OLDER AMERICANS ACT

OUTREACH

HANDBOOK

AGING SERVICES DIVISION
NORTH DAKOTA DEPARTMENT
OF HUMAN SERVICES

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PREFACE

The Older Americans Act Outreach Handbook was developed to give all outreach workers, especially those new to the field, a baseline of information relevant to the provision of outreach services.

The Handbook is designed to be a self-directed study. Within one month of employment, all newly hired outreach workers are required to review each topic area. Upon conclusion of the study, the Checklist on page 88 must be completed and submitted to the respective Regional Aging Services Program Administrator. A copy of the completed checklist must also be maintained in the outreach worker's personnel file.

As the outreach worker position continues to evolve, it is important that the worker continue to enhance and upgrade their skills. After the first year of employment, a minimum of ten hours per year of in-service training, relative to outreach functions, is required for each outreach worker.

CHAPTER I

WHAT IS OUTREACH

WHAT IS OUTREACH

Outreach is defined in North Dakota policy as a personalized approach to seeking out older individuals and identifying their service needs with an emphasis on referral and linkage to available services. Service activities also include determining eligibility for home-delivered meals and escort/shopping assistance.

BASIC PHILOSOPHY

Every person should have the right to access services appropriate to their needs so they can lead an independent, meaningful, and dignified life in their own home and community for as long as possible.

Outreach is needed because oftentimes people are unable, for whatever reason, to seek out the services for themselves. Reaching out to people who may not otherwise be able to access a service or are not aware of services is an essential part of the outreach workers responsibilities. Factors that keep people from services and necessitate an outreach response include:

- Economic status
- Isolation
- Social and emotional problems
- Poor health
- Bereavement issues
- May be a member of an ethnic minority
- No permanent residence
- Depression
- Language barriers
- Lack of transportation
- Services are not needed
- Lack of information

Priority for services must be given to the following:

- *Older individuals residing in rural areas* – Rural is any area with less than 20,000 inhabitants.

- *Older individuals with the greatest economic need* – This would include those persons 60 years of age and older who have annual incomes, that fall at or below 100% of the Department of Health & Human Services poverty guidelines.

- *Older individuals with the greatest social need* – This would include persons with physical and mental disabilities, language barriers, and cultural, social, or geographic isolation, including isolation caused by racial or ethnic status that restricts a person's ability to perform normal daily tasks or threatens their capacity to live independently.

- *Minority elderly* – Persons 60 years of age and older who are either African American, American Indian, Alaskan Native, Asian, Pacific Islander, or Hispanic origin.

- *Older individuals with severe disabilities* – Severe disability is defined as a condition attributed to a mental or physical impairment, or a combination of mental and physical impairments that: (A) is likely to continue indefinitely; and (B) result in substantial functional limitation in three or more of the following major life activities: (1) self care, (2) receptive and expressive language, (3) learning, (4) mobility, (5) self direction, (6) capacity for independent living, and (7) economic self sufficiency.

- *Older individuals with limited English proficiency.*

- *Older individuals with Alzheimer's disease or related disorders and their caretakers.*

Perceiving and treating the older adult as a responsible, decision-making person is essential. As an outreach worker, the temptation may be to impose your values, beliefs and opinions. This would be contrary to one of the basic principles of helping others, the right of self-determination.

SELF DETERMINATION

This concept is not difficult to understand, but can become very difficult to implement. Essentially, self-determination means allowing your client freedom of choice. Human service workers do not direct the lives of those they serve. Instead, they help them overcome their problems by offering information, providing opportunities to reach new decisions, and otherwise assisting their clients. Human service workers are ethically bound to help those they serve achieve the things they want in the ways they want to achieve them, so long as the client's goals do not violate the rights of others (Harbert, 1979).

One needs to be aware of a tendency shared by many helping professionals. It is to deny the client self-determination by assuming that we always know what is best. Of course, if one looks at this assumption, you can quickly see that by believing this, you are denying the persons history, education, and past experiences that make them the person they are today. If the goal as an agency is to provide appropriate services, it is essential that each person be viewed and accepted as the individual they are.

The state of North Dakota has identified three goals pertaining to the delivery of all outreach services.

SERVICE GOALS

To maximize the independent functioning of the older adult by assuring that eligible individuals throughout the service area have the opportunity to access appropriate in-home and community services.

To link persons age 60 and older, especially those within the priority target groups, with available services and resources as indicated by an assessment of their needs.

To encourage and promote an independent lifestyle, thus enhancing the quality and dignity of life as desired by that individual.

These goals can be met when professional outreach personnel with enhanced skills interact in our communities and offer their talents in helping others. The outreach standard (pages 9 through 12) identifies service activities designed to help achieve these goals.

STEPS IN PROVIDING OUTREACH SERVICE

At the core of outreach services is the direct contact you have with the individual. Identifying those eligible for services can be difficult. In North Dakota, any persons 60 years of age and older, and his or her spouse of any age, are eligible for outreach services.

HOW IS CONTACT INITIATED?

There are several methods that are used by outreach workers to identify clients within the target groups:

1) Canvassing or cold calling. This is accomplished by going door-to-door, utilizing city and county directories, and visiting with apartment managers and managers of elderly housing units, etc. The outreach worker should identify themselves by name and the agency he/she represents. Assure the older individual that the worker is not selling anything. Explain the reason for the visit – to inform individuals age 60 and older of available services. (The individual will let you know if he/she is younger!) Offer a directory of services and your business card. Ask if they have additional questions or if they have a need for services in the future. Inquire if they are aware of someone else who may be in need of services.

   Canvassing in the rural areas can be more difficult due to time and distance that must be traveled. Provide as much information as possible at county council meetings and senior club meetings. Leave a supply of resource directories with a business card attached at congregate meal sites. Establish relationships with rural parish nurses, local churches and restaurants. Older individuals living in the rural areas often times know of other individuals who may benefit from the services. You may ask the older individual to give a resource directory with attached business card to those individuals.

   Other tips for canvassing include: a) Always wear a name badge that includes your name and agency name. b) Don't bring a huge briefcase or binder with you initially – only the directory of services and/or newsletter/informational sheet, and business card. If you are invited into the home, ask if you can bring informational material with you to review. You can then go to your car to get the information. c) Be respectful. Encourage them to ask questions if they do not understand something. d) If the older individual states that they do not need any services, inquire if you may leave a brochure or business card; encourage them to call if you can be of assistance in the future.

2) Networking with other service providers.

Networking is a process that interconnects you and your program to the other resources. Your linkage with other service providers as well as a basic understanding of that service will put you in a position to more accurately and efficiently make referrals (Weiner, 1978). There are several ways to effectively network, including the following (Tesiny, 1981):

*Keep communication lines open with other service providers.

*Visit other agencies to meet staff and learn about their programs and actually see the "voice on the other end of the line".

*Invite other service providers to your agency to familiarize them with your agencies programs and procedures.

*Work together with other agencies on a project of common interest.

*Get involved in community activities.

Chapter 6, “Resources”, will take a more in-depth look at resources and the role networking plays in knowing your resources. Networking and understanding your resources are critical if you are to meet the needs of those you serve.

3) Doing community presentations. Your agency may provide great services, but if few people know of them, their effectiveness is greatly diminished. Periodic mailings and newsletters will also keep the community informed.

4) Self-referral. An individual in the community is aware that they need information or services and initiates a contact with the outreach worker.

Preference must be given to meeting with the individual on a face-to-face basis. The communication and assessment (to be discussed in greater detail elsewhere) processes are greatly enhanced when the meeting occurs in person. Usually the first meeting with an individual will occur in their home. This allows the outreach worker an opportunity to discuss issues with the person in the least threatening environment. All referrals should be responded to within 2 days or sooner if possible. It is important to remember that many referrals are made at the time a service is needed.

EMERGENCY PROCEDURES

It is critical that all providers establish a policy or procedure to deal with an emergency or crisis and that it exist prior to an actual emergency. As an outreach worker, the following suggestions can help you and-or your program be prepared for an emergency.

1. List and carry with you at all times: law enforcement telephone number; hospital/ambulance telephone numbers; fire department numbers; local clergy.
2. If you have been working with a client for some time, obtain name, address and telephone number of nearest relative.
3. Remain calm and follow established protocol. Contact your supervisor as time and situation permits.
4. Having a basic understanding that emergencies do occur and that the best way to handle these situations is to be prepared. Procedures should be in place that allow you to act with confidence in responding to emergencies.
5. Certification in CPR. See your administrator re: your agencies policies.
6. Certification in basic first aid. See your administrator re: your agencies policies.

Discuss with your project director/supervisor your agency’s procedures.

INTERVIEWING THE OLDER ADULT

As an outreach worker, the interview provides an opportunity to not only provide information but to elicit information as well. It is through this exchange that a proper assessment can be made and services provided as needed.

ESTABLISHING RAPPORT/CLEAR COMMUNICATION

The following factors can help to establish clear channels of communication with your contact (Tesiny, 1981):

- The attitudes of both parties are taken into consideration and are considered important. Do not assume that because you are a helping professional that your values are more correct than the interviewee's.

- A basic understanding of the differences (age, sex, race, religion etc…) and similarities between both parties that may exist.

- A basic understanding that communication occurs in a number of different ways such as; a) verbal – words are used to express thoughts and feelings; b) non-verbal – facial expressions, eye contact, body posture, gestures and movements; c) listening – accurate active listening can communicate real concern for what the client is saying.

- The ability to use a variety of means to communicate at the level of the interviewee.

- An awareness for the need to repeat or rephrase the discussion to ensure that mutual understanding is taking place.

- The outreach worker being aware of the vocabulary used and avoiding office jargon and terminology which the client may not understand and is too embarrassed to question.

- The ability to pace the conversation/exchange at the client's most comfortable level.

- Being able to identify causes of possible distraction such as excessive noise (T.V. and radio), repeated interruptions, hearing problems and vision problems.

CONFIDENTIALITY

Confidentiality means that the outreach worker does not reveal gathered information to others. As an outreach worker, you will be required to keep a record of your involvement with each individual. This record is confidential. Records and information, whether it is oral or written, which identifies your contact, should not be released to other providers/persons unless:

- The client has given specific written consent as to what can be shared and for what period of time.

- A court orders disclosure of information.

- The information released does not in any way jeopardize confidentiality.

- Information pertains to certain exceptions (abuse, crime, threat to an individual or community). These exceptions should be fully discussed with the individual.

If information is to be released without authorization from the individual, full documentation as to why the action was taken should be recorded.

Discuss with your director/supervisor your agency's policies regarding confidentiality.

In situations where the older person has been referred by the staff of another agency, it is important to respect the older person's right to privacy, confidentiality, and selection or rejection of service (Greene, 1986). They may also refuse to involve his/her family. This should also be respected. It is a professional courtesy to inform the referring agency/person that the referral has been received and acted upon without breaching confidentiality.

RELEASE OF INFORMATION

In order to protect confidentiality, a written form of consent called a Release of Information is needed. The release of information form should contain:

- the full name and address of the individual.
- the full name and address of the individual/agency information is being released to or requested from.
- the specific information being requested.
- what the information will be used for.
- specific timeframe that the release will be in effect.
- the individual's signature and date.
- the outreach workers signature and date.

Make sure that the appropriate parties have a copy of the release of information form. That would include:

- a copy of the release for the contact.
- a copy of the release for the outreach worker.
- The original copy of the release to the individual/agency to which information is being requested or given.

PROHIBITED SERVICE ACTIVITIES

An outreach worker shall not present to the public, by title or description of service, that he or she is engaging in social work practice unless currently licensed by the North Dakota Board of Social Work Examiners.

Activities that would be duplicative of others provided in the community, unless documented that the recognized service provider has refused or is otherwise unable to render services needed.

Any breech of confidentiality. Please see your director for the specific confidentiality guidelines used in your agency.

DOCUMENTATION

A written record of your contact is required. This process of recording the information is called documentation. Documentation is a process of recording interactions that occur between you, the contact, or a community resource. What information is needed for the record and the procedure for recording it is an important part of providing quality outreach services.

Documentation offers a written record of the outreach workers:

- assessment of the contact
- identified unmet needs
- actions taken (referral, etc…)
- client requests
- plan to follow-up as needed

This information is essential as you determine client needs and pursue appropriate resources. The information is updated as further contacts are made.

MINIMUM CONTACT INFORMATION

- Type of contact (in person, telephone, collateral, supervisory etc…).
- Date of contact.
- A description of the exchange between yourself and the contact.
- A listing of identified needs.
- Alternatives explored.
- Service delivery options.

It is very important to properly maintain your records. Do not forget that ***these records are confidential***. The records should be kept at the agency's office and kept in a locked file, locked area or an access coded computer program.

Coordination of services means that a unified and informed effort is being made to provide services to an individual. There should be an awareness among those providing services of what the other is doing, and efforts made not to duplicate those services. A basic procedure to begin coordinating services for someone is to get written permission (Release of Information), from the individual, to contact the other providers involved. Coordinated efforts by all community resources allow for optimum quality and efficiency in the use of all available resources.

WHAT IS ADVOCACY?

Everyone is called upon to be an advocate at some time in their life. As an outreach worker this will be especially true, since much of your job is advocacy. Yet when we talk about being an advocate, what exactly does that mean? According to Webster's New World Dictionary, advocacy is "the act of advocating, or speaking or writing in support of something." Funk and Wagnall defines advocacy as "the act of interceding or pleading a cause." Basically, advocacy refers to efforts to represent the interests of specific populations, to reallocate resources in their

favor, or to provide services to them (The Planner as an Advocate-People and Planning). When looking more closely at what this means for you, the outreach worker, we need to look at the definition of advocacy as stated in the North Dakota Aging Services Policies and Procedures Manual. There it is defined as "actions taken on behalf of older individuals to secure their rights and benefits." As you can see from each of these definitions, advocacy involves action. The person doing the action is called an "advocate." An advocate works with individuals to link them with available resources or acts as an intermediary, making sure they receive the services to which they are entitled. Remember that in advocacy, the goal is to arrive at the best alternative for the client.

It is inappropriate to advocate for services or change on behalf of a client when or if the client has not agreed to your actions.

Each agency will have specific parameters for advocacy; therefore, it is important to discuss your role as an advocate with your director/supervisor.

Outreach Program Service Standard 650-25-50

Outreach service is a personalized approach to seeking out older individuals and identifying their service needs with an emphasis on referral and linkage to available services. Priority for services must be given to older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; and older individuals with Alzheimer's disease or and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and older individuals at risk for institutional placement.

Performance Standards 650-25-50-01

Eligible Clients 650-25-50-01-01
Individuals 60 years of age and older.

Location of Services 650-25-50-01-05
Outreach service shall originate in the client's own home. If the service originates in another location, documentation explaining why it was not possible to complete the service in the client's home must be entered in the Narrative section of the web-based SAMS Outreach/HDM Assessment form.

Delivery Characteristics 650-25-50-01-10
Outreach must be delivered countywide throughout the entire service area.

1. All referrals must be contacted within two working days.
2. All contacts, including telephone calls, must be documented in the Narrative section of the web-based SAMS Outreach/HDM Assessment form. Each contact must have a stated purpose. The documentation shall include the stated purpose of the outreach contact, a brief descriptive statement of the outreach interaction, including any service needs identified; alternatives explored; service delivery options offered; the services accepted or refused by the client; and the client's choice of provider(s).
3. The SAMS Outreach/HDM Assessment form must be completed and data entered in the SAMS web-based system to document need. The contract entity should attempt to obtain all data requested in the assessment. NAPIS data, the Nutrition Screening Checklist and ADL's/IADL's are required for federal reporting purposes. Each outreach contact must be documented in the Narrative section of the web-based SAMS Outreach/HDM Assessment form.
4. Individuals seeking services must be provided with service options within the service area. The individual has the right to make an independent choice of service providers.
5. When an individual is eligible for services, the individual or legally appointed representative must make all decisions concerning acceptance of services.
6. Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program.

7. A signed release of information document must be on file before information can be shared or released.

Billable Unit of Service 650-25-50-05

For billing purposes, the contract entity must use the service billing unit system for each service procedure identified in the Service Delivery Procedures Section of this Standard (650-25-50-06).

For escort/shopping assistance service activity, a unit of service for billing purposes is 15 minutes. A unit of service begins when the outreach worker leaves his/her office/home and ends upon return to the office/home. Shopping for multiple clients must be pro-rated to each client. Voice messaging, time documenting outreach interactions, training, and other administrative functions are not billable units. Expenses for these functions should be included in the unit cost.

Each billable unit of service received by a client must be recorded in the client's individual record in the web-based SAMS system on a monthly basis.

Service Delivery Procedures 650-25-50-06

The following service delivery procedures must be followed for reimbursement through an Older Americans Act contract:

1. Initial Outreach Assessment – 8 Units of Service
    a. Conduct an assessment of the client using the SAMS Outreach/ HDM Assessment form.
    b. Determine needed services including eligibility for home-delivered meals, if applicable.
    c. Discuss service options with client.
    d. Obtain release of information, if applicable.
    e. Make referral to appropriate agency.
    f. Enter assessment data in the SAMS web-based data system. Document the following in the Narrative section of the SAMS Outreach/HDM Assessment form: the stated purpose of the outreach contact, a brief descriptive statement of the outreach interaction including any identified service needs; alternatives explored; service delivery options offered; services accepted or refused by the client; and the client's choice of provider(s). If applicable, document how/why a client who is under the age of 60 is eligible to receive home-delivered meals.
    g. Notify the Nutrition Service contract entity in writing of the eligibility status for home-delivered meals and the nutritional risk status (as determined by the Nutrition Screening Checklist).
2. 30-Day Follow-up In-Home Contact – 2 Units of Service
    a. Conduct follow-up visit in the client's home.
    b. Document in the web-based Narrative section of the SAMS Outreach/HDM Assessment form the stated purpose of the outreach contact and a brief descriptive statement of the outreach interaction, including client satisfaction with service(s).

