

ELDERLY SERVICES IN HEALTH CENTERS:

**A Guide to Address
Unique Challenges of
Caring for Elderly People
with Disabilities, Frailty,
and Other Special Needs**



NATIONAL ASSOCIATION OF
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Unique Challenges
of Caring for Elderly People
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and Other Special Needs
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A Guide to Address Unique Challenges of Caring for
Elderly People with Disabilities, Frailty, and Other Special Needs**

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I. INTRODUCTION AND RECOMMENDATIONS

In February 2007, NACHC produced the document “Elderly Services In Health Centers: A Guide to Position Your Health Center to Serve a Growing Elderly Population.” That document presented issues for health centers to consider to meet elders’ health care needs and to take advantage of opportunities presented by the growing elderly population.

This document continues NACHC’s efforts to position health centers to assure elderly people access to quality health care, but with a focus on individuals with medical or mental health conditions that limit their ability to care for themselves. As the number of people over the age of 75 increases, health centers will find they have to adapt their service package to reflect a range of unique and challenging health care needs.

In this document, NACHC provides information to strengthen health centers’ understanding of options related to service delivery systems as well as patient care issues for serving disabled and frail elderly people. Readers will learn:

- **Why health centers are strengthening and expanding systems for serving elderly populations,**
- **What are delivery systems and specialized services that some health centers have considered,**
- **What are conditions that are essential to address when serving frail and /or disabled elders,**
- **Where to look for additional information.**

Relatively healthy older people, particularly those in the 60 to 70 age range, are likely to need services similar to other adult health center populations. They may face challenges similar to their younger counterparts; language barriers, limited health literacy, or cultural factors may impact health care access. Yet for the older-old, these familiar challenges are compounded by additional barriers to optimal care and quality of life. The disabled of any age often need supportive services to remain as healthy as possible and in the community. As the population ages into the 75+ or 85+ categories, there is more likelihood for the presence of disability and the need for special services. Many more health centers are now beginning to serve disabled elders and even more centers are realizing that, given demographic changes, they must plan to provide services in the future that encompass not only the physical needs of vulnerable patients, but also the psychosocial needs that significantly impact health, health care access, and quality of life.

RECOMMENDATIONS

- **HEALTH CENTERS SHOULD EXPECT THAT SOME OF THEIR ELDERLY PATIENTS WILL HAVE DISABILITIES AND SPECIAL NEEDS AND PLAN TO MEET THOSE NEEDS THAT ARE MOST CRITICAL IN THEIR COMMUNITY.**
- **CASE MANAGEMENT OR CARE COORDINATION IS MOST IMPORTANT FOR THIS SUBSET OF ELDERS.**
- **ADULT DAY HEALTH CARE CAN BE AN IMPORTANT PART OF A HEALTH CENTER'S APPROACH TO PRIMARY CARE FOR ELDERS WITH DISABILITIES.**
- **PARTNERING WITH OTHER HEALTH AND SOCIAL SERVICE AGENCIES IS ESSENTIAL TO ASSURE ACCESS TO RESOURCES THAT MAY NOT BE AVAILABLE WITHIN THE HEALTH CENTER.**
- **HEALTH CENTERS WITH A SIGNIFICANT MEDICARE/ MEDICAID ELIGIBLE GROUP SHOULD CAREFULLY EXAMINE THE BENEFITS OF CONTRACTING WITH OR DEVELOPING A MEDICARE SPECIAL NEEDS PLAN TO DETERMINE IF THIS WOULD BE IN THE INTEREST OF THE PATIENTS AND HEALTH CENTER.**
- **HEALTH CENTERS WITH A LARGE NUMBER OF DISABLED ELDERS MAY WISH TO CONSIDER PARTNERING WITH OR DEVELOPING A PACE PROGRAM, ALTHOUGH THIS IS A MAJOR UNDERTAKING.**

II. DISABILITY IN THE ELDERLY: WHAT IT MEANS TO HEALTH CENTERS

The following topics areas are covered:

Demographics of Aging and Disability

Elders in Health Center Communities

Delivery Issues When Caring for Disabled Elders

Additional Services Health Centers May Provide

Health Plans and Demonstration Programs for the Disabled Elderly

Disability usually refers to the lack of ability to carry out normal functional activities.

In the field of aging, disability is measured by judging how a person performs Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).

ADLs include very basic activities like eating, toileting, bathing, transferring in and out of bed, and walking (Katz, Ford, Moskowitz, Jackson and Jaffee, 1963). IADLs include additional activities needed to get along in the world such as shopping, taking medications, using the phone, and other activities. (Lawton and Brody, 1969.)

People may be disabled if they do not have the cognitive ability to perform functions without supervision or assistance.

Broader definitions of disability may include hearing or visual impairment, mental illness, or significant medical conditions which require adaptive behavior or limit ability to work.

The more ADLs or IADLs in which a patient requires assistance, the more disabled they are considered to be. Typically, eligibility for a nursing home or for some community based long term care programs may require need for assistance with **two or more** ADLs.

❖ **DEMOGRAPHICS OF AGING AND DISABILITY**

In our health centers we are feeling the effects of aging. Our communities are aging and where we once could concentrate on serving the “Moms and Kids” population with a few elders sprinkled in, we are now challenged to serve a growing elderly population.

- Over the next 25 years, the U.S. population will see a doubling of the over-65 population from 35 million to over 70 million.
- The oldest old, those 85 years of age, will grow from 2% of the population now to 5% by 2030 (http://www.aoa.gov/prof/Statistics/future_growth/future_growth.asp).
- These over-85 elders will have a number of chronic diseases and functional disabilities.
- Many of these elders will live in the inner city urban areas and rural areas served by health centers and increasing numbers will be minorities such as African Americans, Latinos and Asian-Americans.
- Many will be adult patients of our health centers whom we have been serving for many years and who will age into the elderly category with additional special needs.

❖ ELDERS IN HEALTH CENTER COMMUNITIES

- They will not be affluent. Over half will live on incomes below 200% of the federal poverty level and will need help with all of the co-pays, deductibles, and services that are left uncovered by Medicare. They will need help applying for Medicaid.
- Lack of income and economic security may well become an increasing problem for elders as more and more employers drop fixed benefit pension plans as well as contributions to retirees' health care.
- In the over-85 group, more than a third will need assistance with personal care related to their disabilities (<http://www.census.gov/prod/2006pubs/p23-209.pdf>).
- A greater burden will fall on health centers to provide both chronic care and the functional assistance needed for elders who wish to remain living in the community.
- Language access and other factors related to cultural sensitivity will be key quality of care elements for this growing patient population.

❖ DELIVERY ISSUES WHEN CARING FOR DISABLED ELDERS

There is no single approach to services for this population. Service providers, researchers, and policy makers have been working for at least the last 30 years trying to design key services for elders with functional disabilities caused by physical and cognitive problems. The goals of their work have included improved quality of life, the avoidance of institutionalization in nursing homes, improved functioning with chronic diseases, reduction of high costs and inappropriate health care utilization, and numerous others.

Findings from this work include:

- **The elderly disabled often have numerous chronic conditions and functional disabilities that require clinicians and service providers to take an ongoing cooperative management approach with the patient and family.** The goal of this approach is to live the best possible life with chronic problems and avoid preventable deterioration of health and functional ability. In this arena, the patient, the family, and paid or unpaid caregivers often have a significant impact on care and quality of life, although the health center medical provider is still a critical partner in the process of providing and authorizing necessary care.
- **Not every physician chooses to focus on caring for disabled elders.** Physicians who work with this population must value chronic medical and disability care and be able to work closely with the patient, family, caregivers and other professionals to provide the best care. There are also physiological differences in the elderly population that must be taken into account in treating and prescribing medications. Some health centers may be lucky to have on staff some of the scarce group of physicians who are sub-boarded in geriatric medicine. Others will have internists or family practitioners providing care to the disabled elderly. The specific training and background of physicians may be less important than their willingness to understand different approaches in caring for the elderly and their enjoyment of working with the population.
- **Care for the disabled elderly clearly benefits from the involvement of a multi-disciplinary team.** The team might include, at a minimum, the physician or other medical provider such as a nurse practitioner or physician assistant, the nurse who assists the doctor with medical management, and a social worker who works on putting in place community or home-based supports for the patient and family. Psychologists, licensed clinical social workers, and physical therapists may also be part of the team. The team may integrate their work in an informal way through casual exchanges, or may meet in a more formal way in team meetings where the most complex patient needs are discussed and strategies are brainstormed and agreed to by members of the team.

- **The elderly with disabilities are the most likely to require special case management or care coordination services**, which can be provided by a nurse, a social worker, or a skilled community health worker. Care coordination should include assistance with the psycho-social and functional issues that are important to a person with disabilities or special needs. Typically the care manager will focus on supporting the patient's ability to perform activities of daily living and assist with psycho-social interactions and other service arrangement that will enable the patient to live at home for as long as possible. Care managers may also be in a position to bridge gaps in terms of language or cultural barriers to access.

In a typical case management process for an elderly patient with disabilities, the care coordinator:

1. Conducts an **in-home assessment** where the care coordinator can note the person's true abilities in functioning at home as well as an assessment of psycho-social needs and physical improvements needed in the home;
2. Works with the patient and/or their family members or caregiver to **set priorities for how to meet critical needs**, including making arrangements for other services to be provided in the home, whether they be provided by the health center or other community organizations;
3. **Monitors** the success of additional services, intervenes periodically or in a crisis, and reassesses the situation after a suitable period of time;
4. **Shares** with the rest of the team information and observations that are taken into account in designing the medical treatment plan.

❖ **ADDITIONAL SERVICES HEALTH CENTERS MAY PROVIDE**

Most health centers will be serving elders with disabilities in their normal adult clinics. Some may wish to set aside special clinic times for the elderly including those with disabilities and special needs. Set-aside times can allow for somewhat longer patient visits which are helpful in treating elders with long histories and multiple chronic problems. Some health centers may also choose to set up additional services as part of their approach to primary care for the elderly. These may include adult day health care, home health care, assisted living, and nursing homes. Unfortunately we do not have an accurate count of how many health centers are involved in each of these options at the current time.

ADHC is a community-based health and long term care service aimed at elders or adults who are disabled enough to be in a nursing home or at risk of nursing home placement. When coordinated with other health center services, particularly primary care clinic services, ADHC can be critical in allowing elders to avoid nursing home placement and helping informal caregivers to continue providing care over an extended period.

Participants live at home and are brought into the center from 3 to 5 days a week. Services may vary from state to state but typically include an assessment and care plan with nursing services; physical, occupational, or speech therapy; socialization and transportation; social work case management; behavioral care, meals appropriate for the health condition of the participant, and personal assistance services related to toileting and bathing; and other services as needed. The service also affords respite to family members who may be caring for the disabled elder at home. For a general description of adult day services issues see http://www.nadsa.org/documents/hcbs_techbrief.pdf.

Relationships with Health Centers: ADHC can be part of a health center's primary care approach to serving the elderly. Health centers in several states currently operate ADHC centers directly. Health centers may also partner with freestanding ADHC centers to provide physician care to participants.

Advantages:

- Adult day health care can be a critical part of a primary care approach to serving the elderly with disabilities.
- ADHC can help build a center's reputation as an elder-serving organization.
- ADHC can be a building block for moving toward a Program of All-Inclusive Care for the Elderly (PACE).

Business and Billing Issues:

- ADHC services are not covered by Medicare but are covered by many states as a Medicaid benefit.
- States may choose to cover ADHC either as a state Medicaid plan option or as a Medicaid home and community based waiver service.
- ADHC services may be paid for by a state Medicaid program either through fee-for-service reimbursement or FQHC prospective payment system rates.
- Health centers should check with their state primary care association with regard to health center specific ADHC.

Barriers:

- Operating an ADHC requires knowledge of state regulations and reimbursement procedures, which can be substantially different from health center regulations.
- Plans for ADHC require understanding of the elderly market in a given community.
- Participants may come from existing health center patients, although individuals from outside the health center patient group may also want to participate.
- Staffing may be difficult in some communities because shortages of physical therapists and other required staff.
- ADHC requires an up-front investment in a facility that includes significant square footage as well as specialized equipment used for physical therapy and other disability related activities.

See www.nadsa.org for general information on adult day health services.

Home Health Care refers to skilled and unskilled services provided by licensed agencies in the patient's home.

Services may include skilled nursing, physical, speech, and occupational therapies, as well as aide or personal assistance services provided by non-professional staff. Services are ordered by the patient's physician and relate to an acute episode of illness or hospitalization. Home Health Agencies deliver services within both Medicare and Medicaid reimbursement guidelines.

Relationships with Health Centers: Some health centers are licensed as home health providers. Health centers may also partner with a specific home health agency in order to get dedicated home health nursing staff assigned to the center's patients and doctors. To assure coordination and continuity of care, home health nursing staff may attend health center team meetings on a periodic basis.

Advantages:

- Health centers may partner with home health to improve coordination of clinical care leading to improved patient and provider satisfaction.
- There may be good business reasons to own or operate a home health agency.

Business and Billing Issues:

- Home care is a competitive business with complex market and reimbursement issues.
- Health centers should assure that they receive expert advice in this area before seriously considering getting into the home health agency business.
- Home health care is likely to present a crowded market for most health center communities.

Barriers:

- Licensing and regulations are very different from health center requirements.
- Centers should be familiar with the market for home health services and consider carefully the costs and benefits of providing this service vs. contracting with or cooperating with existing home health agencies.

Nonetheless, it may make sense for some health centers to pursue home health licensing depending upon the dynamics and needs of the local community.

See : http://www.eldercare.gov/eldercare/Public/resources/fact_sheets/home_care.asp.

Assisted living facilities typically provide a mix of services and residence for disabled elders who may be in need of extra assistance but do not require nursing home care. Most assisted living services are paid for privately but some are reimbursed through Medicaid.

Relationships with Health Centers: Health centers may play similar roles in assisted living as in nursing homes (see below).

1. They may follow their patients who move to an assisted living facility, either by providing services on site or by arranging to have them come to the clinic.
2. A health center physician may serve as a medical director or consultant to an assisted living facility in the health center community.
3. A health center may serve as a partner or owner in developing or operating an assisted living facility.

Although assisted living may be thought of as a service for more affluent elders, forty-one states offer assisted living for Medicaid recipients through home and community based waiver programs. (For more information about assisted living facilities in general, go to www.alfa.org or to <http://www.aarp.org/research/housing-mobility/assistedliving/aresearch-import-924-INB88.html>). Also be aware that low income patients may use so called “board and care” homes as an equivalent to assisted living and health centers should make every effort to provide appropriate care to elders living in such homes.

- Advantages:**
- Centers can follow existing patients who change residency to an assisted living site.
 - Health centers may attract additional elderly patients by providing services on-site or providing transportation to the health center.
 - In the case of smaller board and care sites, health centers may be able to significantly improve care by lending their medical expertise.

- Business and Billing Issues:**
- Providing services in assisted living should be the equivalent of providing care in the patient’s home, and Medicare FQHC reimbursement should be available to the center.
 - The health center may contract directly with an assisted living entity for other services such as medical direction.
 - Centers interested in owning or operating an assisted living facility must understand regulations, the market for such services, and do careful business planning.
 - Health centers delivering services should understand Medicare and Medicaid regulations that may apply to billing for services in a home setting.

- Barriers:**
- Staffing capacity to care for complex medical and disability problems that will exist in assisted living and board and care settings must be adjusted.
 - Centers should be aware of the community reputation of sites who they partner with in any extensive way.

Nursing Homes or Skilled Nursing Facilities (SNFs) provide residential care, health, and personal assistance services to very disabled elders in an institutional setting.

SNFs were one of the early types of long term care services available in most communities prior to the development of home and community based services which allow disabled patients to be served at home.

Relationships with Health Centers: Health centers play varied roles in relation to nursing homes, from following existing patients, to having their physician serve as medical director of nursing homes, to owning and/or operating nursing homes. Community health centers that partner with skilled nursing facilities (SNFs) can enhance the well being of their patients, the community and their organizations. The health center may provide a range of services to help a patient remain in the community, but at times some patients will enter a SNF. In small rural communities without other long term care services, a SNF may be seen as very much a community-based option that allows a patient to remain housed in that community rather than having to move away to receive services. Collaboration with SNFs can strategically position a community health center to participate in the future of this part of its aging patient population. SNFs have a history of partnering with multiple organizations to meet the needs of their patients as well as regulatory requirements they face. Community health centers may provide some or all of the services that a SNF is looking for, including:

- Medical services by physicians, nurse practitioners, clinical social workers, pharmacists, dentists, optometrists, specialists, podiatrists
- Pharmacy services
- Laboratory and radiology services
- Medical direction
- Transportation services

Advantages: **Partnering with SNFs promotes a continuum of care.** Very often patients move from home to hospital to skilled nursing facility to home again. Some health center disabled elderly patients will move from living in the community to short- or long-term placement in a skilled nursing facility. However, in many cases, the clinicians that have cared for the elder in the community health center do not provide care in skilled nursing facilities. The continuum of care is interrupted when new clinicians need to take over the care.

