. I have never passed any kind of judgement or opinion about you. The questions I ask, I ask to everyone in the same order. The only purpose of this assessment is to better understand you and your needs. I feel badly that I have made you feel uncomfortable. Let's try to continue with this and let me know if I make you feel uncomfortable again. Was it the question about sad or depressed moods that bothered you?

Questions are from the CLIENT ASSESSMENT AND PLANNING SYSTEM (CAPS) form from

on:

INTERVIEWER: I would like to talk to you about some of the personal tasks you do during the day. We will talk about shopping, eating, dressing, bathing and toileting. For each topic I will give you several examples and you tell me which one is closest to your situation. If you need me to repeat the options, I, of course, will be happy to. First, let's talk about dressing. What would be closest to your situation : 1) Can dress and undress without assistance or supervision; 2) Can dress and undress, but may need to be reminded or supervised to do so on some days; 3) Needs assistance from another person to do parts of dressing and undressing; 4) Dependent on others to do all dressing and undressing.

NT: I can do everything but ... that snap in the back or zip dresses with back zippers all the way up. So I guess you would say number 3.

Interviewer would mark number 1.

INTERVIEWER: Now I would like to talk about toileting and the situation that would be closest to you.

CLIENT: Just mark down that everything is fine.

INTERVIEWER: I would like the opportunity to read you the options and then you can tell me which one to mark.

CLIENT: Well, this is embarrassing, I don't like to talk about this and I don't think it is necessary.

INTERVIEWER: Please do not be embarrassed; there is nothing to be embarrassed about. I talk to a ... different people in different ...ons. Some people have problems in some areas and some people have problems in some other area. All I need to know is: 1) Can you toilet without physical assistance or supervision. May need grab bars/ raised toilet seat or (can manage own closed drainage system); 2) Needs stand-by assistance for safety or encouragement. May need minimal physical assistance with parts of the task, such as clothing, adjustment, washing hands; 3) Needs substantial physical assistance with parts of tasks, such as wiping, cleansing, clothing adjustment. You may need a protective garment; 4) Cannot get to the toilet unassisted or (you need someone else to manage care of catheter); 5) Physically unable to be toileted. Now, Mr. Jones which of those situations is closest to your situation? I think it would be easier to hand the client a card with the options on it. The interviewer would still have to read the options, but the client can read along. Having cards makes it easier for clients who get embarrassed and for clients with short-term memory loss.

WHAT CAN BE DONE TO HELP YOU DO YOUR JOB?

In research, we have developed the rules and boundaries for each questionnaire we use. Assessing the tool as questions arise, and the program may develop rules and standards as it goes along. When you have questions about what a question means, how to probe a question or how to determine an answer, ask! If there isn't an established answer there should be. You can help set standards that will help you and other social workers and nurses do their job better and easier. Would cards with explanations on them for dressing and toileting help? If the wording is incorrect, let's change it. The comprehensive assessment should be read the way it is written, if it is written correctly. If it is not being understood and reliable information is not being gathered, then let's change the wording. Your help and feedback is necessary. You are the one in the field asking the questions; only you can tell us what is being understood, where the problems are, and how we can help you with your job.

THE INTERVIEW

Interview Skills

Establishing Rapport – Warmth, Empathy and Genuineness

- **Warmth** – conveys a feeling of interest, concern, well-being and affection to another individual. It promotes a sense of comfort and well-being in the other person. Examples: "Hello. It's good to meet you." "I'm glad we have the chance to talk about this." "It's pleasant talking with you."
- **Empathy** – being in tune with how a consumer feels, as well as conveying to that consumer that you understand how she/he feels. Does not mean you agree. Helps consumer trust that you are on their side and understand how they feel. It also is a good way to check to see if you are interpreting what you observe correctly. Mirroring non-verbal can send empathetic messages. Example of leading phrases: "My impression is that…" "It appears to me that…" "Is what you're saying that…" "You seem to be…." "I'm hearing you say that…"
- **Genuineness** – means that you continue to be yourself, despite the fact that you are working to accomplish goals in your professional role. Being yourself and not pretending to be something you are not. This conveys a sense of honesty and makes them feel that you are someone they can trust.

General Interviewing Skills

Before the Interview – review the case and think about the possible things you will need to assess with this consumer. Are there any cues from the initial information that help you to come up with an approach to the interview? For example: Is the consumer a native English speaker, blind, mentally-impaired?

Pre-interview Planning – Be Prepared

- Review case file and gather cues about consumer
- Formulate questions based on cues
- Plan interview approach

Meeting the Consumer – Establish Rapport

- Introductions should be formal and cordial
- Small talk to get the conversation going
- Pay attention to verbal and non-verbal cues

Begin Assessment Interview – Explain Process

- Explain purpose of interview
- Explain your role to the consumer
- Ask the consumer for feedback – do they understand the process and purpose?

Concluding the Interview

- Clarify – Next steps
- Explain – Additional paperwork needed before authorization of services
- Discuss – Notification process of authorized hours
- Answer – Questions the consumer may have

The Interview: Choosing the Right Questions

Direct or Closed-ended Questions –
- Are questions that seek a simple "yes" or "no" answer.
- Specifically ask for information. For example: "Are you coming tomorrow?" or "Do you eat three times a day?"
- These questions do not encourage or allow for an explanation of why the answer was chosen, or for an elaboration of thought or feeling about the answer.
- They can be leading –they ask a question in narrow terms such that they seem to be "hinting" at the answer.

Open-ended Questions –
- Cannot be answered by yes or no.
- These questions begin with 'who', 'what', 'where', 'when' or 'how.'
- They give consumers more choice in how they answer and will encourage them to describe the issue in their own words.
- Open-ended questions seek out the consumer's thoughts, feelings, ideas and explanations for answers.
- They encourage elaboration and specifics about a situation. For example: "How are you able to bath yourself?"

Indirect Questions –
- Ask questions without seeming to.
- They are not stated as a question.
- In these the interviewer is asking a question without stating it in question format. For example: "You seem like you are in a great deal of stress today."

The Interview: Open-ended Questions for Interviews

Open-ended questions cannot be answered by yes or no. These questions usually begin with "who", "what", "why", "where", and "when."

1. How have you been managing at home since I saw you last/since you got home from the hospital?
2. What do you need in the way of help right now?
3. Let's talk about things you are able and not able to do.
4. Help me understand….
5. What do you mean by_____?
6. Would you tell me more about…?
7. What else can you tell me that might help me understand?
8. Could you tell me more about what you're thinking?
9. I'd be interested in knowing…
10. Would you explain…?
11. Is there something specific about _____that you are asking for?
12. Would you explain that to me in more detail?
13. I'm not certain I understand…Can you give me an example?
14. I'm not familiar with_____, can you help me to understand?
15. What examples can you give me?
16. You say that you're not able to [cook/bathe/…_] . How have you been managing [your meals/bathing/…]?
17. When you say _____, what do you mean?
18. I'd like to help you get the best possible service; what more can you tell me that will help me understand your need?

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publisher

The Interview: Other Assessment Cues

Non-verbal Assessment Cues:

Your Body Speaks Your Mind

- Between 60-80% of our message is communicated through our body language, only 7-10% is attributable to the actual words of a conversation.
- Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

Eye Contact

It is important to look a consumer directly in the eye. Hold your head straight and face the consumer. This establishes rapport and conveys that you are listening to the consumer. This is not staring, but being attentive. However, be conscious of cultural differences and respect them.

Facial Expressions

These are the strongest non-verbal cues in face-to-face communication. Be aware of your own non-verbal – what are my habits that could be interpreted wrongly. Make certain that your facial expressions are congruent with your other non-verbal behavior. (Crossing arms, hands on hips, other…not portraying your interest) What do I see in the other person's face? If unclear, ask for interpretation.

Body Positioning

Posture, open arms versus crossed. When interviewing consumers look for cues in their body positioning, and be aware of your own. Sitting in an attentive manner communicates you are interested.

Environmental Cues:

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Importance of observations (i.e., house condition, cleanliness of consumer, tour house, etc.).

Sensory Cues:

- Data obtained by smelling.
- Tactile information – sticky floors, surfaces.

The Interview: Clarifying Information

It is important to probe for details and clarify information in order to get the best outcomes from the interview. Look for:

1. **Conflicting information.**
   - What is observed is not consistent with information given
     For example, consumer says she can't feed herself but she has been knitting, an activity that demonstrates manual dexterity. Perhaps the consumer's difficulty is in lack of strength; probing questions would be needed to tease out the basis of the statement that she cannot feed herself. Also, consider good days versus bad days. You may be seeing the consumer whose condition and abilities fluctuate.

   - What the consumer says is inconsistent
     For example, he says that he has no trouble bathing himself and he tells you that he is unable to walk without someone's constant assistance because he can't hold onto the handrails of a walker or a cane and he's unsteady on his feet. Perhaps the consumer who is at risk of falling is extremely modest and doesn't want anyone to see his naked body.

   - What the consumer says and the family says are in conflict.
     For example, the consumer says that he needs no help in dressing. The daughter with whom he lives and who is also his primary caretaker says that she dresses him every day. Probing questions are needed to determine whether the daughter is dressing her father because it's faster than to let him do it himself or if he is unable to dress himself. Issues to be considered would include his ability to reach, balance when standing, and perform tasks that require manual dexterity such as buttoning and zipping.

2. **Unrealistic expectations of the program.**
   For example, the consumer had fallen and broken her hip. When she fell, she had lain on the floor for 7 hours until a neighbor heard her calling for help. The consumer just returned home from a rehab facility for therapy following hip replacement. She wants round-the-clock care so that if she falls again, she will get immediate help. Her concerns are understandable, but not within the Program scope. An alternative would be to make referrals to organizations that can provide her with a panic button so that she can summon assistance in the event of another fall.

3. **Safety issues.**
   For example, a consumer says she is independent bathing. Thought she's unsteady on her feet, she says that she holds onto the towel rack to aid in stability. You look in the bathroom and confirm that what she's using to stabilize her is not a properly installed grab bar but a towel rack that is starting to come loose from the wall behind the bathtub. She needs help getting into and out of the tub and a grab bar and shower bench. If she discusses this with her physician and obtains a prescription for these items, it's possible that Medi-Cal will pay for these safety devices. Without assistance into and out of the tub, she's at risk of falling.

How to Probe to Clarify Information

When probing to clarify information the goal is to check that you have heard the consumer correctly, you are clear on the details of the information, and you have a complete picture of the situation. The following are a few methods that can be used to verify information and to decrease the risk of misunderstanding what the consumer has said.

1. Paraphrasing – Feedback the consumer's ideas in your own words. For example, the consumer says that he doesn't go to church anymore because he can't be far from a toilet after taking his diuretic. You say, "I see, you take a diuretic in the morning and have to be close to the toilet. How long does that last?"

2. Stating your observations – Tell the consumer your observations about his behavior, actions and environment to find out if they are on target. For example, if you see that he can't get out of the chair without help, say so.

3. Demonstration – Have the consumer to show you an activity. For example, you wonder how well the consumer transfers. You ask the consumer to show you the apartment. That gives you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.

4. Asking clarifying questions – These questions are questions that get to details. For example:
   - "What do you mean by that? You said that you were tired a lot; tell me what the mean to you." If the consumer doesn't explain what they mean it is open to interpretation.
   - "Could you explain that, tell me more about that?"
   - "I'm not sure I understand." The simply directs the consumer's comments by letting him know you do not understand.

The Interview: Handling Difficult Situations

Most of the time the interview will go smoothly, but there are times when things will come up that will make getting good information more difficult. Here are some hints to help make each situation more successful.

1. The angry consumer – It is best to try to handle the anger at the beginning of the interview. This shows the consumer you care, and aren't there just to get your agenda accomplished. It never helps to ignore the anger; it will be a constant barrier to getting useful information.
   - Acknowledge the anger by gently confronting the consumer by saying something like, "You seem very upset and I am not sure why. Could we talk about what is upsetting you before we start?"
   - To get an angry person to open up explain (or re-explain) your purpose and that you need them to help you so you can best understand their needs and how the program can help them.
2. The consumer who is very sad / grieving – If the consumer is overcome by sadness and starts to cry.
   - Don't ignore or pretend they are not upset, crying. In some cases, it may not be obvious about the reasons for the sadness/grief, which may not become apparent until you ask a specific question that triggers the grief/sadness. Be direct but polite and sensitive. Let them talk briefly about the reason for the sadness/grief. You may say something like, "I'm sure that is very difficult for you", or "I'm sorry."
   - Try to be reassuring and let them know it is safe to express their feelings. A comment like, "It is OK to cry; we all cry," or, "I understand," can be effective.
   - Validate the situation by saying something like, "I have had other consumers who have the same reaction. It is hard." or, "These are difficult issues you're are dealing with, it is very normal."
   - If the consumer is too distraught about a recent death or other stressful event to focus on the issues you need to discuss for your assessment, it might be most appropriate to offer to reschedule the interview.

3. The consumer who rambles without focus – These consumers often want to tell long stories and often have a difficult time getting to 'the point'.
   - Remind the consumer of the goal of the interview. "That is very interesting Mrs. Jones, I really need to find out the details of how you get along each day so that I can help you get the services that you need. Can you tell me specifically how you prepare your meals?"
   - Rephrase the question in a more closed ended question, "I understand there have been many issues with your personal care. Do you need help with bathing?", if so you can then probe for specifics.

4. The consumer who answers with only a word or two – This can be very difficult because without information it is hard to get a good picture of the consumer's need.
   - Use open ended questions to try to get the consumer to give you a better picture.
   - Ask the consumer to paint you a picture of their day, "tell me what your day normally looks like." It is difficult to answer a question like this with one or two words and may get them to open up, or will allow you opportunities to probe for further information.

5. The consumer who is embarrassed – Some of the questions asked during the interview may be embarrassing to consumers. Especially those related to bowel and bladder care, and menstruation.
   - Reassure the consumer and acknowledge these may be embarrassing questions but that you need the information so they can get the assistance they need. "I know this may be embarrassing for you but I need to find out exactly what your needs are. Now you had said you have problems getting around. I'm wondering if that makes if difficult for you to get to the bathroom in time and causes you to have accidents."

6. Communication blocks:
   - Hearing difficulties –
     - Ask the consumer if they have a hearing aide. If they do check to see if it is in and if it is on. If the consumer cups his/her hand over the ear, the hearing aid will whistle if it is turned on.
     - Talk slowly without jargon.
     - If the person doesn't seem to understand, paraphrase yourself.
     - Ask if one ear is better that another and position yourself on that side.
     - You may need to follow up with a family member to get clarification of information.

   - Language barriers –
     - If they understand and speak some English make sure you go slowly, give them plenty of time to think of their answers and do not compound your questions.
     - Follow State regulations (MPP 21-115) and county procedures to arrange for an interpreter if the consumer does not speak English and you do not speak his/her language.

ALTERNATIVE RESOURCES TO CONSIDER

Adult Day Care offers non-medical services to adults 60 and older who are in need of some supervision and assistance. Day care activities are held at senior centers and include music, exercise, arts and crafts, discussion groups and outings. Some centers provide transportations, if necessary.

Adult Protective Services (APS) services adults 65 and older as well as disabled adults 18 to 65 who are harmed or threatened with harm. APS investigates cases of neglect, abandonment, and physical, fiduciary or sexual abuse. After a report of suspected abuse comes into the Call Center (800) 510-2020, an assessment is made by a social worker, and recommendations are made as to how the situation can be improved. Coordination with law enforcement begins as soon as criminal abuse is identified. Referrals to other programs often follow, along with emergency provisions of food, shelter or in-home aid. *(These may be considered alternative resources if any personal care services are provided by these referrals.)*

AIS Call Center has one easy phone number – (800) 510-2020 – that is the gateway for information and assistance. This is also the number to report elder or dependent adult abuse, or to apply for a variety of services for older adults, persons with disabilities and their families.

Alzheimer's Day Centers give respite to family caregivers assisting persons with Alzheimer's disease. These specialized day programs provide valuable interaction for seniors with Alzheimer's disease and related memory problems.

Brown Bag Program delivers surplus food items each month to low-income adults age 60 and older, helping to supplement their food budgets. Food is gleaned by volunteers (mostly seniors themselves) and donated by farmers, warehouses, packing companies and retail food chains.

Family Caregiver Support Program targets the needs of those who care for a family member. Services include support groups, respite, counseling and help with identifying resources. *(Can be considered as Alternative Resource as long as PCSP is provided; i.e. grooming, bathroom, feeding, changing diapers, etc.)*

Home-Delivered Meals are offered to adults 60 and older who are homebound due to illness or disability, who ask to have meals delivered to them. A social worker will visit to assess the need. If appropriate for the program, a hot meal is delivered each weekday and frozen meals are provided for the weekends. The cost is a voluntary donation.

Linkages serves functionally impaired and disabled adults age 18 and older, who are at risk of nursing home or board and care placement and ineligible for other care management programs.

Multipurpose Senior Services Program (MSSP) is for seniors age 65 and above who are eligible for Medi-Cal and at risk of nursing home placement. Care management services are provided to help clients – many with medical problems – to live safely in the community.

Nutrition Centers provide hot, nutritious lunches during the week, for adults age 60 and older. Besides promoting better nutrition, these centers reduce the isolation of many older adults who may live alone.

Ombudsman Program provides advocates for residents in long-term care facilities. These advocates maintain a presence in the facilities; respond to, and resolve complaints; act as mediators; support residents rights; and witness certain legal documents. Visits by Ombudsmen are unannounced, and all discussions with residents are confidential.

Project CARE is a community network program that provides an early warning of distress for frail, ill or disabled persons living at home. Services include daily "Are you OK?" phone checks, Postal Alert, Gatekeeper, minor home repairs and more.

COMMUNICATING IN DIFFICULT SITUATIONS

1. Listen for full understanding of the person's perspective. Allow them the opportunity to give you a clear picture of what they are trying to say.

2. Put the person at ease using non-verbal cues that show interest and concern.

3. Take the time you need to really understand the situation. In the long run, spending a few more minutes now will save time in avoiding conflict.

4. Respond to concerns the consumer may have in an affirming manner. Restate their concerns in a way that shows you have heard their issues.

5. Focus on the overall goal of the situation. Avoid personalization of the issues. Keep the conversation professional.

6. Understand what you do Today will have an Effect on Tomorrow. The more effective you are in dealing with the issue at hand, the less the issue will grow and consume your energies.

HANDLING HOSTILITY

The following are suggestions for handling consumer hostility:

1. Don't get angry or defensive. Recognize your own reactions. Remember that this is a professional, not personal, issue.

2. Don't patronize or lecture. Saying things such as, "why don't you just calm down" will only escalate the problem and is disrespectful to the consumer.

3. Allow the consumer to voice his/her concerns. Respond with acceptance and understanding. Be empathetic. Listen to understand the situation from the consumer's perspective.

4. Be positive – don't attack them. Show them respect for their discomfort.

5. Greet anger with calmness – set the mood for calm discussion and resolution.

6. Understand the facts regarding the situation that is upsetting the consumer. If you don't have the facts, state what you will need to find out and when you will get back to them.

7. Focus on present and future. Avoid allowing the consumer to get stuck in the past. Emphasize what can be done positively in the future, not what has happened in the past.

8. Ask questions – "How can I help?" Often the consumer knows what they want from you. If you understand their wants you will be able to discuss future possibilities with that in mind.

9. Summarize for clarification and understanding.

10. Be honest about your next steps. If you can't fix the problem outright, don't make promises that you cannot keep. If there are consequences to the behavior, let the consumer know.

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publishers and *Connecting with self and others*, Sherod Miller et.al. Interpersonal Communications Programs, Inc.

THINGS TO CONSIDER WHEN DEALING WITH SOMEONE WHO IS HOSTILE

1. Try to evaluate as honestly as you can by reasoning with yourself whether his/her anger is justified.

2. Put hostile people in perspective. You are probably nothing but an afterthought to them, so don't take their antics personally. They're not concerned about you because they're too busy worrying about themselves.

3. Take your pick – positive or negative. You cannot concentrate on constructive, creative alternatives or solutions while you cling to negative feelings. Vent your emotions to a fellow worker or your supervisor and cool off. Think about the result you really want, the consequences or outcome that will benefit the consumer the most.

4. Don't expect hostile people to change. They will not, and in a way that is good because their behavior is predictable. They may not change but by choosing a better approach you can change the outcome.

5. Learn to respond as well as listen. Ask questions instead of making accusations. If you let others save face, you give them room to change their minds.

6. Request feedback. Use open-ended questions to let emotional people vent their feelings before you try to reason with them and explore options.

7. Be straightforward and unemotional. The more you remain calm and matter-of-fact, the sooner you gain another's confidence. People want to feel you are leveling with them, that they can trust you. Remember that respect from other begins with self-respect.

8. Be gracious. Someone else's rudeness does not give us the right to be rude. Treat the other with the kindness you would like to be shown and allow them to feel important. When our own egos are healthy, we are rich; we can afford to be generous.

SOME FACTS ABOUT GRIEF

Two simple *Definitions* of grief are:
1. The conflicting feelings caused by the end of or change in a familiar pattern or behavior.
2. A normal, natural and painful emotional reaction to loss.

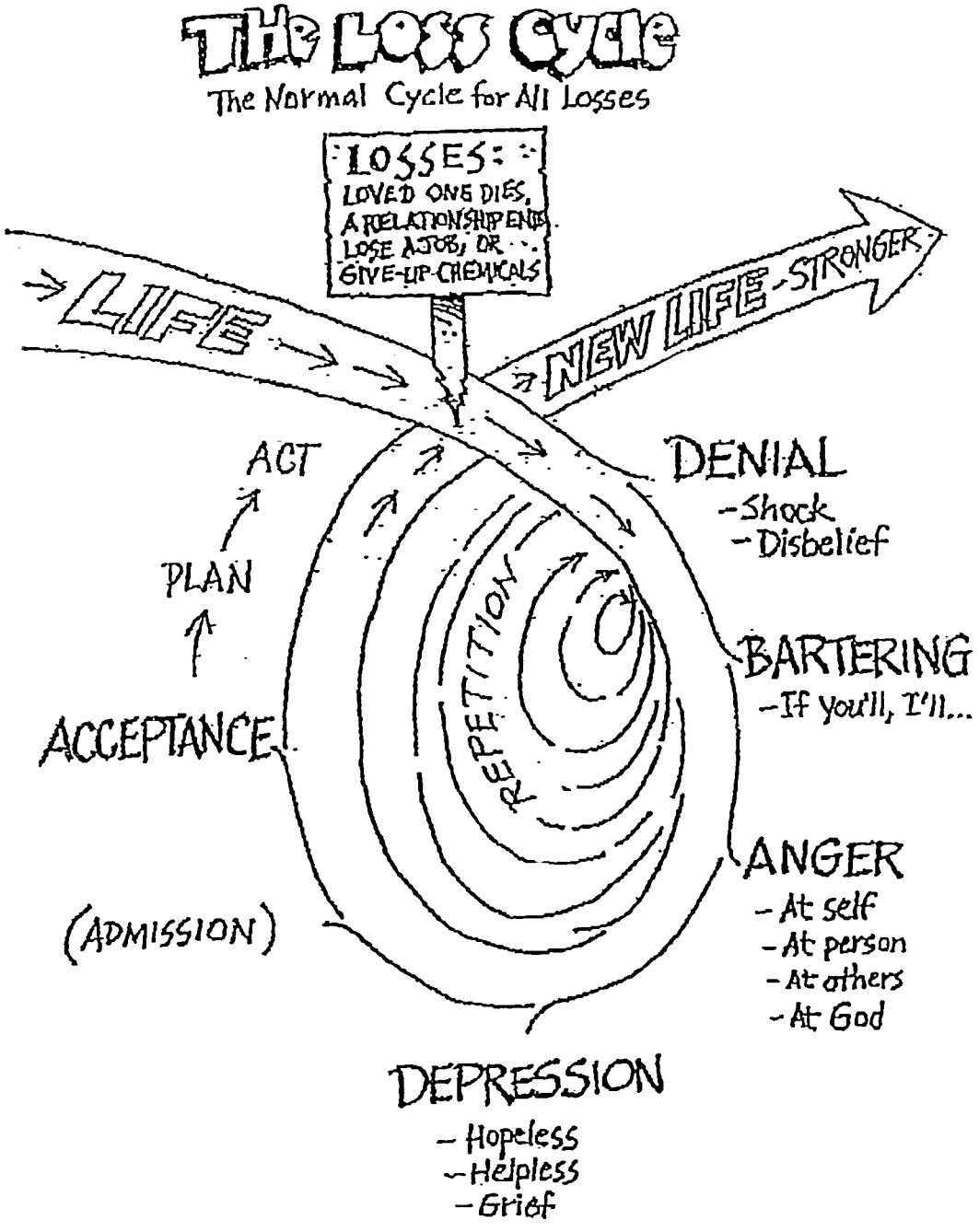
Causes of Grief
- Passing of a human life, as well as for the
- Death of a relationship (divorce),
- Loss of health and function and loss of independence, and
- Loss of a pet.

Grieving involves intense feelings - love, sadness, fear, anger, relief, compassion, hate, or happiness, to name a few. These feelings are intense, disorganizing and can be long-lasting. Grieving has been described as drowning in a sea of painful emotions.

Stages of Grief.
1. Shock – Immediately following the death of a loved one, it is difficult to accept the loss. A feeling of unreality, a feeling of being out-of-touch.
2. Emotional Release – Awareness of enormity of loss is realized accompanied by intense pangs of grief. In this stage a grieving individual sleeps badly and weeps uncontrollably.
3. Panic – Feelings of mental instability, wandering around aimlessly, forgetting things, physical symptoms.
4. Guilt – Feelings of guilt about failures in relationship, ability to change situation, to save deceased.
5. Hostility / Anger – Feelings of anger over the situation, cause of death and sometimes even at the deceased.
6. Inability to Get Back to Normal – Difficulty in regaining normality of daily living. Difficulty in concentrating on the day-to-day activities. The grieving person's entire being, emotional, physical and spiritual, is focused on the loss that just occurred.
7. Acceptance of Loss – Life balance slowly returns. There are no set timeframes for healing. Each individual is different.
8. Hope – The pains of grief are still present but the grieving person is able to find hope for the future. The individual is able to move forward in life with good feelings knowing they will always remember and have memories of the loved one.

Note: Consumers may pass through each stage more than once, and may be in more than one stage at a time. There is no particular order in which they may work through these stages. Even if they appear to have reached the end, another loss may trigger them to go back in to another stage.

Helping Consumers through the Grief Process
- Encourage consumer to take their time going through the grief process. Support them and family not to try to rush the process.
- Explain to the consumer that because this is a time of instability and high emotions, it is not a good time to make major life decisions.
- Encourage use of support groups for drug and alcohol if consumer / family have history of dependency.
- Help consumer to understand that they will have good days and bad days.
- Encourage them to seek out people who can listen to their stories and remember their loved ones.
- Reinforce that grief is a very personal and individual process – no one experiences it the same way.


The Loss Cycle
The Normal Cycle for All Losses
LOSSES:
LOVED ONE DIES,
A RELATIONSHIP ENDS
LOSE A JOB, OR
GIVE-UP-CHEMICALS
LIFE
NEW LIFE - STRONGER
DENIAL
- Shock
- Disbelief
BARTERING
- If you'll, I'll...
ANGER
- At self
- At person
- At others
- At God
DEPRESSION
- Hopeless
- Helpless
- Grief
ACCEPTANCE
(ADMISSION)
PLAN
ACT
REPETITION

GENERAL ETIQUETTE
For
Interacting with People with Disabilities

If you are interacting with people with disabilities for the first time: BE YOURSELF !
As in any new situation, everyone will feel more comfortable if you relax.

Tips on Conversation:

1. Talk with the person with a disability, not their spouse, assistant, interpreter, or others nearby. Maintain the eye contact and body language you would normally use during any other conversation.

2. An important thing to remember in any conversation with someone who has a disability is: "assume nothing." If you have a question about what to do, what language or terminology to use, or what assistance — if any — they might need, the person with the disability should be your first and best resource. Do not be afraid to ask their advice.

3. Be patient — not only with the person with the disability, but with yourself. Frustration may come from both sides of the conversation, and needs to be understood and dealt with by both parties.

4. The most important thing to focus on during a conversation with a person who has a disability is the overall goal. It is simply communication between two individuals. Ultimately, it is what is communicated — not how it is communicated — that will be important.

SPECIFIC DISABILITIES

The following summary of the characteristics of different types of disabilities contains many true statements, but no absolute truths: *Remember that every person with a disability is an individual.*

While this summary is about disabilities, it is important to remember that you are not interacting with disabilities; you are interacting with *individuals* with disabilities. Remember also that they are people first.

It is most important to ask the individual what terminology they prefer, or if they need assistance. With this in mind, the following general guidelines are offered.

BLIND OR VISUALLY IMPAIRED

Things to Know:

1. Most persons who are blind have some sight, rather than no sight at all.

2. Many people who are blind are mobile and independent. Some people who are blind view blindness not as a disability as much as an inconvenience.

3. While many people who are blind can use Braille, the majority of persons who are blind do not.

Things to Do:

1. Introduce yourself. Identify who you are and what your job or role is. Give the person verbal information that is visually obvious to those who can see. If you have met before, remind them of the context; they won't have the visual cues to jog their memory.

2. Be descriptive when giving directions. Saying "over there" has little meaning to someone who cannot see you point. "Four doors after turning right from the elevator" would be much more helpful.

3. Always ask someone if they need your assistance and how you can assist them. Lead someone who is blind only after they have accepted your offer to do so. Allow them to hold your arm, rather than you holding them. It is important to let people with vision impairments control their own movements.

4. Many techniques are used as tools for independence, but individuals with disabilities use only things that work for them. Remember to describe sights or objects from their perspective, not yours. Tell them when you have brought new items into their environment, describing what they are and, most importantly, where you have put them.

Things to Avoid:

1. Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.

2. Do not use references that are visually oriented like, “over there near the green plant.”

3. Do not interact with a service dog while it is working (in harness).

Things to Consider:

1. Persons who are blind have more often been told what to do rather than asked what they would prefer doing. This attitude is not acceptable towards any person.

DEAF AND/OR HEARING IMPAIRED

Things to Know:

1. Most persons who are deaf or hearing impaired have some hearing, rather than no hearing at all.

2. Sign language is not another form of English; it is an official language with its own grammar, contexts and rules. Not all persons who are deaf use sign language.

3. Lip-reading, while helpful without sound clues, is only 30% - 50% effective, and sometimes less. Not all persons who are deaf lip-read.

4. Long conversations with persons who can lip-read can be very fatiguing to the person who has the disability.

5. Not all persons who are deaf write and read.

6. Not all persons who are deaf speak.

Things to Do:

1. Find out how the person communicates best.

2. If the person uses an interpreter, address the person, not the interpreter.

3. If the person reads lips, speak in a normal, not exaggerated, way. Short simple sentences are best.

4. If the person lip-reads, avoid blocking their view of your face. Make sure the lighting is good.

5. Gain the person’s attention before starting a conversation.

6. If there is some doubt in your mind whether you were understood, rephrase your statement and assure that understanding has been reached.

7. Be aware of situations where a person may be waiting for a service (transportation, a table, the start of an activity) where the common way to communicate is an announcement or the calling of the person's name. Advise them when their name is called. Make sure you take notes when someone cannot hear you, and develop an alternative method of notifying them.

Things to Avoid:

1. Do not become impatient or exasperated with the person if it takes longer to communicate.

2. Make sure there are no physical barriers between you and the person you are in conversation with.

3. If the person is using hearing aids, avoid conversations in large, open and noisy surroundings.

Things to Consider:

1. Persons who may deal very well one-on-one in communication may have a hard time with two or more speakers, especially if there are many interruptions and interjections.

2. Showing impatience to someone who is deaf or hearing impaired may cause the less assertive person to back off from telling you of his or her needs.

3. When someone asks, "What did you say?" the answers, "Never mind," "Nothing," or "It's not important," are very common replies. These are insulting and demeaning because they communicate that the person is not worth repeating yourself for.

PEOPLE WHO USE WHEELCHAIRS OR OTHER MOBILITY DEVICES

Things to Know:

1. There are many reasons (not just being paralyzed) which might require someone to use a wheelchair. These might include loss of stamina or equilibrium, or a temporary condition like a fracture or recovery from surgery.

2. There are a wide range of physical capabilities among people who use wheelchairs. This means that persons who use them may require different degrees of assistance, or no assistance at all.

3. Some persons do not use wheelchairs exclusively, but may also use canes, leg braces and, in some cases, no assistive devices at all—or only for short periods.

4. All wheelchairs are not the same. Different sizes and shapes meet different needs. Some wheelchairs move manually and others are motorized. Just because one person can access an area in his or her wheelchair does not mean that everyone with a wheelchair may be able to do so.

Things to Do:

1. If you are asked to fold, carry or store a wheelchair, treat it with the same respect that you would if you were holding someone's eyeglasses. They are similar in many ways. Wheelchairs can break, they are difficult to have repaired on short notice and on weekends, and it is extremely disruptive to the user when they are out of commission.

2. When you meet someone seated in a wheelchair, extend your hand to shake if that is what you normally do. A person who cannot shake hands will let you know. They will appreciate being treated in a normal way.

3. When speaking to someone who uses a wheelchair, remember to give the person a comfortable viewing angle of yourself. Having to look straight up is not a comfortable viewing angle.

Things to Avoid:

1. Do not approach someone who is using a wheelchair and start pushing him or her without asking.

2. When communicating, do not stand too close to the person in a wheelchair. Give him or her some space.

Things to Consider:

1. It is a very common experience for persons who use wheelchairs to be told that some place is accessible when it is not. Listen carefully when anyone who uses a wheelchair tells you that some area which you thought was accessible is not.

2. Do not assume that the person using a wheelchair needs assistance. Ask the person if there is anything special you can provide.

CONDITIONS WHICH CAUSE DIFFICULTY WITH SPEECH

Things to Know:

1. There are many reasons for having difficulty with speech. Deafness, cerebral palsy, stroke, head injury, physical malformation of speech mechanisms, and general speech impairment are just a few.

2. It is not unusual in stressful situations for someone's speech to become harder to understand.

Things to Do:

1. If you do not understand what a person is saying, bring it to his or her attention immediately and ask how the two of you may communicate more effectively.

2. If it is a stressful situation, try to stay calm. If you are in a public area with many distractions, consider moving to a quiet or private location.

3. Consider writing as an alternative means of communication.

4. If there is no solution to the communication problem that can be worked out between you and the person, consider asking if there is a person who could translate or interpret what he or she is saying.

Things to Avoid:

1. Do not pretend to understand when you really do not.

2. Do not become exasperated or impatient with the communication process.

3. Do not finish sentences for the person with a disability.

Things to Consider:

1. Many persons with difficulty speaking find themselves in situations where people treat them as if they are drunk, developmentally disabled or mentally ill. They are accustomed to being avoided, ignored, or even hung up on by phone.

2. Accessibility for persons with difficulty in speech lies within your power. Your patience and communication skills are as important to someone with speech that is difficult to understand as a grab bar or a ramp is to someone who uses a wheelchair.

DEVELOPMENTAL DISABILITIES

Things to Know:

1. Developmental Disability refers to conditions occurring before adulthood which sometimes result in below average intelligence, impaired motor functioning, cerebral palsy, autism or other disabling conditions.

2. A low intelligence test score alone does not necessarily indicate that a person is developmentally disabled.

3. What is seen by most people is behavior reflecting slow, arrested, or incomplete development before a person reaches the age of eighteen.

4. It is important to remember that, even though someone is an adult, there are certain characteristics which are described as childish or childlike, leading to the erroneous conclusion that a person has a "mental age of 4 or 5". A person who is 30 years old with a mental age of five has had 25 more years of life experience upon which to base his or her behavior.

5. Because each person with a developmental disability is an individual, there is no "overall" description one can give to alert that a person is developmentally disabled. Every person with a developmental disability will display characteristics differently, with varying levels of intensity.

6. Not all people with developmental disabilities look disabled, nor will they act in the same way when making contact with people.

Things to Do:

1. A calm, patient attitude on your part will prove to be your most effective tool.

2. Be aware that a "yes" response may be inappropriately given out of fear of disapproval or in an attempt to please.

3. If a person with a developmental disability is lost, be aware that residents of Board and Care homes may have their names printed on their clothes, collar or similar location.

Things to Avoid:

1. People with developmental disabilities may not have any speech, or may have very limited speech. Avoid frightening a person with developmental disabilities, as they may be unable to respond because of fear. They may, however, respond to questions, especially those requiring a "yes" or "no" answer.

Things to Consider:

1. Medication may slow their speech or reactions, or cause them to walk in a manner which arouses suspicion.

CEREBRAL PALSY

Things to Know:

1. Cerebral palsy is a condition that results from damage to the central nervous system before birth, or early in life.

2. "Cerebral" refers to the brain and "Palsy" to a disorder of movement or posture.

3. It is neither progressive nor communicable, and has little or no relation to intelligence.

4. Cerebral Palsy is characterized by an inability to fully control motor functions. A person with Cerebral Palsy may have spasms; involuntary movement; disturbance of gait or mobility; seizures; abnormal sensation and perception; impairment of sight, hearing, or speech; and mental retardation.

Things to Do:

1. To the uneducated observer, a person with Cerebral Palsy may be thought to be ill or drugged. Your experience with others who are under the influence of a variety of drugs could help you to determine the difference.

Things to Avoid:

1. Do not make assumptions about the intelligence of persons with Cerebral Palsy.

Things to Consider:

1. Over a half million people in the United States have Cerebral Palsy. Many are wheelchair users and you may refer to the previous section concerning wheelchairs for additional information.

EPILEPSY

Things to Know:

1. Epilepsy is a symptom of a disorder of the central nervous system occurring either as a result of head trauma or as a condition present from birth, which may result in seizures.

2. Epilepsy is not a disease, nor is it progressive, related to intelligence, or necessarily related to another disability.

3. One person in a hundred has epilepsy; however, 80% of those diagnosed will have good control of seizures through medication.

4. There are three seizure patterns:

    - The Grand Mal convulsion consists of a loss of consciousness, stiffening, muscle rigidity and spasms.

    - The Petit Mal seizure may not be readily recognized, as it usually consists of a lapse of from 5 - 25 seconds and gives the appearance of daydreaming or staring.

    - The Psychomotor seizure may be seen only as staring or confusion, dizziness or fear, or other behavior such as lip smacking or erratic arm movements.

Things to Do:

1. At the scene of a seizure, your best action would be to keep the person from getting injured by removing objects from the area which might cause injury (chairs, tables, etc.).

2. If the person is still unconscious after a seizure, turn him or her on their side, with the face downward.

Things to Avoid:

1. Do not restrain the movements of a person having a seizure.

2. Do not put anything between the teeth.

3. Do not give the person anything to drink.

Things to Consider:

1. Medical aid for epilepsy is usually not necessary unless a seizure lasts longer than 15 minutes.

2. The person may not remember what has happened, and may require your assistance for a short period of time while getting reoriented.

3. Seizures usually draw a crowd of onlookers. This is an excellent opportunity to set an example for others by your conduct, and educate the uninformed as to successful intervention techniques.