3. Telephone Contact, E-mail, Text Message, or Brief Face-to-Face Visit [Outside of the Home] (respond to referral/30 day follow-up, linkage to service) – 1 Unit of Service
    a. Contact the referral entity or client via telephone, e-mail, text message, or through a brief face-to-face visit (outside of the home) regarding the referral or receipt of services.
    b. Document in the web-based Narrative section of the SAMS Outreach/HDM Assessment form the stated purpose of the outreach contact and a brief descriptive statement of the outreach interaction, including client satisfaction with service(s).
4. Outreach Canvassing Contact – 2 Units of Service
    a. Conduct canvassing contact to determine if individual is eligible for Older Americans Act services and/or other services.
    b. If applicable, make appointment to and/or complete SAMS Outreach/HMD Assessment form.
    c. If the client is ineligible or refuses services, enter available data in the web-based SAMS system and complete an entry indicating purpose of contact and the basis for ineligibility or client refusal of services.
5. Outreach Reassessment – 4 Units of Service
    a. At a minimum, all clients receiving on-going services must be reviewed annually to reassess need. Review existing client data to assure it is correct. Reassess to determine if additional needs are identified and make referrals and linkages to appropriate services.
    b. Enter reassessment data in the SAMS web-based data system. Document the following in the Narrative section of the Assessment form: the stated purpose of the outreach contact, a brief descriptive statement of the outreach interaction including any identified service needs; alternatives explored; service delivery options offered; services accepted or refused by the client; and the client's choice of provider(s).
6. Reassessment for Continued HDM Eligibility – 4 Units of Service
    a. For continued receipt of home-delivered meals, the client must be reassessed every six (6) months or sooner as applicable, to assure continued eligibility. Review existing client data in the SAMS Outreach/HDM Assessment form to assure it is correct. Re-assessment must include completion of the Nutrition Screening Checklist and ADL/IADL's. Determine if additional services are needed and make appropriate referrals.
    b. Enter reassessment data in the SAMS web-based data system. Document the following in the Narrative section of the SAMS Outreach/HDM Assessment form: the stated purpose of the outreach contact, a brief descriptive statement of the outreach interaction including any identified service needs; alternatives explored; service delivery options offered; services accepted or refused by the client; and the client's choice of provider(s). If applicable, document how/why a client who is under the age of 60 is eligible to receive home-delivered meals.
    c. Notify the Nutrition Services contract entity in writing, of continued eligibility for home-delivered meals or the need to discontinue service provision.

7. Initial Congregate Meal Assessment (applicable only if the outreach worker is assisting a client to complete assessment information and Nutrition Screening Checklist) – 2 Units of Service
    a. Interview client to complete assessment using the SAMS Congregate Meal Assessment form.
    b. Enter assessment data in the SAMS web-based data system. Document in the Narrative section of the SAMS Congregate Meal Assessment the stated purpose of the contact, why the client needs assistance, and a brief descriptive statement of the interaction.
    c. If additional needs are identified, schedule home visit to conduct an initial outreach assessment using Outreach/HDM assessment form.
    d. Notify the Nutrition Service contract entity in writing, of the nutritional risk status (as determined by the Nutrition Screening Checklist).
8. Annual Congregate Meal Reassessment (applicable only if the outreach worker is assisting a client to complete assessment information and Nutrition Screening Checklist) – 1 Unit of Service
    a. Review/update assessment data as applicable. Complete the Nutrition Screening Checklist.
    b. Enter assessment data in the SAMS web-based data system. Document in the Narrative section of the SAMS Congregate Meal Assessment the stated purpose of the contact, why the client needs assistance, and a brief descriptive statement of the interaction.
    c. If additional needs are identified, schedule home visit to conduct an initial outreach assessment using Outreach/HDM assessment form.
    d. Notify the Nutrition Service contract entity in writing, of the nutritional risk status (as determined by the Nutrition Screening Checklist).
9. Escort/Shopping Assistance – see Section 650-25-50-05.

Service Activities 650-25-50-10
Service activities include:

1. Identify and contact targeted older individuals in the service area.
2. Receive referrals, make home visits, identify possible service needs based on completion of SAMS Outreach/HDM Assessment form, and through observation and communication.
3. Provide information and referral service allowing the client to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service.
4. Determine eligibility for the home-delivered meals service. Initial determination of eligibility may be accomplished by telephone. The Outreach Services contract entity must immediately notify the Nutrition Services contract entity of preliminary approval for receipt of home-delivered meals. Within two weeks of beginning meal service, a home visit and the SAMS Outreach/HDM Assessment form must be completed to verify eligibility. The Nutrition Services contract entity must be notified in writing of eligibility status and nutritional risk status (as determined by the Nutrition Screening Checklist). For continued home-delivered meal service, a client must be reassessed at least every six months or sooner, as needed. The Outreach Service contract entity must notify (in writing) the Nutrition Services contract entity of continued eligibility or the need to discontinue service provision.

5. Assist clients to complete the Congregate Meal Assessment including the Nutrition Screening Checklist. Document in the Narrative Section of the web-based SAMS Congregate Meal Assessment form, the stated purpose of the outreach contact, why the client needs assistance, and a brief descriptive statement of the outreach interaction. If additional needs are identified, schedule a home visit to conduct an initial outreach assessment using the Outreach/HDM Assessment form.
6. Provide or arrange for escort/shopping assistance. Escort/shopping assistance consists of accompanying and personally assisting, or arranging for someone to accompany and personally assist, a client with physical or cognitive difficulties to obtain a service outside the home environment. The escort/shopping assistance service activity was developed as a safety net and is a service of last resort. It cannot be authorized if there is another service delivery option. When arranging for escort/shopping assistance, availability of family members, friends, and volunteer organizations, and retail businesses to provide the service must be considered and accessed when possible. Documentation must reflect these efforts.

   The escort shall accompany and assist the client in a safe and patient manner and remain with the client for the duration of the escort/shopping assistance trip. Shopping assistance is limited to shopping for groceries and other essential items. If a client is homebound, the worker may shop for allowable items. The transportation provided as a part of this service should be coordinated with an established transit services provider.
7. Identify and document unmet service needs. Contact client for follow- up (on-site or via telephone contact) within thirty days to assure identified unmet service needs have been addressed and that the client is satisfied with the service and choice of provider.
8. Adhere to the contract entity's written referral process as stated in the contract entity's Policies and Procedures Manual to coordinate service provision with other agencies.

Staffing Requirements 650-25-50-15

1. Possess the ability to develop rapport with older persons.
2. Possess a valid driver's license and have access to an automobile.
3. Possess effective verbal, writing, and computer skills.
4. Within one month of employment, all newly hired outreach workers shall successfully complete the Aging Services Division outreach training as outlined in the Older Americans Act Outreach Handbook.
5. A minimum of ten (10) hours per year of in-service training is required for each outreach worker, relative to outreach functions. This will not be required during the first year of employment when the outreach worker is completing the Division's outreach training.
6. The contract entity shall maintain documentation verifying that the outreach worker has met and maintains staffing requirements.

Note: It is recommended that the contract entity consider employing outreach staff with a Bachelor's degree in a human service field and/or experience working with the target population.

Prohibited Activities 650-25-50-20

1. Activities that are provided by another entity in the community, unless documented in the web-based Narrative section of the SAMS Outreach/HDM Assessment form that a

recognized service provider has refused or is otherwise unable to render services needed.

2. Breach of confidentiality.

Administrative Requirements 650-25-50-25

Administration 650-25-50-25-01
Develop and adhere to a written program manual of policies and procedures to include, at a minimum, the following:

a. Defined service area.
b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and older individuals at risk for institutional placement.
c. Frequency, method, and timeframe for delivery of services as appropriate.
d. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
e. Procedures to assure the confidentiality of client specific information.
    i. No information about a client is disclosed by the contract entity unless informed consent is received from the client or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.
    ii. An appropriate release of information document is signed and on file before client records are released.
    iii. All client specific information is maintained in a locked file, locked area or access coded computer program.
f. Service contribution (program income) procedures that assure:
    i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a sealed envelope given to the outreach worker or returned by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.
    ii. No client is denied service due to inability or unwillingness to contribute.
    iii. A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.
    iv. Each service provider must choose to do one of the following: 1) Provide to clients served at home, the full cost of the outreach service, with information indicating that clients may, but are not required to contribute for the outreach

service; or 2) Provide to clients served at home, the full cost of the outreach service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the outreach service.

v. Measures are taken to protect the privacy of each client with respect to his or her contribution.

vi. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to the funds.

vii. Service contributions for outreach services are used to expand outreach services.

g. Fiscal procedures that address receipt of Older Americans Act and related funds; deposit of funds, and payment process.

h. Written emergency disaster preparedness plan approved by the local governmental official(s) having responsibility for disaster planning and designate an individual who is responsible to carry out provisions of the plan.

i. Procedures to assure the provision of information and referral services.

j. Non-discrimination towards clients.

k. Grievance procedures for clients.

l. Referral process.

m. Records retention.

n. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

2. Provide or make available training to paid personnel concerning the provision of services to older individuals. At a minimum, paid personnel must receive training on the following: overview of the Older Americans Act, service contributions, review of applicable service standards or service requirements and necessary training to deliver the specific service, confidentiality, and fire safety.

3. Use of volunteers in provision of services, as applicable. (Volunteer hours and the estimated cost must be reported on the Monthly Data and Payment Report.)

Legal Requirements 650-25-50-25-05

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.

2. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-50-25-10

1. Assess/reassess needs of older individuals in the defined service area.

2. Coordinate services within the community to avoid duplication.

3. Evaluate overall program to determine whether or not services were delivered; at what cost; and to what extent goals/objectives were met.

4. Conduct service evaluations with provision for client input; develop and maintain a report of the findings for utilization in planning.

5. Use information to implement, continue, expand or end a particular service or activity.

Advocacy Requirements 650-25-50-25-15

1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

CHAPTER II

AGING PROCESS

AGING PROCESS - SECTION A

WHAT IS AGING

Do you have an image that comes to mind when someone mentions aging? Chances are you do. Those images likely include such things as wrinkles, gray hair, stooped shoulders and perhaps a walking cane. While these may be characteristics generally associated with old age, it is important to realize the wide variation in individual aging. Disease, exposure to the environment, lifestyle, and especially genetics, are factors that affect how an individual ages. These variables make generalizations of the aging process difficult.

Aging services providers are uniquely positioned to promote effective health prevention programs to help older individuals remain healthy and independent. An excellent example of this is the Administration on Aging's "*You Can! Steps to Healthier Aging"* campaign. A part of the U.S. Department of Health and Human Services' *"Steps to a HealthierUS"* initiative, the campaign is designed create public awareness and make programs available to help older Americans improve their nutrition and increase their physical activity, thus allowing the individual to feel better and improve their health and well-being.

As you seek to expand your knowledge about aging, you will find yourself confronted with a disparity in research and information available. It is important to recognize these differences exist. ***Consider your goal as not diagnostic but rather recognizing issues that can be improved through assistance or referral.*** With this in mind, a broad base of information will benefit both you and the older individual.

This chapter is divided into two sections. Section A will address both the physical changes that occur as one ages and those changes that happen because of age related events over a lifetime. The latter will be referred to as psychosocial changes. Section B will discuss the most common diseases and lifestyle issues that profoundly affect the aging process.

WHAT ARE THE PSYCHOSOCIAL ASPECTS OF AGING

Many events in life require an emotional adjustment to be made by the person experiencing it. For the young adult, the events that precipitate change often are the result of some gain, such as a new career, home or the beginning of a family. For the older individual, it is important to realize the increased frequency at which life events begin to represent losses rather than gains. These might include the death of a family member or friend, retirement, failing health or the need to relocate from their home.

As an outreach worker, the significance of these life events cannot be underestimated in your efforts to conduct a complete and accurate assessment of the older individuals needs.

No two individuals will be affected in the same manner, therefore it is also important to recognize the possible impact of such events. This knowledge will help you in exploring possible areas of concern the older individual may not have previously shared during the interview process. The chart below shows specific life events and some changes that might be associated with them. This illustration is not meant to be a complete listing (Miller, 90):

Sixty-fifth Birthday

- Devaluation
- Negative attitudes
- Age-determined expectations
- Stereotypes and myths
- Degradation

Relocation from Family Homestead

- Loss of space
- Change of neighborhood
- Move from friends

Retirement

- Loss of income
- Loss of identity/role
- Loss of status/authority
- Loss of structure/schedule
- Loss of purpose in life
- Loss of peer contacts

Death of Friends

- Loss of companions
- Threat to own mortality
- Loss of socialization

Chronic Illnesses

- Immobility
- Sensory decline
- Medications/side effects
- Dependency/vulnerability
- Loss of money

Widowhood

- Loss of helper
- Loss of companion
- Loss of sexual partner
- Emptiness, loneliness, grief
- Changes in responsibility
- Dependency on others

PHYSICAL CHANGES AND THE AGING PROCESS

There are physical changes that are automatically associated with aging such as gray hair and wrinkles. However, the body changes in many other ways over time.

STATURE

It is not unusual for height to decrease. This is caused by the thinning of vertebral disks and poorer muscular control. Two diseases that affect the skeleton are osteoporosis and rheumatoid arthritis. It is likely that you will visit many individuals with one of these two diseases. Because of their prevalence, each will be discussed in Section B.

SKIN

Changes in the skin are associated with the normal aging process. Many of these changes can be directly attributed to exposure to the sun and care of the skin over the life span.

You may notice the loss of elasticity, dryness and an appearance of spots of pigmentation on the skin. The loss of elasticity greatly increases the appearance of wrinkles. The older individual may also experience increased itching due to dryness.

NAILS

The rate of nail growth decreases with age. The nails may thicken, appear dull, opaque, and yellow or gray in color. They often become fragile and brittle. Clipping one's toenails often become difficult for the older individual due to both the thickening of the nails and the decreased flexibility of the body. For those with diabetes, it is recommended that a health care professional provide nail care.

You will want to maintain information regarding resources for foot care in your resource file.

SENSORY CHANGES AND THE AGING PROCESS

Both **vision** and **hearing** changes will be discussed at length, but changes also occur in the other senses. The sense of **taste** may diminish over time and is more prevalent when accompanied by lifestyle habits such as smoking or tobacco use. The lack of taste may also be a side effect of the medications taken by older individuals. Desensitization, especially in the ability to distinguish between taste categories such as sweet, salty, or sour is the most common. It is not unusual for the use of spices, especially sugar and salt, to increase in the older individual's diet in an attempt to compensate for this loss. This in turn may impact other dietary controlled diseases, such as diabetes and high blood pressure.

You will likely hear the complaint "food just doesn't taste good any more." This lack of taste appeal may discourage the older individual from eating which indirectly leads to poor nutrition.

Studies show decreased sensitivity to **smell** closely parallels that of diminished taste.

Sensitivity to **touch** may also decrease as one ages. This is attributed to the changes in the skin mentioned earlier, as well as decreased numbers of nerve endings particularly in the fingertips, palms of the hands, legs and feet.

Burns and other skin damage become greater risks for the older individual because they may not feel the hot pain against their skin until the damage has been done.

HEARING AND THE AGING PROCESS

There are no magic formulas to determine the degree of hearing loss individuals will experience as they age. Like so many other aspects of aging, the degree and type of loss is dependent upon their individual experiences including: exposure to loud noises, diseases, medications and the subtle changes in ear. It is estimated that between 40% and 60% of those over 65 will experience some degree of hearing loss. This percentage will increase as the older individual ages.

The most common permanent hearing loss for the older individual is the inability to detect high frequency tones. Called **presbycusis,** this type of loss initially affects only the highest frequencies and usually goes unnoticed until the progression is such that normal speech tones

are affected. As the loss increases, speech discrimination may become difficult since consonant sounds are in the higher frequencies and vowels in the lower. The individual may only be hearing a garbled collection of vowel sounds. To better understand this type of hearing loss, read aloud a sentence or two omitting the f's, s's, sh's and th's

Hearing loss can also result when sound waves are blocked form reaching the eardrum. A frequent cause of this type of loss in the older adult is the blockage of the ear canal by excessive wax. Fortunately, this can be reversed by having the ears irrigated by a physician. If earwax is not the culprit and a permanent loss has occurred, then either surgery or a special hearing aid may help restore some hearing abilities.

DETECTING A HEARING LOSS

Early detection of a hearing loss in important to the success of both adjustment and treatment. The average elderly individual will wait five years before seeking assistance with a hearing problem.

Presbycusis, as described above, allows the older adult to hear some sounds but not others. This results in unclear messages being received. It is important therefore, to observe their behavior for clues of a hearing loss. This information could be vital in making a correct assessment. For example, when you ask "How are you?" and the reply is "Eight-six," this could raise questions regarding mental status when hearing loss may be the problem.

COMMON BEHAVIOR INDICATORS OF HEARING LOSS

- inattentiveness
- inappropriate response
- frequent request to repeat
- loud speech
- loud volume of radio or TV
- an intense focus on your moth as you speak
- person consistently turns one ear towards conversations

If the person already has a hearing aid and displays some of these behaviors, you will want to ask questions about the effectiveness of their aid, the length of time since their last exam and whether the batteries have been replaced recently.

HOW A HEARING LOSS MIGHT AFFECT THE OLDER INDIVIDUAL

To best serve the needs of the hearing impaired adult, it is important to realize that the actual loss of hearing is not the only change occurring. As mentioned earlier, psychosocial changes will likely accompany this loss. When assessing their needs, these may prove to be greater issues than the hearing loss itself.

Those who suffer from hearing impairment may feel socially isolated, angry, fearful, embarrassed or anxious. They may also experience a lowered self-esteem or become depressed. Depression is twice as common in those elderly who are hearing impaired.