- In combination with creating a continuum of care, clinicians work in different and diverse settings, which can stimulate creativity, relieve stress of repetitive work systems, and kindle long-term relationships with patients, which furthers job satisfaction.
- Developing ways to maintain community members in their own communities improves the quality of life for the elder, their family and the community. Maintaining elders in proximity to their last home permits families and friends to maintain neighborhood ties, which strengthens communities.

Business and Billing Issues:

- Clinical services offered by community health centers to SNF patients are generally provided in two ways:
 1. Under agreement for mutual referrals whereby skilled nursing facilities refer and provide access to its patients to the community health center and each entity is responsible for its own billing and collections. In this case the health center should be able to access Federally Qualified Health Centers reimbursement for qualified visits provided in the SNF. (See NACHC guidance for health center billing for SNF visits.)
or
 2. Under contract where charges and services are agreed in advance, billed by the skilled nursing facility, which compensates the community health center.
- A health center physician may serve as medical director of a SNF or the health center may provide other professional services, typically provided under a contract between the health center and the SNF.
- Nursing home visits made by nurse practitioners and physicians are billable through Federally Qualified Health Centers Medicare.
- If a patient is covered by a Medicare Advantage plan, the health center and the nursing home must have contracts with the plan for payment.
- Depending on the plan, the health center will bill either the nursing home or the plan for the medical visits.
- If a patient has Medicaid only, most states allow nursing home visits made by physicians and/or nurse practitioners at a negotiated rate.

Barriers:

- Skilled nursing facilities are heavily regulated and the burden of regulation falls directly on clinicians in terms of restrictive deadlines to meet care and documentation requirements.
- The requirements for reimbursement are cumbersome.
- The 24-hour care needs of frail and ill elders in a skilled facility are an additional responsibility for on call and coverage staff.
- Despite regulatory surveys, Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) accreditation and staffing measures, determining the quality of care provided in skilled nursing facilities is difficult. The public image of a facility is an important measure of quality, which can bolster or damage a community health center's reputation. For more information go to www.jointcommission.org.
- Health Center physicians serving as Medical Director for a SNF will not receive Federal Torts Claims Act (FTCA) malpractice coverage for this part of their work.

Community health centers in partnership with skilled nursing facilities build on an existing continuum of care and create caring and competent communities. Partnerships with skilled nursing facilities can be financially rewarding, improve organizational reputations, and enhance the overall capabilities of the health center and its staff. Beyond partnering with SNFs some health centers may also choose to own and operate a SNF in their community. The level of regulation and very different nature of SNF business mean that health centers should approach this level of involvement with caution.

❖ HEALTH PLANS AND DEMONSTRATION PROGRAMS FOR THE DISABLED ELDERLY

HEALTH PLANS/DEMONSTRATION PROGRAMS — Program of All-Inclusive Care for the Elderly (PACE)

Several community health centers operate a PACE program, a home and community based service that allows severely disabled elders who are eligible for nursing home placement to remain in the community. PACE is usually based in adult day health centers and operates as a small Medicare Advantage capitated managed care plan at risk for providing all Medicare and Medicaid covered services including long term care and acute hospital care. Primary care services are also provided by the PACE program in a clinic setting utilizing employed or contracted medical providers. PACE programs typically provide all personal assistance and home health services delivered in the patient's home as well as case management and coordination of all medical specialty care, dental care, hospital care, and nursing home care should it become necessary. **PACE programs receive a high capitation rate compared to other elderly health plans but must manage all services for elders who would otherwise be in skilled nursing facilities. This includes being at risk for all medical and long term care costs.** A health center taking on this program must be comfortable assuming significant financial risk as well as be able to assume the significant regulatory requirements for PACE that parallel much larger Medicare Advantage health plans. Despite the risk, PACE is one of the few accepted models for fully integrating health and long term care services for disabled elders and is a very significant resource for communities that have the programs.

PACE began as a Medicare waiver program but is now a full Medicare benefit. Since it integrates Medicaid services, it requires contracting with the state as well. Different states have varied arrangements with PACE programs regarding covered services and the Medicaid part of the capitation rate. There are currently 42 PACE programs operating in 22 states. For a list of these and other developing PACE programs, go to <http://www.npaonline.org/website/download.asp?id=1740>. Several of these programs are operated by community health centers.

In addition to PACE there are several health plan options and state-based demonstration plans focusing on care for elders with disabilities that health centers should be aware either as potential partners or as models for future development in their communities.

HEALTH PLANS/DEMONSTRATION PROGRAMS — Medicare Advantage Special Needs Plans (SNPs)

The Medicare Modernization Act of 2003 (MMA) authorized the development of several new types of health plans for the elderly. The new Special Needs Plans (SNPs) are of particular relevance to the disabled elderly population. MMA allowed for three types of Special Need Plans, one aimed at residents of SNFs, a second aimed at dual Medicare and Medicaid eligible individuals, and a third aimed at patients with one or more chronic disease problems. To date, most SNPs have targeted the dually eligible but all three could be relevant to health centers serving the disabled elderly. These new types of plans, in addition to the risk-adjusted payment methodology now used by Medicare, mean that it will be more likely that elders with disabilities may be enrolled in private Medicare health plans. Traditionally plans might have avoided such “heavy care” members, but the new plans and new rate methodology mean that they will get paid more to care for Medicare beneficiaries with complex medical needs, and are beginning to see such members as attractive. These SNP plans are more likely to be present in urban areas rather than in rural areas because of the concentration of potential members and the availability of provider networks.

Skilled Nursing Facility SNPs allow specialization in patients who are already institutionalized. Health centers may wish to explore partnering with such plans if their physicians are serving a significant number of nursing home residents or if they contract with or own nursing homes. Typically such plans can provide a more comprehensive and coordinated package of medical care to SNF residents than would be normally provided, thus saving on high cost care and, ideally, providing better quality of life for residents. United Health's Evercare SNF plan is one of the models for this type of plan. (http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Evercare_Final_Report.pdf).

Dual Eligible SNPs are especially relevant to health centers because health center patients are more likely to be low income and qualify for Medicaid as well as Medicare. These plans receive higher capitation rates than Medicare-only plans because Medicaid recipients have higher levels of disease problems and complicating socio-economic factors and thus are considered by CMS to be of higher risk. Not only do dual eligible patients have more chronic disease problems but they are also more likely to have functional disabilities as well. Because of the higher rates that these plans receive health centers may partner with them to both receive higher payments and additional benefits including disease management and care coordination or case management for their patients. Plans may be willing to either provide case management directly to health center patients enrolled in the plan or may be willing to pay the health center to provide specialized management and coordination services which will allow better control of high cost utilization such as hospital use. There may be possibilities for health centers to assist disabled plan members with home and community based service needs in so far as these impact medical care use.

SNPs for Chronic Conditions: There are fewer examples of the third type of Special Needs Plans for patients with chronic conditions. These may however also provide health centers with the ability to provide additional disease management and care coordination services to disabled elders who fall into the target population for such plans.

Factors for Health Centers to Consider: Health centers should keep in mind several additional factors in considering Medicare Advantage plan options.

- Unless the health center or a health center network owns the plan, these plans are private, usually for-profit. Some patients and centers may be opposed to the use of private plans for Medicare which allows plans to collect administrative, profit, and overhead costs which are much higher than traditional Medicare.
- Health centers should familiarize themselves with Medicare Advantage Federally Qualified Health Centers (FQHC) wrap-around payment provisions which allow collection of 100% of the Medicare FQHC rate for these patients. In order to collect Medicare Advantage wrap-around payments, centers should be aware of the conditions which their contract with the plan, or subcontract with a medical group, must meet. NACHC has distributed issue briefs which summarize these requirements. (<http://iweb.nachc.com/downloads/products/86.pdf>).
- Quality bonuses, case management fees, utilization related incentives, and certain other payments may be available under the Healthcare Advantage Plan in addition to FQHC payments for visits.
- Centers should be particularly attentive as to how contracts are structured to assure added value to the patients and financial stability for the health center.
- Dual eligible types of SNPs may allow the health center to collect a Medicaid wrap-around payment in addition to Medicare related payments if their Medicaid rate is higher than their FQHC rate and if their state allows for such Medicaid wrap-around payments for dual eligibles. Centers should check with their state primary care association if they are not familiar with these provisions.

In addition to Medicare Advantage plans, which are available nationally, there may be relevant state specific plans that can assist health centers in caring for disabled elders. A variety of mechanisms are used by states to integrate care for Medicare and Medicaid eligible elders.

- Several states have waiver programs that allow enrollment of elders into health plans which use both Medicare and Medicaid funds. Such plans, in addition to accepting financial risk, provide care coordination services and long term care services including home and community based services along with being responsible for Medicare covered acute care services (Saucier, Burwell, & Gerst, 2005). They attempt to avoid use of nursing home services by providing appropriate primary care and community services. Examples include Minnesota Senior Health Options and Massachusetts Senior Care Options. Health centers or their networks may consider contracting with plans in these states.
- Some states are also attempting to integrate Medicaid services for the disabled and elderly with a Medicare SNP plan for dual eligibles. These plans may not require waivers. Examples include New York and Washington (Tritz, 2006).
- Other states have Medicaid-only plans that are at risk for all Medicaid covered services and that coordinate home and community based services at the same time as beneficiaries receive their medical care through either traditional fee-for-service Medicare or through a Medicare Advantage plan. Such states include Texas, Florida, Wisconsin, and Arizona.

Health centers should be aware of Medicaid plans so they can coordinate medical services with home and community based services provided by these Medicaid plans. In all of these examples, enrollment in the Medicare part of the health plan must be voluntary. Medicaid plan enrollment may be either voluntary or mandatory depending on the state. Health centers can contact their state Medicaid agencies to understand what special plans are in place for the dual eligible population with disabilities. There may also be subcontracting opportunities available for health centers to provide certain types of care coordination or community based services.

III. SPECIAL ISSUES IN SERVING ELDERS WITH DISABILITIES AND SPECIAL NEEDS

The following pages address some of the fundamental challenges and considerations related to serving older adults with special needs at community health centers. While neither the topics covered nor summaries are exhaustive, each section provides background information with an overview of key factors to consider; a synopsis of the role health centers can play; and helpful web-links for further information or resources.

The following topics areas are covered:

Caring for the Elderly

Common Health Concerns for Frail Elders

Social Issues

Housing Issues

❖ CARING FOR THE ELDERLY

The elements of providing health care for older adults are essentially the same as for other patient populations. However the methods of service-delivery may vary in some important ways. Complex conditions such as dementia, frailty, disability, isolation, dependence or depression require tailored means of communicating with patients and providing or coordinating needed care.

This section will address four areas of patient care that require special attention for older adults at community health centers:

- Maximizing the Patient Visit Encounter
- Medication Management for Older Adults
- Case Management
- End of Life Care

CARING FOR THE ELDERLY — Maximizing the Patient Visit Encounter

Background: Among older adult patients, the frequency of doctor visits for known conditions tends to increase steadily with age. As medical needs grow, the challenge of addressing patient concerns and needs during each patient encounter tends to grow as well. These challenges are compounded by health-related factors such as hearing impairment or other communication difficulties, decline in memory or cognitive function, difficulty expressing or prioritizing concerns due to depression, despair or other conditions often associated with aging, frailty or disability.

Given the pressures of cost constraints and a push to see more patients faster in most health care settings, both patients and medical providers can feel rushed and dissatisfied. It takes open communication as well as planning and prioritizing on the part of both parties to make the most of each patient visit.

**Role of
the Health
Center:**

According to a survey from the Commonwealth Fund, (http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039), a positive doctor-patient relationship contributes to the patient's perception of optimal health care, which is patients who have a regular primary care provider tend to receive better care and have better outcomes. This is particularly true for ethnic minorities.

Elderly patients often feel more confident in their health care provider when clinicians consider not only their physical functioning, but also their mental health, cognitive status, and resources or social supports. A professional appearance also matters to elderly patients. Many prefer the doctor's white coat and respond well to a pleasant demeanor.

Prior to an initial appointment, patients should be informed to come prepared to discuss their medical history including chronic illnesses, current medications, hospitalizations, surgeries, and other specialists currently involved.

Advise and encourage patients to prepare for each visit in the following ways:

- Keep a chronological list of medical events such as date and type of surgeries and hospitalizations, and dates when illnesses were diagnosed.
- Bring all medications and over the counter products including vitamins and herbal remedies.
- Bring copies of medical records.
- Bring home monitoring records for diabetes and hypertension.
- Have questions ready. All questions may not be addressed in a single visit, so choose the top one or two concerns to discuss at each encounter.
- Bring a family member or friend to the visit for support. This is especially helpful for patients with multiple medical issues, communication difficulties, or cognitive impairments.

Communicate clearly the following steps:

- Encourage patients to exchange ideas, concerns, and expectations and to ask questions to gain understanding about any diagnosis or treatment plan.
- Provide clear medication information including instructions, reasons for taking them, expected results, and any possible side effects to watch out for.
- Discuss the follow-up plan including next visit or diagnostic tests, and what to expect physically between now and the next visit.
- Provide written instructions including any changes in medications, upcoming tests or other important information.

Conduct a social history to:

- Identify the patient's primary caregiver.
- Know of children/family who live in the area.
- Identify sources of income.

- Understand social services in place (such as case management, or a meal program).
- Assess potential gaps in services that may be a barrier to optimal health.

When the patient leaves after their appointment they should know:

- How to get their medication refills, who to call if there is a problem with health or medications.
- What happens if there are urgent or emergent needs before the next visit.
- How to alert the doctor if there is a change in their health status.

Helpful Links:

Reinberg, Steven, “A ‘Medical Home’ Improves Health Care for Minorities,” Health Day News, June 27, 2007 <http://www.healthfinder.gov/news/newsstory.asp?docID=605941>)

“The patient-physician relationship: A partnership for better health care and safer outcomes.” Guidelines developed by the AMA in partnership with AARP: www.ama-assn.org/ama1/pub/upload/mm/370/amaaarpmessage.pdf.

CARING FOR THE ELDERLY — **Medication Management for Elders**

Background: Medication management for seniors is often complex due to multiple medication needs in combination with functional limitations and other obstacles. Elderly patients are at high risk for experiencing problems with drug therapy due to factors such as:

- **Physical limitations** — Vision problems or other functional impairments may prevent patients from understanding or following medication instructions.
- **Social circumstances** — Living alone or lacking reliable caregivers, particularly when cognitive or physical impairment limits the patients’ ability to appropriately manage their medication regimens.
- **Complex medication regimens** — Seniors often must take several different medications at various times throughout the day and week, making it difficult to understand, keep track of, and comply with a complicated drug treatment plan.
- **Multiple health care providers and multiple sources of medications** — Health care providers may include a primary care provider and numerous specialists, who prescribe controlled and other prescription medications, over the counter medications, and herbal remedies, increasing the probability of overmedication or drug reactions.
- **Inadequate prescription drug coverage** — Often elderly patients neglect to take medications they cannot afford, and they may or may not tell their provider. At times providers are required to change prescribed medications as drug plan formularies change, causing the patient to adapt in less than optimal ways.
- **Pharmacist accessibility** — While mail-order prescriptions may be more convenient and more affordable for some patients, this method of dispensing eliminates the opportunity to interact directly with a pharmacist.
- **Transportation and accessibility issues** — Elderly patients may encounter difficulty getting to the pharmacy or health center due to mobility impairment, difficulty accessing transportation services, and limited resources or assistance from family or other caregivers.

Role of the Health Center:

The following recommendations will help to reduce medication error and improve compliance among elderly patients:

Adhere to safe prescribing practices for the elderly: This is a relatively new area of study and practice. Expertise in this field may be limited especially given the shortage of providers specializing in geriatric care. By consistently following medication management guidelines for the elderly (and other vulnerable populations), problems resulting from noncompliance or drug interactions can be minimized.

Maintain vigilance in prescribing: It is important that providers be aware of all medications which the patient is taking, including over-the-counter medications, supplements, herbal products, or another person's medications, both to monitor for drug interactions, and to evaluate each medication—whether it is necessary, contraindicated, or duplicating other prescribed medications.

Consider compliance issues: Patients may choose to discontinue medications due to side effects without notifying their providers. It may not be clear if symptoms resulted from a particular medication, drug interaction, or illness.

Simplify drug regimens in any way possible to improve compliance: This includes:

- Prescribing the lowest effective dosage of medications.
- Providing clear written instructions about when and how to make medications. It may help to provide instruction in large print, and in the patient's native language. For patients with cognitive impairments, it may also be necessary to communicate directly with family or other caregivers.
- Arranging for the use of medi-sets, bubble packs or other devices available to simplify dosing.

Provide patient education: Advise patients regarding routines that will help them manage their medications effectively.

Keep a list of everyone who has prescribed medications and a current list of all medications with dosages: The list should include over the counter medications, herbal remedies and any medications prescribed by other health care providers. In case of emergency, this list should be stored in the wallet/purse and in visible place in the home (i.e., on the refrigerator).

- Never share medications with others, or take someone else's medications.
- Do not put more than one medication in the same bottle or container.
- Use one pharmacy for all of the patient's medications. This will enable the pharmacy to track medication side effects and be able to anticipate a problem with a new medication.

Encourage patients to ask questions: Discuss the name and purpose of the medication, side effects to watch for, whether or not to take the medication with food, what to do if a dose is missed, how long to take the medication, and how to store the medication. If a caregiver is involved, always include that person in discussions about medications.

