Department Of Disability and Aging Services

Case Management
Certification Exam

Study Guide
and
Reference Manual

Vermont Agency of Human Services (AHS)
Department of Disabilities Aging and Independent Living (DAIL)
www.ddas.vermont.gov

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This study guide should help you prepare for the Case Management Certification Exam for the provision of case management services under Older Americans Act and Choices For Care programs. It is not intended to be a training guide to become a Case Manager. It should be used in addition to the core training and orientation you have completed through your agency.

This Case Management Reference Manual and Study Guide reflects current DDAS Case Management Standards, and will be updated whenever there is an update to DDAS Case Management Standards.

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The mission of the Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability ~ with dignity, respect and independence ~

Purpose

The Division supports older Vermonters and Vermonters with disabilities to live as they choose, pursuing their individual goals and preferences within their chosen communities. The Division:

- seeks to ensure their basic human and civil rights, health, well-being, and safety
- provides effective leadership for disability and aging policy and services in Vermont
- meets federal and state mandates by developing and managing public resources effectively

Core Values and Principles

Person-centered: We help people to make choices and to direct their own lives - pursuing their own choices, goals, aspirations and preferences.
Natural Supports: We recognize the importance of family and friends in people's lives. We respect the unique needs, strengths and cultural values of each person and each family.
Community participation: We support consumers' involvement in their communities, and recognize the importance of their contributions to their communities.
Effectiveness: We pursue positive outcomes through effective practices, including evidence-based practices. We seek to develop and maintain a trained and competent workforce, and to use staff knowledge, skills and abilities effectively.
Efficiency: We use public resources efficiently – avoiding unnecessary activities, costs, and negative impact on our environment.
Creativity: We encourage progress through innovation, new ideas, and new solutions. We accept that creativity involves risk, and we learn from mistakes.
Communication: We communicate effectively. We listen actively to the people we serve and to our partners. We are responsive.
Respect: We promote respect, honesty, collaboration and integrity in all our relations. We empower consumers, staff and partners to achieve outcomes and goals. We provide opportunities for people to grow, both personally and professionally.
Leadership: We strive to reach our vision and to demonstrate our values in all our work. We collaborate with consumers and other partners to achieve outcomes, goals and priorities. We are accountable.

DDAS Consumer Outcomes

Respect: Individuals feel that they are treated with dignity and respect.

Self-Determination: Individuals direct their own lives.

Person-Centered: Individuals needs are met, and their strengths and preferences are honored.

Independent Living: Individuals live as independently and interdependently as they choose.

Relationships: Individuals experience satisfying relationships, including connections with family and their natural supports.

Participation: Individuals participate in their local communities.

Well-being: Individuals experience optimal health and well-being.

Communication: Individuals communicate effectively with others.

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Case Management Standards

Case Management Standards promote principles of self-determination, independence and empowerment of older adults and younger adults with disabilities. Case management services respect individual rights, strengths, values and choices, encouraging individuals to direct and participate in their own Action Plan and services to the fullest extent possible. While it may be crucial to collaborate with an individual's family and medical staff regarding an individual's Action Plan, their perspective should not become the sole determinate of outcomes. Outcomes should first and foremost reflect the desires of the individual receiving services.

The following standards were written to provide guidance for case managers and to describe acceptable case management. These standards apply to case management services provided to adults 60 years of age and older and to younger adults with disabilities through the Home and Community Based Medicaid Waiver, Enhanced Residential Care Waiver and Older Americans Act.

Goal of Case Management

To ensure that older adults and younger adults with disabilities receive appropriate, effective and efficient services, allowing them to retain or achieve the maximum amount of independence possible and desired.

Definition of Case Management

Case management is a professional service to help older adults and younger adults with disabilities access the services they need to remain as independent as possible in accordance with the wishes of the individual, and/or working with a legal representative of that individual, and advocating on behalf of that individual for needed services or resources. Case management targets those individuals with psychosocial or medical needs that extend beyond advocacy counseling, public benefits or financial issues. Case management includes:

1. completing a comprehensive assessment to identify the individual's strengths and needs, (including the physical, psychological, financial, and social needs of the individual) and discussing and offering options;

2. arranging for and coordinating an efficient and effective package of services to meet the needs of the individual. This includes the development and implementation of an Action Plan/Care Plan with the individual and/or family to identify and access the formal and informal resources and services which are necessary to meet the identified needs of the individual;

3. monitoring the formal and informal services delivered to ensure that services specified in the plan are being provided and that the individual's identified needs are met; and

4. performing periodic reassessments of the individual with the individual and/or if necessary, with the primary caregiver or family member, and revising the Action Plan as needed.

Principles of Case Management

1. Case management services promote self-determination, independence, and empowerment of older adults and younger adults with disabilities.

2. Case management services foster respect, dignity, privacy, and confidentiality for the individual being served.

3. Case management services respect individual rights, strengths, values and choices, encouraging individuals to direct and participate in their own Action Plans and services to the fullest extent possible.

4. Case management services respect individual self-determination, including the opportunity for individuals to decide whether or not to participate in a program, service or activity.

5. Case management services are provided in an efficient manner, preventing duplication of services to maximize the benefits and services available to all individuals.

6. Case management services respect the right of individuals to receive services under conditions of acceptable risk, in which the individuals assume the risk associated with decisions which they make through a process of informed consent.

7. Case management services will not be used to secure improper or inappropriate gain for the case manager or the case manager's employer.

Case Management Outcomes

Quality case management services attempt to achieve the following outcomes:

1. The individual is aware of available options for which s/he is eligible and receives chosen services.

2. The individual expresses satisfaction with case management services.

3. If relevant, the individual's primary caregiver or family expresses satisfaction with case management services.

4. The individual's Action Plan is comprehensive and individualized.

5. The individual expresses satisfaction with her/his level of involvement in the development of the Action Plan.

6. The services are provided in an efficient and effective manner, and duplication of effort and services are minimized.

Case Management Standards

1. The case manager will promote self-determination, independence, and empowerment of older adults and younger adults with disabilities.

2. To the extent possible, the case manager will ensure that an individual is being served in the least restrictive and most appropriate setting of her/his choice.

3. The case manager will respect individual rights, strengths, values and preferences, encouraging individuals to direct and participate in their Action Plans and services to the fullest extent possible.

    a. Case managers will not make decisions for individuals. Where there is a legally appointed surrogate decision-maker and the individual is unable to participate in addressing an issue, assistance may be given to the surrogate's decision-maker.

    b. It is the responsibility of the case manager to ensure that an individual has the right to receive services under conditions of acceptable risk in which the participant assumes the risk associated with decisions, which she/he makes under conditions of informed consent.

4. The case manager will be knowledgeable about services and ensure that individuals and caregivers are aware of available resources and services.

5. The case manager will provide services in an efficient and effective manner, to avoid duplication of services, unnecessary costs, and unnecessary administrative tasks.

6. The case manager will respond to requests for information and/or assistance from individuals, caregivers and/or third party referrals.

7. The case manager will assess, with the client's and/or surrogate decision-maker's consent, her/his circumstances, problem areas, and strengths using the assessment tool designated by the Department.

    a. The case manager will initiate and oversee the initial assessment and reassessment of needs/strengths.

    b. The assessment will evaluate the following areas: activities of daily living, instrumental activities of daily living, health status, finances, social/emotional status, living environment, existing formal/informal support services, and current program/services involvement.

    c. Any immediate needs should be clearly identified and documented.

    d. For Area Agency on Aging case managers the initial Intake section of the assessment tool designated by the Department will be completed at the first face-to-face contact. Documentation will be recorded in the Client Record when this is not possible, as to why. Additional sections of the full assessment will be completed based upon the case manager's professional judgment for those individuals with needs that extend beyond advocacy counseling and/or benefit programs. In all cases, a thorough enough assessment must be completed to ensure that all needs are identified; however the full assessment form will always be completed for those individuals participating in Medicaid Waiver Programs.

    e. The assessment will be updated at least annually; more frequently if there is a major change in the individual's circumstances.

8. The case manager will assist an individual and caregiver, (when appropriate) to develop and implement an Action Plan.

    a. Action Plans will be completed with individuals with complex case management needs that extend beyond advocacy and/or benefits counseling.

    b. The Action Plan will address issues and goals, plan/strategy, the responsible person for each task, and the target date for each issue and goal.

    c. The initial Action Plan will be completed at the first face-to-face contact, if possible. The Action Plan will be updated at the annual reassessment or more frequently if there is a major change in the individual's circumstances.

9. The case manager will, together with the individual and caregiver, (when appropriate) monitor all case management services, and changes in the individual's/caregiver's needs. The case manager will contact the individual/caregiver as indicated by the assessment and action plan, as needs arise, and/or as required by applicable program standards.

10. The case manager will maintain complete and accurate client files.

    a. Case manager's client files will contain a current release of information or an explanation of why a release of information could not be obtained. Permission, written or verbal, will be documented in the client file.

    b. The case manager's client files will also contain copies of client records, intake/assessment forms, copies of the most current public benefit applications, and correspondence related to benefits and services.

11. The case manager will abide by the case manager's agency policy concerning conflicts of interest and the appearance of conflict of interest, between the interests of the individual and those of the case manager and/or the case manager's employer.

12. Case managers are mandated reporters. Case managers will follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting and case management agency policies.

13. Area Agency on Aging case managers will respond to a self-neglect referral within 48 hours. Situations that present as an emergency must be attended to immediately or referred to the appropriate resources.

14. The case manager will abide by principles of confidentiality as outlined in the case management agency policy.

Case Management Action Plan

The purpose of the Case Management Action Plan is that a person receiving services has an individualized, personalized plan for their supports, formal and informal. The plan is created with the assistance of a person's Case Manager. The plan identifies the supports the person has chosen to use, the person's intention or desired outcomes of their supports, who is responsible for the supports, and, how and when those supports will be reviewed for effectiveness. The plan acts as a bridge from the Independent Living Assessment (ILA) to the actual delivery of support services.

- A Case Management Action Plan must be completed for people receiving services that have complex case management needs that extend beyond advocacy or counseling for benefit programs.

- A plan must be completed for all people receiving Choices for Care Highest/High needs at home or in an Enhanced Residential Care (ERC) setting.

- If a person receives services though CFC Moderate Needs or the Older American's Act, and, do not have complex case management needs, the case manager is not required to complete a plan, although their case management services must comply with current DDAS Case Management Standards. Case managers shall use their professional judgment and document, in the person's case notes, their decision to not use a Case Management Action Plan.

- The person, their legal representative, caregiver or family member, develops the plan with the case manager.

- The plan provides a written summary of Issues and Goals, the Plan/Strategy of each support, the Responsible Person(s) for providing that support, and the Target Dates for completion.

- The plan is not simply a to-do list for the case manager.

- Documentation of the plan can be in any format which meets the intent and all the requirements of a Case Management Action Plan, including that it be a format that is easily shared and understood by the person receiving supports.

How does a Case Management Action Plan benefit the person being supported?

- The plan is intended to assist the person, and the people who support them, to better understand the intent and purpose of the supports, and who is responsible to carry out each part of the plan. It should be written so that the person can easily understand and refer to it. It should enable a person to easily review their plan and the agreements that have been made. The plan also allows the person to build upon their own strengths and be an active participant in their supports.

How does the Case Management Action Plan benefit the case manager?

- The plan allows the case manager to quickly review the over-all issues and support plans for a person.

- It serves as a quick reference tool a case manager can use when contacting and visiting a person receiving services. It allows the case manager to accurately record the progress or lack of progress in the person's record.

- The plan guides necessary follow-up with others providing support in the plan.

- The plan is beneficial for a case manager who may suddenly need to take over another case manager's caseload.

How does the plan benefit the case management supervisor?

- The plan can serve as a quick supervisory tool for following the progress or lack of progress of a person' supports.

- The plan can help supervisors to review how a case manager uses the data from assessments to understand a person's needs, and then develop an appropriate plan with the person receiving supports.

When do I complete a Case Management Action Plan?

- A plan is completed at the time of initial assessment, should be regularly discussed by the person receiving supports and their case manager, and updated as a person's support needs change. Progress, lack of progress, and changes to the plan are recorded in the person's file. Any significant change that triggers the need for a new assessment must also trigger the need for a new plan.

How lengthy is an Action Plan?

- Each plan should be clear, concise and easy to understand by both the person receiving services and anyone providing supports. It is not meant to be a narrative of the ILA or other assessments. As many pages as necessary should be used to outline the major issues, goals and strategies.

Who receives the Case Management Action Plan?

- The person receiving services and their case manager. A copy of the plan may also be shared with those providing support as long as the person receiving services allows it.

Who signs the Action Plan and where?

- The Action Plan must be signed and dated by the person receiving services (or their legal representative) and by the case manager who developed the plan with the person.

- If an individual declines or is unable to sign their plan, documentation of that must be noted in the person's file.

What is included under Issues and Goals?

- All of the issues and goals, identified by the person receiving services, which services are able to support.