COMMUNICATING WITH THE HEARING IMPAIRED

There are many things that you can do to improve the communication process with a hearing impaired individual. Refer to the Communication chapter for additional information.

- Get the person's attention by either a light touch on the hand, or by calling their name initially.
- Face the individual at eye level and be sure your face is visible as you speak. Many older individuals become very adept at lip reading.
- If female, brightly colored lipstick will help the older individual in attempts to read your lips. Males with mustaches should keep them trimmed so their lips can easily be seen.
- Avoid exaggerated lip movement.
- Keep you hands away from your mouth.
- Speak a little louder, DO NOT SHOUT.

VISION AND THE AGING PROCESS

The degree of individual change in vision varies much like the other senses. However, some vision changes do occur uniformly across aging populations and are therefore more predictable. Typically, at around age 40, the lens of the eye begins to change, making close work more difficult to focus on. Known as **presbyopia**, this change occurs as the lens becomes less flexible and inelastic. Appropriate eyewear is usually successful in accommodating for this change and therefore presbyopia typically presents no serious problem.

The lens of the eye also begins to yellow with age, creating difficulties in distinguishing between color intensities especially cool tones such as blue, green and violet. The ability to clearly distinguish color may diminish by as much as 35% during the older individuals 6th decade and near 80% by the 8th decade (Ebersole and Hess 1990).

These changes in the lens also affect the intensity of light received by the retina. By age 60 the retina of the eye may be receiving one-third the light it once did. Consequently, glare typically becomes a significant problem, including both sunlight and the reflection of light on shiny surfaces.

Both depth perception and peripheral vision may be affected. Increasing difficulties with many activities such as driving, or even navigating through a crowd may occur. Falls and accidents may increase as a result of these changes.

Though the changes above may be considered typical of the aging eye – **disease, not age** – is the most common cause of severe visual impairment in the older individual. Please refer to Section B for specific information regarding cataracts, glaucoma, macular degeneration and diabetes.

VISUAL IMPAIRMENT AND THE OLDER INDIVIDUAL

In completing your assessment, it will be important to understand how the visual impairment of an individual is affecting his/her ability to function on a daily basis. Activities most commonly impacted include: driving a car, grocery shopping, seeing markings on appliances, watching television, and reading.

DETECTING A VISUAL IMPAIRMENT

Frequently, the older adult will openly share concerns about their vision. In some cases the changes may have occurred slowly and the individual has adapted to the point that they are unaware of the impairment. In other cases, they may be too embarrassed to discuss this loss with anyone, least of all a stranger. Like detecting a hearing loss, there are several visual cues that may be used in detecting visual impairment. It is important to keep these cues in the context of the person's usual environment, i.e., dirty clothing may not be an indication of poor sight if the person has never been concerned with their appearance.

CUES FOR DETECTING VISUAL IMPAIRMENT

- Spotted, soiled or mismatched clothing.
- Heavily applied makeup.
- Heavy use of non-visuals such as searching with their hands for an object, or searching for the edge of a chair to walk around it.
- Intense lighting is used.
- The person consistently sits nearest to the direct source of light.

PSYCHOSOCIAL AFFECTS OF VISUAL IMPAIRMENT

As stated earlier, the psychosocial changes associated with impairment are often as significant to the person's well being as the loss itself. Boredom, depression, feelings of dependency, fear of total blindness, and a fear of falling are often serious concerns for those experiencing visual impairment.

Several things can be done to better accommodate the visually impaired.

- Insure adequate light is present.

- Reduce glare, avoiding reflective surfaces.
- Avoid color-coding if safety is a factor.
- Avoid abrupt changes in light.
- Use large print when possible.
- Use non-verbals such as a light touch on the hand to show you are listening.

In some areas, via a rehabilitation center or the State School for the Blind, services are available to the visually impaired that provide an assessment of their living quarters to better ensure safety. A person's needs are also assessed in terms of visual aids that could enhance their ability to perform everyday living skills. You will need to research the availability of these services in your region, and make the information a part of your resource file.

INTERNAL ORGAN CHANGES AND THE AGING PROCESS

Studies show there is little change in the digestive system as a result of aging. One important change that may affect digestion is the loss of teeth, usually due to periodontal disease of the gum and supporting tissue. The effectiveness of dentures is estimated to be only 12% of ones own teeth. Consequently, the denture wearer must chew food much longer in order to reach the same level of mastication. Chewing difficulties may lead to dietary modifications that include softer foods, reducing dietary bulk and potentially creating digestive problems such as constipation.

KIDNEY AND BLADDER

The capacity of both the kidney and bladder diminish with age. This result is a slowing of the filtering process by the kidneys, increasing the potential of drug overdose since the amount of medicine in the bloodstream will tend to concentrate more quickly.

A reduced bladder capacity will increase the frequency of urination. Weakening of muscle tone may also create difficulty in the emptying of the bladder, making the older individual more susceptible to urinary tract infections.

Incontinence is an issue that you as an outreach worker will frequently come into contact with. However, because it is not a normal aspect of the aging process, it will be addressed in Section B.

HEART AND LUNGS

While the efficiency of performance for both the heart and lungs diminishes as one ages, the primary cause of problems with these major organs is disease related not age related. The most prevalent diseases will be found in Section B.

COGNITIVE CHANGES AND THE AGING PROCESS

Cognition is the processes by which information is acquired, stored and used. There are no indications that the aging process directly effects comprehension or problem solving skills. While older individuals do sometimes exhibit difficulties in these areas, the cause is frequently related to other issues. Comprehension and speech are directly affected by the person's ability to hear clearly, their education level, and often to the medication they are taking. Other issues that are not a part of normal aging, such as strokes, may also impact these abilities.

Most studies report no consistent memory loss occurring with age. Some older adults will perform as well on memory test as do young adults. If memory is affected, short-term memory loss appears more frequently than does long term loss. For the disease free older adult, the greater issue is often a delayed ability to retrieve information. This delay may be frustrating to the point of compounding the problem, making retrieval even more difficult.

Severe memory loss is commonly the result of diseases such as Alzheimer's, which will be specifically discussed in Section B. ***Causes of temporary or permanent memory loss might include: Alzheimer's Disease, medication, malnutrition, infection, lack of stimulation, surgery, stroke and depression.***

DEMENTIA

Dementia refers to impaired intellectual functioning that includes the inability to remain in control of one's daily life. Those aspects of brain function affected include: short-term memory, logic, ability to recognize familiar objects or people and the ability to carry out motor tasks. Dementia is often the result of an organic brain disorder such as Alzheimer's or Parkinson's disease. If treated promptly, the following causes of dementia may be successfully reversed: reactions to medications, infection, thyroid dysfunction, alcoholism and poisoning. Therefore, it is imperative that the individual receive an evaluation by a physician.

As an outreach worker providing services to the older adult, you will be viewing cognitive abilities in terms of how they affect the older adult's functioning on a daily basis. Can the individual remember to turn off the stove after cooking? Will he/she become lost if they leave their home? These are important considerations.

Organizations such as the Alzheimer's Association can provide screening/assessment of cognitive abilities.

AGING AND SOCIALIZATION

Socialization with both family and friends remains as important to the elder adult as it was in their younger years. Contrary to popular myth, the family still provides the major source of support as the older adult ages.

In today's society questions such as "who" we are, and "why" we are, tend to be answered in terms of our interaction with others. The older adult desires to continue being active, thriving, productive members of the community in which they live. The opportunity to maintain these interactions is sometimes drastically limited by retirement, physical disabilities, illness and loss. Support from the family assists in the maintenance of this vital interaction as long as possible.

Most older adults prefer to receive assistance from family members, and if family is not available, friends and neighbors are the next choice, followed by formal organizations (Lewis, 1990).

AGING PROCESS – SECTION B

In many cases the disease free older adult will initially require few services from you beyond information regarding the Senior Center, meals, health screenings and transportation. The majority of your contacts and especially those in the target population of frail elderly, will often be dealing with diseases which combined with "normal" aging escalates their needs. It is with this in mind that Section B, focusing on the most prevalent diseases and disabilities experienced by the aged, has been included.

This information is not intended to be used as a diagnostic framework. It should be used as one tool in the quest to obtain a clearer understanding of possible needs and consequences facing the older adult as disease becomes a factor in their lives.

The following diseases and lifestyle issues will be discussed both clinically and psychosocially.

ALCOHOL ABUSE

For approximately 10% of the older adult population, alcohol/drug abuse is a problem. This figure parallels the current rate of addiction for all ages. The older adult is also slightly more likely to be addicted to prescription medication than the average population. While the prevalence may be similar, in many cases the symptoms, attitudes toward treatment and the effects on the individual and the family may be quite different.

Alcohol abuse in the older adult often goes undetected and/or untreated for much longer periods of time. Detection is often more difficult because the older use typically does not frequent bars and is rarely arrested for driving while intoxicated. Missed work is seldom a factor because of retirement. The older addicted adult is most likely "using" quietly in their own home—alone. Until they become a behavior problem for the other residents, family or neighbors, their drinking may be viewed as harmless; one of the last pleasures in life for an old person who doesn't have that much longer to live. This societal attitude is reflected in the overall lack of intervention techniques and programs for older adults.

It is also important to recognize the attitude with which most older adults view addiction. They are generally from an era in which those with such a problem were viewed as weak and immoral. Today's concept of addiction as a disease is one that the older adult is either unaware of, or based upon the above attitude, disagrees with. This lack of understanding often perpetuates the "secret" of addiction, preventing the admission of and therefore treatment of the problem.

Another factor that adds to the difficulties in detection, is that many of the symptoms are those generally associated with other diseases, or even "old age". They may have tremors, impaired memory, fragmented sleep patterns, unsteady gait and depression. You will notice as you continue reading about diseases affecting the older adult, that these same symptoms mimic and are easily mistaken for those associated with such conditions as Alzheimer's, Parkinson's, depression, medication interactions and others. This underscores the significance of a professional evaluation.

Listed below are specific behaviors that might be considered "cues" for an addiction problem. It is important to realize that each of these must be kept in the context of normal behavior for the

particular person. The degree of a change and inconsistency is actually the greatest indicator of a problem.

POTENTIAL CUES FOR ALCOHOL/DRUG RELATED ADDICTIONS

- Physical appearance is inconsistent, i.e. one time the person is neat and tidy, the next unclean and unkempt.
- Inconsistency in condition of living quarters, i.e. neat and tidy on one visit, dirty and unkempt on the next.
- Increase in numbers and seriousness of bruises, scratches and cuts.
- Changes in activities and/or personality.
- Family relationship problems.

It may be very difficult for an outreach worker to make an assessment that indicates alcohol/drug problems. The difficulties lie not only in recognizing the symptoms as stated above, but also because the person who is addicted is the LEAST likely to share that information. It is not realistic to expect that you should always recognize this issue within the scope of your limited visitations. However, it is likely that at some point you will experience an initial interview that leaves little doubt regarding the presence of an alcohol/drug issue. It is important that you discuss with your supervisor the appropriate policies regarding your ability to follow up, refer and intervene in issues that concern addition.

TREATMENT FOR ALCOHOL/DRUG ADDICTION

Treatment for older adults is similar to that of other age groups, however, the most successful treatment is less intense and delivered at a slower pace. The context of how the older adult views their addiction is primary in the successful delivery of recovery services to that older adult.

Your resource file should contain referral information regarding treatment options currently available.

ALZHEIMER'S DISEASE

Both the cause and cure of Alzheimer's disease are unknown. Onset may begin as early as age 40 and as late as 90. Most frequently the person is over age 65. Symptoms occur very slowly with initial changes frequently attributed to "aging." Recent memory loss is the first and most obvious symptom, followed by the loss of intellectual function and judgment as the disease progresses. Personality changes often occur, the most common being apathy. Others include increased self-centeredness, dependency, clinging behavior and angry outbursts. In later stages the sleep cycle is disrupted and the person frequently paces and wanders. At some point, a caregiver must perform dressing, feeding, and personal hygiene activities.

Diagnosis is based upon an evaluation of the prolonged history of the patient, and the elimination of all other causes of dementia by physical examination and laboratory tests. *Many reversible conditions mimic Alzheimer's, making it vital for a person who exhibits symptoms of memory loss, confusion and disorientation, to receive evaluation by a physician.*
You will also want to pay close attention to the needs of the caregiver. The stresses involved in caring for an Alzheimer's patient can be overwhelming and exhausting. Information regarding the North Dakota Family Caregiver Support Program, support groups and respite care should be included in your resource file.

ARTHRITIS

The definition of arthritis is literally "inflammation of a joint." This term is often used generically to describe any joint discomfort. There are over 100 types of arthritis, three of which are prevalent for the aging adult. Generic symptoms associated with arthritis are swelling, warmth, redness and pain.

Osteoarthritis is the most common joint disease encountered by the older adult and is referred to as degenerative joint disease. Weight bearing joints such as the spine, knees and hips are most commonly affected. Osteoarthritis results in the cartilage of a joint eroding, often to nonexistence. It is not unusual for bone spurs to develop within the affected joint, creating increased pain and joint stiffness at night, as well as malformation of the joint. Mobility may be greatly decreased as the disease progresses.

Rheumatoid arthritis is a progressive disease that typically is present between the ages of 20 and 60. The older adult has likely carried this disease into old age. While it may attack any connective tissue throughout the body, it often primarily involves the inflammation of the joint membrane. Cartilage disintegrates as fibrous connective tissue forms often creating deformities such as twisted drawn hands. Rheumatoid arthritis is characterized by morning stiffness and by remissions followed by reactivity.

Gout is a metabolic disease that causes painful arthritis. Uric acid build up in the body causes sharp crystals to form within a joint, typically first in the big toe. The result is often painful, hot, swollen and tender. Discomfort usually lasts for several days then recedes, only to recur later.

These three types of arthritis are treated primarily with anti-inflammatory medications. For each, diet, rest and exercise will often have some impact on either the symptoms or the reoccurrence. Arthritis is not curable, but the symptoms can be treated and early diagnosis is critical to long-term management of these diseases.

PSYCHOSOCIAL ASPECTS OF ARTHRITIS

Two major effects of arthritis, on-going pain and decreased mobility, may greatly impact the quality of life for the older adult. Walking often becomes both difficult and painful, the hands may no longer be able to grasp objects, creating difficulties with self-care and feeding. Constant pain may impact the coping skills and irritability of the individual.

Issues of concern that may accompany the serious progression of arthritis include: isolation, poor nutrition, withdrawal, embarrassment, and depression.

Information from the Arthritis Foundation should be a part of your resource file. Not only do they have excellent information to share but also in some areas they may even offer services such as walking aids to individuals suffering with arthritis.

CANCER

Changes in the immune system as one ages, has been implicated in the increased incidence of cancer, which continues to be one of the two leading causes of death for the older adult. Often the detection of cancer in the older adult is significantly delayed because the symptoms are disguised in another disease or simply attributed to "aging." This delay is thought to greatly impact the opportunity for successful treatment.

Treatment for the older individual is as varied as for any other age group, but may be complicated by frailty or disability.

Since early detection is vital to successful treatment, it is important to be familiar with warning signs that warrant an examination by a physician. Refer to the American Cancer Society website for warning signals.

CATARACTS

Cataracts are cloudy or opaque areas which form on the transparent lens located inside the eye. Cloudiness dims the passage of light flow and impairs vision. Cataracts usually develop gradually, without pain, redness, or tearing in the eye. When vision loss interferes with activities of daily living, surgery is the recommended treatment, during which, the clouded lens is removed and replaced with an intraocular lens implant. This is typically a safe procedure with very few complications and a high success rate.

Several factors linked with the formation of cataracts include: high blood pressure, diabetes, and exposure to various forms of radiation.

Section A. Vision and the Aging Process should be referred to for specific cues in detecting vision problems. The Communication chapter discusses special techniques for improved communication with the visually impaired.

CORONARY ARTERY DISEASE

Coronary artery disease, also known as ischemic heart disease, is the major cause of heart disease and death in the older adult. Characterized by a condition known as atherosclerosis, the large arteries of the heart narrow due to a build up of plaque. This can lead to a myocardial infarction (MI) or heart attack. Damage to the heart may result depending upon the severity of the attack.

Risk for the development of coronary heart disease includes several factors that cannot be changed including: heredity, gender (male), race (black) and age. Other risk factors may be modified including: cigarette smoking, high blood pressure, elevated serum-cholesterol levels and diabetes. Obesity, sedentary lifestyle and excessive stress are also contributing factors.

DEPRESSION

Depression may very from feeling low to complete withdrawal or even suicide. Older people experiencing depression often state that, during such times, they feel discouraged, worried, or disgusted with their own uselessness. They often make statements such as “there is just no reason to go on living” or “I would welcome death” (Weiner, Brok, Snadowsky 1987).

The most common causes of depression in the elderly are bereavement and grief for the many changes in life events. Those changes may include: a loss of identity due to retirement, loss of a life long home as health needs increase, loss of independence as vision and mobility change and the adjustment to the physical changes that are occurring.

Symptoms of depression in the elderly include: withdrawal, self-neglect, sleep disturbance, pessimism, sadness, fatigue, slowness of thought and action, change in appetite, lack of libido, hopelessness, and agitation. Statements regarding suicide should never be taken lightly regardless of the age of the speaker. Suicide Prevention and Crisis Intervention Numbers should be a part of your resource file.

DIABETES

Diabetes mellitus occurs because the body cannot properly convert food into the energy needed for daily activity.

Insulin, the regulator of glucose into the blood stream, is either not present or is not performing effectively.

The long-term effects of this disease on the body can be devastating. Vulnerability to blindness, kidney failure, heart disease, stroke and gangrene may be a result of the damage that is done to the blood vessels over time.