When a prescriber and a patient partner to make appropriate decisions and plans about medications, the outcomes will likely be more positive. The provider will have the necessary information for appropriate prescribing decisions, and the elderly patient will be more informed about how to use and what to expect from the medications.

Helpful Links:

AARP meds safety resources: www.aarp.org/health/rx_drugs/usingmeds/

American College of Emergency Physicians: www3.acep.org/ACEPmembership.aspx?id=30846

US Department of Health Services meds safety pages: www.ahrq.gov/consumer/safemed/safemed.htm

American Society of Health Systems Pharmacists resources: www.ashp.org/patient-safety/issuebriefs.cfm

CARING FOR THE ELDERLY — Case Management

Background: Geriatric case management is a key ingredient of quality health care services for older adults. High rates of chronic conditions, dementia, frailty or disability, and sub-optimal home environment and social supports call for the integration of primary care and case management for elderly patients of community health centers.

Case management may support health center disease management efforts but is primarily aimed at supporting the coordination of services that are necessary for living safely in a home environment. Without case management services, patients may have difficulty following home-care instructions, taking medications properly, scheduling appointments, arranging transportation, or accessing the array of home and community-based services to support independent living

The need for case management is particularly high among elderly patients suffering from isolation, depression, frailty, or chronic or disabling conditions. Patients may lack the social supports or capacity to reach out for help, and family members or other caregivers may lack the resources they need to provide appropriate or adequate care. Given these challenges, the fragmentation of social services in conjunction with medical care can function as an overwhelming barrier to access necessary care to support the “whole patient”.

Role of the Health Center:

Health center based case management can offer an integrated and holistic approach to patient care that encompasses medical, psycho-social and home care needs. Case management ideally includes an assessment provided in the patient’s home by social workers or nurses trained in geriatric care followed by the development of a care plan with the patient and/or their family. Long or short-term services may be necessary, depending on the patient’s needs. A flexible approach will be most effective, and allow for services to be tailored as needed. Case managers may also intervene in emergency situations, monitor the effectiveness of services, and reassess the patient’s needs on a regular basis. Case managers can assist in the following areas:

Facilitate communication between the patient, provider and family or caregivers.

- Interpret medical diagnoses, procedures and instructions.
- Prioritize needs to address at a medical visit.
- Facilitate family meetings to discuss living arrangements, finances, medical decision-making, end of life care, or other needs.

Support independent living through needs assessment and linkage with community resources.

- Talk about home delivered meals.
- Facilitate personal assistance services.
- Assess financial management.
- Discuss accessible transportation.

Advocate for the patient's needs.

- Inform patient about public benefits and other financial resources.
- Promote accessible and affordable housing.
- Discuss in-home care.

Provide psycho-social and other support.

- Address needs related to loneliness and isolation.
- Conduct geriatric depression screening.
- Telephone check-ins or monitoring.

For a geriatric case management program to be most successful, it is important to attract staff who appreciate the diverse life experiences, expectations and needs of older adults.

It will help to connect with local training programs, provide internships, and offer professional development. Some health centers may be able to have trained community health workers perform these functions but the community health worker should be supervised by an MSW level social worker or by a registered nurse. Language access and delivery of culturally appropriate services are also essential components of providing quality care.

When health centers are not equipped to provide in-house case management services, or to meet the level of need among the patient population, it is important to develop relationships for effective collaboration with local programs in order to maximize integration of medical and social service needs. Clinical providers and staff should be trained to identify patients in need of social services in order to make appropriate referrals.

**Helpful
Links:**

American Case Management Association (ACMA) – a non-profit membership organization for Hospital/Health System Case Management Professionals: www.acmaweb.org/

National Association of Professional Geriatric Care Managers: www.caremanager.org/

Geriatric Care Managers: A Profile of an Emerging Profession, AARP Research Report, Nov. 2002.

<http://www.aarp.org/research/work/employment/aresearch-import-768-DD82.html>

Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors, Journal of the American Geriatric Soc; 54(7): 1136-1141, 2006

http://www.medscape.com/viewarticle/541536_print

CARING FOR THE ELDERLY — **End of Life Care**

Background: Community health centers face many challenges to providing patients with optimal end-of-life care. Primary care is typically fragmented from specialty, palliative and hospice care. This break in the continuity of care as patients approach death can be alienating, stressful and painful for patients, family members, caregivers and providers. Patients often have difficulty getting their own wishes met as they get swept up in high tech acute care medicine.

Given the inevitability of death, and the fact that most people die after the age of 65, health care for the elderly should incorporate ever-improving models of end-of-life care. As geriatric care is more fully integrated in primary care settings, this issue is expected to come more into focus at community health centers.

**Role of
the Health
Center:**

What follows are key components of end-of-life care, and how these can be incorporated at community health centers to promote continuity and quality of care, and enable health care providers and other caregivers to follow the wishes of the patient:

End of Life Decisions: Given the unique needs and choices of individual patients, it is important to help identify personal goals for end-of-life care. Ideally, routine assessment of elderly patients on intake, or once trust has been established, includes plans for medical decision-making and life-sustaining treatment choices. These issues should be discussed with patients in a direct way, and documented in advance whenever possible. Social services or case management staff can assist when necessary. These documented wishes should be revisited at critical times such as a new diagnosis or health crisis. These discussions need to be approached with sensitivity and support for the patient's comfort level as to when and how to address them.

Advance Directives: A "living will" documents patient wishes concerning medical treatment at the end of life, when the patient is no longer able to make medical decisions. A "medical power of attorney" (or healthcare proxy) allows an individual to appoint a surrogate decision-maker who is authorized to make decisions on the patient's behalf when s/he is unable to do so. Laws about advance directives vary by state.

Palliative Care: The goal of palliative care is to improve the quality of a seriously ill person's life, and to support the patient and family when faced with terminal illness. This includes managing physical symptoms, assessing psychological and spiritual needs, patient support system and discharge planning issues. Palliative care is part of hospice care, but it can begin any time during a patient's illness. A team approach to palliative care is optimal, with the primary care provider and social services playing an active role. While it is not currently the norm, palliative care can be provided at community health centers. Patient wishes and end-of-life decisions are central to making a palliative care plan.

Hospice: The focus of hospice care is on supporting patients and their loved ones as they approach death due to a life-limiting illness or injury. The goal once hospice becomes active is to care for patients, not to cure them. Usually care is provided in the home, but it can also be provided at hospitals, long-term care facilities or other settings. Hospice is covered by Medicare for patients with a prognosis of 6 months or less. Medicaid also pays for hospice services in 41 states, as does TRICARE and many private insurance plans, HMO's and other managed care organizations. As with palliative care, hospice involves a team-oriented approach. Ideally primary care is part of the team, though this is difficult when the patient is being cared for outside of the health center.

- Primary care providers have a level of patient history and connection that other providers of end-of-life care rarely have.
- Health centers must reach out to hospice and palliative care providers to develop strong relationships that will support continuity of care for patients.
- Involvement in end-of-life care often requires home visits or other settings for care planning and other needs.

Family/Caregiver Support: End-of-life care involves not only supporting terminally ill patients, but also their loved ones, caregivers and providers. Examples of caregiver support that can be provided within community health centers are:

- Social services staff can be a liaison between family members and the patient, primary care provider, and hospital or hospice care providers.
- Bereavement calls to family members can be very meaningful. Loved ones who need additional support can be guided to use hospice bereavement services.
- Periodic memorial services for deceased patients to honor the relationship between patients and professional staff, and offer space for providers and staff to process feelings about patients who have recently died.

Helpful Links:

For more information about models and resources for end-of-life care, see Caring Connections, the National Hospice and Palliative Care Organization, at www.nhpco.org

Promoting Excellence in End-of Life Care, A National Program of the Robert Wood Johnson Foundation - Innovative Models and Approaches for Palliative Care
<http://www.promotingexcellence.org/i4a/pages/index.cfm?pageid=1>

National Cancer Institute, End-of-Life Care- Questions & Answers
<http://www.cancer.gov/cancertopics/factsheet/Support/end-of-life-care>

Center to Improve Care of the Dying: www.medicaring.org

Hospice Foundation of America: www.hospicefoundation.org

Hospice Patients Alliance: www.hospicepatients.org

Improving Care for the Dying: www.growthhouse.org

National Hospice Foundation: www.hospiceinfo.org

National Hospice and Palliative Care Organization: www.nhpco.org

❖ COMMON HEALTH CONCERNS FOR FRAIL ELDERERS

The health concerns addressed in this section are not unique to older adults, but they disproportionately impact this patient population, and can impact all levels of patient care, regardless of what presents as the chief health complaint. This section does not highlight the most common acute or chronic health conditions of older adults, but rather those that typically require special sensitivity and often added resources to be adequately addressed among elderly health center patients.

- Alzheimer's/Dementia
- Depression
- Incontinence
- Physical Frailty, Disability and Personal Assistance Services
- Nutrition and Elders

HEALTH CONCERNS — Alzheimer's/Dementia

Background: Dementia takes many forms, progresses along a variety of paths, and has numerous causes and treatments. Generally dementia is characterized by loss of memory and other intellectual abilities significant and persistent enough to interfere with daily life.

The most common cause of dementia is Alzheimer's disease, accounting for up to two-thirds of all cases. Alzheimer's is a progressive and fatal brain disease with no known cure. Vascular dementia is the next most common form of dementia, accounting for 20% of cases. (Lantz, 2001) Other forms of dementia can be caused by a variety of other diseases or conditions, some of which are reversible. Examples of treatable causes of dementia include metabolic disorders such as vitamin B12 deficiency, chronic drug abuse, tumors that can be removed, or hypoglycemia.

Dementia is most common among the age 85+ population. The prevalence of dementia doubles every five years after age 60, until about age 90. It affects only about 1% of people age 60-64, but 30-50% of those age 85+. Dementia is the leading cause of institutionalization among the elderly (The Merck Manual of Geriatrics, 2006) and is now known as the seventh leading cause of death in the United States (www.alz.org). Especially in the past 15 years, progress has been made toward improved treatment of symptoms, and more thorough research into dementia causes and cures.

Individuals suffering from dementia face numerous **challenges** which can put them at risk and impede their ability to access needed health care:

- Confusion about medications, appointments, and reporting symptoms;
- Increasing difficulty or inability to travel independently;
- Increased reliance on others to provide or coordinate care;
- Anxiety, hostility, agitation, personality changes and behavior disorders;
- Decreased ability to communicate effectively;
- Inability to perform normal activities of daily living without supervision; and
- Presence or absence of capable caregivers.

**Role of
the Health
Center:**

Given the high correlation between old-age and dementia, it is necessary for health centers providing geriatric care to develop expertise in the evaluation and treatment of dementia in its many forms. Early identification and thorough assessment are important parts of providing appropriate care for elderly patients suffering from cognitive decline.

Provide important elements of dementia care including:

- Routine mini mental status exams;
- Comprehensive neuro-psych assessment when dementia is indicated;
- Identification and treatment of reversible causes;
- Timely assessment of capacity for medical decision-making, driving or independent living; and
- Awareness of signs of abuse, neglect or self neglect.

Links to the following services will help insure that appropriate care is provided to this vulnerable population:

- Neuro-psych evaluation and assessment;
- Case management to provide psycho-social support and to assist with coordination of meals, transportation, personal care and possibly also act as a liaison to family members or other caregivers;
- Adult Day Health Care;
- Education and support for family or other caregivers; and
- Referral to Adult Protective Services when abuse or neglect is suspected.

Helpful Links:

For more information, visit the Alzheimer's Association website at www.alz.org. Refer family members to their 24-hour helpline at 1-800-3900.

Alzheimer's Disease Education and Referral Center of the National Institute on Aging: www.nia.nih.gov/Alzheimers/AlzheimersInformation/AboutUs.htm

Alzheimer's and Dementia – The Journal of the Alzheimer's Association
www.alzheimersanddementia.org/

HEALTH CONCERNS — Depression

Background: According to epidemiological data, depression affects approximately 10% of older primary care patients (Koenig & Blazer, 1992), and 20% of the low-income elderly (Arean, et al, 2001). Baby Boomers are expected to have even higher rates of depression in old age. Depression alone is associated with increased disability and death in older people (Penninx, et al, 2001). However, even though effective depression treatments exist, very few older adults access these services, and the low-income elderly are least likely to receive such treatment (Strothers, et al, 2005).

Depression is characterized by a pervasive depressed mood and a loss of interest or pleasure in previously enjoyed activities, but it can also present with a lack of energy, fatigue, poor sleep and appetite, physical slowing or agitation, poor concentration, thoughts of guilt, irritability or suicide. Our clinical experience shows that these symptoms are often complicated by chronic medical problems, cognitive impairment and substance abuse. Conditions such as heart attack, stroke, hip fracture or macular degeneration are known to be associated with the development of depression. If untreated, depression will not resolve on its own, and can last for many years. Of those who pursue treatment, very few older adults seek care from a mental health specialist; most request help from their primary care physician.

Depression Treatment in Primary Care — Primary care settings have become common sites of mental health treatment for depressed older adults. Consequently, recognition and management of late-life depression is an important responsibility for clinicians who are caring for older patients. The symptoms of depression in elders can be quite different than in younger adults. A depressed mood is seldom the chief complaint. Many older patients present with unexplained somatic symptoms, report an increase in worry or nervousness or a loss of interest or pleasure in previously enjoyed activities.

Suicide — It is well known that rates of suicide in the elderly are higher than in any other age group. Someone over the age of 65 completes a suicide every 90 minutes, equaling 16 deaths a day in the current population. Over 60% of those who commit suicide had a clinically diagnosable depression. More than 65% of all suicide victims sought medical attention within three months prior to their suicide and over a third had seen a doctor a week before their demise (Arbore, workshop on “The Deadly Triangle” March 2007).

Barriers to Treatment — Despite the well-documented prevalence of depression and suicide in the elderly population, many elders hold great disdain for being labeled as depressed, and thus deny or minimize their symptoms. Additional barriers to treatment include a lack of affordable and reliable transportation, isolation, substance abuse and an absence of a supportive person who can encourage and support the elder in seeking treatment.

**Role of
the Health
Center:**

Best Practices: In response to these treatment barriers, a substantial body of evidence utilizing collaborative care for depression has emerged over the last ten years. A community health center model that emphasizes coordinated care by primary care, mental health and substance abuse treatment providers has enhanced treatment access and improved outcomes for many older adults. **The IMPACT model** (Unutzer, et al, 2002) is one such model that allows health center staff to identify and track depressed patients who are receiving treatment, enhance patient self-management, support care with close monitoring and utilize mental health consultation for difficult cases.

Other mental health interventions that have shown benefit to this patient population include:

- Harm reduction for elders struggling with drug or alcohol abuse;
- Cognitive behavioral therapy to challenge ideas about aging and health, and reminiscence therapy; and
- Mental health specialty providers who can make available psychiatric assessment, neuropsychological testing and medication evaluation for patients who have complex medical and/or psychiatric difficulties.

These services tend to be best received by elders when they take place in the primary care setting. However, health centers without these services will also benefit by creating relationships with community providers. The presence of geriatric case managers who can augment services by providing home visits, linkage to community resources, referral to other health center groups (such as health education groups for weight management or psychosocial groups to address grief and loss) and support for the health and independence of the elder also provide a critical link.

Patient Empowerment: By welcoming and incorporating the feedback of a Patient Advisory Group into the health center, staff is educated by their patients, and patients are empowered to participate in their care by helping to shape it for themselves and others. The group is convened by health center staff for the purpose of eliciting feedback from patients about available services. This feedback can come in the form of patient input regarding:

- Existing mental health services;
- New or developing programs or groups;
- Patient education materials that are used in the health center;
- The stigma attached to the use of mental health services by today's elders; and
- Creative solutions (which providers may never identify) to treatment barriers for depression and other mental health issues.

**Helpful
Links:**

IMPACT: Evidence-Based Depression Care - A program of the University of Washington, Department of Psychiatry and Behavioral Sciences: <http://impact-uw.org/>

National Institute of Mental Health- Older Adults: Depression & Suicide Facts <http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml>

Background: Five to fifteen percent of adults over age 65 living in the community have a problem with urinary and/or fecal incontinence. Up to 50 percent of older adults living in nursing homes have urinary and/or fecal incontinence. Studies have found that incontinence is an important factor in the decision to institutionalize elderly patients. Yet incontinence is not a normal part of aging, and has numerous medical and physiological causes. Once the type and cause of incontinence is identified, it can usually be cured or greatly improved with treatment.

Shame and embarrassment associated with incontinence is not only common, but harmful to patients who could be offered care to improve their condition. Fewer than half of older adults affected by incontinence consult a health professional or even mention the problem at an office visit.

Untreated incontinence can lead to increased isolation and emotional distress as well as rashes and other health problems. Incontinence is often caused by weakened or overactive bladder muscles. It can also be a symptom of conditions such as bladder stones, blockage from an enlarged prostate, tumors or urinary tract infections. The treatment for incontinence varies, depending on the cause. Medications, minor surgical procedures, or exercises can often effectively treat the problem.

