MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

3022

2007 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HCR 3032

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 5, 2007

Recorder Job Number: 2847

Committee Clerk Signature	Judy Schock

Minutes:

Chairman Price: Opens the hearing on HCR 3022.

Representative Lois Delmore, District 43 Grand Forks ND: I am here to introduce the bill, but I will let Mr. Wetzel take over as he has much more expertise in this than I have.

Rodger Wetzel, Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center: See attached testimony. Until one goes through this you can not understand the complexity of the challenges when you go to the Dr. with a loved one and he says they have Alzheimer's, and there is not much you can do. You than ask where do we go from here. I will be happy to share information I have put together. See attached.

Kristi Pfliger-Keller, Western ND Regional Center Director with Alzheimer's Association MN-ND Chapter: See attached testimony.

Bruce Murray, a lawyer with the ND Protection and Advocacy Project (P&A): See attached testimony.

Chairman Price: Anyone else to testify in favor? Anyone in opposition? If not we will close the hearing on HCR 3022

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 5, 2007

Recorder Job Number: 2848

Committee Clerk Signature	Judy Schmidt

Minutes:

Chairman Price: Let's take out HCR 3022.

Representative Hatlestad moves a do pass consent calendar. **Representative Kaldor** seconds the motion.

Chairman Price asks for discussion, having none the vote was 12 yeas, 0 nays, 0 absent.

Representative Weisz will carry the bill to the floor.

Date: 2/5
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HCR 3022 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass Consent Calendar

Motion Made By Rep Hatlestad Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) "Click here to type Yes Vote" 13 No "Click here to type No Vote" 0

Absent 0

Floor Assignment Rep Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HCR 3022: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3022 was placed on the Tenth order on the calendar.

2007 SENATE HUMAN SERVICES

HCR 3022

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3-21-07

Recorder Job Number: 5366

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Senator J. Lee opened the hearing on HCR 3022 directing the Legislative Council to study the availability and future need for dementia-related services, as well as funding for programs for individuals with dementias.

Representative Lois Delmore (District #43) introduced HCR 3022 which deals with dementia related services as well as funding for the programs for individuals with dementias. North Dakota has been known as an aging population but this particular issue covers more than simply people who are in that aging population. She gave an example of a person younger than she is who has been diagnosed with Alzheimer's. There is a need for services in North Dakota. Last time they studied definitions. They didn't go into any of the services that are provided. As they look at this particular area, there are over 16,000 people who have dementia in the state of North Dakota and the number is growing all the time.

Discussion indicated that often times when people think of this they think of people who are 70 or older but, unfortunately, there are younger people that have a need for services in the state.

Kristi Pfliger-Keller (Alzheimer's Association MN-ND Chapter) testified in favor of HCR 3022. See attachment #1. She also noted that physical activity and health and obesity can be risk factors in developing memory loss later on in life (meter 06:15).

She pointed out that she is currently working with a 37 year old man who has just recently developed early onset Alzheimer's. He has a family and a business and he faces a whole entirely different shift of needs. He doesn't qualify for a lot of the current services.

Senator Dever asked if they can conclusively determine that a person has a certain dementia.

Ms. Pfliger-Keller said there is not one test. It really is a process of elimination.

There was no opposing or neutral testimony.

The hearing on HCR 3022 was closed.

Senator Erbele moved a Do Pass on HCR 3022.

The motion was seconded by Senator Dever.

Roll call vote 6-0-0. Motion carried. Carrier is Senator Erbele.

Date: 3-21-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HCR 3022

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Erbele

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HCR 3022: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3022 was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

HCR 3022

HCR 3022 - TESTIMONY
HOUSE HUMAN SERVICES COMMITTEE
Representative Clara Sue Price, Chair
February 5, 2007

Chairman Price and members of the House Human Services Committee, my name is Rodger Wetzel. I am the Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center here in Bismarck. I developed our Eldercare Program 21 years ago. For many services, St. Alexius serves much of western North Dakota.

I also am the Vice Chairman of the Board of the Minnesota-North Dakota Chapter of the Alzheimer's Association, and it is in this capacity that I appear before you today.

I have been working in the field of aging in N.D. for 36 years, including serving as a senior services project director; a regional Aging Services coordinator; as the Assistant Director of the state Aging Services Division of the NDDHS; and for the past 21 years as Director of the Eldercare Program at St. Alexius.