AUTISM

Things to Know:

1. Autism is a severely incapacitating lifelong developmental disability that appears during the first three years of life.

2. In it's broad definition, autism or autistic-like symptoms occur in about five out of every thousand children.

3. Autism is four times more common in males than in females, and is found throughout the world in families of all racial, ethnic and social backgrounds.

4. Symptoms of autism include:

    - Slow development, or lack of physical, social and learning skills.

    - Immature rhythm of speech and limited understanding or use of words.

    - Abnormal responses to sensations: sight, hearing, touch, pain, balance, smell, taste, etc.

    - Abnormal ways of relating to people, objects and events.

Things to Do:

1. Quite often, when you come into contact with people with autism, they will be in their neighborhood or where family or friends are near.

2. There are no hard and fast rules for dealing with people who have autism.

3. Be aware of the symptoms of autism.

4. A calm, persistent approach should work best.

Things to Avoid:

1. Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with autism might cause them to flee.

2. Attempting to confine a person who is autistic might cause great fear and resistance.

Things to Consider:

1. Autism is perhaps the most challenging disability with which to cope.

2. At first glance, the actions of persons with autism may seem to be hostile, antagonistic, bizarre or drug-induced.

3. People with autism sometimes feel pain when others would not, and at other times feel no pain.

4. Your attention may be drawn to people who are autistic by their "odd" behavior.

5. People with autism may show a fascination with something inanimate (especially wheels or circular objects), walk into traffic without looking, or be engaged in other aggressive or self-injurious behavior.

PSYCHIATRIC DISABILITIES AND NEUROLOGICAL DISORDERS (ALZHEIMER'S DISEASE, MENTAL ILLNESS, TRAUMATIC BRAIN INJURIES)

Disabilities which do not manifest themselves with physical symptoms can present unexpected complications when interacting with anyone you do not know. What might be considered a "normal" conversation could change without warning or apparent cause.

The onset of the broad group of disabilities which affect the brain can be from a variety of causes: injury, illness, age, drug abuse, trauma or for no apparent reason. In some cases, the person with a disability may exhibit no symptoms most of the time; even medical professionals can have difficulty identifying the full extent of the mental disability, or its causes.

Things to Know:

1. Alzheimer's Disease normally affects people who are older. Childlike characteristics or symptoms may suddenly appear, and memory loss is the most common sign that Alzheimer's Disease is present. People who have Alzheimer's Disease often wander away from their residences, and may have very plausible explanations of where they think they are going.

2. Mental Illness covers a broad range of psychiatric disabilities: schizophrenia, manic depression, severe depression, and most anxiety disorders. Some of these mental illnesses can be treated with medicine but, because they do not recognize that they are ill, people who have mental illness frequently stop taking their medication.

3. Traumatic Brain Injury (TBI), or head injuries, can occur in accidents which sometimes appear minor. A person with a TBI may not recognize that their characteristics or actions change when the injury's symptoms are manifested. Even if there are normally no signs of a TBI present, a sudden change in speech pattern or volume, a burst of anger, or an indecipherable sentence could be an indication that a head injury has occurred.

Things to Do:

1. Mental disabilities can be so varied that there are no easy rules for dealing with the symptoms they cause.

2. Be alert for unusual characteristics, actions or phrases; if they present, assume that there may be some type of disability present.

3. A calm, friendly approach works best while interacting with anyone.

Things to Avoid:

1. Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with a mental disability might cause them to flee or react violently.

2. Tones of voice, actions, or appearance which are threatening to a person with a mental disability could trigger an unexpected or unwanted reaction.

Things to Consider:

Neurological disorders and the broad range of mental illnesses present challenges for medical professionals, family members, friends, and the people affected by the

disabilities. Your interactions and conversations with people who have such disabilities may be frustrating or unnerving at times. By remaining calm, friendly and helpful you should be able to attain your objective despite the complications which are involved.

HIDDEN DISABILITIES

Not all disabilities are apparent. A person may have trouble following a conversation, may not respond when you call or wave to them, may make a request that seems strange to you, or may say or do something that seems inappropriate. The person may have a hidden disability, such as low vision, a hearing impairment, a learning disability, traumatic brain injury, mental retardation, or mental illness.

Don't make assumptions about the person or their disability. Be open-minded.

LEARNING MORE

Lack of knowledge or misinformation may lead you to shy away from interacting with persons with certain disabilities. Preconceptions about mental illness, AIDS, cerebral palsy, Tourette Syndrome, Alzheimer's Disease and other disabilities often lead to a lack of acceptance by those around the person.

Remember that we are all complex human beings; a disability is just one aspect of a person. Learning more about the disability may alleviate your fears, and can pave the way for you to see the person for who they really are. Keep practicing, and enjoy the experience.

LANGUAGE TIPS

There are some general hints which can help make your communication and interactions with people with all types of disabilities more successful:

1. The preferred terminology is "*disability*" or *disabled*, not "*handicap*" or "*handicapped*." Never use terms such as "*retarded, dumb, psycho, moron"* or *"crippled"*; they are very demeaning and disrespectful to people with disabilities.

2. Remember to put *people first*. It is proper to say "*person with a disability"*, rather than "*disabled person*."

3. If you are unfamiliar with someone, or their disability, it is better to wait until they describe their situation to you than to make your own assumptions about them.

Many types of disabilities have similar characteristics, and your assumptions may be wrong.

Repeated Reminders — Tips on Conversation:

1. Talk with the person with a disability, not their spouse, assistant, interpreter, or others nearby. Maintain the same eye contact, tone of voice and body language you would normally use during any other conversation.

2. An important thing to remember in any conversation with someone who has a disability is: "assume nothing." If you have a question about what to do, what language or terminology to use, or what assistance — if any — they might need, the person with the disability should be your first and best resource. Do not be afraid to ask their advice.

3. Unless you know that you are speaking with someone who has a cognitive or hearing disability, use your normal speaking speed. It is always a good idea to speak clearly, without mumbling or slurring words.

4. Don't be overly friendly, paternalistic, or condescending when speaking to a person with a disability. Most people, even if they are unable to speak to you in a "normal" manner, have normal or above-average intelligence. Your use of abnormal speech or simplistic language will lessen the chances of having a successful conversation.

5. Be patient — not only with the person with the disability, but with yourself. Frustration may come from both sides of the conversation, and needs to be understood and dealt with by both parties.

Once again, the most important thing to focus on during a conversation with a person who has a disability is the overall goal. ***It is simply communication between two individuals.*** Since about 20% of people in our society have some type of disability, you never really know when that will be a factor in one of your conversations.

WORKING WITH BLIND CONSUMERS IN IHSS

Aid codes for blind aid are “20”, “26”, “28”, etc.

- Best corrected vision for statutory blindness 20/200 or visual field <15º

Most common causes of blindness:

- Lack of oxygen and other delivery impairments at birth
- Macular degeneration (degenerative blemishes on the retina), which results in “tunnel vision”
- Glaucoma (increased pressure and hardening of the eyeball)
- Diabetes (diabetic retinopathy)
- Cataract (lens becomes opaque)
- Now often corrected or improved by surgery
- Retinal detachment (retina is light-sensitive cells at back of eyeball. If they detach from the optic nerve, visual image cannot reach the brain.)

Medications currently used for blindness:

- Botopic – drops
- Timopic – drops
- Xalatin – drops
- Diamox – pills
- Laser treatments

Assessment of home care needs of the blind:

- Legal blindness covers a wide range of vision. Don’t assume about consumer capabilities.
    - Ask consumer how much vision they do have
    - Ask consumer to identify number of fingers held up by worker
    - Ask consumer to describe worker appearance
    - Ask consumer to describe color of clothing worker is wearing

- Find out how much training consumer has had.
    - What kind?
    - How much mobility training?
    - What “gizmos/trick”?
    - Those with intensive schooling are often Braille capable and very adept to getting around.
    - Those who are blind from birth often have mental health issues overlay basic blindness impairment. Isolation due to never having the sight experience.
    - Those with late or adult onset tend to have a slower diminution of sight, allowing time to adapt.

- Community resources.
    - Department of Vocational rehabilitations; OCB
    - Living Skills Centers
    - Guide dogs
    - Special mobility training
    - Nonprofit organization serving the blind
    - Special services from utilities
    - Large print books

- Explore other health problems and their impact on functioning

- IHSS Tasks
    - Domestic: Explore for sign of vermin too small for consumer to see, also crumbs, grease or mold.
    - Meals & Cleanup: Same as above. Explore for vermin, encourage microwaving.
    - Laundry: Explore for spots and stains. Consumers often have trouble with use of bleach, pre-spotting, coordination of colors, storing clothing in matching sets to facilitate dressing.
    - Dressing: Store clothes in matching styles, colors. Consumers feel seams to determine right-side out. Also feel label to feel back for front. These are some of the skills taught in the training programs.
    - Bowel and Bladder: Often creates a mental problem due to shame.
    - Feeding: Consumers rely on things being in place; don't move anything without permission. Plate and table settings need to be in designated spots.
    - Bathing and Grooming: Most men use an electric razor. Observe hairstyle as a factor in grooming time. Provider may need to do set-ups.
    - Accompaniment to MD visits: Can be approved only for consumers who need physical assistance.
    - Paramedical: Can be involved with administration of insulin injections.
    - Setting up medi-sets can be helpful.

CULTURAL RESOURCES

Enhancing Your Cultural Communication Skills
The following questions may assist clinicians in assessing clients and families from culturally diverse backgrounds.

So that I might be aware of and respect your cultural beliefs...

1. Can you tell me what languages are spoken in your home and the languages that you understand and speak?
2. Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
3. Can you tell me about beliefs and practices including special events such as birth, marriage and death that you feel I should know?
4. Can you tell me about your experiences with health care providers in your native country? How often each year did you see a health care provider before you arrived in the U.S.? Have you noticed any differences between the type of care you received in your native country and the type you receive here? If yes, could you tell me about those differences?
5. Is there anything else you would like to know? Do you have any questions for me? (Encourage two-way communication)
6. Do you use any traditional health remedies to improve your health?
7. Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
8. Are there certain health care procedures and tests which your culture prohibits?
9. Are there any other cultural considerations I should know about to serve your health needs?

http://www.med.umich.edu/multicultural/ccp/questions.htm#skills

Suggested Content for Enhancing Cultural Competency

1. Interview and assess consumers in the target language or via appropriate use of bilingual/bicultural interpreters.
2. Ask questions to increase your understanding of the consumer's culture as it relates to health and daily living practices.
3. Where appropriate, formulate plans, which take into account cultural beliefs and practices.
4. Write instructions or use handouts if available.
5. Effectively utilize community resources.
6. Request the consumer to repeat back information provided to ascertain understanding of the message (educational and language barriers).
7. Clearly communicate *expectations*. Speak slower, not louder. When appropriate, use drawings and gestures to aid communication.
8. Make no assumptions about education level or professionalism.
9. Avoid using phrases such as "you people" and "culturally deprived", which may be considered culturally insensitive.
10. Reflective approach is useful. Examine your own biases and *expectations* to understand how these influence their interactions and decision-making.
11. Listen carefully.

Adapted from: Patient Education Oversight Committee, UMHS
www.med.umich.edu/pteducation/cultcomm2.htm

ALZHEIMER'S FACTS

Definition of Alzheimer's Disease
Alzheimer's disease is a group of disorders involving the parts of the brain that control thought, memory, and language. It is marked by progressive deterioration, which affects both the memory and reasoning capabilities of an individual.

Description of Alzheimer's Disease
Alzheimer's disease is the most common form of dementia (mental deterioration of memory and thought processes) among the elderly. It is estimated that 4.5 million Americans over the age of 65 are affected with this condition. After the age of 65, the incidence of the disease doubles every five (5) years and, by age 85, it will affect nearly half of the population.

Alzheimer's disease was first described in 1906 by German neurologist Alois Alzheimer. The disease causes irreversible changes in the nerve cells of certain vulnerable areas of the brain. It is characterized by nerve-cell loss, abnormal tangles within nerve cells and deficiencies of several chemicals, which are essential for the transmission of nerve messages.

The disorder leads to behavioral and personality changes, forgetfulness, confusion, inability to learn new material, paranoia and motor activity problems. Language difficulties also are common in people with Alzheimer's disease. The disease typically progresses to the stage where it is difficult for the patient to be understood by others or to understand others, and in the final stages, the patient is bedridden.

Although nearly half of those over 85 may have Alzheimer's disease, it is not a "normal" part of aging.

Causes and Risk Factors of Alzheimer's Disease
The cause of Alzheimer's disease has yet to be determined, but there are five (5) theories that warrant further investigation:

1. **Chemical Theories.**
   A. **Chemical Deficiencies**. One of the ways in which brain cells communicate with one another is through chemicals called neurotransmitters. Studies of Alzheimer's diseased brains have uncovered diminished levels of various neurotransmitters that are thought to influence intellectual functioning and behavior.
   B. **Toxic Chemical Excesses**. Increased deposits of aluminum have been found in Alzheimer's disease brains.

2. **Genetic Theory**.
   Researchers have linked late-onset Alzheimer's to the inheritance of a gene that directs production of apolipoprotein (ApoE). In early-onset Alzheimer's, researchers identified a mutation on chromosome 14, which accounts for 10 percent of Alzheimer's cases. Additionally, a mutation was found on chromosomes 1 and 21. In 1997, researchers found another mutation on chromosome 12 that is linked to late-onset Alzheimer's.

3. **Autoimmune Theory**.
   The body's immune system, which protects against potentially harmful invaders, may erroneously begin to attack its own tissues, producing antibodies to its own essential cells.

4. **Slow Virus Theory**.
   A slow-acting virus has been identified as a cause of some brain disorders that closely resemble Alzheimer's.

5. **Blood Vessel Theory**.
   Defects in blood vessels supplying blood to the brain are being studied as a possible cause of Alzheimer's.

The chances of getting Alzheimer's disease increases with age and usually occurs after the age of 65, after which the chances of getting the disease double every five years.

There are only two definite factors that increase the risk for Alzheimer's disease before age 65: a family history of dementia or Alzheimer's, and Down syndrome. Down syndrome is a combination of physical abnormalities and mental retardation characterized by a genetic defect in chromosome pair 21.

Symptoms of Alzheimer's Disease

The U.S. Agency for Health Care Policy Research provided this list of questions to help recognize the condition:

- *Learning and retaining new information*. Does the person misplace objects and/or have trouble remembering appointments or recent conversations? Is the person repetitive in conversation?
- *Handling complex tasks*. Do familiar activities like balancing a checkbook, cooking a meal, or other tasks that involve a complex train of thought, become increasingly difficult?
- *Ability to reason*. Does the person find it difficult to respond appropriately to everyday problems, such as a flat tire? Does a previously well-adjusted person disregard rules of social conduct?
- *Spatial ability and orientation*. Does driving and finding one's way in familiar surroundings become impossible? Does the person have problems recognizing familiar objects?
- *Language*. Does the person have difficulty following or participating in conversations? Does the person have trouble finding the words to express what they want to say?
- *Behavior*. Does the person seem more passive or less responsive than usual or more suspicious or irritable? Does the person have trouble paying attention?

The onset and symptoms of Alzheimer's disease are usually very slow and gradual, seldom occurring before the age of 65. It occurs in the following three (3) stages:

Stage 1: forgetfulness, poor insight, mild difficulties with word-finding, personality changes, difficulties with calculations, losing or misplacing things, repetition of questions or statements, and a minor degree of disorientation

Stage 2: memory worsens, words are used more and more inappropriately, basic self-care skills are lost, personality changes, agitation develops, can't recognize distant family or friends, has difficulty communicating, wanders off, becomes deluded, and may experience hallucinations

Stage 3: bedridden, incontinent, uncomprehending, and mute

Diagnosis of Alzheimer's Disease

An estimated 5 to 10 percent of all mental deterioration in persons over the age of 65 is due to reversible conditions, such as depression, underlying physical disease (metabolic disorders, cardiovascular disease or pernicious anemia), excessive and inappropriate drug use, loss of social support, or change in social environment. Therefore, it is important to diagnose Alzheimer's disease to ensure that any mental impairment is not reversible.

In order to diagnose Alzheimer's disease, a physician must:

- take a detailed medical history
- conduct physical and neurological examinations
- consult the diagnostic criteria stated below
- conduct laboratory examinations, such as urine tests, a CAT scan, magnetic resonance imaging (MRI), or positron emission tomography (PET) to detect structural abnormalities of the head and brain
- conduct a functional and mental status assessment test
- do a complete inventory of any prescription and over-the-counter drugs the patient is taking

The diagnostic criteria for dementia and Alzheimer's disease is as follows:

Dementia

A. Multiple cognitive deficits manifested by both 1 and 2:
   1. Impaired short- or long-term memory
   2. One or more of the following cognitive disturbances:
      - Impaired language ability
      - Impaired ability to carry out motor activities
      - Impaired ability to recognize objects
      - Impaired abstract thinking (e.g., planning and organizing)

B. Deficits in A are sufficient to interfere with work or social activities and represent a significant decline in function.

C. Deficits do not occur exclusively during the course of delirium.

Alzheimer's Disease

Dementia as determined by A through C (stated above), plus:

D. Disease course is characterized by gradual onset and continuing cognitive decline.

E. Cognitive deficits are not caused by any of the following:
   - Another progressive central nervous system disorder (e.g., Parkinson's or Huntington's disease)
   - A systemic condition (e.g., hypothyroidism or niacin deficiency)
   - A substance-induced condition

F. Disturbance is not better explained by another disorder (e.g., major depressive disorder or schizophrenia).

Treatment of Alzheimer's Disease

Although there is currently no cure for Alzheimer's disease, a great deal can be done to manage it. There are four (4) approaches to managing the disease. The approaches and solutions are:

- Relieve behavioral symptoms associated with dementia, including depression, agitation and psychosis. Medications, called cholinesterase inhibitors, such as tacrine (Cognex), donepezil (Aricept), rivastigmine (Exelon) or galantamine (Reminyl), enhance the effectiveness of acetylcholine (the chemical messenger found in the neurotransmitter system which coordinates memory and learning) by slowing its breakdown. Unfortunately, these medications only temporally improve the symptoms associated with Alzheimer's. The effects of the drugs will fade as the deterioration of brain cells progresses. More recently, memantine (Namenda) was approved by the FDA. Memantine blocks the effects of a different chemical, glutamate, which is felt to over-stimulate nerve cells and cause their degeneration. Additionally, doctors may prescribe antidepressants, antipsychotics, anticonvulsants, beta blockers, benzodiazepines, serotonin reuptake inhibitors, and drugs such as Desyrel, BuSpar, and Eldepryl, to control the agitation, psychosis, depressive features, anxious features, apathy, and disturbances in sleep and appetite.

- Relieve cognitive dysfunction to improve memory, language, attention, and orientation. Doctors may prescribe precursors, cholinesterase inhibitors, and cholinergic receptor agents.

- Slow the rate of illness progression, thereby preserving quality of life and independence.

- Delay the time of onset of illness. Medications and therapies to combat these problems are still in the development and clinical trial stages. For instance, the research shows that vitamin E slows the progress of some consequences of Alzheimer's for about 7 months, and scientists are investigating whether ginkgo biloba can delay or prevent dementia in older people, and if estrogen can prevent Alzheimer's in women with a family history of the disease. Researchers are looking at methods to enhance cerebral metabolism, stabilize membranes, promote neuronal sprouting, decrease inflammation, neurotoxins and excitatory amino acids, as well as alter metabolism of key proteins.

In addition to the pharmaceutical approaches, conservation methods also can be beneficial to the management of Alzheimer's disease, such as:

- eating a proper diet
- getting daily exercise
- continuing intellectual stimulation and social contact
- implementing memory aids, such as a prominent calendar, lists of daily tasks, and labels on frequently used items that can help compensate for memory loss and confusion
- providing a comfortable and stimulating environment and always trying to give simple and easy to understand instructions
- participating in support groups

http://scc.healthcentral.com/bcp/main.asp?page=ency&id=100&ap=445&brand=30#Symptoms

CARE OF CONSUMER WITH ALZHEIMER'S

As the disease progresses, your loved one's personality, abilities, and moods may change. As you help the person, be patient and always look for new ways to do things. Something that worked one day may not work the next.

Getting Dressed
Clothing is a good way for a person to express themselves. Looking good can make a person feel better. That's why it's important to think about what the person likes and what they don't like.

- Don't rush the person. Be flexible. If the person wants to wear the same outfit over and over, try getting more than one of the outfit or get ones that are similar.
- Make sure clothing is simple and comfortable. Shirts or sweaters with buttons in front are easier to wear than pullover tops. Also, larger clothes may be easier for the person to put on.
- It's common for someone with Alzheimer's to wear layers of clothing. Try not to worry. If they are too hot, they will remove some of the items.
- People with Alzheimer's sometimes don't like to change their clothes. In this case, dress them in clothes that can be worn during the day and to sleep at night.

Eating Meals
Eating problems are often seen in people with Alzheimer's as the disease progresses. In the beginning, you may see changes in the person's appetite. What they like to eat may change as well. Sometimes there will be weight loss, overeating, or trouble with eating. To encourage people with Alzheimer's to eat, some simple changes can be a big help. Snacks between meals can help increase weight. A change in mealtime routines, such as playing soft music, has also been shown to keep people at the dinner table longer.

To help, make changes in how food is served:

- Take away pits, bones, peels, or wrappers. Food should be able to go straight from the plate to the mouth.
- Reduce distractions such as the phone or television during mealtime.
- Serve foods that can be eaten easily, or with their hands.
- Add different textures and color to food. It will help keep your loved one interested in what they're eating.

Driving
Alzheimer's affects many of the functions that a person needs to drive safely. It is important for families to think about the issue of driving and talk about it with the doctor. If you notice any of the changes below, you should consider stopping your loved one from driving right away.

Being confused:

- Getting lost
- Forgetting to use turn signals
- Confusing the brake pedal and the gas pedal
- Being confused about directions or detours

Driving unsafely:

- Hitting the curb while driving
- Failing to yield
- Problems with changing lanes or making turns
- Driving at the wrong speeds

If you need to tell your loved one that (he/she) can no longer drive, it is important to be sensitive. Remember, Alzheimer's disease affects the ability to reason. Don't try too hard to convince the person. A simple statement may be best. If you can't get the person to stop driving, here are some things you should consider:

- Have your doctor call the State Department of Motor Vehicles to ask that (he/she) take a driver's test.
- Try other ways to get around such as buses, taxis, senior vans, family, and friends.
- Check with your local Alzheimer's Association to learn about transportation options in your community.

Dental Care

Good dental care can be hard for people with Alzheimer's. Brushing is sometimes hard because the person can't understand or won't accept help from others.

- Keep instructions short. Like "hold your toothbrush," "put paste on the brush," "brush your top teeth," and so on.
- Show them how to do it. Hold a brush and show the person how to brush their teeth. Try to brush teeth or dentures after each meal and make sure they floss every day. Also remove and clean dentures every night. While the dentures are out, brush the person's gums and roof of the mouth.
- Caregivers are key in helping the person have good dental care. They are the ones most likely to notice any problems. If you notice a problem, talk to the dentist right away. Tell the dentist that the person has Alzheimer's, so they can create a special routine.

Bathing

Bathing is often the hardest personal care task that caregivers face. Because it is so private, the person with Alzheimer's may feel embarrassed or threatened.

- Do what you can ahead of time, such as making the room warmer and having bath towels nearby. Some people may not like to be undressed by someone else. In this case, wrap a towel around their shoulders to add more privacy.
- Make the person feel in control. Involve and coach him or her through each step.
- Create a safe and pleasing atmosphere. Place non-slip adhesives on the floor surface. Put grab bars in the bathtub to prevent falls. Test the water in advance to prevent burns. Set the water heater to 120 degrees to avoid burns.

Using the Bathroom

Often, people with Alzheimer's have trouble using the bathroom. They may have loss of bladder and/or bowel control. It can be caused by many things. Some of these can be medicines, stress, a physical condition, and the environment.

- Make the bathroom easy to see. Post signs that read "toilet" to help someone find the bathroom. Keep the door open and a light on, especially at night.
- Watch for signs the person you care for has to use the toilet. Track how often they go to the bathroom, and take them to the bathroom ahead of time.
- Make sure clothes are easy to put on and take off, for using the bathroom.

Be supportive. Help the person with Alzheimer's keep a sense of dignity. Reassure them. It will help them be less embarrassed.

http://www.alzheimersconcern.com/3008.php

HOME SAFETY WITH ALZHEIMER'S

There are a lot of simple steps you can take to make the home safer for someone with Alzheimer's. Here are a few tips you can use.

Make it Easier to See

- Add lighting in places between rooms, stairways, and bathrooms. Changes in levels of light can be confusing.
- Place different colored rugs in front of doors or steps to help the person expect staircases and doorways.

Make Daily Activities Safer

- Watch over the person when he or she is taking any medications.
- Close off all items or areas that could be a danger. Use locks and child safety latches.
- Clean out the refrigerator. Take out all food that may be spoiled.
- Limit the use of equipment that could be a danger. (Such as stoves/ovens, grills, toasters or knives).
- Try to get appliances that have an automatic shut-off. This can help prevent burns or fires.

Be Ready for an Emergency

- Keep a list of important phone numbers at hand. (Such as numbers for police, and fire, as well as the doctor, hospital and poison control.)
- Check fire extinguishers and smoke alarms. Have fire drills often.
- Consider signing up for the Safe Return Program at http://www.alz.org/Services/SafeReturn.asp. This is a nationwide program that helps those with Alzheimer's get home safely if they wander off alone.

http://www.alzheimersconcern.com/3007.php

Fact Sheet: Caregiver's Guide to Understanding Dementia Behaviors

Caring for a loved one with dementia poses many challenges for families and caregivers. People with dementia from conditions such as Alzheimer's and related diseases have a progressive *brain* disorder that makes it more and more difficult for them to remember things, think clearly, communicate with others, or take care of themselves. In addition, dementia can cause mood swings and even change a person's personality and behavior. This Fact Sheet provides some practical strategies for dealing with the troubling behavior problems and communication difficulties often encountered when caring for a person with dementia.

Ten Tips for Communicating with a Person with Dementia

We aren't born knowing how to communicate with a person with dementia—but we can learn. Improving your communication skills will help make caregiving less stressful and will likely improve the quality of your relationship with your loved one. Good communication skills will also enhance your ability to handle the difficult behavior you may encounter as you care for a person with a dementing illness.

1. Set a positive mood for interaction. Your attitude and body language communicate your feelings and thoughts stronger than your words. Set a positive mood by speaking to your loved one in a pleasant and respectful manner. Use facial expressions, tone of voice and physical touch to help convey your message and show your feelings of affection.

2. Get the person's attention. Limit distractions and noise—turn off the radio or TV, close the curtains or shut the door, or move to quieter surroundings. Before speaking, make sure you have her attention; address her by name, identify yourself by name and relation, and use nonverbal cues and touch to help keep her focused. If she is seated, get down to her level and maintain eye contact.

3. State your message clearly. Use simple words and sentences. Speak slowly, distinctly and in a reassuring tone. Refrain from raising your voice higher or louder; instead, pitch your voice lower. If she doesn't understand the first time, use the same wording to repeat your message or question. If she still doesn't understand, wait a few minutes and rephrase the question. Use the names of people and places instead of pronouns or abbreviations.

4. Ask simple, answerable questions. Ask one question at a time; those with yes or no answers work best. Refrain from asking open-ended questions or giving too many choices. For example, ask, *"Would you like to wear your white shirt or your blue shirt?"* Better still, show her the choices—visual prompts and cues also help clarify your question and can guide her response.

5. Listen with your ears, eyes and heart. Be patient in waiting for your loved one's reply. If she is struggling for an answer, it's okay to suggest words. Watch for nonverbal cues and body language, and respond appropriately. *Always strive to listen for the meaning and feelings that underlie the words.*

6. Break down activities into a series of steps. This makes many tasks much more manageable. You can encourage your loved one to do what he can, gently remind him of steps he tends to forget, and assist with steps he's no longer able to accomplish on his own. Using visual cues, such as showing him with your hand where to place the dinner plate, can be very helpful.

7. When the going gets tough, distract and redirect. When your loved one becomes upset, try changing the subject or the environment. For example, ask him for help or suggest going for a walk. *It is important to connect with the person on a feeling level, before you redirect.* You might say, *"I see you're feeling sad—I'm sorry you're upset. Let's go get something to eat."*

8. Respond with affection and reassurance. People with dementia often feel confused, anxious and unsure of themselves. Further, they often get reality confused and may recall things that never really occurred. *Avoid trying to convince them they are wrong.* Stay focused on the feelings they are demonstrating (which are real) and respond with verbal and physical expressions of comfort, support and reassurance. Sometimes holding hands, touching, hugging and praise will get the person to respond when all else fails.

9. Remember the good old days. Remembering the past is often a soothing and affirming activity. Many people with dementia may not remember what happened 45 minutes ago, but they can clearly recall their lives 45 years earlier. Therefore, *avoid asking questions that rely on short-term memory*, such as asking the person what they had for lunch. Instead, try asking general questions about the person's distant past—this information is more likely to be retained.

10. Maintain your sense of humor. *Use humor whenever possible, though not at the person's expense.* People with dementia tend to retain their social skills and are usually delighted to laugh along with you.

Handling Troubling Behavior

Some of the greatest challenges of caring for a loved one with dementia are the personality and behavior changes that often occur. You can best meet these challenges by using creativity, flexibility, patience and compassion. It also helps to not take things personally and maintain your sense of humor.

To start, consider these ground rules:

We cannot change the person. The person you are caring for has a brain disorder that shapes who he has become. When you try to control or change his behavior, you'll most likely be unsuccessful or be met with resistance. It's important to:

- *Try to accommodate the behavior, not control the behavior*. For example, if the person insists on sleeping on the floor, place a mattress on the floor to make him more comfortable.
- *Remember that we **can** change our behavior or the physical environment.* Changing our own behavior will often result in a change in our loved one's behavior.

Check with the doctor first. Behavioral problems may have an underlying medical reason: perhaps the person is in pain or experiencing an adverse side effect from medications. In some cases, like incontinence or hallucinations, there may be some medication or treatment that can assist in managing the problem.

Behavior has a purpose. People with dementia typically cannot tell us what they want or need. They might do something, like take all the clothes out of the closet on a daily basis, and we wonder why. It is very likely that the person is fulfilling a need to be busy and productive. *Always consider what need the person might be trying to meet with their behavior—and, when possible, try to accommodate them.*

Behavior is triggered. It is important to understand that all behavior is triggered—it doesn't occur out of the blue. It might be something a person did or said that triggered a behavior or it could be a change in the physical environment. *The root to changing behavior is disrupting the patterns that we create.* Try a different approach, or try a different consequence.

What works today, may not tomorrow. The multiple factors that influence troubling behaviors and the natural progression of the disease process means that solutions that are effective today may need to be modified tomorrow—or may no longer work at all. The key to managing difficult behaviors is being creative and flexible in your strategies to address a given issue.

Get support from others. You are not alone—there are many others caring for someone with dementia. Call your local Area Agency on Aging, the local chapter of the Alzheimer's Association, a Caregiver Resource Center or one of the groups listed below in *Resources* to find support groups, organizations and services that can help you. Expect that, like the loved one you are caring for, you will have good days and bad days. Develop strategies for coping with the bad days (see the FCA Fact Sheet, *Dementia, Caregiving and Controlling Frustration*).

The following is an overview of the most common dementia-associated behaviors with suggestions that may be useful in handling them. You'll find additional resources listed at the end of this Fact Sheet.

Wandering

People with dementia walk, seemingly aimlessly, for a variety of reasons, such as boredom, medication side effects or to look for "something" or someone. They also may be trying to fulfill a physical need—thirst, hunger, a need to use the toilet or exercise. Discovering the triggers for wandering are not always easy, but they can provide insights to dealing with the behavior.

- Make time for regular exercise to minimize restlessness.
- Consider installing new locks that require a key. Position locks high or low on the door; many people with dementia will not think to look beyond eye level. Keep in mind fire and safety concerns for all family members; the lock(s) must be accessible to others and not take more than a few seconds to open.
- Try a barrier like a curtain or colored streamer to mask the door. A "*stop*" sign or "*do not enter*" sign also may help.
- Place a black mat or paint a black space on your front porch; this may appear to be an impassable hole to the person with dementia.
- Add "child-safe" plastic covers to doorknobs.
- Consider installing a home security system or monitoring system designed to keep watch over someone with dementia. Also available are new digital devices that can be worn like a watch or clipped on a belt that use global positioning systems (GPS) or other technology to track a person's whereabouts or locate him if he wanders off..
- Put away essential items such as the confused person's coat, purse or glasses. Some individuals will not go out without certain articles.
- Have your relative wear an ID bracelet and sew ID labels in their clothes. Always have a current photo available should you need to report your loved one missing. Consider leaving a copy on file at the police department or registering the person with the Alzheimer's Association Safe Return program (see *Resources*).
- Tell neighbors about your relative's wandering behavior and make sure they have your phone number.

Incontinence

The loss of bladder or bowel control often occurs as dementia progresses. Sometimes accidents result from environmental factors; for example, someone can't remember where the bathroom is located or can't get to it in time. If an accident occurs, your understanding and reassurance will help the person maintain dignity and minimize embarrassment.

- Establish a routine for using the toilet. Try reminding the person or assisting her to the bathroom every two hours.
- Schedule fluid intake to ensure the confused person does not become dehydrated. However, avoid drinks with a diuretic effect like coffee, tea, cola, or beer. Limit fluid intake in the evening before bedtime.
- Use signs (with illustrations) to indicate which door leads to the bathroom.
- A commode, obtained at any medical supply store, can be left in the bedroom at night for easy access.
- Incontinence pads and products can be purchased at the pharmacy or supermarket. A urologist may be able to prescribe a special product or treatment.
- Use easy-to-remove clothing with elastic waistbands or Velcro^{O} closures, and provide clothes that are easily washable.

Agitation

Agitation refers to a range of behaviors associated with dementia, including irritability, sleeplessness, and verbal or physical aggression. Often these types of behavior problems progress with the stages of dementia, from mild to more severe. Agitation may be triggered by a variety of things, including environmental factors, fear and fatigue. Most often, agitation is triggered when the person experiences "control" being taken from him.

- Reduce caffeine intake, sugar and junk food.
- Reduce noise, clutter or the number of persons in the room.
- Maintain structure by keeping the same routines. Keep household objects and furniture in the same places. Familiar objects and photographs offer a sense of security and can suggest pleasant memories.
- Try gentle touch, soothing music, reading or walks to quell agitation. Speak in a reassuring voice. Do not try to restrain the person during a period of agitation.
- Keep dangerous objects out of reach.
- Allow the person to do as much for himself as possible—support his independence and ability to care for himself.
- Acknowledge the confused person's anger over the loss of control in his life. Tell him you understand his frustration.

- Distract the person with a snack or an activity. Allow him to forget the troubling incident. Confronting a confused person may increase anxiety.

Repetitive speech or actions (perseveration)

People with dementia will often repeat a word, statement, question or activity over and over. While this type of behavior is usually harmless for the person with dementia, it can be annoying and stressful to caregivers. Sometimes the behavior is triggered by anxiety, boredom, fear or environmental factors.

- Provide plenty of reassurance and comfort, both in words and in touch.
- Try distracting with a snack or activity.
- Avoid reminding them that they just asked the same question. Try ignoring the behavior or question and distract the person into an activity.
- Don't discuss plans with a confused person until immediately prior to an event.
- You may want to try placing a sign on the kitchen table, such as, "*Dinner is at 6:30*" or "*Lois comes home at 5:00*" to remove anxiety and uncertainty about anticipated events.
- Learn to recognize certain behaviors. An agitated state or pulling at clothing, for example, could indicate a need to use the bathroom.

Paranoia

Seeing a loved one suddenly become suspicious, jealous or accusatory is unsettling. Remember, what the person is experiencing is very real to them. It is best not to argue or disagree. This, too, is part of the dementia—try not to take it personally.

- If the confused person suspects money is "missing," allow her to keep small amounts of money in a pocket or handbag for easy inspection.
- Help them look for the object and then distract them into another activity. Try to learn where the confused person's favorite hiding places are for storing objects, which are frequently assumed to be "lost." Avoid arguing.
- Take time to explain to other family members and home-helpers that suspicious accusations are a part of the dementing illness.
- Try nonverbal reassurances like a gentle touch or hug. Respond to the feeling behind the accusation and then reassure the person. You might try saying, "I see this frightens you; stay with me, I won't let anything happen to you."

Sleeplessness/Sundowning

Restlessness, agitation, disorientation and other troubling behavior in people with dementia often get worse at the end of the day and sometimes continue throughout the night. Experts believe this behavior, commonly called *sundowning,* is caused by a

combination of factors, such as exhaustion from the day's events and changes in the person's biological clock that confuse day and night.

- Increase daytime activities, particularly physical exercise. Discourage inactivity and napping during the day.
- Watch out for dietary culprits, such as sugar, caffeine and some types of junk food. Eliminate or restrict these types of foods and beverages to early in the day. Plan smaller meals throughout the day, including a light meal, such as half a sandwich, before bedtime.
- Plan for the afternoon and evening hours to be quiet and calm; however, *structured, quiet activity is important*. Perhaps take a stroll outdoors, play a simple card game or listen to soothing music together.
- Turning on lights well before sunset and closing the curtains at dusk will minimize shadows and may help diminish confusion. At minimum, keep a nightlight in the person's room, hallway and bathroom.
- Make sure the house is safe: block off stairs with gates, lock the kitchen door and/or put away dangerous items.
- As a last resort, consider talking to the doctor about medication to help the agitated person relax and sleep. Be aware that sleeping pills and tranquilizers may solve one problem and create another, such as sleeping at night but being more confused the next day.
- It's essential that you, the caregiver, get enough sleep. If your loved one's nighttime activity keeps you awake, consider asking a friend or relative, or hiring someone, to take a turn so that you can get a good night's sleep. Catnaps during the day also might help.

Eating/Nutrition

Ensuring that your loved one is eating enough nutritious foods and drinking enough fluids is a challenge. People with dementia literally begin to forget that they need to eat and drink. Complicating the issue may be dental problems or medications that decrease appetite or make food taste "funny." The consequences of poor nutrition are many, including weight loss, irritability, sleeplessness, bladder or bowel problems and disorientation.

- Make meal and snack times part of the daily routine and schedule them around the same time every day. Instead of three big meals, try five or six smaller ones.
- Make mealtimes a special time. Try flowers or soft music. Turn off loud radio programs and the TV.
- Eating independently should take precedence over eating neatly or with "proper" table manners. Finger foods support independence. Pre-cut and season the food. Try using a straw or a child's "sippy cup" if holding a glass has become

difficult. Provide assistance only when necessary and allow plenty of time for meals.
- Sit down and eat with your loved one. Often they will mimic your actions and it makes the meal more pleasant to share it with someone.
- Prepare foods with your loved one in mind. If they have dentures or trouble chewing or swallowing, use soft foods or cut food into bite-size pieces.
- If chewing and swallowing are an issue, try gently moving the person's chin in a chewing motion or lightly stroking their throat to encourage them to swallow.
- If loss of weight is a problem, offer nutritious high-calorie snacks between meals. Breakfast foods high in carbohydrates are often preferred. On the other hand, if the problem is weight gain, keep high-calorie foods out of sight. Instead, keep handy fresh fruits, veggie trays and other healthy low-calorie snacks.