There are two main types of diabetes, Type I, or insulin-dependent diabetes and Type II, noninsulin-dependent, also known as Adult Onset diabetes. Type I is the most severe an generally occurs in childhood. It requires lifelong treatment of insulin injections. For the older adult, the most prevalent is Type II, which can usually be successfully controlled with oral medication and diet modifications. Exercise and a well balanced diet are critical for successful treatment of either type.

It is important that the older adult who experiences these symptoms be referred for a physical examination. Proper foot care is vital for those with diabetes since circulation is affected and the blood supply to the feet may be reduced, causing numbness. It is recommended that nail care be performed by a medical professional. Diabetics should examine their feet daily for redness, blisters or infections. Because healing is slowed and feeling is reduced, there is a dangerous potential for serious infection to develop without the person’s awareness.

The American Diabetes Association is an excellent resource for additional information regarding diabetes and its treatment.

GLAUCOMA

Occurring most frequently in person with a family history of the disease, glaucoma is the result of a build up in eye pressure. This is due to an inadequate drainage of the nutrient fluid that bathes the eye. Once this pressure is transferred to the optic nerve, irreparable damage results, and may include total blindness.

The initial symptoms of glaucoma are subtle. A great deal of damage may be done before medical attention is sought. The most obvious symptom is a gradual loss of peripheral vision. The person may complain of bumping into things or may fail to see passing cars in the next highway lane. This will eventually deteriorate to tunnel vision and finally total blindness if untreated. Another symptom is blurred vision that lasts for an extended period of time. This is often accompanied by rainbows in halo forms. It is recommended that anyone over the age of 40 have regular eye exams that include glaucoma screening.

Early treatment can prevent blindness, and may consist of special eye drops, oral medications, laser treatments, or in some cases surgery.

HOME SAFETY

As difficulties increase with decreases in mobility and vision, it is important that the living environment be assessed in order to alleviate as many opportunities for accidents as possible.

If you feel the situation is unsafe, it is important to discuss this with the older adult and work **together** to seek ways in which the environment can be improved to better meet their needs.

HYPERTENSION

Hypertension, also know as high blood pressure is sometimes called the "***silent disease***" because one may appear perfectly healthy and have dangerously high blood pressure. A blood pressure reading measures the force exerted by blood flowing against blood vessel walls.

Untreated high blood pressure can be very dangerous, precipitating such conditions as stroke, heart disease and kidney failure. Fortunately, hypertension can usually be treated with medication and diet. In mild cases, diet alone may lower the pressure to safe levels. Frequently, medication must be taken for a lifetime once it is begun. Medication should be taken at the same time every day when possible. This helps to maintain the blood pressure at a more consistent level. "Doubling up" to make up for missed doses is dangerous and should not be done.

INCONTINENCE

Incontinence is the loss of control over bladder or bowels. Urinary incontinence, the most common, affects 1 in 10 adults, of which only 15% will be male.

Urinary incontinence is not caused directly by aging. Life changes such as childbirth, diseases that restrict mobility or affects cognitive skills, and changes in muscle tone and bladder capacity are the primary culprits contributing to incontinence. Medications may also trigger incontinent episodes.

Incontinence, often viewed in terms of the loss of control over ones body, is considered by many to be the worst possible condition. What begins as a restriction in activities to avoid accidents may develop into lowered self-esteem, withdrawal, isolation and even depression.

It is imperative that anyone dealing with incontinence be examined by a physician. Incontinence is a sign that "something isn't right" and in one third of the cases can be successfully prevented. In those cases where total prevention is not possible, frequency and degree of leakage can be improved. Assistance via adaptations that maintain regular social activity are also available.

MEDICATIONS

Older adults are often more sensitive to medications. The reasons are many and include:

- Multiple diseases may alter the way the body handles drugs.
- Multiple medications may interact creating side effects.
- Increased numbers of medications increase the likelihood of errors in taking them.
- Physiological changes in the body as one ages changes the ability to absorb and excrete medication, increasing the potential for overdose.

It is not unusual for an older adult to be taking several different medications prescribed by separate physicians. ***When making a medical referral always encourage the older adult to take all medications they are currently using to the appointment with them.*** This provides an opportunity for a single physician to review the medications for interaction and duplication.

If when visiting, he/she expresses concern regarding their medication, it is appropriate to encourage them to call the pharmacist and ask questions regarding the interaction of medications and their side effects.

If you have questions regarding specific medications, the pharmacist is an excellent resource. NEVER diagnose or advise based upon the information received. A referral to a physician is a priority if you perceive that a problem with medication exists.

MACULAR DEGENERATION

The leading cause of blindness among adults in the United States is macular degeneration. The macula is the key focusing area of the retina. Symptoms of degeneration include: blurring of reading matter, distortion or loss of central vision, and distortion in vertical lines. With early detection, some cases can successfully be treated.

OSTEOPOROSIS

Sometimes called "thin bones," osteoporosis affects 25% of women over the age of 65 and 6% of men in the same age group.

Developing silently over the years, it may go unnoticed until the spine becomes noticeably curved (often called “dowager’s hump”) or until a hip, wrist or other bone breaks. At this point, even a minor fall may result in a break, or a hip bone might fracture causing a fall.

Osteoporosis is diagnosed primarily by x-ray. Diet and exercise throughout the life span can significantly impact both the development and progression of osteoporosis. The diet should include high calcium foods such as dairy products, leafy green vegetables, salmon and sardines. Smoking, drinking alcohol and beverages with caffeine also increase the body’s need for calcium. Eating excessive protein may also cause the loss of calcium through the urine. Supplements are often recommended if the diet doesn’t supply adequate amounts.

Regular exercise that places moderate stress on the spine is important. This can be done in many ways such as walking, jogging, dancing or bicycling. Treatment involves stopping further bone loss and includes the same procedures as prevention – diet and exercise. The physician may also prescribe medication in order to slow the rate of bone loss.

PARKINSON’S DISEASE

Parkinson’s disease affects over one million people in the United States and is the most predominant neurological disease of older persons (Ebersole and Hess 1990). Primarily a motor disorder, Parkinson’s disease is characterized by tremors and muscular rigidity. Caused by a decrease of dopamine to the brain, traditional treatment includes the drug L-Dopa, which requires careful monitoring for side effects including hallucinations, depression and confusion.

It is important to note at this time, that the side effects listed also mimic symptoms of other diseases we’ve discussed such as Alzheimer’s. **This underscores the point that this information is not meant to be diagnostic but to provide you with the basic knowledge necessary to make appropriate referrals.**

Self esteem is often affected as the disease slowly progresses. The risk for depression may increase as tremors become more noticeable and perhaps embarrassing, speech becomes difficult and socialization typically decreases.

As with other disorders of this type, early diagnosis and treatment is imperative.

SELF NEGLECT

Self-neglect is the term used to describe the older adult who either chooses not to or for some reason cannot meet their own daily needs. This might include failure to obtain or accept medical treatment, inadequate food, poor personal hygiene and inadequate home care.

STROKES

Also known as a cerebral vascular accident (CVA), stroke continues to be the leading cause of disability for the older adult. A stroke occurs when a vein in the brain becomes blocked or ruptures. It may result in temporary or permanent paralysis, confusion, loss of speech, clouding of memory, dementia, unconsciousness, and death. The greatest indicators of risk are high blood pressure and smoking.

Successful treatment is dependent upon the immediacy of medical treatment and the degree of permanent brain damage that has occurred. Medical care, physical therapy, speech therapy and recreation are all typical aspects of the treatment.

CHAPTER III

COMMUNICATION

COMMUNICATION

FUNDAMENTALS OF COMMUNICATION

Four Primary Components of Communication

Sender → Message → Receiver → Feedback

What do you think of when you hear the word communication? Maybe you think of someone talking, using the telephone, television, computers, or writing. Communication itself involves the process of someone sending a message, someone receiving that message and providing feedback. Ideally, the key to successful communication is the ability to shift back and forth effectively between these two roles (sender to receiver and back again).

Recall a recent conversation in which you participated. Remember your role as both sender and receiver. Which role required the greatest effort on your part? If you were recalling an average conversation, you probably discovered that the greater effort was expended while in the role of the sender. Typically we spend considerable energy in trying to get our own message across and minimal energy goes into understanding someone else's message. For effective communication as a professional helper, **equal emphasis** must be placed on these two roles. No matter how well you deliver the message, if you are unable to listen closely with both your eyes and ears, opportunities to provide service may be missed.

As an outreach worker who will often initiate the meeting with an older adult, the communication process will begin with you as the sender. Let's look at some things that are helpful to know or do in that role.

WHAT THE SENDER SHOULD KNOW OR DO

1. **Know the Receiver**
2. **Deliver a Clear Message**
3. **Understand and Utilize Feedback**

WHO IS THE RECEIVER?

Sometimes, the only information available prior to face-to-face contact is a name and address. This requires you to be alert to clues that show "who" the person is. These clues will be found in the information shared and by your observation of age, general appearance, behaviors and living environment.

If the individual has an existing file, take a moment to skim it. Familiarize yourself with their age, living arrangements and the general assessment taken upon the last visit. This knowledge will help to place the person in the context of where they may be in the aging process and also alert you to potential areas of concern.

Assigning characteristics to an individual (stereotyping) based solely upon information regarding age, life experiences, health, cultural background and work history is never appropriate.

Anticipating potential barriers prior to contact, provides you the opportunity to reduce or even eliminate those barriers before they negatively impact your attempt to build good rapport with the individual.

Example: You will be visiting an 83 year old white male, of German descent who retired from farming. What might be significant communication factors?

- Educational background.
- Language barrier may exist, i.e., may be more fluent in German.
- Language barrier may exist in terms of the use of words that may have different meanings today than they had when the older adult was growing up.
- There may be a need to slow the pace of conversation to allow for extended response time.
- There may be vision or hearing disabilities.
- The older adult may be reticent about sharing personal information because in his/her day "you solved your own problems."

All the above are examples of factors whose impact can be minimized with awareness and preparation. How? Take care to speak at the level of the older adult's understanding. Avoid use of jargon and words with dual meanings. Try to follow the older adult's lead to establish the conversation pace. If you are aware of a language barrier prior to your visit, try to locate someone who can translate information for you. (The specifics of these skills will be discussed in greater detail in this module).

It cannot be over emphasized that all known information prior to face-to-face contact with the older adult (including previous records and referral information) should be viewed as "**awareness tools.**" This knowledge and awareness can help alleviate potential barriers in the assessment process. However, to make assumptions regarding the older adult's needs or abilities before the interview, will diminish the likelihood of an objective assessment that is both thorough and accurate.

HOW DOES ETHNICITY AFFECT COMMUNICATION?

It can be difficult to overcome barriers created because of cultural differences. If either party holds prejudices, trust is more difficult to develop. You may not be able to change how another individual views your entire culture. You can, however, impact how they view you as a helping individual as well as how you view them. Knowledge of another culture is the greatest tool for both alleviating your own prejudices and eliminating potential barriers that arise because of a lack of cultural understanding.

An example you may be familiar with, is the difference between how some cultures and the American Indian culture view eye contact. For example, for most Americans eye contact shows an interest in the conversation and the person. For the American Indian, direct eye contact is an indication of disrespect. Entering the interview process with an American Indian without this

basic knowledge of cultural differences could build communication barriers that halt the helping process.
If there are populations with whom you consistently work, which are different culturally from your own, maximize your ability to serve those individuals by taking the time to learn about their culture. To learn more about other cultures in your community, seek out individuals who are familiar with them and are willing to share their knowledge with you.

DELIVERING THE MESSAGE

Do you know someone who speaks so rapidly that carrying on a conversation with them takes tremendous concentration? Just trying to understand the words and processing the meaning under those conditions can be exhausting.

When you consider the older adult who may have visual or hearing disabilities, as well as a slowed response time, the need to set a slow comfortable pace takes on an even greater significance.

Below are tips for increasing the accuracy of your messages.

- SLOW DOWN, a relaxed speaking rate and clear speech will enhance the receiver's ability to listen.
- Identify the message to be sent, KEEP IT SIMPLE.
- Project a warmth in your tone.
- Change your voice pattern to reflect the nuances of feelings and to emphasize important information.
- Insure words with multiple meanings are clarified and understood.
- Avoid jargon and clichés.
- Avoid the use of slang or words that may have several different meanings.
- Incorporate timely pauses which allow the receiver adequate opportunity to process the information, facilitating the ability to respond.

If it becomes clear to you that the receiver has not understood the message, it may be helpful to repeat the message as stated. If there is a need to repeat further, try to rephrase the message instead of repeating it a second time, which often creates anxiety and increases frustration.

REPHRASING EXAMPLE

"When was your last doctor's appointment?"

Could be rephrased as:

"Have you seen your doctor recently?"

Be aware of behaviors that sometimes accompany a rephrased statement. A shake of the head or a look of frustration can easily be interpreted by the older adult. This will likely increase their anxiety level and may affect the success of the communication process.

I – MESSAGES

I – messages are valuable communication tools that convey respect toward the individual being spoken to. The message is phrased in a way that conveys feelings and concern rather than placing blame or finding fault. To understand the difference in the feelings evoked by the choice in phrasing, consider the following.

An older adult has mentioned to the outreach worker that they have stopped taking their heart medication. The outreach worker responds:

> "You should never stop taking your medication without speaking to the doctor first."

What feelings might this response elicit from the older adult? (Defensiveness, embarrassment and anger may have come to mind).

In contract, what if the response had been:

> "I am concerned when you stop taking your medication without speaking to the doctor first."

Would the older adult have felt differently? Absolutely! **By expressing concern without judgment or blame, further communication has been encouraged.** The older adult may then share the "why," disclosing that the medication was stopped because the prescription had run out and no transportation was available to pick up the refill. Use of the first response would likely inhibit the sharing process. Thus a somewhat simple problem, with significant ramifications for this older adult, might remain unsolved.

HOW TO USE I – MESSAGES

Learning to use I – messages takes practice and may feel awkward at first. A basic model can be helpful in the beginning. I feel _____ when you _____. Inserting feeling words into the first blank and action words into the second. After using this module for a while, you will find it becomes easy to vary the format.

UNDERSTANDING AND UTILIZING FEEDBACK

Feedback is the meter by which you measure the effectiveness of the communication process. The greater the feedback, the more likely the information being shared will be understood by both parties. Questions, agreement, opinions, volunteered information, fault-finding, correcting, and disagreeing are all examples of feedback. Feedback is also reflected by nonverbal behaviors. For example, squinting eyes, a furrowed brow, and blank or quizzical eyes all may show a lack of comprehension. A smile or nod shows you are listening and interested.

Awareness of nonverbal signals is critical to good communication and is discussed in the section entitled Body Language.

HOW TO ASK A QUESTION

A common form of feedback is the question. Questions are useful for obtaining clarification and preventing misunderstandings. Depending upon the information you are seeking, a question may be either open or closed.

Closed questions can often be answered with a single word and tend to limit the amount of information that will be shared. They generally begin with a verb such as are, is, was or were. In contrast, an open question allows the person being questioned to provide a broader spectrum of information. Open ended questions tend to begin with words like: where, when, what, who, which or how. Responses to open ended questions usually provide answers to specific questions that might be necessary for filling out forms. Simultaneously, they may reveal a rich history that will help in understanding the whole person. Open-ended questions provide an opportunity for the communication process to flow freely from sender to receiver and back again. Here are some examples of how closed questions can be turned into open-ended ones.

Closed: Are you feeling poorly today?
Open: How are you feeling today?

Closed: Why don't you consider _____?
Open: What are some options you have considered?

Closed: Did you get a good night's sleep?
Open: How have you been sleeping lately?

Closed: Will the Dr.'s directions be difficult to follow?
Open: What difficulties might there be in following the Dr.'s directions?

Obviously there are times when closed questions are necessary. For example, a person's social security number is not likely to come up in a conversation without you directly asking the question. The following questions are used to clarify the communication and are both necessary and appropriate for good communication. "Would you like to talk about it?" "Would you like me to contact your daughter?" "Will you sign this release of information form?"

If you notice that a conversation between you and another individual is very one-sided with you doing most of the talking, review the messages being sent. Are you asking primarily closed questions? This is likely the case. Use this awareness as a learning experience and make a point of practicing the use of open ended questions whenever possible.

QUESTIONS TO BE AVOIDED

Leading questions and **double-barreled** questions also interfere with successful communication. The leading question "You've been eating three meals a day, haven't you?" gives the impression that a specific answer of "yes" is expected. This always sets up the possibility that the receiver will respond as expected whether or not the response is factual or represents their true feelings.

Double-barreled questions are two questions asked, one after the other. The respondent is denied the opportunity the answer the first question before the second is asked. They may be two questions in which the same answer can be given, or they may be two separate questions requiring totally different answers.
Examples:

- Do you have a ride to the Dr. today? Would you like for me to take you?
- Where does your daughter live? Is it far from here?

Asking two questions at once requires the respondent to mentally shift gears in order to answer both of them. This often results in only one question being answered. The sender is loosing access to valuable information in this process. It is also likely that being questioned in this manner is both annoying and confusing to the receiver, complicating future communication attempts.

CONVEYING AN ATTITUDE OF DESIRE TO COMMUNICATE

Whether in the role of sender or receiver, conveying an attitude that is receptive to the other individual is vital. Attitude is "a manner of acting, feeling or thinking that shows one's disposition, opinion, etc" (Webster's 1982). This definition shows that words are not the primary indicator of attitude. You may be saying the right words, but your behavior may be sending a completely different message.

Let's look at an example:

> An outreach worker explains at the door that he/she would like to come in to share information regarding services available. Once inside, the worker takes out the assessment form, holding it very close to her/his body and begins asking questions and making check marks.