- The goals should be what the person receiving services hopes to accomplish with the support of their services.

- Issues and goals should reflect the words and sentiments of the person receiving supports.

- If a person receiving support does not wish to address an area of concern identified by the ILA or other assessments, that should be noted on the plan or in the person's record.

- The status of the issues and goals should be recorded in the person's record kept by their provider.

- Example:

    - Issue – Depression or "I feel down a lot."

    - Goal – Increased energy which would allow me to participate in XXXX (hobby, interest, etc.) as often as I choose. (ie. I would like to have the energy to complete a quilt for my daughter by Hanukkah.)

    - Goals should be measurable so that the person receiving services and the case manager will know when they have been achieved or need to be reevaluated.

What is included under plan/strategy?

- An outline of the activities that will be used to pursue each goal for each issue.

- There may be more than one activity for each issue/goal.

- An example of a plan/strategy is: Referral to Elder Care Clinician for additional assessment and treatment.

- The Status of the plan(s)/strategies should be documented in the person's record.

- Responsible Persons is the person who will carry out **each** plan/strategy for **each** specific issue/goal is recorded. The Responsible Person may include the case manager, the provider, the person receiving supports, their family, caregiver and other formal as well as informal supports.

- The person receiving support should be given appropriate responsibility implementing and pursuing their plan.

What is included under Target Date?

- Target Date refers to the time frame in which the Responsible Person hopes to achieve each specific plan/strategy for each issues/goals.

- The Target Date status should be recorded in the person's record.

- The dates should be specific and appropriate to the specific issue, goal, plan and strategy. The dates should not automatically default to "ongoing", year-long, or a reassessment based timeframe (i.e.: 7/05-7/06).

- If a goal is actually an ongoing goal, then it is acceptable to use the annual review date as the completion date or in some cases "ongoing" if the goal is to maintain skills. All aspects of a person's plan should be reviewed during a person's annual reassessment.

Please Note

The following Case Study and Case Management Action Plan are intended as an example.

Each plan that is developed with a person receiving supports must be individualized to that person's needs.

Two people with similar issues may have different goals, plans, strategies, responsible persons and target dates.

Currently, The Case Management Certification Exam will contain a number of questions about planning services and supports, but will NOT ask you to review a Case Study and Develop a Case Management Action Plan.

Case Management Action Planning Case Study

Central VT Council on Aging (CVCOA) case manager, Marie, is meeting with Michael Cornell, an individual in need of services, and his granddaughter Jennifer. Marie received the Choices for Care Clinical Certification of Highest Needs from the Long Term Care Clinical Coordinator. Michael age 86, took a bad fall six weeks ago and has been receiving rehabilitation services at a local nursing facility. Discharge planning was not thorough as Michael insisted he was ready to go home with services in place or not. It appeared at the time that Jennifer would be able to be a significant source of help as she was willing to move in with Michael. It was questionable if Jennifer was going to be able to provide Michael with all the assistance he needs, but they agreed to give it a try. Since Jennifer moved in, she has been offered a very good job at IBM and does not wish to turn it down. Jennifer is willing to help as much as she can, but it has become apparent to both Michael and Jennifer that he will not be able to remain at home without the CFC program.

Before rehab, Michael was in the Central VT Medical Center for a hip replacement, and a broken arm which was put in a cast. Michael has diabetes, (two toes amputated in the last two years), macular degeneration and poor hearing. During the ILA assessment it became clear that while Michael is already connected with the Association for the Blind & Visually Impaired and has hearing aides; it can be a challenge to get him to wear his hearing aides. Michael has become quite confused since his stay at the nursing facility and currently his decision making skills are severely impaired. He needs extensive assistance with dressing, bathing, toileting and transfers. Michael is not eating well and continues to lose weight. Michael tells Jennifer and Marie that he has no energy, feels down a lot and doesn't even care about tending to his garden this year. He use to enjoy socializing with people and hobbies like woodworking, gardening and painting, but they don't interest him much any more. Michael attended the local Congregational Church, but has not been to church services since his fall. He agrees that it might be helpful to talk with the pastor, have people around during the day and is willing to accept services that will help him to be able stay at home. Michael and Jennifer are interested in agency directed services at this time and clearly want to receive case management services from CVCOA.

Marie has already assisted Michael and Jennifer with the application for Long Term Care Medicaid. It appears to Marie that he will be eligible because he's been on Community Medicaid and has limited income.

Michael, Jennifer and Marie are now developing Michael's Action Plan together.

Case Management Action Plan

Client Name: Michael Cornell Date: April 12, 2007

Issues and Goals	Plan/Strategy	Responsible Person	Target Date
1. Issue: I feel down a lot. Goal: Increased energy	-Refer to Elder Care Clinician for further	AAA CM/ECC	July 12, 2007
and interest in my hobbies.	assessment and treatment.		
2. Issue: Not eating well and losing weight.	-Refer to Nutrition Director at CVCOA for	AAA CM	April 19, 2007
Goal: Eat well to manage my diabetes and gain	nutrition consult for Michael & Jennifer.		
10lbs.	-Refer to Meals on Wheels (MOW) 2x a week.	AAA CM	April 19, 2007
	-Jennifer wants to cook evening & weekend	Jennifer	July 12, 2007
	meals.		
	-Michael will have nutritious meals at Barre Project	AAA CM/BPI	
	Independence (BPI) 3x a week.		
	-Michael, Jennifer & Marie will review in 3 months	AAA CM/	July 12, 2007
	progress toward goal.	Michael/Jennifer	

We agree to carry out the responsibilities outlined in this Action Plan to the best of our ability.

Please sign and date:

_____ _____

Client/Representative Date Case Manager Date

Please sign/date the last page of the Action plan. **Original for client** **Yellow for office file** **Pink for case file**

Updated 10/10/2008

Case Management Action Plan

Client Name: Michael Cornell Date: April 12, 2007

Issues and Goals	Plan/Strategy	Responsible Person	Target Date
3. Issue: Alone during the day. Goal: I would like to	-Refer to BPI. Michael agrees to attend 3x a wk.	AAA CM/Michael	April 19, 2007
socialize with people and try some activities like	-BPI will help Michael focus on his hobbies.	BPI/Michael	May 12, 2007
woodworking, painting and gardening.	-Michael agrees to give BPI a one month try and	Michael/AAA CM	May 12, 2007
	then discuss if it's right for him.		
4. Issue: Michael's spiritual needs are not being met.	-Michael would like Jennifer to call the minister,	Jennifer	April 19, 2007
Goal: Michael's spiritual needs will be met through	Barbara Watkins to arrange for a visit.		
visits from his minister and attending church.	-Michael will let Barbara know that he would	Michael	April 30, 2007
	like spiritual visits 1-2 x a month if possible.		
	-Jennifer agrees to bring Michael to church 2x a	Jennifer	July 12, 2007
	month. Michael's friend John will bring him 2x	John	July 12, 2007
	if Michael wants.		

We agree to carry out the responsibilities outlined in this Action Plan to the best of our ability.

Please sign and date:

_____ _____

Client/Representative Date Case Manager Date

Please sign/date the last page of the Action plan. Original for client Yellow for office file Pink for case file

Case Management Action Plan

Client Name: Michael Cornell Date: April 12, 2007

Issues and Goals	**Plan/Strategy**	**Responsible Person**	**Target Date**
5. Issue: Assistance needed with personal care,	-CVHH&H will provide PCA 7x a wk. for	CVHH&H	July 12, 2007
dressing, bathing, laundry and housework.	personal care.		
Goal: Michael will have the PCA assistance he needs			
7x a wk. for independence in his home.			
6. Issue: Jennifer would like 1 weekend a month free	-CVHH&H will provide up to 720 hrs. of	CVHH&H	July 12, 2007
to visit friends. Goal: Respite 1 weekend a month	respite per year.		
for Jennifer to avoid caregiver burnout.	-Jennifer and Marie will explore other options	CVHH&H	July 12, 2007
	as needed.		

We agree to carry out the responsibilities outlined in this Action Plan to the best of our ability.

Please sign and date:

_____ _____

Client/Representative Date Case Manager Date

Please sign/date the last page of the Action plan. Original for client Yellow for office file Pink for case file

Updated 10/10/2008

Case Notes

- Case notes provide written documentation of contacts and actions with the person receiving services, and other informal and formal supports in the person's life; as well as plans for follow-up.

- Case notes should be clear and concise and reflect collaboration that is occurring between providers of service outlined in the person's plan, as well as internal collaboration at the agency.

- Case notes can facilitate and support supervision by outlining the progress and/or lack of progress in implementing a person's plan for their supports.

- Case notes should provide a clear record that would enable a new case manager not familiar with the person being supported, to effectively continue all supports.

- Case notes document a person's permission, or lack of permission, to the agency to share or request information from other agencies. Case notes must be kept detailing what information, regarding the person receiving services, is shared with whom and for what purpose.

- Case notes are not a place for the case manager to indicate their personal opinions and assumptions.

Communication Skills

There are many aspects to effective communication from self-awareness and attention to non-verbal as well as verbal communication; genuineness, acceptance, trust and empathic understanding to name just a few.

Self-awareness

Becoming self-aware is the first step towards improving our communication skills. Most of our behaviors are natural for us. We are not aware of the impact these behaviors have on others. That leaves us with blind spots that others may not want to mention to us because they do not want to hurt our feelings, they are afraid of a reaction from us, or they do not especially care. Through self-awareness we learn what impact our behaviors – both positive and negative – have on others. That knowledge helps us become more effective in our interactions and communication with others. One good way to become more self-aware is to ask for constructive feedback from supervisors and co-workers and to reflect on the feedback that is received.

Non-verbal Communication

Our bodies are always communicating messages to other people, whether we want it to or not, and whether we are aware of it or not. Effective case managers are mindful of what their bodies are saying and are also mindful of what the individual they are working with might be conveying nonverbally. Nonverbal behavior refers to posture, facial expressions, movement, tone of voice and the like.

Quality of Your Presence

The quality of our presence is very important when we are working with people. The following are ways you can make sure you are physically present to others:

- Face the person squarely adopting a posture that indicates involvement.

- Adopt an open posture. For example crossed arms and crossed legs can be signs of lessened involvement with or availability to others. If your legs are crossed, this does not mean you are not involved, but it is important to ask yourself to what degree your posture communicates openness and availability to the person you are meeting with.

- Remember that it is possible at times to lean toward the other. In North American culture a slight inclination toward a person is often seen as indicating your interest in the person and what they are saying. Leaning back can be a way of conveying less interest. Leaning too far forward too quickly might scare someone. It can be seen as a way of demanding some kind of closeness and intimacy. It is important to not be rigid in terms of leaning forward or backward, but simply to be aware of the needs of the other person and what you are nonverbally conveying to them.

- Maintain good eye contact. It is important to be aware of cultural differences in terms of eye contact. In North American culture fairly steady eye contact is a good way of saying "I am with you." This of course if different than staring.

- Try to be relatively relaxed while engaged in these behaviors.

(Source: *The Skilled Helper*, Gerard Egan, Brooks/Cole Publishing Company, Monterey, California, 1982.)

Open-ended Questions

Open-ended questions are expansive questions that require a person to provide a more detailed response than a "yes" or "no" answer. Note the difference between asking someone: "Does your family help you at home?" versus "How does your family help you at home?" Open-ended questions frequently encourage a person to explore the reality of their situation more fully and provide more information. Sometimes this fuller exploration reveals next steps that can be taken.

Realness or Genuineness

It is important to simply be ourselves when we are working with others. This means being able to be present to our own feelings, and what we are experiencing and to be able to convey what we are experiencing as is professionally appropriate. It also means being able to come into a direct personal encounter with the other person on a person-to-person basis. For example, it is respectful to convey to someone that we are confused by what they just said if we are indeed confused and to ask for clarification.

Prizing, Acceptance, Trust

Effective communicators convey a sense of prizing or valuing the other; her feelings, her opinions, her person. This is a non-possessive form of caring. It is an acceptance of the other individual as a separate person, having worth in her own right. From this stance we value another human being as a person with many different thoughts, feelings and potentialities. Conveying a sense of prizing or valuing the individual is key in beginning to establish a trusting relationship.

Empathy

Empathy is often characterized as the ability to "put oneself in another's shoes", or experiencing the outlook or emotions of another person within oneself, a sort of emotional resonance. Case managers are accurately empathic when they get inside the other person's world, get a feeling for what their world is like, and look at the outer world through the other's person's perspective or frame of reference. Accurate empathy also means communicating this understanding in a way that shows they have some understanding of the other person's feelings and experiences. We do not want to indicate that we know exactly how another person feels or that we have never experienced what the other is going through so we have no idea of how they feel. In most cases, accurate empathy helps to establish rapport between people. It also helps others to develop the kind of openness and trust that is most useful for people in exploring their challenging situations.

(Source: *The Skilled Helper*, Gerard Egan)

Conducting a Home Visit

A case manager usually conducts a first home visit after a person has made a request for services or a referral is received from an interested party.