Bathing

People with dementia often have difficulty remembering "good" hygiene, such as brushing teeth, toileting, bathing and regularly changing their clothes. From childhood we are taught these are highly private and personal activities; to be undressed and cleaned by another can feel frightening, humiliating and embarrassing. As a result, bathing often causes distress for both caregivers and their loved ones.

- Think historically of your loved one's hygiene routine – did she prefer baths or showers? Mornings or nights? Did she have her hair washed at the salon or do it herself? Was there a favorite scent, lotion or talcum powder she always used? Adopting—as much as possible—her past bathing routine may provide some comfort. Remember that it may not be necessary to bathe every day—sometimes twice a week is sufficient.
- If your loved one has always been modest, enhance that feeling by making sure doors and curtains are closed. Whether in the shower or the bath, keep a towel over her front, lifting to wash as needed. Have towels and a robe or her clothes ready when she gets out.
- Be mindful of the environment, such as the temperature of the room and water (older adults are more sensitive to heat and cold) and the adequacy of lighting. It's a good idea to use safety features such as non-slip floor bath mats, grab-bars, and bath or shower seats. A hand-held shower might also be a good feature to install. Remember—people are often afraid of falling. Help them feel secure in the shower or tub.
- Never leave a person with dementia unattended in the bath or shower. Have all the bath things you need laid out beforehand. If giving a bath, draw the bath water first. Reassure the person that the water is warm—perhaps pour a cup of water over her hands before she steps in.
- If hair washing is a struggle, make it a separate activity. Or, use a dry shampoo.

- If bathing in the tub or shower is consistently traumatic, a towel bath provides a soothing alter-native. A *bed* bath has traditionally been done with only the most frail and bed-ridden patients, soaping up a bit at a time in their beds, rinsing off with a basin of water and drying with towels. A growing number of nurses in and out of facilities, however, are beginning to recognize its value and a variation—the "*towel* bath"—for others as well, including people with dementia who find bathing in the tub or shower uncomfortable or unpleasant. The towel bath uses a large bath towel and washcloths dampened in a plastic bag of warm water and no-rinse soap. Large bath-blankets are used to keep the patient covered, dry and warm while the dampened towel and washcloths are massaged over the body. For more information, see the book *Bathing Without a Battle,* (details in the *Recommended Reading* section below), or visit *www.bathingwithoutabattle.unc.edu/main_page.html*.

Additional Problem Areas

- Dressing is difficult for most dementia patients. Choose loose-fitting, comfortable clothes with easy zippers or snaps and minimal buttons. Reduce the person's choices by removing seldom-worn clothes from the closet. To facilitate dressing and support independence, lay out one article of clothing at a time, in the order it is to be worn. Remove soiled clothes from the room. Don't argue if the person insists on wearing the same thing again.
- Hallucinations (seeing or hearing things that others don't) and delusions (false beliefs, such as someone is trying to hurt or kill another) may occur as the dementia progresses. State simply and calmly your perception of the situation, but avoid arguing or trying to convince the person their perceptions are wrong. Keep rooms well-lit to decrease shadows, and offer reassurance and a simple explanation if the curtains move from circulating air or a loud noise such as a plane or siren is heard. Distractions may help. Depending on the severity of symptoms, you might consider medication.
- Sexually inappropriate behavior, such as masturbating or undressing in public, lewd remarks, unreasonable sexual demands, even sexually aggressive or violent behavior, may occur during the course of the illness. Remember, this behavior is caused by the disease. Talk to the doctor about possible treatment plans. Develop an action plan to follow before the behavior occurs, i.e., what you will say and do if the behavior happens at home, around other adults or children. If you can, identify what triggers the behavior.
- Verbal outbursts such as cursing, arguing and threatening often are expressions of anger or stress. React by staying calm and reassuring. Validate your loved one's feelings and then try to distract or redirect his attention to something else.
- "Shadowing" is when a person with dementia imitates and follows the caregiver, or constantly talks, asks questions and interrupts. Like sundowning, this behavior often occurs late in the day and can be irritating for caregivers. Comfort the

person with verbal and physical reassurance. Distraction or redirection might also help. Giving your loved one a job such as folding laundry might help to make her feel needed and useful.

- People with dementia may become uncooperative and resistant to daily activities such as bathing, dressing and eating. Often this is a response to feeling out of control, rushed, afraid or confused by what you are asking of them. Break each task into steps and, in a reassuring voice, explain each step before you do it. Allow plenty of time. Find ways to have them assist to their ability in the process, or follow with an activity that they can perform.

Credits and Recommended Reading

Bathing Without a Battle*,* by Ann Louise Barrick, Joanne Rader, Beverly Hoeffer and Philip Sloane, (2002), Springer Publishing, (877) 687–7476.

Caring for a Person with Memory Loss and Confusion: An Easy Guide for Caregivers, (2002), Journeyworks Publishing, Santa Cruz, CA, (800) 775–1998.

Communicating Effectively with a Person Who Has Alzheimer's, (2002), Mayo Clinic Staff, *www.mayoclinic.com/invoke.cfm?id=AZ00004*

Steps to Enhancing Communication: Interacting with Persons with Alzheimer's Disease,(1996), Alzheimer's Association, Chicago, IL, (800) 272–3900.

Steps to Understanding Challenging Behaviors: Responding to Persons with Alzheimer's Disease**,** (1996), Alzheimer's Association, Chicago, IL, (800) 272–3900.

The Validation Breakthrough: Simple Techniques for Communicating with People with "Alzheimer's-Type Dementia," Naomi Feil , 2nd Edition 2002, Health Professions Press, Baltimore, MD, (410) 337–8539.

Understanding Difficult Behaviors: Some Practical Suggestions for Coping with Alzheimer's Disease and Related Illnesses, A. Robinson, B. Spencer, and L.White, (2001), Eastern Michigan University, Ypsilanti, MI, (734) 487–2335.

For More Information

Family Caregiver Alliance
180 Montgomery St., Suite 1100
San Francisco, CA 94104
(415) 434–3388
(800) 445–8106
www.caregiver.org
info@caregiver.org

Family Caregiver Alliance (FCA) seeks to improve the quality of life for caregivers through education, services, research and advocacy.

Through its National Center on Caregiving, FCA offers information on current social, public policy, and caregiving issues and provides assistance in the development of public and private programs for caregivers.

For residents of the greater San Francisco Bay Area, FCA provides direct support services for caregivers of those with Alzheimer's disease, stroke, traumatic brain injury, Parkinson's and other debilitating health conditions that strike adults.

FCA Publications

Practical Skills Training for Family Caregivers**,** Mary A. Corcoran, 2003, Family Caregiver Alliance, 180 Montgomery Street, Suite 1100, San Francisco, CA 94104, (800) 445–8106. *www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=954*

FCA Fact Sheets. All Family Caregiver Alliance Fact Sheets are available free online. Printed versions are $1.00 for each title—send your requests to FCA Publications, 180 Montgomery St., Suite 1100, San Francisco, CA 94104. For the full list, see: *www.caregiver.org/caregiver/jsp/publications.jsp?nodeid=345*

FCA Fact Sheet: Dementia, Caregiving and Controlling Frustration

FCA Fact Sheet: Taking Care of YOU: Self-Care for Family Caregivers

FCA Fact Sheet: Hiring In-Home Help

FCA Fact Sheet: Community Care Options

Other Web Sites

Alzheimer's Disease Education and Referral (ADEAR) Center
(800) 438-4380
www.alzheimers.org

This service of the National Institute on Aging offers information and publications on diagnosis, treatment, patient care, caregiver needs, long-term care, education and research related to Alzheimer's disease.

Eldercare Locator
(800) 677–1116
www.eldercare.gov

This service of the Administration on Aging offers information about and referrals to respite care and other home and community services offered by state and Area Agencies on Aging.

Alzheimer's Association Safe Return Program
(800) 272–3900
www.alz.org/SafeReturn

A nationwide program that identifies people with dementia who wander away and returns them to their homes. For a $40 registration fee, families can register their loved one in a national confidential computer database. They also receive an identification bracelet or necklace and other identification and educational materials.

This fact sheet was prepared by Family Caregiver Alliance in cooperation with California's statewide system of Caregiver Resource Centers. Reviewed by Beth Logan, M.S.W., Education and Training Consultant and Specialist in Dementia Care. Funded by the California Department of Mental Health. *FS-CGTU20050610*.

THE WRONG AND THE BETTER WAY TO

DOCUMENT

When thinking about, "How do I document this case," always paint a solid picture of need so that others who review the case will be able to understand the need for services and hours authorized. This solid picture should always identify the consumer's functional impairments and the risk they pose to the consumer, and should spell out how In-Home Supportive Services will reduce the risk. In addition, remove all judgmental comments; instead, simply report observed behaviors and environmental conditions.

Here are a few examples that reflect two different ways to document FI ranking and/or hours authorized. The "better way" examples are often abbreviated versions of appropriate documentation. Documentation should always include information about the FI ranking and the hours authorized:

Wrong way: "The consumer needs Meal Preparation services."
Better way: "Consumer has congestive heart failure, which causes her to become short-of-breath, with minor exertion. As a result, she is only able to prepare a light breakfast (she states she has more energy in the morning), and needs meal preparation services for lunch and dinner."

[NOTES: Here the second example presents a description of functioning, but is missing information regarding types of meals and time required to prepare the meals and number of days a week needed.]

Wrong way: "Consumer's house is filthy."
Better way: "During the home visit, I observed animal feces on the floor in several places. Consumer's couch appeared stained, and had the odor of urine emanating from it. I noticed a pile of unwashed dishes in the kitchen sink, and a layer of black mold in the bathroom sink."

[NOTES: Here the "better way" presents facts and detailed observations; the statement, as originally written, could be an expression of the worker's judgment based on her own standards of cleanliness and does not provide information regarding how the social worker came to this conclusion.]

Wrong way: "Consumer needs one hour per week for Ambulation."
Better way: "During the home visit, I observed consumer attempting to ambulate. His gait appeared unsteady – he nearly fell twice during the visit – and he stated that he is afraid to walk unassisted. Consumer stated that he spends approximately 8-9 minutes per day, getting to and from the bedroom, bathroom and kitchen. This is equivalent to 1 hour per week for Ambulation."

[NOTES: MPP 30-757.14(k) defines Ambulation as, "consisting of assisting the recipient with walking or moving the consumer from place to place inside the home..." Based on the information, this consumer would also need assistance to and from the car for medical appointments. It should be evaluated and addressed here.]

Wrong way: "Consumer no longer needs Bathing services."
Better way: "Telephone call from consumer. She stated that her broken wrist is completely healed, and that her orthopedic surgeon removed her arm-cast today. She further stated that she is now bathing for herself, unassisted. Bathing services removed as of this date."

[NOTES: In this case, the consumer stated no further need for Bathing services, but the removal of a cast does not, per se, mean that the consumer can return to the former functioning level immediately. The worker would need additional information about the consumer's functioning now before eliminating Bathing. It is possible that the orthopedic surgeon will prescribe a regimen of physical therapy to regain functioning in the consumer's hand. If the fracture was in the consumer's dominant hand, then it is probable that the consumer will still need assistance with Bathing and Dressing until full functioning is regained.]

Wrong way: "Consumer needs total care. Maximum hours authorized."
Better way: "Consumer has Multiple Sclerosis, and she spends the entire day in bed. She requires assistance with all ADLs and IADLs because she lacks the physical strength and endurance to perform any Domestic and Related Services or Personal care."

[NOTES: Here the "better way" presents a description of functioning, and its connection to the specific types of services needed to address the impairment. Good documentation would also address hours of service needed. The social worker should not assume that all consumers who need care in most or all areas of IHSS would need maximum hours. Appropriate questions should be asked to determine specific tasks, amount of time, and frequency needed.]

Wrong way: "Consumer needs Protective Supervision."
Better way: "According to the physician's evaluation on a SOC 821, the consumer has a diagnosis of dementia from Alzheimer's disease and a history of wandering in the street, unable to recognize danger."

[NOTES: Here the physician's evaluation suggests elements of the consumer's behavior and cognitive limitations that could assist the SW in concluding that Protective Supervision is warranted. However, a full evaluation should be done by the SW, using the Protective Supervision criteria found in MPP 30-757.17 et seq. Additional information should be gathered about current behavior that consumer exhibits that places him/her at risk for injury, hazard or accident. Additionally, information should be solicited from others involved in the care of the consumer such as involved family members, the Regional Center, Mental Health, Day Care Centers, schools, etc.]

Wrong way: "Consumer was uncooperative."
Better way: "Three months ago, I suggested to consumer that the local Senior Center would be a resource for him, for both socialization and daily lunches. To date, he continues to state a feeling of isolation; however he has not contacted the Senior Center yet."

[NOTES: The "better way" describes the consumer's statements and actions and the social worker's efforts to resolve some of the issues identified during the home visit; the "wrong way" suggests uncooperativeness. Consumers have the right to refuse services, and not to follow the SW's suggestions. While, from the SW's perspective, going to the Senior Center could reduce social isolation, the social worker should determine if there are other issues that can be resolved such as of transportation.]

HEY, HEY, HEY, READ ALL ABOUT IT!

IHSS Social Workers are Documenting! Documenting! Documenting!

Documentation is important in each and every one of our IHSS cases; it allows the reader to have a visual picture of what took place while the social worker was in the home, and what has transpired since the home visit. This is important when, and if, the case is transferred to another worker or another county. It lays a foundation, which a consumer's history is built on. Case narrative is the readers visual picture of what has been going on with the consumer, his/her family dynamics, living environment, provider history and any changes in the consumer's health conditions.

Documentation / Narrative will be a valuable resource to you when you need to fall back on certain dates and times that a particular incident took place. It can be anything from a consumer being hospitalized, to a consumer alleging abuse by a caretaker. (Remember however, narrative alone is not enough if there is an allegation of abuse, you must also cross-report any abuse to APS/Law Enforcement on a SOC 341).

When documenting your case it is simple, just pretend that you work for the local news paper, no it is not the Daily Planet, it is the "IHSS" or the "Independent Helping Services Sentinel". Sentinel means "Look out, or Guard" which is the job of each social worker to look out for the best interest of their consumer, and guard them against possible fraud, or neglect. As a reporter for the Sentinel, it is your job to be accurate, grab the reader's attention and tell a story that will allow your reader to be there with you.

Remember you are a star reporter, the Clark Kent of Social Services, you may not have a cape, and phone booths are really hard to find these days, but you have something more powerful, and that is you are a social worker. You are providing services to the elderly and dependent adult allowing them to remain in their own home as long as possible. So what you need to do to insure safety, and insure that your consumer is receiving the appropriate services, is simple, just follow the rules of journalism: Who, What, When, Where, How, and Why. So grab your mighty pen, which can write faster than a speeding bullet, okay maybe not faster, but pretty quickly, and practice the following:

Who is calling you?	The client, doctor, family member, Lois Lane, or a friend?
What are they calling you about?	Need a new provider, changes in their medical conditions, no longer in the home, hospitalized, can't find a phone booth or just needing information about other community resources that may be available to them.
When did the incident occur?	Was it today, yesterday, last week, last year or will it be sometime in the future.
Where was the client when it occurred?	In her own home, in the hospital or racing a locomotive.
How has this affected the client?	Emotionally, physically, financially? Did the provider quit, or has consumer hired a new provider.
Why did this happen?	Was it because of the consumer, the provider, a family member? Was it because of bills were not being paid, or because of theft?

*Remember the importance of documentation: "If it isn't documented it did not happen."

State Hearings:
When going to a State Hearing, it is important that you have completed an assessment tool, covering each area of service, and documented the home visit. The State Hearing Judge will rely on documented information from your case, and testimony from you, the consumer, and other witnesses. If you did not document certain events, and the consumer denies that you addressed these issues, it will be a case of "he said, she said" and the Judge usually will err on the side of the consumer. So for better results on those rare occasions when you have a case that is appealed by a consumer, you need to make sure that your documentation is accurate, filed appropriately in your case, and that it allows the reader reviewing your case to build a visual picture of what transpired during your home visit, and how you came up with your assessments, and the hours you granted or denied.

If you follow the simple rules of journalism, who knows-one day when a new social worker comes down the road and picks up one of your cases they may say "Wow who was that Super Social Worker?!!!!!!!"

NARRATIVE GUIDE

(Note: This is only a guide. Each case should be reviewed on a case-by-case basis and documented according to your specific findings and county procedures.)
Remember to always address: ***Who? What? When? Why? How?***

1. Reason for the interaction (annual reassessment, client request because of recent hospitalization, etc).

2. Age of consumer.

3. Current living arrangement (note who else is present during the interview).

4. Condition of the home (cleanliness, cluttered, odors, unkempt, lifestyle choice).

5. Consumer's general attitude and condition during the interview (ability to understand and answer questions).

6. Consumer's diagnosis (past and present).

7. Observations noted at the time of the home visit.

8. Consumer's current functional capabilities/limitations.

9. A summary supporting any changes to Functional Index Ranking.

Example:

Prior notes indicate the consumer was able to walk or move around inside the house without assistance. Due to a recent hip surgery and failure to show any significant improvement and the fact the consumer can no longer walk or move around the house without being at risk of falling and/or injury, the consumer currently requires assistance with ambulation.
Or
Prior notes indicate the recipient had hip surgery 6 months ago with significant medical improvement. It was observed that the consumer is now able to stand, walk, and move around inside the house without any limitations. The consumer does not require assistance walking or moving around inside the house.

10. Complete name of alternative resources and/or voluntary services and hours provided.

11. Description and justifications for Protective Supervision needs or changes.

12. Description and justifications for Paramedical needs or changes.

13. If it was established at the prior home visit that Paramedical services were temporary, a review and notation should be documented in the summary regarding the continuance or denial of the current Paramedical services.

DOCUMENTATION EXAMPLES

Meal Prep: *Rank 5* – Clt. post CVA – R (dominant) side paralysis – IP must cut meat in bite-sized pieces daily – 5 min. extra per day – 7.58 hrs./wk.

Reason for Assistance: Clt. is post CVA – R (dominant) side paralysis

Daily Needs:
Breakfast – 10 minutes – mostly eats oatmeal, toast, coffee or juice
Lunch – 20 minutes – eats soups or stew
Dinner – 35 minutes – mostly grilled meat, fish or poultry, some type of vegetables and potato

Shared Living Exceptions: Clt. lives alone for now but plans to move in with daughter.

Additional information to document exception: IP must cut meat, fish or poultry and vegetables into bite-sized pieces.

Meal Cleanup: *Rank 5* – Extra time needed b/c of clt.'s spasticity. IP has to clean up many spills following each meal. 10 min. breakfast; 15 min. lunch and dinner = 4.67 hrs./wk.

Reason for Assistance: Clt. has cerebral palsy.

Daily Needs:
Breakfast – 10 minutes
Lunch – 15 minutes
Dinner – 15 minutes

Shared Living Exceptions: Clt. lives with a live-in provider; Clt. and IP did not agree to have need for related services prorated.

Additional information to document exception: Due to clt.'s spasticity, there are many spills to clean up following each meal.

Bowel & Bladder: *Rank 3* – Clt. uses urinal and commode. Needs 9 min./daily = 1.05 hrs./wk.

Reason for Assistance: Shortness of breath

Daily Needs: 9 min./daily
2 min. X 3 daily to empty and rinse urinal = 6 min./daily
3 min. X 1 to empty and clean commode after bowel movement = 3 min./daily

Additional information to document exception: Clt. uses urinal for bladder care and commode for bm. Able to wipe self after bm.

Feeding: *Rank 2* – Clt. severely depressed and will not eat without constant encouragement – 6 meals/day b/c she can't eat much at a time. Needs 15 min./meal = 10.5 hrs./wk.

Reason for Assistance: Severe depression; will not eat without constant encouragement.

Daily Needs:
15 min. each meal, 6 meals

Additional information to document exception: 6 meals because clt. can't eat much at a time.

Bed Bath: *Rank 3* – Clt. sponge bathes b/c wheelchair won't fit into bathroom. Can bathe self once basin and supplies are brought to her and returned. Bathes 3x/wk. Needs 10 min./ daily = .5 hrs./wk.

Reason for Assistance: Wheelchair-bound.

Clt. needs 3 times per week @ 10 minutes each time.

Additional information to document exception: Can wash, rinse and dry body once basin and supplies are brought to her.

Bathing: *Rank 4* – Clt. can't reach feet from shower bench. Needs help w/ shampoo b/c arthritis of shoulders. Able to clean dentures. 3 showers/wk @ 15 min. ea. = .75 hrs./wk.

Reason for Assistance: Severe arthritis of shoulders and unable to reach feet from shower bench.

Clt. needs IP help in shampooing and applying conditioner, combing hair, soaping and rinsing from legs to feet while in the shower – 3 times per week @ 15 minutes each time.

Additional information to document exception: Able to clean dentures. Able to reach most of body parts. Nails done at the nearby nail salon.

Dressing: *Rank 2* – Clt. can dress self but needs wardrobe advice b/c of his developmental disability. Time needed = 0 hrs./wk.

Reason for Assistance: Can dress self but due to cognitive impairment, needs prompting on clothing selection. Clt. needs verbal assistance in selecting appropriate clothes.

Additional information to document exception: No need to document exception since Rank 2 and 0 hours are not an exception.

Repositioning and Rubbing Skin: *Rank N/A* – Clt. needs help on and off stationary bike in home 2x/day @ 1 min. ea. = .47 hrs./wk.

Reason for Assistance: Clt. is heavy and has poor balance. Bike ride is for circulation problems.

Client need to ride bike 2 times daily; 1 min. on and 1 min. off = 4 min./daily

Additional information to document exception: Once on the bike, Clt. able to pedal (very little resistance).

Transfer: *Rank 3* – Clt. needs boost to get up and elbow support to sit down. Transfers 8x/day @ 1 min. in each direction = 1.87 hrs./wk.

Reason for Assistance: 94 years old; history of falling and dizziness; diagnosed with osteoporosis.

Clt. needs boost to get up and elbow support to sit down 8 times per day @ 1 min. in each direction (4 times per day bed to wheelchair; 4 times per day wheelchair to couch).

Additional information to document exception: Clt. is 85 lbs., 5'5', very frail and scared of falling again.

Prosthetics: *Rank N/A* – Clt. can take meds if put into mediset. Needs 1x/wk. @ 10 min. = .40 hrs./wk. (Total Need) .17 hrs./wk. (Authorized Need)

Reason for Assistance: Poor eyesight and forgetful.

Clt. needs IP to prep meds in the mediset weekly @ 10 min./wk.

Additional information to document exception: Clt. takes meds 3 times a day. IP reminds clt. once a day while IP is at home providing other IHSS hours. (Insignificant amount of time so no extra would be authorized.) Daughter volunteers to call 2 times a day to remind clt. to take meds. (Phone calls = 1 min. each call; 14 min./wk. = .23 wk. SOC 450 form on file to show .23 min./wk. as Alternative Resources.)

Ambulation: *Rank 3* – Clt. able to walk with walker but needs elbow support down stairs in morning and up at night @ 12 min. ea. = 2.80 hrs./wk.

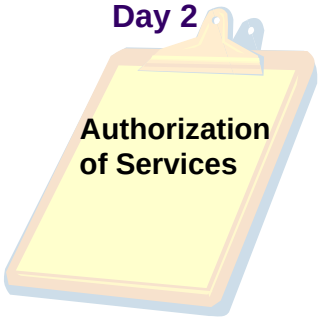
Reason for Assistance: Unsteady on feet; able to walk with walker but needs elbow support negotiating the stairs.

Clt. needs elbow support down stairs in the morning and going upstairs at night and once in the middle of the day when clt. naps and/or showers.

4 times/day @ 3 min. each time = 12 min./daily

Additional information to document exception: All bedrooms are on the second floor. (4 bed, 3 bath; full bath second floor and ½ bath first floor)

Assessment and Authorization: Day 2



Authorization of Services

When Authorizing Services

- IHSS operates under a "safety" standard, not a "comfort" standard.
- MPP 30-761.25 states: *"no services shall be determined to be needed which the consumer is able to perform in a safe manner without an unreasonable amount of physical or emotional stress."*

Authorizing Services

- Consider functional rankings first.
- Break service up into components.
- Ask about the frequency and duration of each task.
- Consult existing regulatory guidelines.
- Document exceptions.
- Think critically – "What is the need?"
- Consider "good days" and "bad days".
- Consider that at reassessment, functional rankings may change.

HTGs

HTG Legislative Objectives

- HTG development is a key element of the Quality Assurance Initiative to:
  - promote accurate and consistent service authorizations statewide
  - facilitate equity in service authorizations

HTG Statutory Basis

- Collaborative effort:
  - CDSS, counties, advocates, consumers, providers and other interested stakeholders.
- Provide a tool for county workers:
  - Defines the scope of tasks.
  - Specifies a range of time *normally* required.
  - Provides criteria to assist in determining when an individual's service need falls outside the range.

Line	SERVICES
AA	Domestic Services
BB	Preparation of Meals
CC	Meal Clean Up
DD	Routine Laundry, Etc.
EE	Shopping for Food
FF	Other Shopping & Errands
GG	Heavy Cleaning
HH	Respiration
I I	Bowel & Bladder Care
JJ	Feeding
KK	Routine Bed Baths
LL	Dressing
MM	Menstrual Care
NN	Ambulation
OO	Moving in and out of Bed (Transfer)
PP	Bathing, Oral Hygiene, Grooming
QQ	Rubbing Skin, Repositioning, Etc.
RR	Care and Assistance with Prosthesis
SS	Accompaniment to Medical App't.
TT	Accompaniment to Alt. Resources
UU	Remove Grass, Weeds, Rubbish
VV	Remove Ice, Snow
WW	Protective Supervision
XX	Teaching & Demonstration
YY	Paramedical Services
ZZ	Meal Allowance

Services Unchanged by New HTGs

New Hourly Task Guidelines

The regulations are to be implemented for cases from September 1, 2006 forward at the time of all assessments and reassessments.

Line	SERVICES
AA	Domestic Services
BB	Preparation of Meals
CC	Meal Clean Up
DD	Routine Laundry, Etc.
EE	Shopping for Food
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UU	Remove Grass, Weeds, Rubbish
VV	Remove Ice, Snow
WW	Protective Supervision
XX	Teaching & Demonstration
YY	Paramedical Services
ZZ	Meal Allowance

HTG Guidelines – Differences

Current (domestic, laundry, shopping)

- Single values

New

- Ranges that relate to Functional Index rankings

Both

- Maintain individualized authorizations
- Retain worker judgment

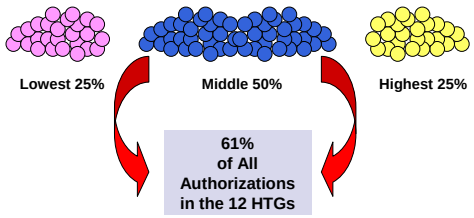
HTG Development Process

Time Ranges

- Range needed to reflect the norm
- Process
  - Standards reviewed from other states
  - Interviews with providers and consumers
- CMIPS data most reliable
  - Total Needs of all 360,000 active consumers
  - Interquartile statistical measurement used

HTG Development – Time Ranges

- The **Interquartile** is the central half of the values when arraying all values in order from the smallest to the largest.



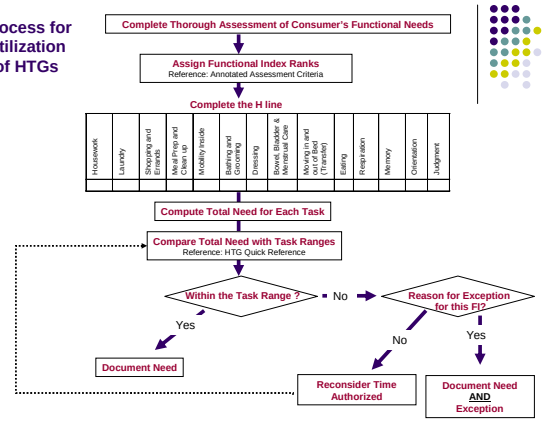
HTG Development – Time Ranges

- Those outside the range represent unusual or extra ordinary cases…

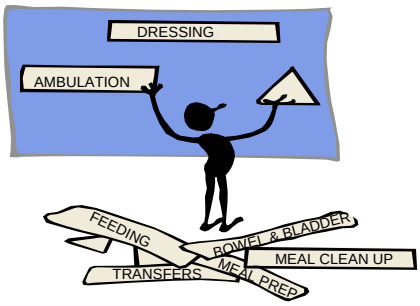
HTG Core Elements

- Do not replace the individualized assessment process.
- HTG ranges relate to the consumer's FI.
- No individual can have a range of time applied unless the time range meets his/her needs.
- When individual assessment indicates a need for time different than the HTG range, the different amount of time (exception) shall be authorized up to the allowable program limits (195/283 caps).
- The need for the authorized service level shall be documented in the case file.

Process for Utilization of HTGs



Exercise: Category Definitions



Changes to Categories

ACTIVITY	OLD	NEW
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

Changes to Categories

ACTIVITY	OLD	NEW
Getting on and off seats and wheelchairs	Rubbing Skin and Repositioning	Transfer (Moving In/Out of Bed)
Getting in and out of vehicles	Rubbing Skin and Repositioning	Ambulation

Changes to Categories

Bed Baths	Revised to include ***all*** sponge bathing
Bowel and Bladder	Revised to clarify the portions of the task that are **Paramedical**

Bowel and Bladder Care

"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.

Meal Cleanup

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.

Meal Cleanup

- For meal cleanup, a recipient 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.
- A recipient who has less control of utensils and/or spills food frequently may require more time to cleanup.

Feeding

- "Feeding" tasks include assistance with reaching for, picking up, and grasping utensils and washing/drying hands before and after feeding.
- "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.

Bathing, Oral Hygiene, and Grooming

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

Repositioning and Rubbing Skin *does not include:*

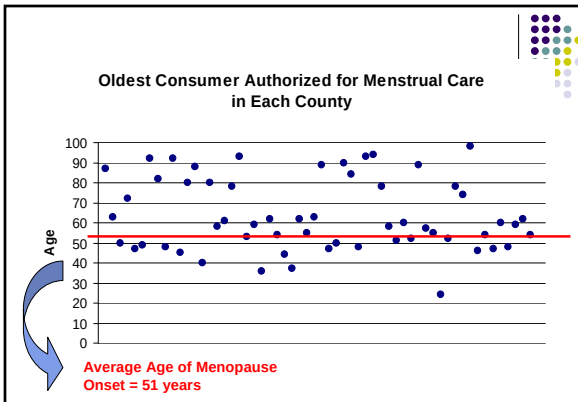
- Care of pressure sores (skin and wound care). This task is assessed as a part of "paramedical" services specified at Section 30-757.19.
- Ultra violet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to the skin. These tasks are assessed as a part of "assistance with prosthetic devices" specified at Section 30-757.14(i).

Transfer *does not include:*

- Assistance on/off toilet. This task is assessed as a part of "bowel and bladder" care specified at Section 30-757.14(a).
- Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as a part of "repositioning and rubbing skin" specified at Section 30-757.14(g).

Menstrual Care

- 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," or "bathing, oral hygiene, and grooming."
- 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.



Good News!

Proration & Alternative Resources

Use of Guidelines

- Functional Index ranking should be a key contributing factor, but not the only factor in determining amount of time per task.
- Services provided are subject to time guidelines unless the consumer's needs require an exception to the guideline.

HTG Exceptions

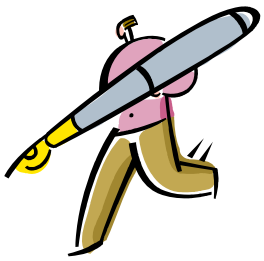
- Assessed needs for services are outside of the HTGs.
- Result: consumer receiving more or less time.
- Because assessed needs are individualized, exceptions are **expected**.

Use of Guidelines

- Exceptions cannot be made due to inefficiency or incompetence of the provider.
- All exceptions must be documented in the case file.

Exceptions

- *Document in a way that clarifies the need*
- *State **why** more or less time is necessary for both safety **and** maintenance of independence*



Exercise: Documenting Needs

- In groups discuss the scenarios.
- Utilize Narrative Guide, Annotated Assessment Criteria and Regulations.
- Prepare responses to the questions provided.

Variable Assessment Intervals

Variable Assessment Intervals: 18-Month Option

- Does not apply to IHSS Plus Waiver cases.
- County may extend the time for reassessment for up to 6 months beyond the 12-month period.
- This should be done only on a case-by-case basis.
- Reason for extension must be documented.

Variable Assessment Intervals: Less than 12 Months

- Need for supportive services is expected to decrease in less than 12 months.
- At intake consumer has a condition that is likely to improve over time.
- Consumer has surgery or an acute medical condition.
- Anticipated changes in living situation.
- Unsure of stability of situation.

Universal Precautions

MPP 30-757-.1(a)(1)(A)1

- Protective practices necessary to ensure safety and prevent the spread of infectious diseases.
- Should be used by anyone providing service which may include contact with blood or body fluids.
- Should include protective barriers such as gloves or facemask.

Infectious Diseases

- Blood-borne:
  - HIV
  - Hepatitis B, Hepatitis C
  - Other blood-borne pathogens (bacteria and viruses that can cause disease in humans)
- Skin / Wound
  - Staph and Methicillin-resistant *Staphylococcus Aureus* (MRSA)
- Fecal
  - Hepatitis A
  - Parasites
  - Bacterial Dysentery

How Germs or Pathogens Can Enter the Body

- Open sores
- Abrasions
- Acne
- Cuts and burns
- Damaged or broken skin such as sunburn or blisters
- Dry, chapped, cracked or peeling hands
- Cat scratches and scrapes
- Open or torn hangnails
- Mucus membranes
- Sexually transmitted

Barriers Should Be Used For Protection . . .

- Gloves
- Protective outer layer
- Mask
- Resuscitation bags
- Sharps disposal

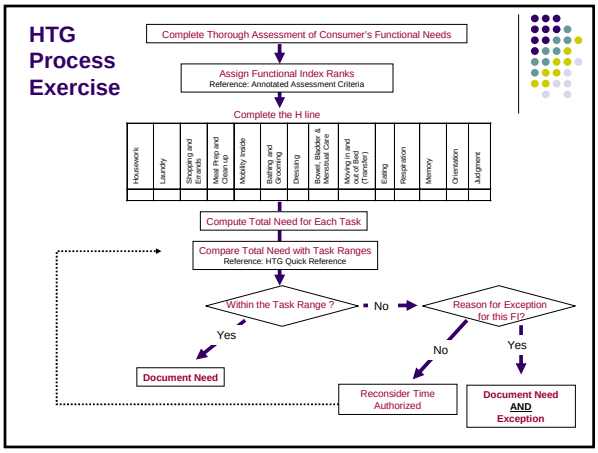
Universal Precautions and Clean Techniques

should be applied to….

all body fluids

of all consumers!

HTG Process Exercise



HTG Process Exercise

HTG Process Exercise

- Identify reasons for FI ranking given
- Identify service hours and exceptions
- Give clear indication of REASON for exception (↑ or ↓ HTG) for a consumer with this FI

Service Category FI	Hours	Exception? Y / N
1.		
2.		
3.		
4.		


Thanks For Your
Participation!

HTG DEVELOPMENT PROCESS

Statutory Basis

SB 1104 mandates CDSS to create Hourly Task Guidelines:

SEC. 43. Section 12301.2 is added to the Welfare and Institutions Code, to read:
12301.2. (a) (1) The department, in consultation and coordination with county welfare departments and in accordance with Section 12305.72, shall establish and implement statewide hourly task guidelines and instructions to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours to meet those needs.
(2) The guidelines shall specify a range of time normally required for each supportive service task necessary to ensure the health, safety, and independence of the recipient. The guidelines shall also provide criteria to assist county workers to determine when an individual's service need falls outside the range of time provided in the guidelines.
(3) In establishing the guidelines the department shall consider, among other factors, adherence to universal precautions, existing utilization patterns and outcomes associated with different levels of utilization, and the need to avoid cost shifting to other government program services. During the development of the guidelines the department may seek advice from health professionals such as public health nurses or physical or occupational therapists.
(b) A county shall use the statewide hourly task guidelines when conducting an individual assessment or reassessment of an individual's need for supportive services.
(c) Subject to the limits imposed by Section 12303.4, counties shall approve an amount of time different from the guideline amount whenever the individual assessment indicates that the recipient's needs require an amount of time that is outside the range provided for in the guidelines. Whenever task times outside the range provided in the guidelines are authorized, the county shall document the need for the authorized service level.
(d) The department shall adopt regulations to implement this section by June 30, 2006. The department shall seek input from the entities listed in Section 12305.72 when developing the regulations.

12305.72. The department shall convene periodic meetings in which supportive services recipients, providers, advocates, IHSS provider representatives, organizations representing recipients, counties, public authorities, nonprofit consortia, and other interested stakeholders may receive information and have the opportunity to provide input to the department regarding the quality assurance, program integrity, and program consistency efforts required by Sections 12305.7 and 12305.71. The program development activities that shall be covered in these meetings shall include, but are not limited to:
…
(b) Development and implementation of statewide hourly supportive services task guidelines as provided in Section 12301.2.