I have been interested in, and concerned about, our state's increasing and changing needs for services for persons with dementia, such as Alzheimer's, for many years. It was about 30 years ago that, as a regional staff person for N.D. Aging Services, I did my first presentations on this topic, which was considered a "new" need at the time, to senior and other groups in the Devils Lake region.

In my current position I have served on a nursing home board for 6 years; I developed and chair a statewide conference which addresses Alzheimer's and dementia services; I have facilitated 2 family caregiver support groups for 21 years (one of which we can link to rural facilities via telemedicine) in which I have worked with hundreds of family caregivers; I represent western N.D. on the Minnesota-N.D. Alzheimer's Board; and most importantly, I have 7 relatives who have, or who have had, a variety of dementias, including now both my mother, age 83, and my father, age 88. I have had relatives with dementias in their own homes, in family caregiver homes, in senior apartments, in basic care, in assisted living, and in nursing homes. Some have been in urban areas and others in very rural areas.

I appreciated the study resolution that was passed, and accepted for interim study, during the previous session, which supported studying some of the same issues. But I also then appreciated the need to narrow the topic to studying the legal and regulatory definitions of dementias, since the wording in some of our laws is fairly old, and several different, but

related terms have been used, such as "Alzheimer's," "dementia," memory loss/care," "organic brain syndrome," "incapacitated," etc.

Now is a critical time to study the availability and future need for dementia-related services, as well as funding for programs for individuals with dementias, in this ever-growing population in our state.

For example, we know that thousands of family members struggle with caring for their loved ones with dementias at home. These loved ones have memory losses, mix up days and nights; have delusions, hallucinations, paranoia, and personality changes; often do not accept the fact that they have a dementia; sometimes don't even recognize their family caregivers, and usually do not express gratitude to their spouses or other family members.

In my support groups, about ½ of spouses have shared that they have needed to take anti- depressant medications themselves, due to the stresses and unknowns of caregiving.

Some families need access to 24-hour information and support; others wonder when it is time to place their family member in a facility; while others are confused about locked units in basic care facilities vs. assisted living facilities vs. nursing homes. Many get limited practical information from various medical specialities, including primary care physicians, neurologists, and psychiatrists, who may focus primarily on the diagnosis, but not on the challenges of caregiving, decision-making, and the variety of daily living and behavior problems.

Regarding behavior problems, we do know that many behavior problems do not require medications to manage or control them, but often they can be managed in all environments with appropriate training of family members, agency staff, and facility staff. I appreciate the challenges faced by staff in all agencies who are committed to caring for this population. I have two sisters-in-law, and a sister, who are CNAs, and have worked with older adults.

We also know that family caregivers may need a variety of services to help them, including personal cares, supervision when gone, respite care, day care, or brief (1-2 week) care.

It is very important to our state's aging population, family caregivers, service providers, funding sources, legislators and other policy makers to study the availability of and future needs for dementia-related services, and funding needs for dementia-related programs in our state.

I thank you for your commitment to quality human services in North Dakota, and I appreciate the opportunity to speak to you today in support of this proposed legislation.

I would be happy to answer any questions that you might have. Thank you!

Rodger Wetzel, MPA, LSW, HCA/C
Director
Bus: 701-530-7389
Fax: 701-530-7388
e-mail: rwetzel@primecare.org

Community Health and Eldercare
900 East Broadway
PO Box 5510
Bismarck, ND 58506-5510

DEMENTIA:

A loss of intellectual functions (thinking, remembering, reasoning) of sufficient severity to interfere with a person's daily functioning. It is *not* a disease in itself, but rather a group of symptoms which may accompany certain diseases or physical conditions.

ALZHEIMER'S DISEASE:

A progressive, degenerative neurological dementia which affects the brain. It is the most common permanent dementia.

Symptoms include:

- **-gradual memory loss, especially short-term**
- **-decline in ability to perform routine tasks**
- **-impairment of judgement**
- **-disorientation (person, place, time)**
- **-personality changes**
- **-difficulty in learning or relearning skills**
- **-loss of language/word-finding skills**
- **-loss of communication skills**
- **-difficulty with mathematical calculations**
- **-difficulty with abstract thinking**
- **-coordination problems (fine and gross motor)**
- **-disruption of sleep-wake cycle/pattern**
- **-sometimes delusions/hallucinations**
- **-increased anxiety and agitation**

Reprinted courtesy of the Alzheimer's Support Groups at St. Alexius Medical Center.