Home Visit Tips

- Begin assessing from the moment you park your car at the person's house – stop – look – listen to everything you see, hear, and smell.
- Be respectful to the person – remember that you are a guest in their house.
- Be on time. Being late may cause anxiety and anger. If you are running late and it is possible phone the person to let them know.
- Take in the "feeling" of the home – is it bare? Is it filled with flowers and cards? Does it have a lot of pictures of loved ones? Are there signs of hobbies?
- Does the person have pets?
- Look underneath what the person says for feelings.
- Pay attention and acknowledge what is being said with a nod, touch or verbal feedback.
- Ask questions to dig deeper, but be careful not to direct their thinking to yours.
- Be empathic and compassionate.
- Allow silences.
- Allow for tears and do not rush to quiet them.
- Respect what is being said and do not finish people's sentences.
- Build on individuals strengths.

- Respect cultural diversity – people have different genders, social classes, religious and spiritual beliefs, sexual orientation, age, physical and mental abilities and cultural backgrounds. An example of a cultural diversity issue for an older adult residing in Vermont is the person being Native American or African American.

- After you and the person complete an Independent Living Assessment (ILA) together, be prepared to discuss options for services and programs the person is eligible for, but let the person direct you in forming their support plan.

When defining client strengths, consider:

- The person's knowledge, education or life learning and their self-awareness.

- The history of achievement, what has been accomplished before and even during the current situation.

- What types of hobbies, interests and talents does this person possess?

- How does the person exhibit pride, dignity and images of themselves?

- What are their choices and desires for the time being and the future?

- Their relationship to family and friends.

- The methods they use to cope.

- Experiences.

- Feelings and emotions.

- Cultural values, customs and traditions.

- Their community and or creative activities.

- Their willingness and ability to ask for help.

- Their physical, mental and functional status.

Strength Based Models

- Focus on the whole person in their environment where the goal is to discover, develop and build a person's internal and external resources.

- Look at utilizing both formal and informal supports. Formal supports refer to someone being paid. Informal supports refer to someone who is not paid to provide a specific form of assistance. Informal supports might include: church members who volunteer to help, extended family or a friend offering assistance, people in the community such as the newspaper delivery person or mail carrier briefly checking-in on someone.

- Emphasize joint participation and decision-making with the person.

- Reinforce choices and focus on what is wanted by the person and how they can obtain their desired result.

- Capitalize on what can be done and compensate for what cannot be done.

- Help the person cope with social isolation.

- Find underutilized or untapped capacities for change and for growth.

Intervening In Difficult Situations

Not everyone wants to change, sometimes people want things to be different, but not if it means they must take action to make their lives different.

There are people you cannot help: *why?*

- This can be a result of who you are, or who the person you are supporting is.
- Sometimes, a person triggers difficult experiences within you. You may have feelings that are difficult to sort out – don't ignore this, and ask for supervision support on this.
- A person may have a personality disorder – this causes impairment in social and occupational functioning and problems in living that are reflected in the way they relate to others.
- Sometimes, nothing seems to work or be helpful to a person you are supporting, and you feel as though it's a never-ending pit of your attention and energy. It is important to recognize that chances are, any other Case Manager would feel the same way with this person.

What you can do?

- Maintain your own identity – have confidence in your skills, wisdom and experience.
- Stay within boundaries of sensible supportive assistance – focus on the current life situation.
- Strengthen the person's best defenses – attempt to relieve symptoms experienced by them and focus on their best strengths.
- Get help from co-workers, eldercare clinicians, and your supervisor.
- Take very good care of your own self.

Self-Neglect

The Area Agencies on Aging have the primary responsibility for the provision of case management services for people age 60 and over who are experiencing self-neglect.

Self-neglect means an adult's inability, due to physical and or mental impairments, to perform tasks essential to caring for oneself, including but not limited to;

- providing essential food, clothing, shelter and medical care;
- obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety;
- or managing financial affairs.

Signs and symptoms of possible self-neglect:

- Dehydration
- Malnutrition
- Hypo/Hyperthermia
- Excessive dirt or odor of person or dwelling
- Inadequate or inappropriate clothing
- Absence of eyeglasses, hearing aids, dentures or prostheses
- Unexpected or unexplained deterioration of health
- Bedsores
- Signs of excess drugging, lack of medication
- Decreased alertness, responsiveness and orientation
- Home extremely cluttered, disorganized
- Pets uncared for

Check with your own agency for their expectations regarding self-neglect

Self-Neglect General Guidelines

- While it is important to respect self-determination and the person's wishes as much as possible, health and safety concerns must also be addressed when they exist.

- Establish and maintain an effective relationship with the person you are supporting.

- Complete a comprehensive assessment.

- Identify and prioritize problems to be addressed.

- Work with the person developing goals related to self-neglect, and a plan to support them as effectively as the person allows.

- It is important to consult with your supervisor and keep him/her informed of any instances of self-neglect.

- Case managers are not responsible for changing a person's self-neglecting living situation if the person is unwilling to accept assistance.

- Case managers are not responsible for making decisions for a person. If a person is not competent, the need for a surrogate decision maker should be addressed.

- Any competent adult can petition the court to appoint a guardian for another person.

- In order for a person to be declared legally incompetent, there must be at least one physician or mental health professional's statement to support a finding of incompetence, and the decision is made by the probate court.

Actions to consider if a person refuses services, does not adhere to their plan, or conditions worsen:

- Refer to or consult with other disciplines: RN, LNA, rehab, dietitian, MSW, eldercare clinician, AAA. (APS may provide consultation, but do not refer to APS unless a vulnerable older adult is experiencing abuse or exploitation from another person.)

- If the person you are supporting gives permission, identify one or two family or community members to assist as their "point person".

- Identify barriers and brainstorm ways to overcome the self-neglect.

The Goal is to maintain the person with as few restrictions as possible. Allow the person to make the decisions they are capable of, including choosing where they live. People have a right to make bad decisions and to suffer consequences. If a person is clearly incompetent, assure that their needs are being met in least restrictive way.

Violence and Abuse (Definitions under the Adult Abuse Statute, Title 33, CH. 69)

Abuse - as it applies to a "vulnerable adult"

- Any treatment of a vulnerable adult which places life, health and welfare in jeopardy or which is likely to result in impairment of health, or conduct committed with intent to cause unnecessary harm, pain or suffering.

- Unnecessary confinement or restraint, intentional subjecting person to behavior, which should be expected to result in intimidation, fear, humiliation, degradation, agitation, disorientation.

- Administering of drug or substance for purpose other than legitimate purposes.

- Any sexual activity with vulnerable adult by caregiver, who volunteers for or is paid by caregiver facility or program.

Exploitation - as it applies to a "vulnerable adult"

- Willfully using, withholding, transferring or disposing of funds/property of vulnerable adult without or in excess of legal authority.

- Acquiring possession/control of or an interest in funds/property through use of undue influence, harassment, duress, fraud.

- Act of forcing or compelling person against his/her will to perform service for the profit of another.

- Any sexual activity when person doesn't consent, or is incapable or resisting/declining due to age or disability or fear of retribution/hardship.

Neglect - as it applies to a "vulnerable adult"

Purposeful or reckless failure or omission of a caregiver to:

- Provide care/arrange for goods/services necessary to maintain health or safety.

- Make a reasonable effort to protect person from abuse, neglect or exploitation by others.

- Carry out plan of care when such failure results in physical or psychological harm or a substantial risk of death, unless caregiver is acting pursuant to wishes of adult or his representative, or a terminal care document as defined in chapter 111 of Title 18.

- Report significant changes in health to MD, RN or immediate supervisor, when caregiver employed by organization that provides care.

Who needs to report to Adult Protection Services (APS)?

Mandated Reporters – Case Managers and all caregivers are mandated reporters. By law, if you support a person who is a vulnerable adult who you believe is being abused by an intimate partner, family member or caregiver, you must report that abuse.

When do I need to report?

Within 48 hours.

Who is vulnerable adult?

Someone who is 18 or older and is a resident of licensed facility, or has been receiving personal care services in their home for at least a month. Also, an adult with a physical, mental or developmental disability which interferes with their ability to provide for their care without assistance, or that impairs their ability to protect themselves from abuse, neglect or exploitation.

How to make a report?

Call APS at 1-800-564-1612
Fax report to: 241-2358

Indicators of abuse:

- Unexplained bruising, injuries or pain.
- Unexplained behavioral or general health changes.
- Unexplained fear of being around specific family members, staff or friends.
- Unexplained fear of specific personal care situations.
- Missing personal items and/or meds.
- Family, friends or staff who are overly defensive or uncooperative with investigations.

Informed Consent and Negotiated Risk

Self-determination

It is the right of every legally competent person to make decisions about his or her own life, regardless of the nature of their decisions, or the consequences to himself/herself.

Informed consent

The way that legally competent people, or their legal guardian, are given the opportunity to make fully informed decisions regarding their supports and services, using all information available that may influence those decisions.

Negotiated risk

It is a process of negotiation which results in a formal written agreement that respects the preferences, choices, and capabilities of a person receiving supports and services. It is intended decrease the possibility that a person's decisions or choices will place themselves or others at risk of significant harm. A negotiated risk agreement should involve the person receiving supports or his/her legal guardian, their case manager and appropriate service provider(s).

Acceptable risk

The level of risk a person receiving supports and services, or his/her legal guardian, is willing to accept after they have made a decision using the informed consent process. Factors associated with risk to the person may include, but are not limited to:

- The person's medical condition,
- behaviors,
- life style preferences,
- living environment,
- level of care needs, or
- refusal of supports and services.

Risk of significant harm

It is the imminent or foreseeable risk of death, significant or permanent injury, or illness which would be serious enough to require hospitalization.

What to do.

- DAIL staff and all service providers shall support a person's right to self-determination, and assist that person making decisions using informed consent.

- Case managers and service providers shall support a person's informed choice regarding life, liberty, and the pursuit of health and happiness, unless the person's actions or decisions put other persons at risk of significant harm.

- The person has the right to receive services as long as they have given informed consent choosing to assume the acceptable risk associated with decisions that he/she makes.

- If a provider, or other concerned party believes that a person is making decisions that put themselves or others at risk of significant harm, the provider shall confer with the person's case manager (if applicable).

- If the case manager believes that the person has the capacity to understand the options available and the consequences of his/her decisions, and that others are not at risk, the case manager shall share this information with the provider or concerned party. The concerns of others, along with the case manager's responses, shall be documented in the person's case management record.

- If the case manager questions a person's ability to understand the consequences of their decisions or choices, and their ability to give informed consent, the case manager must assess the person's mental status or arrange for the timely assessment of the person's mental status by a qualified medical professional or mental health professional.

Substantially impaired

- When an assessment of the person's mental status suggests that the person's capacity to understand the consequences of his/her decisions or choices is substantially impaired, and, as a result, the person or others are at risk of significant harm, the case manager must assure the protection of the health and welfare of the person. Action steps may include the following:

    - review of the person's status and situation with their Medicaid Waiver team;
    - modification of support and/or service plans;
    - initiating proceedings to secure guardianship.

Not substantially impaired

When an assessment of the person's mental status suggests the person's capacity to understand the consequences of his/her decision or choices is **NOT** substantially impaired, but the person is still placing themselves at significant risk of harm, the case manager shall review that person's status and situation with the Medicaid Waiver team and service providers. The Medicaid Waiver team will review other services or actions which may reduce or eliminate the risk of harm, and present these to the person.

When to use a negotiated risk agreement

If a person refuses services, supports or proposed actions intended to reduce or eliminate the risk of significant harm, the case manager and/or provider(s) shall attempt to create a negotiated risk agreement with that person. A negotiated risk agreement can only be utilized with people who have the capacity to understand the consequences of their decisions. Written negotiated risk agreements include:

- a description of the person's needs, including a description of those needs which cannot be met;

- a description of the services which can be provided;

- a description of the potential risks to the person and/or others;

- a statement that other service options have been explained to the person or their legal guardian, and that they understand and accept the risks associated with the current service plan; and

- the signatures of the person or their legal guardian, case manager, and other relevant parties.

When a negotiated risk agreement is created, a copy of the agreement shall be given to the person or their legal guardian, their case manager and applicable service providers. A copy of the agreement shall be placed in the person's case management record.

Others at risk of harm

If assessment reveals that a person is able to understand the consequences of their decisions, but is putting other people at risk of significant harm, the case manager and the Medicaid Waiver team can consider involuntary termination of services. Providers shall follow their internal protocols and DDAS requirements for the specific program. When appropriate, referrals shall be made to other professionals, such as, but not limited to, local police, Adult Protective Services, mental health services, etc.

When disagreement exists among the case manager, providers and/or members of the Medicaid Waiver Team regarding risk, the case manager shall request technical assistance from the Department of Disability and Aging Services (DDAS).

Guardianship

If any adult believes that another person is unable to understand the consequences of their decisions, or provide informed consent due to a mental or cognitive impairment, they may petition for guardianship of that person through a local probate court at any time.