Would someone peering over concealed forms, asking you personal questions, encourage you to respond? It is not likely! What can you do to insure your attitude is one that is receptive to giving and receiving information? The first thing to remember is that sincerity and respect are the basis for good relationships and the lack of either WILL undermine the entire communication process. Three areas that reflect sincerity and respect are:

REFLECTIONS OF SINCERITY AND RESPECT

1. **Your acceptance of the person**
2. **Demeanor (voice tone and mannerisms)**
3. **Appearance.**

ACCEPTANCE OF THE PERSON

This encompasses more than just viewing the older adult as an individual who may or may not require your assistance. The following concepts are inherent within "acceptance" of any person. As an outreach worker, you will primarily work with older adults, let's view each in those terms.

Individuality – Society stereotypically lumps the "old" together as if one is like any other. It is important to realize that older adults are as diverse as any other age group. An appreciation for the uniqueness of each person will provide a strong base for building rapport and trust.

Self-determination – An individual has the right to make choices for themselves whether or not, in someone else's opinion, it is the correct decision to be made. THERE IS NO AGE AT WHICH THIS RIGHT AUTOMATICALLY CEASES! The outreach worker's goal is to provide as much information as possible to the individual potentially receiving service. This affords the older adult the opportunity to make informed **choices** regarding the acceptance of services. **Participation of the individual involved is vital to successful assessment, assistance and referral.**

Assumed competency – A companion to self-determination, assumed competency means an individual is assumed to be capable of making their own choices until one has reason to believe otherwise. To approach the assessment/referral process with a preconceived notion of incompetency is a great disservice to the individual being served.

Confidentiality – This means information that is gathered will not be shared with others without the older adult's permission. The implication is that you can be trusted with personal information. Individuality, self-determination, assumed competence and confidentiality are all concepts that can be "loudly" disputed with actions. Here are two examples:

Example 1:

> An outreach worker has explained confidentiality and its importance to an individual, but in the course of the visit has shared details about a neighbor's personal life. The message most likely to be heard by the older adult in this instance is that their own personal information is also likely to be shared.

Example 2:

> While conducting an assessment, the outreach worker asks questions of the frail adult but immediately turns to the caregiver for a response. The older adult might easily feel their competency and self-determination is in question when such behavior occurs.

These concepts must be a strong part of your professional values and attitude. They must be reflected both in **words** and **actions**. Anything less will undermine communication and ultimately the helping process.

APPEARANCE

You may ask, "How does my appearance make a difference in the communication process?" The answer lies in the power of impression. When we meet someone new, our first impression is based upon physical appearance. How one is dressed, one's makeup and/or hairstyle and

personal hygiene all contribute to those impressions. How receptive would you be to someone at your door dressed in blue jeans, a wrinkled shirt and hair that is in obvious need of care? As an eighty-five year old, would you take seriously the offer of assistance from someone dressed in a mini skirt loudly chewing gum? Would you believe that either of these persons could actually meet your needs despite their words? By presenting yourself dressed inappropriately or unkempt, a barrier is created that results in lost time and opportunity. Time that could have been used in building the rapport needed to understand and meet the older adult's needs.
If you have questions or concerns regarding appropriate apparel, take the time to discuss this with your supervisor.

DEMEANOR

One's demeanor is primarily determined by nonverbal signals. Facial expression, posture, tone of voice and eye contact are just a few that will impact the message being sent. Studies suggest that **if your words and actions do not agree, the receiver of the message will believe the actions!** Facial expression also can support or contradict your words. A positive reply accompanied by a negative nod or raised eyebrow may be interpreted as disapproving or questionable, despite the words being spoken. We are often unaware of the facial expressions that accompany our speech. After studying the following list of Facial Expression Do's and Don'ts, use one of the two exercises that follow to evaluate your manner of communicating.

FACIAL EXPRESSION DO'S

1. Do use direct eye contact except when culturally inappropriate.
2. Do reflect warmth and concern in your facial expression.
3. Do address the client on an equal eye level.
4. Do vary facial expressions.
5. Do keep the mouth relaxed; with occasional smiles.

FACIAL EXPRESSION DON'TS

1. Don't avoid eye contact.
2. Don't speak to the client at a higher or lower eye level.
3. Don't stare or fixate on a person or object.
4. Don't nod head excessively.
5. Don't yawn.
6. Don't retain a frozen or rigid facial expression.
7. Don't smile at inappropriate times.

TONE OF VOICE

While tone of voice has been mentioned briefly, this is also an area by which the verbal message can be contradicted. A change in the emphasis can give the same sentence many meanings. To clearly understand the impact of voice tone, read the following sentences aloud stressing the word that is in bold print. Notice the different meaning in each sentence.

> **That** was a wonderful story you shared.
> (Not any story but **that** story.)
>
> That was a **wonderful** story you shared.
> (That story was exceptional.)
>
> That was a wonderful **story** you shared.
> (It was a story not a joke or a statement.)
>
> That was a wonderful story **you** shared.
> (That was special because of who shared it.)

Another tone variance that can change the meaning of single words or phrases is sarcasm. Have you heard someone say "Great!" in a tone that you knew was not meant as a positive statement in spite of the meaning of the word? Sarcasm sends mixed messages that are often difficult for the receiver to translate. There is rarely a place in the interview process in which sarcasm is appropriate.

The overall tone of a conversation will vary depending on the situation. For example, urgency is often conveyed by louder, rapid speech, comfort by a softer, slower rate. When the goal is obtaining the information necessary for an assessment, it is essential to match your tone and pace to that of the older adult.

Exercise: Pair up with a colleague and carry on a conversation in which one of you speaks rapidly, and the other slowly, then switch. Do you find the difference in pace frustrating? Consider how you would have felt had the speaker been a stranger asking you personal questions. The responsibility to match both the pace and tone lies with the outreach worker.

BODY LANGUAGE

Nonverbal signals can either enhance or hinder effective communication and have been discussed throughout this chapter. Posture and physical proximity are two additional areas in which body language can contradict the verbal message. Using the list of Do's and Don'ts below, evaluate your use of these non-verbal signals and answer the following two questions. (The same video taped interview used earlier can again be used.)

1. Are there signals that you consistently use that might inhibit the free flow of conversation?

2. What behaviors can you adopt that will enhance your communication skills?

POSTURE DO'S

- Do keep your arms and hands moderately expressive.
- Do use only appropriate gestures.
- Do lean slightly forward.
- Do appear attentive but relaxed.

POSTURE DON'TS

- Don't maintain rigid body position, i.e. arms tightly folded, legs crossed.
- Don't turn your body at an angle to the other individual.
- Don't fidget or wring your hands.
- Don't squirm or rock in the chair.
- Don't slouch or put your feet on the desk.
- Don't place a hand or fingers over the mouth.
- Don't point your finger for emphasis.

PHYSICAL PROXIMITY DO'S

- Do maintain three to five feet between chairs.
- Do respect the social boundaries of touch – hand, forearm, and shoulder.
- Enter with tablets or forms at your side. Remaining there until needed.

PHYSICAL PROXIMITY DON'TS

- Don't stand excessively close or far away.
- Don't talk across a desk or barrier.
- Don't pose with a note tablet or forms as if ready to write down everything that is said.

Modified from Direct Social Work Practice, Hepworth and Larsen (1990) p. 177.

RECEIVER

Both the sender and receiver use many skills already discussed. There are, however, some responsibilities that lie primarily with the receiver. They are:

1. Knowing the sender
2. Listening with concentration
3. Obtaining clarification
4. Responding to the message

KNOWING THE SENDER

How a message is received in part depends on whom the sender is. Is the sender a person whom the receiver trusts and respects? If the receiver (in this case, the older adult) has just met the sender (the outreach worker), these perceptions will be based on those factors discussed earlier. These factors include: the delivery of the message, the attitude of the worker, the appearance of the worker and nonverbal indicators of the message.

KEEP IN MIND --- If the receiver is an older adult who has little contact with society, what you say and how you say it may take on disproportionate qualities. You may be viewed as the "expert" who understands "all" things. This is a grave responsibility and should not be taken lightly.

LISTENING TO THE MESSAGE

The terms hearing and listening are often interchanges, however, they actually have very different meanings. **Hearing is a function of the ears** and simply is the ability to detect sound being transmitted. **Listening is a function of the mind** that requires both processing and interpretation on behalf of the participant. *Listening requires effort!*

There are many ways in which to listen to a message. To do so effectively requires active participation on behalf of the receiver. One such method is called ACTIVE LISTENING.

Active listening implies four characteristics: (Molyneaux and Lane, 1982)

1. Attentiveness to the speaker.
2. Desire to understand the speaker's viewpoint.
3. Willingness to suspend judgment or evaluation of the ideas/feelings expressed by the speaker.
4. Willingness to check your understanding by putting into words what you feel the speaker has conveyed.

All four of the characteristics are important in both verbal and nonverbal communication.

Nonverbal signals that convey both attentiveness to the speaker and your willingness to listen include:

- Maintaining frequent, direct eye contact (except when culturally inappropriate).
- Maintaining mutual eye level, if client is sitting, you sit, if standing, you stand.
- Exhibiting warmth and concern with facial expressions and tone of voice.
- Avoiding distracting behaviors such as tapping on a surface, fidgeting, yawning, or tapping one's foot.
- Exhibiting an open body posture by leaning slightly toward the speaker, arms held loosely at one's side or laying comfortably on chair arm or lap.
- Occasionally nodding the head, smiling or exhibiting other facial expression appropriate to what is being said.

Verbal signals include:

- Short statements such as "yes," "hmmm," "and then." These signal to the speaker that they still have the floor.
- Non-judgmental responses to the content of the speaker's message, including paraphrasing or summarizing in your words.
- Reflecting the speaker's feelings. (This discussed at length in the next section).
- Asking questions to clarify the message. (See section on asking questions).

Exercise: Test your reflecting skills by sitting with a colleague or friend and holding a discussion for about 30 minutes while applying the following rule. After one person speaks, the listener must verbally summarize the message satisfactorily before making a reply. How well were you able to reflect the speaker's messages?

RESPONDING TO THE MESSAGE

By responding to what the speaker has said, you are conveying a message of affirmation. Not only are you displaying an interest in them as an individual, but also a desire to understand.

In most cases, feeling words are not actually used in the communication process, but are implied. This requires you to look beyond the words spoken by using the listening skills previously discussed (appearing attentive, looking for nonverbal cues, etc.) and then responding appropriately to the feelings expressed.

An effective means of responding to feelings is called reflective listening. This technique "mirrors" the feelings of the speaker showing that you understand the emotions expressed. This type of reflecting also allows the speaker an opportunity to "view" their feelings, often providing

self-clarification. Reflective listening does not offer an opinion about the feeling, it only expresses understanding.

Here is an example of a reflective response:

Older adult gazing out the window while speaking:

"I used to go to the Senior Center everyday with my friends. There are many things I just don't do anymore now that I can't drive."

Response:

"It sounds as if you are sad because of all the changes that have accompanied your being unable to drive now."

Notice that the response did not parrot the message, but instead used the feeling word "sad" to express what the original message had implied. There are other implications that might be indicated from the original message. Can you think of different feeling words that could have been used?

HOW TO RESPOND TO A FEELING MESSAGE

Responding reflectively often takes practice. At first you may want to use a model such as:

You feel _____ because _____ (Hepworth & Larsen, 1983).

As you become more comfortable with the technique, you will be able to vary your response a great deal. Taking the time to look this over will help broaden your response base.

When a feeling message is received, wait 10 to 15 seconds to respond. Give yourself time to think. Use this time to ask yourself questions: what is the person feeling and why?

- **Do** present your response in a tentative manner. Suggest by your voice tone and body language that you are checking for accuracy with your response. This will help the older adult to feel comfortable with correcting or clarifying.

- **Don't** presume to TELL the person how they are feeling.

When words aren't being used to express feelings, you will be doing some guessing based upon the nonverbal cues you are receiving.

Example:

While making a follow-up visit to deliver some paperwork to an older adult, he/she greets you at the door and verbally responds that he/she is doing well. However, you notice he/she sits on the edge of his/her chair, fidgeting and wringing his/her hands.

Reflective Response:

"You seem anxious today, is something wrong?"

It is important to keep your reflective response open, neither adding to nor taking away from the original message. By doing so you show, if not a clear understanding, at least a desire to understand the message. To respond in a closed manner suggests either a lack of interest in what was said or simply that you did not understand what was **really** said.

Let's look at the original example using closed responses:

Older adult gazing out the window while speaking:

"I used to go to the Senior Center everyday with my friends. There are many things I just don't do anymore now that I can't drive."

1. **Minimizing**
   "Oh, I am sure there are still many other things you can do."

2. **Personalizing**
   "Yes, that is hard, but not as bad as when my mother had her stroke and went straight into a nursing home."

3. **Temporizing**
   "I'm sure you'll get used to being at home all the time, you'll feel better about it in no time."

4. **Sympathizing**
   "That is so awful, how can you stand it?"

5. **Universalizing**
   "I know it is hard, but everyone has to quit driving eventually."

6. **Judgmentalizing**
   "You should just be happy that you still have friends, and not worry so much about driving."

COMMUNICATION BY TELEPHONE

It is always preferable to meet face-to-face with an older adult when conducting interviews or assessments. Occasionally, circumstances may warrant an initial interview be conducted over the phone, to be followed by face-to-face contact. Your supervisor can offer you guidelines for determining when a telephone interview is appropriate.

Whether you are conducting an interview or simply making a follow-up call, communicating with older adults via the telephone creates a different set of challenges.

HERE ARE SOME HINTS TO IMPROVE TELEPHONE COMMUNICATIONS

1. Identify yourself immediately and explain why you are calling.

2. Speak slowly.

3. Keep the information you are relaying short and to the point. Avoid long drawn out explanations when possible.

4. Allow time for the receiver to respond.

5. Ask clarifying questions to insure the message you are sending or receiving is being correctly understood.

6. If your message is not being understood, rephrase it instead of repeating it word-for-word.

7. If directions are given or an appointment has been made over the phone, always follow-up with written confirmation.

8. When you meet face-to-face after a telephone interview, always refer to the phone conversation and allow time for the association to be made between you and the person on the phone.

Using the telephone offers unique challenges to the person who has difficulty hearing. The telephone company as well as hearing aid businesses offer a variety of devices to improve this mode of communication. General information on what is available and who could supply it would be an excellent addition to your Resource manual.

WRITING CASE RECORDS AND NARRATIVES

Case records and narratives are an important documentation process for the agency records. Your written words will clarify information on the assessment form, as well as briefly describe the interview process with the older adult. For specific information regarding how to fill out the participant assessment form including the narrative portion, refer to the module entitled Assessment.

It is important to remember that the information within a client's record is not privileged information by law. This means that in a dispute the records can be subpoenaed, as can the outreach worker. It is, therefore, important that the content of the narrative has observations and not opinions.

Example of an observation:

> Mr. Smith's kitchen was cluttered and unclean. The sink was filled with dirty dishes. Trash was overflowing on to the floor and raw meat was sitting out on the counter. It was greenish and odorous.

Example of an opinion:

> Mr. Smith does not clean his house, the conditions are deplorable and the food he is eating is probably spoiled.

The second example makes several assumptions and does not allow the reader to visualize the condition in which Mr. Smith is living. Since each person may define "deplorable" differently, there is no way for the reader to understand the extent of the problem. Questions arise when one reads the second example. Does Mr. Smith choose not to clean his house or is he unable to? Is the house just cluttered or is it unclean? Is Mr. Smith indeed eating spoiled food, risking his health? These questions cannot be answered clearly based upon the information available. The kind of help Mr. Smith needs is unclear. The first documentation, however, shows a basis for referrals and assistance.

PERSONAL VALUES AND COMMUNICATION

Each person has their own set of values and beliefs, some of which may be shared by others. It is important to realize how one's own value system influences the manner in which they view and communicate with others. A great disservice is done to an individual when their unique value system is ignored and they are judged by your own. Leave judgmental behaviors behind.

Example:

> After much thought and discussion, a family has decided that the older adult in their family needs to be placed in a nursing home. The outreach worker hesitates to provide referral information because he/she believes that anyone who places a family member in a nursing home really doesn't care about them.

COMMUNICATION WITH INDIVIDUALS WITH DISABILITIES

While the core components of listening and speaking do not change when addressing a disabled individual, there are many tools that can be used to enhance the communication process. Affirming the value of the individual must be the basis for your communicating. Three tools that should be used in listening include:

1. Listen slowly, don't show impatience with the pace.

2. Listen with your heart, accept the individual, don't reflect judgment by your stance or gestures.

3. Listen with your eyes, allow yourself to be receptive to visual cues.

CUES FOR COMMUNICATING WITH INDIVIDUALS WITH VISUAL IMPAIRMENTS

- Always identify yourself immediately upon entering the room. If you have met previously, provide a description of that meeting to help the individual in placing you.

- Ensure lighting is at its best. Sit near a light source so that your face is not shadowed.

- Sit or stand at eye level to the individual.
- Sit or stand as near as is comfortably possible to the impaired individual.
- If others are in the room, always address the impaired individual by name when speaking to them.
- If written instructions are used, contrast is important. Light lettering against a dark background works best, though this can vary from person to person. Ask if they have a preference.
- Before helping the individual, explain to them what you are going to do.
- If helping in walking, it is usually more comfortable for the impaired individual to take your arm than for you to grasp theirs. Ask them how they feel most comfortable.

HEARING IMPAIRMENT AND COMMUNICATION

When hearing is limited, other tools are used to assist in understanding what is being said. The hearing impaired individual will pay special attention to the gestures of a speaker. Your lip movement, body language and eye movement are all used to clarify the message. Below are ways in which you can improve the delivery of your message to a hearing impaired individual.