Some causes of permanent dementias:

Degenerative diseases:

- Alzheimer's disease
- Pick's disease
- Huntington's disease
- Progressive supranuclear palsy
- Parkinson's disease (not all cases)
- Cerebellar degenerations
- Amyotrophic lateral sclerosis (ALS) (not all cases)

Vascular dementias:

- Multi-infarct dementia
- Cortical micro-infarcts
- Lacunar dementia (large infarcts)
- Binswanger disease
- Cerebral embolic disease (flat, air, thrombus fragments)

Anoxic dementias:

- Cardiac arrest
- Cardiac failure (severe)
- Carbon monoxide

Traumatic dementias:

- Dementia pugilistica (boxer's dementia)
- Head injuries (open or closed)

Infectious dementias:

- AIDS dementia
- Opportunistic infections
- Creutzfeldt-Jakob disease (subacute spongiform encephalopathy)
- Progressive multifocal leukoencephalopathy

- Post-encephalitic dementia
- Behcet's syndrome
- Herpes encephalitis
- Fungal meningitis or encephalitis
- Bacterial meningitis or encephalitis
- Parasitic encephalitis
- Brain abscess
- Neurosyphilis (general paresis)

Normal pressure hydrocephalus (communicating hydrocephalus of adults)

- Chronic or acute subdural hemtoma
- Primary brain tumor
- Metastatic tumore (carcinoma, leukemia, lymphoma, sarcoma)

Multiple sclerosis (some cases)

Auto-immune disorders

- Disseminated lupus erythematosis
- Vasculitis

Toxic dementias:

- Alcoholic dementia
- Metallic dementia (e.g., lead, mercury, arsenic, manganese)
- Organic poisons (e.g., solvents, some insecticides)

Other:

Reversible Dementias

Characteristics of reversible dementias:

- Can be reversed or cured
- Temporary condition
- Brain regains lost functions when treated

Common causes of reversible dementias:

- **Brain disease**
  - Tumors
  - Subdural hematoma
  - Hydrocephalus
- **Depression**
  - Response to life's stresses
  - Chemical imbalances in the brain
- **Medication**
  - Negative drug interactions
  - Drug overdose
  - Alcohol abuse
- **Malnutrition**
  - Vitamin (A, C, B-12 and folate) deficiencies
  - Mineral (iron) deficiencies
- **Heart disease -- Lack of oxygen to the brain causes confusion**
  - Arrhythmias
  - Congestive heart failure
  - Myocardial infarction

- **Traumas**
  - Usually due to falls
  - Concussions (skull fractures) or contusions (bruises) to the head
- **Metabolic or endocrine disorders**
  - Thyroid disease
  - Hypo/hyperglycemia and other electrolyte imbalances
  - Dehydration
  - Accidental hypothermia
  - Renal failure
  - COPD (Chronic Obstructive Pulmonary Disease)
- **Infection**
  - Produces fever, affecting brain's cognitive abilities
- **Environmental changes**
  - Visual and hearing loss
  - Loss of daylight and decrease in activities can result in "sundowning"
  - Heavy metal poisoning from gas leaks, exhaust fumes or other toxins

How is Alzheimer's disease diagnosed?

There is no single diagnostic test for Alzheimer's disease. If the presence of Alzheimer's disease is suspected, a complete physical examination and more frequent medical, neurological and psychological evaluations are strongly recommended to establish the progressive nature of the symptoms. Universally applied screening instruments often are used by a variety of professionals (e.g. physicians, psychologists, nurses, social workers, etc.) with the general population, such as the Mini-Mental Status Examination.

A *definitive* diagnosis can only be made at the time of autopsy. The numerous test and evaluation procedures currently employed result only in a *possible* or *probable* diagnosis of Alzheimer's disease.

For a probable diagnosis of Alzheimer's disease, it is necessary to observe a well-documented progression of symptoms. Complete evaluations must be performed periodically using the person's previous performance as the comparison measure. Such evaluations or tests are necessary to rule out conditions other than Alzheimer's disease, particularly reversible forms of dementia.