Abuse, neglect or exploitation

Pursuant to Vermont statute 33 V.S.A. § 6903, all Long-Term Care service providers are mandated reporters. If at any time, the case manager or provider(s) suspects the individual's health and welfare is a risk due to the action of another person (legal guardian, family, friends, provider, etc.), the case manager or provider(s) must report to the Department of Disabilities, Aging and Independent Living, Division of Adult Protective Services at 1-800-564-1612.

AGING

People do not age at the same rate – rates of physiological, chronological, psychological and social aging vary within each person and from person to person.

Physical Changes Associated with Aging

- Muscular-skeletal Systems Changes:
  - The body becomes less muscular and body fat increases.
  - Bones and joints deteriorate, often causing stiffness and pain.

- Nervous System Changes:
  - 7% of brain weight is lost by age 80.
  - Senility is not part of the normal aging process.
  - By age 50, 1/3 of adults begin to have some short-term memory loss.
  - Over 100 reversible conditions mimic Alzheimer's Disease or related disorders – examples: medication side-effects, stroke, and alcoholism.

- Sensory Changes:
  - All 5 senses change with aging.
  - Taste, smell, hearing and seeing often decline.

- Digestive System Changes
  - There are reduced gastric secretions.

- Cardiovascular System
  - Energy levels and strength of heart muscles may decline in old age.

- Respiratory System
  - Lung capacity decreases with aging.

- Other Changes:
  - Immunity reduced.
  - Kidney function reduced.
  - Slower movement and reaction time.
  - Slower recovery from illness, stress or injury.
  - Slight decline in recalling recent events.

Emotional/Behavioral Changes Associated with Aging:

It is important to have an understanding of aging. It is more important to ask each aging adult you meet what the experience is like for THEM.

- Personality and Aging:
  - A person's ability to change and adapt has little to do with age, and more to do with lifelong character.
  - Basic personality stays the same but may become more intense as we age.
  - Greater longevity and adaptability corresponds with staying active, having an interest in life, coping positively with loss and being optimistic.
  - Intimate relationships are important to many older people.

- In Mary Pipher's book, Another Country, she refers to old age as "another country." She states that conflicts between young and old are caused by different ways of interpreting the world based on their own experiences, which have shaped a worldview. "The generations have very different mental landscapes and that is what interferes with communication and compassion."

Setting Limits and Boundaries

Maintaining a sense of professional distance when supporting people

- When you are involved in difficult situation with a person, define boundaries with that person and yourself. Give the person a specific time and day that you are willing to set aside specifically for them. This will give them a sense of continuity and will allow you to respond in a more focused manner.

- Doing for rather than supporting others may create dependency. Attempt to empower people while providing them support. This will help maintain an understanding of who is responsible for what, while also giving you the opportunity to step back and see things from a more objective perspective.

- Set limits. Limit setting will allow you to be more effective and give a person a clear message about what you can and cannot do for them. Setting limits protects you from unnecessary intrusions. If a person calls you at home, you should politely indicate that you do not normally work from home and that you will call the person back during regular working hours.

- Infantilizing people you support can only bring about negative results. It is important to realize that many of the people receiving services and supports have lived very long lives without being treated as children. When you find that you are telling someone to do something rather than listening to him or her, pull back and rethink your strategy. A person's unwillingness to do what you think they should do only creates a tug and pull scenario.

- Be real. Be honest. The greatest gift we have to give to another person is honesty. It does not have to be presented in a harsh manner, but it does have to be real. It lets the person know realistically what can be done to support them.

- Don't promise anything you are not sure you can deliver. That can put unrealistic expectations on you, and the person you are supporting will be disappointed if that promise is not kept.

- Present information regarding your objective assessment to the person. Try not to interject your personal opinion.

- Listen. Even the most demented or mentally confused person is able to find a window of lucidity. There is often a great deal of truth said despite our belief that someone may not know what is in his or her best interest. They may, and we must just take the time to listen.

- Rushing through a visit gives the person the message that you don't really care to be there. You may be busy, but your stress will lessen if you focus on the visit; everything else will be there tomorrow.

- Sometimes when you ignore a problem, it will fix itself. Often it will become more cumbersome later. (Which would you rather deal with?)

- Try not to judge. Only judge others if you wish to be judged yourself.

Time Management

- Set aside time every single day to plan your day (in writing.)
- Plan also for the weekends, vacations, etc.
- Make “to do” lists.
- Learn to distinguish between what is “important” and what is “urgent.”
- Learn the art of prioritizing.
- Break a project down to manageable pieces.
- Reschedule uncompleted tasks immediately.
- Take necessary walk and stretch breaks – drink plenty of water, breathe deeply.
- Block out time every single day to return phone calls, e-mails, etc.
- Keep up to date with record keeping!!!! Do not let this pile up on your desk, and clutter your mind with the stresses of overdo paper work. The longer you put it off, the more stress you will feel.
- Ask for help and support as needed.
- Keep personal calls and matters to a minimum – don’t let this sap your energy.
- Allow ample time to get to meetings and home visits – being late can cause stress.
- Get away from your desk for a lunch break.
- Be assertive with fellow workers that interrupt your work needlessly.

Be sure and leave your job issues at work, so your time away from work will be enjoyable

How to avoid burn-out

Burn out is the end result of chronic stress and over-commitment.

- Recognize that you are overdoing it – If you neglect your hygiene, home upkeep or ignore or deny backaches/headaches/ stress symptoms, ask yourself if you are over-committed.

- Recognize changes in the personal patterns you use to manage your life.

- Spend at least 15 minutes every day alone – Take a walk, sit in a room with complete silence or soft music, and aim for objectivity in your life. Use pad of paper and pencil or tape recorder and ask yourself, "Where am I today? How did I get here?"

- Identify the long-term priorities and goals in your life.

- Ask yourself these questions: What's really important to me? How do I spend time off? Am I eating and sleeping well? Am I living a healthy life? Am I having fun? Am I spending time with friends and loved ones?

- Reserve time to talk, once a week, and face to face, with someone important to you - Talk about your life without any interruptions by cell phones, kids, etc. Tell each other what's bothering you at home and at work, make future plans for times together. You must trust this person and take the chance of being hurt or disappointed – but go ahead!

- Cultivate closeness with the people around you-
  Say what you really mean and think. Start with the "I" statement. Listen well to the other person.

Treasure your sense of humor – be able to laugh at yourself, as well as someone else's joke

Supervision

The purpose of receiving Supervision is to enhance skills, knowledge and attitude in order to achieve competency as an outcome in providing care. It aids professional growth and development, and improves client outcome.

Three aspects of supervision

- Administrative - communicating agency policy and ensuring accountability.

- Educational – acquisition of knowledge and skills and attitudes important to the helping profession – discussion and analysis of interactions with people receiving supports and services.

- Support – increasing job performance by decreasing job stress – addressing obstacles to good performance. While a good supervisor provides constructive criticism as well as support and encouragement; it is not the role of a supervisor to provide therapy for personal problems. If a case manager's personal issues are interfering with work, a supervisor may suggest an Employee Assistance Program (EAP), or another appropriate referral for counseling or therapy in the community.

Agency Policy

Each agency has its own policy on supervision. Be sure that you have a copy of this policy to refer to. Policies differ, but often address such issues as availability of supervisor, review of records, evaluation methods, and the training available.

Confidentiality

Confidentiality is assuring information will be kept secret, with access limited to appropriate persons. People receiving services should be informed of their right to confidentiality when information is initially gathered, and periodically afterwards. Permission for Release of Information forms should be signed, up-to-date and stored in the individual's record.

- An example of a breach of confidentiality is sharing information about a person with their neighbor.

- It is not a breach of confidentiality to share information with an Adult Protective Service worker who is in the midst of an active investigation regarding that person.

It is the responsibility of the Case Manager to safeguard all information in their possession.

Ways to safeguard information may vary agency to agency, but here are some ideas:

- Keep files that contain anyone's personal information locked when not using them.

- Do not publicly discuss the names of people you supply support to.

- Necessary consultations should take place in private settings.

- Volunteers, other staff members, people on your Board of Directors, consultants and any other individuals or organizations you work with to provide services should understand your organization's confidentiality practices and policies.

- Advise people receiving services of the need to keep written and computer records, how those records are protected, and how they may be used.

Choices for Care - CFC

Choices for Care (CFC) is a Medicaid-funded, long-term care program to pay for care and support for older Vermonters and people with physical disabilities. The program assists people with everyday activities at home, in an enhanced residential care setting, or in a nursing facility.

Choices for Care services are based on person-centered planning, and services should be delivered that ensure quality while protecting the health and welfare of people receiving services.

A program within CFC is Moderate Needs for people who need minimal support and services to remain living at home. This program offers limited case management, adult day services, and/or homemaker service.

CFC program information can be found on the DDAS Website (http://www.ddas.vermont.gov/) and in the Choices for Care 1115 Long Term Care Medicaid Waiver Regulations (http://dail.vt.gov/dail-statutes/statutes-ddas-cfc-documents/cfc-medicaid-waiver-regulations).

Eligibility

To be eligible for the CFC program a person must be a Vermont resident, aged 18 or older, who meets both clinical and financial eligibility criteria.

Services

Case Management

- Assist people accessing CFC-funded services and supports, and other services which are not funded by CFC, such as medical, social, and educational services. Provide detailed needs assessment, and assist people creating a comprehensive plan for their services, and provide ongoing assessment and monitoring.

Adult Day

- Community-based non-residential services designed to assist impaired or isolated adults to remain as active in their communities as possible, maximizing their level of health and independence and ensuring the optimal functioning. Includes a range of health and social services for participants and provide daytime respite to primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Personal Care

- Assist people in their home with activities of daily living (ADL) and instrumental activities of daily living (IADL) that are essential to the health and welfare of the individual.

Respite Care

- Provided to people who are unable to care for themselves, and are furnished on a short-term basis because of the absence or need for relief for those persons who normally provide unpaid care. Respite care, up to a maximum of 720 hours per year, includes personal care assistance, supervision and socialization. Respite can be provided by:

    - Home Health Agencies
    - Employees of Certified Consumer or Surrogate Directed Employers
    - Adult Day Providers
    - Medicaid Certified Nursing Facilities
    - Enhanced Residential Care Providers
    - Approved Hospital “Swing Bed” Providers

Companion

- Non-medical care, supervision and socialization provided to people on a short-term basis, who are unable to care for themselves and are socially isolated. Companion service, up to a maximum of 720 hours per year, includes limited personal care assistance, assistance with household tasks, supervision and socialization. Respite can be provided by:

    - Home Health Agencies
    - Employees of Certified Consumer or Surrogate Directed Employers
    - Vermont Senior Companion Program

Assistive Devices and Home Modifications

- An Assistive Device is an item which is used to increase, maintain, or improve functional capabilities.
- Home Modification is a physical adaptation to the home which is necessary to allow safe access to and use of, the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home.
- Assistive Devices and Home Modifications must be approved by DDAS.

Personal Emergency Response System

- An electronic device that enables individuals at high risk of institutionalization to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Professionally trained PERS staff assesses the nature of the emergency and obtain appropriate help for the individual as necessary.

Enhanced Residential Care

- A daily, bundled package of services provided to individuals residing in an approved Vermont Licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). ERC services are intended to provide "enhanced" services to individuals who require nursing home level of care.

- If a person is found eligible for the CFC program and chooses Enhanced Residential Care (ERC) an ERC provider is not required to admit the individual.

- Providers:
    - Licensed Level III Residential Care Homes
    - Licensed Assisted Living Residences (ALR)

- Services:
    - Nursing Overview
    - Personal Care Service
    - Medication Management
    - Daily Recreation Activities
    - 24-Hour On-Site Supervision
    - Laundry Services
    - Household Services
    - Case Management Services - provided to all individuals in the ERC setting as a separate CFC service.

Nursing Facility

- A daily, bundled package of services provided to individuals residing in an approved Vermont Licensed Nursing Facility.

Live-in Care

- Unlicensed living arrangement where the person receiving care lives in the home of an unrelated caregiver. In this arrangement, room, board, and care are provided to no more than two people who are unrelated to the caregiver. Though this living arrangement is not a formal CFC service, individuals may utilize home-based services in this arrangement.

Program for all-inclusive Care for the Elderly (PACE)

- An interdisciplinary team, consisting of professional and paraprofessional staff, assesses a person's needs, develops care plans, and delivers all services which are integrated for a seamless provision of total care.

Flexible Choices

- An option which converts a person's home-based service plan into a cash allowance. Working with a consultant, the individual develops a budget. The budget details what goods and services will be used to meet that person's needs.

HOUSING

Case managers help people pursue and choose housing which meets each person's desires and needs. If a change necessitates either a person's need or desire to move, case managers should plan early for that change

Housing options available to aging or younger disabled people include:

- Independent housing - no built-in in-home services.

- Reverse Mortgage - people tap into the equity in their home to pay for in-home services.