Risk factors for incontinence among the elderly include the following:

- Depression
- Heart Attack
- Stroke
- Congestive Heart Failure
- Obesity
- Chronic obstructive lung disease
- Chronic cough
- Diabetes
- Difficulty with activities of daily living

**Role of
the Health
Center:**

Training medical providers to ask patients about incontinence at routine appointments, particularly elderly patients with associated risk factors, is key to effectively addressing incontinence among elderly patients.

Unless specifically asked about it, patients are often reluctant to disclose problems with incontinence, even when talking with their own physician.

Common treatment options to improve bladder control include the following:

- Pelvic muscle exercises (known as Kegel exercises) strengthen muscles that help hold urine in the bladder longer. This simple and safe treatment can help with stress or urge incontinence.
- Biofeedback can be used to improve awareness of signals from the body and to teach pelvic muscle exercises.

- Timed voiding and bladder training help determine the pattern of urination and leaking. Emptying the bladder at planned times can help control urge and overflow incontinence.
- Medications can be used to treat some causes of incontinence. Because some medications can also cause incontinence, it is always important to review prescribed medications.
- Surgery or other procedures including injected implants into the area around the urethra can improve or cure some types of incontinence.

An assessment by a medical provider should be performed to determine the specific type of incontinence the patient is experiencing, and the best methods of treatment.

Language that is used to describe symptoms, causes or treatments related to incontinence should be appropriate for the age and culture of the patient.

- Use the words that the patient uses, or offer clear language to help describe symptoms in a way that “normalizes” or de-stigmatizes the problem. For example, referring to adult incontinence pads or absorbent undergarments as “diapers” can be demeaning to some patients.
- Be sensitive to the language preference of patients, and be sure to discuss the issue privately with patients whenever possible.
- Train and support caregivers involved in handling incontinence to preserve the dignity of the elderly individual.
- Help the patient feel comfortable talking about this problem.

Helpful Links:

To learn more about the types, causes and treatments of incontinence, see **The National Association for Continence (NAFC)** website at www.nafc.org, or 1-800-BLADDER.

International Foundation for Functional Gastrointestinal Disorders (IFFGD)
www.aboutincontinence.org/

The Simon Foundation for Continence: www.simonfoundation.org/

HEALTH CONCERNS — **Physical Frailty/Disability and Personal Assistance Services**

Background: Physical frailty and disability increase with age. Over 44 % of the elderly population age 65+ have some type of disability. Of these, 9.7 % have difficulty with basic self-care activities. In the 85+ population, nearly 75% have a disability, and 24% require assistance with self-care. (2005, American Community Survey)

Frailty is not a disease, but a combination of advanced age and a variety of medical problems resulting in unintentional weight loss, exhaustion, weakness, slow walk and low levels of physical activity. Frailty is predictive of falls, worsening mobility, disability, hospitalization and death. Rates of frailty and disability are higher in women than men and are associated with being African American, having lower education and income, living alone and high rates of chronic diseases. (Fried, 2001)

Disability is usually defined in terms of a decline in functional ability. While disability has numerous medical- and service-based criteria, among older adults it tends to be defined in terms of limitation in basic Activities of Daily Living (ADLs) such as eating, dressing, bathing, toileting or Instrumental Activities of Daily Living (IADLs) such as cooking, grocery shopping, or making phone calls.

The trend in the United States is toward “compression of morbidity”, or delayed onset of disability. This positive development is attributed to a variety of factors including improved preventive care and treatment of chronic conditions and disease such as hypertension and diabetes. (Fries, 2005)

Personal Assistance Services (PAS) are the basic building blocks of long term care services for people with disabilities. These services can be provided by paid or unpaid formal or informal caregivers. Family members often act as informal caregivers, but frequently lack the training, resources or support to provide optimal care. In recognition of this problem, the National Family Caregiver Support Program was a 2000 amendment to the Older Americans Act, developed by the Administration on Aging of the US Department of Health and Human Services. The program allocates state funding for community services designed to provide support for family caregivers of older adults, such as education, training, respite care and counseling. Caregivers should be directed to the local Area Agency on Aging (AAA) to find out what support is available.

Role of the Health Center:

The role of primary care is a critical part of delaying and managing health conditions related to frailty and disability, yet the onset of frailty and disability can impede the ability of elderly patients to access primary care.

The need for more frequent medical appointments as frailty or disability progresses converges with the following factors:

- Difficulty traveling independently or getting to medical appointments;
- Decreased mobility, isolation and fewer social supports;
- Decline in physical activity and socialization contribute toward higher rates of depression; and
- Greater reliance on formal or informal caregivers who may lack the ability or means to provide needed assistance.

Strategies to mitigate the above factors in order to maximize access and maintain a strong health partnership with elderly patients include the following:

- Offer linkage to case management services to coordinate in-home needs such as personal assistance, home delivered meals, or transportation.
- Provide buildings, bathrooms, and exam tables suitable for frail and disabled adults.
- Consider hearing and vision impairments; reduce background noise and distractions; provide large-print written materials in high contrast colors.
- Accommodate the need for longer appointment times to address multiple conditions, medication needs, and a slower overall pace.

- Educate staff about best practices in working with disabled patients including respecting patients' preferences regarding how assistance is provided or transfer to exam tables accomplished.
- Identify frail elderly or disabled patients who are suffering from self-neglect, hunger, poor hygiene or other preventable health-related conditions due to unmet needs for assistance with personal care, including ADLs or IADLs. These individuals may be living alone without social supports, or relying on caregivers who cannot or do not provide the necessary care.

An in-home assessment by a trained social worker can help identify unmet personal care needs, and provide linkage to appropriate services.

Some important issues that health centers should consider regarding family members as caregivers are:

- Some elders prefer an unrelated individual to provide personal care.
- Some family members are not willing or able to provide appropriate care.
- To assess a situation, interview the patient without the caregiver present.
- Individuals living with the elderly patient are not necessarily providing needed care.
- If family caregivers are also paid, that income may be very important to the family.

For elderly patients who are able to hire a caregiver, other challenges exist:

- State or federal programs will pay for in-home care of low-income people with disabilities who meet need, income and asset requirements. Many states include PAS as a Medicaid covered service. In some cases, paid caregivers can also be family members.
- Whether caregivers are paid privately, or by public benefit programs, there may be little oversight. Many disabled people of any age prefer to supervise their own workers. Others prefer to have agency trained and supervised workers.
- Many elderly recipients of in-home care are not able to effectively hire, train and supervise their own workers without some assistance.
- Low pay creates a very limited pool from which to hire.

Strategies health centers can use to treat elderly patients in need of personal care assistance:

- Be aware of signs of neglect (i.e., patient not taking prescribed medications, or not maintaining a healthy weight).
- Educate caregivers or refer for community resources.
- Interview patient in the absence of caregiver if you suspect a problem.
- Simplify medication dosing or home-instructions whenever possible.
- Refer to case management for patients who appear to have unmet needs or problematic or inadequate in-home care arrangements.

**Helpful
Links:**

For more information view the Center for Personal Assistance Services (CPAS) website which provides research, training, dissemination and technical assistance on issues of PAS in the U.S., at www.pascenter.org.

Population Reference Bureau (PRB) – Disability and Aging
www.prb.org/Articles/2007/DisabilityandAging.aspx

National Council on Independent Living (NCIL) – Seniors with Disabilities
www.ncil.org/resources/seniors.html

HEALTH CONCERNS — **Nutrition and Elders**

Background: As adults age, their nutritional needs, food tolerance, and access to nutritious foods change. Approximately 85% of older persons have one or more chronic diseases. As a result many require a special diet which is nutrient-dense, supplying a rich supply of nutrients in a relatively small volume. Some medications can also result in food interactions that can interfere with the nutritional status of seniors.

Proper eating and nutrition are directly related to health issues seniors commonly encounter. The dietary habits of patients can directly impact the health of patients with certain medical conditions. Numerous factors influence which foods are consumed by older adults, too often resulting in unmet nutritional needs. Eating more fresh fruits and vegetables, and less processed foods may be the most important diet change all people including seniors can make. Yet access to these foods can be limited by barriers faced by many elderly patients of community health centers. Dietary habits of seniors are often driven by factors unrelated to nutritional needs:

- Changes in how food tastes,
- Diminished appetite or thirst,
- Difficulty chewing or swallowing,
- Access to healthy foods including cost and proximity to grocery stores,
- Difficulty cooking due to physical or cognitive limitations,
- Inability to read or understand food labels.

**Role of
the Health
Center:**

Nutrition education is an important component of care for elderly patients of community health centers. This education should be tailored not only to particular health conditions and nutritional needs, but other practical considerations such as living situation and ability to cook or shop. Patients should be encouraged to include family or other caregivers who are assisting with shopping or meal preparation in any nutrition education programs.

Nutrition Counseling: Lower-income older adults will benefit from tips on how to keep food costs down, while still maintaining a healthy diet. Nutrition counseling should consider budget restraints and offer practical suggestions to improve the likelihood of compliance with dietary recommendations:

- Look for generic or store brands to reduce cost.
- Plan your menu around items on sale or in season.

- Prepare more of the foods you enjoy.
- Quickly refrigerate any leftovers to eat in a day or two.
- Share meal preparation and costs with a friend, neighbor or family member.
- Home-cooked foods can be healthier and cheaper.

Medical Needs: The specific health needs of the elderly patient must be considered in nutrition counseling. For example, the need to decrease fat consumption is important for patients with heart disease, diabetes, hypertension and obesity.

- Offer simple suggestions such as using low-fat dairy products.
- Trim fat or skin from chicken or meat before cooking, and bake food instead of frying.
- Decrease sodium to control hypertension. Simple suggestions include taking salt off the table, and reducing high-sodium food consumption such as canned soups.

Sensitivity is important whenever making dietary recommendations. Preferences and habits are often rooted in cultural practices that should be honored and respected even when changes are advised for health reasons.

Medication Interaction: Some commonly prescribed or habitually used medications effect the nutritional status of elderly patients. These factors should be considered when making dietary recommendations. For example:

- Frequent use of laxatives may decrease absorption of minerals such as calcium and potassium. Potassium may be a particular concern if one is taking certain kinds of medicine for high blood pressure.
- Aspirin is often prescribed to relieve arthritis pain. Sometimes aspirin may cause bleeding in the stomach, which could lead to iron deficiency. Chronic aspirin use has also been associated with folacin (a “B” vitamin) deficiency.

Dental Problems: The loss of teeth, coping with dentures, or other dental problems can limit the variety or type of foods tolerated by older adults. Fifty percent of people over age 60 have lost all their teeth. When this happens, people often begin eating softer foods, which are lower in fiber. Some people may also eliminate vegetables or other fresh foods because they are hard to chew.

Food Safety: Older adults, especially those with chronic conditions, may be particularly sensitive to certain food safety issues. For examples:

- Because the sense of taste or smell may not be as sensitive among the elderly, it becomes more difficult to tell if foods are spoiled. It can help to date foods in the refrigerator to help avoid eating foods that are no longer fresh.
- Certain kinds of foods should be fully cooked to prevent disease. For example, it is important to fully cook eggs, pork, fish, shellfish, poultry, and hot dogs.
- Some foods should be avoided altogether. These might include raw sprouts, some deli meats, and certain products that are not pasteurized.

Fraud: Many nutrition products make claims that are untrue. Seniors can be particularly vulnerable to questionable supplements or fraudulent marketing scams that can waste resources or do harm. Patients should be advised not to take any nutritional supplements, medications or other treatments without the approval of their doctor.

Community and government programs are designed to support and supplement access to food for frail and/or low-income elders. While these programs generally do not provide products that are tailored to the specific health needs of the individual, they can be a valuable source of foods that can contribute toward the caloric and nutritional needs of elders facing barriers to access. The web-based Benefits Check-Up program (www.benefitscheckup.org) is a useful tool to determine eligibility for nutrition programs or services. The local Area Agency on Aging or tribal organization will direct patients to local resources.

Home delivered meal programs are especially helpful for patients who are homebound, mobility impaired or otherwise unable to shop or cook. These programs often operate by donation, and do not charge a standard fee.

Food stamps from the Federal Government help qualifying individuals buy groceries. Eligibility for food stamps varies by state.

Congregate Meals offered by many senior centers or other community centers provide free or low-cost meals for older adults. These programs also provide an opportunity to socialize with peers, and in some cases with social service providers who might help provide linkage to other needed services.

**Helpful
Links:**

Nutrition and the Elderly: A Resource Guide for Community Educators – the Food and Nutrition Information Center, 2002: www.nal.usda.gov/fnic/pubs/bibs/gen/nutritionelderly.html

Good Nutrition- It's a Way of Life; Age Page, National Institute on Aging, US Department of Health and Human Services, National Institute of Health, 2005
www.niapublications.org/agepages/nutrition.asp

Food Stamp Nutrition Connection, US Department of Agriculture
http://foodstamp.nal.usda.gov/nal_display/index.php?info_center=15&tax_level=3&tax_subject=275&topic_id=1336&level3_id=5216

The Elderly Nutrition Program Fact Sheet, Administration on Aging, US Department of Health and Human Services: http://www.aoa.gov/press/fact/alpha/fact_elderly_nutrition.asp

❖ SOCIAL ISSUES

Given high levels of frailty, disability and chronic illness of older adults, social issues loom large in meeting the basic needs of this population. Dependence on others to meet basic needs can have a tremendous impact on family relations. Financial needs become significant as income or assets may become more limited, health or personal care needs increase, and the ability to manage finances independently may diminish. Another personal freedom that often becomes compromised by advanced age and disability is the ability to drive safely. For many patients, health care providers are in a key role to assess ability or unmet need.

This section will address these common social issues:

- Family Relations
- Money Management
- Driving Safety

An additional area of focus in this section is on a population of elders that has many social needs and challenges:

- Elderly Migrant Farm Workers

We hope that the spotlight on this minority population, and proposed models of care, will not only improve patient care for elderly migrant farm workers, but inspire thought and planning to address other elderly patient populations with unique needs.

SOCIAL ISSUES — **Family Relations**

Background: For elderly patients, especially those who are suffering from physical or cognitive decline, the proximity, availability and financial resources of relatives can have a significant impact on the patient's health and well-being. Family members can have an extremely supportive or damaging role in the life of frail older adults, depending on the nature of the relationship. For those who are reliant on or living with family members, it is incumbent upon the health care provider, in conjunction with social services, to pay close attention in order to identify untenable situations. Even well-intended family members may require education, resources or support to provide appropriate care.

Factors to Consider

There are a number of health-related scenarios involving family relations that require sensitivity and attention of health care providers.

Grandparents Caring for Grandchildren – When adult children are absent or inappropriate caregivers for their own young children (often due to substance abuse, imprisonment or mental illness) older adults may find themselves raising grandchildren. Though this might be the best alternative for the children, it can be extremely taxing for older adults. The financial, physical and/or emotional strain on older adults may result in the neglect of the elder's own needs.

Cognitive Decline – If capacity of an elderly patient is in question, family members may or may not be available to help with financial, medical or personal decision-making or planning. Public programs are limited, and for individuals or families with limited resources, court fees may be prohibitive. It is not unusual for older adults who lack capacity to be without a legal guardian, making it extremely difficult to insure that living arrangements, medical care, financial management or other needs are addressed appropriately.

Abuse or Neglect – Elderly patients may be living with adult children, grandchildren, or other family members who are dependant on the older adult for housing or money. Very often these situations involve substance abuse and/or mental illness. It should not be assumed that relatives living with an elderly patient are in a caregiving role. They may in fact be entirely neglecting the elder’s basic needs. In other situations, family members may take advantage of access to the finances of a trusting elderly relative. These situations are compounded by cognitive or physical impairment, and strained family relations or loyalties that may prevent the elderly patient from reporting problems to a health care provider.

Strain of Dependency – Even well-intended and skilled family caregivers can suffer from the daunting responsibilities of caregiving. The stress can be intensified by a complex family history of conflict or abuse, conflicting demands of caring for parent(s) and children simultaneously (“the sandwich generation”) or limited time, money or other resources.

Family Conflict – Family members may have strong differences of opinion about medical care or end of life issues of an elderly relative. These agonizing decisions can be alleviated by encouraging elders to document their wishes.

Role of the Health Center:

Providing case management services, or working closely with local community-based programs is key to identifying and helping to address or resolve patient needs related to family relations. Learning true patient wishes and needs may require home visits and/or meeting with them without family members present.

- Offer family meetings** with a social worker, medical provider, family members and the patient. These can be arranged at the clinic, hospital, nursing home, or the patient’s home.
- Identify community resources** to support grandparent caregivers. For more information and resources by state, see the National Center on Grandparents Raising Grandchildren (below).
- Link older adults with services** that help document decisions, assess capacity, and support elderly patients in planning for incapacity.
- Train staff and providers** on recognizing the signs of elder abuse and neglect, and mandated reporting of suspected abuse. For resources and information see the National Center on Elder Abuse (below).
- Support family members** through resources, communication, and education.