Tasks

CDSS met with County representatives, consumers, providers, advocates, public authority representatives, and other interested parties. The group evaluated the 25 IHSS tasks and ruled out the tasks that were not amenable to task guidelines. Specifically, the four tasks of *Domestic*, *Laundry*, *Shopping* and *Errands* were excluded from the implementation efforts because Time Task guidelines already exist for those tasks. *Heavy Cleaning* was excluded because it's a task that, when authorized, is only authorized for one month and because the need is more a function of the degree of dirt that needs to be cleaned and clutter that needs to be removed. *Respiration* was excluded because it covers many

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

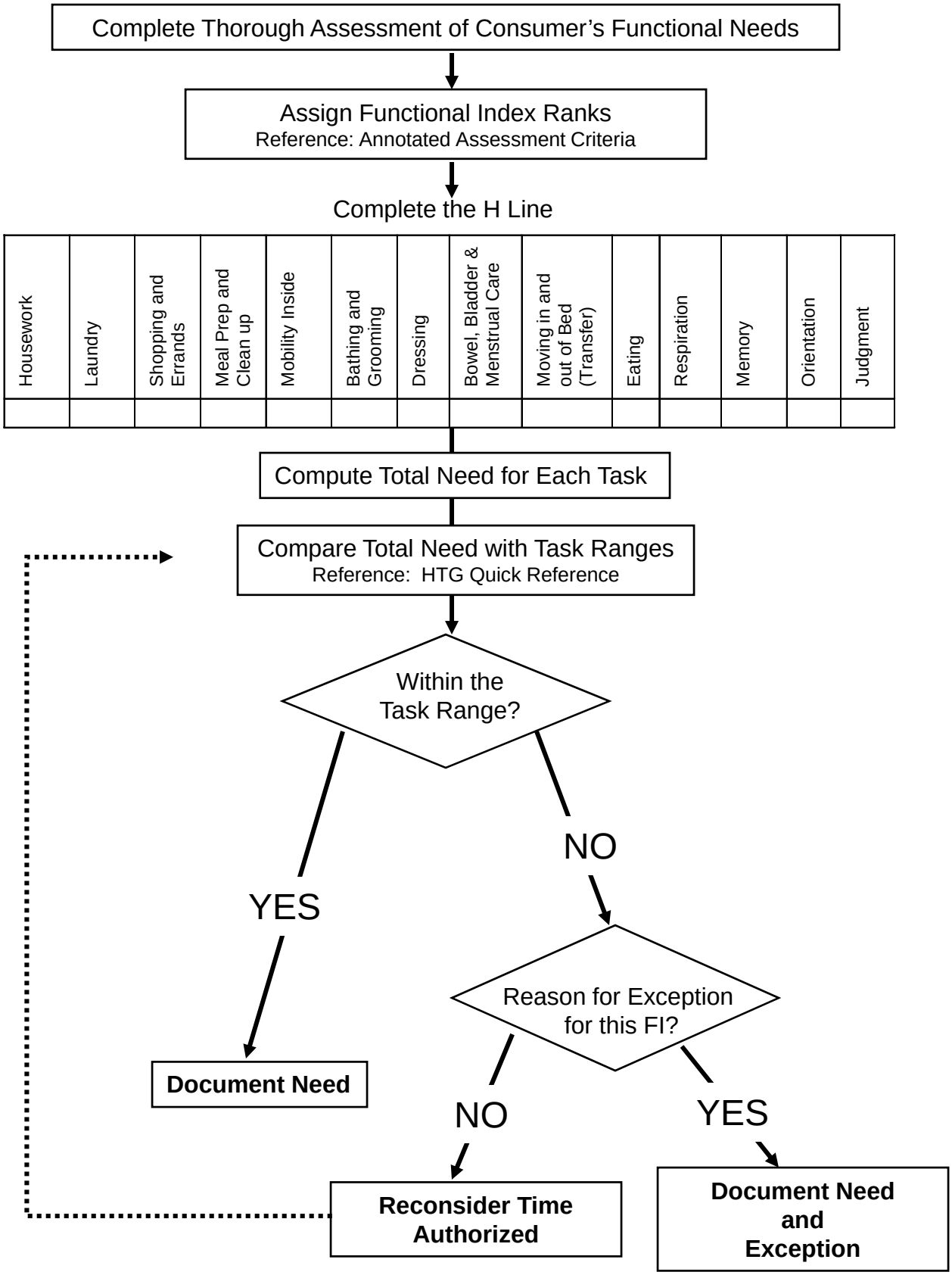
The County Welfare Directors Association coordinated efforts to develop the Task Tool. IHSS staff of many counties throughout the State participated in efforts to clarify task definitions and task components. The first step in assuring statewide uniformity is to assure that all workers throughout the 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



NEW HTGs
CHANGES TO CATEGORIES

ACTIVITY	CATEGORY	
	OLD	***NEW***
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.

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 (i.e., MSSP, Linkages, 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.

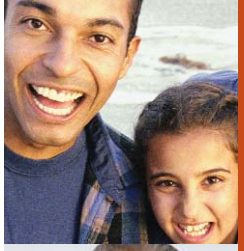
Some places have needle exchange programs, where addicts can bring in old needles and exchange them for new ones.' Addicts may start to feel sick if they go too long without the drug. When they finally get the drug, they often need a fix so badly that they do not take the time to sterilize the needle.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

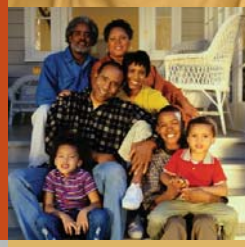
Many drug users go to shooting galleries to get drugs. These are often in abandoned buildings or unclean locations. Equipment or supplies for sterilizing works are often not available there. At shooting galleries, people often rent out or share works. They may be used by many people each day. The HIV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

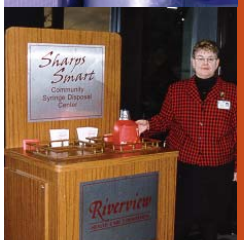
A common practice in many cities is for addicts to sell repackaged needles. These are sold as clean needles but are really not clean. Addicts are selling their old needles to make money to buy more drugs. Never trust a needle bought on the street.

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



Community Options for Safe Needle Disposal





UNITED STATES ENVIRONMENTAL PROTECTION AGENCY

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 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.

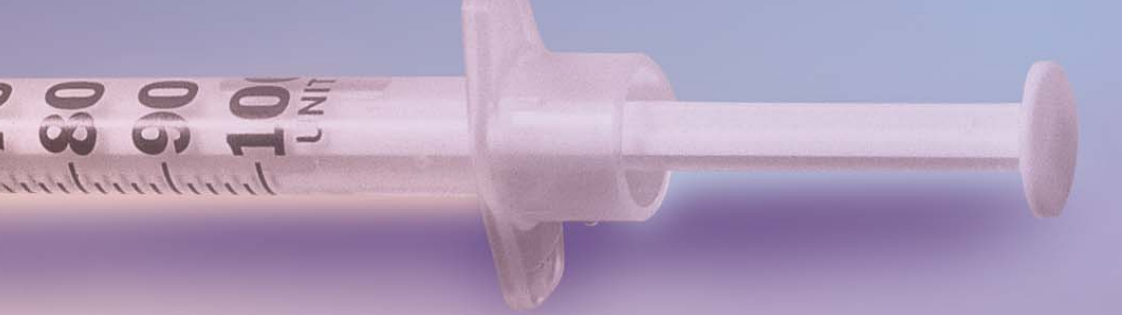
People exposed to sharps face not only the risk of a painful stick, but also the risk of contracting a life-altering disease such as HIV/AIDS or Hepatitis B or C. All needle-stick injuries are treated as if the needle were infected with a disease. Victims of sharps-related injuries face the cost of post-injury 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.

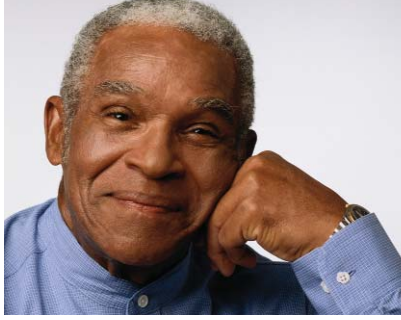
Needle-stick injuries are a preventable health risk, and states and municipalities can take specific actions to protect their residents from this risk.

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





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.

Where can I find more inform

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>.

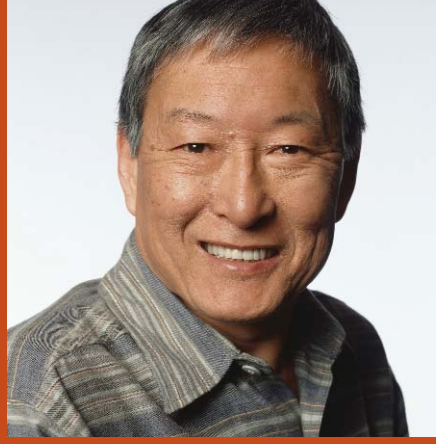
Home Needle Destruction Devices

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.



Programs in Action

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.**

The mention of any company, product, or process in this publication does not constitute or imply endorsement by the U.S. Environmental Protection Agency.

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.

United States
Environmental Protection Agency
5305W
Washington, DC 20460

EPA530-K-04-001
October 2004
www.epa.gov/osw

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

Original Article: http://www.mayoclinic.com/health/mrsa/DS00735

MEDI-CAL MEDICAL SUPPLIES LISTING

The following is a list of medical supplies commonly used in the home that may be covered by Medi-Cal. The list is provided for general information only and is not all inclusive. For Medi-Cal reimbursement, medical supplies require a prescription. Some supplies require authorization by Medi-Cal which is obtained by the pharmacy submitting a Treatment Authorization Request (TAR). The following factors determine whether a TAR is required:

1. Supplies not listed require a TAR;
2. Some supplies have quantity limits which, if exceeded, require a TAR; and
3. Some supplies are available without a TAR for specific conditions, and if needed for conditions other than those listed, require a TAR.

The best resource for consumers is the pharmacy that accepts Medi-Cal. Therefore, social workers should advise consumers with questions about whether specific supplies are covered by Medi-Cal to call their local pharmacy.

ALCOHOL, ISOPROPYL
ALCOHOL PREP PADS
ASPIRATOR, NASAL
BANDAGES, NONMEDICATED OR MEDICATED
BREAST PUMP
CATHETERS
COLOSTOMY SUPPLIES
CONDOMS
CUSHIONS, INVALID
DIABETIC SUPPLIES
DIAPERS, DISPOSABLE
DIAPHRAGM
DRESSINGS
EAR SYRINGE
EYE PADS
FEEDING SUPPLIES (Gastrostomy/nasogastric/jejunostomy)
FOUNTAIN SYRINGE
GLOVES, DISPOSABLE
HEARING AID BATTERIES
HOT WATER BOTTLE
HYPODERMIC NEEDLES AND SYRINGES
ILEOSTOMY SUPPLIES
INCONTINENCE SUPPLIES
INHALERS
INTRAVENOUS ADMINISTRATION SUPPLIES
INVALID CUSHION (rubber and vinyl)
NEBULIZER, BULB TYPE
NEEDLES, HYPODERMIC
OSTOMY SUPPLIES
PADS, STERILE

PEAK FLOW METERS, NON-ELECTRONIC
SHEETING, WATERPROOF
SYPRINGES (bulb/hypodermic)

DURABLE MEDICAL EQUIPMENT – GENERAL INFORMATION

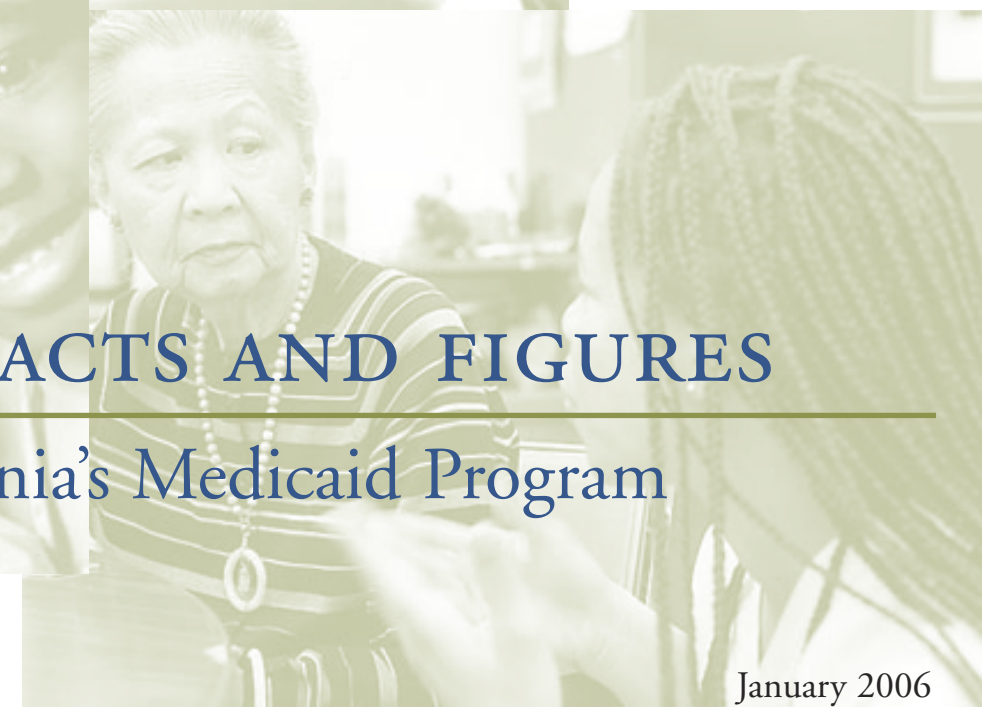
This document contains general information about Durable Medical Equipment (DME) and Medi-Cal program coverage. Regulations regarding DME are contained at *California Code of Regulations* [CCR], Title 22, Section 51321.

The best source of information regarding coverage of medical equipment is the person/organization that provides the equipment and accepts Medi-Cal reimbursement. **DME suppliers are familiar with the Medi-Cal requirements for purchase of DME and can work with the physician to obtain needed information.**

As all DME requires a prescription, consumers who do not have prescriptions for DME should first discuss their need for DME with a physician or other licensed practitioner.

Program Coverage	Medi-Cal covers Durable Medical Equipment (DME) when provided on the written prescription of licensed practitioners within the scope of their practice.
Medical Necessity	The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed DME items may be covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.
Alterations to Real Property	Alterations or improvements to real property (for example, a non-portable wheelchair ramp to front door) are <u>not</u> covered, except when authorized for home dialysis services.
Items Not Covered	The following items are **<u>not</u>** covered by Medi-Cal: • Books or other items of a primarily educational nature • Air conditioners/air filters or heaters • Food blenders • Reading lamps or other lighting equipment • Bicycles, tricycles or other exercise equipment • Televisions • Orthopedic mattresses, recliners, rockers, seat lift chairs or other furniture items • Waterbeds • Household items • Modifications of automobiles or other highway motor vehicles • Other items not generally used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them.
Recipient Responsibilities	Recipients are responsible for appropriate use and care of DME purchased for their use under the Medi-Cal program.

Provider Responsibilities	Rendering providers of DME shall ensure that all devices and equipment are appropriate to meet the recipient's medical needs. If a piece of equipment or a device, when in actual use, fails to meet the recipient's needs, and the recipient's medical condition has not significantly changed since the device/equipment was dispensed, the rendering provider shall adjust or modify the equipment, as necessary, to meet the recipient's needs. The rendering provider, at no cost to the Medi-Cal program, shall replace any equipment or device that cannot be adjusted or modified.
Eligibility Requirements	To receive reimbursement, a recipient must be eligible for Medi-Cal on the date of service.
Prior Authorization of DME	Some items of DME are subject to prior approval by a Medi-Cal Field Office before they can be provided. The supplier of DME completes a Treatment Authorization Request and submits it with necessary documentation to the Medi-Cal Field Office for authorization. The following is a summary of the prior authorization requirements. Prior authorization is required: • For the purchase of DME, when the cumulative cost of purchasing items within a group exceeds $100 within the calendar month. • For the repair or maintenance of DME items within the group, when the cumulative cost exceeds $250 within the calendar month. • For the rental of DME, when the cumulative cost of rental for items within the group exceeds $50 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. • For oxygen, when more than the equivalent of two "H" tanks (approximately 500 cubic ft.) are provided during one calendar month. • For the purchase, rental, repair or maintenance of any <u>unlisted</u> devices or equipment, regardless of the dollar amount of the individual item or cumulative cost.
Medicare/Medi-Cal Recipients	Prior authorization is <u>not</u> required for the purchase, rental, repair or maintenance of DME for recipients covered by both Medicare and Medi-Cal (crossover recipients). However, if Medicare does not approve the purchase, repair or maintenance of DME, the claim is subject to all Medi-Cal prior authorization requirements. Retroactive authorization from Medi-Cal must be obtained if the service has already been rendered and denied by Medicare. A copy of the denial <u>must</u> accompany the TAR and prescription.



Medi-Cal FACTS AND FIGURES

A Look at California's Medicaid Program

January 2006

California HealthCare Foundation

Introduction

Medi-Cal, California's Medicaid program, is the main source of health care insurance for more than six million people, or one in six Californians. It will draw nearly $19 billion in federal funds into the state's health care system and account for 14 percent of General Fund spending in fiscal year 2005–06. Medi-Cal is a complex program that pays providers for essential acute and long-term care services delivered to a wide range of beneficiaries. Although many people associate Medi-Cal with welfare, more than half of funds pay for medical and long-term care for the elderly and adults with disabilities. Medi-Cal also provides essential support to California's safety net providers. Because it is the single largest source of coverage in the state, a thorough grasp of Medi-Cal is essential to understanding how health care is financed and delivered in California.

Medi-Cal provides coverage to one in six Californians.

About Medicaid

Medicaid is:

- A program created by Title XIX of the Social Security Act that provides coverage for acute and long-term care services to 52 million Americans, including low-income children, parents, seniors, and people with disabilities.
- State administered, governed by federal and state rules, and jointly funded with federal and state dollars.
- An entitlement program that requires federal and state governments to spend the funds necessary to operate mandatory program components.
- The nation's largest purchaser of health care services, collectively spending about $300 billion in federal and state dollars.
- A 40-year old program that is continually evolving in terms of the populations it covers, the services for which it pays, and the manner in which care is delivered and financed.

Medicaid is a 40-year-old federal-state program that is now larger than Medicare.

About Medi-Cal

Medi-Cal is:

- The nation's largest Medicaid program, in terms of the number of people it serves (6.5 million), and the second largest in terms of dollars spent ($34 billion).
- The source of health coverage for:
  - One in six Californians under age 65;
  - One in four of the state's children; and
  - The majority of people living with AIDS.
- Paying for:
  - 42 percent of all births in the state;
  - Two-thirds of all nursing home days; and
  - Two-thirds of all revenue in California's public hospitals.
- Bringing in nearly $19 billion in federal funds to California's health care providers.

Medi-Cal is the nation's largest Medicaid program.

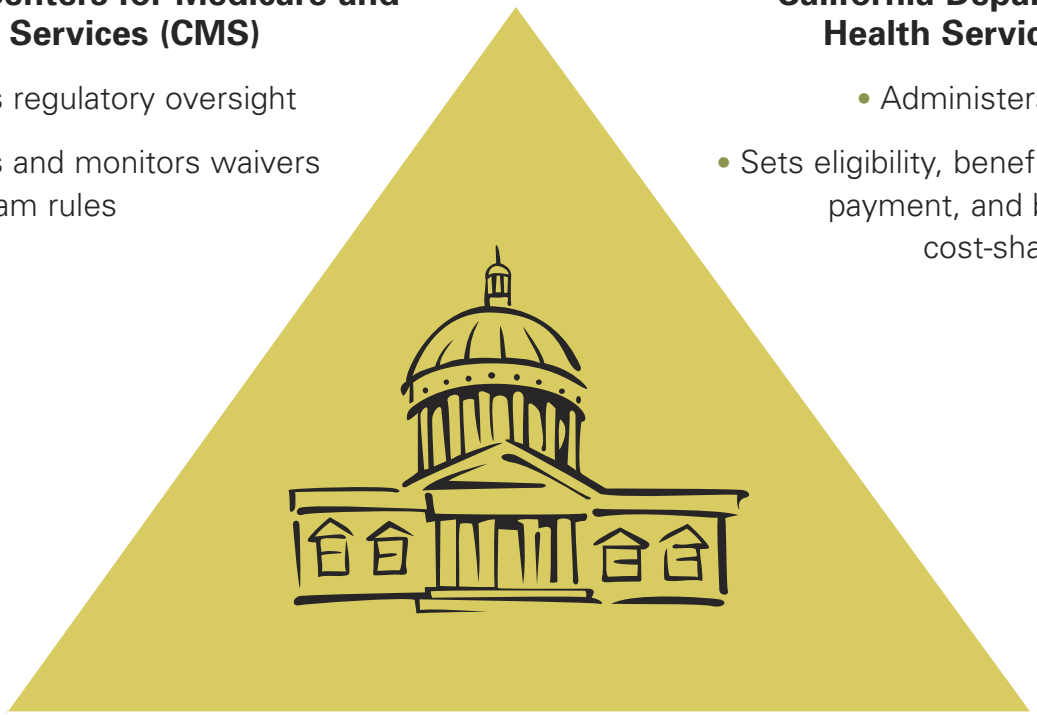
Agencies Governing Medi-Cal

Federal Centers for Medicare and Medicaid Services (CMS)

- Provides regulatory oversight
- Reviews and monitors waivers to program rules

California Department of Health Services (DHS)

- Administers Medi-Cal
- Sets eligibility, benefit, provider payment, and beneficiary cost-sharing levels

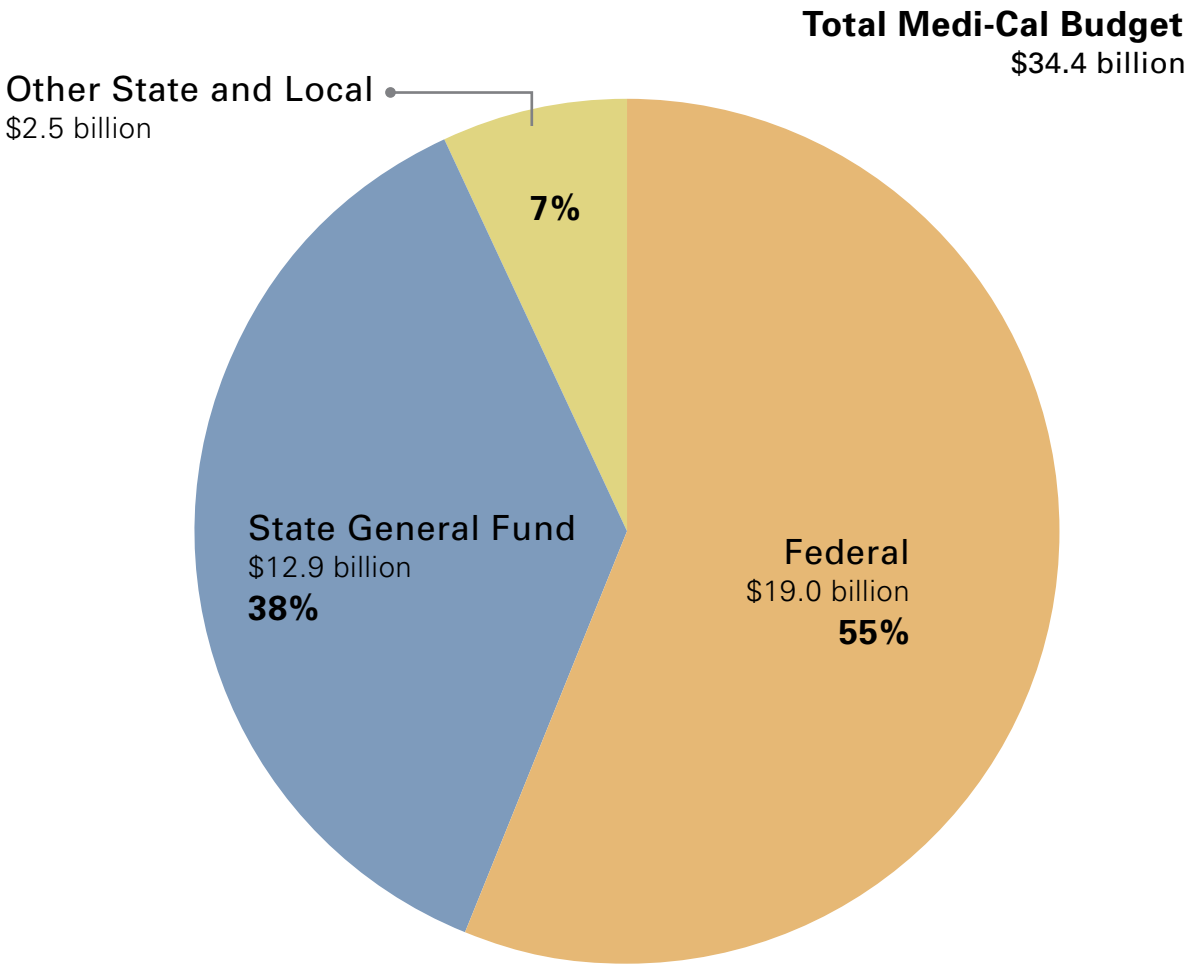


County Health and Social Services Departments

- Conduct eligibility determination
- Oversee enrollment and recertification

Medi-Cal is governed by the federal, state, and county governments.

Budget Funding Sources
State FY 2005–2006

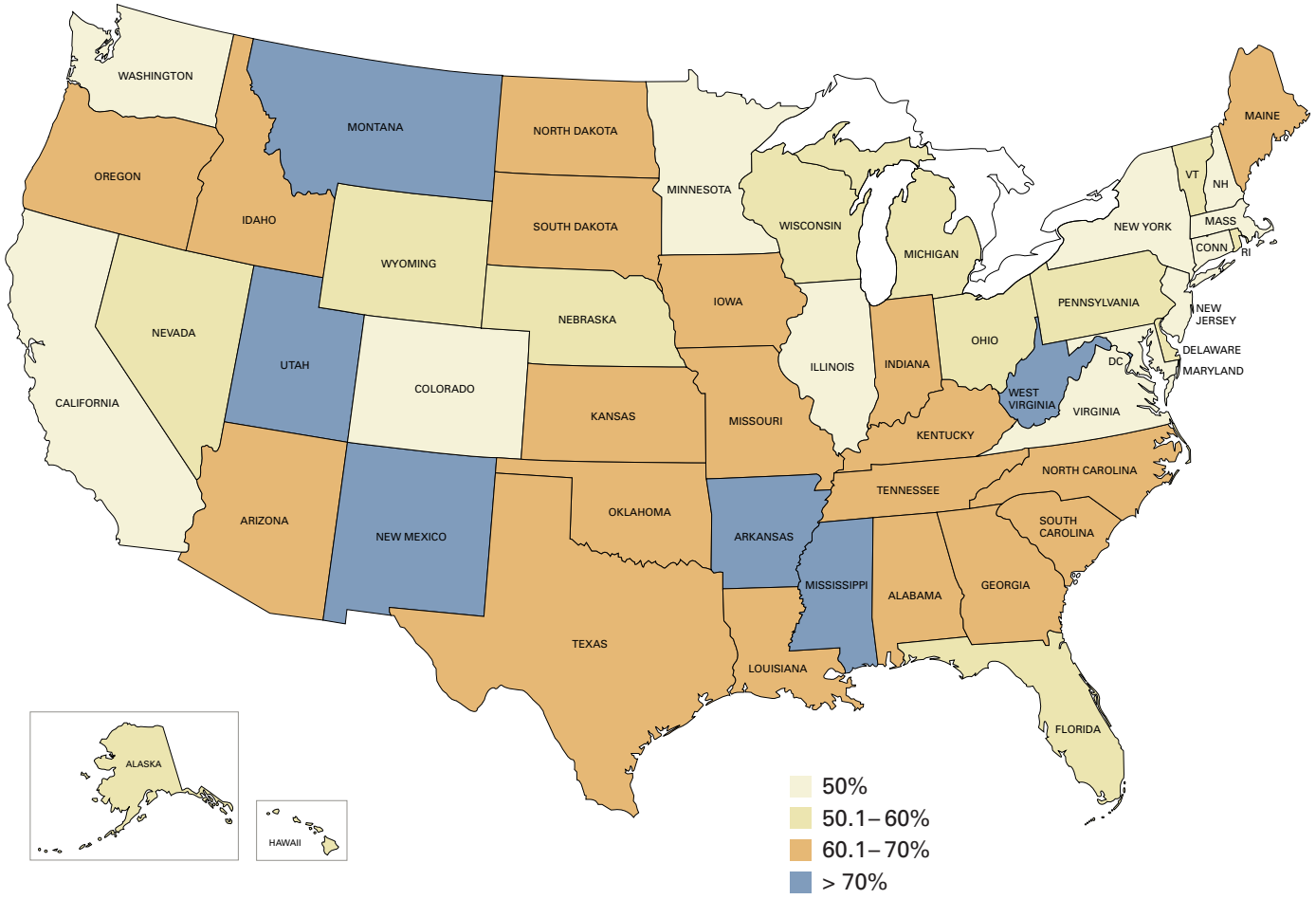


Source: Legislative Analyst's Office, Analysis of the 2005–2006 Budget Bill, February 2005; Governor's Budget 2005–2006.

Federal funds account for 55 percent of Medi-Cal's budget.

Federal Matching Rates

Medical Assistance Percentage, 2006



Source: Kaiser Family Foundation (www.statehealthfactsonline.org).

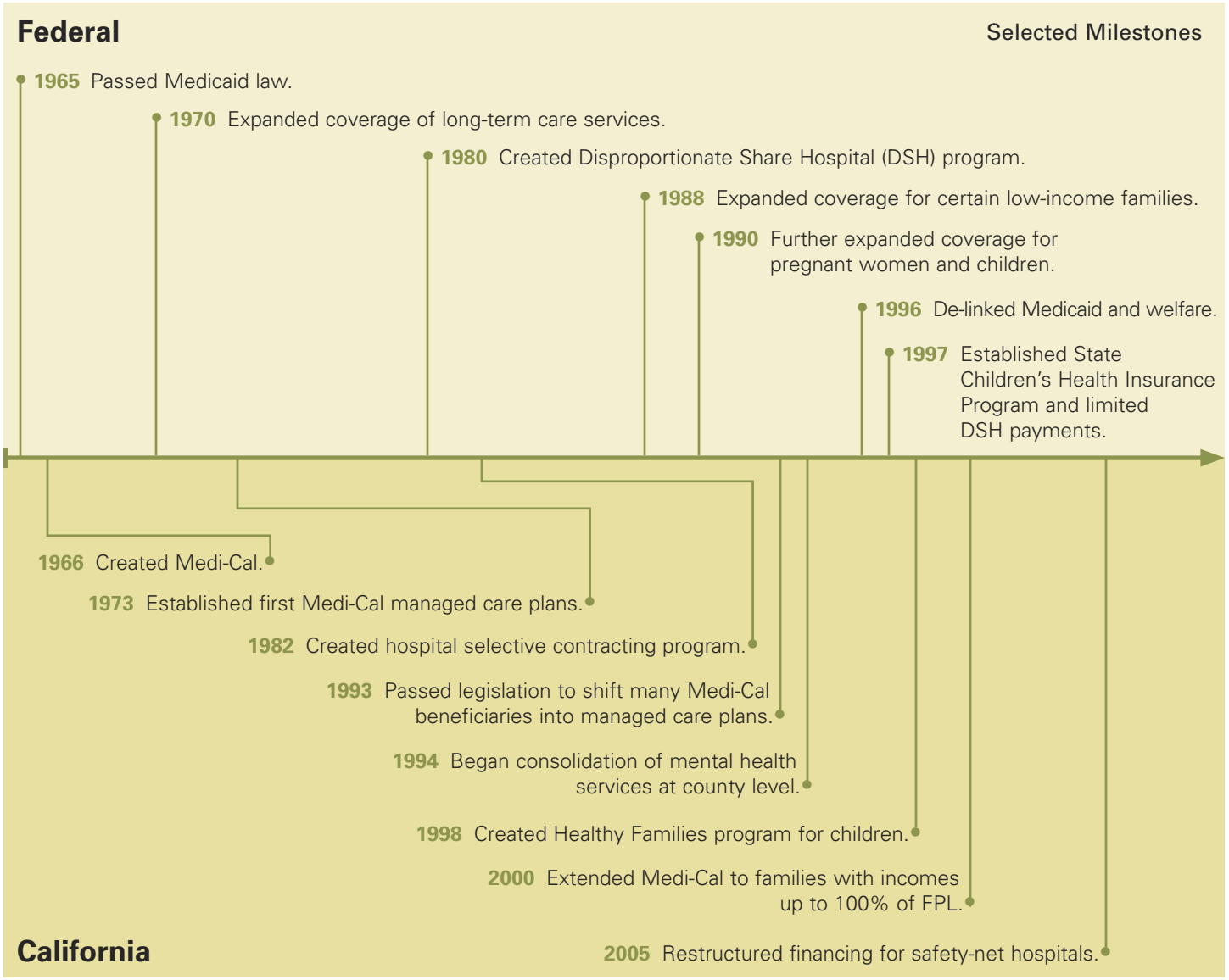
Medi-Cal
Overview

<< PREVIOUS NEXT >>

- For every dollar California spends on Medi-Cal, the federal government contributes 50 cents.
- The federal matching rate takes into account a state's resources to fund Medicaid (per capita income), but not a state's need (percent of population below poverty).
- According to the GAO, this formula is unfavorable to states like California that have a high percent of population below poverty relative to the national average.

GAO is the U.S. Government Accountability Office.

Legislative History



Medi-Cal has evolved over time in response to changing federal and state policies.

Comparison to Medicare

CATEGORY	MEDI-CAL	MEDICARE
Population	Low-income families and children, persons with disabilities, and seniors (65+)	Seniors (65+) or permanently disabled
Services Covered	Primary, acute, and long-term care	Primary and acute care
Cost Sharing	No premiums or copayments for lowest-income beneficiaries	Beneficiaries must pay premiums and deductibles
Funded by	Federal and California governments	Federal government and beneficiaries
Administered by	California with oversight by Centers for Medicare and Medicaid Services (CMS)	Federal government through CMS

There are over one million California seniors and people with disabilities who are eligible for both Medi-Cal and Medicare.

Eligibility Factors

- Eligibility for Other Public Assistance Programs (see page 10)
- Family Income (see page 11)
- Family Assets
  - For most beneficiaries, the upper limit starts at $2,000 for one person and increases with family size.
  - Countable personal property includes but is not limited to savings, checking, stocks, bonds, and certain life insurance policies and annuities.
  - The home is usually not considered.
  - Personal assets are not considered for certain pregnant women and children who are under certain levels of federal poverty.
- U.S. Citizenship (see page 12)
- California Residency (documented)
- Institutional Status
- Deprivation*

Medi-Cal eligibility is based on numerous factors.

*Deprivation exists when a parent is absent from the home, or is incapacitated, disabled, deceased, employed less than 100 hours per month, or has earnings that are below 100 percent of the Federal Poverty Level ($16,090 for a family of three).

Eligible Groups

Mandatory
States must cover:

- Low-income families participating in CalWORKs, and those who meet financial standards for AFDC that were in-effect in July 1996
- Seniors and people with disabilities participating in the Supplemental Security Income (SSI) program
- Pregnant women and children with family incomes below specified levels
- Children receiving foster care and adoption assistance
- Certain low-income Medicare beneficiaries

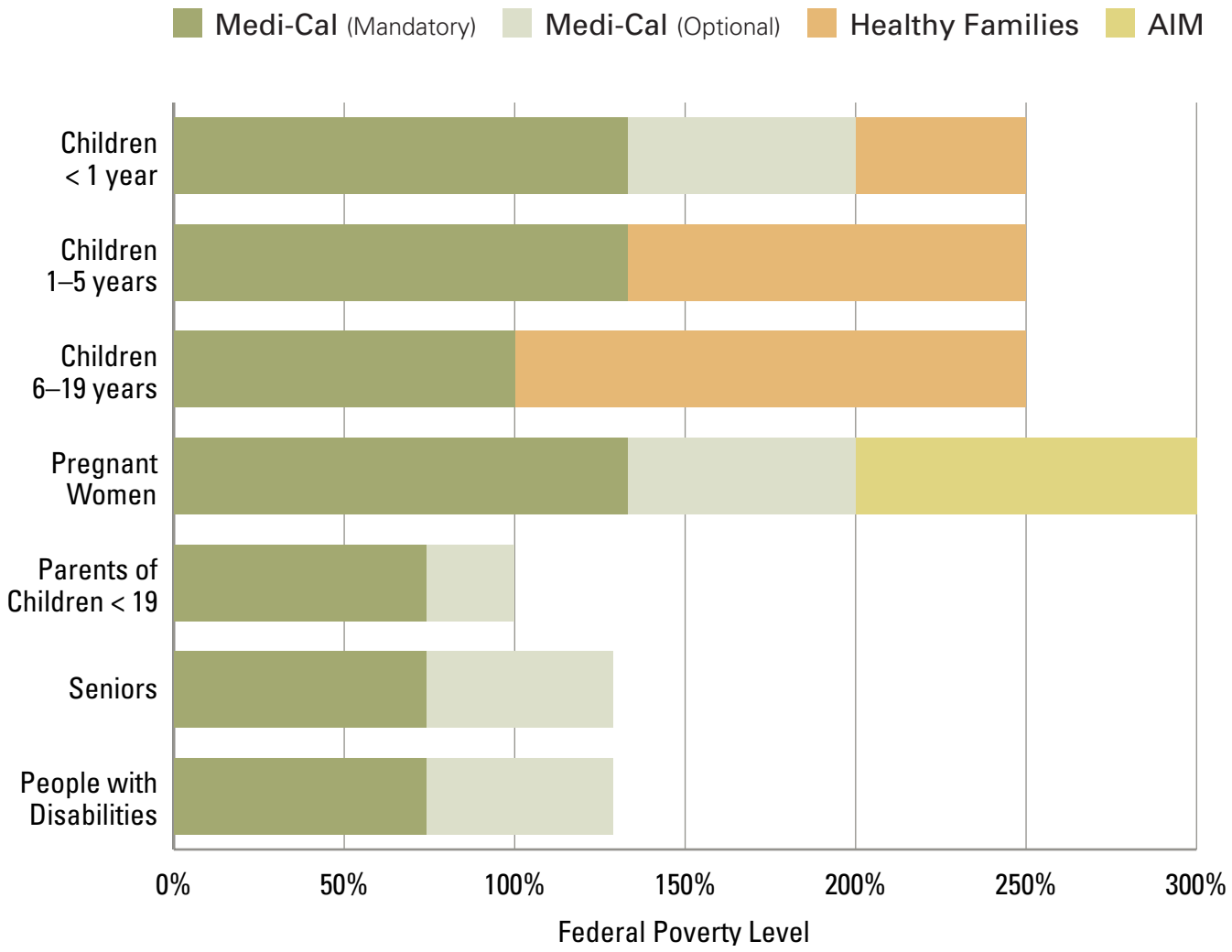
Optional
States may cover:

- Other pregnant women, children, seniors, and adults with disabilities based on their income levels and family size
- Individuals who qualify for cash assistance except on the basis of income, and those eligible for cash assistance who choose not to participate, may qualify for Medicaid by "spending down" to specified levels (Medically Needy)
- Pregnant women and children who do not meet Medically Needy deprivation requirements, and certain nursing facility residents, among others (Medically Indigent)
- Children and pregnant women, while eligibility is being determined (Accelerated Enrollment and Presumptive Eligibility)

Note: Not a comprehensive list. Multiple criteria have contributed to the creation of more than 160 eligibility categories or aid codes for beneficiaries.

Federal law requires that all state Medicaid programs cover certain (mandatory) groups, and allows states to receive federal matching funds for certain other (optional) groups.

Income Limits



Notes: AIM is Access for Infants and Mothers. Reflects Full-scope Medi-Cal only. Excludes Medically Needy and the 250 Percent Working Disabled Program. Federal poverty level (FPL) for a family of three is $16,090 through March 2006. Individuals must also meet other eligibility requirements (e.g., assets, deprivation, residency, immigration status); California is required to cover pregnant women and children up to 185 percent FPL. Medi-Cal provides coverage to seniors and people with disabilities with monthly incomes up to 100 percent FPL plus $230 (for an individual).

Medi-Cal income limits vary by population.

Immigrant Coverage

- Immigrants may be eligible for Medi-Cal if they meet the categorical, financial, and residency requirements.
- Full-scope Medi-Cal (with federal matching funds) is available to Lawful Permanent Residents ("green card holders"), refugees, and immigrants granted asylum, among others.
- Full-scope Medi-Cal (with no federal match) is available to PRUCOL immigrants.
- Restricted Medi-Cal, which primarily covers emergency and pregnancy-related services, is available to other immigrants.