- Subsidized Senior Housing Project (http://www.vsha.org/ra.htm) Also known as Section 8 housing. Rent is a percentage of income. Section 8 Vouchers can also be used to obtain housing in a rental that is not designated as a senior housing building.

- HomeShare Vermont (http://www.homesharevermont.org/) A person shares their home with an unrelated person who provides assistance in exchange for housing.

- Congregate shared housing - several unrelated persons share a residence operated by a management company. Services such as meals, activities, housekeeping, or laundry may be included.

- Adult Family Care - a family provides support and care to one or two unrelated persons in the family home.

- Residential Care Home – a home where grooming, medication, other personal needs, and/or general supervision of physical and mental well-being are provided.

- Assisted Living Residence - Mandatory scope of care including housing, health and supportive services for the support of the resident's independence and aging in place.

- Skilled Nursing Facility – shared rooms in a facility for persons who need frequent skilled nursing services for chronic conditions. A private room may be possible at additional cost to the individual.

- Continuing Care Retirement Communities - housing offering a range of health care, social and other services. The community allows residents to age in place by providing levels of service from independent living to assisted living and finally nursing home level of care. Substantial entry fees and monthly fees may be expected.

Assistive Community Care Services

o Assistive Community Care Services (ACCS) is a Medicaid State Plan option for SSI and Medicaid eligible Vermonters who reside in participating Residential Care Homes or Assisted Living Residences.

o ACCS services are paid for by Community Medicaid. Services are provided by Level III Residential Care Homes and/or Assisted Living Residences that are enrolled in the ACCS program.

o Staff members are supervised by a State-Certified Manager and a Licensed Registered Nurse.

o ACCS Services include: case management, personal care services, nursing assessment and routine tasks, medication assistance, on-site assistive therapy, and restorative nursing.

o To be eligible an person must:

- Be a Vermont resident age 65 or older, or be 18 or older and have a disability;
- Need ACCS services;
- Live in a participating Residential Care Home or Assisted Living Residence; and,
- Meet the income and resource criteria for VT Medicaid ACCS program.

For more information:
Agency on Aging Senior HelpLine
1-800-642-5119

Attendant Services Program - ASP

The Attendant Services Program supports independent living for adults with disabilities, who need physical assistance with daily living activities. This is a "Consumer Directed Personal Care" program. Program participants hire, train, supervise and schedule their personal care attendant(s). The participant is the employer, and the attendant's hourly wage is funded by the ASP program.

Services Include:

- Assistance with daily living activities such as dressing, bathing, grooming, toileting, transferring, mobility, range of motion exercises, positioning and eating.

- Assistance with instrumental activities such as meal preparation, medication management, care of adaptive and health equipment, management of finances and mail, shopping and cleaning.

Eligibility:

- Be a Vermont Resident,
- be at least 18 years old, and
- have a disability and need physical assistance with instrumental and daily living activities in order to live in their homes:

    - General Fund Personal Services: Have a disability. Need physical assistance with at least one activity of daily living or meal preparation. Have Medicaid.

    - General Fund Participant Directed Attendant Care (PDAC): Have a permanent and severe disability. Need physical assistance with at least two activities of daily living, and be able to direct own personal care services.

    - Medicaid Participant Directed Attendant Care (PDAC): Have a permanent and severe disability. Need physical assistance with at least two activities of daily living, and be able to direct own personal care services. Be willing to hire an attendant other than a spouse or civil union partner; and have Medicaid.

Adult Day Services

Adult Day Services provide a variety of services which help aging adults and adults with disabilities remain as independent as possible, and living in their own homes. Adult Day Services are also designed to allow participants to remain as active in their communities as they wish. The primary goals of Adult Day services are to maximize each participant's level of health, independence and optimal functioning.

Adult Day services are provided in community-based, non-residential centers. Adult day centers provide a safe supportive environment. Participants can receive a range of professional health, social and therapeutic services. Adult day services also provide respite, support and education to family members, caregivers and legal representatives.

Services Include:

- Professional Nursing
- Respite
- Personal Care
- Therapeutic Activities
- Nutritious Meals
- Social Opportunities
- Activities to Foster Independence
- Support and Education to Families and Caregivers

Eligibility:

- Aging Vermonters
- People age 18 and over with disabilities

Adult Day Services are paid for using the following funding/programs:

- Choices for Care (CFC)
- Community Rehabilitation & Treatment (1115 Waiver)
- Day Health Rehabilitation Services (DHRS)
- Dementia Respite Grant
- Developmental Services Waiver
- Private Pay
- Veteran's Administration
- DAIL requires certified ADS programs that receive state funding (General Funds) to offer a sliding fee scale for participants.

Nursing Home Level of Care

Nursing Home Level of Care refers to an individual meeting the clinical criteria for eligibility to receive long-term care services in a nursing facility. Under the Choices For Care (CFC) program an individual who meets Highest or High Needs may choose one of three locations in which to received approved long-term care services:

- At Home
- Enhanced Residential Care Facility
- Nursing Facility Setting

To determine nursing home level of care, (or clinical eligibility for Highest/High Needs under CFC) the following areas are assessed:

- Care and services needed
- Current conditions and treatments
- Psychosocial factors

For additional information refer to the Choices for Care Clinical Eligibility Worksheet

Dementia and Alzheimer's Disease

Scientists know that most people remain both alert and able as they age, although it may take them longer to remember things.

Dementia:

- People who have a serious change in their memory, personality, and behavior.

- The symptoms of dementia are caused by changes in the brain.

- Symptoms may include:

    - Becoming lost in familiar places;
    - inability to follow directions,
    - disorientation about time, people, places;
    - Neglecting personal safety, hygiene, and nutrition.

Some conditions that cause dementia can be reversed and treated.

The two most common forms of dementia are Alzheimer's Disease and multi-infarct dementia. These are irreversible and cannot be cured.

- The severity of symptoms varies according to whether a person with Alzheimer's is in its early stage, middle stage or later stage. An example of a symptom that best indicates early stage Alzheimer's is recent memory loss that affects job skills. Alzheimer's may cause some people to need total care at its end stage.

- Diagnose:

    - People who worry about memory problems should see their doctor.

    - The doctor may order a physical, neurological and/or psychiatric evaluation.

- A complete physical examination is very important if Alzheimer's is suspected for the following reasons:
    - To rule out other treatable of reversible causes of dementia.
    - To rule out adverse drug reactions.
    - To encourage early treatment if there is a probable diagnosis of Alzheimer's.

- Treatment:
    - In the early stages of Alzheimer's, prescription drugs designed to delay the worsening of the diseases are sometimes used.
    - Medications to reduce behavioral problems may be used.
    - A healthy diet is encouraged.
    - Assistance with daily routines, activities, and social contacts.
    - Adult Day Services may be a valuable resource.

- For more information:
    - Fletcher Allen Health Care Memory Center of Vermont: 1-802-847-1111
    - Dartmouth-Hitchcock Psychiatric Associates – Geriatric Services at 1-800-556-6249
    - "Guidelines for Initiating Meaningful, Quality Home Visits With People Who Have Alzheimer's Disease and Related Dementia" can be found on the website for the Wisconsin Department of Health and Family Services. (http://dhfs.wisconsin.gov/aging/Genage/ALZFCGSP.HTM)

Alcohol and Prescription Drug Abuse

Case Manager needs to be able to identify behaviors symptomatic of chemical misuse or abuse, and to know where help is available.

The following indicators may be symptomatic of a substance abuse problem: (by John Penzer)

- Aberrant behavior.
- Unexplained money issue.
- Medical/dental problems.
- Mood swings/depression.
- Family/job/legal issues.
- Persistent infections.
- Forgetfulness.
- Loss of energy/ sudden surges of energy.
- Complaints of nervousness.
- Sleep/eat disorders.
- Dilated pupils.
- Feelings of guilt/persecution/paranoia.
- Sudden major lifestyle changes.
- Request for frequent RX refills.

According to "Alcoholics Anonymous" (AA):

- Alcoholism is a disease.
- Recovery only begins when person admits they are powerless over alcohol and their life is unmanageable.
- AA Program is one of total abstinence, one day at a time.
- Sobriety is maintained through members sharing their experience, strength, and hope at meetings.

www.Alcoholics-anonymous.org

According to Substance Abuse and Mental Health Services Administration (www.samhsa.gov):

- Alcohol abuse and misuse is the major substance abuse problem among older adults. In the United States it is estimated that 2.5 million older adults have problems related to alcohol.

- Health professionals tend to miss the diagnosis of alcoholism more often in Geriatric populations than in younger ones.

- Older people have the highest rate of success and the greatest sobriety after treatment when they receive appropriate, professional intervention and treatment.

- Adults over the age of 65 are more likely to be affected by at least one chronic illness, many of which can make them more vulnerable to the negative effects of alcohol consumption.

- Three age-related changes significantly affect the way an older person responds to alcohol: decrease in body water, increased sensitivity and decreased tolerance to alcohol, and decrease in the metabolism of alcohol in the gastrointestinal tract.

- Memory impairment associated with alcohol use may not be permanent. Chronic alcoholism, however, can cause serious, irreversible changes in brain functioning. Alcohol use may have direct neurotoxic effects leading to a syndrome called alcohol-related dementia (ARD) or may be associated with the development of other dementing illnesses such as Alzheimer's disease or Wernicke-Korsakoff syndrome.

- Elders receive over 30% of prescriptions and account for over 50% of the hospitalizations resulting from drug reactions.

- 17% of elders experience problems with abuse of alcohol or misuse prescription drugs.

- Mixing alcohol and prescription or over-the- counter medications may cause adverse drug reactions.

Intervention may include:

- Identifying problem.
- Address issue – be direct and show concern.
- Refer to an Elder Care Clinician for further assessment and/or treatment.

- Maintain list of resources in your area. (Alcohol & Drug Abuse Prevention Consultants through the Office of Alcohol & Drug Abuse Programs, Vermont Department of Health can be a valuable resource.
- http://healthvermont.gov/adap/prevention/staff.aspx
- Some types of therapy include inpatient or outpatient.
- Use of medications.
- Hospitalization stay or rehab.
- Work with therapists or psychiatrists.
- 12 step support groups such as AA.

Chemical dependence is a chronic, progressive, incurable, life-threatening disease but it is highly treatable. By intervening, you can help your client make a life-saving decision.

Mental Health

Depression

Depression is not a normal part of aging – it is one of the most treatable of all medical conditions.

Facts about depression in older adults

- Later-life depression affects more women than men.
- Clinical depression can be treated successfully in more than 80% of all cases.
- Depression often goes undetected because patients do not report their symptoms, and when they do, they are often misinterpreted as symptoms of a medical illness.
- Clinical depression can be triggered by other chronic illnesses such as diabetes, stroke, heart disease, cancer, chronic lung disease, Alzheimer' Disease, arthritis and Parkinson's Disease.
- Reoccurrence is a serious problem – up to 40 % of people continue to experience depression over time.
- The majority of older people in America know little or nothing about depression.
- Only a third of older Americans believe that depression is a "health" problem.
- Less than half of older adults seek help from a health professional.
- A family history of depression increases risk.
- Changes in "neurotransmitters" or brain chemicals can contribute to depression.
- Some medications can cause depression.

Symptoms of clinical depression

- Feeling sad or irritable throughout the day.
- Loss of interest or pleasure in activities once enjoyed.
- Changes in weight or appetite.
- Changes in normal sleep patterns.
- Fatigue or loss of energy.
- Feeling worthless, hopeless or unreasonably guilty.
- Inability to concentrate, remember things, or make decisions.
- Restlessness or decreased activity.
- Complaints of physical aches and pains for which no medical causes found.
- Recurrent thoughts of suicide or death (not just fear of dying).

Treatment for clinical depression

- Diagnose by medical professional.
- Medications (must be taken daily for two to four weeks before fully effective).
- Psychotherapy.
- Combination of medications and psychotherapy.
- Exercise.
- ECT, electroconvulsive therapy, is now considered a safe and effective treatment.
- Support groups.

Eldercare Clinicians

All AAA's have Eldercare Clinicians available to help. Contact your local AAA, or speak to your supervisor, to access this program.

Suicide

People 75-84 years old have the highest suicide rate of any age in America, with men accounting for 80% of all suicides

Some facts about suicide:

- Women are more likely to make suicide attempts, but men are much more likely to be successful at killing themselves as they choose more lethal methods.
- Suicide is the 8th leading cause of death in America.
- Major risk factors are mental disorders and substance abuse.
- Most suicides are committed by using firearms.
- There is a high suicide rate in jails.
- 70 % of seniors that kill themselves see their MD within the preceding month.
- Depression is the highest risk factor for suicide.
- Most general physicians have little if any training in evaluating suicide risk among elderly.
- Proper detection than treatment of depression in elders is uncommon.

Some warning signs of suicide:

- Talk about death and suicide and no reason to live.
- Preoccupied with death and dying.
- Withdrawal from friends and social activities.
- Have a recent severe loss.
- History of violence or hostility.

- Have a sense of hopelessness.
- Give away prized possessions.
- Prepare for death (Do living will).
- Take unnecessary risks and/or be impulsive.
- Lose interest in personal appearance.
- Have attempted suicide before.