Helpful Links:

National Family Caregiver Support Program: www.aoa.gov/prof/aoaprogram/caregiver/caregiver.asp

National Center on Grandparents Raising Grandchildren: <http://chhs.gsu.edu/nationalcenter/>

National Center on Elder Abuse: www.ncea.aoa.gov

Family Caregiver Alliance, Planning for Incapacity resources and more: www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=437

SOCIAL ISSUES — **Money Management**

Background: It is estimated that 5-10% of all elders living in the community would benefit from some form of assistance with daily money management (National Center on Elder Abuse, 2003). This commonly includes the need for assistance with reading bills, writing checks, paying bills on time, banking, budgeting, or making sound financial decisions. The need is highest among older adults with:

- Dementia/cognitive impairment/memory loss
- Visual impairment or physical conditions that limit the ability to read or write.
- The loss of a spouse or other individual who previously handled the finances
- Limited literacy or English language proficiency
- Lack of familiarity with standard banking, credit or tax practices (i.e., recent immigrants)

In some cases, a trustworthy family member or other caring individual will step in to assist with basic needs. Too often however, seniors are isolated and lack reliable support. When elderly patients lose the physical or cognitive ability to manage their finances independently, they become vulnerable to financial exploitation, eviction, homelessness, impoverishment, or institutionalization.

Some important considerations concerning money management needs:

Privacy ◊ Most seniors, regardless of their financial, mental or physical status, are very private about their financial situation. Many are reluctant to accept assistance of any kind, even if it is provided free of charge.

Trust ◊ Money management needs must be addressed with sensitivity, and by a trusted individual such as a medical provider or social worker. Always support the older adult in achieving the “least restrictive” arrangement to insure their financial well-being.

Exploitation ◊ Low-income seniors are just as vulnerable to financial exploitation as those with higher income or assets. It is not unusual for SSI checks or other limited resources to be taken over, often by family members or others who may be dependant on the impaired older adult for money and/or housing.

Ideally, arrangements are made to protect the financial needs and resources of older adults *prior* to cognitive impairment or financial abuse by known or unknown predators. For these arrangements to be effective, it is critical that designated individuals are reliable, trustworthy, capable and respectful of the needs and desires of the older adult.

Common planning tools include:

- **Power of Attorney (POA)** — A legal document appointing someone to act in place of, or on behalf of an individual. The POA ends when the individual loses capacity. This tool is useful for patients who are able to make their own decisions, but cannot manage their finances due to physical disability.
- **Durable Power of Attorney (DPA)** — This legal document adds special provisions to a POA, allowing it to remain in effect after the individual loses decision-making capacity. DPAs can become effective when they are signed, or at a specified time or contingency, such as incapacity of the individual (“springing DPA”).
- **Bill Paying Service** — Some community-based organizations offer a bill-paying service for individuals who are able to make their own financial decisions, but require assistance with check-writing, reading bills, and related tasks due to a physical impairment. These services are primarily for older or disabled adults without reliable assistance within their own network of friends and family.

Other steps can be taken to assist with daily money management of individuals who are not able to do independently, did not sign a DPA or make other prior arrangements, or are particularly vulnerable to unscrupulous caregivers, scams, or other financial abuse:

- **Representative Payee** — Government benefits such as Social Security, Railroad Retirement or others, can be managed by an appointed Representative Payee. The appointed individual receives and signs checks on behalf of the beneficiary. A medical statement is often required to establish the need for a Representative Payee. If misconduct by a Representative Payee is suspected, the relevant government agency and/or Adult Protective Services should be contacted immediately.
- **Guardianship / Conservatorship** — Through a court process, a person or entity can be legally appointed to manage the finances and/or personal affairs of someone who lacks the mental capacity to do so. Laws governing guardianship or conservatorship vary by state, with some public and private programs offering limited fee-based services.

Role of the Health Center:

Some older adults might benefit from one of the above measures, but the appropriate person or service may not be available. Limited financial resources may preclude a required court process. In these cases, individuals may suffer from neglect or financial exploitation by unscrupulous family members, acquaintances or predators. To prevent or address such situations, community health centers can take the following steps:

- Train staff and providers to identify patients who may need financial assistance.
- Refer patients in need to case management or reputable community services.
- Report suspected financial exploitation to Adult Protective Services
- Assist patient with completing DPA or DPOA before there are questions of mental incapacity.
- Designate staff to be familiar with public and private conservatorship/guardianship programs and reputable money management services and elder law attorneys.

**Helpful
Links:**

AARP sponsors Money Management Programs in many states, providing Bill Payer and/or Representative Payee services. For more information see www.aarpmpmp.org

The National Center on Elder Abuse provides valuable publications and links related to financial and other forms of elder abuse. Go to www.ncea.aoa.gov

To find out about what services are offered in your area, contact the Eldercare Locator, sponsored by the National Association of Area Agencies on Aging, at 1-800-677-1116, or www.eldercare.gov

Daily Money Management Programs: A Protection Against Elder Abuse, National Center on Elder Abuse, 2003
http://www.ncea.aoa.gov/NCEARoot/Main_Site/pdf/publication/DailyMoneyManagement.pdf

National Guardianship Association (NGA): www.guardianship.org/

SOCIAL ISSUES — Driving Safety

Background: Although everyone ages differently and some are perfectly capable of continuing to drive into the seventies and beyond, driver safety is an important issue that should be addressed with all seniors. Not only are older adults more likely to get in multiple-vehicle accidents than younger drivers, but car accidents are more dangerous for seniors than for younger people. (de Benedictis, Kemp, Russell and White)

Key risk factors for senior drivers:

- Vision decline, particularly at night
- Hearing loss, which affects roughly 1/3 of adults over age 65
- Limited mobility & increased reaction time
- Medications, which may caused drowsiness and other side effects
- Drowsiness, as aging makes sleeping more difficult, resulting in daytime tiredness
- Dementia or brain impairment, which may cause delayed reactions, impaired judgment, and increased frustration.

**Role of
the Health
Center:**

Physicians in community health centers may be involved for a period of months or years, through several phases of the driving decision: assessment, counseling, compliance with state laws, and adapting to driving cessation.

- Evaluate a senior's ability to drive safely. In some cases, family members encourage the senior to brush up on their driving skills, or give up driving altogether. Regardless of family concerns, an assessment of driving habits should be part of a normal periodic health risk assessment. If there are concerns, a variety of assessment tools are available to evaluate driving-related functions including visual acuity and visual fields, general cognitive function, long-term memory, short-term memory, executive skills. An assessment by a clinical psychologist may help in assessing cognitive function and memory. It is important to assess based on clinical judgment of the patient's function rather than factors such as age, race or gender.

- Advise the patient of his/her medical condition and/or medications that may impair driving performance, and preparing and planning for the time when driving should cease. Key is helping patients plan alternatives to driving for medical appointments as well as other activities so that they can continue to lead fulfilling lives.
- Assure compliance with state laws: Health centers are faced with balancing the issue of public safety with concern for confidentiality and potentially harming the relationship between the provider and patients. There are no easy answers.

Most states do not have specific prohibitions regarding driving with dementia, but all states allow health professionals and others to inform the Department of Motor Vehicles when a person is perceived as medically unfit to drive due to dementia or other conditions.

- Help patients adapt to driving cessation. Providers should be alert for signs of depression, neglect and social isolation associated with driving cessation. A good practice is to refer to a social worker to help develop a transportation plan when making a recommendation to cease driving.
- Document efforts to assess and maintain patient's driving safety. This will help protect the health center if the patient continues to drive and poses a safety risk for him/herself and others.

Tips for the Primary Care Provider include:

- Seniors may listen to the suggestions of others they trust. (Of the older adults who reported that someone had talked to them about their driving, more than half said they listened and followed the suggestions of others.)
- Of married drivers, 50% want to hear from their spouses, but 15% said their spouse was the *last person* they wanted to hear from.
- Many older people think that physicians can precisely determine their ability to drive safely.
- Tests are available to evaluate reflexes, vision, flexibility and visual attention. They can be administered by rehabilitation centers, hospitals and VA Medical Centers. Costs run from \$200 to \$1,000, seldom covered by insurance or Medicare. May be free for eligible veterans at VA.
- In cases of dementia, when a person becomes unable to evaluate his/her own driving skills; doctor and family must take unilateral action.
- Key to helping seniors adapt is to have a plan for alternate transportation to ensure that s/he is able to continue to lead a fulfilling life.
- A simple test for the office assessment is to ask the mother of the driver's grandchild "Would you let your father drive the car with your child in it?" Look for the slightest hesitancy.

**Helpful
Links:**

ADReS (Assessment of Driving-Related Skills), described in chapter 3, p. 33-41. American Medical Association, Physician's Guide to Assessing and Counseling Older Drivers, Chapter 3.

<http://www.ama-assn.org/ama/pub/category/10791.html>

Tools for patients and family members:

- *Drivers 55+: Self-Rating Form* (AAA Foundation for Traffic Safety) www.aaafoundation.org/quizzes/index.cfm?button=driver55
- *We Need to Talk: Family Conversations with Older Drivers*, p. 17 www.thehartford.com/talkwitholderdrivers
- AARP Driver Safety Program, www.aarp.org

SOCIAL ISSUES — **Elderly Migrant Farm Workers**

Background: A migrant is defined as an individual who must be absent from a permanent place of residence for the purpose of employment. Although national data on all migrants is largely unavailable, there is data on the migrant farm worker population that we can learn from in order to better serve the elderly migrant population at large.

Migrant workers are predominantly Latino, although many are African American, Haitian, Anglo or Asian. Less than half (48%) of migrant farm workers are US citizens or Permanent Residents of the US. (National Agricultural Workers Survey, 2000). Many began as newly arriving immigrants, and speak little or no English. The combination of language barrier, economic insecurity, environmental and workplace exposure add to the isolation and vulnerability of migrant farm workers. These factors are compounded as age progresses, and health problems become more acute or disabling.

Elderly farm workers have been part of the labor pool throughout the history of migratory farm work. Migrant farm workers follow the crop cycle, creating a lifestyle with unique challenges. Farm work is the second-most dangerous occupation in the United States, after mining. While older adults, age 65+, make up only 1% of the migrant farm worker population (U.S. Department of Labor, 2000), they represent one of the most impoverished and underserved populations in the United States.

Health and health care for elderly migrant farm workers has historically been compromised by many factors, including:

- High rates of poverty
- Low levels of education
- Limited access to health care
- Poor nutrition and sanitation
- Hazardous work conditions

These factors lead to high risk for health problems that tend to be managed poorly or inconsistently due in part to the transient nature of the migrant work:

- Substance Abuse/Alcoholism
- Depression
- Occupation-related injury
- Chronic conditions including diabetes, cardiovascular disease, asthma and tuberculosis.
- Dental problems

Eligibility issues add to the challenge because many are not able to access benefits they are potentially eligible for. Those who paid into Social Security may not be able to prove their claim for payments. Others eligible for Medicaid or other programs may not stay in one place long enough to receive the benefit, or lack the connection to social services or resources to assist. Many disabled elderly cannot negotiate the SSI system for disability payments.

Role of the Health Center:

Health care providers serving mobile populations face unique challenges. The Migrant Clinicians Network (www.migrantclinician.org) identifies high rates of “no shows”, patients lost to follow-up, and limited availability of complete medical history as significant barriers to optimal patient care. Mobile clinics and outreach services can help, but to do not address the gaps created as patients relocate.

The Migrant Clinicians Network (MCN) has been working since the mid-1990s to develop methods to track and coordinate treatment of patients with TB and diabetes, and cancer-screening for this population. These developments make important strides toward improving continuity of care for migrant workers.

Active outreach and truly accessible services are essential elements of health care for elderly migrant workers:

- Negotiate and arrange home-bound care of migrant camps in partnership with farmers and other agricultural stakeholders.
- Provide evening and weekend care provided by mobile clinics and at the health center.
- Offer culturally and linguistically appropriate care by trained personnel who can work from a car, van or a mobile unit.
- Integrate technology including portable medical/dental equipment and wireless portable comuters that can populate databases for good care and follow up.
- Provide access to pharmaceutical assistance programs to help pay for medications.
- Assure social services to assist with needs including transportation and negotiating Social Security and other benefit programs.

The Tri-County Community Health Center in North Carolina has developed unique programs to engage elderly migrant workers. They have found that older farm workers can be successfully employed at health centers, usually in low skill jobs bringing consistency and a sense of belonging. Farm workers can also be invited to join advocacy or leadership groups to interact with policy making aspects of the health center.

Helpful Links:

Migrant Clinician's Network: www.migrantclinician.org

❖ HOUSING ISSUES

This section will address the unique and complex housing issues that older adults often face. While housing issues are not strictly healthcare related, when housing needs are not addressed, health suffers, and treatment plans fail. Understanding the housing options and needs that older adults often face will aid health centers in addressing unmet or changing needs and making appropriate referrals for elderly patients. Further more, living arrangements among older adults, such as living alone or homelessness, are associated with numerous health issues that may require awareness or attention within community health centers.

The following issues are reviewed in the following pages:

Overview of Housing Issues for Elders

Living Alone

Homelessness

HOUSING ISSUES — Overview of Housing Issues for Elders

Background: The relationship between health and housing is complex and challenging for many older adults. Fundamental housing needs can become huge areas of concern for frail or disabled older adults. In addition to critical matters such as affordability and access, the decision-making process about when or if to move to senior housing or another residential setting can be overwhelming, confusing and taxing for elders and their family members.

Elderly patients and their family members who are facing housing decisions often need support or guidance in the process, without which their health or safety may be jeopardized by an unsuitable or unsafe living environment. There are many factors to consider when evaluating housing needs and preferences:

Cost - Older adults enduring financial hardship experience high levels of stress, and often live in compromising situations. Limited resources can restrict seniors, contributing to isolation, shame, and often despair or self-neglect. Lack of adequate options for affordable and accessible housing is a significant problem. For each federally subsidized senior housing unit, there are 10 eligible seniors on the waiting list for it. The average time on a waiting list is 13.5 months. (Aging Services: The Facts, American Association of Homes and Services for the Aging, www.aahsa.org)

Health and Safety - Often modifications can be made to improve home safety. An in-home assessment can identify hazards which can often be addressed at little or no cost. Examples include installing grab bars in the bathroom, improving lighting, or removing

rugs that present a trip hazard. In some cases, ramps are needed to facilitate wheelchair access, or neighborhood safety must be considered. In other situations, a more supervised setting is necessary to provide needed care. According to the American Association for Homes and Services for the Aging (AAHSA), among people age 65 today, 69% will need some form of long term care, whether in the community or in a residential care facility.

Location - For seniors who have mobility issues or who are dependant on caregivers or services for transportation, proximity to essentials such as a clinic, hospital, grocery store or pharmacy become increasingly important. Living with family or a short distance from a senior center, church or other community setting can have the positive effect of allowing opportunities for socialization and support even if mobility is limited.

Management - A person who may have enjoyed a larger home or yard as a younger person may find this a huge challenge as they age. Yard maintenance and home repair become increasing less manageable. Disrepair or “blight” can create hazards, or in some cases problems with neighbors or other officials. A low-maintenance option is often ideal, such as senior or supportive housing.

Role of the Health Center:

It is helpful for seniors and their family members to anticipate and plan for how housing needs may change over time, and to take steps before a crisis arises. This might involve exploring and getting on waiting lists for subsidized housing, making back-up plans with family members or other caregivers, or moving to a more manageable setting before the need is urgent.

Health centers can help seniors and their family members by reviewing housing options.

Remaining at home might require making modifications and/or hiring in-home personal assistance or homecare services. In some situations, a family member or other individual can provide live-in care.

HUD subsidized housing is affordable housing that is available to seniors with low to moderate incomes. A cost-sharing subsidy from the federal government allows owners to offer rent that is adjusted according to income.

Supportive senior housing provides on-site support services for designated rental units. Some programs feature personal support and/or attendant services, and staff to handle regular scheduled care. Many are operated by not-for profit organizations and services may be funded by the state or federal government.

Retirement communities provide an independent living option for older adults. These often incorporate recreational programs and social activities that can provide a sense of community and support. Continuing care retirement communities (CCRCs) provide housing and services for life, allowing the resident to stay even as their needs change.

Residential care facilities for the elderly or board and care facilities are often available to provide a combination of housing and some assistance. Board and care often refers to less formal “mom and pop” houses which may or may not be licensed.

PACE (Program for All-Inclusive Care for the Elderly) provides a model of care that includes medical and long term care services, and in some cases has affiliated housing units available. Participants receive services in their home or at a center depending on their particular needs.

Assisted living varies by cost and location, and generally includes some level of daily care in a relatively home-like environment. Constant nursing care is not provided.

Skilled nursing facilities provide meals, laundry and round-the-clock care for patients unable to live independently for a short or long term period. They are licensed by the state to provide nursing care, personal care, and medical services.

Case management or other social services can play a key role in exploring and securing appropriate housing for elderly patients.

- Assist as feasible to evaluate needs and resources.
- Refer patients to health center or community resources. Often senior centers, independent living programs or Area Agencies on Aging can provide current lists of available housing options.

Helpful Links:

For more information, see the American Association of Homes and Services for the Aging (AAHSA) at www.aahsa.org.