A complete evaluation should include:

- A detailed medical history.
- A documentation of mental and behavioral changes in recent months.
- A thorough physical and neurologic examination, including the testing of sensory-motor systems, to rule out other disorders.
- A "mental status test" to evaluate orientation, attention, recent recall and the ability to calculate, read, write, name, copy a drawing, repeat, understand and make judgments.
- A psychiatric assessment to rule out the presence of a psychiatric disorder, particularly depression.
- Neuropsychological testing to measure a variety of functions that include memory, orientation, language skills, intellectual abilities and perception.
- Routine laboratory tests, including blood work and urinalysis,
- Health screenings and other testing such as chest x -ray, electroencephalography (EEG) and electrocardiography (EKG), as well as certain specialized tests as deemed appropriate.
- Brain scans, such as CAT, MRI and PET scans

Ten Warning Signs of Alzheimer's Disease or Another Dementia

Some change in memory is normal as we grow older, but the symptoms of Alzheimer's disease or another dementia are more than simple lapses in memory. People with Alzheimer's or another dementia experience difficulties communicating, learning, thinking and reasoning—problems severe enough to have an impact on an individual's work, social activities and family life.

The Alzheimer's Association believes that it is critical for people with Alzheimer's and other dementias and their families to receive information, care and support as early as possible. To help family members and health care professionals recognize the warning signs of Alzheimer's disease and other dementias, the Association has developed a checklist of common symptoms.

Check (✓) if you have seen these signs in your family member or person receiving your care/services.....

Memory loss. One of the most common early signs of Alzheimer's or another dementia is forgetting recently learned information. While it's normal to forget appointments, names or telephone numbers, those with dementia will forget such things more often and not remember them later.

Difficulty performing familiar tasks. People with dementia often find it hard to complete everyday tasks that are so familiar we usually do not think about how to do them. A person with dementia may not know the steps for preparing a meal, using a household appliance or participating in a lifelong hobby.

Problems with language. Everyone has trouble finding the right word sometimes, but a person with dementia often forgets simple words or substitutes unusual words, making his or her speech or writing hard to understand. If a person with dementia is unable to find his or her toothbrush, for example, the individual may ask for "that thing for my mouth."

Disorientation to time and place. It's normal to forget the day of the week or where you're going. But people with dementia can become lost on their own street. They may forget where they are and how they got there, and may not know how to get back home.

Poor or decreased judgment. No one has perfect judgment all of the time. Those with dementia may dress without regard to the weather, wearing several shirts on a warm day or very little clothing in cold weather. Those with dementia often show poor judgment about money, giving away large sums to telemarketers or paying for home repairs or products they don't need.

Problems with abstract thinking. Balancing a checkbook is a task that can be challenging for some. But a person with dementia may forget what the numbers represent and how to do the math.

Misplacing things. Anyone can temporarily misplace a wallet or key. A person with dementia disease may put things in unusual places, like an iron in the freezer or a wristwatch in the sugar bowl.

Changes in mood or behavior. Everyone can become sad or moody from time to time. Someone with dementia can show rapid mood swings—from calm to tears to anger—for no apparent reason.

Changes in personality. Personalities ordinarily change somewhat with age. But a person with dementia can change dramatically, becoming extremely confused, suspicious, fearful or dependent on a family member.

Loss of initiative. It's normal to tire of housework, business activities or social obligations at times. The person with Alzheimer's disease may become very passive, sitting in front of the television for hours, sleeping more than usual or not wanting to do usual activities.

If you recognize any warning signs in yourself or a loved one, it is recommended that you consult a physician for a better diagnosis. There may be other medical problems, some of which are treatable, which are causing the dementia.