CUES FOR COMMUNICATING WITH INDIVIDUALS WITH HEARING IMPAIRMENTS

- Speak louder than usual, DO NOT SHOUT.
- Articulate clearly and slowly.
- Use a soft touch on the hand to gain their attention.
- Use the individual's name so they know you are speaking to them.
- Keep your hands away from your mouth. Men with mustaches and beards will need to keep them closely trimmed.
- High frequency sounds are often difficult to hear. Keep your voice pitch as low as is naturally possible.
- Eliminate excess words from your sentences. Keep the message short.
- If your message is not understood rephrase it instead of repeating it word-for-word.
- Avoid using cues that show impatience or frustration such as shaking the head or sighing.

PHYSICAL IMPAIRMENT AND COMMUNICATION

Wheelchairs and walkers should not be regarded as a tragedy. In many cases, they represent increased mobility and independence for the person using them.

AIDS FOR COMMUNICATING WITH THOSE WHO HAVE PHYSICAL IMPAIRMENT

- Stand or sit at eye level to the individual.
- Don't lean on the wheelchair or walker, they are part of an individual's personal space.
- If you perceive a need for assistance, ask how you can be of help. Let the individual guide you.

COMMUNICATION WITH INDIVIDUALS WITH COGNITIVE IMPAIRMENT

Communication with an individual who has a cognitive impairment often requires a great deal of patience. The impairment can range from a minor memory loss to the inability to understand or respond. Dependent upon the degree of impairment, the following may be helpful.

- Identify yourself, provide cues the individual can use to relate to whom you are.
- Identify time of day and place frequently.
- Be prepared to repeat a message often, rephrasing it, eliminating all unnecessary words.
- Ask questions to keep the individual on the tract needed to complete the assessment or make the referral.
- Listen slowly, don't show impatience with the speaker's pace.

SPEAKING WITH FAMILY MEMBERS

At times, it may be necessary for you to communicate with the family members of an older adult. When doing so, there are several things to remember:

- You must get permission from the older adult before contacting a family member.
- Only the specific information you have permission to discuss can be shared.
- Your role is that of support, to provide assistance and information and does not include judging, moralizing, advising or taking sides.

When meeting with an older adult and their family, one of the first tasks of business should be to explain confidentiality to everyone present. One difficult issue that sometimes arises is when family members expect you to share information that is confidential. When this occurs, stand firm in protecting the older adults right to privacy. Gently explain that you are not at liberty to share the requested information and suggest that they ask the older adult for additional information

CHAPTER IV

TARGET POPULATIONS

TARGET POPULATIONS

Targeting Program Services to Priority Groups

Services provided under the Older Americans Act must be made available to all individuals age 60 and older. However, the Act further requires that programs and services be targeted to individuals in the following groups:

- Individuals with greatest economic need (with particular attention to low income minority individuals and older individuals residing in rural areas)
- Individuals with greatest social need, (with particular attention to low income minorities and older individuals residing in rural areas)
- Older individuals residing in rural areas
- Individuals with severe disabilities
- Individuals with limited English proficiency (LEP)
- Individuals with Alzheimer's or related disorders (and the caretakers of such individuals)

The activities undertaken most frequently to achieve targeting objectives include:

- The Aging Services Division of the North Dakota Department of Human Services **requires nutrition projects to conduct outreach activities**
- The Aging Services Division monitors and evaluates project targeting efforts through **programmatic assessment**
- **Meal site placement** is encouraged and developed where target groups reside (i.e. small rural communities, subsidized housing complexes, etc)
- **Service coordination** with other organizations (i.e. Social Services, Alzheimer's Association, Public Health agencies, Lutheran Social Services, etc) that serve target populations
- **Provision of special services** (i.e. culturally sensitive diets, handicapped accessibility) to attract target populations
- Set aside **program funds specifically for minority groups** (i.e. minority groups)
- Aging Services Division may issue **policy guidelines** to achieve targeting objectives
- **Canvassing efforts** by outreach staff to identify individuals meeting targeting criteria
- Using **Informational and referral activities**
- Encouraging **program participants to tell their friends** about services
- **Community presentations** (i.e. health fairs, etc)

- Provide all OAA services in **handicapped accessible facilities**
- **Advertise services** through media sources (agency newsletters, radio spots, speaker bureau)

Potential barriers to be aware of in relation to effective targeting efforts could include:

- Inability of consumers to overcome the stigma associated with an “assistance program”
- Language barriers/lack of minority or bilingual staff
- Lack of Transportation resources to access other potential OAA services
- Nonacceptance by other participants (potentially friends, neighbors, etc)

Target Populations for Older Americans Act Services

“OLDER INDIVIDUALS RESIDING IN RURAL AREAS”

The older population is growing and is expected to double by 2050. Throughout the nation, rural areas generally have a higher proportion of older persons in their total population than urban areas. Rural areas are aging rapidly as a result of aging-in-place, out-migration of young adults, and in some cases immigration of older persons from metro areas. The aging of the population introduces a range of issues, such as adequate health care, housing, and transportation for the older population and society in general. With an aging population, the number of persons at risk of disability and chronic conditions increases, creating a greater need for medical, rehabilitative, and social services.

THINGS TO KNOW – COMMUNITY DYNAMICS IN RURAL AREAS

In day-to-day activities, rural persons prefer to deal with someone they know rather than with a stranger. The preference for extended family ("kin") can be advantageous as a support network (e.g., providing child care to a family during an illness). Familiarity, however, can also create some unusual problems. For instance, because most people in a rural area are acquainted, leaks in confidentiality can have serious consequences for someone who is seeking health care or social services.

It is not unusual for rural people to report that even though they are well acquainted with most residents in the community, they feel there is no one they can trust and with whom they can discuss personal problems. This attitude stems from residents in small towns having a genuine interest in and questioning others about the well being of neighbors and relatives. Public knowledge about personal problems can be devastating for all involved. In brief, social and economic structures can impose restrictions for those who desire to seek professional help for concerns having moral overtones, such as drug and alcohol dependency, conflicts in personal relationships, or behaviors associated with mental illness.

Self-reliance, which includes self-care practices, is a characteristic attributed to rural residents. Historically, self-care helped people to survive in austere, isolated, and rugged environments. Self-reliance is reflected in the statement, "We take care of our own," implying a preference for receiving care from familiar people. "Neighborliness" and family support can be beneficial in

promoting healthy behaviors, and a close-knit family can be highly supportive to a member who has a medical problem (e.g., chronic obstructive pulmonary disease).

Such support can be detrimental in some situations. For example, a member with a drinking problem may be deterred from acknowledging the problem or seeking appropriate help because of family members' enabling behaviors. Emotional problems may be viewed by a family as a character flaw. Secrecy is reinforced by the rule of silence, that is, what happens in the family stays in the family. To save the family integrity within the community, it becomes important not to let anyone in town know about the problem (e.g., substance abuse; domestic violence; incest; rape; emotional disorders; having a condition that may be associated with a stigma, including certain types of cancer and a positive HIV blood test). Likewise, attempting to adhere to established family and community standards can be a source of tremendous stress for individuals who are struggling to develop their own sense of identity, especially adolescents and others with low self-esteem.

Economic structures can also affect a person's health status and his or her health care seeking behaviors. For example, family enterprises are characteristic of rural environments. Small businesses such as farms, ranches, or family-owned grocery stores and service stations generally do not provide employee benefits, such as health insurance. As a result, some rural individual then define health as "the ability to work; to do what needs to be done." This comment reinforces a work ethic and could be interpreted to mean, "Illness is not being able to do one's usual work"; thus, not accessing health care until too ill to work.

THINGS TO KNOW – PREFERENCES FOR SUPPORT IN RURAL AREAS

Senior services staff must be sensitive to a target group's preferences regarding social support. The first level includes services volunteered by family and friends. Although generally this help is not paid for, there is an expectation of reciprocity. The second level includes services that are provided by a group (e.g., civic organization, homemakers club, a faith community). Members of the group may provide assistance to needy individuals and families in the community (e.g., volunteering time, providing food, and making financial contributions). Both of these social support systems offer a mutually understood "insurance policy" should a catastrophic event occur for others in the network. The third level of support includes formal government services, public health agencies, visiting or community nursing services, mental health centers, and school counseling services. Generally, remuneration by clients is expected for these services, albeit on a sliding scale.

Comparing the utilization patterns of the three levels of social support, urban residents tend to prefer the third level, as they often do not have access to the informal systems that are more common in a small town. Historically, rural persons have learned to rely on the first two levels of social support as a way to cope with the hardships associated with geographical isolation. This pattern of help-seeking behavior has reinforced their ideas of self-reliance. Demographic changes have disrupted informal support networks and forced many rural residents to rely more on public support. However, reluctance persists because outreach services to a rural community can be provided by professionals who often are strangers to the people who live there.

“OLDER INDIVIDUALS IN GREATEST SOCIAL AND ECONOMIC NEED”

Generally, the economic status of older persons has improved over the past few decades, and poverty rates have declined. However, there are wide disparities in poverty rates among the elderly.

THINGS TO KNOW – POVERTY STATUS OF INDIVIDUALS 60 YEARS AND OLDER.

1) **Rural Elderly Person.** The poverty rate increases with greater rurality.
2) **Older Women.** Older women are much more likely to be poor than older men.
3) **Older Persons Living Alone.** Older persons living alone are considerably more likely to be poor than older persons who live with their spouse or another person.
4) **The Oldest Old – 85+.** The oldest old are the most economically vulnerable population, but also the most in need of health, medical, and other services, especially in rural areas hard-pressed to provide such services.

"OLDER INDIVIDUALS WITH SEVERE DISABILITIES"

Most seniors are healthy and independent, but aging usually brings reduced physical and/or intellectual functioning. The fastest growing group of seniors is mostly women aged 85+ who also have the highest disability rates and the most severe disabilities. In addition, the number of seniors with disabilities who live in the community is expected to rise steeply in the foreseeable future. Many of these persons will probably require significant or intensive help.

The most common seniors' disabilities are those affecting mobility(74.2%), agility (65%), hearing (41.8%), seeing (26.5%), speaking (8.7%), 'other' (31.5%).

THINGS TO KNOW - SENIORS' DISABILITIES AND THEIR IMPACT

Seniors' disabilities include those that existed at birth (e.g., Down's syndrome, developmental handicaps), resulted from accidents and physical or mental trauma (e.g., spinal cord injury, post traumatic stress disorder), arose from an illness (e.g., emphysema, cancer), or are often found among aging individuals (e.g., osteoporosis, Alzheimer's disease). Many seniors report multiple disabilities. However, if individuals are categorized according to just one disability their other serious needs may be downplayed or overlooked.

When disabilities exist from birth or occur early in life, individuals often experience lifelong barriers to employment, transportation, appropriate housing and recreation, plus lifelong social discrimination. Because many never had the opportunity to develop work skills, they tend to remain trapped in long-term unemployment, poverty and dependence on public sources of income.

When disabilities occur later in life, individuals may face major and rapid changes in their lifestyles and living standards. Persons who were working, socializing and traveling may lose these involvements partially or completely. In either case, they often face lower incomes, numerous caregivers and the use of assistive devices. When these changes happen abruptly, as with a severe stroke, the impact can be devastating.

THINGS TO KNOW - SUPPORTING INDEPENDENCE AND PARTICIPATION

It is often cheaper and more appropriate to keep seniors with disabilities independent than to institutionalize them. Some promising, creative and cost-effective opportunities are available, while others are still in the development stage.

Build partnerships among key players. Meeting the multiple needs of seniors with disabilities demands strong cooperation among all the stakeholders (i.e. government services, healthcare, transportation, social services, informal caregivers, consumers,

etc.). All groups must plan cooperatively to consider relevant needs, while at the same time avoiding overlap.

Develop a coordinated continuum of appropriate services. "One-stop" access to all necessary services in a community/region with just one phone number to call to help link seniors promptly with appropriate services. (Currently under study.)

Inform and educate. Seniors and caregivers need to know more about issues such as the availability of services, nutrition, the use of assistive technology and elder abuse. These types of information are readily available through the North Dakota Senior Info-Line and Web Site

Support informal caregivers. Informal caregivers provide most of the community care for older adults. They need flexible and creative supports like the North Dakota Family Caregiver Program to carry on this demanding role.

THINGS TO "DO" AND "AVOID" WHEN WORKING WITH AN INDIVIDUAL WITH IMPAIRMENTS:

Visual Impairment

THINGS TO DO:

Introduce yourself and identify who you are. Give the person verbal information that is visually obvious to those who can see.

Be descriptive when giving directions. Saying "Step up here," has little meaning to someone who can't see you point. "Three steps forward, then two steps up," would be much more helpful.

Lead someone who is blind only after they have accepted your offer to do so. Touch their arm, then offer your arm to guide them. Allow them to hold your arm rather than you holding theirs. It is important to let them control their own movements. Verbally describe the area as you go.

Describe things from their perspective, not yours. Some persons who are blind use a "clock" reference for things directly in front of them (an obstacle in their path). For example, a large rock at 10 O'clock. Before using this method, ask the person if it is useful to them.

Face the person with a visual impairment when talking. If your eyes are directed towards them, your voice will be as well.

Make sure the aisle is clear of obstacles.

Inform person of snow levels and/or icy conditions when boarding or departing bus. This can help prevent accidents.

Count out loud when returning change from bus fare.

THINGS TO AVOID:

Do not use references that are visually oriented like, “Go ahead and get on the bus. It’s parked over there by the stop sign.”

Do not interact with a guide dog while it is working.

Hearing Impairment

THINGS TO KNOW:

Find out how the person best communicates.

If the person reads lips, speak in a normal, not exaggerated way. Short simple sentences are best. Avoid blocking their view of your face.

Get their attention by tapping their shoulder or waving your hand in front of them before starting a conversation.

If there is some doubt whether they understood you correctly, ask them! If they did not understand, rephrase your statement. When someone asks, “What did you say?” the answers, “Never mind,” “Nothing,” or “It’s not important,” are very common replies. These are insulting and demeaning because they communicate that the person is not worth repeating yourself for.

THINGS TO AVOID:

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

If the person is using hearing aids, try to avoid conversations in large, open, and noisy areas.

Speech Impairment

THINGS TO DO:

If you do not understand what the person is saying, bring it to their attention immediately and ask how the two of you may better communicate.

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

Consider writing as an alternative means of communication.

If no solution to the communication problem can be worked out with you and the person, consider asking if there is someone who can interpret what they are saying.

THINGS TO AVOID:

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

Do not interrupt. Wait for sentences to be completed.

Do not become impatient or frustrated with the communication.

Do not finish people's sentences for them.

THINGS TO CONSIDER:

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

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

Wheelchair Bound

THINGS TO DO:

Do not assume a person using a wheelchair needs assistance. Ask them if they need assistance first. People may require different degrees of assistance.

When you handle someone's wheelchair, treat it with the same kind of respect you would if you were holding someone's eyeglasses. They are similar in many ways … they can break, they are difficult to have repaired on short notice and weekends, and it is extremely difficult for the person when the chair is out of commission.

When speaking to someone who uses a wheelchair, try to speak at the same level in which they are sitting. Having to look straight up is uncomfortable.

When helping a person down a step, ask them which way they prefer it be done for them to feel secure.

Use the 4-point tie down when transporting a person using a wheelchair as paratransit laws require.

THINGS TO AVOID:

Do not start pushing someone who uses a wheelchair without asking.

When communicating, do not stand too close to the person in the wheelchair. Give them some space.

Do not push open a door using a person's feet or foot pedals.

Developmental Disability

THINGS TO KNOW:

A developmental disability is a condition that arises in infancy or childhood. It can also be caused from a serious head injury. This disability can cause problems in language, learning, mobility, and capacity for independent living.

THINGS TO DO:

Speak in concrete terms, use short sentences and avoid abstract instructions.

Complete one step of instructions at a time before instructions for next steps are given.

Demonstrate how things should be done. Explain what you are doing as you do it.

Give extra time to complete a task.

Speak in a normal voice. If you have difficulty in communicating, ask attendant for better ways to communicate effectively.

Based on level of disability, individual may not be able to ask for personal assistance or follow directions. Look for behavior or body language clues to anticipate individual needs.

THINGS TO AVOID:

Do not become impatient if the individual does not understand the directions given.

Do not get defensive. Bluntness may be part of the person's natural way of communication.

Do not use terms that describe level of disability.

Emotional Disability

THINGS TO CONSIDER:

Speak directly. Use clear, simple communication. Most people, whether or not they have a mental health disability, appreciate it; and if someone is having difficulty processing sounds or information, as often occurs in psychiatric disorders, your message is more pat to be clearly understood. Speak directly to the person; do not speak through a companion or service provider.

Offer to shake hands when introduced. Always use the same good manners in interacting with person who has a psychiatric disability that you would use in meeting any other person. Shaking hands is a uniformly acceptable and recognized signal of friendliness in American culture. A lack of simple courtesy is unacceptable to most people, and tends to make everyone uncomfortable.

Make eye contact and be aware of body language. Like others, people with mental illness sense your discomfort. Look people in the eye when speaking to them. Maintain a relaxed posture.

Listen attentively. If a person has difficulty speaking, or speaks in a manner that is difficult for you to understand, listen carefully – then wait for them to finish speaking. If needed, clarify what they have said. Ask short questions that can be answered by a "yes" or "no" or by nodding the head. Never pretend to understand. Reflect what you have heard, and let the person respond.

Treat adults as adults. Always use common courtesy. Do not assume familiarity by using person's first name or by touching their shoulder or arm, unless you know the person well enough to do so. Do not patronize, condescend, or threaten. Do not make decisions for the person, or assume their preferences.

Do not blame the person. A person who has a mental illness has a complex, bio-medical condition that is sometimes difficult to control, even with proper treatment. A person who is experiencing a mental illness cannot "just shape up" or "pull himself up by the bootstraps." It is rude, insensitive, and ineffective to tell or expect a person to do so.