Some ways to help a person that is suicidal:

- Contact their family physician, a private therapist, or psychologist.
- Have them talk to religious or spiritual leader.
- Contact suicide prevention crisis intervention center.
- Remove dangerous objects from home (guns, knives, etc).
- Offer empathy not sympathy, offer hope there are alternatives.
- Ask person about this, and be direct, don't act shocked.
- Be willing to listen and allow for expressions of feelings.
- Don't ask "why?" – this encourages defensiveness.
- Don't be sworn to secrecy – seek support on this.

Delirium

Delirium is usually characterized by the acute onset of impaired cognitive functioning resulting from diffuse brain dysfunction. The course is usually fluctuating and brief. Delirium is most often a reversible condition when the underlying cause is diagnosed and treated in a timely manner. Due to the seriousness of many of the causes of delirium, about 10 to 30 percent of delirious patients progress to coma and death.

Older adults may be at risk of delirium due to adverse drug reactions.

Symptoms may include:

- Reduced ability to maintain attention. For example, questions must be repeated because attention wanders.
- Disorganized thinking as indicated by rambling, irrelevant or incoherent speech.
- Reduced level of consciousness --- i.e. difficulty keeping awake.
- Perceptual disturbances --- i.e. misinterpretations, illusions or hallucinations.
- Disturbance of sleep-wake cycle with insomnia or daytime sleepiness.
- Increased or decreased psychomotor activity.
- Disorientation to time or place, (usually not to person, but it can occur in severe delirium)
- Memory impairment --- i.e. inability to learn new material, such as the names of several unrelated objects after 5 minutes or to remember past events, such as history of current episode of illness.

Common Causes of delirium include but are not limited to:

- Adverse drug reactions.
- Urinary tract infections.
- Electrolyte imbalance.
- Brain trauma.
- Postoperative states.
- Cardiac failure.
- Thyroid dysfunction.

The Elder Care Clinician Program

For Information
Call the SENIOR HELPLINE
1-800-642-5119

The Center for Substance Abuse & Mental Health Services (SAMHSA) indicates that good mental health is ageless. A healthy mind is as important as a healthy body. Good mental health can help us to: enjoy life more, handle difficult situations, stay better connected with family, friends and community and keep our bodies strong. Being in good mental health doesn't mean that we will never feel sad, lonely or 'down'. But when these feelings disrupt our life or go on for too long, there may be a bigger problem. Unusual feelings of sadness or depression can happen when: we have to move from our home, people we love get sick or die, we have to depend on others to get around, or even to do the simple things we used to do ourselves or physical health problems seem overwhelming.

The Vermont Elder Care Clinician Program is a service provided to help older adults who experience mental health concerns such as depression, anxiety and substance abuse. Any individual aged 60 and over experiencing a mental health concern, which interferes with their daily life can be served. Services may include assessment, screening, supportive counseling, medication and related mental health treatment. Elder Care Clinician Program staff includes social workers, psychologists, qualified mental health professionals and mental health outreach workers. Psychiatrists are part of the treatment team, for consultation, prescribing and monitoring medications. An Elder Care Clinician can meet with individuals in their home or in an office setting if it is preferred. The number of times a person meets with an Elder Care Clinician depends upon individual needs. The Elder Care Clinician will work with an individual to develop a treatment plan.

It is important to remember that counseling and support can be a benefit whether we are 16 or 60! Throughout life we will experience transitions, joys, challenges and stressors that may cause problems that can be successfully treated at any age. Change is always possible.

For further information on the Elder Care Clinician Program call the Senior HelpLine at 1-800-642-5119.

Food Stamps

Food Stamps are a benefit used to shop for food. A Vermont Express Electronic Benefit (EBT) card is used to spend food stamps. The EBT card is accepted at most stores that sell food. Food stamp benefits are used with the money normally spend for food, to enable an individual to buy more food and food with better nutrition.

Individuals who are 65 or older, or have a disability, are able to get food stamp benefits deposited directly into their bank account. Individuals who do not have a bank account can use food stamp benefits on a Vermont Express card like cash.

Food stamps can be used to buy almost any food item, plus vegetable seeds and plant sets.

Food stamps cannot be used to buy hot deli foods, wine, beer, cigarettes, pet food, soap, paper products or household supplies.

Anyone may be eligible for food stamps. You don't have to be a renter, homeowner or have a place to cook to get food stamps.

When applying for food stamps the applicant is required to pass a resource test. Resources are what you or anyone in your household has or owns. The resources considered are cash on hand, checking or savings accounts, saving bonds, and stocks and bonds. It also considers campers, snowmobiles, and part of the value of cars, trucks and motorcycles. Not considered are the house and land an individual(s) lives on, personal belongings, life insurance policies and prepaid burials accounts. Refer to your Case Management Core Training materials for detailed information about allowable resources.

When a food stamp applicant is awarded food stamps, it does not count as income when applying for other benefits.

Please refer to vermontfoodhelp.com for further information.

Supplemental Security Income (SSI) and Social Security Disability Income (SSDI)

Supplemental Security Income (SSI)

Supplemental Security Income (SSI), is a federal program that provides monthly cash payments to individuals who have low incomes nor own many things. SSI is for elderly people and blind or disabled people of any age, including children. It is administered through the Social Security Administration.

To get SSI you must:

- Be 65 or older.
- Be totally or partially blind.
- Have a medical condition that keeps you from working, and is expected to last at least one year or result in death.
- Cash, bank accounts, stocks and bonds are counted as resources. Your home, and usually the car you own and use are not counted as resources. Refer to your Case Management Core Training materials for detailed information about allowable resources.
- To be eligible for SSI, an individual must also apply for any other cash benefits for which they may be eligible.
- Individuals who are eligible for SSI are usually also automatically eligible for food stamps and Medicaid.
- Even if an individual never paid into Social Security, they can receive SSI if they meet the eligibility and resource requirements.

Social Security Disability Income (SSDI)

Social Security pays benefits to individuals who cannot work because they have a medical condition that is expected to last at least one year or result in death. Federal law requires this very strict definition of disability. While some programs give money to people with partial disability or short-term disability, Social Security does not.

To be eligible for disability benefits, you must meet two different earnings tests:

- A "recent work" test based on your age at the time you became disabled; and
- A "duration of work" test to show that you worked long enough under Social Security.
- Certain blind workers have to meet only the "duration of work" test.

Disability benefits should be applied for as soon as an individual becomes disabled. It often takes three to five months to process an application for disability benefits.

To apply for disability benefits, an individual needs to complete an application for Social Security Benefits and the Disability Report.

Medicare coverage automatically begins after an individual has received disability benefits for two years.

Additional information on the application process can be found at Http://www.ssa.gov/pubs/10029.html.
Knowledge of this additional information is not required for the Case Management Certification Exam.

Community Resources

Area Agencies on Aging

Area Agencies on Aging, (AAA's) are private, non-profit organizations whose purpose is supporting elders sixty and older to remain active, healthy and to live independently for as long as they wish. Staff and volunteers connect elders, family and caregivers with a wide range of services, programs, and benefits. AAA's provide case management services for disabled adults over 18, and individuals 60 and older, who receive long-term care services from the Choices for Care program. Case management services are also provided for adults 60 and older through Older Americans Act (OAA) programs.

Case Management services are designed to promote the independence and empowerment of older adults and people with disabilities. Case managers visit individuals in their homes and provide a comprehensive assessment which identifies the individual's needs. The assessment addresses physical, psychological and social needs. AAA's have access to extensive information about long term care services in Vermont. Case management may consist of just a brief visit or two, or can be longer term. Case managers advocate on behalf of the individual for services or resources. They also link consumers with a variety of programs, which include; Community Medicaid, Fuel, Food Stamp Program, prescription coverage, assistance with transportation, etc.

Local AAA's coordinate a number of senior community mealsites around the state. These meals are available to anyone age 60 or older and their spouse of any age. Donations are encouraged to help cover the cost of the meal. Senior Mealsites not only satisfy nutritional needs, but provide opportunities for social interaction and access to referral information and other services. Home Delivered Meals, commonly referred to as Meals on Wheels are delivered directly to the consumer's home. There is no specific charge but donations are encouraged.

The AAA's maintain a toll-free Senior Helpline which provides telephone information and referrals for people age sixty or older, their family members and caregivers. It operates weekdays during normal business hours. AAA's can answer questions about almost any service or benefit for older adults in Vermont. Topics and questions are frequently related to Advocacy, Home Care, Nursing Homes, Senior Centers, Transportation, Medicaid, Medicare, Adult Day Programs, Legal Assistance, Senior Housing and many other issues.

There are five AAA's in Vermont:

- Area Agency on Aging for Northeastern Vermont
- Central Vermont Council on Aging
- Champlain Valley Agency on Aging
- Council on Aging for Southeastern Vermont
- Southwestern Vermont Council on Aging

Community Action Programs

Community Action Agencies are nonprofit private and public organizations that were established under the Economic Opportunity Act of 1964 to fight America's War on Poverty. They help people, (regardless of age) to help themselves in achieving self-sufficiency. A wide range of services are provided: housing assistance, emergency fuel and utility assistance, emergency food shelves, (Addison, Grand Isle and Franklin Counties), transportation assistance, food stamp outreach, food and nutrition education, garden programs, furniture vouchers, farm to family coupons, tax preparation assistance, assistance in filling out various application forms, information/referral services, case management, advocacy, and other locally based services.

The Community Action Programs work closely with other local service providers, state agencies, faith-based charities, and the private sector, to maximize available resources available to help move low-income people out of poverty and into economic self-sufficiency.

There are five Community Action Agencies in Vermont:

- Bennington-Rutland Opportunity Council, Inc (BROC)
- Central Vermont Community Action Council, Inc. (CVCAC)
- Champlain Valley Office of Economic Opportunity, Inc. (CVOEO)
- Northeast Kingdom Community Action, Inc. (NEKCA)
- Southeastern Vermont Community Action, Inc. (SEVCA)

Home Health Programs & Services in Vermont

Vermont's home health and home care agencies, both non-profit and private, provide a wide range of services to individuals of all ages. Services include assistance with in-home medically-necessary health care, as well as assistance with long term care needs. They provide nursing services, case management, and paraprofessional assistance with personal care and activities of daily living. Services are paid for in a variety of ways including; health or long term care insurance, state grants, Medicare and Medicaid, and privately paid fee-for-service.

In addition to the primary programs agencies offer, many have a variety of specialized programs which may include; private pay long term care and care management services, maternal child health programs, high-tech nursing, Hospice and Palliative Care, Health Promotion, etc. The primary services most agencies offer are:

- Home Care - services considered medically-necessary and require referral from a physician. Services include:

    - Skilled nursing.
    - Medication administration.
    - Medically-necessary personal care.
    - Medical social work.
    - Rehabilitation – physical, speech and occupational therapy.

- Homemaker - The Vermont Homemaker Program provides services to older citizens and disabled adults to help them maintain their independence. The services provided help people live at home in a healthy and safe environment. Services include assistance with:

    - Personal Needs.
    - Household Chores.
    - Shopping.
    - Cleaning.
    - Laundry.

- Medicaid Choices for Care Program - Choices for Care is a Medicaid-funded, long-term care program to pay for care and support for older Vermonters and people with physical disabilities. The program assists people with everyday activities at home, in an enhanced residential care setting, or in a nursing facility. Services include:

    - Assistance with personal care.
    - Assistance with activities of daily living.
    - Participant-Centered Care Planning.
    - Case Management.
    - Respite Care.

- Medicaid Traumatic Brain Injury Waiver - The Traumatic Brain Injury Program diverts and/or returns Vermonters, with a moderate to severe traumatic brain injury, from hospitals and facilities to a community-based setting. This is a rehabilitation-based, choice-driven program intended to support individuals to achieve their optimum independence and help them return to work. Services include:

    - Life Skills Aides.
    - Community re-entry.
    - Respite Services

Vermont's Weatherization Program

- The mission is to reduce the energy costs for low-income families, particularly for elderly persons, people with disabilities, and children by improving the energy efficiency and comfort of their homes while ensuring their health and safety.

- The program was started in 1976 in response to the nation's energy crisis. Initially, funding was provided for solely by the U.S. Department for Energy (USDOE). This changed in 1990 when the State of Vermont Legislature established the Vermont Weatherization Trust Fund (WTF). The WTF provides state funding for weatherization.

- Weatherization Services available to income-eligible people include:
    - Comprehensive "whole house" assessment of energy related problems.
    - State-of-the-art building diagnostics including: blower door, carbon monoxide, and heating system testing and infrared scans.
    - "Full-service" energy-efficient retrofits including dense-pack sidewall insulation, air sealing, attic insulation, heating system upgrades and replacements.
    - Weatherization assistance is available to both home owners and renters.