The Global Deterioration Scale for Assessment of Primary Degenerative Dementia

Level	Clinical Characteristics
1 No cognitive decline	No subjective complaints of memory deficit. No memory deficit evident on clinical interview.
2 Very mild cognitive decline **(Forgetfulness)**	Subjective complaints of memory deficit, most frequently in following areas: (1) forgetting where one has placed familiar objects; (2) forgetting names one formerly knew well. No objective evidence of memory deficit on clinical interview. No objective deficits in employment or social situations. Appropriate concern with respect to symptomatology.
3 Mild cognitive decline **(Early Confusional)**	Earliest clear-cut deficits. Manifestations in more than one of the following areas: (1) patient may have gotten lost when traveling to an unfamiliar location; (2) co-workers become aware of patient's relatively poor performance; (3) word and name finding deficit becomes evident to intimates; (4) patient may read a passage or a book and retain relatively little material; (5) patient may demonstrate decreased facility in remembering names upon introduction to new people; (6) patient may have lost or misplaced an object of value; (7) concentration deficit may be evident on clinical testing. Objective evidence of memory deficit obtained only with an intensive interview. Decreased performance in demanding employment and social settings. Denial begins to become manifest in patient. Mild to moderate anxiety accompanies symptoms.
4 Moderate cognitive decline **(Late Confusional)**	Clear-cut deficit on careful clinical interview. Deficit manifest in following areas: (1) decreased knowledge of current and recent events; (2) may exhibit some deficit in memory of ones personal history; (3) concentration deficit elicited on serial subtractions; (4) decreased ability to travel, handle finances, etc. Frequently no deficit in following areas: (1) orientation to time and person; (2) recognition of familiar persons and faces; (3) ability to travel to familiar locations. Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations occur.
5 Moderately Severe cognitive decline **(Early Dementia)**	Patient can no longer survive without some assistance. Patient is unable during interview to recall a major relevant aspect of their current lives, e.g., an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouses' and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.
6 Severe cognitive decline **(Middle Dementia)**	May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season, etc. May have difficulty counting from 10 both backward and, sometimes, forward. Will require some assistance with activities of daily living, e.g., may become incontinent, will require travel assistance but occasionally will display ability to familiar locations. Diurnal rhythm frequently disturbed. Almost always recall their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment. Personality and emotional changes occur. These are quite variable and include: (1) delusional behavior, e.g., patients may accuse their spouse of being an impostor, may talk to imaginary figures in the environment, or to their own reflection in the mirror; (2) obsessive symptoms, e.g., person may continually repeat simple cleaning activities; (3) anxiety symptoms, agitation, and even previously nonexistent violent behavior may occur; (4) cognitive abulia, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.
7 Very Severe Cognitive decline **(Late Dementia)**	All verbal abilities are lost. Frequently there is no speech at all only grunting. Incontinent of urine, requires assistance toileting and feeding. Lose basic psychomotor skills, e.g., ability to walk. The brain appears to no longer be able to tell the body what to do. Generalized and cortical neurologic signs and symptoms are frequently present.

Reisberg, B., Ferris, S.H., Leon, M.J. & Crook, T. The global deterioration scale for assessment of primary degenerative dementia. *American Journal of Psychiatry, 1982, 139:1136-1139*

Relationship Between Alzheimer's Disease Progression and Child Development

Age of acquisition	Ability	Alzheimer's stage at which ability is lost
18+	Parenting Skills (hold baby)	7 - severe AD
12 + years	Hold a job	3 – earliest symptoms of AD
8 – 12 years	Handle simple finances	4 – mild AD
5 – 7 years	Select proper clothing	5 – moderate AD
5 years	Put on clothes unaided	6 – moderately severe AD
4 years	Shower unaided	
4 years	Toilet unaided	
3 – 4.5 years	Control urine	
2 – 3 years	Control bowels	
15 months	Speak 5 – 6 words	7 – severe AD
1 year	Speak 1 word	
1 year	Walk	
6 – 10 months	Sit up	
2 – 4 months	Smile	
1 – 3 months	Hold up head	

Growing up

Birth

Dementia is progressing

Death

COMMUNICATION STRATEGIES

1. **Initial Communication** - look into eyes and introduce yourself(may be every time)
2. **Communicate in positive ("do") rather than negative ("don't") terms.**
3. **Avoid questions by stating information in positive terms.** Offer only 1-2 choices. Show items if possible.
4. **Simplify your message. (5-6 words at most)**
5. **Break tasks into the simplest steps, giving directions one step at a time.**
6. **Speak to the demented person as an adult.**
7. **Use non-verbal communication--touch, tone of voice, facial expressions, and gestures.**
8. **Speak slowly, calmly, deliberately.**
9. **Assess if the person has vision or hearing problems.**
10. **Keep a sense of humor.**
11. **Do not reason or be "logical".**
12. **Don't argue or correct.**
13. **Don't say "Don't you remember?" Don't say "Who am I?"**
14. **Encourage him/her to point/gesture, if possible, if you don't understand what is being said.**
15. **Offer a guess if he/she cannot find the correct word. (Unless this is upsetting.)**
16. **Show interest in what he/she is saying. (Even if you don't understand)**
17. **Use trial and error** - see what works today.
18. **Ask other staff/family what communication techniques are most/least effective. (Do this first!)**
19. **Repeat questions using the same words.**
20. **Reduce background noise - move if necessary.**
21. **Give praise for responses.**

s: r112596.rw