Question the accuracy of media stereotypes of mental illness. The movies and the media have sensationalized mental illness. In reality, despite the overabundance of "psychotic killers" portrayed in movies and television, studies have shown that people with mental illness are far more likely to be victims of crime than to victimize others. Most people with mental illness never experience symptoms that include violent behavior. As within the general public, about 1% - 5% of all people with mental illness are exceptionally easily provoked to violence. (National Alliance for the Mentally Ill., 1990).

Relax! The most important thing to remember in interacting with people who have mental health disabilities is to be yourself. Do not be embarrassed if you happen to use common expressions that seem to relate to a mental health disability, such as "I'm crazy about him" or "This job is driving me nuts." If you are afraid you have made a faux pas, ask the person how he feels about what you have said. Chances are, you'll get a flippant remark and a laugh in answer.

See the person. Beneath all the symptoms and behaviors someone with a mental illness may exhibit is a person who has many of the same wants, needs, dreams, and desires as anyone else. Don't avoid people with mental health disabilities. If you are fearful or uncomfortable, learn more about mental illness. Kindness, courtesy, and patience usually smooth interactions with all kinds or people, including people who have a mental health disability.

Treat people with mental health disabilities as you would wish to be treated yourself.

ADL and IADL Impairments

ACTIVITIES OF DAILY LIVING (ADL'S)

People who are healthy tend to take most of the simple activities that they perform each day for granted. But for a disabled and/or older person, performing these activities may present a real challenge. **Bathing**, **dressing**, **getting in and out of bed or chair**, **walking**, **going to the**

toilet and even eating can all become a problem. Many seniors who require help with such activities are largely independent, requiring help with one or two ADL's. In such cases, intermittent help from a family member or friend may be all that is needed. However, in many cases, particularly when needs are more extensive and/or the importance of scheduling these activities is critical, informal care arrangements may not be adequate.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

Instrumental activities of daily living are considered those, which are less basic than ADL's. They need to be performed, but scheduling may not be as critical. IADL's include such activities as **meal preparation, managing medication, managing money, heavy housework, light housekeeping, shopping, assistance in accessing transportation, assistance in using the telephone**. Many more seniors require, or simply prefer, assistance with IADL's than with ADL's. Some seniors may merely want someone to escort them when they are shopping and help them avoid any situations that might cause them to fall. Other seniors may have become forgetful and welcome assistance with their bill paying and medical appointments. Still others, who have become weakened by illness, may require assistance with many IADL's as well as one or more ADL's. The good news is that whatever the need, there are workers and programs to provide appropriate support.

WHEN SHOULD WE COMPLETE ADL AND IADL ASSESSMENT?

An assessment is typically done on consumers who are failing to thrive in their environment. The **home visit** assessment utilizing the Social Assistance Management System (SAMS) is an essential part of the geriatric assessment that is frequently completed by Older American Act Outreach Staff. This assessment is important to understand the impact of the consumer's environment on his/her problems, particularly problems with fall risk and functional disability. The home visit adds to the functional assessment via direct observation of a patient carrying out activities of daily living.

INDICATIONS FOR URGENT HOME VISIT ASSESSMENT.

A home visit assessment should be done as a part of all Older American Act assessments, but the following problems may mandate a more urgent response/home visit assessment.

- Client living by self.
- Emotionally impaired (i.e. depressed, Alzheimer's/dementia, etc).
- Mobility impaired.
- History of falls or accidents.
- Impending admission to an institution (i.e. nursing homes, hospitalization).
- Incomplete recovery during a recent hospital discharge.

POINT OF IMPORTANCE.

The proper evaluation of older adult consumers who have a complex web of both medical and nonmedical problems requires the expertise of multiple health care providers specialists. The Older American Act assessment process for many older adults is the entry and referral point for more comprehensive assessment and service implementation.

Diminished Capacity

The way in which a dementing illness affects an individual will vary with each person and the progression of the illness. Kindness, patience and respect go a long way toward working effectively with a person who has dementia. The following are only a few guidelines to consider when working with a person that may show signs of diminished capacity:

Approach the person slowly, from the front. Moving quickly or approaching from behind may startle an individual and stimulate agitation.

Treat the individual as an adult. Include the person in the conversation and avoid talking "down" to the person and talking about him/her as if they were not present.

Maintain a sense of humor. Laughter and humor have positive effects on physical and mental health.

Maintain a calm environment. Being rushed or around a lot of activity tends to increase confusion and restlessness of someone experiencing symptoms of a dementing illness.

Limit choices. Reduce confusion by limiting choices the person has to make when accessing services.

Look for and be aware of safety concerns. Safety is a major concern in the environment. Senior service staff needs to continually be aware of sources of danger such as smoking, cooking, and driving that poses risks not only to the individual experiencing diminished capacity but also the general public. Report safety concerns to appropriate agencies including your employer, the individual's family and possibly adult protective service providers.

Communicating with individuals having diminished capacity. Many people with dementia are far more sensitive to a speaker's tone of voice and body language than actual words spoken. Therefore it's important to be aware of how you are communicating, not just what you are saying.

Consider age related changes in vision and hearing. Good lighting, a quiet environment, hearing aids, and eye glasses may help increase a person's understanding of what you say.

Call the person by name. This can help ensure you have the person's attention.

Speak slowly and clearly. Memory impaired individuals need more time to comprehend and process information.

Keep statements short and to the point. Limit statement and/or questions to one idea at a time. Give instructions one-step at a time. Long sentences, complex instructions, and lengthy explanations are likely to overwhelm the person.

Keep questions simple. Ask one-part questions. Avoid open-ended questions, which can increase confusion and stress.

Use non-verbal communication. Communication is more than just the use of words. Your non-verbal communication should reinforce your words. Gestures, pointing,

demonstration, facial expressions, and visual aids help communicate what we want done. Be aware of your feelings and attitudes. They are often communicated unintentionally through tone of voice and facial expression.

"CULTURAL COMPETENCE"

Cultural competence acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs."

THINGS TO KNOW – CONCEPTS OF CULTURAL COMPETENCE

The following elements contribute to an agency's/systems ability to become more culturally competent. The system should:

Value Diversity. Valuing diversity means accepting and respecting differences. People come from different backgrounds and their customs, thoughts, ways of communicating, values, traditions, and institutions vary accordingly. The choices that individuals make are powerfully affected by culture.

Diversity between cultures must be recognized, but also diversity within them. People generally assume a common culture is shared between members of racial, linguistic, and religious groups. However, individuals may share nothing beyond similar physical appearance, language, or spiritual beliefs. Recognizing intra-culture differences help illuminate the complexities of diversity that challenge us.

Cultural Self-Assessment. Through the cultural self-assessment process, staff is better able to see how their actions affect people from other cultures. The most important actions to be conscious of are usually taken for granted. For instance, physical distance during social interactions varies by culture. If a person is aware of her/his own cultural behaviors, she/he can learn to modify them when appropriate.

Consciousness of the Dynamics of Cultural Interactions. There are many factors that can affect cross-cultural interactions. For example, biases based on historical cultural experiences can explain some current attitudes. Native-Americans and African-Americans, among other groups, have experienced discrimination and unfair treatment from members of the dominant American cultures. These experiences and the mistrust that grew from them is passed down among members of the historically oppressed groups, but is often ignored within the dominant culture. Thus there often exists an understandable mistrust towards members of the dominant culture by historically oppressed groups.

Adapt to Diversity. Cultural competence should specially focus on changing activities to fit cultural norms. Cultural practices can be adapted to develop new tools for service provision and delivery. Using relevant cultural matter to change or modify services can affect positive change for minority group elders.

"LIMITED ENGLISH PROFICIENCY INDIVIDUALS"

As an outreach worker, chances are that you or your colleagues will encounter a limited English proficient (LEP) individual in carrying out your basic tasks.

One of the most important steps for effective communication is to know your agencies policy and plan for communicating with LEP individuals.

THINGS TO KNOW – COMMON STRATEGIES FOR ASSISTING LEP INDIVIDUALS

Determine your organization's language service needs, which LEP populations reside in the service area, demographic characteristics of LEP individuals, what languages are spoken.

Identify language resources (Vocational Rehabilitation Departments, Colleges or Universities, Telephone Services, etc.) to help you meet those needs, and ensure that all agency personnel know how to access and effectively utilize those resources.

Familiarize yourself with effective and innovative methods of communication with LEP individuals.

Conduct outreach activities to ensure that all community members, regardless of national origin or language, know that they can access your programs.

Over the past ten years, as the immigrant population has grown, so has the community of LEP individuals needing access to important services. The population of LEP individuals has grown in number, as well as in diversity, leaving senior program staff the challenge of providing timely and effective interpretation and translation services for an increasing number of different language groups.

GUIDE TO ETIQUETTE AND BEHAVIOR FOR WORKING WITH PEOPLE WITH DISABILITIES

This summary is about disabilities. It is important to remember that you are not working with disabilities, you are working with individuals who have disabilities. All of the following guidelines are valid until someone with a disability tells you they want it done a different way. With this in mind, please consider the following guidelines:

Use common sense. People with disabilities want to be treated the same way everyone else does. Remember, a person is a person first, the disability comes second!

Don't be patronizing. Show the person the same respect that you expect to receive from others. Treat adults as adults!

Be considerate and patient. Anticipate what the person's needs might be and offer assistance when possible. Be patient if the person requires more time to communicate, to walk, or to accomplish various tasks.

Don't put unnecessary pressure on yourself to know and to do everything "right." Be patient with yourself in learning what the specific needs of the person are. Don't be embarrassed if you find yourself doing or saying the wrong thing. Remember, the person with a disability is usually aware of and sensitive to your discomfort and your good intentions in the situation.

Don't be afraid to offer assistance. If the person looks as if they need assistance, ask if there is something you can do. Do not automatically give help unless the person clearly needs or has asked for it.

Communicate with the person, not his or her interpreter, companion or assistant.

Respect the person's privacy. Refrain from asking questions which would otherwise be inappropriate to ask of any other person, (i.e. private life, medical condition).

Be sensitive to their needs. Persons are much more independent than people give them credit for. Many times, negotiating the physical environment is less frustrating than trying to communicate with persons who are not sensitive to their needs.

SENSITIVITY ISSUES

Comments from people about how they are treated as a person with a disability:

Sometimes people think I do not need what everyone else does. My wants and needs are the same as anyone else. I do get cold, lonely, sad, and hungry like everyone else.

Stereotypes are hard to beat – Media portray us as being different or the cause of many problems. We are not "Jerry's Kids!" We do not want pity or to be a charity case.

Talk with me, not about me. I do not like it when my staff talks about my life as if I am not even in the room. That is not appropriate and you wouldn't like that either. It is my life, ask me what I want, okay.

Treat me as an adult, not a child. Don't expect me to go to bed at 8:30 p.m. or eat only foods that are good for me. Do you go to bed that early and only eat what is good for you? Why do you keep telling me to diet and exercise to lose weight? Are you at your ideal body weight? Support and encourage me but don't tell me what to do. Maybe I will make mistakes but that is okay. That is normal.

Don't have such low expectations for me. Maybe I want to get married, buy and house, drive a car, have a good paying job --- Maybe I could be on a regular bowling team or join a club in my community. Support me and believe in me.

Respect is very important to me. Do not say things that will embarrass me in public. Do not point out my disability when it is not necessary. Respect the way I have to do things and treat me like you would want to be treated. Give me time to do things for myself.

What is the role of a support person?

Provide support – avoid patronizing or parenting.

Listen to what the person is saying.

Help people to make informed decisions, but not to make decisions for them.

Allow people to make mistakes.

Serve as a role model for the community. How you act and how you describe people sets the tone. Live by the Golden Rule.

Use people first language.

PEOPLE FIRST LANGUAGE GUIDELINES

WHEN REFERRING TO A PERSON'S DISABILITY, TRY USING PEOPLE FIRST LANGUAGE.

People First Language	Labels
People with disabilities	The handicapped or disabled
People with mental retardation; he has a cognitive impairment	The mentally retarded; he's retarded
My son has autism	My son is autistic
She has Down's Syndrome	She's a Down's kid; a mongoloid
He has a learning disability	He's learning disabled

People first language, continued	Labels, continued
I have paraplegia	I'm a paraplegic
She has a physical disability; she has a mobility impairment	She's crippled
He's of short stature	He's a dwarf or a midget
She has an emotional disability	She's emotionally disturbed
He uses a wheelchair	He's wheelchair bound or confined to a wheelchair
He receives special education services	He's in special education
Congenital disability	Birth defect
Accessible parking, bathrooms, etc.	Handicapped parking, bathrooms, etc.
She has a need for..	She has a problem with..

- ✓ Do not refer to a person's disability unless it is relevant. Remember, people are people first, disability second!

- ✓ Use disability rather than handicap to refer to a person's disability.

- ✓ Avoid negative or sensational descriptions of a person's disability.

- ✓ Don't use "normal" to describe people without disabilities; instead say people without disabilities or typical, if comparisons are necessary.

- ✓ Never assume that a person with a communication disorder also has a cognitive disability such as mental retardation.

- ✓ Don't portray people with disabilities as overly courageous, brave, special, or super human.

CHAPTER V

ASSESSMENT

ASSESSMENT PROCESS

The SAMS Outreach/HDM Assessment is the tool used to document service needs identified options explored, client choice, and outreach activities.

The SAMS Assessments are intended to collect information based on the client's response(s), information reported by significant other (such as family or friends), and the Outreach Workers observation. In most cases, the applicant/client is the respondent of choice, and the Outreach Worker should make every attempt to conduct the interview with the applicant/client.

Outreach service is a personalized approach to seeking out older individuals, identifying their service needs, and assisting them to access available services. The Outreach service shall originate in the client's own home. If the service originates in another location, documentation explaining why it was not possible to complete the service in the client's home must be entered in the Narrative section of the SAMS Outreach/HDM Assessment.

The Outreach Worker should attempt to obtain all data requested in the assessment. NAPIS data, the Nutrition Screening Assessment and ADL's/IADL's are required for federal reporting purposes.

All contacts, including telephone calls, must be documented in the Narrative section of SAMS Outreach/HDM Assessment. The documentation shall include:

- Date of contact
- Type of contact (Telephone/Home/other)
- Service needs identified
- Alternatives explored
- Service delivery options offered
- Client requests
- Plan to follow-up as needed

Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or a restricted computer program.

User's Guide
For Completion of Older Americans Act
SAMS Assessments

The SAMS assessments are intended to collect information based on client responses and worker observations. The worker is able to record required data for reporting purposes and gather pertinent information for a specific service. Completion of the OAA Outreach & HDM 2005 assessment allows the worker to determine a client's functional impairment level and correlate the level of impairment to the need for home and community-based services.

This document was developed to give guidance and clarification in completing SAMS assessments. All assessments (OAA Congregate Meals, OAA Health Maintenance, OAA Transit, and OAA Outreach & HDM 2005) have the following two sections:

Section I. General Information – includes assessment information, client identification, and contact information.

Section II. Demographics – includes required demographic information and indicators.

The assessments are customized to gather pertinent data for each service:

OAA Congregate Meals: Includes an additional section to assess nutritional status and the Nutrition Screening Checklist; scoring of the Checklist is outlined.

OAA Transit: Includes an additional section to assess mobility.

OAA Health Maintenance: Includes an additional section to assess current health status, nutrition, impairments, medication use, and cognitive/emotional status.

The OAA Outreach & HDM 2005 assessment includes the following additional sections:

Health Information: Gathers information on nutritional status and data for the Nutrition Screening Checklist (scoring of the Checklist is outlined); gathers information on impairments, current health status, medication use, and cognitive/emotional status.

Services/Program Information: Gathers information on services/programs the client currently participates in or will consider applying for.

ADL's/IADL's: Allows for determination of a client's level of functional impairment; definitions of levels of impairment are included.

Based on information from Synergy Software Technologies, Inc., the guide also identifies questions that are linked between the SAMS 2000 and the assessment document. Linking all questions between SAMS 2000 and the assessment is a goal for future system upgrades.

I. General Information

I. A. Assessment Information (Date, type, etc.)

1. What is the date of the assessment?

   Enter the date the assessment was completed.

2. Specify the type of assessment.

   Initial Assessment – the first assessment completed and entered on the SAMS system.

   Reassessment – any assessment completed after the initial assessment and entered on the SAMS system.

3. What is the date of the client's next assessment?

   Automatically defaults to 6 months from the date of the assessment.

4. What is the name of the person conducting the assessment?

   Enter the name of the person who conducted the assessment.

5. What is the name of the agency the assessor works for?

   Enter the name of the agency.

6. Who was the client referred by? (Outreach/HDM Assessment only)

   Select as appropriate.

7. Where was the client interviewed? (Outreach/HDM Assessment only)

   Select as appropriate.

8. What is the Termination Date?

   Enter the date the client no longer received services. Do not terminate if client is receiving services from another service provider or program.

9. What are the reasons for Termination?

   Select as appropriate.

I. B. Client Identification

1-a through 1-c. What are the client's last name, first name, and middle initial?

Enter the client's name. Data is linked between SAMS 2000 and the Assessment.

2. What is the client's Social Security Number?

Complete using 0's for the first five digits; enter the last four digits of the client's social security number. (If other numbers are needed, i.e. insurance, Medicare/Medicaid, click on Notes and add needed information). Used to pre-fill assessment but not transferred from assessment to SAMS 2000 client record.

3 – 4. What is the client's birth date/enter the age of the client in years?

Enter the client's birth date - the age will automatically fill-in. Used to pre-fill assessment but not transferred from assessment to SAMS 2000 client record.

5. What is the client's gender?

Select as appropriate. Data is linked between SAMS 2000 and the Assessment.

6 – 9. Enter the client's telephone number, mailing and residential addresses, and directions to client's home.