Grief, Bereavement and Hospice

Grief is a reaction to any loss, and can affect one emotionally, spiritually, behaviorally, physically, and cognitively. Each person will have their own way of grieving a loss. Some common characteristics of grief, depending upon the severity of loss are:

- A seeming state of shock or numbness, inability to grasp what has occurred which can last up to two or more weeks.
- Expressions of intense emotional and bodily distress, lasting 20 to 60 minutes.
- Tightness of throat, choking feeling with shortness of breath, empty feeling in abdomen, a need to sigh, lack of muscle power, intense mental pain.
- Crying, sobbing, restlessness.
- Loss of appetite and sexual drive, sleep disturbances and feelings of exhaustion.
- Feelings of depression, sadness, and an inability to concentrate.
- Preoccupation with thoughts of the deceased; these are caused by psychological cues that decrease in time.

Healing comes slowly through the process of grieving. It may be helpful to think of grieving as a process we spiral through, rather than a linear movement from shock to acceptance and recovery.

Most research indicates it takes at least one year to move through the grief process because it takes a year to completely move through the anniversary dates, where acute grief may resurface. Depending on how significant a loss is and the nature of the loss, (sudden, expected, violent death etc.) it may take significantly longer. We do not forget people we love who have died. Instead, we learn to live through the loss and honor the memory of our loved ones.

While a person who is grieving may experience periods of depression; clinical depression and grieving are not the same and need different treatment approaches.

Hospice

A specially coordinated home-based program that helps individuals of all ages with a terminal illness, along with their families, cope with death by living life to the fullest. An interdisciplinary team emphasizes care directed toward pain and symptom control, maximizing independence and socialization and providing support. Services include:

- Care for Terminally Ill.
- Respite Care.
- Volunteer Services.
- Bereavement Services.
- Team Approach to Services - Medical Director, Nurse, Social Worker, Licensed Nursing Assistant, Clergy, Volunteers and Volunteer Coordinator.
- Palliative Care Program (Hospice-like services for those who are seriously ill but not yet eligible for hospice.)
- Skilled Nursing.
- Licensed Nursing Assistant Services.

Hospice services are also offered in nursing or other residential facilities, but most are “visiting” programs, delivering services in an individual’s home.

A central concept of hospice is hope which includes:

- Not being in pain.
- Receiving care and comfort that meets one’s daily needs.
- Living until one dies.
- Being treated with dignity and respect.
- Treatments to enhance the quality of life, (not find a cure) which includes, but are not limited to: oxygen, antibiotics, pain management, physical therapy, emotional and spiritual support and care.

To be admitted to hospice the following criteria must be met:

- Individual has a primary caregiver.
- Referral for hospice services by a physician.
- Individual agrees to participate in the plan of care.
- Expected life expectancy is limited and no active treatment is planned, beyond that which will enhance the quality of life.

Palliative Care

Palliative care is an approach that improves the quality of life for patients and their families facing life threatening illness, accomplished through prevention and relief of suffering.

Palliative care includes:

- Relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends to neither hasten nor postpone death.
- Integrates the psychological and spiritual aspects of care.
- Offers a supportive system to help individuals live as actively as possible until death.
- Helps family cope during individual's illness and in their own bereavement.
- Use of a team approach to address needs of individuals and their families.
- Enhances quality of life and may positively influence the course of the illness.

Hospice and palliative care focuses on caring, not curing.

Nutrition

The role of food and nutrition in human functioning is extensive and the subject is a complex matter. While it is not necessary to have the in-depth nutritional knowledge of a dietitian, it is helpful to have some basic facts about nutrition.

Some of the following factors may lead to a loss of appetite and malnutrition in older adults:

- Chronic illness.
- Depression.
- Medication.
- Decrease in the pleasure of eating.

The Independent Living Assessment (ILA) contains a section related to a person's nutrition. It is called "The NSI Determine Your Nutritional Health Checklist". The NSI checklist leads to a score that determines risk and warning signs that may indicate difficulty:

- The person has a medical condition that changes the way they eat.
- The impact their medication has on appetite.
- There may be dental problems that make eating difficult.
- There may be an issue with food affordability.
- There may be involuntary weight loss/gain.
- There may be inadequate fluid intake.
- May show that the elder is not consuming the minimum of what is necessary for health.

Finally, this section leads to an understanding of what care is necessary and what social connections the elder has.

An NSI score of 3-5 indicates that an individual is at moderate nutritional risk. It is recommended that a person see what they can do to improve their eating habits and lifestyle. Resources such as the Area Agency on Aging, senior nutrition program, senior citizens center, Health Department and/or physician's assistance are recommended. It is recommended that the nutritional score be rechecked in 3 months.

An NSI score of 6+ indicates that an individual is at high nutritional risk. It is recommended that the person talk with their doctor, dietician or other qualified health or social services professional about improving their nutritional health.

Completion of nutrition screening, along with conversation, opens doors for referrals to a registered dietitian or MD who can intervene.

The Administration on Aging supports The Elderly Nutrition Program that is intended to improve the diet of elders. This program provides congregate Meals and Home-Delivered Meals which are available free of charge regardless of income.

There are a number of other services including nutrition screening, assessment, education and nutrition counseling. Each of the five Area Agencies on Aging has a Nutrition Director who can provide consultation. Mary Woodruff can also be consulted at the Department of Disabilities, Aging & Independent Living. Her email address is Mary.Woodruff@ahs.state.vt.us.

The Food Pyramid helps one learn the different food groups and recommended number of servings to eat daily. Portion sizes affect weight and blood sugar control.

Dehydration Prevention

Dehydration takes place with the rapid loss of fluid from the body such as with fever, diarrhea, or vomiting. It can make you feel bad and can damage your health. Below are the signs and symptoms of dehydration. If you have these symptoms, drink some water and call your doctor so that you can get help.

- thirst
- dry tongue
- dry nose and/or mouth
- sunken eyes
- dry, flushed skin
- dark, amber-colored urine
- weakness
- speech difficulty
- confusion
- constipation
- rapid heart beat
- headache

The sense of thirst declines with age. You may not drink enough water and other fluids to meet your needs. Most people need 6-8 ounce glasses of fluid each day. That's a total of 48-64 ounces of fluid (up to 2 quarts or a 2 liter bottle). Water also comes from the foods we eat, especially fruits and vegetables.

The following are suggestions, besides drinking water, to increase fluid intake:

- Take medicines with a large glass of water or other liquids.
- Eat Popsicles, juice bars, or gelatin desserts (Jello).
- Eat soup before or with meals.
- Drink fruit or vegetable juice daily.
- Drink lemonade or flavored waters.
- Add juices, sauces or gravy to foods.

Constipation

Straining, trouble moving your bowels, feeling full or bloated, having gas or stomach pain, and moving your bowels less times than usual are all problems found with constipation.

Constipation may be caused by medication, not enough fluids, a change in diet, illness, lack of activity or new foods.

Try these hints:

- Drink 6 to 8 cups of fluids a day.
- Try to eat meals and snacks at the same time daily.
- Make time for bowel movements.
- Try not to rely on medications, (laxatives, stool softeners, enemas or mineral oil).
- Try to be more active (walking).
- Eat more fiber.

Food & Drugs – Mix With Care

Foods and nutrients can interfere with a drug's interaction. Just as drugs can interfere with the way your body uses nutrients, some foods can interfere with a drug's action and make it less effective or much stronger and potentially harmful.

Some drugs should be taken with meals, snacks, or large amounts of fluids because they can irritate the digestive tract. These drugs may include certain diuretics, some antibiotics, oral hypoglycemic agents for diabetes, iron and potassium supplements and arthritis medication.

Some drugs can lead to nutritional problems because they can interfere with the way the body uses certain nutrients.

Some foods and nutrients can cause severe side-effects when mixed with certain medications.

Aspirin and vitamin C mixed can irritate the stomach lining, monoamine oxidase (MAO) inhibitors should not be combined with some foods, and some protein supplements should not be consumed with some medications.

Mixing alcohol and another drug, can intensify the effect of the medication and may be very dangerous.

Medicaid and LTC Medicaid

Please refer to Core Module Training materials for a comprehensive overview of Community and Long-Term Care Medicaid.

Community Medicaid

- Medicaid is a government health insurance program for Vermonters.
- Medicaid was enacted in 1965 as part of the Social Security Act.
- The Center for Medicare and Medicaid Services (CMS) is the branch of federal government that governs Medicaid.
- The Department for Children and Families (DCF), Economic Services Division (ESD), determines eligibility for the Medicaid program in Vermont.

Eligibility

- People who receive Supplemental Security Income (SSI) benefits automatically receive Medicaid – they are eligible by virtue of the fact that they receive SSI.
- Medicaid also assists other people who meet applicable category, resource and income tests.
- Medicaid for the aged, blind, disabled (known as SSI Related Medicaid) and Medicaid for families with children (known as ANFC Related Medicaid) is available for people who meet eligibility criteria. The eligibility criteria used to determine eligibility for SSI Related Medicaid and ANFC Related Medicaid are different.

SSI Related Medicaid

For low income people who are 65 or older, disabled or blind. Includes Medicaid for Working People with Disabilities, Breast and Cervical Cancer Treatment Program, Disabled Child at Home Care (Katie Beckett) and Medicare Savings Programs.

Resource or Asset Limits for SSI Related Medicaid

- Resources are what a person has or owns. Some resources are liquid and some are non-liquid.

  Examples of liquid resources are:
  - CD's,
  - Bonds,
  - Checking and Savings Accounts.

  An example of a non-liquid resource is a vehicle.

- Some resources are excluded and some count toward the resource maximum. Refer to your Case Management Core Training materials for detailed information about allowable resources.

Medicaid for Working People with Disabilities

- Income after deductions and disregards must be below a percentage of the Federal Poverty Level (FPL) and income must be below the group's Protected Income Level (PIL) after special work incentive disregards are applied. Refer to your Case Management Core Training materials for detailed information about allowable resources.

SSI Related Income

- Protected Income Level (PIL) – The PIL is an income test, based on the federal poverty level (FPL). The worker compares a group's (one or more persons) net income to the PIL to determine their financial eligibility for Medicaid. PILs are updated annually reflecting the cost of living.
- All countable sources of income received by group members, earned and unearned are considered in determining eligibility.
- Some sources of income will be excluded according to Medicaid rules.
- Disregards and deductions allow a group to reduce its countable income prior to an income test.
- Income remaining after disregards is compared to the PIL.
- If a group fails their income test, a spend-down is calculated. A spend-down works like a deduction on a car or house insurance policy.

Medicaid Spenddown

- A spend-down works like a deduction on a car or house insurance policy. Someone's spenddown is usually for a six-month period although in some cases it may be less.
- After a client is determined to be over the income (or resource) guidelines, an eligibility specialist will determine the applicant's spenddown. For an income spenddown, the worker will take the difference between a client's net countable income (gross income minus allowed program deductions) and the Medicaid income level for a household of that client's size and multiply that by six. The resulting figure is someone's income spenddown.
- A resource spenddown is figured in a similar manner. For a resource spenddown, the worker will take the difference between a client's net countable resources (gross resources minus allowed program deductions) and the Medicaid resource level for a household of that client's size and multiply that by six.
- There are numerous ways to meet someone's spenddown. Some of the things that can be used to meet spenddowns are:
    - Over-the-counter medical expenses such as aspirin, antacids, laxatives, non-covered diabetic supplies, lotions, depends, etc. that you for and are medically necessary.
    - Unpaid medical bills still owed, as long as they have not already been used in a previous spenddown. These old bills can still be used as long as the client is still being billed for the charge as seen by the worker in the form of a copy of the bill dated within the last 60 days. The medical bills may be from a hospital, doctor, drug store, dentist etc.
    - Payments that have been made on any medical bills since the beginning of a current spenddown period.
    - Medically necessary personal care services. (If living in a Residential Community Care Home, there are forms required for this deduction.)
    - Prescription co-payments that have been paid since the beginning of a current spenddown period.
    - Mortgage or rent payments cannot be used to meet a spenddown.
- Medicaid coverage would begin on the date that the spenddown is met.

Medicare Savings Programs

There are four Medicare Savings Programs or Buy-In programs, in which DCF pays for monthly Medicare premiums, and sometimes pays for deductibles and co-payments. Benefits vary between the four buy-in programs, depending upon the recipient's income. The four programs are:

- Qualified Medicare Beneficiaries (QMB): Pays for Medicare Part A and B premiums, deductibles, and co-insurance for people with income at or below a percentage of the federal poverty level (FPL). Refer to your Case Management Core Training materials for detailed information about allowable resources.

- Qualified Working Disabled Individuals (QDWI): Pays for Part A premiums if disabled and working with income below a percentage of the FPL. Refer to your Case Management Core Training materials for detailed information about allowable resources.

- Special Low Income Medicare Beneficiaries (SLMB): SLMB pays Medicare Part B premiums if person is aged or disabled and entitled to Medicare Part A and their countable income is a percentage of the FPL. There is no resource test for SLMB. Refer to your Case Management Core Training materials for detailed information about allowable resources.