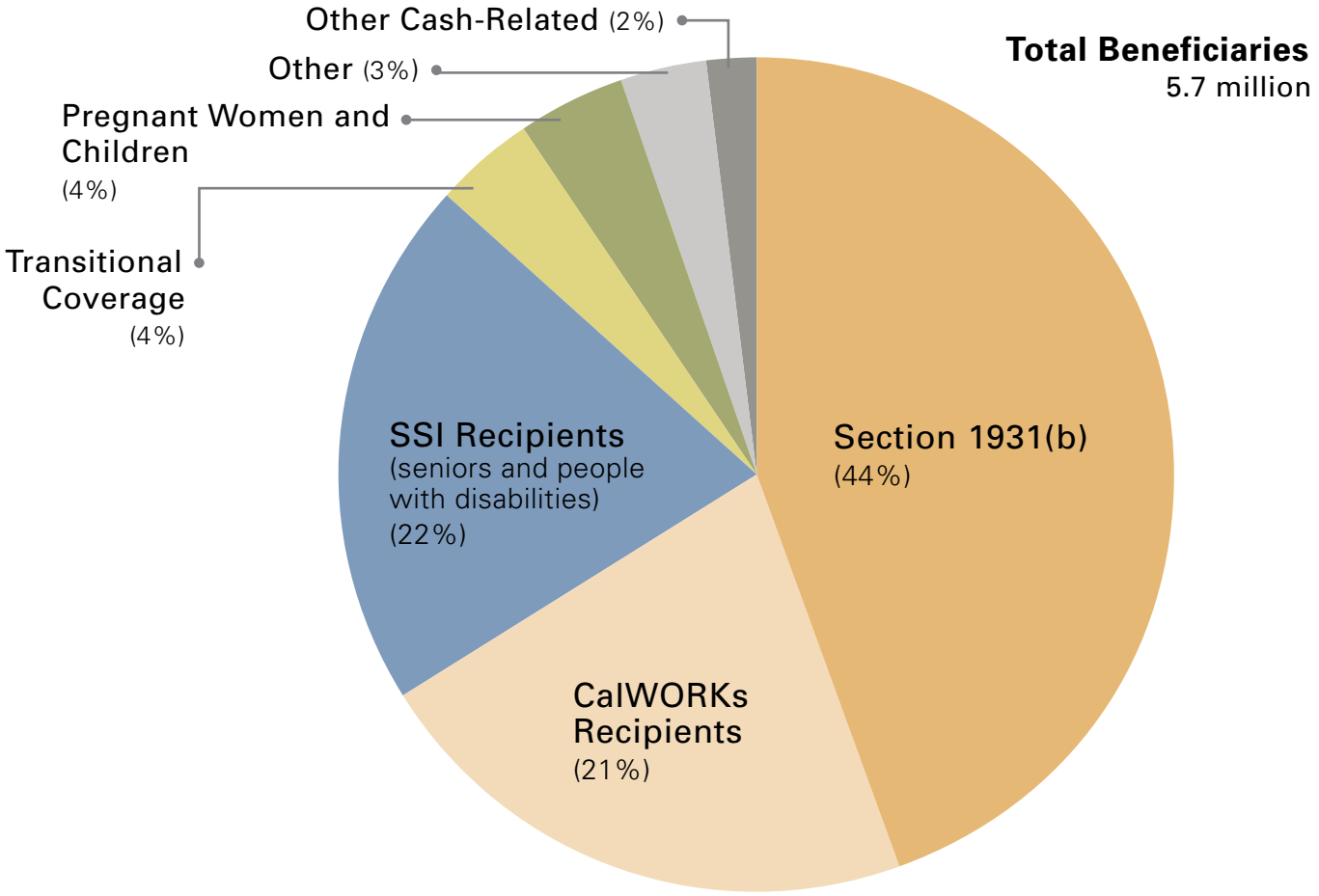
Some immigrants are eligible for full-scope Medi-Cal, while others may be eligible for a limited set of Medi-Cal benefits.

Note: PRUCOL is Permanently Residing Under Color of Law, and refers to people that the Department of Homeland Security knows are in the country and has no plans to deport or remove. See 42 CFR Section 435.408 for the federal definition and 22 CCR Section 50301.3 for the state definition. Restricted Medi-Cal also covers breast and cervical cancer treatment, long-term care, and kidney dialysis treatment.

Source: Western Center on Law and Poverty, *Medi-Cal Eligibility Guide, How to Get and Keep Low-Income Health Coverage* (Spring 2005).

Mandatory Eligibility Categories

Required by Federal Law



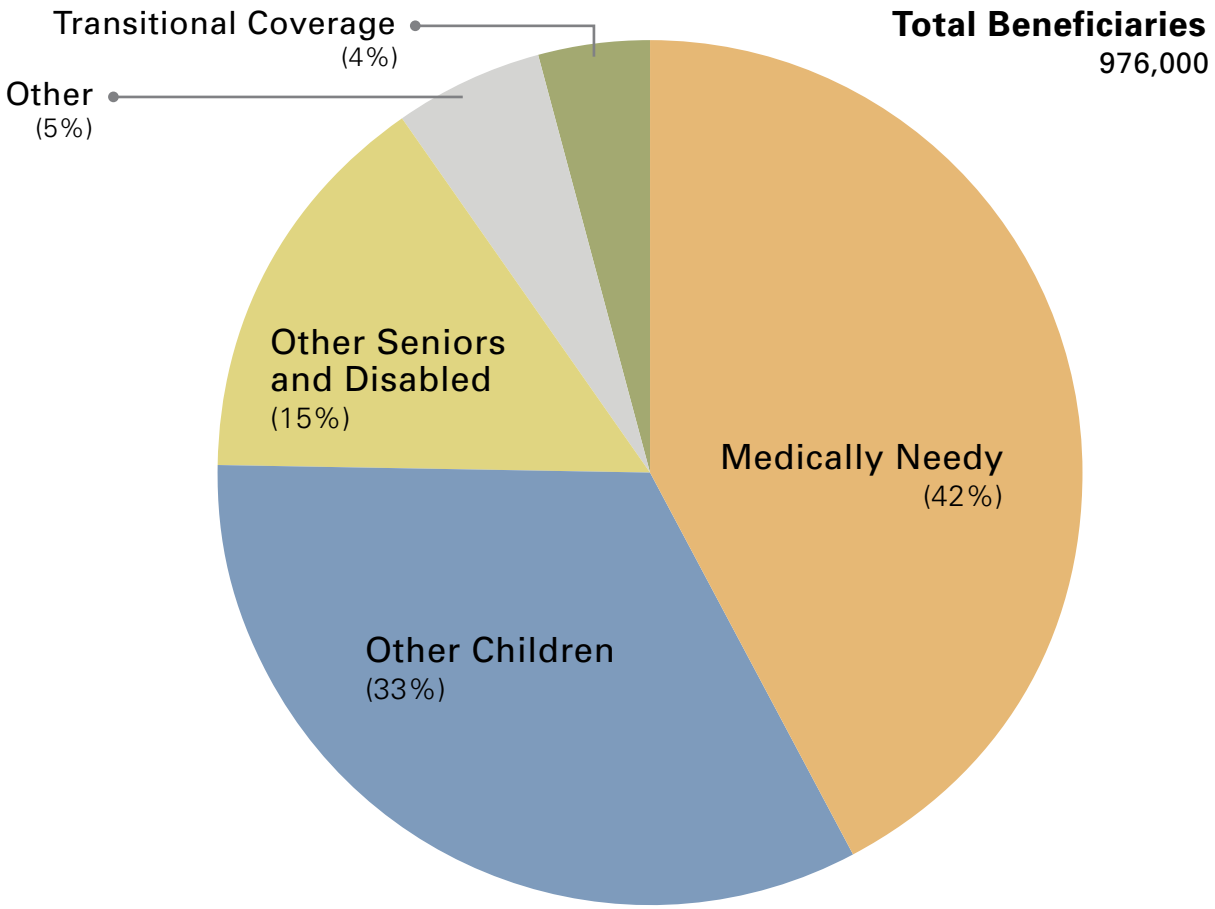
Notes: "Section 1931(b)" includes parents and children with incomes below AFDC threshold in July 1996. "Pregnant Women and Children" includes children under 6 years old in families with incomes less than 133 percent FPL; children ages 6 to 19 in families with incomes less than 100 percent FPL; and pregnant women with incomes less than 133 percent FPL ($16,090 for a family of three).

Source: Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Optional Populations: Coverage and Benefits,* February 2005; and Medstat analysis of Medi-Cal MIS/DSS data as of August 2005 enrollment (updated through October 2005).

Those eligible under the 1931(b) program account for the largest share of the mandatory Medi-Cal population.

Optional Eligibility Categories

Allowed by California



Notes: "Other Children" includes those children less than six years old with family incomes of 133 to 200 percent FPL; pre-enrollment mechanisms (includes Child Health and Disability Prevention (CHDP) Gateway and Accelerated Enrollment); and the medically indigent. "Other Seniors and Disabled" includes those with incomes above 74 percent FPL ($16,090 for a family of three); under Home and Community-based Services (HCBS) waiver; and working disabled persons. "Other" includes the medically indigent and some In-Home Supportive Services (IHSS) recipients. Pie slices do not add up to 100 percent due to rounding.

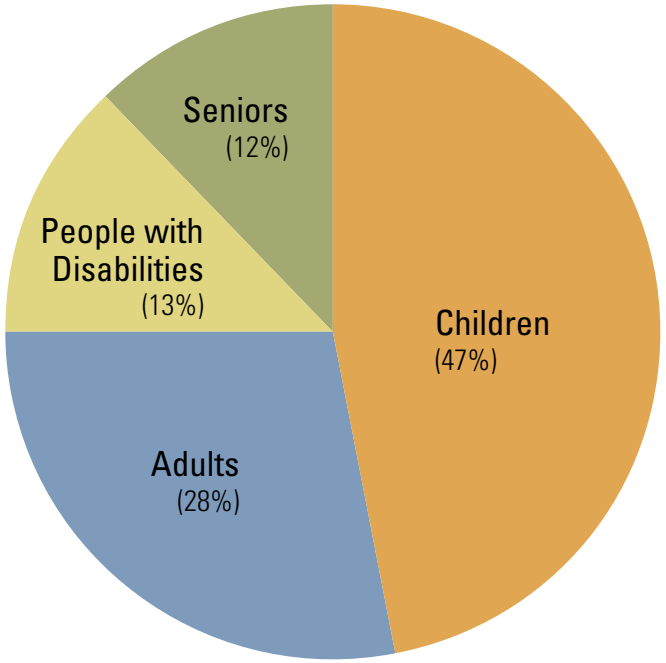
Source: Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Optional Populations: Coverage and Benefits,* February 2005; and Medstat analysis of Medi-Cal MIS/DSS data as of August 2005 enrollment (updated through October 2005).

Those eligible through the Medically Needy program account for the largest share of the optional Medi-Cal population. They include many people with high health care expenses, including many nursing facility residents.

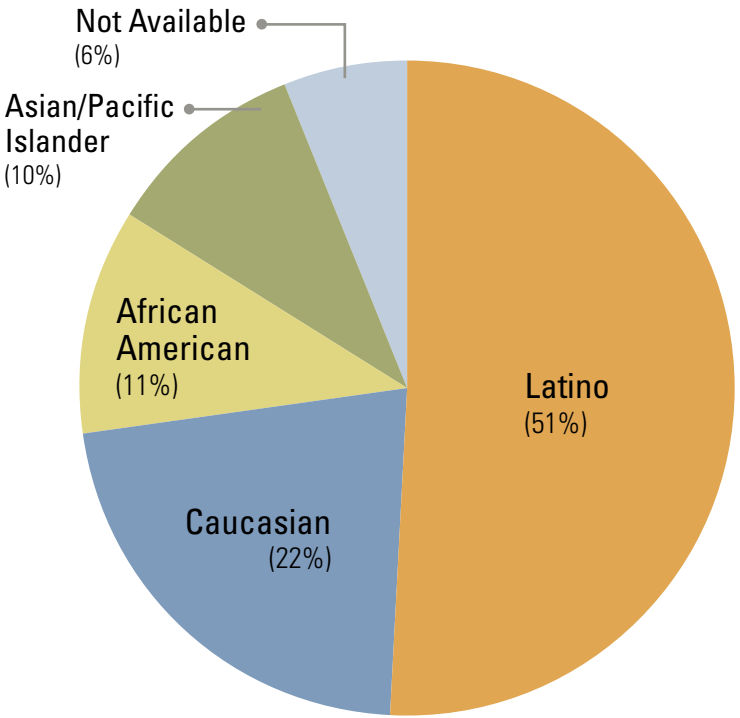
Beneficiary Profile

Children account for nearly half of Medi-Cal beneficiaries, while Latinos represent a majority of those enrolled.

Age/Disability



Ethnicity



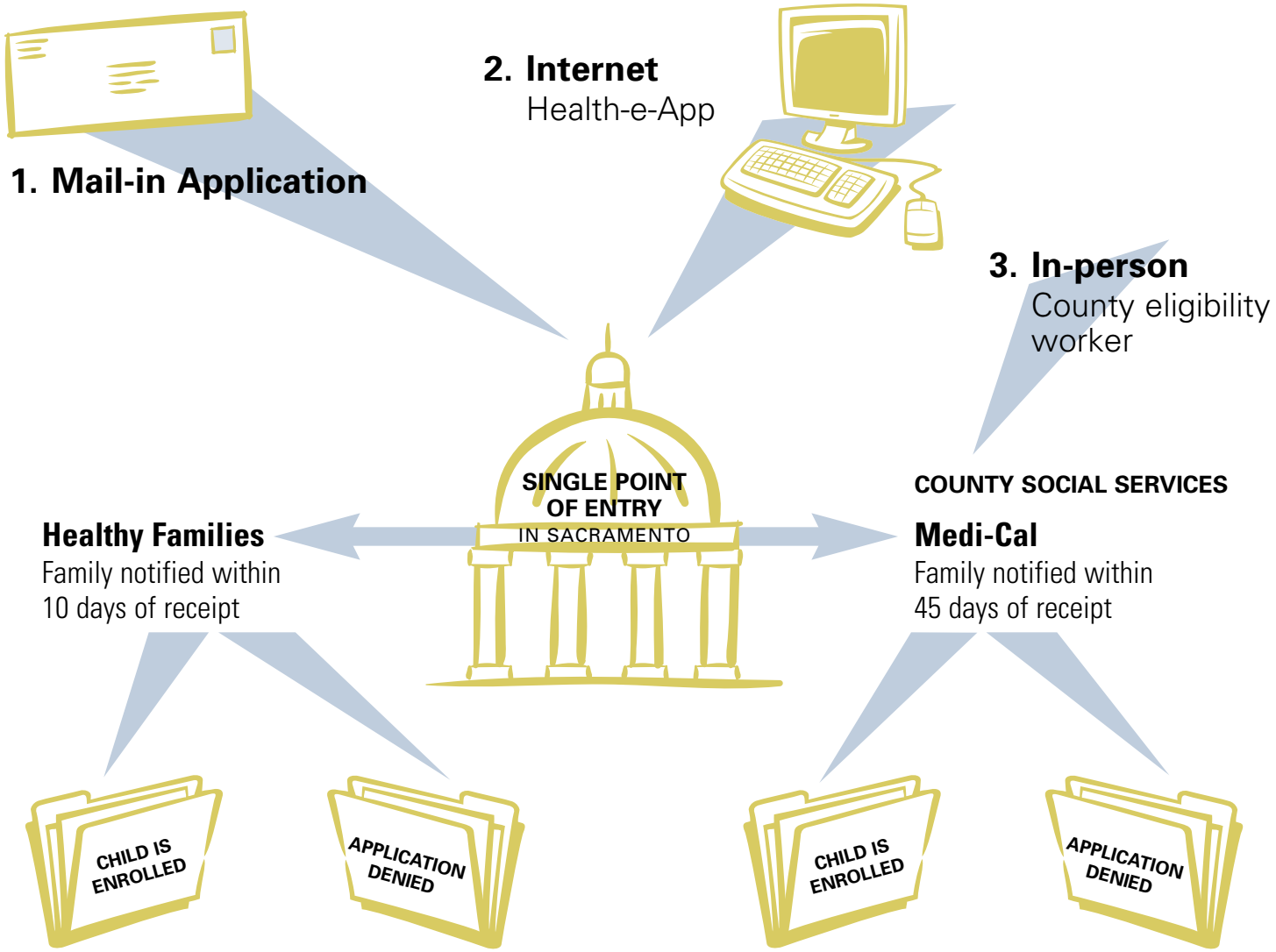
Source: Medstat analysis of MIS/DSS, updated through August 2005 (May 2005 data).

Individual Application Process

- For those receiving Supplemental Security Income (SSI) or CalWORKs, Medi-Cal coverage is automatic.
- Other individuals may apply for Medi-Cal at their local county social services office or at hospitals and clinics where county eligibility workers are located.
- Doctors can request immediate temporary coverage for pregnant women and children while they apply for the program.
- Pregnant women, children, and adults may also apply for Medi-Cal using a mail-in application. (See page 17.)
- Applicants can now submit Medi-Cal applications electronically using Health-e-App, an Internet-based system, with the help of certified application assisters. (See page 17.)

The application process varies based on the individual's circumstances.

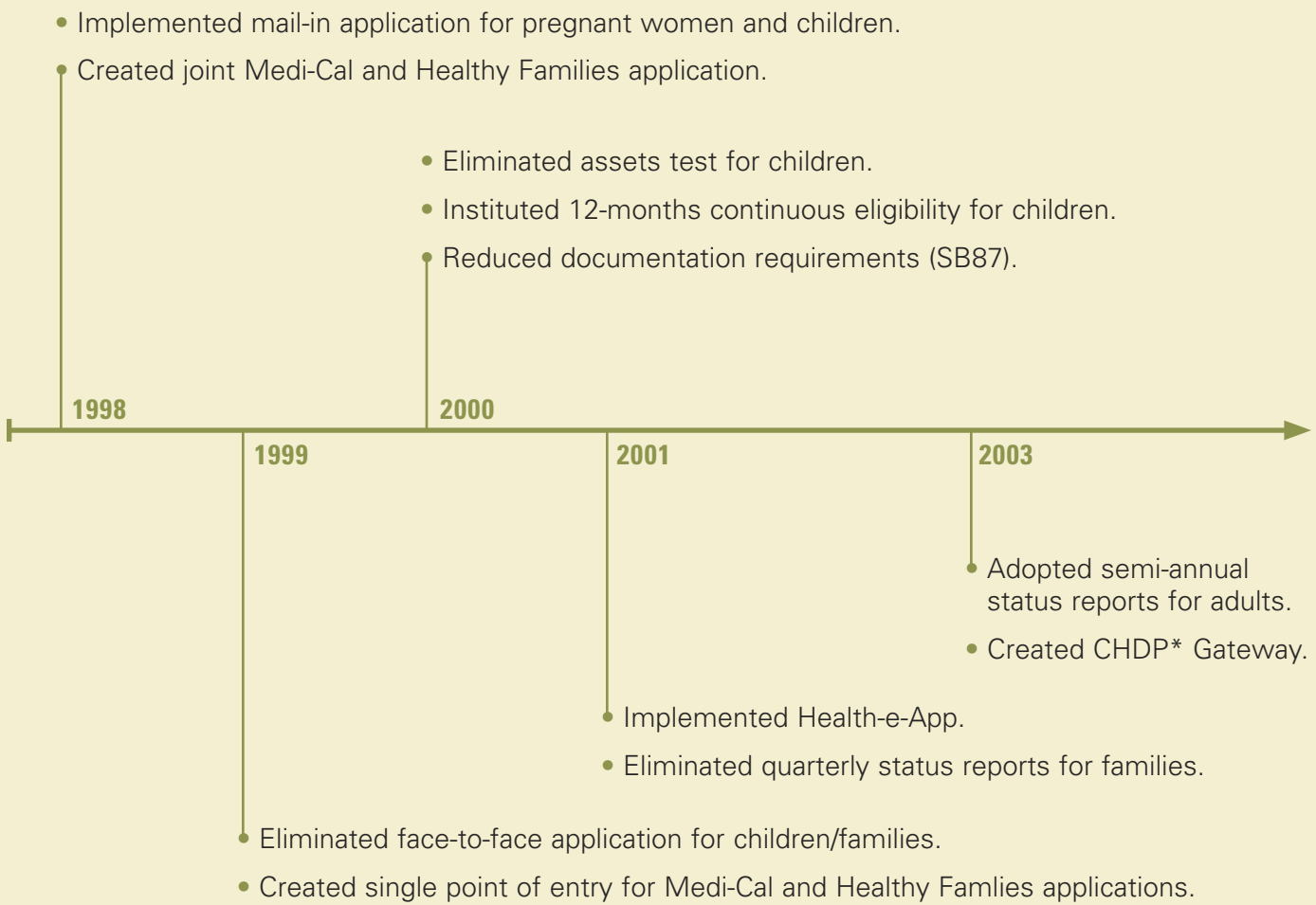
Options for Child Enrollment



There are several ways for parents to enroll their children in Medi-Cal.

Recent Enrollment Process Changes

The enrollment process has evolved significantly in recent years.



*Child Health and Disability Prevention program.

Source: The Lewin Group, 2003.

Enrollment Practices for Children

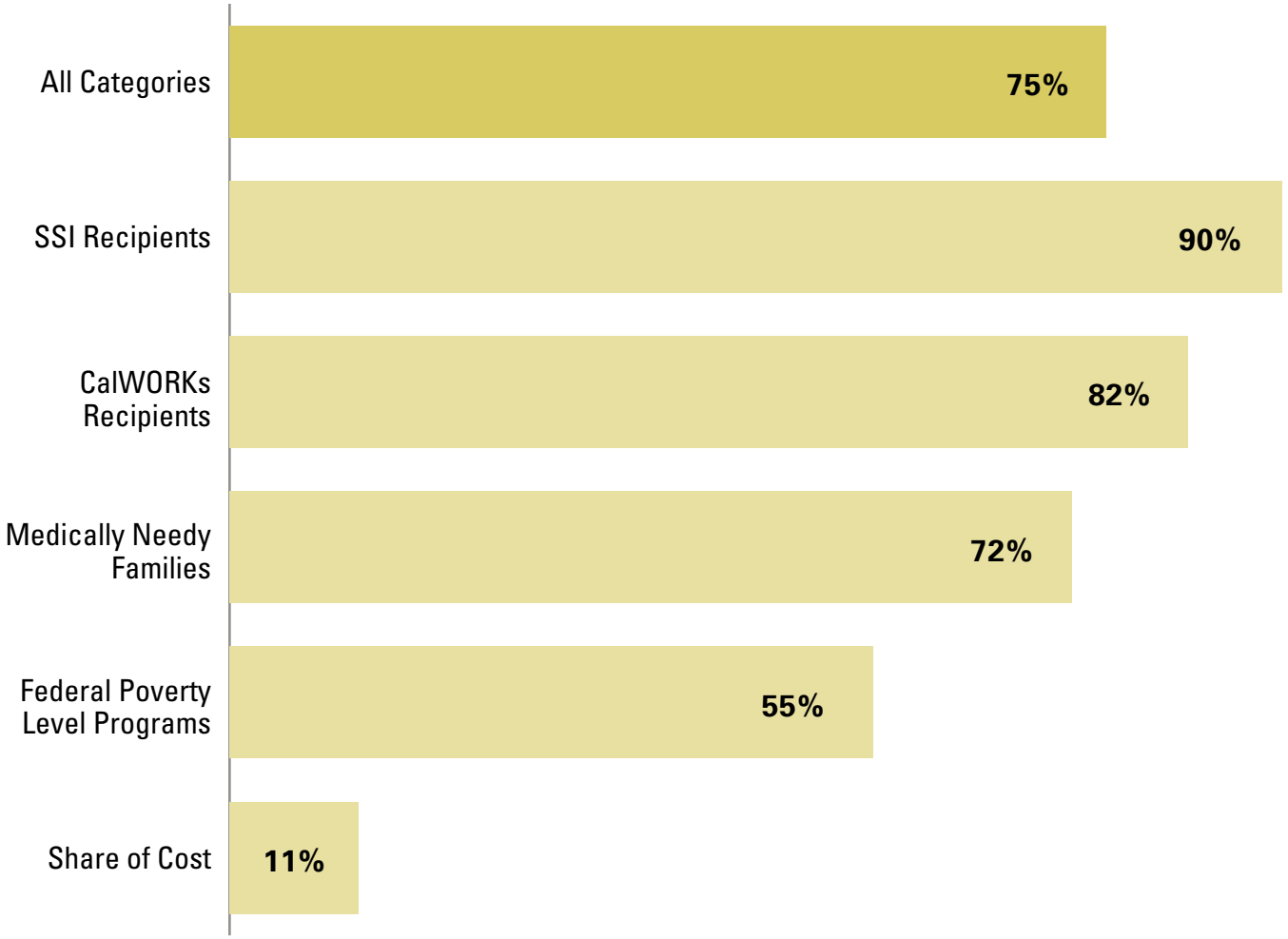
Actions Taken by States to Streamline Enrollment

- Eliminated asset test
  47 states, including California
- Eliminated requirement for face-to-face interview
  45 states, including California
- Created joint application for Medicaid and SCHIP program
  34 states, including California
- Provide 12-months of continuous eligibility
  17 states, including California
- Adopted presumptive eligibility
  9 states, including California
- Allow parents to self-declare their income
  9 states, not including California

Source: Kaiser Family Foundation (www.statehealthfacts.org); accessed December 15, 2005.

California has taken several steps to streamline enrollment for children, but additional opportunities remain.

Enrollment After One Year

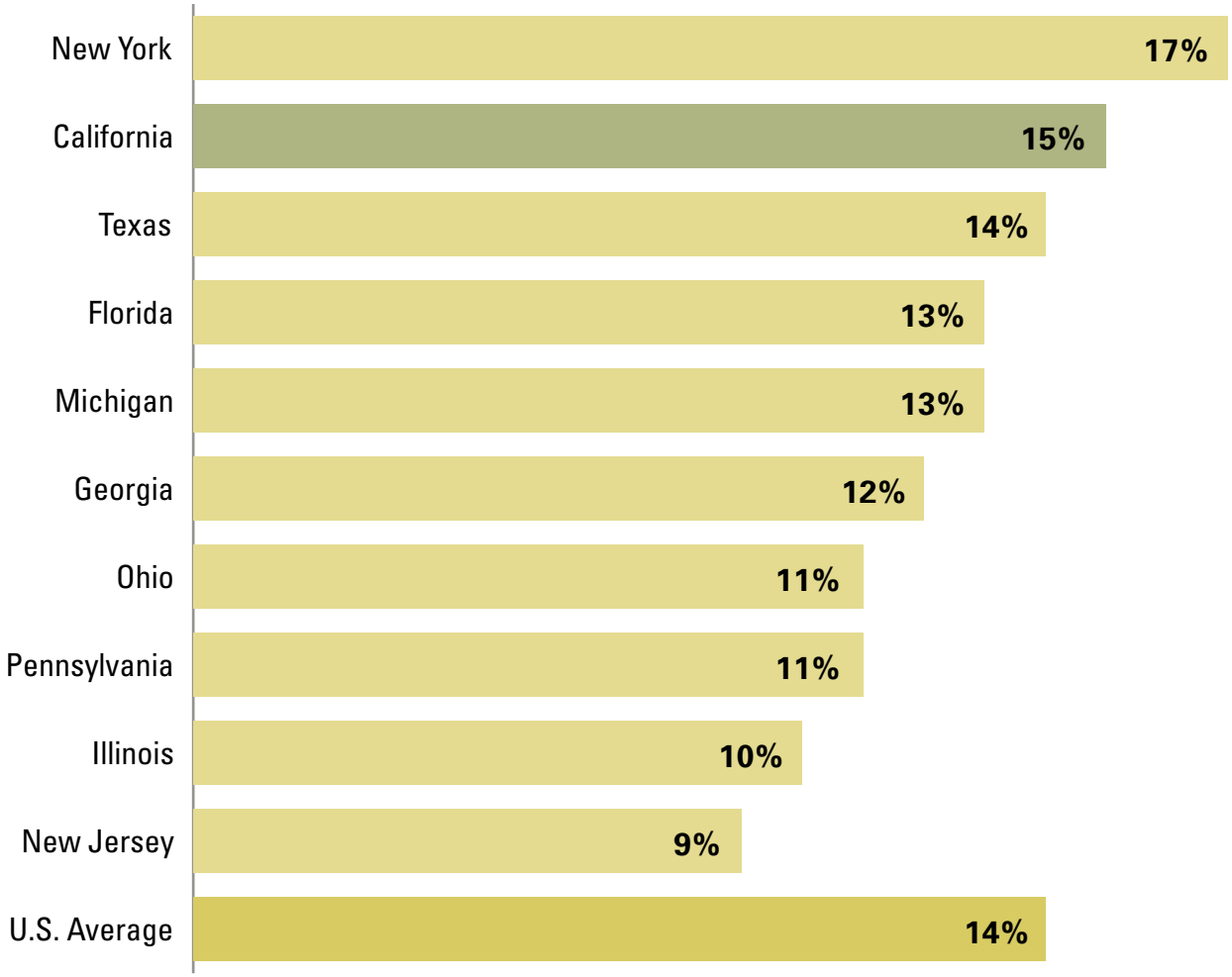


Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (August 2005 data).

- Seventy-five percent of all beneficiaries remain enrolled after one year.
- Nearly all disabled persons who qualify for Medi-Cal through SSI stay covered after 12 months.
- Individuals who are required to pay a share of their costs are much less likely to retain coverage.

Enrollment in Other States

Non-elderly Population Covered by Medicaid



Source: Kaiser State Health Facts (2003 data).

California ranks second among the ten largest states in percent of population enrolled in Medicaid and is just above the national average.

Medi-Cal Benefits

Required Services*

- In/outpatient hospital
- Physician visits
- Lab tests and x-rays
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21
- Family planning and supplies
- Clinic in Federally Qualified Health Centers (FQHC)
- Certified midwife
- Certified nurse practitioner
- Nursing home care for adults over 21

Optional Services*

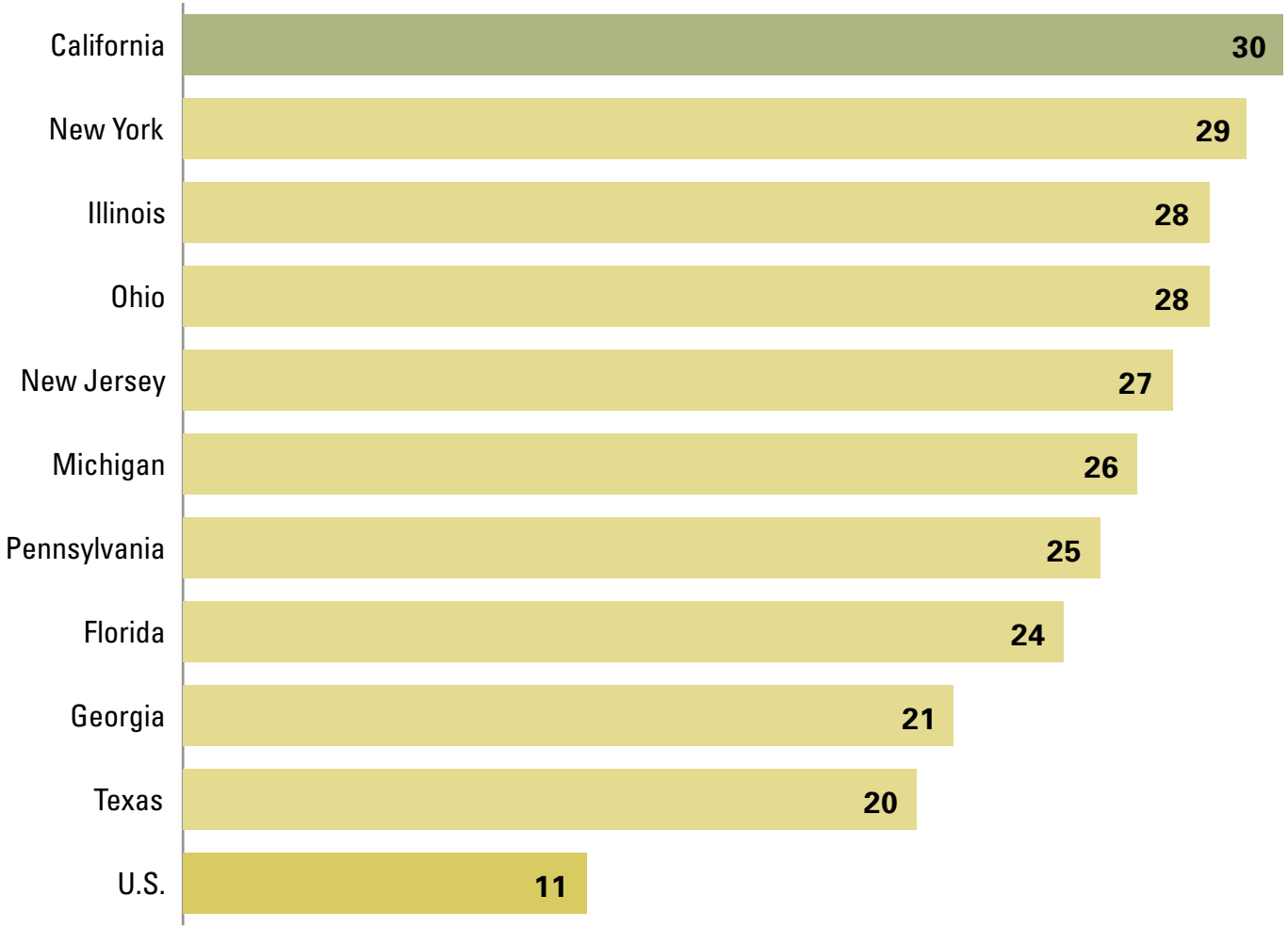
- Prescription drugs
- Vision services and eyeglasses
- Dental care and dentures
- Medical equipment and supplies
- Targeted case management
- Adult day health
- Personal care services
- Physical therapy
- Intermediate Care Facilities for Mentally Retarded (ICF-MR)
- Inpatient psychiatric for children under 21
- Rehabilitation for mental health and substance abuse
- Home health care
- Hospice
- Occupational therapy
- Chiropractic

*Partial lists.

Source: Department of Health Services, 2003.

All states are federally required to provide certain benefits. California offers a number of additional benefits. Partial lists of both are shown here.

Major Optional Benefits Covered,
by State (of 31 total)



Source: Medstat analysis using Kaiser Commission on Medicaid and the Uninsured, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services,* June 2005 and Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Medicaid Benefits Online Database*. California does not cover direct billing for Private Duty Nursing.

California covers more optional benefits than any other of the 10 largest states.

Services which account for the most Medi-Cal spending on optional benefits include:

- Adult day health
- Dental services
- ICF-MR/DD*
- Medical equipment and supplies
- Personal care services
- Prescription drugs
- Targeted case management

*Intermediate Care Facilities for the Mentally Retarded / Developmentally Disabled

Cost Sharing

- Beneficiaries are charged copayments for selected services; however, providers are not allowed to refuse service for lack of payment.

  COMMON COPAYMENT AMOUNTS:

  - Physician office visit: $1
  - Inpatient hospital: $1
  - Non-emergency services received in an emergency room: $5
  - Drug prescription or refill: $1

- Some beneficiaries are exempt from copayments, including children 18 years of age or under and women receiving perinatal care.

- There are generally no premiums in Medi-Cal.*

*There are exceptions, such as the 250 Percent Working Disabled Program. Also, individuals who qualify for cash assistance except on the basis of income may qualify for Medicaid by spending down their income to specified levels.

Source: WIC Code Sections 14132 and 14134.

Providers are not allowed to refuse services for lack of payment of Medi-Cal copayments.

Delivery Systems

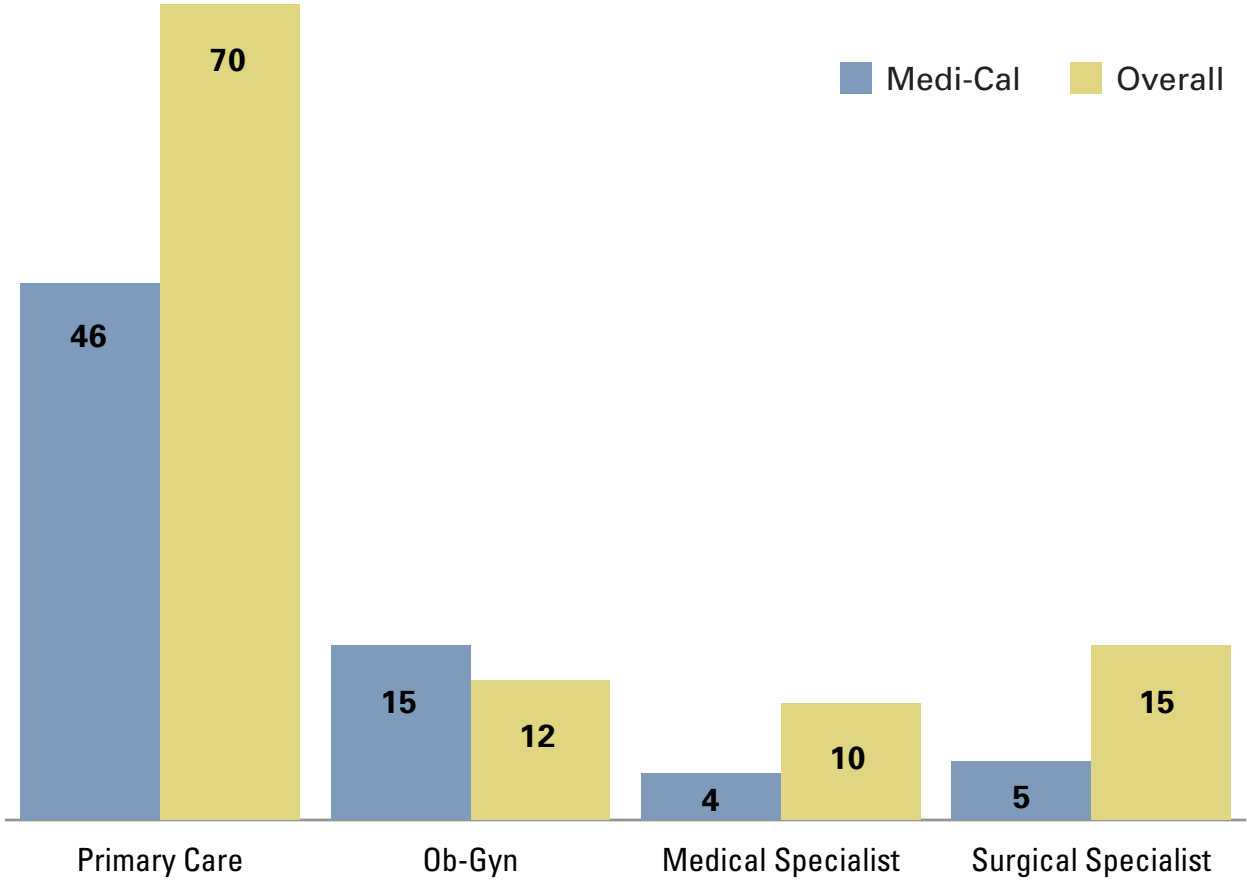
AREA	FEE-FOR-SERVICE	MANAGED CARE
Availability	All 58 counties	22 large counties
Market Share	52% of all beneficiaries	48% of all beneficiaries
Population	• Most elderly and disabled IN COUNTIES WITHOUT MANAGED CARE: • Children • Pregnant women • Non-disabled parents	MANDATORY ENROLLMENT • Children • Pregnant women • Non-disabled parents VOLUNTARY ENROLLMENT • Most elderly and disabled*
Expenditures†	74%	26%
Exclusions	N/A	• Mental health • Dental • Long-term care • California Children Services (CCS) for the seriously ill and disabled

*Managed care enrollment is manadatory for seniors and people with disabilities in counties with a County Organized Health System.
†Do not include services delivered in Disproportionate Share Hospitals (DSH).