US Department of Housing and Urban Development- Information for Senior Citizens: www.hud.gov/groups/seniors.cfm

Assisted Living Federation of America: www.alfa.org/i4a/pages/index.cfm?pageid=3278

Rebuilding Together (formerly *Christmas in April*): www.rebuildingtogether.org/

National Resource Center on Supportive Housing and Home Modification www.usc.edu/dept/gero/nrcshhm/

HOUSING ISSUES — **Living Alone**

Background: Living arrangements can have a significant impact on the health and well-being of elderly patients. When mobility or opportunities for social engagement decrease with age, the presence or absence of support within the home becomes increasingly important. For those who are living alone, the lack of in-home companionship or assistance contribute towards high levels of loneliness, and often unmet needs. There are strong correlations between aging, living alone and declining physical and mental health of older adults.

Among the age 65+ population in this country, more than one-third of all non-institutionalized people live alone. This represents approximately 40% of older women and 19% of older men (U.S. Census Bureau, 2005). As both women and men advance in age, they are more likely to live alone. Nearly 50% of women and 23% of men age 75 and over find themselves living alone (2006 Older American Update, www.agingstats.gov). Many of these individuals are living alone for the first time, without all of the necessary skills or resources. Cooking, shopping, budgeting or handling other household matters or health needs can be daunting responsibilities for those who find themselves living alone for the first time in later life.

Many elderly patients do not have the support they need to live alone safely, or to get to medical appointments or follow-through on home-care instructions. Because advanced age often coincides with living alone, it may be difficult to identify needs before they become urgent. Any social contact, including not only medical care or social services, but

a greeting from a mail carrier or neighbor, or a phone call from a volunteer, will reduce the risk of unidentified needs that put an elderly patient at undue risk.

Elevated risks associated with living alone include:

- **Isolation and Depression** – With advanced age, living alone often means having very few contacts with others at home or in the community. The compounding effects of isolation and depression can lead to a rapid cycle of decline with escalating unmet needs and few opportunities for support or intervention.
- **Chronic Self-Neglect** – This includes both the inability to provide for one’s own basic needs, as well as the refusal to accept services that could provide needed support. Questions of capacity are important in instances of self-neglect, in order to determine the individual’s mental capacity to make informed personal choices.
- **Vulnerability to predators or undue influence** – Elderly patients who are living alone may be less able to protect themselves from financial scams or other forms of manipulation preying upon their loneliness and oftentimes limited mental or physical functioning.
- **Disability and unmet needs related to self-care** – Living alone makes it very difficult to arrange for or monitor in-home or personal assistance services. Many elderly patients are unable to properly hire or supervise home-care workers, and do not have the assistance they need on a regular basis.
- **Homelessness or institutionalization** – Poorly managed health care needs can lead to premature institutionalization or preventable homelessness, as can inadequate daily support with personal assistance, housekeeping or money management. Eviction may result from unpaid rent or hazards such as cooking fires. The risk of foreclosure is high when a mortgage goes unpaid, even if the resources are available.

Role of the Health Center:

The primary care provider may be the first professional to become aware of a problematic home situation.

- Assess overall physical functioning and mental capacity to determine a patient’s ability to live safely at home. It is important to weigh the balance between safety and autonomy; many individuals would prefer to live alone despite risks involved. The goal is to minimize those risks, and support the patient’s wishes whenever possible.
- Implement case management to strengthen the ability of older adults to live alone despite the challenges they may face. An integrated approach to primary care and case management is ideally achieved by in-house case management services provided by the health center. When that is not feasible, it is critical for health centers serving older adults to develop a strong partnership with community-based case management and social services. Through linkage to case management for elderly patients in need, the following types of community resources will often be necessary:
 - Home delivered meals
 - Telephone check-ins or peer support
 - In-home personal assistance or home care services
 - Medic-Alert system
 - Visiting Nurse

- Medi-sets/bubble packs
 - Money Management or Bill-Paying Assistance
- Contact the local Office on Aging to start to identify community resources for seniors. The contact information in your area is available from the National Eldercare Locator (see below).

Skilled benefits eligibility screening and application assistance will be necessary to maximize resources available for patients. Special training in senior benefits and advocacy is typically needed for staff to effectively serve elderly patients. The web-based Benefits Check-Up tool provides on-line benefits eligibility screening for older adults with links to applications and services.

Helpful Links:

National Center on Elder Abuse - information about self-neglect and other forms of elder abuse – www.ncea.aoa.gov

National Eldercare Locator – links to local resources www.eldercare.gov

Benefits Check Up – www.benefitscheckup.org

HOUSING ISSUES — **Homelessness**

Background: Homelessness is a problem faced by a growing number of older adults. Homeless elders include individuals who have grown old while homeless, as well as those who become homeless in later life. Chronically homeless adults often suffer from mental illness and/or substance abuse. Later-life homelessness may occur due to dementia, extreme poverty, lack of affordable housing, isolation and limited functioning.

Homeless elderly are a diverse population including urban/rural and all ethnic/racial groups. While the majority of older homeless are men, women make up a larger proportion of older homeless who use services. (Rosenheck, et al, “Special Populations of Homeless Americans”, Office of the Assistant Secretary for Planning & Evaluation, US Department of Health & Human Services, <http://aspe.hhs.gov/progsys/homeless/symposium/2-Spclpop.htm>)

There is a growing consensus among advocates for the homeless that people aged 50 and older should be included in the “older homeless” category. Homeless people age 50-65 are not yet age-eligible for Medicare, but their physical health is often compromised due to poor nutrition and harsh living conditions. The health status of homeless adults age 50-65 tends to be closer to that of a 70 year old (National Coalition for the Homeless, 2006).

Estimates vary, but it is reported that people age 55-64 make up approximately 6% of the homeless population (Homeless and the Elderly, <ftp://ftp.hrsa.gov/bphc/docs/2003pals/2003-03.htm>). While this is not a large proportion, the elderly are largely invisible among the homeless, and typically have needs that are greater than their younger counterparts. With the aging of the “baby boomers” and the increased demand for affordable housing, we can expect the numbers to continue to grow.

Elevated risks associated with homelessness include:

- **The rate of chronic and acute health problems is extremely high among homeless people** generally. For older individuals, these conditions are exacerbated by age-related factors such as frailty, functional impairments, dementia, poor nutrition or effects of long-term substance abuse or untreated chronic mental illness.
- **High rates of hospitalizations** among this population require respite or recuperative care settings that are not often available.
- **Managing appointment times and transportation needs** of older adults, especially those who are homeless, is frequently problematic.
- **Difficulty providing timely follow-up** adds to the challenge of securing housing or benefits. Basic needs such as regular access to appropriate foods or a place to store medications can become significant barriers as well.

Added challenges faced by many older adults relate to questions of capacity, neglect or self-neglect. Homeless shelters and services are rarely designed for seniors, and may not be fully accessible. Loneliness, depression and suicide among older adults is typically high, and may be higher among the homeless population. Theft is often a concern among the homeless, and the elderly can be easy targets in shelters or on the streets.

Role of the Health Center:

The following strategies can help maximize the ability of health centers to provide care to homeless elderly:

- Provide case management services to offer a single point-person to coordinate care. Ideally, a case manager will have training in geriatric care, mental health and addiction. Health center liaisons with shelter case managers can also be effective. Be creative and look for ways to maintain contact with homeless elders. A surprising number of homeless elders have cell phones. “Home visits” can be conducted at alternate locations such as a library or café.
- Participate in shelter “health committees” or related functions to facilitate collaboration and help shape policies of benefit to patients. Strong relationships with local programs will help integrate care and improve or maximize the availability of resources that could benefit older adults.
- Advocate to secure subsidized or stable housing. This may involve not only paperwork but negotiating with family members or setting up contracts with property managers. Follow-up care and support services are often needed to maintain appropriate housing.
- Involve Adult Protective Services in cases of abuse, neglect or self-neglect.
- Allow for flexible drop-in or urgent care to allow for homeless patients to get care when they show up.
- Provide mental health evaluation and treatment to stabilize an elderly homeless patient.
- Engage mobile outreach teams or community health workers who can help identify or locate homeless elders in need of health services, and assist with access needs such as transportation assistance or coordination with specialty care.

Helpful Links:

National Coalition for the Homeless (NCN): www.nationalhomeless.org

National Health Care for the Homeless Council: www.nhchc.org/

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V. TOOLS

The following pages are tools you may want to adapt to your health center. Included are forms, health education materials, fact sheets, check lists, etc. The source of each tool is identified in case you want additional information.

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The patient-physician relationship:

A partnership for better health care and safer outcomes

Patient responsibilities	Physician responsibilities
Partnership	
I will partner with my physician and actively work to improve my health.	I will encourage my patients to work with me to improve their health.
Communication	
I will share my health concerns with my physician.	I will earn my patients' trust and do my best to improve their health.
I will talk openly about my health with my physician.	I will listen to my patients respectfully and honor their confidentiality.
I will ask my physician questions that will help me understand my health or condition.	I will answer my patients' health questions clearly and check that my answers have been understood.
I will talk to my physician about personal choices and future decisions, including end-of-life care and organ donation.	I will answer my patients' questions about their health care choices and document their decisions.
Shared decision making	
I will work with my physician to learn about my health or condition and set treatment goals.	I will educate my patients about their health situation and treatment options.
I will work with my doctor to choose medical treatments that are right for me.	I will explain medical options to my patients and help them choose high quality, safe treatment plans.
Patient-physician partnership	
I will do my best to follow my treatment plan and manage my own health care.	I will monitor my patients' health and their ability to safely manage their own health care.
I will tell my physician if I am concerned. I will tell my physician if I believe that a new treatment plan is necessary.	I will listen to my patients' concerns and help them create new treatment plans if better treatment choices become available.
I will do my best to improve my own health.	I will provide advice and information to help my patients improve their health.
I will tell my physician when money or other problems keep me from receiving medical care.	I will educate my patients about available resources that can help them access high quality, safe medical care.

Based on the AMA Code of Medical Ethics



AQ29.06-0943.pdf:2/07

Personal Health Record (PHR) Checklist

A personal health record (PHR) is a continually updated collection of important information about your health or the health of someone you're caring for. When collecting information from your health records, be sure to include:

- Personal identification, including name, birth date and social security number
- Emergency contacts
- Names, addresses and phone numbers of physician, dentist and other specialists
- Health insurance information
- Living wills and advance directives
- Organ donor authorization
- A list of significant illnesses and surgeries
- Current medications and dosages
- Immunizations and their dates
- Allergies
- Important events, dates and hereditary conditions in your family history
- Results of a recent physical examination
- Opinions of specialists
- Important test results
- Eye and dental records
- Correspondence with insurance provider(s)
- Permission forms for release of information, operations and medical procedures
- Exercise regimen
- Use of herbal medications
- Record of mental health care or counseling

Source: American Health Information Management Association®, 2006



My Personal Medication Record

My Personal Information

Name _____
 Date of Birth _____
 Phone Number _____
Emergency Contact
 Name _____
 Relationship _____
 Phone Number _____
Primary Care Physician
 Name _____
 Phone Number _____
Pharmacy/Drugstore
 Pharmacist _____
 Phone Number _____

How to Use This Guide

- Save this document to your PC.
 - Edit the copy on your PC to keep track of your medications (including prescription drugs, over-the-counter drugs, herbal supplements, and vitamins.)
 - Share the information with your doctors and pharmacists at all visits.
 - Keep a printed copy always with you.
- You should review this record when*
- Starting or stopping a new medicine.
 - Changing a dose.
 - Visiting your doctor

Last Updated:

Other Physicians

Name of Physician _____
 Specialty _____
 Phone Number _____
 Name of Physician _____
 Specialty _____
 Phone Number _____
 Name of Physician _____
 Specialty _____
 Phone Number _____

My Allergies

My Medical Conditions

In Cooperation with the SOS Rx Coalition

What I'm taking	Form (pill, injection, liquid, patch, etc.)	Dosage	How Much and When	Use (regularly or occasionally)	Start/Stop Dates (1/5/05 - 3/5/05) (1/5/05 - ongoing)	Notes, Directions, Reasons for Use
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

* Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements.

Over 60 Health Center CASE MANAGEMENT CHECKLIST

Client Name: _____
Case Manager: _____

Date: _____
MR# _____

X	SERVICE	DATE REF'D	OUTCOME Agency/Contact/Phone #	
	Chore worker/IHSS # hrs: _____			
	Transportation (Paratransit, Taxi Scrip)			
	Food (Meals on Wheels, Congregate Meals, Food Bags)			
	Weapons Assessment (Are there weapons in your home? If yes, are they in a secured place)			
	ADHC/Other Day Care/ Senior Ctr. # days/wk _____			
	Senior Companion/Friendly Visitor/ TeleCare			
	Caregiver Respite (Family Caregivers Alliance, Alzheimer's Association)			
	Housing (Section 8, senior housing)			
	LOC (Indep, B&C, SNF)			
	Home Repairs			
	Financial Issues (Benefits - MediCal, Money Management) INCOME: \$ _____ /mo Source: _____ Source: _____ Amount: _____ Amount: _____			
	Financial Assistance (Graham Fund, SoS) for what purpose and how much?			
	Home Health Care			
	Home Safety (rugs, smoke alarms, grab bars, shower bench, handheld shower)			
	Mental Health Services (PHP, therapy, psychiatry, support groups)			
	Substance Abuse Services (smoking cessation, counseling)			
	End of Life Decisions (burial plans, DPA-HC, DPA-F, Code Status – DNR)			

ADL/IADL	ADL # IADL#			
MMSE	Date			
	Score			
GDS	Date			
	Score			
# of hospitalization in past 6 mos	Date			
	#			

FUNCTIONAL IMPAIRMENT:

- Eating
 - Dressing
 - Bathing
 - Toileting
 - Getting in/out bed
 - Walking
- Total # ADLS:** _____

- Meal prep
 - Shopping
 - Med management
 - Money management
 - Using telephone
 - Heavy housework
 - Light housework
 - Transportation ability
- Total # IADLS:** _____

Home Safety Checklist

Check the box that applies:

Don't
know/
Doesn't
apply

Yes No

Living Room - Family Room

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Can you turn on a light without having to walk into a dark room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are lamp, extension or phone cords out of the flow of foot traffic? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are passageways in this room free from objects and clutter (papers, furniture)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are curtains and furniture at least 36 inches from baseboard heaters or portable heaters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your carpets lie flat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your small rugs and runners stay put (don't slide or roll up) when you push them with your foot? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Kitchen

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 7. Are your stove controls easy to see and use? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you keep loose fitting clothing, towels, and curtains that may catch fire away from the burners and oven? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Can you get to regularly used items without climbing to reach them? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a step stool that is sturdy and in good repair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Bedrooms

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 11. Do you have working smoke detectors on the ceiling outside of bedroom doors? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Can you turn on a light without having to walk into a dark room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have a lamp or light switch within easy reach of your bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is a phone within easy reach of your bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Is a light left on at night between your bed and the toilet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are the curtains and furniture at least 36 inches from your baseboard heater or portable heater? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Bathroom

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 17. Does your shower or tub have a non-skid surface, such as a mat, decals, or abrasive strips? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Does the tub/shower have a sturdy grab bar (not just a towel rack)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is your hot water temperature set to 120° or lower? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does your floor have a non-slip surface or does the rug have a non-skid backing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you able to get on and off the toilet easily? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Stairways

- 22. Is there a light switch at both the top and bottom of inside stairs?
- 23. With the light on, can you clearly see the outline of each step as you go down the stairs?
- 24. Do all stairways have sturdy handrails on both sides?
- 25. Do handrails run the full length of the stairs, slightly beyond the steps?
- 26. Are all steps in good repair (not loose, broken, missing or worn in places)?
- 27. Are stair coverings (rugs, treads) in good repair, without holes and not loose, torn, or worn?

Hallways and Passageways

- 28. Do all small rugs or runners stay put (don't slide or roll up) when you push them with your foot?
- 29. Do your carpets lie flat?
- 30. Are all lamp, extension and phone cords out of the flow of foot traffic?

Front and Back Entrances

- 31. Do all entrances to your home have outdoor lights?
- 32. Are walkways to your entry free from cracks and holes?

Throughout Your House

- 33. Do you have an emergency exit plan in case of fire?
 - 34. Do you have emergency phone numbers listed by your phone?
 - 35. Are there other hazards or unsafe areas in your home that are not mentioned in this checklist that you are concerned about?
- If so, what? _____

What home safety changes do you want to make?

- 1. _____
- 2. _____
- 3. _____

Provided by: California Department of Aging, Senior Housing Information and Support Center
Adapted from: *Home Safety Checklist Summary*, developed by the Community and Home Injury Prevention Project for Seniors (CHIPPS)
Sponsored by: Community Health Education Section, San Francisco Department of Public Health

End-of-Life Care: Questions and Answers

When a patient's health care team determines that the cancer can no longer be controlled, medical testing and cancer treatment often stop. But the patient's care continues. The care focuses on making the patient comfortable. The patient receives medications and treatments to control pain and other symptoms, such as constipation, nausea, and shortness of breath. Some patients remain at home during this time, while others enter a hospital or other facility. Either way, services are available to help patients and their families with the medical, psychological, and spiritual issues surrounding dying. A hospice often provides such services.

The time at the end of life is different for each person. Each individual has unique needs for information and support. The patient's and family's questions and concerns about the end of life should be discussed with the health care team as they arise.

The following information can help answer some of the questions that many patients, their family members, and caregivers have about the end of life.

