

## IN-HOME CARE

**Service Category:** In-Home Care

**Issue Area:** Health/Nutrition

### Community Need

According to the Iowa Department of Elder Affairs Case Management Program for the Frail Elderly 2003 Activity Report, 8,335 frail elderly Iowans participated in the Case Management Program of 11,709 total frail elderly consumers. Of those participating, at least 50% experienced some limitations in 2 or more activities of daily living.

*(Insert your own)* Area Agency on Aging, Case Management program for the Frail Elderly have *(insert # from www.state.ia.us/elderaffairs)* chronic long-term care and/or elderly waiver clients who lack sufficient in-home independent living support and services. Without these needed services, clients will be at significantly greater risk for premature institutionalization. Senior Companions can assist clients with building or maintaining their independent living skills, thereby forestalling institutionalization.

*Additional information or details relating to **community need** in county/service area:*

### Service Activity

*(Enter a number)* Senior Companions will provide in-home services to *(enter a number)* chronic long-term care clients. At least two times each week for two to four hours, Senior Companions will work one-on-one with clients to build and maintain independent living skills. The assistance will focus on client's ability to perform activities of daily living (ADLs) including meal preparation, self-care, and medication compliance.

*Additional information or details relating to **service activity** in county/service area:*

**Anticipated Inputs**

Working in partnership with (*enter a number*) stations, (*enter a number*) Senior Companions will provide ADL support services at least two times a week for two to four hours for 48 to 52 weeks per year to approximately (*number of*) clients. Senior Companions will participate in forty hours of pre-service orientation training. Each month, Senior Companions will receive an average of four hours of in-service training on aging issues including, but not limited to hospice, cancer, and hearing

*Additional information or details relating to **inputs** in county/service area:*

**Anticipated Accomplishments/Output**

Participating frail chronic long-term care clients will receive weekly scheduled assistance by the Senior Companions.

*Indicators:* Number of clients who receive weekly in-home care service.

*Target:* (*Enter a number*) clients will receive weekly in-home care service from Senior Companions for at least (*enter a number*) weeks.

*How Measured\*:* Volunteer Time Sheet, Volunteer Log

\*If you already have an instrument that you are using to collect the number of clients who receive in-home care service from Senior Companions, and the number of weeks they receive this service, you may continue to use that instrument if you prefer.

**Anticipated Impact/Data Sources:*****Intermediate Outcome***

Clients will maintain and/or improve the number of activities of daily living they are able to perform.

*Indicator:* Percent of Senior Companion clients who demonstrate maintenance and/or improvement in the number of activities of daily living they are able to perform.

*Target:* (*Enter a number*) percent of Senior Companion clients will maintain and/or improve at least 3 of the 5 areas of daily living activities.

*How Measured:* Independent Living Skills Assessment

***End Outcome***

Clients will be better able to remain in their own homes due to the service provided by the Senior Companions Program.

*Indicator:* Percent of clients that supervisors and/or case workers report are better able to remain in their own homes due to the service provided by the Senior Companions Program.

*Target:* Supervisors and Caseworkers will report that (enter a percent) of the clients are better able to remain in their own homes due to the service provided by the Senior Corps Companions Program.

*How Measured:* Independent Living Skills Assessment

(Optional) **Volunteer Timesheet: In-Home Care**

Volunteer Name: \_\_\_\_\_ Site Station: \_\_\_\_\_

Name of Client receiving in-home care: \_\_\_\_\_

**Volunteer:** *This timesheet is for services provided to the client listed above. Complete a separate timesheet for each client you are visiting.*

*For each day of your in-home service, enter the date, the number of hours of your visit, your travel time, and the total hours of service that day. The first row is an example.*

Date of service	Number of hours with client (in-home service)	Travel time	Total hours of service today
(Example) 4/25/2004	4 hours	30 minutes	4.5 hours
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

### SCP In-Home Care Volunteer Log

Supervisor: \_\_\_\_\_

Site/Station: \_\_\_\_\_

**Instructions:** List the clients receiving in-home care and the date each started receiving these services. From Volunteer timesheets, enter the number of hours of in-home care each client received for each week. There is an example provided in the first row.

Client name	Date service started	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15
(Example) <i>Judy Lim</i>	4/5/04	4	4	4	6	0	4	4	4	4	4	4	3	5	4	4
1.																
2.																
3.																
4.																
5.																
6.																
7.																
8.																
9.																
10.																
11.																
12.																

## INDEPENDENT LIVING SKILLS ASSESSMENT

Date: \_\_\_\_\_

*The purpose of this Assessment is to track any changes in the client's activities of daily living. This Assessment should be completed by a supervisor or caseworker.*

*Thank you.*

Please return this form to:

*(Insert the name and address of your SCP program)*

Person Completing Assessment: \_\_\_\_\_

Title: \_\_\_\_\_

Client's Name: \_\_\_\_\_

<b>Rate each area by checking one of the options (<i>improved, maintained, or declined</i>).</b>	<b>Improved</b>	<b>Maintained</b>	<b>Declined</b>
1. Client is able to fix own meal.			
2. Client is able to get own medicine.			
3. Client is able to get groceries.			
4. Client is able to dress him/herself.			
5. Client is able to attend to hygiene.			

6. Is the client better able to remain in his/her own home due, in part, to the service provided by the Senior Companions Program?

Yes

No

Not Sure

7. What is the most important contribution of the Senior Companion Program for this client?

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THANK YOU