Source: Department of Health Services; Medstat analysis of Medi-Cal MIS/DSS, updated through August 2005.

About half of Medi-Cal beneficiaries are in fee-for-service, including most seniors and people with disabilities.

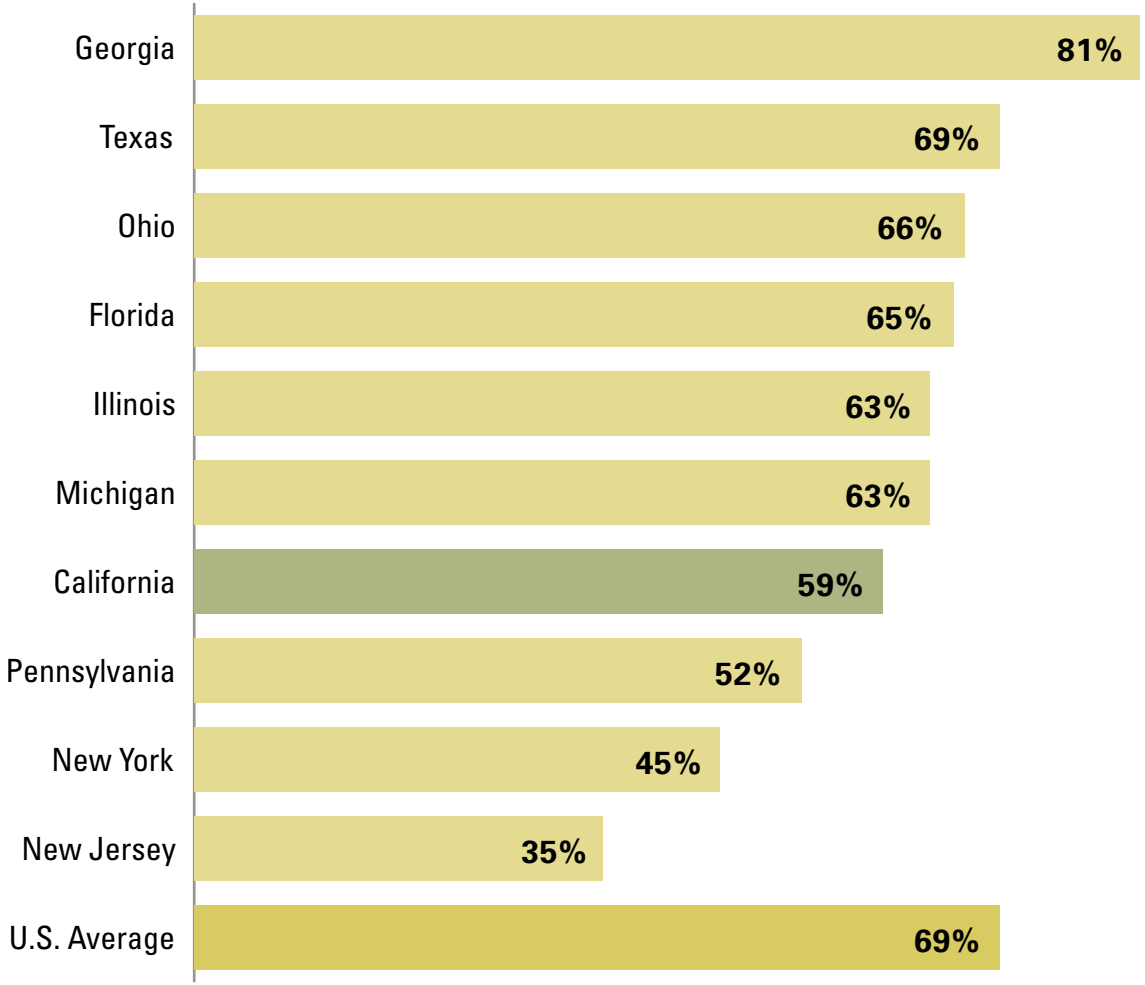
Physician Participation
per 100,000 People



Source: Bindman A., *Physician Participation in Medi-Cal, 2001,* California HealthCare Foundation, Oakland, CA: May 2002.

- Physicians can choose whether or not to participate in Medi-Cal.
- There are only 46 primary care providers for every 100,000 beneficiaries in California, well below the federal minimum standard of 60 to 80.

Physician Payment Rates
as Percentage of Medicare



Source: Urban Institute/Center for Studying Health System Change, 2003 Medicaid Physician Fee Survey.

Medi-Cal pays physicians 59 percent of Medicare rates for the same service, an amount less than the national average.

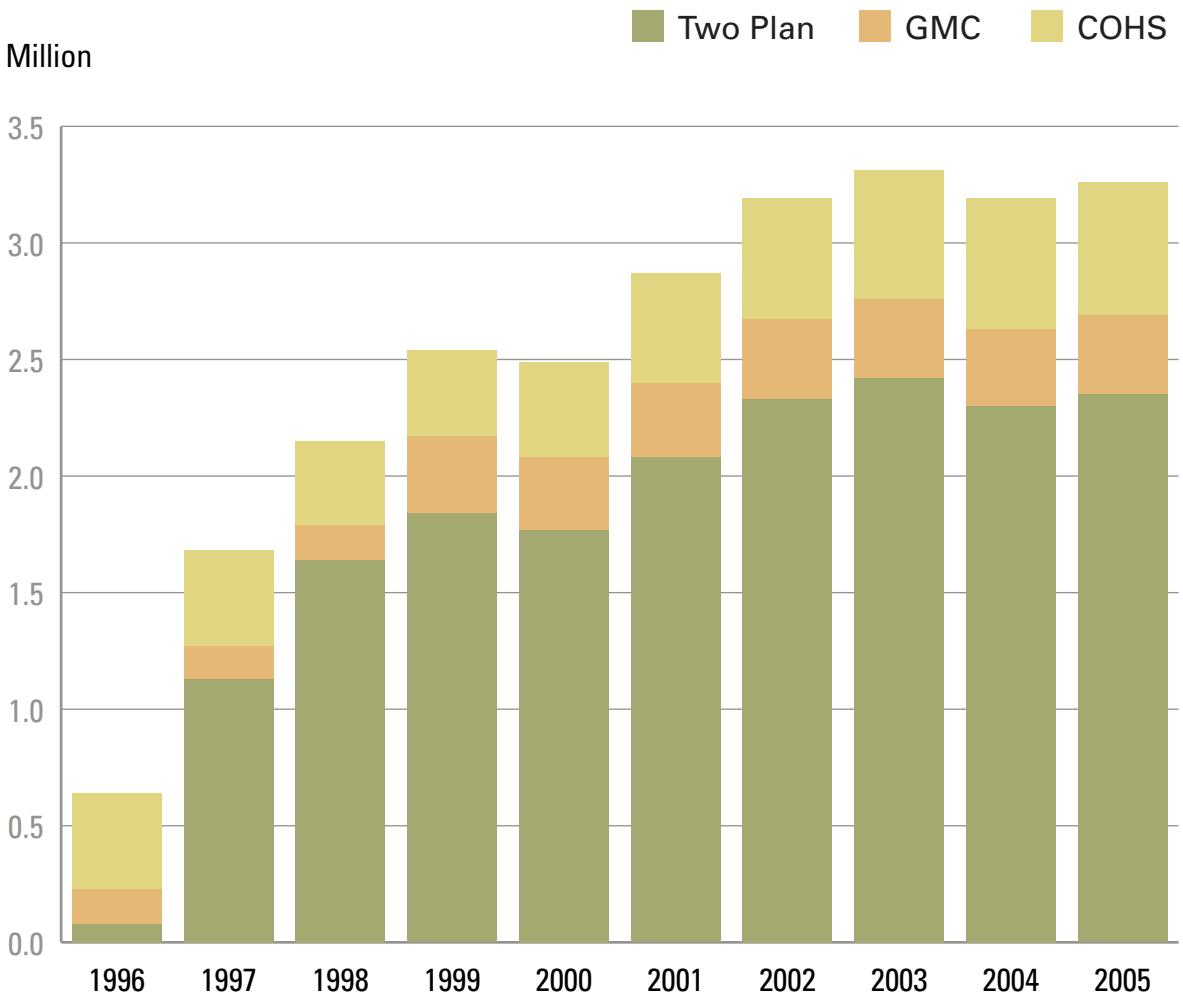
Managed Care Models by County

- **County Organized Health System (COHS)**
  - 559,587 beneficiaries in 8 counties
  - 5 county organized health plans
  - Implemented in 1983
- **Geographic Managed Care (GMC)**
  - 338,194 beneficiaries in 2 counties
  - 8 commercial health plans
  - Implemented in 1993
- **Two Plan**
  - 2.35 million beneficiaries in 12 counties
  - 10 local initiatives and 3 commercial health plans
  - Implemented in 1993

Source: Medstat analysis of Medi-Cal MIS/DSS enrollment data for May 2005.

California has a unique system of managed care, with three different models operating across 22 counties.

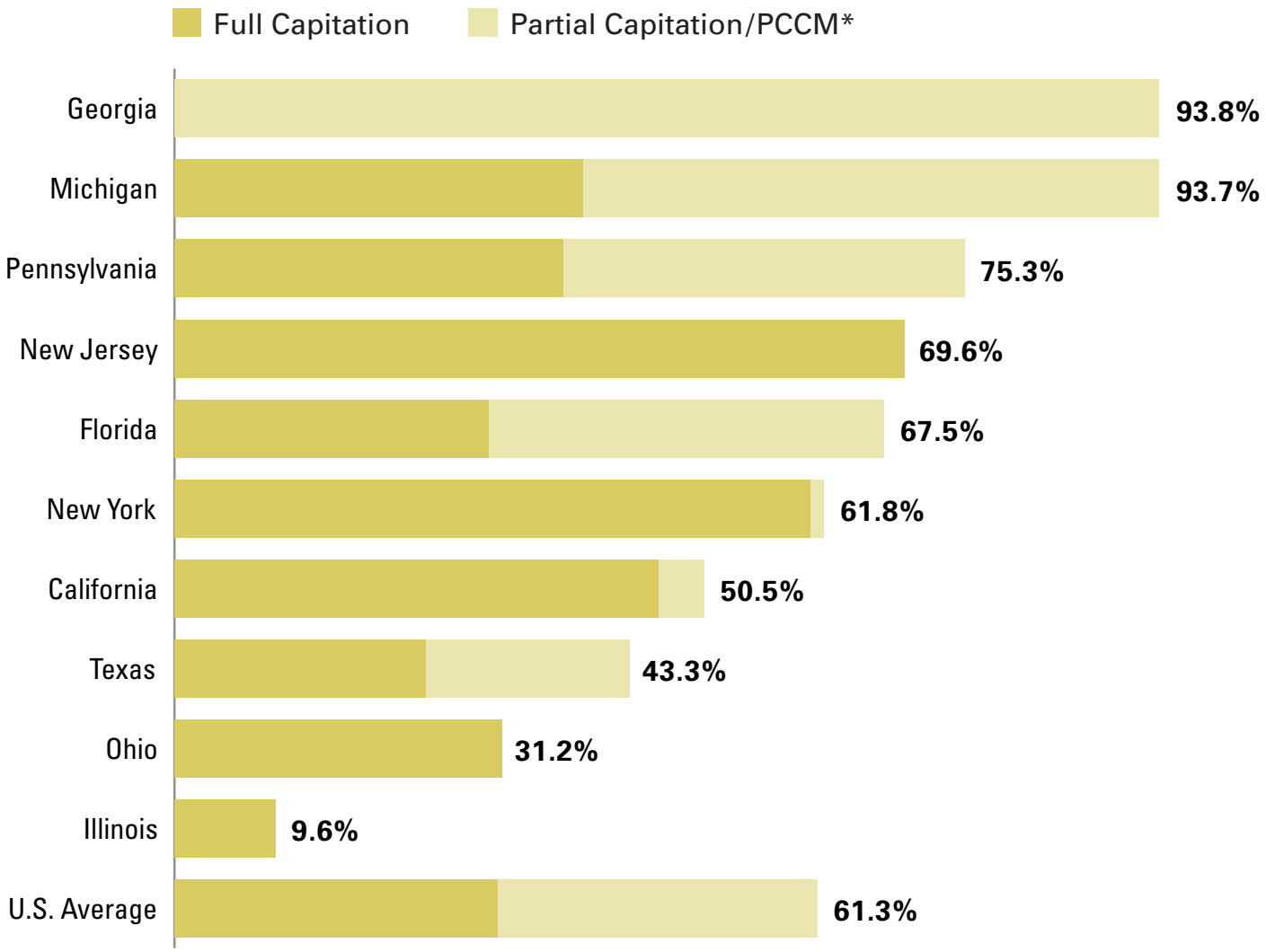
Managed Care Enrollment Trends



Source: DHS Medi-Cal Beneficiaries by Managed Care Plan Files (HCP0203 and HCP0505).

After many years of growth, managed care enrollment has changed little in recent years.

Managed Care Penetration

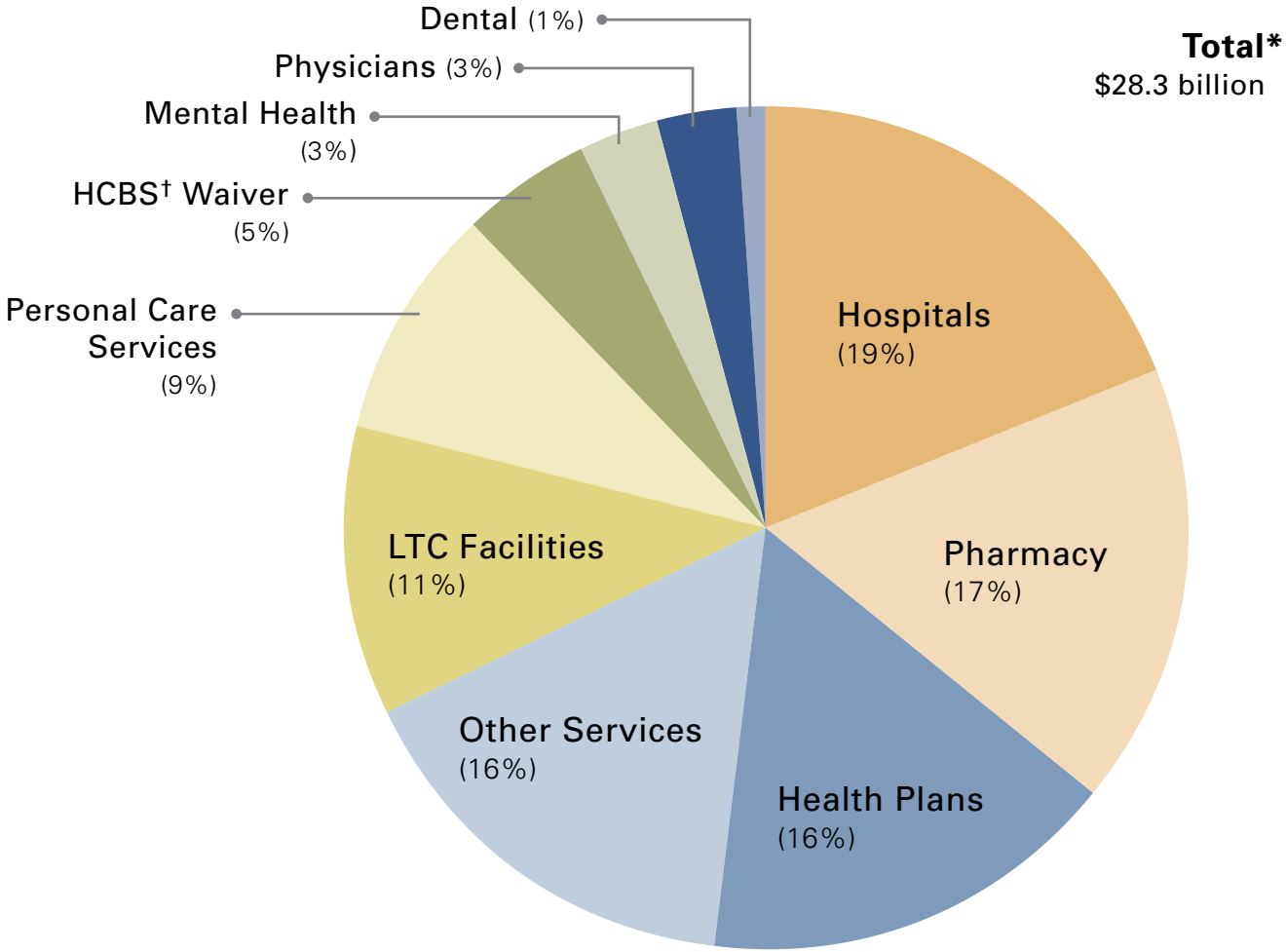


*Primary Care Case Management.

Source: California HealthCare Foundation estimates using 2004 data from Kaiser Family Foundation (www.statehealthfacts.org).

Compared to other state Medicaid programs, Medi-Cal has a smaller share of its members in managed care, but a higher share in fully capitated managed care.

Expenditure Distribution

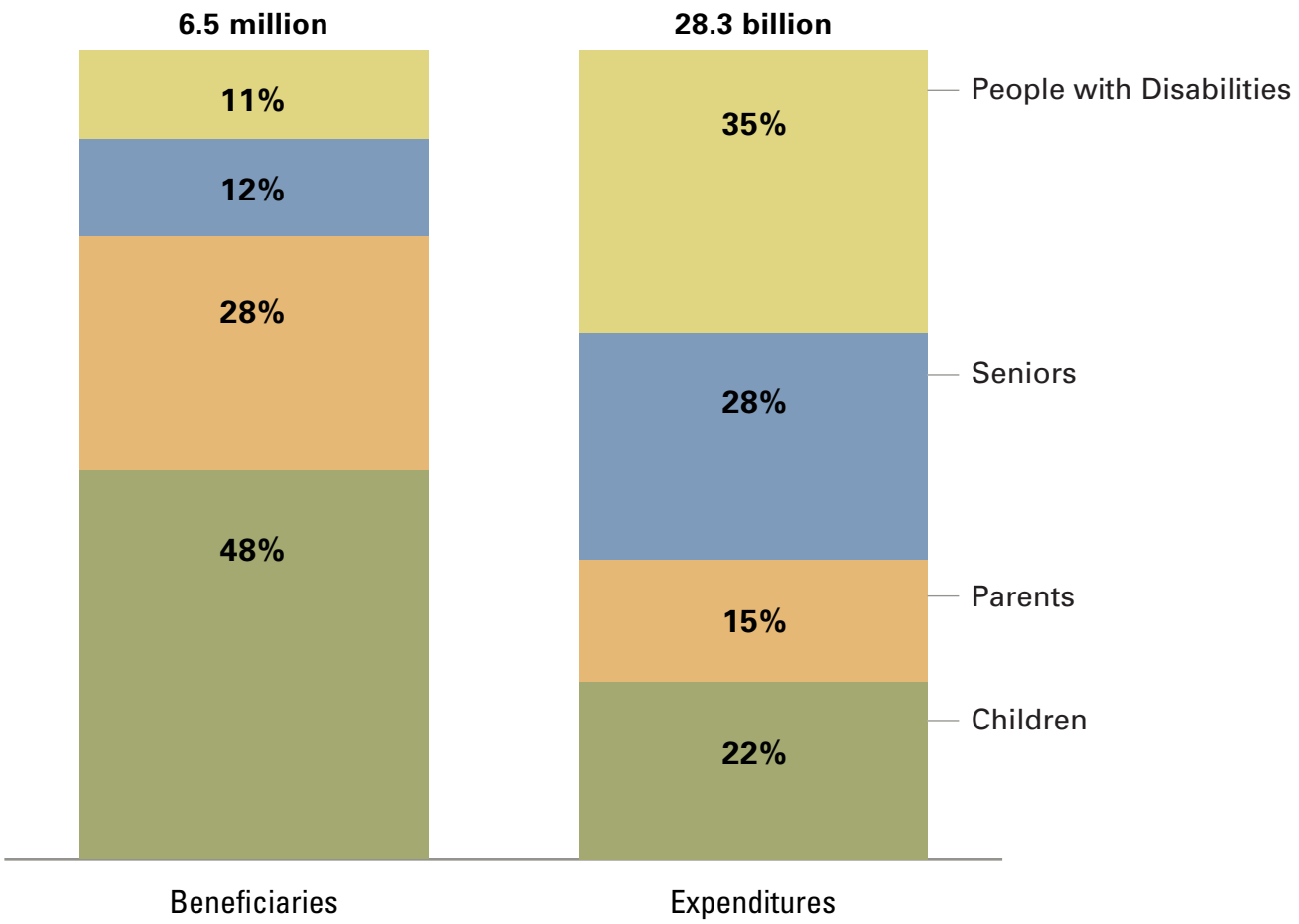


*With the exception of capitation payments, all expenditures represent fee-for-service payments. Includes only claims data, e.g. excludes administrative expenses and DSH payments.
†Home and Community Based Services

Source: Medstat analysis of Medi-Cal MIS/DSS data August 2005 (updated through October 2005). Includes only claims data, e.g. excludes administrative expenses.

Hospitals account for the largest share of Medi-Cal payments, followed closely by pharmacies and health plan capitation payments.

Beneficiaries and Cost



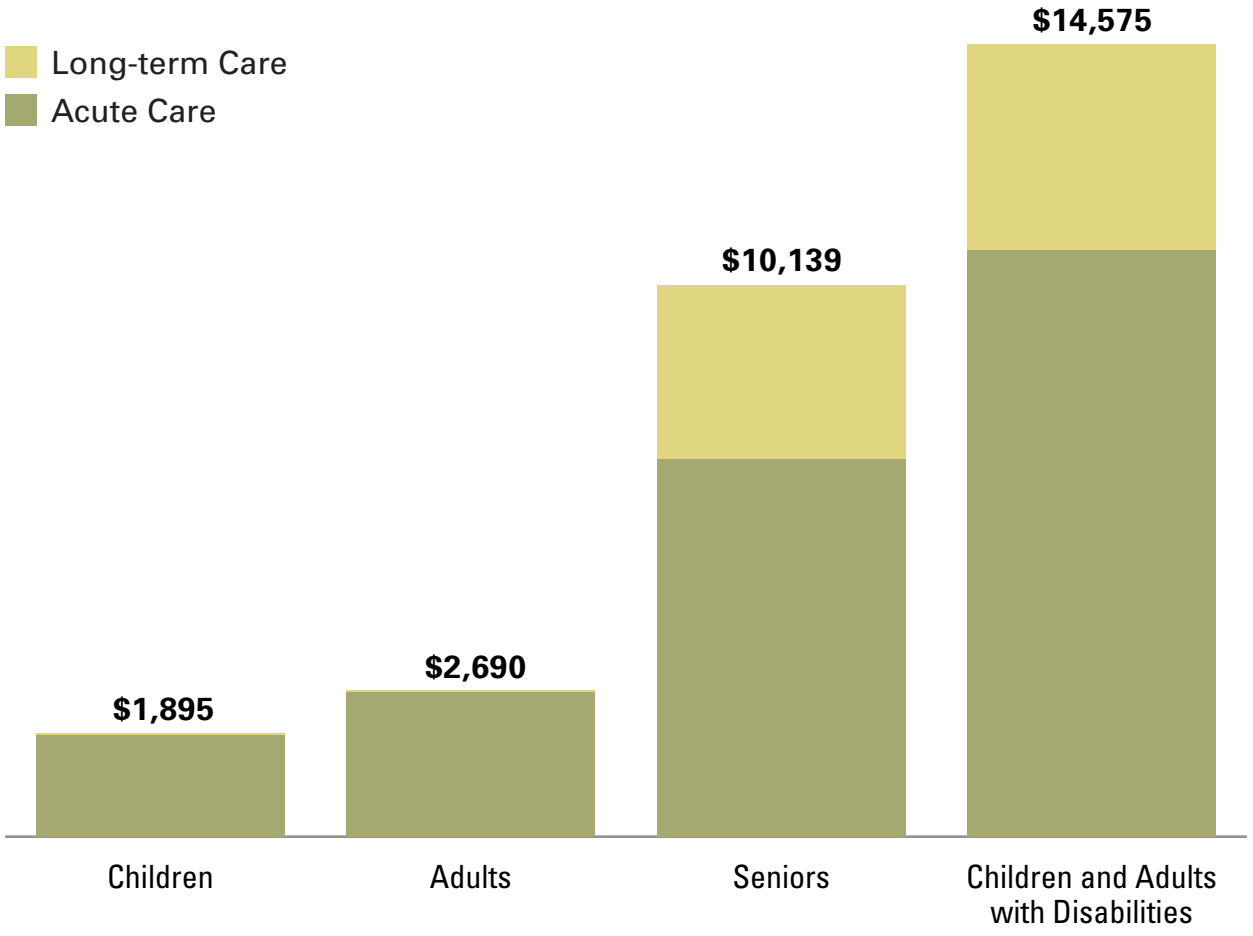
Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (May 2005 data).

Medi-Cal
Expenditures

<< PREVIOUS NEXT >>

Seniors and people with disabilities account for only 23 percent of beneficiaries, but 63 percent of expenditures.

Annual Cost Per Beneficiary

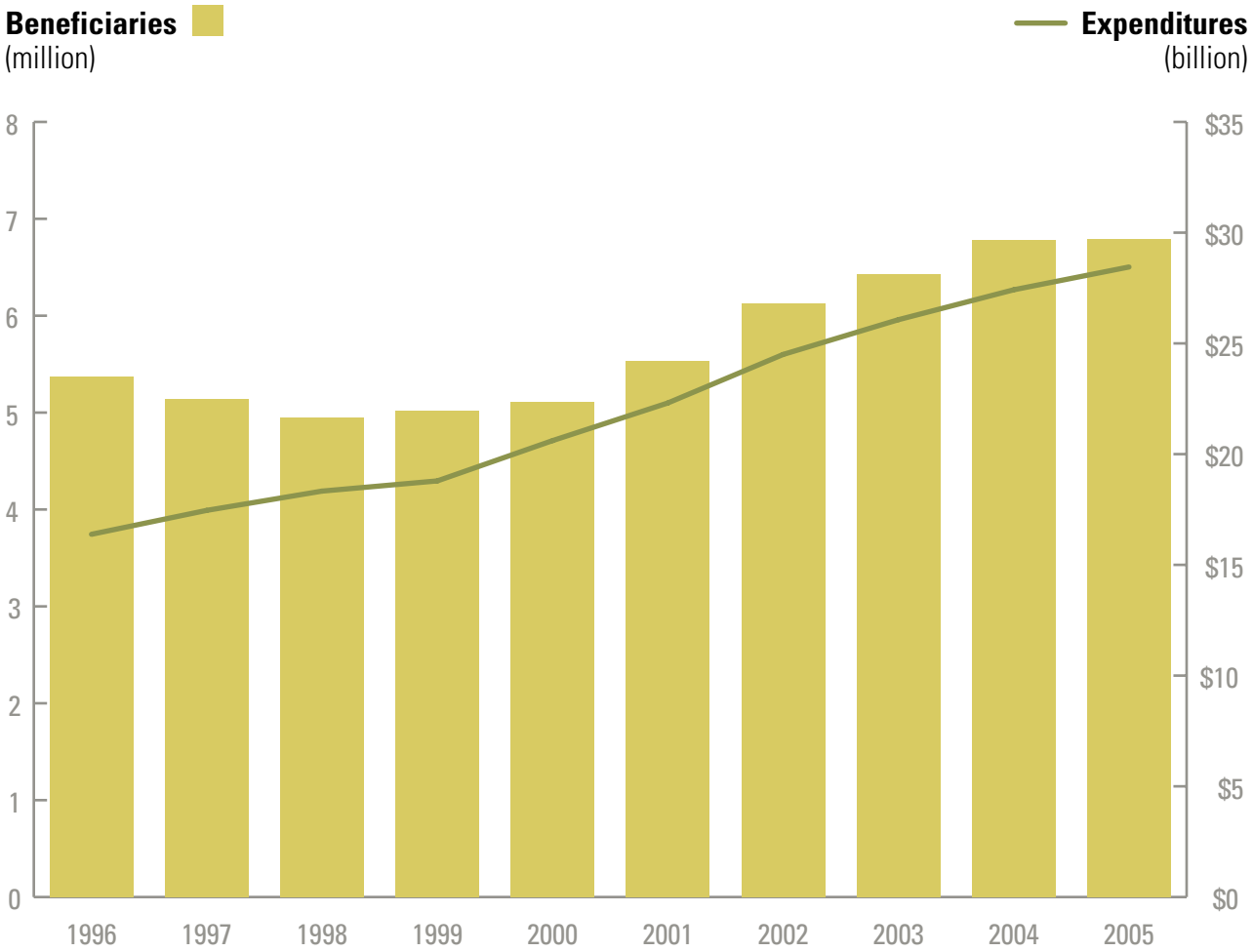


Note: Fee-for-service population only. Long-term care includes nursing facilities, intermediate care facilities, and home and community based services.

Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (August 2005 data).

Due to intensive use of both acute and long-term care services, Medi-Cal expenditures are substantially greater for seniors and people with disabilities than for other beneficiaries.

Enrollment and Expenditure Trends



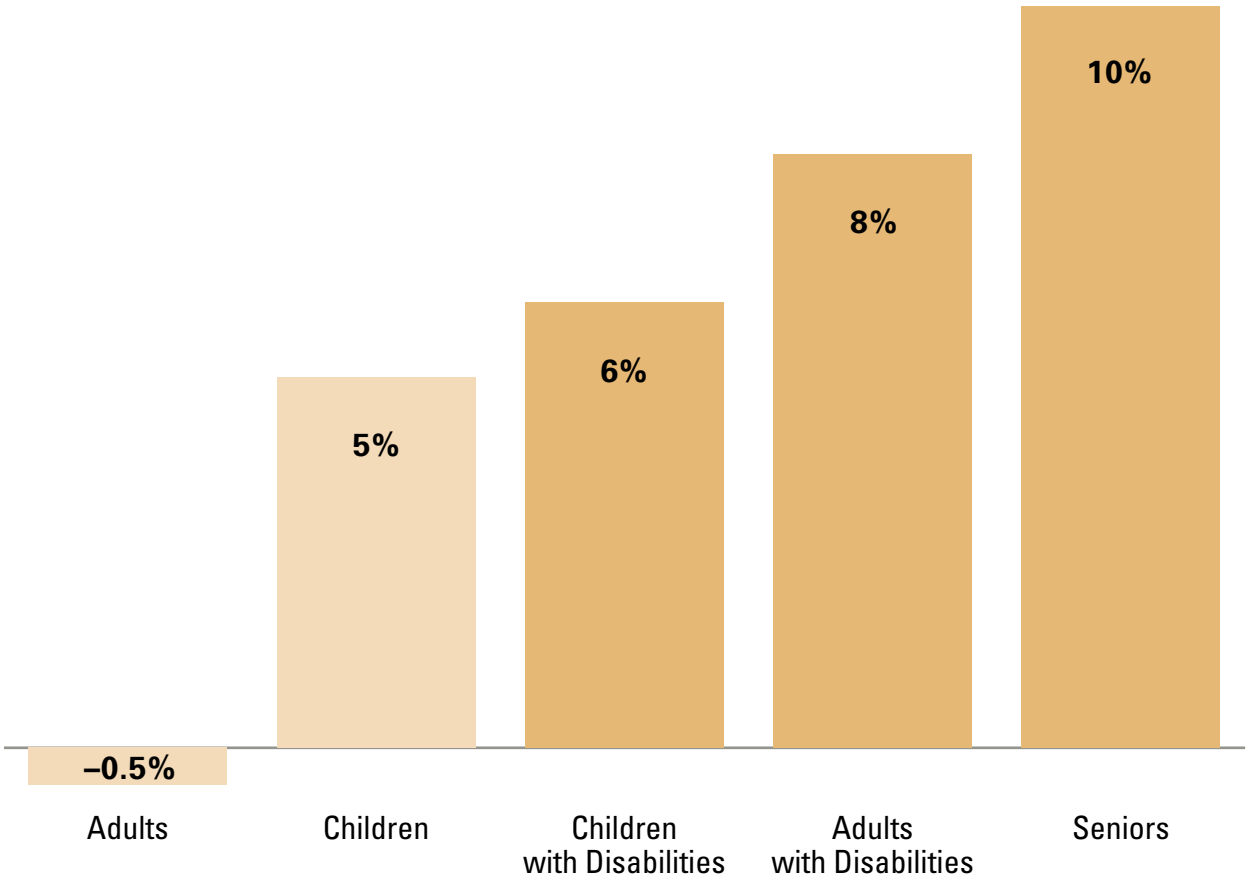
Notes: Includes claim expenditures only; administrative expenditures and DSH payments are excluded. Enrollment figures are based on the calendar year while the expenditure figures are based on the fiscal year.

Source: DHS Medical Care Statistics Section (1996 to 2003) and Medstat analysis of Medi-Cal MIS/DSS data (2004 and 2005).

Over the past decade, Medi-Cal expenditures increased by nearly 75 percent due to enrollment growth and rising costs per beneficiary.

Spending Trends

Average Annual Growth, 2000–2005

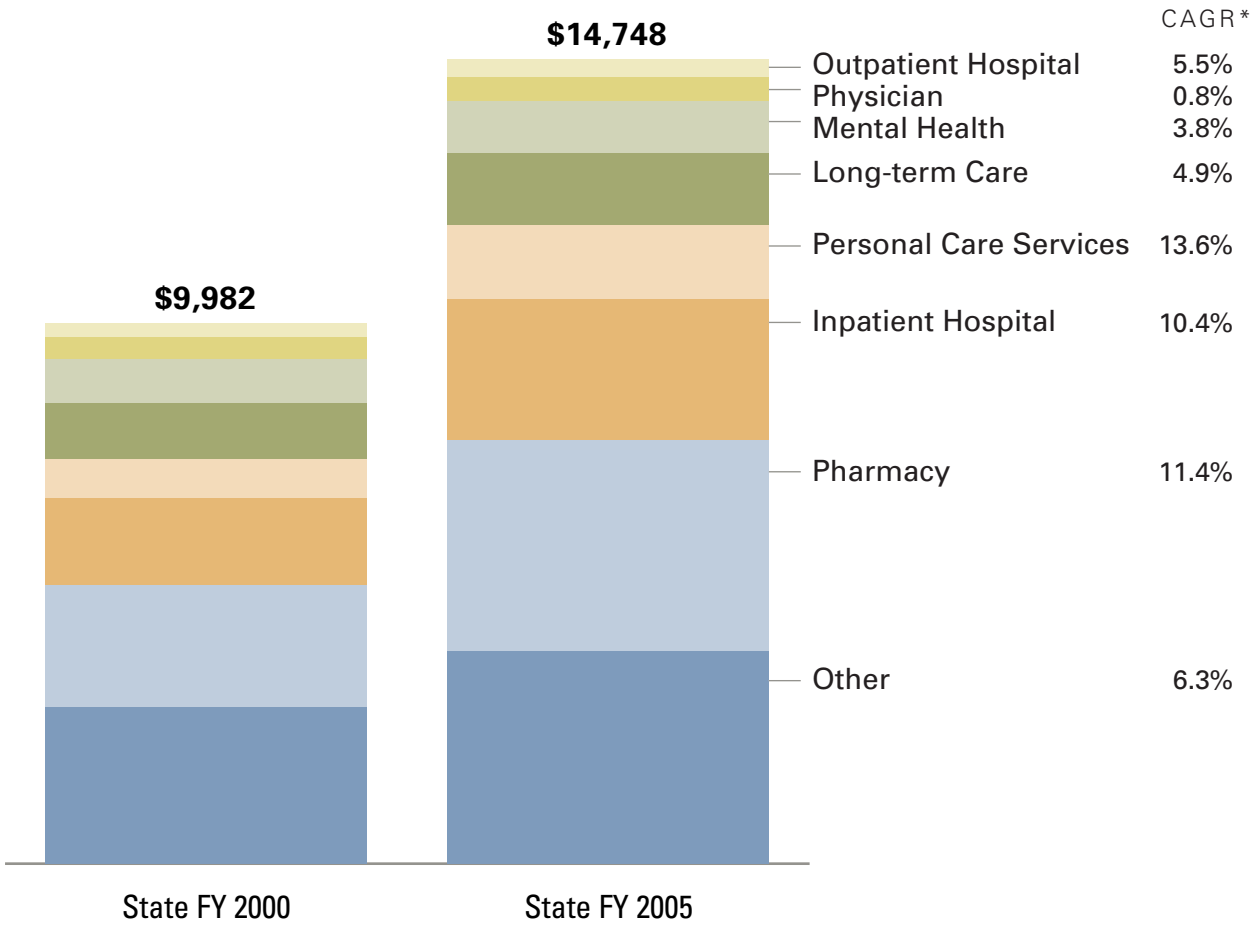


The cost per person for seniors and persons with disabilities has increased the most rapidly since 2000.

Source: Medstat analysis of Medi-Cal MIS/DSS data, update through August, 2005. Based on analysis of fee-for-service population and payments in state fiscal years 1999–2000 and 2004–2005.

Spending Trends by Service

Adults with Disabilities



*Compound annual growth rate.