- Qualified Individual (QI-1): QI-1 pays Medicare Part B premium if entitled to Medicare Part A and their income is a percentage of the FPL. There is no resource test for QI-1. People receiving QI-1 cannot receive other federally funded medical assistance such as Medicaid, VHAP, or VHAP Pharmacy. Refer to your Case Management Core Training materials for detailed information about allowable resources.

Long Term Care Medicaid

Long-Term care is skilled nursing care provided in: nursing facility, home-based waiver setting, Enhanced Residential Care (ERC) setting, hospital swing bed or hospice.

- Eligibility for Long-Term Care Medicaid
- Individuals who meet the following criteria:
    - US citizen or anyone who has lawful permanent resident status while residing in the US for a minimum of 5 years.
    - Clinically eligible for Highest or High level of care.
    - Vermont resident.
    - Age 65 or older, or, blind or disabled according to Social Security standards.

- Meets LTC institutional standard. Refer to your Case Management Core Training materials for detailed information about allowable resources.

- Meet LTC resource standards. Refer to your Case Management Core Training materials for detailed information about allowable resources.
- Meets permissible transfer rules.
- Must provide proof of asset transfers in the 3 years prior to the date of application.
- Proof of any trusts created within 5 years of the date of application, including an accounting of all assets placed in or removed from the trust in the last 5 years if irrevocable or the last 3 years if revocable.
- A face-to-face interview with the applicant or authorized representative may be required. Phone interviews can be done if necessary.

- All nursing facility residents have a look-back and patient share requirement.
- All HBW/ERC recipients with income above the PIL and/or resources above the approved level have a look-back and patient share assessment requirement. Refer to your Case Management Core Training materials for detailed information about allowable resources.

What Income Counts?

Gross income such as, but not limited to:

- Social Security
- Pensions
- Annuities
- Wages
- Interest income from bank accounts, promissory and mortgage notes
- Payments from trusts

What Resources are Evaluated as Countable?

Countable resources include, but are not limited to:

- Cash on hand, bank/credit union accounts, checking, savings, etc.
- Stocks, bonds, mutual funds

Burial Funds

- Burial funds may be excluded if all criteria are met. They must be designated as burial funds through title or statement. They must be placed in a separately identifiable fund and not commingled with other funds.

The following resources are excluded only if they meet the exclusion criteria:

- Annuities
- Life estate interests
- Life Insurance
- Promissory notes
- Retirement funds such as IRA, etc.
- Trusts

The following resources require legal review:

- Annuities
- Contracts for Care (excluded bank account)
- Life Estate deeds
- Promissory/Mortgage Notes
- Trusts
- Other relevant legal documents

Resource Spenddown and Retroactive Medicaid

- One or more of the following actions may be taken to reduce excess resources in order to qualify for up to 3 months retroactive Medicaid:
  - Set up burial fund up to the approved maximum.
  - Spend money on medical expenses.
  - If income is below the Protected Income Level (PIL), difference may be spent on housing, food, clothing, etc.

Transfers

- If individuals exceed the allowed resource limit, they may transfer some resources without a penalty only if the permissible transfer rules apply.

What will LTC Recipient Pay Toward The Cost of Their Care?

- The patient share is the monthly amount the individual must contribute to the cost of their long-term care.

- To determine a recipient's Patient Share, the following are deducted from the gross monthly income:
  - A Personal Needs Allowance (PNA) for nursing facility residents.
  - Insurance premiums such as Medicare or Medicare supplement.
  - A home upkeep deduction (nursing home residents only) if medical provider certifies the person is expected to return home within 6 months of admission date and all other criteria are met.
  - A Community Maintenance Allowance (CMA) Home-Based/ERC individuals only.
  - Allocations to community spouse or dependent family members.
  - Non-covered medical expenses.

- The remaining balance, if any, is the Patient Share. This amount is paid each month directly to the nursing facility or the highest paid provider of HBW/ERC services for the previous month's care. April's care is paid May 1.

Community Spousal Resource Allocation for LTC Medicaid

- If the CFC applicant is married/civil union, there is a total countable resources for the household. Refer to your Case Management Core Training materials for detailed information about allowable resources.
- LTC individual must remove name from accounts that exceed the allowed maximum. The total of all LTC individual's accounts must remain at or below the maximum. Refer to your Case Management Core Training materials for detailed information about allowable resources.

Community Spousal Income/Allocations

- Community spouse may elect to receive an income allocation from their LTC spouse if their gross income is less than the approved maximum per month.
- The community spouse cannot receive an amount that exceeds the maximum allocation.

Chronic Medical Conditions

An elder with a temporary condition which will clear up, has a very different experience from one with a chronic condition.

- Chronic illness:
  - The disease can impact all aspect of life.
  - People must adjust to new view of themselves.
  - People should become educated about illness and how to manage day-to-day living.
  - Pain and fatigue may be a part of every day.
  - Often, modifications must be made to environments and activities.
  - Physical changes from the disease may affect appearance.
  - People might find it hard to cope with loss and feel isolated.
  - People may fear loss and control over their lives, and their ability to make decisions about it.
  - People 85+ are the fastest segment of the population and are more likely to suffer from one or more chronic illnesses and need some assistance.

- Heredity may account for 30% of characteristics considered part of aging.

- Life choices such as diet, exercise, smoking, attitudes and personality affect aging and quality of life.

- 85% of people 65 or older have some significant physical problems.

- 13% of elders need help with bathing and dressing.

- 18% of elders need help with light housekeeping, laundry and meal preparation.

Arthritis

Arthritis is defined as any inflammatory condition of the joints, characterized by pain, swelling, heat, redness, and limitation of movement.

- Types:
  - Osteoarthritis (OA)
  - Rheumatoid Arthritis (RA)

Osteoarthritis is a degenerative joint disease. It starts in the cartilage of a joint and affects the hips, knees, vertebrae and fingers.

- Predisposing Factors:
    - Age and overuse of a joint
    - Previous injury to a joint
    - Obesity

- Signs and symptoms of OA:
    - Swelling of a joint
    - Pain and stiffness of the joints
    - Deformity of affected joints
    - Immobility of the affected joints

Rheumatoid Arthritis (RA):

- Chronic, progressive, systemic (whole body), debilitating disease of connective tissues.
- Autoimmune disease/possibly virus related.
- May affect younger people (20-55 years)
- Begins in the fluid of the wrist, fingers and hands.
- May attach other body systems (heart, lungs, muscles, eyes, nervous system, skin)
- Periods of exacerbation and remissions
- Risk Factor - Possibly a genetic predisposition

Signs and Symptoms

- Painful, stiff, swollen, reddened joints
- Fatigue/malaise
- Weight loss
- Decreased sensations in hands

Problems Associated with OA and RA:

- Debilitation as symptoms progress
- Stress and depression
- Skin breakdown due to immobility
- Decreased appetite
- Constipation
- Secondary disease issues with RA

Treatments and Medications

- Surgery to replace damaged joints
- Balance of rest and mild exercise
- Physical and/or Occupational Therapy
- Assistive devices, (cane, walker, grabber, etc.)
- Medications: Non-steroid anti-inflammatory drugs, (Naprosyn, Motrin, Voltaren, Feldene, Nalfon) aspirin, pain medications.

Cerebrovascular Accident

A cerebrovascular accident or CVA is defined as either damage to or the death of a specific area of the brain due to an insufficient supply of blood. Stroke is the third leading cause of death in the USA. A stroke may cause a comatose state.

Common Names: Stroke or Shock

Types:

- Brain Hemorrhage – loss of a large amount of blood in a short period of time.
- Brain Ischemia – decreased oxygenated blood supply, which accounts for about 80% of all strokes.
- Transient Ischemic Attack or TIA – temporary decreased supply of blood. TIA's are a warning sign of possible impending strokes. They may be associated with arterial plaque or a blood clot.

Risk Factors:

- heart disease
- prior strokes
- diabetes
- high cholesterol
- hypertension (high blood pressure)
- smoking
- estrogen replacement therapy and/or birth control pills
- family history
- age

Signs and Symptoms:

- severe onset headache
- severe nausea and vomiting
- slurred speech
- change in cognition and/or level of consciousness
- numbing, tingling or sudden weakness of limbs
- hemorrhage of the retina

Problems associated with left brain injury/right side hemiplegia (paralysis)

- Speech/language deficits: aphasia (inability to speak/understand language), dysarthria (difficulty pronouncing words)
- Behavioral involvement: anger, increased frustration, inappropriate laughter and/or crying, depression
- Memory deficits: difficulty with common tasks such as dressing, may need extensive feedback, may appear cautious, anxious and disorganized.

Tips for Caring for the Left Brain Injured Person

- Lack of speech does not mean lack of understanding
- Do not assume level of understanding
- Do not shout
- Use alternate forms of communication

Problems associated with right brain injury/left side hemiplegia (paralysis)

- Spatial/perceptual deficits: judgment impairment. Unable to accurately judge distance, size, position, rate of movement, form and how parts relate to the whole.
- Behavioral involvement: impulsiveness, demanding and self-centered, judgment affected, unable to grasp humor, uncontrollable crying, confabulation, labile affect
- Memory deficits: poor attention span, short-term memory problems.

Tips for Caring for the Right Brain Injured Person

- Don't overestimate abilities (observe capabilities, don't just trust the person's word)
- Keep their living space neat and simple
- Break tasks into small segments
- Move slowly
- Do not nag

Treatments and medications:

- hospitalization
- physical therapy, occupational therapy, speech therapy
- adaptive equipment
- feeding tubes
- catheters
- diet changes
- psychological interventions
- medications (anti-depressants, anti-hypertensives, anti-cholesterol)

Diabetes Mellitus (DM)

Diabetes Mellitus is defined as a set of disorders where the pancreas either produces inadequate amounts or no insulin for the body to manage blood glucose (sugar), carbohydrate, fat and protein metabolism.

Types:

- Insulin Dependent Diabetes Mellitus or Type I
- Non-insulin Dependent Diabetes Mellitus or Type II
- Diabetes Insipidus
- Gestational Diabetes
- Cortisone Related Diabetes

Type I Diabetes Mellitus:

- Usually begins under the age of 30
- Body does not make any insulin
- There may be a strong familial tendency.
- The person needs to take insulin injections on a daily basis.

Type II Diabetes Mellitus:

- Usually begins over the age of 40
- There is a deficiency in insulin production.
- There may be a familial tendency.
- It can be controlled with diet, oral hypoglycemics or insulin

Blood Glucose (Sugar) Levels

- Normal range is 80-160
- Abnormal range is less than 70 or greater than 180
- Need to monitor blood glucose levels

Signs and Symptoms

- Unplanned weight loss
- Fatigue
- Polydipsia (increased thirst)
- Polyphagia (increased hunger)
- Polyuria (increased urine)
- Blurred vision

Hypoglycemia: Sudden in onset

- Cold, clammy skin
- Hunger
- Weakness, fainting
- Shakiness, nervousness
- Confusion
- Blurred vision
- Slurred speech
- Loss of consciousness

Hyperglycemia: Gradual onset

- Increased thirst
- Rapid weight loss
- Vision changes
- Dry skin/mouth
- Fruity breath
- Abdominal pain/vomiting
- Itching
- Fatigue
- Coma

Problems Associated with Diabetes Mellitus:

- Blindness/Glaucoma
- Renal (kidney) Failure
- Poor circulation/gangrene/amputation
- Non-healing wounds
- Heart Disease/Attacks and Strokes
- Neuropathy (inflammation or degeneration of the peripheral nerves
- Sexual Dysfunction

Treatments and Medications

- Blood Tests
- Diet
- Medications: Insulin, Oral Medications, Dialysis, Eye Treatments for Glaucoma, Medication for sexual dysfunctions, surgery, exercise and weight management.

Myocardial Infarction

Defined as the development of ischemia (decreased blood flow) and necrosis (death) of heart tissue. It results from a sudden decrease in the blood flow to a portion of the heart or the increased need for oxygen to a portion of the heart.

Common Name: Heart Attack

Risk Factors:

- Family History
- Sex and Age
- Hypertension
- Smoking
- Diabetes Mellitus
- High Cholesterol
- Obesity/overweight
- Inactive Lifestyle
- Estrogen Use

Signs and Symptoms:

- Severe chest pain may be described as crushing, sharp or burning. May radiate to the arm, shoulder or jaw. (Please note there may also NOT be this type of pain.)
- Cold, clammy skin
- Nausea, vomiting, hiccups
- Shortness of breath
- Sweating
- Rapid pulse/anxiety

Problems Associated with MI

- Permanent Heart damage
- Emotional Issues/fear
- Death

Treatments and Medications

- Hospitalization/surgery
- Oxygen
- EKG, Cardiac Catheterization
- Medication
- Pain Medication (Morphine, Demerol)
- Anticoagulant Therapy (Heparin, Coumadin, ASA)
- Cardiac Mediations (Nitrates, Beta Blockers, Calcium Blockers)
- Antihypertensives (Maxide, Aldomet)
- Physical Therapy/Exercise/Cardiac Rehab
- Stress Management
- Diet