1. **How long is the patient expected to live?**

Patients and their family members often want to know how long a person is expected to live. This is a hard question to answer. Factors such as the where the cancer is located and whether the patient has other illnesses can affect what will happen. Although doctors may be able to make an estimate based on what they know about the patient, they might be hesitant to do so. Doctors may be concerned about over- or under-estimating the patient's life span. They also might be fearful of instilling false hope or destroying a person's hope.

2. **When caring for the patient at home, when should the caregiver call for professional help?**

When caring for a patient at home, there may be times when the caregiver needs assistance from the patient's health care team. A caregiver can contact the patient's doctor or nurse for help in any of the following situations:

- The patient is in pain that is not relieved by the prescribed dose of pain medication;
- The patient shows discomfort, such as grimacing or moaning;



- The patient is having trouble breathing and seems upset;
- The patient is unable to urinate or empty the bowels;
- The patient has fallen;
- The patient is very depressed or talking about committing suicide;
- The caregiver has difficulty giving medication to the patient;
- The caregiver is overwhelmed by caring for the patient, or is too grieved or afraid to be with the patient; or
- At any time the caregiver does not know how to handle a situation.

3. What are some ways that caregivers can provide emotional comfort to the patient?

Everyone has different needs, but some emotions are common to most dying patients. These include fear of abandonment and fear of being a burden. They also have concerns about loss of dignity and loss of control. Some ways caregivers can provide comfort are as follows:

- Keep the person company—talk, watch movies, read, or just be with the person.
- Allow the person to express fears and concerns about dying, such as leaving family and friends behind. Be prepared to listen.
- Be willing to reminisce about the person’s life.
- Avoid withholding difficult information. Most patients prefer to be included in discussions about issues that concern them.
- Reassure the patient that you will honor advance directives, such as living wills.
- Ask if there is anything you can do.
- Respect the person’s need for privacy.

4. What are the signs that death is approaching? What can the caregiver do to make the patient comfortable?

Certain signs and symptoms can help a caregiver anticipate when death is near. They are described below, along with suggestions for managing them. It is important to remember that not every patient experiences each of the signs and symptoms. In addition, the presence of one or more of these symptoms does not necessarily indicate that the patient is close to death. A member of the patient’s health care team can give family members and caregivers more information about what to expect.

- **Drowsiness**, increased sleep, and/or unresponsiveness (caused by changes in the patient’s metabolism).

The caregiver and family members can plan visits and activities for times when the patient is alert. It is important to speak directly to the patient and talk as if the person can hear, even if there is no response. Most patients are still able to hear after they are no longer able to speak. Patients should not be shaken if they do not respond.

- **Confusion** about time, place, and/or identity of loved ones; restlessness; visions of people and places that are not present; pulling at bed linens or clothing (caused in part by changes in the patient's metabolism). Gently remind the patient of the time, date, and people who are with them. If the patient is agitated, do not attempt to restrain the patient. Be calm and reassuring. Speaking calmly may help to re-orient the patient.

- **Decreased socialization and withdrawal** (caused by decreased oxygen to the brain, decreased blood flow, and mental preparation for dying).

Speak to the patient directly. Let the patient know you are there for them. The patient may be aware and able to hear, but unable to respond. Professionals advise that giving the patient permission to "let go" can be helpful.

- **Decreased need for food and fluids**, and loss of appetite (caused by the body's need to conserve energy and its decreasing ability to use food and fluids properly).

Allow the patient to choose if and when to eat or drink. Ice chips, water, or juice may be refreshing if the patient can swallow. Keep the patient's mouth and lips moist with products such as glycerin swabs and lip balm.

- **Loss of bladder or bowel control** (caused by the relaxing of muscles in the pelvic area).

Keep the patient as clean, dry, and comfortable as possible. Place disposable pads on the bed beneath the patient and remove them when they become soiled.

- **Darkened urine or decreased amount of urine** (caused by slowing of kidney function and/or decreased fluid intake).

Caregivers can consult a member of the patient's health care team about the need to insert a catheter to avoid blockage. A member of the health care team can teach the caregiver how to take care of the catheter if one is needed.

- **Skin becomes cool to the touch**, particularly the hands and feet; skin may become bluish in color, especially on the underside of the body (caused by decreased circulation to the extremities).

Blankets can be used to warm the patient. Although the skin may be cool, patients are usually not aware of feeling cold. Caregivers should avoid warming the patient with electric blankets or heating pads, which can cause burns.

- **Rattling or gurgling sounds** while breathing, which may be loud; breathing that is irregular and shallow; decreased number of breaths per minute; breathing that alternates between rapid and slow (caused by congestion from decreased fluid

consumption, a buildup of waste products in the body, and/or a decrease in circulation to the organs).

Breathing may be easier if the patient's body is turned to the side and pillows are placed beneath the head and behind the back. Although labored breathing can sound very distressing to the caregiver, gurgling and rattling sounds do not cause discomfort to the patient. An external source of oxygen may benefit some patients. If the patient is able to swallow, ice chips also may help. In addition, a cool mist humidifier may help make the patient's breathing more comfortable.

- **Turning the head toward a light source** (caused by decreasing vision).

Leave soft, indirect lights on in the room.

- **Increased difficulty controlling pain** (caused by progression of the disease).

It is important to provide pain medications as the patient's doctor has prescribed. The caregiver should contact the doctor if the prescribed dose does not seem adequate. With the help of the health care team, caregivers can also explore methods such as massage and relaxation techniques to help with pain.

- **Involuntary movements (called myoclonus), changes in heart rate, and loss of reflexes in the legs and arms** are additional signs that the end of life is near.

5. **What are the signs that the patient has died?**

- There is no breathing or pulse.
- The eyes do not move or blink, and the pupils are dilated (enlarged). The eyelids may be slightly open.
- The jaw is relaxed and the mouth is slightly open.
- The body releases the bowel and bladder contents.
- The patient does not respond to being touched or spoken to.

6. **What needs to be done after the patient has died?**

After the patient has passed away, there is no need to hurry with arrangements. Family members and caregivers may wish to sit with the patient, talk, or pray. When the family is ready, the following steps can be taken.

- Place the body on its back with one pillow under the head. If necessary, caregivers or family members may wish to put the patient's dentures or other artificial parts in place.

- If the patient is in a hospice program, follow the guidelines provided by the program. A caregiver or family member can request a hospice nurse to verify the patient's death.
- Contact the appropriate authorities in accordance with local regulations. If the patient has requested not to be resuscitated through a Do-Not-Resuscitate (DNR) order or other mechanism, do not call 911.
- Contact the patient's doctor and funeral home.
- When the patient's family is ready, call other family members, friends, and clergy.
- Provide or obtain emotional support for family members and friends to cope with their loss.

7. What additional resources offer information about end-of-life issues?

The following National Cancer Institute (NCI) resources are available by calling the Cancer Information Service (CIS) (see below) at 1-800-4-CANCER (1-800-422-6237). They can also be accessed on the NCI's Cancer.gov Web site at http://cancer.gov/cancer_information/coping/ by clicking on the title under "End-of-Life Issues."

- The NCI fact sheet *Hospice* provides information about hospice care and includes contact information for hospice organizations.
- *Advance Directives* is an NCI fact sheet that discusses a patient's rights regarding medical treatment.
- The NCI fact sheet *Home Care for Cancer Patients* provides information and resources related to home care services.
- The NCI booklet *Advanced Cancer: Living Each Day* provides practical support to cancer patients, families, and friends.
- PDQ® supportive care summaries on loss, grief, and bereavement.

###

Sources of National Cancer Institute Information

Cancer Information Service

Toll-free: 1-800-4-CANCER (1-800-422-6237)

TTY (for deaf and hard of hearing callers): 1-800-332-8615

NCI Online

Internet

Use <http://cancer.gov> to reach the NCI's Web site.

LiveHelp

Cancer Information Specialists offer online assistance through the *LiveHelp* link on the NCI's Web site.

This fact sheet was reviewed on 10/30/02

Physician or Health Provider Assessment of Individual Needs

To the provider:

To the provider: Your patient or a family member has taken this form from the Alzheimer's Association Web site. We ask that the patient or the family member obtain accurate information about functional

abilities from you, their health provider. The information you provide on this form will ensure the most appropriate care recommendations for your patient. To learn more about the Alzheimer's Association, visit our website at www.alz.org.

Name: _____

Date of assessment: _____

List of diagnoses

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Person's Abilities and Needs

For each item, indicate the level of assistance needed at this time. Only select one level.

Personal Care

Bathing (including sponge bath, shower or tub):

___ Independent: receives no assistance (gets in and out of the tub if tub is the usual means of bathing)

___ Assistance: receives assistance in bathing only one part of the body (such as the back or a leg)

___ Dependent: receives assistance in bathing more than one part of the body (or is not bathed) and is not able to transfer to tub or shower on their own

Additional Information: _____

Dressing:

___ Independent: gets clothes and gets completely dressed without assistance

___ Assistance: gets clothes and gets dressed without assistance except for tying shoes

___ Dependent: receives assistance in getting clothes or in getting dressed or stays partly or completely undressed

Additional Information: _____

Toileting:

- Independent: goes to bathroom, cleans self and arranges clothes without assistance (may use object of support such as a cane, walker or wheelchair and may manage night bedpan or commode, emptying it in the morning)
- Assistance: receives assistance in going to the bathroom or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode
- Dependent: doesn't go to the room termed "bathroom" for the elimination process (may require the use of disposable briefs)

Additional Information: _____

Transfer:

- Independent: moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)
- Assistance: moves in and out of bed or chair with assistance
- Dependent: doesn't get out of bed

Additional Information: _____

Continence:

- Independent: controls urination and bowel movement completely by self
- Assistance: has occasional "accidents"
- Dependent: supervision helps keep urine or bowel control; catheter is used, or is incontinent

Additional Information: _____

Feeding:

- Independent: feeds self without assistance
- Assistance: feeds self except for getting assistance in cutting meat or buttering bread
- Dependent: receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids

Additional Information: _____

Katz S, Downs TD, Cash HR, et al. Progress in the development of the index of ADL. Gerontologist. 1970;10:20-30. Copyright © The Gerontological Society of America. Reproduced by permission of the publisher.

Daily Tasks**Ability to use telephone:**

- Independent: operates telephone on own initiative – looks up and dials numbers etc.
- Assistance: dials a few well known numbers
- Assistance: answers telephone but does not dial
- Dependent: does not use telephone at all

Additional Information: _____

Shopping:

- Independent: takes care of all shopping needs independently
- Assistance: shops independently for small purchases
- Assistance: needs to be accompanied on any shopping trip
- Dependent: completely unable to shop

Additional Information: _____

Food preparation:

- Independent: plans, prepares and serves adequate meals independently
- Assistance: prepares adequate meals if supplied with ingredients
- Assistance: heats and serves prepared meals, or prepares meals but does not maintain adequate diet
- Dependent: needs to have meals prepared and served

Additional Information: _____

Housekeeping:

- Independent: maintains house alone or with occasional assistance with heavy work or other domestic help
- Assistance: performs light daily tasks such as dishwashing, bedmaking
- Assistance: performs light daily tasks but cannot maintain acceptable level of cleanliness
- Assistance: needs help with all housekeeping tasks
- Dependent: does not participate in any housekeeping tasks

Additional Information: _____

Laundry:

- Independent: does personal laundry completely
- Assistance: launders small items- rinses socks, stockings etc.
- Dependent: all laundry must be done by others

Additional Information: _____

Mode of transportation:

- Independent: travels independently on public transportation or drives own car
- Assistance: arranges own travel via taxi but does not otherwise use public transportation
- Assistance: travels on public transportation when assisted or accompanied by another
- Assistance: travel limited to taxi or automobile with assistance of another
- Dependent: does not travel at all

Additional Information: _____

Responsibility for own medications:

- Independent: is responsible for taking medication in correct dosages at correct time
- Assistance: takes responsibility if medication is prepared in advance in separate dosages such as a pill box
- Assistance: is not capable of dispensing own medication

Additional Information: _____

Ability to handle finances:

- Independent: manages financial matters independently. Budgets, writes checks, pays rent, bills, goes to bank, collects and keeps track of income.
- Assistance: manages day to day purchases, but needs help with banking, major purchases etc.
- Dependent: incapable of handling money

Additional Information: _____

Lawton MP, Brody EM. Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist. 1969;9:179-186. Copyright © The Gerontological Society of America. Reproduced by permission of the publisher.

Stages of Dementia

Based on your assessment, indicate the level of memory or cognitive impairment.

___ Stage 1: No cognitive impairment

Unimpaired individuals experience no memory problems and none are evident to a health care professional during a medical interview.

___ Stage 2: Very mild cognitive decline

Individuals at this stage feel as if they have memory lapses, especially in forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects. But these problems are not evident during a medical examination or apparent to friends, family or co-workers.

___ Stage 3: Mild cognitive decline

Friends, family or co-workers begin to notice deficiencies. Problems with memory or concentration may be measurable in clinical testing or discernible during a detailed medical interview. Common difficulties include:

- Word- or name-finding problems noticeable to family or close associates
- Decreased ability to remember names when introduced to new people
- Performance issues in social or work settings noticeable to family, friends or co-workers
- Reading a passage and retaining little material
- Losing or misplacing a valuable object
- Decline in ability to plan or organize

___ Stage 4: Moderate cognitive decline

At this stage, a careful medical interview detects clear-cut deficiencies in the following areas:

- Decreased knowledge of recent occasions or current events
- Impaired ability to perform challenging mental arithmetic—for example, to count backward from 100 by 7s
- Decreased capacity to perform complex tasks, such as marketing, planning dinner for guests or paying bills and managing finances
- Reduced memory of personal history
- The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations

___ Stage 5: Moderately severe cognitive decline

Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. At this stage, individuals may:

- Be unable during a medical interview to recall such important details as their current address, their telephone number or the name of the college or high school from which they graduated
- Become confused about where they are or about the date, day of the week, or season
- Have trouble with less challenging mental arithmetic; for example, counting backward from 40 by 4s or from 20 by 2s
- Need help choosing proper clothing for the season or the occasion
- Usually retain substantial knowledge about themselves and know their own name and the names of their spouse or children
- Usually require no assistance with eating or using the toilet

Stages of Dementia (cont.)

___ Stage 6: Severe cognitive decline

Memory difficulties continue to worsen, significant personality changes may emerge and affected individuals need extensive help with customary daily activities. At this stage, individuals may:

- Lose most awareness of recent experiences and events as well as of their surroundings
- Recollect their personal history imperfectly, although they generally recall their own name
- Occasionally forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces
- Need help getting dressed properly; without supervision, may make such errors as putting pajamas over daytime clothes or shoes on wrong feet
- Experience disruption of their normal sleep/waking cycle
- Need help with handling details of toileting (flushing toilet, wiping and disposing of tissue properly)
- Have increasing episodes of urinary or fecal incontinence
- Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions (for example, believing that their caregiver is an impostor); hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
- Tend to wander and become lost

___ Stage 7: Very severe cognitive decline

This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak and, ultimately, the ability to control movement.

- Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered
- Individuals need help with eating and toileting and there is general incontinence of urine
- Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid. Swallowing is impaired.

Reisberg, B., Ferris, S.H., de Leon, M.J., Crook, T. The global deterioration scale for assessment of primary degenerative dementia. American Journal of Psychiatry, 1982, 139: 1136-1139. Copyright © 1983 by Barry Reisberg, M.D.

Core Components of Evidence-based Depression Care

TWO NEW 'TEAM MEMBERS' Supporting the Primary Care Provider (PCP)	
	Consulting Psychiatrist
TWO PROCESSES	Care Manager
<p>1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes</p>	<ul style="list-style-type: none"> -Caseload consultation for care manager and PCP (population-based) -Diagnostic consultation on difficult cases
<p>2. Stepped Care</p> <ul style="list-style-type: none"> a) Change treatment according to evidence-based algorithm if patient is not improving b) Relapse prevention once patient is improved 	<ul style="list-style-type: none"> -Support anti-depressant Rx by PCP -Brief counseling (behavioral activation, PST-PC, CBT, IPT) -Facilitate treatment change / referral to mental health -Relapse prevention
	<ul style="list-style-type: none"> -Consultation focused on patients not improving as expected -Recommendations for additional treatment / referral according to evidence-based guidelines



Implementing IMPACT

Exploring Your Organization

VISION & GOALS

1. What is our organization's vision for the IMPACT program?

Program options

- A primary care-based depression care program
- A component of an existing chronic disease management /population care management program
- Other

Program scope

- Number of sites, practices, providers, patients

Target population considerations

- Age, gender
- Languages
- Special needs, comorbid medical/psychiatric/substance abuse problems
- Insurance benefits

2. What are our organization's goals for the IMPACT program?

Possible motivating factors for improving depression care and implementing the IMPACT program

- Improved health outcomes – depression, functioning, other
- Increased patient satisfaction
- Increased provider satisfaction
- Increased employer/purchaser demand
- Improved HEDIS or other performance indicators
- Financial incentives for quality care
- Cost savings, e.g., reduction in inappropriate antidepressant use
- Other



CURRENT PRACTICES

3. What is our current "usual care" for depressed patients?

Important questions to answer:

- How and where do patients with depression present their symptoms/illness?
- What are high-risk groups or common comorbid disorders in our patient population?
- What is patient/provider awareness of depression?
- How do we identify depressed patients?
- Do patients receive formal depression diagnoses?
- What is our current treatment for depression?
What is our capacity for proactive follow-up and outcomes monitoring?
- What is our current practice and capacity for antidepressant medication management?
- What is our current practice and capacity for counseling/psychotherapy?
- What is our availability of mental health consultation and referral?
- What is our current practice and capacity for long-term maintenance treatment and relapse prevention?
- What percentage of our depressed patients
 - Receive adequate doses of antidepressants and/or psychotherapy?
 - Improve substantially after three months in treatment?