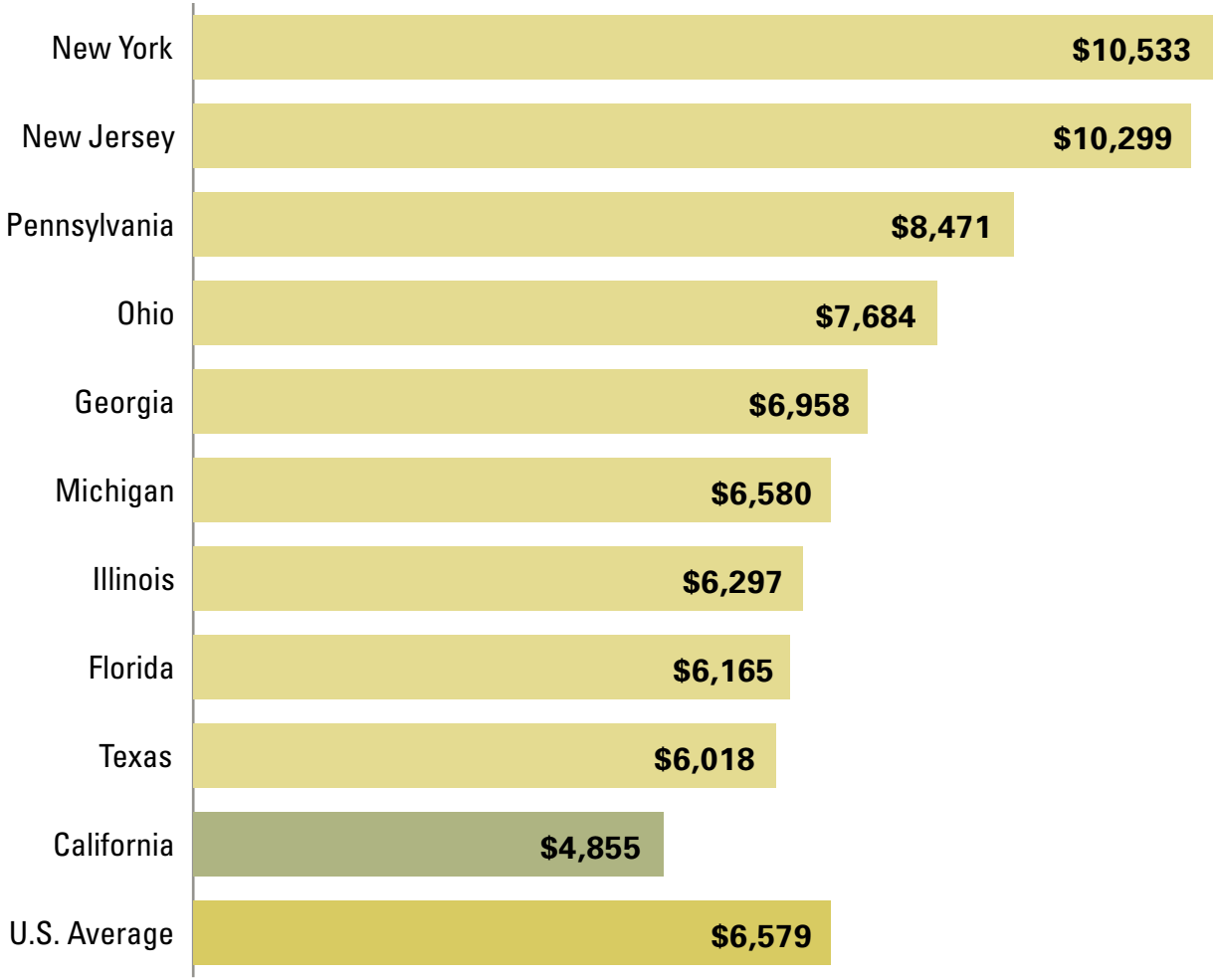
Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (August 2005 data). Fee-for-service only.

Medi-Cal
Expenditures

<< PREVIOUS NEXT >>

Spending for personal care, drugs, and inpatient hospital services have each grown more than 10 percent annually.

State Spending
Average Per Beneficiary

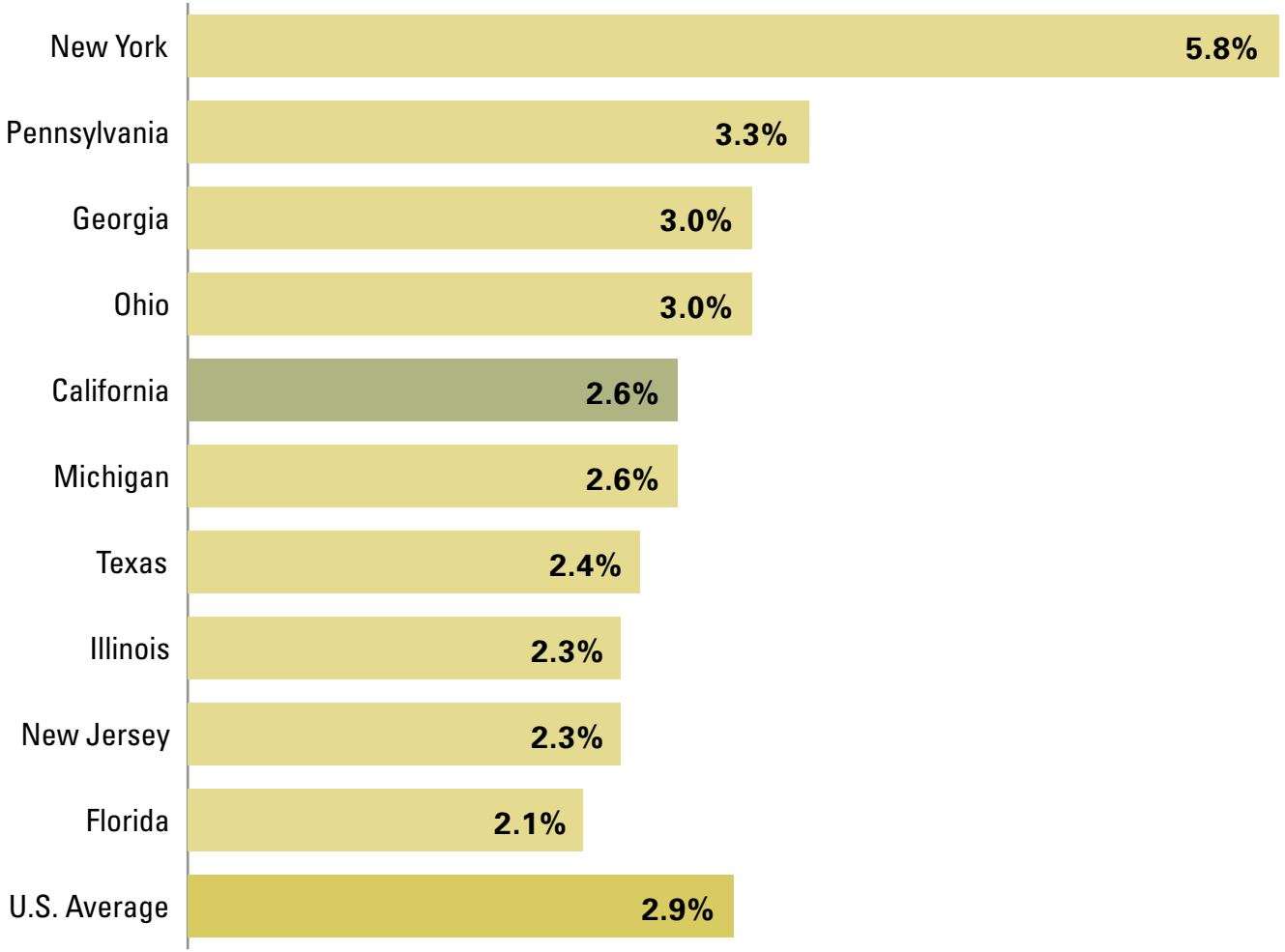


Source: Kaiser State Health Facts. (Federal FY 2004 expenditures; June 2004 enrollment).

California spends less per beneficiary than every other state due to a variety of factors, including low provider payment levels and its lower percentage of elderly and disabled beneficiaries.

State Spending

Share of Personal Income



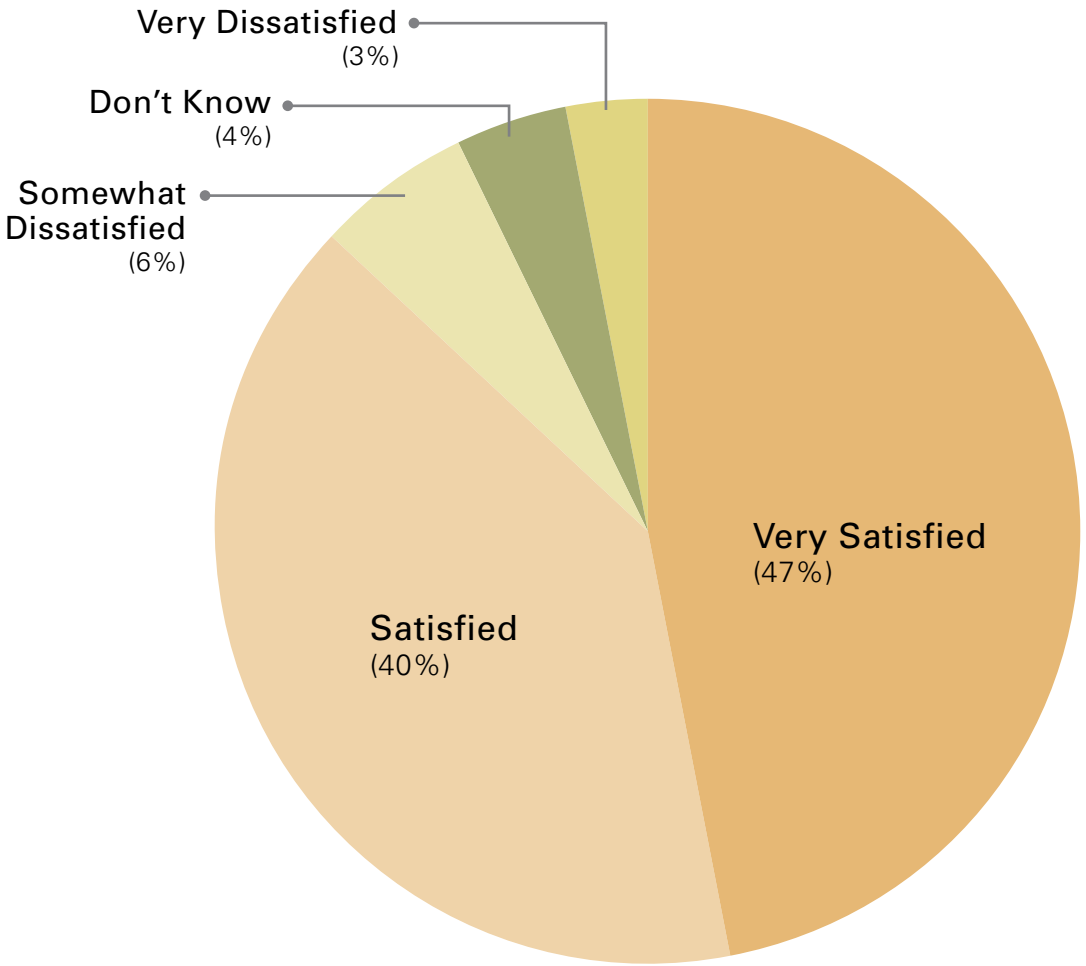
Note: Includes federal and state funds.

Source: Medstat analysis of Medi-Cal MIS/DSS data through October 2005. Expenditures reflect fee-for-service payments only for state fiscal year 2004–05.

California spends 2.6 percent of total personal income on Medi-Cal, comparable to many large states and slightly less than the national average.

Overall Program Experience

"Overall, how satisfied are you with Medi-Cal?"

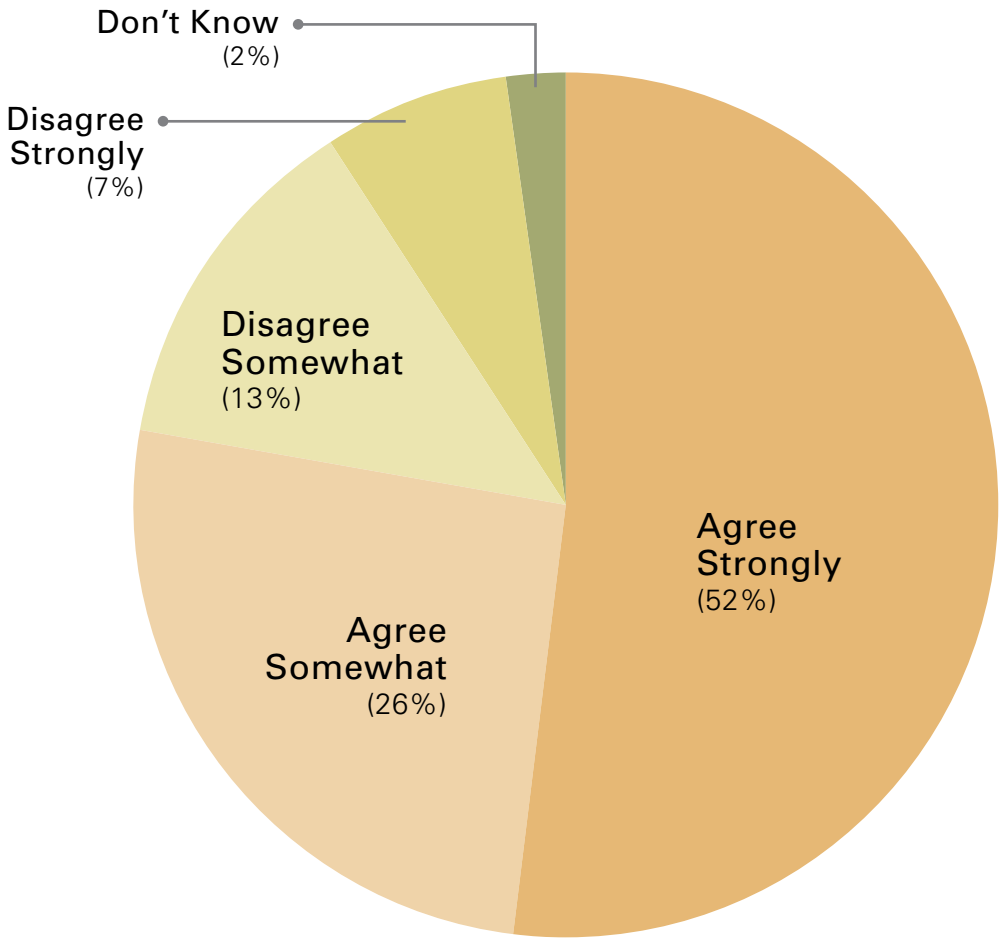


Source: Medi-Cal Policy Institute, *Medi-Cal Beneficiary Survey, 1999.*

- Eighty-seven percent of Medi-Cal beneficiaries report that they are satisfied with the program.
- Satisfaction levels are comparable to employer-sponsored coverage.
- "Medi-Cal is worth the hassle because of what you get in return."

Enrollment Process Experience

"Signing up for Medi-Cal requires too much paperwork."



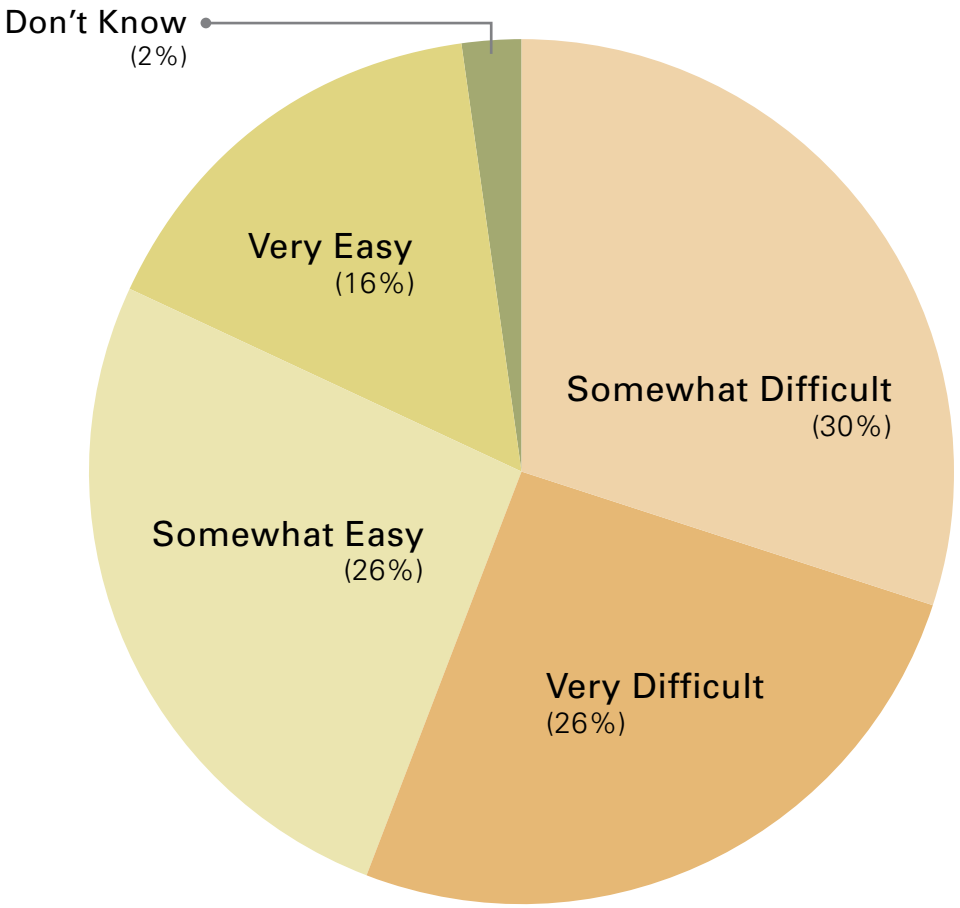
Source: Medi-Cal Policy Institute, *Medi-Cal Beneficiary Survey, 1999.*

There are barriers to enrollment, including:

- Complexity of application process
- Difficulty obtaining required documentation such as income verification
- Lack of knowledge about the program
- Stigma associated with Medi-Cal because of its historic links to welfare
- Fear that enrollment in Medi-Cal will adversely effect future opportunities for citizenship for immigrant families

Experience Locating a Doctor

"Finding a doctor nearby is…"

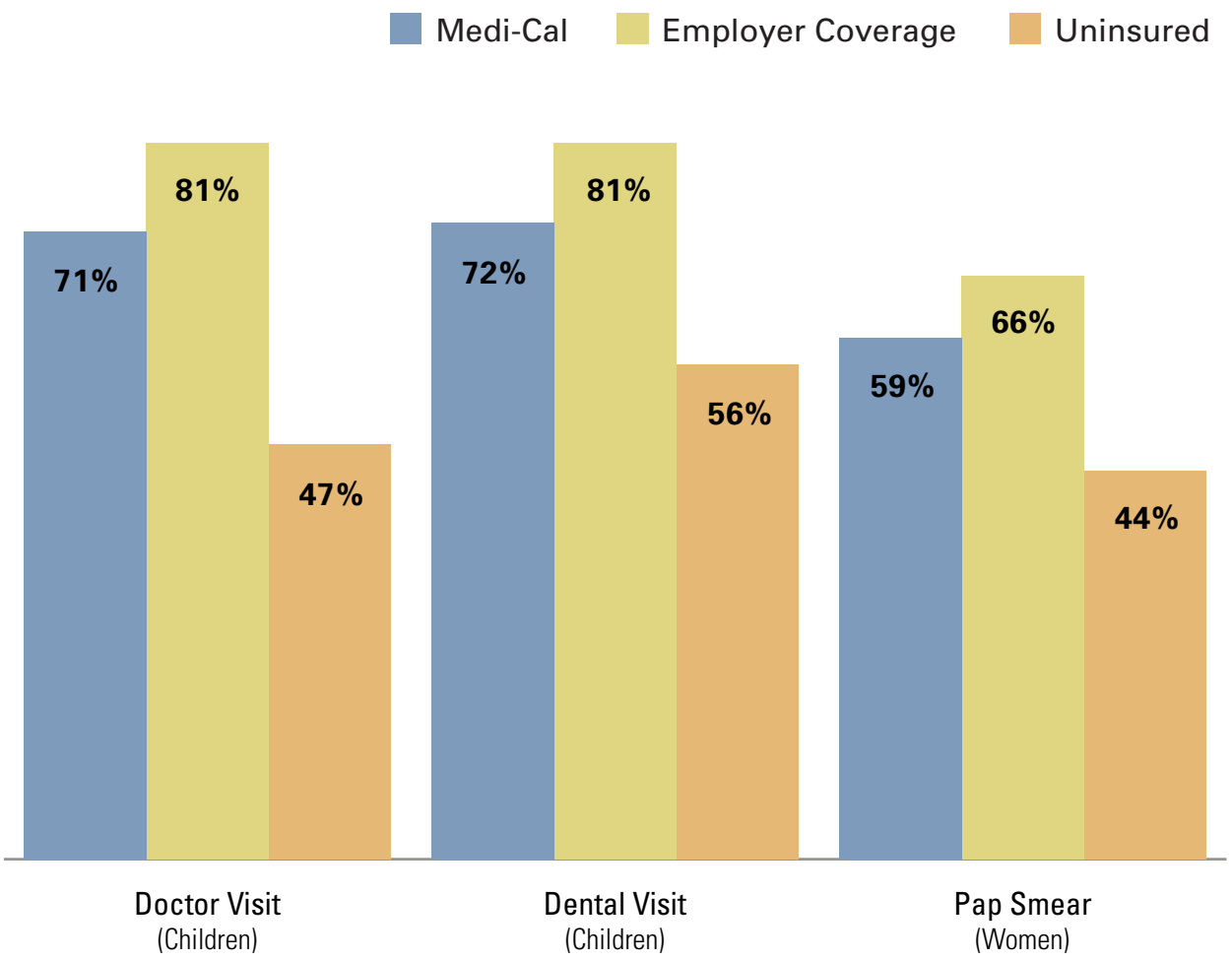


Source: Medi-Cal Policy Institute, *Medi-Cal Beneficiary Survey, 1999.*

- More than half of beneficiaries reported some difficulty in finding a doctor.
- "Medi-Cal is good until you actually go and try to find a doctor. That's the hardest part."
- State and counties provide limited help in this area.

Access to Care Experience

Rates of Use for Primary Care Services

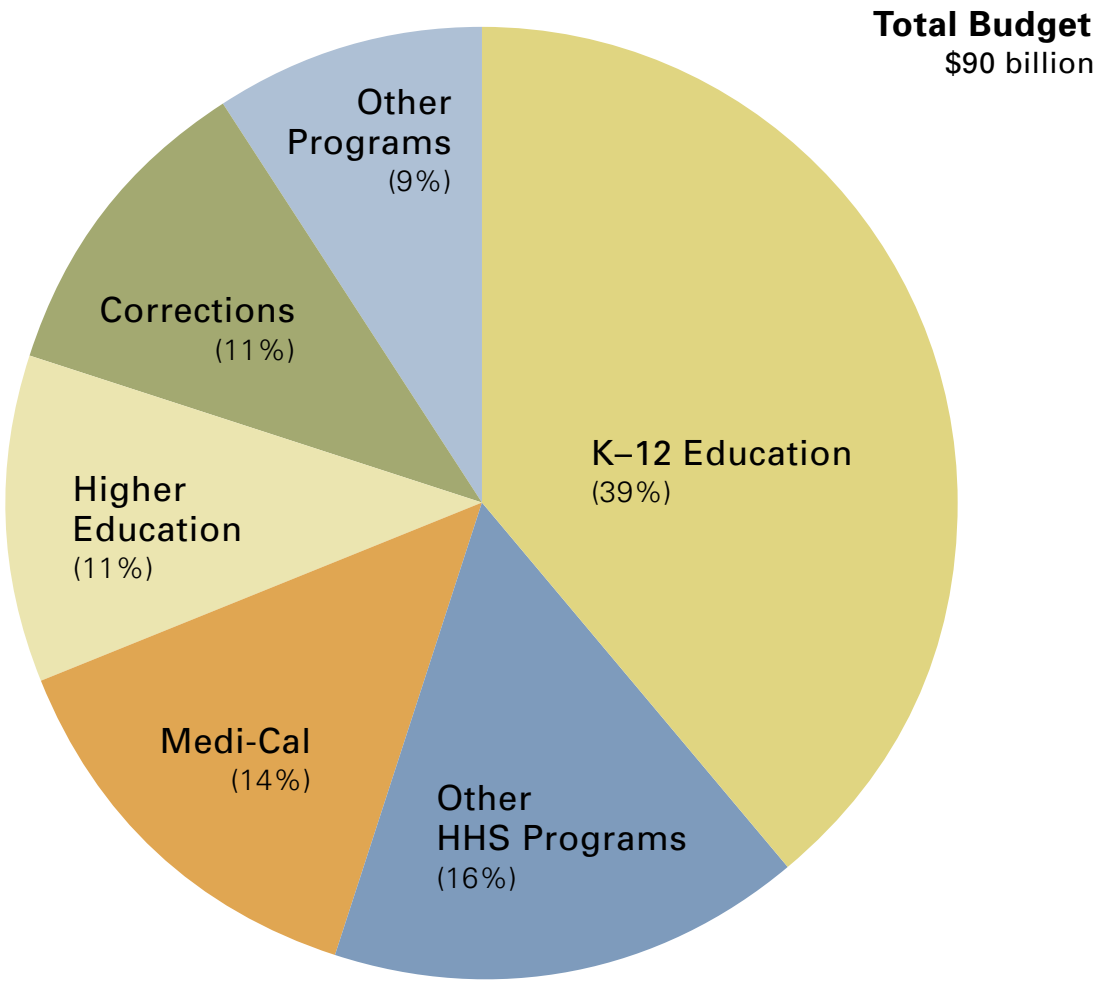


Source: Urban Institute, *National Survey of America's Families 2002.*

Children and women enrolled in Medi-Cal report use rates for primary care services that are comparable to those for people enrolled in employer coverage and much greater than for those who are uninsured.

State Budget Distribution

State FY 2005–2006



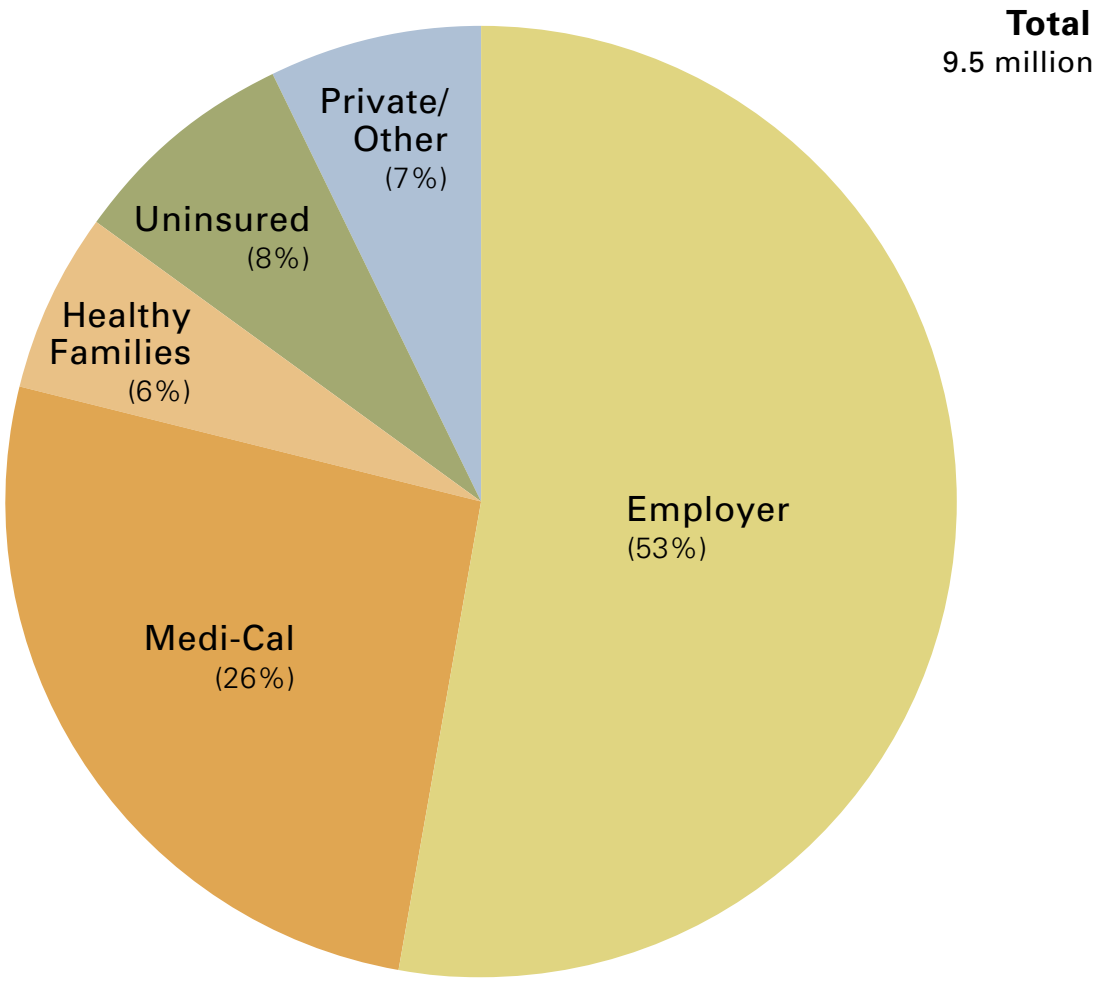
Source: Legislative Analyst's Office 2005–2006 Budget Analysis (February 2005) www.lao.ca.gov/analysis_2005/Health_ss/hss_05_4260_anl05.htm.

Medi-Cal
Importance

<< PREVIOUS NEXT >>

- Medi-Cal accounts for the third largest share of the state's General Fund behind primary education and all other health and human service programs combined.
- California generally receives one dollar from the federal government for every dollar that it spends on Medi-Cal.
- Medi-Cal expenditures are growing faster than other programs.

Child Coverage



Note: Insurance status at time of survey. Includes children under age 18.

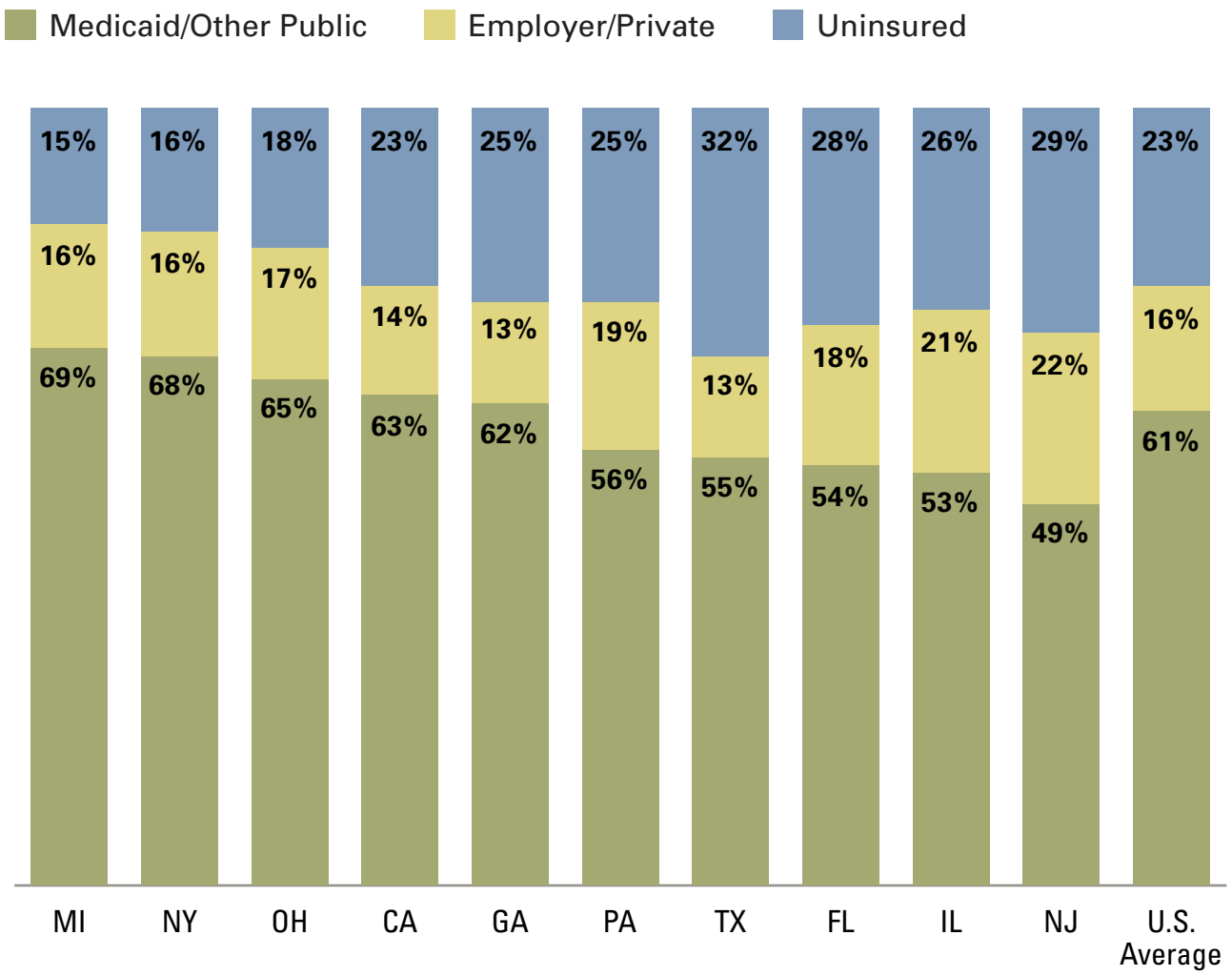
Source: *California Health Interview Survey* (2003 data).

Medi-Cal
Importance

<< PREVIOUS NEXT >>

- Nearly one third of California's children are insured by Medi-Cal and Healthy Families.
- Among uninsured children, about one-half may be eligible for Medi-Cal or Healthy Families.

Low-Income Child Coverage



Note: Children ages 0–18 living in poverty (incomes below 100 percent FPL).

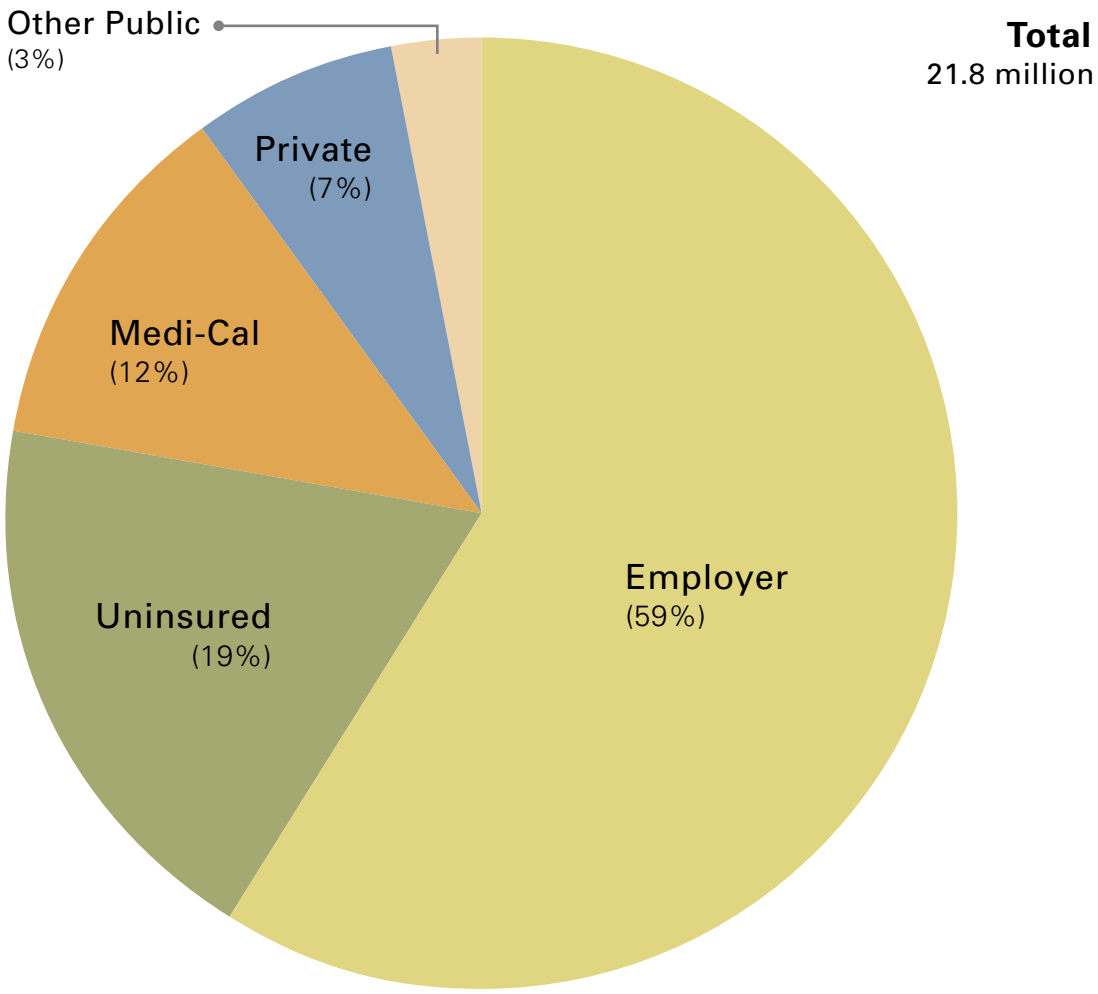
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates based on the U.S. Census Bureau and Current Population Surveys (March 2004 and 2005).

Medi-Cal
Importance

<< PREVIOUS NEXT >>

Compared to the national average, California has a lower rate of employer/private coverage for children, which is offset by a higher rate of coverage through Medi-Cal and other public sources.

Non-Elderly Adult Coverage

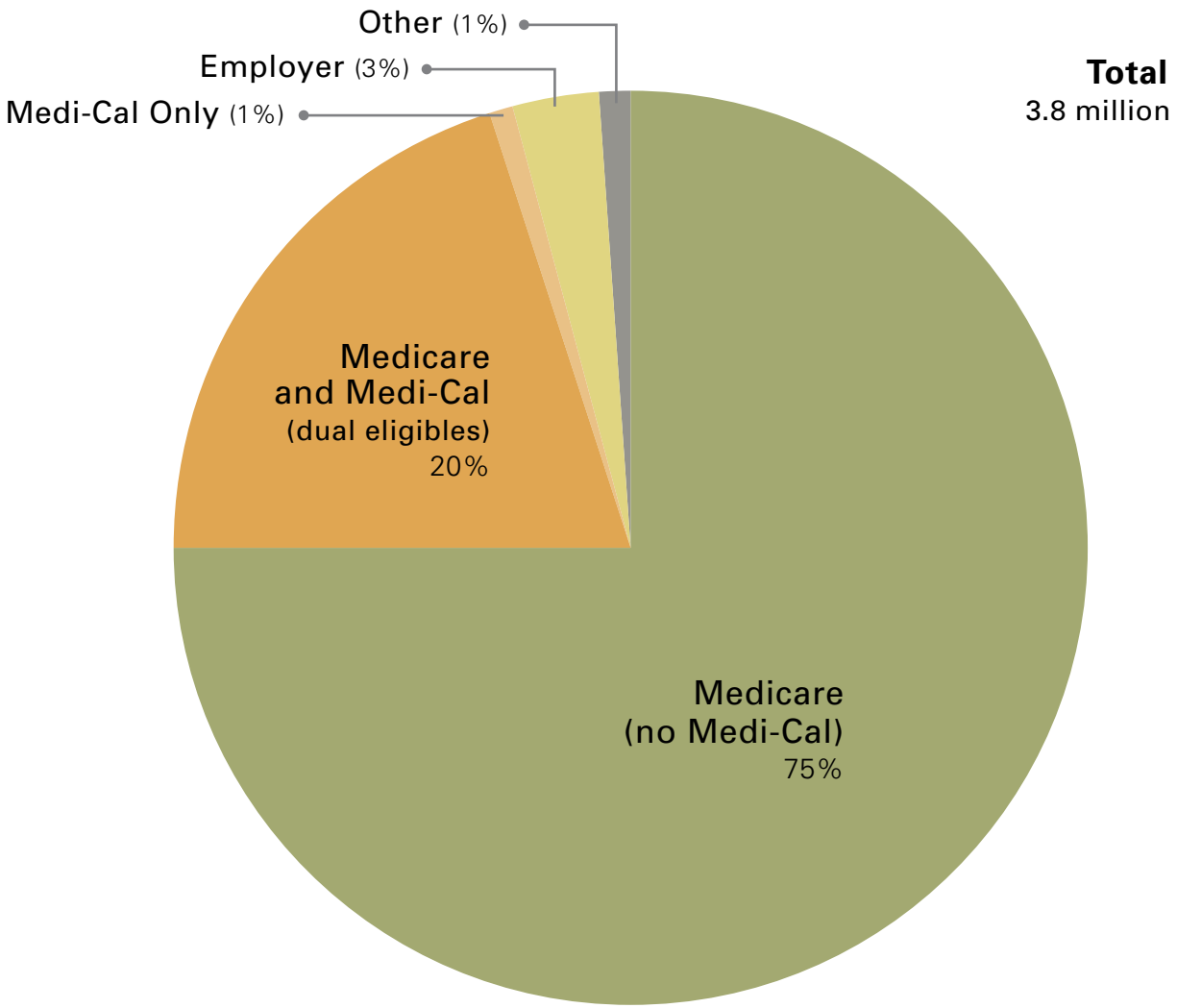


Note: Non-elderly includes ages 18 to 64. Insurance status at time of survey.