Enter requested information. Data is linked between SAMS 2000 and the Assessment. Certain elements may require mapping.

I. C. Contact Information

1a-d. Enter the Name, Relationship, and Work and Home Telephone numbers of the Emergency Contact.

Enter requested information. Data is linked between SAMS 2000 and the Assessment.

2a-b. Enter the Name and Work phone number of the client's primary physician.

Enter requested information. Data is linked between SAMS 2000 and the Assessment.

3 a-d. Enter the Name, Work and Home phone numbers, and mailing address of the client's guardian.

Enter requested information, if applicable.

II. Demographics

II. A. Demographics and Indicators

1. What is the client's ethnicity?

Select as appropriate. Data is linked between SAMS 2000 and the Assessment. May require mapping.

1a. Enter the client's self-described ethnic background.

Enter requested information.

2. What is the client's race?

Select as appropriate. Data is linked between SAMS 2000 and the Assessment. May require mapping.

3. Specify the client's primary language.

Select as appropriate. Data is linked between SAMS 2000 and the Assessment. May require mapping.

4. Select the client's current marital status.

Select as appropriate. Data is linked between SAMS 2000 and the Assessment.

4a. What is the name of the client's spouse/partner.

Enter the name of the client's spouse/partner.

5. Indicate the type of residence that the client currently resides in.

Select as appropriate.

6. Indicate if the client rents or owns the residence in which they currently reside.

Select as appropriate.

7. Select the client's current living arrangement.

Select as appropriate. Data is linked between SAMS 2000 and the Assessment. May require mapping.

8. Does the client reside in a rural area?

Select as appropriate. Used to pre-fill assessment but not transferred from assessment to SAMS 2000 client record.

9. Is the client's income level below the national poverty level?

Select as appropriate. Data is linked between SAMS 2000 and the Assessment.

10. Is the client socially isolated?

Select as appropriate.

III. Health Information

III. A. Nutrition

1. What is the client's idea of his/her appetite?

Select as appropriate.

2. Is the client on any special diets for medical reasons?

Select as appropriate.

3. Describe the client's special diet.

Enter requested information, if applicable.

4. Does the client have trouble eating well due to other problems?

Select as appropriate.

5. Describe the client's other problems that keep him/her from eating well.

Examples may include illness, depression, no teeth, poor fitting dentures, sores in the mouth, etc.

III. A-1. Nutrition Screening Checklist

The Nutrition Screening Initiative was implemented in 1991 to identify individuals who are at nutritional risk and make appropriate referrals before their health has deteriorated to the point that they must be medicated, hospitalized, or institutionalized.

The Nutrition Screening Checklist can be self-administered or conducted by staff that interacts with the client. The "Yes" score is weighted as indicated below:

Nutrition Screening Checklist Question	Yes Score
1. Has the client made any changes in lifelong eating habits because of health?	2
2. Does the client eat fewer than 2 meals per day?	3
3. Does the client eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	1
4. Does the client eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?	1
5. Does the client sometimes not have enough money to buy food?	4
6. Does the client have trouble eating well due to problems with chewing/swallowing?	2
7. Does the client eat alone most of the time?	1
8. Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	2
9. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?	2
10. Does the client have 3 or more drinks of beer, liquor or wine almost every day?	2
11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?	1

All questions must be answered for the score to calculate automatically and transfer to the SAMS 2000 client record. Scoring results of the Checklist are as follows:

0 – 2 **Good**. Encourage client to recheck their nutritional score in 6 months.

3 – 5 **Moderate nutritional risk**. Encourage client to improve eating habits and lifestyle and to recheck nutritional score in 3 months.

6 or more **High nutritional risk**. Refer client to their physician or a licensed registered dietitian to discuss nutritional concerns and ways to improve their nutritional health.

At a minimum, the Nutrition Screening Checklist must be completed once per contract period for each eligible congregate and home-delivered meals client. Refer to the Outreach Service Standard and the Nutrition Services Standard for additional guidance.

III. B. Impairments

1-3. Does the client have problems with vision, hearing, and speech that are not corrected with aids/devices?

Select as appropriate.

4-6. Does the client use a cane, walker, or wheelchair to get around?

Select as appropriate.

III. C. Current Health Status

1-2. What is the client's height and weight?

Enter requested information.

2. Indicate which of the following conditions/diagnosis the client currently has.

Select as appropriate.

III. D. Medication Use

This section is not intended to be a professional medical evaluation of medications used by a client. Information is gathered to determine if a referral (with the client's consent) is appropriate for any of the drug programs or to a health care professional for assessment.

1. List the names of all over the counter (OTC) medications and the client's stated purpose for each medication.

Enter requested information.

2. How many prescription medications does the client take?

   Enter requested information.

3. List the names of all prescription medications and client's stated purpose for each medication.

   Enter requested information.

III. E. Cognitive/Emotional Status

This section is not intended to be a professional medical evaluation. Information is gathered based on the worker's observations during the interview, to determine if a referral (with the client's consent) would be appropriate.

1. Select the choice that most accurately describes the client's memory and use of information.

   Select as appropriate.

2. Comments regarding Dementia (memory/cognition issues)

   Enter requested information, if applicable.

3. Has the client felt depressed, sad, or unhappy.

   Select as appropriate.

IV. Services/Program Information

IV. A. Current Participation in Services/Programs

Select services/programs that client currently uses.

IV. B. Consider Applying for the Following Services/Programs

Select services/programs that client would consider using.

V. ADL's/IADL's

In Federal Fiscal Year 1997, the Administration on Aging required a more detailed client profile for a number of services including home-delivered meals. The detailed client profile requires collection of data for activities of daily living (ADL's) and instrumental activities of daily living (IADL's).

Scoring is as follows: If the answer is "Independent", 0 points are scored. If the answer is "Requires assistance" or "Totally dependent", 1 point is scored. All questions must be answered for the score to calculate automatically and transfer to the SAMS 2000 client record.

V. A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

1 – Independent	The client is able to bathe him/herself independently with or without the use of an assistive device.
2 – Requires assistance	To complete the activity, the client requires cueing or the assistance of another person some, but not all of the time.
3 – Totally dependent	To complete the activity, the client requires complete physical assistance each time.

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

1 – Independent	The client is able to dress him/herself independently with or without the use of an assistive device.
2 – Requires assistance	To complete the activity, the client requires cueing or the assistance of another person some, but not all of the time.
3 – Totally dependent	To complete the activity, the client requires complete physical assistance each time.

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

1 – Independent	The client is completely independent in toileting with or without the use of an assistive device.
2 – Requires assistance	To complete the activity, the client requires cueing or the assistance of another person some, but not all of the time.
3 – Totally dependent	To complete the activity, the client requires complete physical assistance each time.

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?

1 – Independent	The client is able to independently transfer with or without the use of an assistive device.
2 – Requires assistance	To complete the activity, the client requires cueing or the assistance of another person some, but not all of the time.
3 – Totally dependent	To complete the activity, the client requires complete physical assistance each time.

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

1 – Independent	The client is able to independently feed him/herself (includes using straws and special utensils).
2 – Requires assistance	The client is able to feed him/herself but may require physical assistance during part, but not all, or a meal (i.e. may require meat to be cut up, etc.)
3 – Totally dependent	The client is unable to feed him/herself and must be assisted throughout the meal.

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

1 – Independent	The client is able to independently walk in the home with or without the use of an assistive device.
2 – Requires assistance	To complete the activity, the client requires cueing or the assistance of another person some, but not all of the time.
3 – Totally dependent	The client is unable to walk independently in the home.

V. B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

1 – Independent	The client is able to independently plan, prepare meals, and clean up after meals.
2 – Requires assistance	The client needs some physical assistance in preparing meals because of physical or cognitive limitations. Client is unable to prepare a meal but is able to reheat a prepared meal.
3 – Totally dependent	The client is unable to prepare any meal.

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

1 – Independent	The client is able to independently take the correct medications and dosages at the correct time, including giving injections.
2 – Requires assistance	The client is able to take medications with reminders; needs the assistance of another person some, but not all of the time.
3 – Totally dependent	The client is unable to take medication unless administered by someone else.

3. Specify the client's ability to MANAGE MONEY.

1 – Independent	The client is completely independent in all aspects of money management.
2 – Requires assistance	The client needs assistance from another person some of the time with some tasks (i.e. cannot write checks and pay bills without help, but makes day to day purchases and handles cash).
3 – Totally dependent	The client is unable to manage finances at all. May have a legal guardian or conservator.

4. Specify the client's ability to perform HEAVY HOUSEWORK.

1 – Independent	The client is able to independently perform all tasks of heavy housework.
2 – Requires assistance	The client needs assistance from another person some of the time or with some tasks.
3 – Totally dependent	The client is unable to perform the tasks at all.

5. Specify the client's ability to perform LIGHT HOUSEKEEPING?

1 – Independent	The client is able to independently perform all tasks of light housekeeping.
2 – Requires assistance	The client needs assistance from another person some of the time or with some tasks.
3 – Totally dependent	The client is unable to perform the tasks at all.

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

1 – Independent	The client is able to plan for shopping needs and independently perform shopping tasks including carrying small packages.
2 – Requires assistance	Client may be unable to shop alone but can shop with someone to assist (i.e. needs assistance to do major shopping, carrying large packages, etc.).
3 – Totally dependent	The client needs someone to do all shopping and errands.

7. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

1 – Independent	The client is able to independently drive a regular or adapted vehicle or uses regular or accessible public transportation.
2 – Requires assistance	The client is able to ride in a vehicle if assisted in and out by another person. Needs assistance in arranging for or using transportation due to mental or physical impairment.
3 – Totally dependent	The client is unable to ride in a car, taxi, bus or van and requires transportation by ambulance.

8. Rank the client's ability to use the TELEPHONE?

1 – Independent	The client is completely able to use the telephone.
2 – Requires assistance	The client can use the phone with some assistance (i.e. needs someone to look up the number; needs someone to dial the number). Is able to articulate and understand conversations on the telephone.
3 – Totally dependent	The client is unable to use the telephone.

CHAPTER VI

RESOURCES

RESOURCES

As an outreach worker, you will frequently find people who are in need of help or services. Often they will not be aware of what is available to them or how to make contact with an agency or person who can assist them. You may be the key to their getting the help they need or going without it. How can you offer help if you don't have the information they need – when they need it? It's very important that you know what is available. It is equally important that you know the quality of the services you are telling the about to ensure that a proper referral is being made. You will need to know: how to access services; what procedures are used in determining fee schedules, what is the waiting period for services; and so on. The more you know about the resources in your area, the more effective you will be when working with people.

Basically there are three types of resources:

1) *PROGRAM* resources are defined as services/programs that meet the met needs of older individuals.

2) *PEOPLE* resources are the paid, professional staff of your agency and of collateral agencies (providing services similar to your own) as well as volunteers, members of self-help groups, friends, neighbors, and relatives of those people in need.

3) *STRATEGIC* resources include those commodities or means that can be applied to the acquisition and development of program resources. They include money and other tangible resources like facilities, equipment and supplies. They also include such intangibles as political influences and social standing, professional expertise, personal and organizational energy and the legitimacy and legality without which program resources might have little chance of success.

WHERE DO I FIND THE RESOURCES?

1. Ask your supervisor or co-workers if your agency has a resource database available. If there is one, find out when it was last updated. If your agency has no resource database for your service area or it needs updating, meet with your supervisor to discuss the ways that you or someone in your agency can oversee its development or updating.

2. To develop or add to a resource database, contact any service agency in your area (such as a volunteer or community action agency) that may have a resource database from which you could gather your initial information. Examples of contacts to be included in a resource database are listed on page ____.

3. Consult the yellow pages of your service area's phone directories.

4. Talk to outreach workers across the state, workers from other agencies, volunteers or people you work with who may have information that would help you in identifying local, state and national service options.

5. Collect agency brochures since they can give you basic information and ready access to information you may not want to list in your service options database. They can also provide ideas when your agency is developing a new brochure.

HOW DO I KNOW WHAT RESOURCES I NEED TO IDENTIFY?

To identify resources, do a resource inventory. This is a simple and effective way of looking at strengths and gaps in services in your service area. Identify key topics or headings under which you will list the service options.

Service options may include:

- Assisted living facilities-licensed
- Caregiver
- Clinics
- County Social Services
- Disability
- Driving
- Emergency
- Food Pantry
- Funeral Planning
- Grandparent
- Guardian
- Hearing
- Homemaker
- Hospitals
- Income Taxes
- Legal
- Libraries
- Mental Health
- Nutrition
- Prescription Drug Assistance Programs
- Senior Citizen Centers/Clubs
- Social Security Administration
- Transportation
- Vision
- Assistive Technology
- Chore
- Consumer Protection
- Dental
- Domestic Violence/Sexual Assault
- Education
- Emergency Response
- Foot Care
- Gambling
- Grief
- Health
- Home Health Care
- Hospice
- Housing & Utilities
- Insurance
- Legislative Information
- Medicare
- Nursing Homes
- Personal Care
- Respite Care
- Social Groups
- Support Groups
- Veterans Service Officers
- Volunteer Opportunities

As you determine which agencies will be listed on your database, it's important that you know what your clients unmet needs are and what service options they are looking for. Under the various headings on your service options database, list all the agencies that you have identified. For example, under Assistive Technology could be Easter Seals Goodwill ND, Inc.; Interagency Program for Assistive Technology (IPAT), ND Assoc. for the Disabled, Inc. (NDAD), etc.

If you put your resource database on a computer, it's a simple procedure to update the information and print out what you need off the database. Other options could be index cards, three-ring binder with pockets for brochures or you may have a better set up that will work for you. Keep it simple so that you can retrieve and update information quickly. The information should be updated every 6 months to a year to insure accuracy. Also, think about how you will take this with you when you make home visits.

In your database, you will want to list the 1) agencies name, 2) address, 3) phone number, 4) contact person and their extension number, 5) information about their services such as a) hours and days of service, b) eligibility requirements and application procedures, c) costs, d) services offered and description of services, etc. Additional information you may wish to include in your database may be 1) area served, 2) branch offices, 3) accessibility, 4) documents required for application such as birth certificate, etc., 5) waiting lists, 6) date of last update in your database, etc.

HOW WILL I LEARN ABOUT EACH AGENCY?

The next step is to make a contact with the identified resources and start building a working relationship with them. Since your time is limited, start making contacts with those agencies you feel will have the greatest impact for your clients. It's important to continually seek new resources, while updating the information on established resources.

The key to success is preparation. Read the agency's brochure or other information that is available to the public and this may answer many of your questions so that you can use your time more effectively when you meet with a person from that agency. Prepare a list of questions that you need answered in order to make an appropriate referral. If you are not sure what information you still need, go back to your service option list and see which areas remain blank. Call and make an appointment to meet with a representative of their agency (explain why you are seeking an appointment and they will direct you to the appropriate person).

When you go for the appointment, remember that you are representing yourself and your agency. It's very important to make a good first impression – arrive on time, dress appropriately and handle yourself in an organized, professional manner. Introduce yourself, identify the agency you work for and explain why you are seeking this information. Ask the questions you have prepared and write the information down for accuracy. If you don't understand information that's given to you, ask for explanations since it's your responsibility to make sure you have a clear understanding of the information you are seeking. When you have asked the questions you have prepared, ask if there is additional information that you may not be aware of or if they have any questions of you – this will insure that both of you have had the opportunity to learn about each others agency so appropriate referrals can be made back and forth. Let the person know that you will be making periodic phone contact with them to update their information.

WHAT WILL BE THE BENEFIT FOR THE PEOPLE I SERVE?

When you know the resources that are available in your service area, you will be better prepared to meet the unmet needs of your age 60+ clients. Your knowledge will help them learn about the services they need, be better prepared when they go to their first appointment, reduce their level of anxiety and offer them a choice of service options and providers. When agencies work together rather than compete with each other to provide services, it increases the efficiency and effectiveness of each agency.

EXAMPLES OF CONTACTS TO BE INCLUDED IN A RESOURCE DATATBASE

211: A health and social services referral line of Mental Health America of ND.

AGING SERVICES UNIT: Your regional RASPA at your regional Human Service Center.

BENEFITS CHECKUP: Helps people ages 55 and over find programs that may pay for some of their costs of prescription drugs, health care, utilities, and other essential items or services by filling out a simple questionnaire to find programs that can assist you or your loved ones. www.benefitscheckup.org

ELDERCARE LOCATOR (NATIONAL NUMBER: 1-800-677-1116): Provides access to local information & referral (I&R) service providers-identified for every zip code in the US. Available M-F 9-8ET, after hours a message recorder is available to leave your name and phone number;

calls are returned the next business day. For TDD/TTY service - access the relay service at 202-855-1234; to receive a live operator, 202-855-1000; this is not a toll free call, ask the relay operator to ask the information specialist to return the relay call. www.eldercare.gov

FIRSTGOV.GOV: Provides access to conduct business with and get information from government; information on Medicare, Social Security, nutrition, consumer information, etc. www.firstgov.gov

ND INFO.ORG: A transportation service directory that enables individuals to access information about available transit services across the state of ND. www.ndinfo.org

ND Aging and Disability Resource-LINK (Toll Free 1-800-451-8693): A statewide confidential service, which provides free service information to senior adults, people with disabilities, caregivers, and other callers. www.carechoice.nd.gov

CHAPTER VII

REFERENCES

REFERENCES

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Individual's Name: _____

Date of Hire: _____

CHECKLIST

Date Completed by Outreach Worker	Chapter	Title
	I	**What is Outreach**
	II	**Aging Process**
	III	**Communication**
	IV	**Target Populations**
	V	**Assessment**
	VI	**Resources**

Outreach Worker Signature	Date
Supervisor Signature	Date

* Submit a copy of this form to the Regional Aging Program Administrator after it has been completed. Keep one copy in the individual's personnel file and give one copy to the individual.