Source: *California Health Interview Survey* (2003 data).

About one in eight adults in California under age 65 is covered by Medi-Cal.

Elderly Coverage

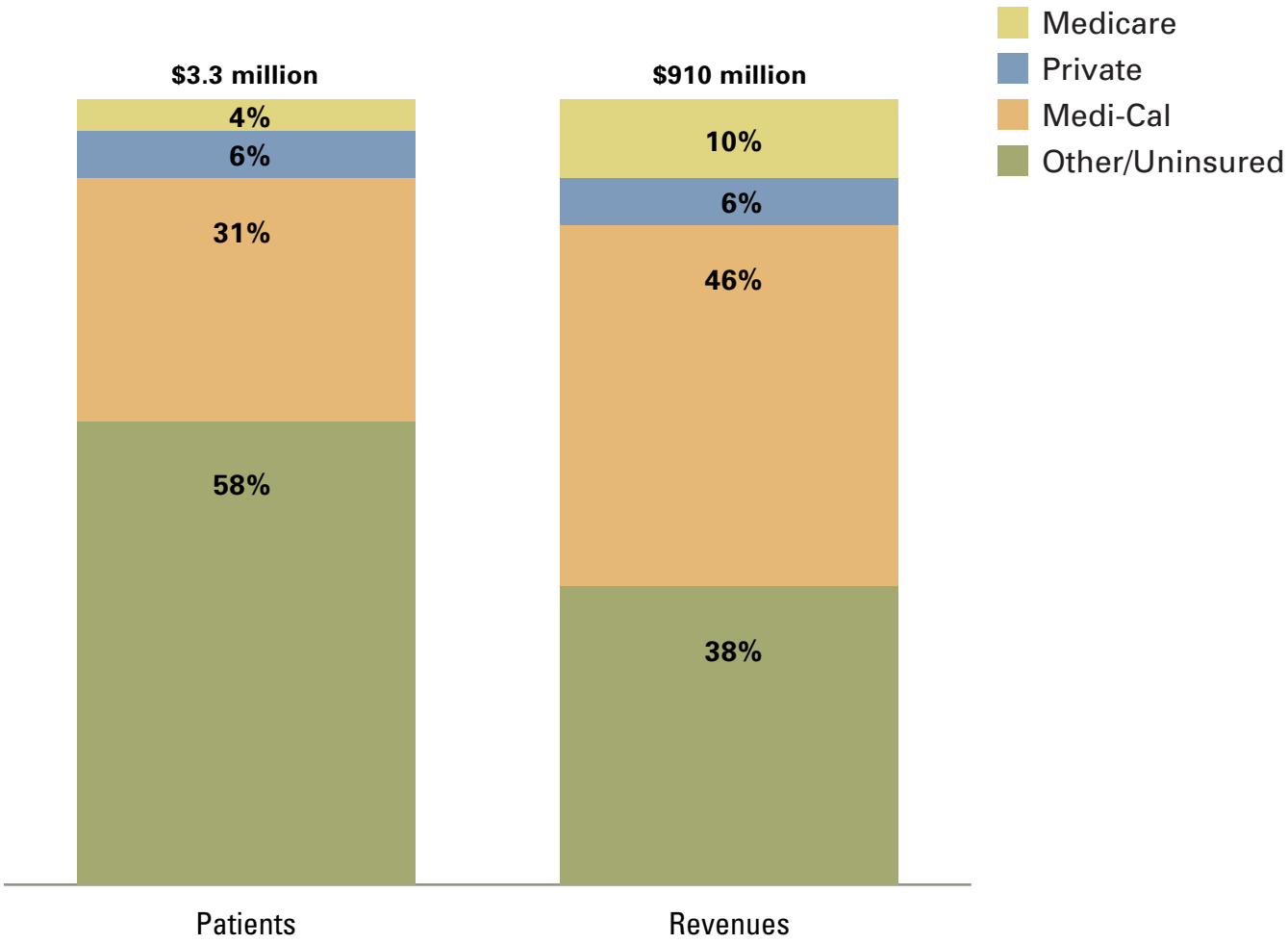


Notes: Elderly includes ages 65 and older. "Other" includes other public, private and uninsured. Insurance status at time of survey.

Source: *California Health Interview Survey* (2003 data).

Medi-Cal provides coverage to one in five seniors in California.

Community Health Centers

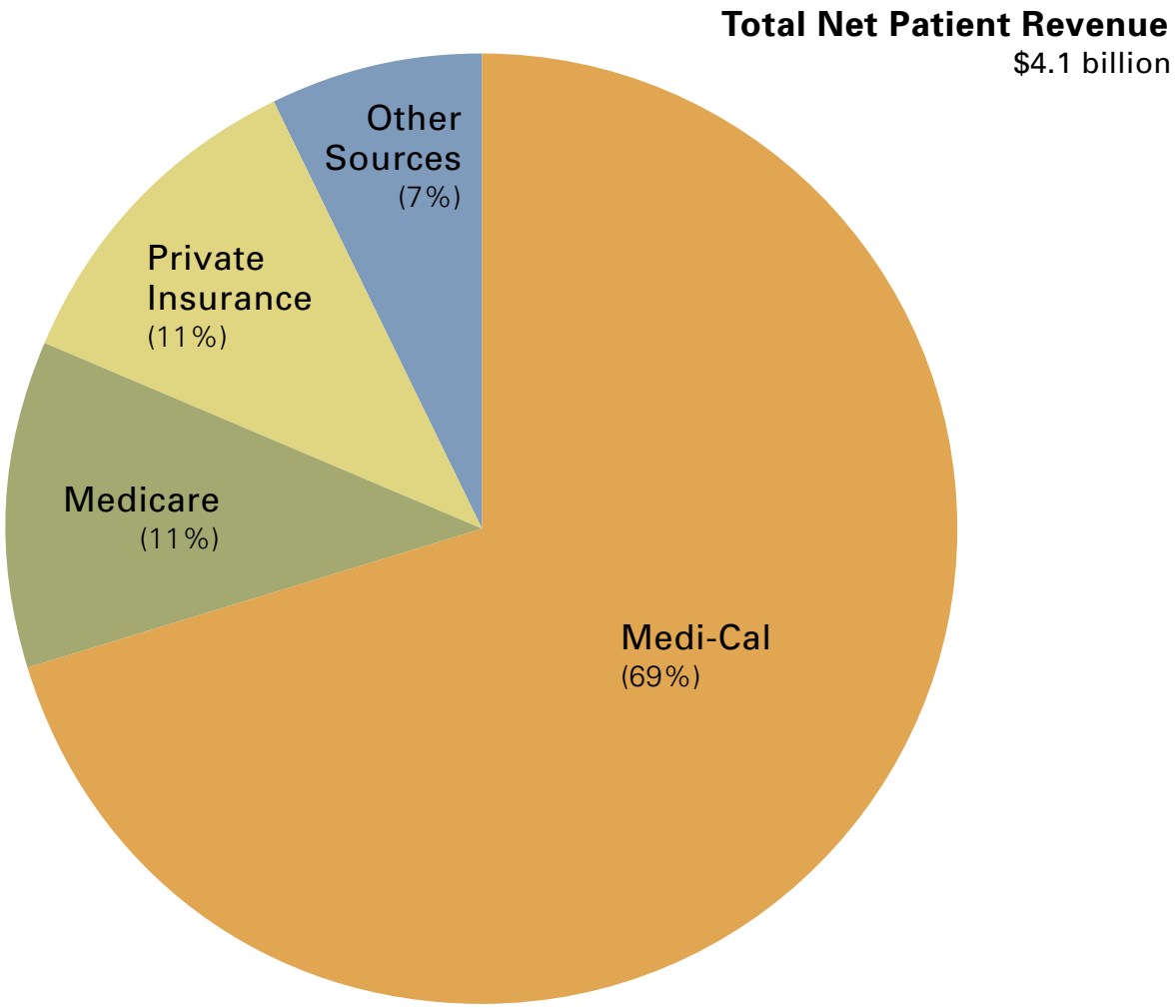


Percentages don't add up to 100 percent due to rounding.

Source: California Office of Statewide Health Planning and Development, Medstat analysis of 2003 Community and Free Clinic data. Revenues shown are net revenues from all sources. "Other/Uninsured" includes Healthy Families, CHDP, FPACT, county medically indigent programs, and all others.

Medi-Cal accounts for one-third of patients and nearly one-half of revenues at community health centers in California.

Public Hospitals



Note: Net patient revenue includes transfer of disproportionate share hospital (DSH) payments out of the hospitals (total net revenue is $5.4 billion excluding DSH transfers out of the hospital). Percentages don't add up to 100 percent due to rounding.

Source: California Office of Statewide Health Planning and Development; Legislative Analyst Office, Analysis of the 2005-2006 Budget Bill.

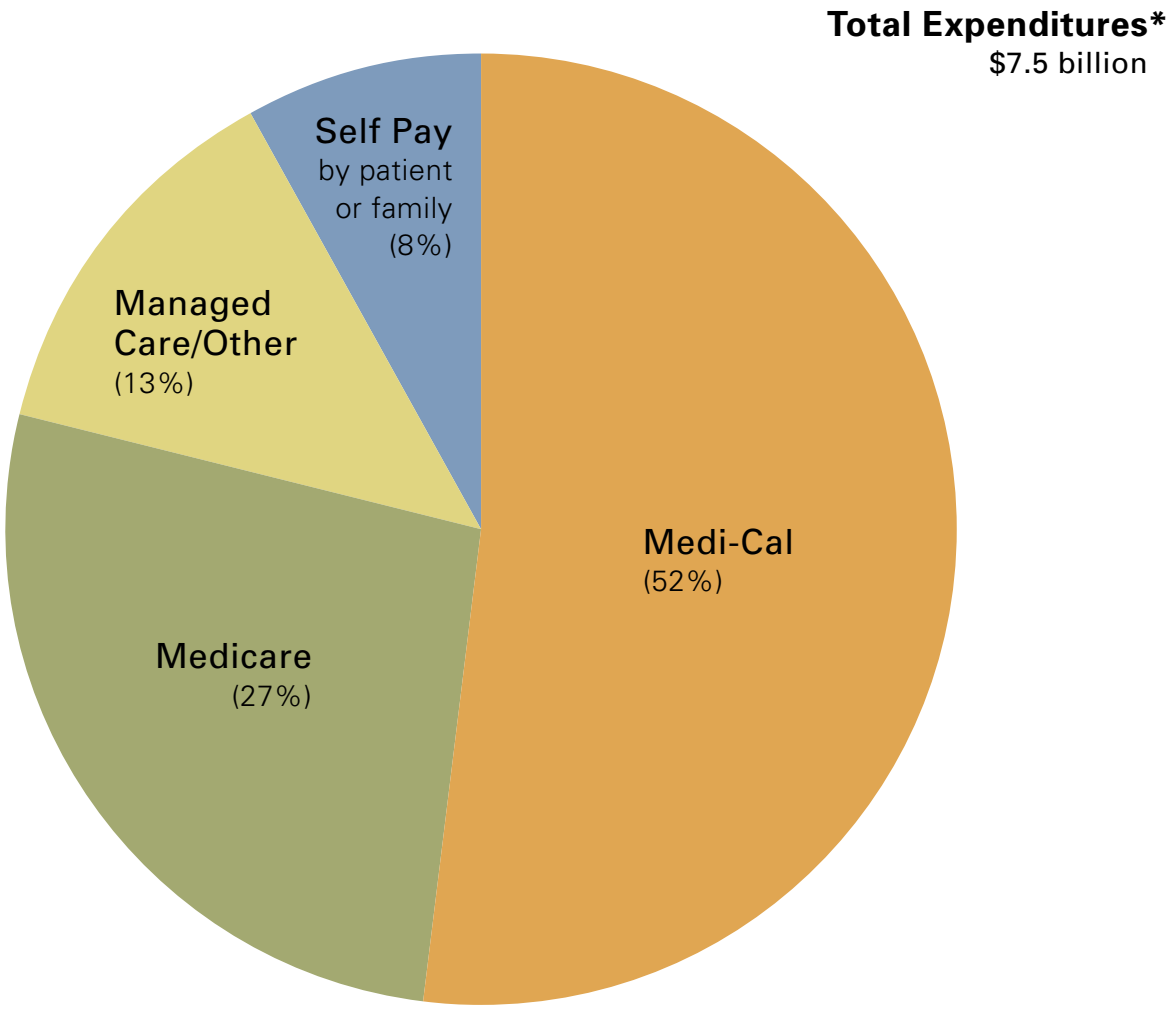
- Medi-Cal accounts for 69 percent of net revenue at California's public hospitals.
- Public and some non-profit hospitals receive supplemental payments to reimburse them for treating Medi-Cal patients and the uninsured.

Supplemental Hospital Payments

- Medi-Cal pays additional (or supplemental) reimbursement to safety-net hospitals that care for a disproportionate share of Medi-Cal and uninsured patients.
- In September 2005, California negotiated a new 5-year waiver agreement with the federal government on financing safety-net hospitals, which affects both the total amount and distribution of supplemental funding across public and private hospitals.
- The sources of supplemental funds include:
  - For public hospitals, from the state's fixed allotment of federal DSH funding, as well as a fixed amount of federal funds through a new Safety Net Care Pool. Counties and public hospitals provide the state's share of funding for these supplemental payments through a combination of Certified Public Expenditures (CPE) and limited Intergovernmental Transfers (IGT).
  - For private hospitals, from DSH-replacement dollars and other supplemental payments. The non-federal match will likely come from the state General Fund.

Major changes were made to hospital financing for the uninsured in 2005.

Nursing Facilities



*In 2003, the California nursing home population was comprised of 205 hospital-based and 1,202 freestanding (non-hospital-based) homes.

Source: Janis O'Meara and Charlene Harrington, University of California, San Francisco. Calculations provided using Office of Statewide Planning and Development, 2004; long-term care annual financial data, January 1, 2002 to December 31, 2002 and hospital financial data, June 30, 2002 to June 29, 2004.

Medi-Cal paid more than half of the cost of care in California's freestanding nursing facilities in 2003. Medicare will only pay for approved short-term care up to 100 days. After Medicare and private insurance benefits are used, individuals and their families must pay for nursing home care out of pocket. Once individuals spend their income and assets, they may become eligible for Medi-Cal.

State Policy Options to Limit Medicaid Expenditures

- Improve efficiency
- Reduce provider fraud and abuse
- Reduce enrollment in the program
- Reduce spending on benefits and services
- Reduce payments to providers and suppliers

Important Challenges in Medi-Cal's Future

- Make better use of technology to simplify the enrollment process
- Sustain enrollment gains of the past decade while also controlling Medi-Cal spending
- Monitor the impact of the Hospital Financing Waiver and the Medicare Drug Benefit
- Maintain adequate provider participation to ensure access to care
- Provide appropriate community-based long-term care per the *Olmstead* decision.
- Measure and monitor the effectiveness of the fee-for-service and managed-care delivery systems
- Respond to policy changes at federal level

Acknowledgment

Much of the information and data for this presentation was provided by Robert Joy and Lisa Maiuro of Medstat/Thomson, and their colleagues Asha Gilson, Dean Scourtes, Paul Schneider, and Suzanne Snyder, and by Peter Harbage. Medstat provides market intelligence, decision support solutions, and research services for managing healthcare costs and quality, and currently provides the Management Information System and Decision Support System (MIS/DSS) for the Department of Health Services. Harbage, a former assistant secretary with the California Health and Human Services Agency, is an independent consultant based in Sacramento, California.

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California HealthCare Foundation
476 9th Street
Oakland, CA 94607
510.238.1040
www.chcf.org

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 she gets out of bed only to go to the bathroom which is adjacent to the bedroom. She 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

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.

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.

Group Tasks:

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.

Group Tasks:

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. How much time would you assess for Housework, Laundry, and Food Shopping?
2. Please indicate your reasons for authorization of hours 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.

Group Tasks:

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 renal failure and hypertension. He was also recently diagnosed with emphysema. George goes to dialysis three times per week. He moved in with his daughter, Marie, two months prior to the home visit. His daughter applied for IHSS on his behalf. Prior to moving in with his daughter, he lived in an upstairs apartment. His daughter states during the home visit that she insisted that he move in with her because she is concerned about his increasing SOB and felt that in the near future he would not be able to negotiate the stairs. The current residence is a small three-bedroom, one-bathroom ranch-style house. The residents are George, Marie, 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 he returned from dialysis shortly before you arrived. 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 he feels that 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 the days that he goes to dialysis he does require some assistance from Marie. Upon further questioning, he states that the type of assistance he requires on dialysis days include assistance off of the couch, ambulation into the bathroom, and assistance to the kitchen to eat.

During the interview, Marie frequently interrupts and contradicts what her father is saying. 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 assist him putting on his pajamas and help 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 as he is unsteady when ambulating outside of the house.

She states that she must constantly remind him to eat because he does not have any appetite. She states that on a couple of occasions she has left him alone on non-dialysis days and that he did not eat dinner on those days. She said she prepares George's meals separately because he is on a high-protein, restricted salt, phosphorous and potassium diet. She states that for breakfast, he usually eats a poached egg and a piece of toast. 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. She fixes his lunch because that's what daughters do for their dads. He usually has cottage cheese and canned fruit or yogurt. That doesn't take much time, she says…maybe 10 minutes. She said typically he eats meat, a small amount of starch and vegetables for dinner and that it takes her about a half hour to prepare his dinner.

You ask Marie if you can speak to her father without her present as you have some personal questions that you need to ask and you believe that he will be more comfortable if she is not present. Marie reluctantly agrees.

After Marie leaves, George states that he is unhappy with his current living arrangement and misses the friends that he had in his 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 asked 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 sofa, 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 does state that he requires assistance off of the couch on dialysis days and that his daughter helps him walk to the bathroom and to the kitchen for meals because he is unsteady on his feet. He also states that she helps him put on his pajamas when he gets home on dialysis days and manage his clothes after using the bathroom. When asked about the time Marie spends helping him with these activities, he replies that you will have to ask Marie because he doesn't have any idea. He states that Marie drives him to and from dialysis. At his apartment a van used to pick him up and bring him home. The van personnel would assist him to and from his apartment and clinic and into and out of the van. George states that he would still be able to use the van, but Marie prefers to drive him.

When Marie returns 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 a 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 to return to a seated position. You note that Marie provides him elbow support when he walks and that it takes approximately five minutes from the time that he gets up from the couch until he returns. Marie states that on non-dialysis days she assists 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's hard because she's worried about how frail he's gotten and she also has her own kids and husband to take care of. Luckily, her youngest is in preschool, so she says it's not so bad, and she's glad to be able to help her dad. When he was living alone, she was so worried about him.

You ask her to be specific about the help she provides him. She stated that on a dialysis day she helps him up 3 times a day to go to the kitchen table for meals and back to the living room sofa, once a day to go to the bathroom and back to the couch, and then to get up to go to the car to go to dialysis and again into the car and then out of the car at the dialysis center and to sit in the waiting room there and then up to go for treatment and then into the car, out of the car, and back onto the sofa at home. Marie states that George has two different doctors that he sees which are his primary physician and his nephrologist. He sees them every other month, alternating between the two, for an average of one time 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 to the car and about 12 minutes to help him from the car to the clinic.

One or two times a week on non-dialysis days, she states she sets up the shower bench, helps him into the shower, and hands him the hand-held shower head. She says that, once seated, he can manage his own shower, but she has to be within earshot to hear him in case he needs her while he showers and helps him get out of the shower and towel dry when he's done with his shower. If he bends over to dry his legs and feet, he gets dizzy when he sits up again, so she does that for him. 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

Needs help with ☐ Breakfast ☐ Lunch ☐ Dinner

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.

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:

HTG DOCUMENTATION WORKSHEET

Category	Documentation of Hours **Important: This Worksheet Should Be Used in Conjunction with Time Per Task Tools** **For All Tasks Include Time for Clean Techniques/Universal Precautions When Required**
Domestic (Housework) **FI Rank (Enter)** ____ **Guideline** **6.00 hours per month per household**	**Task** / **Total Need** / **Adjustments** / **Authorized** Routine housework Additional time Reason for assistance: Additional information to document Need and Adjustments (include shared living factors and other factors such as size of dwelling, Alt. Resources, etc.): Reason for more or less time than guideline (extra bedding changes, etc.):
Laundry **In-home** ☐ **Out-of-home** ☐ **FI Rank (Enter)** ____ **Guideline In-Home** **1.00 hour per week** **Guideline Out-of-Home** **1.50 hours per week** ***Note: Laundry facilities on premises of apartment complex, mobile home park, etc. are considered in-home (DSS Policy).***	**Task** / **Total Need** / **Adjustments** / **Authorized** Routine laundry Additional time Reason for assistance: Additional information to document Need and Adjustments (include laundry done separately, etc.): Reason for more or less time than guideline (extra laundry due to incontinence, etc.):
Shopping and Errands **FI Rank (Enter)** ____ **Guideline Food Shopping** **1.00 hour per week** **Guideline Other Shopping/ Errands** **0.50 hours per week**	**Task** / **Total Need** / **Adjustments** / **Authorized** Food shopping Other shopping/errands Reason for assistance: Additional information to document Need and Adjustments (include distance to nearest store consistent with needs and economy, need for shopping to be done separately, etc.): Reason for more or less time than guideline:

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:

Meal Cleanup

FI Rank (Enter)		
	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**

Note: Compare Total Need with above range.

Note: Assessed time should reflect actual schedule/frequency with which provider performs meal cleanup. Example: Consumer rinses all dishes and provider washes three times per week.

Meal	Frequency (Daily, 3 times per week, etc.)	Assessed Time Per Occurrence	Total Need
Breakfast			
Lunch			
Dinner			

Reason for assistance:

Shared living exceptions:

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

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.

Walking Inside Home				
From/To	**Time Assessed**	**# of Times Per Day**	**# of Days Per Week**	**Total Need Per Week**

Retrieving Assistive Device(s)				
Device	**Time Assessed**	**# of Times Per Day**	**# of Days Per Week**	**Total Need Per Week**

Assistance From House To Car And Car To House For Medical Appt. & Alt. Resource				
	Time Assessed	**# of Times Per Month**	**Total Need Per Month**	**Total Need Per Week (Monthly Need ÷ 4.33)**
From House to Car				
From Car to House				

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:

Routine Bed Baths

FI Rank (Enter)		
	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**

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Bed baths				

Reason for assistance:

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

Dressing

FI Rank (Enter)		
	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**

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with clothing, shoes, socks/stockings				
Assistance with putting on/taking off corsets, elastic stockings, braces, etc.				
Bringing tools to consumer				

Reason for assistance:

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

Bowel and Bladder Care

FI Rank (Enter)		
	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**

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting on/off toilet/commode				
Wiping/cleaning consumer				
Assist with using, emptying, cleaning bedpans/commodes, urinals, etc.				
Application of diapers				
Changing barrier pads				

Reason for assistance:

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

Menstrual Care

Functional Index Rank does not apply.

	Low	High
	0.28	0.80

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need*
External application of sanitary napkins				
Using/disposing barrier pads				

Reason for assistance:

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

****Remember that hours on SOC 293 are weekly. For menstrual care, in most cases, divide weekly need by 4.33 to authorize correct need.***

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.

Assistance From Standing, Sitting, Or Prone Position To Another

Task	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

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:

Feeding

FI Rank (Enter)	

	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

Note: Compare Total Need with above range.

Feeding Or Related Assistance With Consumption Of Food And Fluid Intake

Task	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				
Other Fluids				

Reason for assistance:

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

Repositioning / Rubbing Skin

Functional Index Rank does not apply.

	Low	High
	0.75	2.80

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Rubbing skin to promote circulation				
Turning in bed				
Repositioning				
Range of motion exercises				
Assistive walking				

Reason for assistance:

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

Care and Assistance with Prosthetic Devices and Assistance with Self-Administration of Medications

Functional Index Rank does not apply.

	Low	High
	0.47	1.12

Note: Compare Total Need with above range.

Assistance With Taking Off/Putting On Prosthetic Devices And Vision And Hearing Aids

Device	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Maintaining/Cleaning Prosthetic Devices And Vision And Hearing Aids

Device	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Setting Up Medications

	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Assistance With Self-Administration Of Medications

	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Reason for assistance:

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

Accompaniment to Medical Appts.

Appt. Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*

Reason for assistance:

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

Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)

Accompaniment to Alt. Resources

Note: Assessed only when transport is to/from site where Alt. Resources provide IHSS-type services in lieu of IHSS. Example: Transport to Senior Center where consumer receives meal.

Name of Alt. Resource	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*

Reason for assistance:

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

Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)

Heavy Cleaning

Task	Hours Assessed

Reason for assistance:

<table>
<tr>
<td>Remove Ice, Snow

Note: Limited to removal of snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.</td>
<td>
<table>
<tr><th>Task</th><th>Hours Assessed*</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>
Reason for assistance:

*Remember that this service is seasonal and should not be authorized on a yearly basis.
</td>
</tr>
<tr>
<td>Yard Hazard Abatement

Note: Limited to light work in the yard for removal of high grass or weeds and rubbish when constituting a fire hazard.</td>
<td>
<table>
<tr><th>Task</th><th>Hours Assessed*</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>
Reason for assistance:

*Remember that this service should not be routinely authorized on an ongoing basis.
</td>
</tr>
</table>

IHSS TRAINING ACADEMY
CORE: ASSESSMENT AND AUTHORIZATION

TIME CONVERSION

Minutes	Converted
1	0.02
2	0.03
3	0.05
4	0.07
5	0.08
6	0.10
7	0.12
8	0.13
9	0.15
10	0.17
11	0.18
12	0.20
13	0.22
14	0.23
15	0.25
16	0.27
17	0.28
18	0.30
19	0.32
20	0.33
21	0.35
22	0.37
23	0.38
24	0.40
25	0.42
26	0.43
27	0.45
28	0.47
29	0.48
30	0.50

Minutes	Converted
31	0.52
32	0.53
33	0.55
34	0.57
35	0.58
36	0.60
37	0.62
38	0.63
39	0.65
40	0.67
41	0.68
42	0.70
43	0.72
44	0.73
45	0.75
46	0.77
47	0.78
48	0.80
49	0.82
50	0.83
51	0.85
52	0.87
53	0.88
54	0.90
55	0.92
56	0.93
57	0.95
58	0.97
59	0.98
60	1.00

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

MPP 30-757.1(a):

- 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 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").
- In determining the amount of time per task, universal precautions should be considered. Universal precautions are protective practices necessary to ensure safety and prevent the spread of 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.

Task Definition	Grid	Factors/Exception Examples
Meal Preparation (MPP 30-757.131) Preparation of meals which includes planning menus; removing food from 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 stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.	<table><tr><th></th><th>Low</th><th>High</th></tr><tr><td>Rank 2</td><td>3.02</td><td>7.00</td></tr><tr><td>Rank 3</td><td>3.50</td><td>7.00</td></tr><tr><td>Rank 4</td><td>5.25</td><td>7.00</td></tr><tr><td>Rank 5</td><td>7.00</td><td>7.00</td></tr></table>	**Factors For Consideration Include, But Not Limited To:** ▪ The extent to which the recipient can assist or perform tasks safely. ▪ 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). ▪ 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. ▪ The frequency the recipient eats. ▪ Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** ▪ If the recipient must have meals pureed or cut into bite-sized pieces. ▪ If the recipient has special dietary requirements that require longer preparation times or preparation of more frequent meals. ▪ If the recipient eats meals that require less preparation time (e.g., toast and coffee for breakfast).
Meal Cleanup (MPP 30-757.132) 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. **Note:** This does <u>not</u> include **general** cleaning of the refrigerator, stove/oven, or counters and sinks, as these IHSS services are assessed as "domestic services" (MPP 30-757.11).	<table><tr><th></th><th>Low</th><th>High</th></tr><tr><td>Rank 2</td><td>1.17</td><td>3.50</td></tr><tr><td>Rank 3</td><td>1.75</td><td>3.50</td></tr><tr><td>Rank 4</td><td>1.75</td><td>3.50</td></tr><tr><td>Rank 5</td><td>2.33</td><td>3.50</td></tr></table>	**Factors for Consideration Include, But Not Limited To:** ▪ The extent to which the recipient can assist or perform tasks safely. ○ **EX:** 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 clean up after dinner would require time based on the provider performing cleanup for the dinner meal only. ○ **EX:** A recipient who has less control of utensils and/or spills food frequently may require more time for cleanup. ▪ The types of meals requiring the cleanup. ○ **EX:** 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. ▪ If the recipient can rinse the dishes and leave them in the sink until provider can wash them. ▪ The frequency that meal cleanup is necessary. ▪ If there is a dishwasher appliance available. ▪ Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** ▪ If the recipient must eat frequent meals which require additional time for cleanup. ▪ If the recipient eats light meals that require less time for cleanup.

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

<table>
<tr><th>Task Definition</th><th>Grid</th><th>Factors/Exception Examples</th></tr>
<tr>
<td>Bowel and Bladder Care (MPP 30-757.14(a))
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 gloves; wiping and cleaning recipient; assistance with getting on/off commode or toilet; and washing/drying recipient's and provider's hands.

Note: This does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program or colostomy irrigation, as these are assessed as "paramedical services" (MPP 30-757.19).</td>
<td>
<table>
<tr><th></th><th>Low</th><th>High</th></tr>
<tr><td>Rank 2</td><td>0.58</td><td>2.00</td></tr>
<tr><td>Rank 3</td><td>1.17</td><td>3.33</td></tr>
<tr><td>Rank 4</td><td>2.91</td><td>5.83</td></tr>
<tr><td>Rank 5</td><td>4.08</td><td>8.00</td></tr>
</table>
</td>
<td>
Factors for Consideration Include, But Not Limited To:

The extent to which the recipient can assist or perform tasks safely.
The frequency of the recipient's urination and/or bowel movements.
If there are assistive devices available which result in decreased or increased need for assistance.

EX: Situations 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 decreased need for assistance by the recipient.
EX: 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.

Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

If the recipient has frequent urination or bowel movements.
If the recipient has frequent bowel or bladder accidents.
If the recipient has occasional bowel or bladder accidents that require assistance from another person.
If the recipient's morbid obesity requires more time.
If the recipient has spasticity or locked limbs.
If the recipient is combative.

</td>
</tr>
<tr>
<td>Feeding (MPP 30-757.14(c))
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.

Includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning recipient's face and hands; washing/drying hands before and after feeding.

Note: This does not include cutting food into bite-sized pieces or puréeing food, as these are assessed as part of "meal preparation" (MPP 30-757.131).</td>
<td>
<table>
<tr><th></th><th>Low</th><th>High</th></tr>
<tr><td>Rank 2</td><td>0.70</td><td>2.30</td></tr>
<tr><td>Rank 3</td><td>1.17</td><td>3.50</td></tr>
<tr><td>Rank 4</td><td>3.50</td><td>7.00</td></tr>
<tr><td>Rank 5</td><td>5.25</td><td>9.33</td></tr>
</table>
</td>
<td>
Factors for Consideration Include, But Not Limited To:

The extent to which the recipient can assist or perform tasks safely.
The amount of time it takes the recipient to eat meals.
The type of food that will be consumed.
The frequency of meals/liquids.
Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

If the constant presence of the provider is required due to the danger of choking or other medical issues.
If the recipient is mentally impaired and only requires prompting for feeding him/herself.
If the recipient requires frequent meals.
If the recipient prefers to eat foods that he/she can manage without assistance.
If the recipient must eat in bed.
If food must be placed in the recipient's mouth in a special way due to difficulty swallowing or other reasons.
If the recipient is combative.

</td>
</tr>
<tr>
<td>Routine Bed Baths (MPP 30-757.14(d))
Cleaning basin or other materials used for bed/sponge baths and putting them away; obtaining water/supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing/drying hands before and after bathing.</td>
<td>
<table>
<tr><th></th><th>Low</th><th>High</th></tr>
<tr><td>Rank 2</td><td>0.50</td><td>1.75</td></tr>
<tr><td>Rank 3</td><td>1.00</td><td>2.33</td></tr>
<tr><td>Rank 4</td><td>1.17</td><td>3.50</td></tr>
<tr><td>Rank 5</td><td>1.75</td><td>3.50</td></tr>
</table>
</td>
<td>
Factors for Consideration Include, But Not Limited To:

The extent to which the recipient can assist or perform tasks safely.
If the recipient is prevented from bathing in the tub/shower.
If bed baths are needed in addition to baths in the tub/shower.
Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

If the recipient is confined to bed and sweats profusely requiring frequent bed baths.
If the weight of the recipient requires more or less time.
If the recipient is combative.

</td>
</tr>
</table>

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

Dressing (MPP 30-757.14(f))

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.

	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

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The type of clothing/garments the recipient wears.
- If the recipient prefers other types of clothing/garments.
- The weather conditions.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient frequently leaves his/her home, requiring additional dressing/undressing.
- If the recipient frequently bathes and requires additional dressing or soils clothing, requiring frequent changes of clothing.
- If the recipient has spasticity or locked limbs.
- If the recipient is immobile.
- If the recipient is combative.

Menstrual Care (MPP 30-757-14(j))

Menstrual care 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.

EX: In assessing menstrual care, it may be necessary to assess additional time in other service categories such as "laundry," "dressing," "domestic, "bathing, oral hygiene, and grooming" (MPP 30-757).

EX: In assessing menstrual care if the recipient wears diapers, time for menstrual care would not be necessary. This time would be assessed as part of "bowel and bladder" care.

	Low	High
*Functional rank does not apply	0.28	0.80

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- If the recipient has a menstrual cycle.
- The duration of the recipient's menstrual cycle.
- If there are medical issues that necessitate additional time.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

Ambulation (MPP 30-757.14(k))

Assisting a recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving/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.

	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

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The distance the recipient must move inside the home.
- The speed of the recipient's ambulation.
- Any barriers that impede the recipient's ambulation.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient's home is large or small.
- If the recipient requires frequent help getting to/from the bathroom.
- If the recipient has a mobility device, such as a wheelchair that results in a decreased need.
- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

Moving in and out of Bed - Renamed to Transfer (MPP 30-757.14(h))

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.

Note: Transfer does not include:

- Assistance on/off toilet, as this is evaluated, as 'bowel and bladder" care specified at MPP 30-757.14(a).
- Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as part of "repositioning/rubbing skin" at section MPP 30-757.14(g).

	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

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The amount of assistance required.
- The availability of equipment, such as a Hoyer lift.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient gets in and out of bed frequently during the day or night due to naps or use of the bathroom.
- If the weight of the recipient and/or condition of his/her bones requires more careful, slow transfer.
- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

<table>
<tr><th>Task Definition</th><th>Grid</th><th>Factors/Exception Examples</th></tr>
<tr>
<td>

Bathing, Oral Hygiene, and Grooming (MPP 30-757.14 (e))

Bathing (Bath/Shower) 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 a tub or shower; assistance with reaching all parts of the body for washing, rinsing, and drying and applying lotion, powder, deodorant; and washing/drying hands.

Oral Hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

Grooming includes hair combing/brushing; hair trimming when 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.

Note: This does not include getting to/from the bathroom. These tasks are assessed as mobility under "ambulation" (MPP 30-757.14(k)).

</td>
<td>

	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

</td>
<td>

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The number of times the recipient may need help to bathe.
- If the recipient requires assistance in/out of tub/shower.
- If the recipient needs assistance with supplies.
- If the recipient requires assistance washing his/her body.
- If the provider must be present while the recipient bathes.
- If the recipient requires assistance drying his/her body and/or putting on lotion/powder after bathing.
- If the recipient showers in a wheelchair.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the provider's constant presence is required.
- If the weight of the recipient requires more or less time.
- If the recipient has spasticity or locked limbs.
- If a roll-in shower is available.
- If the recipient is combative.

</td>
</tr>
<tr>
<td>

Repositioning/Rubbing Skin (MPP 30-757.14(g))

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 are limited to:

- 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.
- Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent the patient's capacity and tolerance.
  - Such exercises include carrying out of maintenance programs (e.g., the performance of repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain a range of motion in paralyzed extremities; and assistive walking).

Note: "Repositioning and rubbing skin" does not include:

- Care of pressure sores (skin and wound care). This is assessed as part of "paramedical" specified at MPP 30-757.19.
- Ultraviolet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to skin. These tasks are assessed as part of "assistance with prosthetic devices" at MPP 30-757.14(i).

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	Low	High
*Functional rank does not apply	0.75	2.80

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Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- 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.
- If the recipient has circulatory problems.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient has a condition that makes him/her confined to bed.
- If the recipient has spasticity or locked limbs.
- If the recipient has or is at risk of having decubitus ulcers which require the need to turn the recipient frequently.
- If the recipient is combative.

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HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

Task Definition	Grid	Factors/Exception Examples
Care and Assistance with Prosthetic Devices and Assistance with Self-Administration of Medications (MPP 30-757.14(i)) Assistance with taking off/putting on, maintaining, and cleaning prosthetic devices, vision/hearing aids, and washing/drying hands before and after performing these tasks. Also includes assistance with the self-administration of medications consisting of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken, setting up Medi-sets and distributing medications.		**Factors for Consideration Include, But Not Limited To:** ▪ The extent to which the recipient is able to manage medications and/or prosthesis independently and safely. ▪ The amount of medications prescribed for the recipient. ▪ If the recipient requires special preparation to distribute medications (e.g., cutting tablets, putting medications into Medi-sets, etc.). ▪ If the recipient has cognitive difficulties that contribute to the need for assistance with medications and/or prosthetic devices. ▪ Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** ▪ If the recipient takes medications several times a day. ▪ If the pharmacy sets up medications in bubble wraps or Medi-sets for the recipient. ▪ If the recipient has multiple prosthetic devices. ▪ If the recipient is combative.

	Low	High
*Functional rank does not apply	0.47	1.12

ATTACHMENT D

Utilization of New HTGs – Process