KEY COMPONENTS OF THE IMPACT MODEL

4. Depression care manager's role

- Educates patients and their significant others
- Engages patients in treatment
- Provides proactive follow-up, tracks clinical responses with PHQ-9



- Provides behavioral activation (e.g. physical activity planning) and pleasant events scheduling
- Facilitates adherence to antidepressant treatment
- Facilitates changes in antidepressant medications or other treatment if patients is not improving
- Provides or facilitates access to counseling/psychotherapy as needed

5. Designated team psychiatrist's role

- Consults on treatment plans, focusing on patients who are not improving according to an evidence-based treatment algorithm
- Provides in-person consultation or recommendations for specialty mental health referrals on selected patients

IMPLEMENTATION PROCESS

6. Care Management Staffing and collaborative care

- Who will serve as the depression care manager?
- What is the relationship between depression care managers and primary care providers?
- Where will care managers be located (primary care setting, off-site, based in community)?
- How will care managers and primary care providers communicate (phone, fax, e-mail)?
- What is the relationship between depression care managers and psychiatrists and other behavioral health specialists?
- Where will care managers and behavioral health specialists consultation and supervision take place (primary care, off site, by telephone)
- What role do ancillary staff play?

7. How will we identify our patients who need IMPACT care?

- Referral (self, provider)
- Screening (clinic-based, mail survey, administrative data)



8. Medication management

- Does our organization have formulas or guidelines regarding antidepressant use?
- Do these need to be adjusted?
- Who will sign/authorize prescriptions and refills (doctors, mental health provider)?
- Who will provide antidepressant medication management (primary care providers, nurse practitioners, psychiatrists)?
- Who will coordinate care, monitor side effects, adjust antidepressants as needed?

9. Counseling, Psychiatry, Mental Health Specialty Care

- Who will provide brief, structured counseling/psychotherapy?
- Will mental health providers be on or off site?
- What type of psychotherapy will be available as part of the program (PST, CBT, IPT, other)? Who will provide this therapy (e.g. care managers, other therapist on or off site)?
- Who will provide psychiatric caseload supervision and how (regular, ad hoc meetings, in person or by phone)?
- How will patients be connected to additional specialty mental healthcare if needed?

10. Patient Tracking

- What measures will we use to track depression outcomes (PHQ-9, others)?
- What system will we use to support outcome tracking (EMR, separate registry, Excel spreadsheet, paper tracking form, web database)?

11. Communication

- What mechanisms do we currently have in place for provider-to-provider communication?
- How can these mechanisms be used or improved to support depression care management?



- What are the implications of HIPAA for relationships among the primary care physicians, interested organizations, care managers and mental health consultants?
- How will mental health providers communicate with primary doctors and care managers (in person, e-mail, phone, EMR) – on or off site)?
- How and where will care managers document their contacts with patients (e.g. EMR, paper chart)?

EXPLORE YOUR IMPLEMENTATION STRATEGY

12. How will we create change?

- Will we use a Quality Improvement/practice change model (e.g., PSDA)?
- What is our implementation time line?
- What evaluation and feedback method will we use?

13. Who are our key internal and external stakeholders

- Patients and family members
- Providers (primary care, mental health, care managers, other specialists)
- Health insurance plans
- Practice managers and staff
- Community-based agencies and their staffs
- Purchasers (e.g. employers that purchase health insurance for their employees)

14. Leadership – who will lead this effort?

- What leaders in our organization need to support the program (health plan/practice leadership, primary care leadership, behavioral leadership, administrative support)?
- Who will organize and maintain ongoing leadership support?
- Who is responsible for communication among team members and for keeping the program on track?

15. Who can we consult with and who can help us implement this change?



- Quality improvement programs and staff
- Existing chronic management programs
- Patient and family education staff and resources
- Provider and staff education resources
- IT support (EMR, patient registry, disease management software, telemedicine, Interactive Voice Response [IVR])
- Performance measurement systems
- Medical records
- Our legal department

16. What are our start-up needs?

- Consultation: to educate clinical leaders, practice leaders and managers
- Training: for primary care providers, depression care managers, consulting psychiatrists, practice managers and administrative staff
- Materials: for patients and for providers and documents for process tracking.
- Structural changes: in how we practice – patient flow, scheduling, communication, financing of care

17. What are our financial considerations about implementing IMPACT?

- What are the financial incentives and disincentives to implement IMPACT?
- What would our start-up costs be?
- What would our program maintenance costs be?
- How will we pay for program costs?
- How will we track and evaluate the financial impact of the program?

18. What are our anticipated internal or external forces for and against change?

- Internal: strategic priorities, leadership support, QI and information support
- External: financial, (e.g. pay for performance, regulatory), performance measures, e.g., HEDIS.
- Potential barriers and challenges: e.g., competing priorities, wrong incentives, depression stigma

19. What critical innovation characteristics must we attend to for successful implementation?



- Relative advantage over usual care
- Trialability and observability
- Communication channels
- Institutional norms, roles, social networks, compatibility
- Role of opinion leaders
- Need to coordinate across units and departments
- Infrastructure to support change, external incentives and opportunities

20. What do we need in the long run for program sustainability?

- What information?
- What resources?
- What support?

MOOD SCALE

(short form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

[Home](#) > [Tools](#) > [Clinical Care Tools](#) > [Psychosocial](#) > [Geriatric Depression Scale](#)

Tools
NPO Products
Resources
Grantees
Workgroups
National Office

Geriatric Depression Scale

Instrument Name:

Geriatric Depression Scale

Category:

Clinical Care Tool - Psychosocial

Author:

Jerry Yesavage, MD
Department of Psychiatry and Behavioral Sciences,
Stanford University Medical Center

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References:

Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO: Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research* 17: 37-49, 1983

Keywords:

emotional well-being, psychological well-being, psychosocial well-being, depression assessment, geriatrics

To use this tool:

No permission required (available in various languages)

To view this tool:

www.stanford.edu/~yesavage/GDS.html

type:psychosocial

[Return to top](#) 

Promoting Excellence in End-of-Life Care was a national program of the [Robert Wood Johnson Foundation](#) dedicated to long-term changes in health care institutions to substantially improve care for dying people and their families.

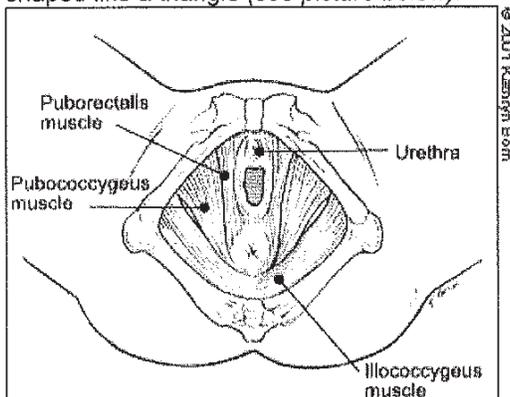
Urinary Incontinence: Kegel Exercises for Your Pelvic Muscles

How do pelvic muscles get weak?

Pelvic muscles help stop the flow of urine. For women, pregnancy, childbirth and being overweight can weaken the pelvic muscles. For men, prostate surgery can weaken pelvic muscles. Weak pelvic muscles can cause you to leak urine. Fortunately, pelvic muscles are just like other muscles—exercises can make them stronger. People who leak urine may have better control of these muscles by doing pelvic muscle exercises called Kegel exercises. This handout focuses on Kegel exercises for women because it is much more common for women to leak urine than for men. If you are a man who leaks urine, talk to your doctor about whether Kegel exercises can help you.

Which muscles control my bladder?

At the bottom of the pelvis, several layers of muscle stretch between your legs. The muscles attach to the front, back and sides of the pelvic bones. Two pelvic muscles do most of the work. The biggest one stretches like a hammock. The other is shaped like a triangle (see picture below).



These are the same muscles that you would use to try to stop the flow of urine. They are the muscles you will exercise and strengthen.

How do I exercise pelvic muscles?

You can exercise almost anywhere and any time—while driving in a car, at your desk or watching TV. To exercise these muscles, just pull in or "squeeze" your pelvic muscles (as if you are trying to stop urine flow). Hold this squeeze for about 10 seconds, then rest for 10 seconds. Do 3 to 4 sets of 10 contractions per day. Be patient and continue to exercise. It takes time to strengthen the pelvic muscles, just like it takes time to improve the muscles in your arms, legs or abdomen. You may not notice any change in bladder control until after 6 to 12 weeks of daily exercises. Still, most women notice an improvement after just a few weeks.

A few points to remember

- Weak pelvic muscles often lead to urine leakage.
- Daily exercises can strengthen pelvic muscles.
- These exercises often improve bladder control.
- Ask your doctor or nurse if you are squeezing the right muscles.
- Tighten your pelvic muscle before sneezing, lifting or jumping. This can prevent pelvic muscle damage and urine leakage.
- Continue to exercise. If the exercises work, continue to do them, just like any other exercises.

Daily pelvic muscle exercise log

I exercised my pelvic muscles _____ times daily.

I spent _____ minutes exercising.

At each exercise session, I contracted my pelvic muscles _____ times.

This handout provides a general overview on this topic and may not apply to everyone. To find out if this handout applies to you and to get more information on this subject, talk to your family doctor.

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Katz Index of Activities of Daily Living

ABBREVIATIONS: I, independent; A, assistance; D, dependent

1. Bathing (sponge, shower, or tub):

- I: receives no assistance (gets in and out of tub if tub is the usual means of bathing)
- A: receives assistance in bathing only one part of the body (such as the back or a leg)
- D: receives assistance in bathing more than one part of the body (or not bathed)

2. Dressing:

- I: gets clothes and gets completely dressed without assistance
- A: gets clothes and gets dressed without assistance except in tying shoes
- D: receives assistance in getting clothes or in getting dressed or stays partly or completely undressed

3. Toileting:

- I: goes to "toilet room," cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying it in the morning)
- A: receives assistance in going to "toilet room" or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode
- D: doesn't go to room termed "toilet" for the elimination process

4. Transfer:

- I: moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)
- A: moves in and out of bed or chair with assistance
- D: doesn't get out of bed

5. Continence:

- I: controls urination and bowel movement completely by self
- A: has occasional "accidents"
- D: supervision helps keep urine or bowel control; catheter is used, or is incontinent

6. Feeding:

- I: feeds self without assistance
- A: feeds self except for getting assistance in cutting meat or buttering bread
- D: receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids

Source: Adapted with permission from Journal of the American Medical Association (1963; 185:915).

Barthel index

"The Barthel Index (formerly: The Maryland Disability Index) is a rating scale completed by a nurse, physiotherapist or doctor from medical records or from direct observation. The ten activities assessed are shown below, together with the corresponding scores. Mahoney and Barthel provided extensive definitions of the levels of independence included in the index (not exhibited here). A score of 0, 5, 10 or 15 is assigned to each level; overall scores range from 0 to 100. The scores are intended to reflect the amount of time and assistance a patient requires."

	With help	Independent
1. Feeding (if food needs to be cut up = help)	5	10
2. Moving from wheelchair to bed and return (includes sitting up in bed)	5-10	15
3. Personal toilet (wash face, comb hair, shave, clean teeth)	0	5
4. Getting on and of toilet (handing clothes, wipe, flush)	5	10
5. Bathing self	0	5
6. Walking on level surface (or if unable to walk, propel wheelchair)	10	15
7. Ascend and descend stairs	5	10
8. Dressing (includes tying shoes, fastening fasteners)	5	10
9. Controlling bowels	5	10
10. Controlling bladder	5	10

Reproduced from Mahoney FI, Barthel DW. Functional evaluation: the Barthel Index. Maryland Stat Med J 1965; 14:62.
Note: a score of zero is given where patients cannot meet the defined criterion.

Quick Information for Your Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • FOOD AND DRUG ADMINISTRATION

Eating Well As We Age



Eating Well

Many older people have trouble eating well. This booklet tells why. Then it gives ideas on what you can do about it. Using the food label is one way to eat well. There are others.

Problem: Can't chew

Do you have trouble chewing? If so, you may have trouble eating foods such as meat, fresh fruits, and vegetables.

What to do: Try other foods

Instead of:

fresh fruit

raw vegetables

meat

sliced bread

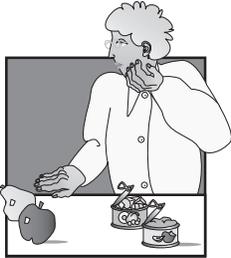
Try:

→ fruit juices and soft canned fruits, such as applesauce, peaches, and pears

→ vegetable juices and creamed and mashed cooked vegetables

→ ground meat, eggs, milk, cheese, yogurt, and foods made with milk, such as pudding and cream soups

→ cooked cereals, rice, bread pudding, and soft cookies



Problem: Upset stomach

Too much gas and other stomach problems may make you stay away from foods you think cause the problem. This means you could be missing out on important nutrients, such as vitamins, calcium, fiber, and protein.

What to do: Try other foods

Instead of:

milk

vegetables such as cabbage and broccoli

fresh fruit

Try:

→ milk foods that may not bother you, such as cream soups, pudding, yogurt, and cheese

→ vegetable juices and other vegetables, such as green beans, carrots, and potatoes

→ fruit juices and soft canned fruits

See a doctor about stomach problems.





Problem: Can't shop

You may have problems shopping for food. Maybe you can't drive anymore. You may have trouble walking or standing for a long time.

What to do:

- Ask the local food store to bring groceries to your home. Some stores deliver free. Sometimes there is a charge.
- Ask your church or synagogue for volunteer help. Or sign up for help with a local volunteer center.
- Ask a family member or neighbor to shop for you. Or pay someone to do it. Some companies let you hire home health workers for a few hours a week. These workers may shop for you, and do other things. Look for these companies in the Yellow Pages of the phone book under "Home Health Services."



Problem: Can't cook

You may have problems with cooking. It may be hard for you to hold cooking utensils and pots and pans. Or you may have trouble standing for a long time.

What to do:

- Use a microwave oven to cook TV dinners, other frozen foods, and foods made up ahead of time by the store.
- Take part in group meal programs, offered through senior citizen programs. Or have meals brought to your home.
- Move to a place where someone else will cook, such as a family member's home or a home for senior citizens.

To find out about senior citizen group meals and home-delivered meals, call (800) 677-1116. These meals cost little or no money.

Problem: No appetite

Older people who live alone sometimes feel lonely at mealtimes. This feeling can make you lose your appetite. Or you may not feel like making meals for just yourself. Maybe your food has no flavor or tastes bad. This could be caused by medicines you are taking.



What to do:

- Eat with family and friends.
- Take part in group meal programs, offered through senior citizen programs.
- Ask your doctor if your medicines could be causing appetite or taste problems. If so, ask about changing medicines.
- Increase the flavor of food by adding spices and herbs.

Problem: Short on money

Not having enough money to buy enough food can keep you from eating well.



What to do:

- Buy low-cost food, such as dried beans and peas, rice, and pasta. Or buy food that contain items, such as split pea soup, canned beans, and rice.
- Use coupons for money off on foods you like.
- Buy foods on sale. Also buy store-brand foods. They often cost less.
- Find out if your local church or synagogue offers free or low-cost meals.
- Take part in group meal programs, offered through local senior citizen programs. Or have meals brought to your home.
- Get food stamps. Call the food stamp office listed under your county government in the blue pages of the phone book.

Read Food Labels

Look for words that say something healthy about the food. Examples are: "Low Fat," "Cholesterol Free," and "Good Source of Fiber."

Also look for words that tell about the relation of food to a disease. A low-fat food may say:

"While many factors affect heart disease, diets low in saturated fat and cholesterol may reduce the risk of this disease."

The words may be on the front or side of the food package. The FDA makes sure these words are true.

Look For 'Nutrition Facts'

Most food labels tell what kinds and amounts of vitamins, minerals, protein, fat, and other nutrients are in food.

This information is called "Nutrition Facts."

- Look at the serving size.
- Find the % Daily Value. The numbers underneath tell how much of each nutrient listed is in one serving.
- About 100% of each nutrient every day is usually healthful. If you're on a special diet, such as a low-sodium or low-fat diet, use the % numbers to pick low-sodium and low-fat food.



For More Information

If you have questions, you can call your nearest FDA office. Look for the number in the blue pages of the phone book. Or call the FDA's toll-free number (888) INFO-FDA (463-6332). Or look for the FDA on the Internet at www.fda.gov

The Food and Drug Administration is an agency of the U.S. Department of Health and Human Services that makes sure foods are safe, wholesome, and honestly labeled.

FDA05-1107C

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

Form section A containing fields for victim name, age, date of birth, SSN, gender, ethnicity, language, address, and present location.

B. SUSPECTED ABUSER Check if Self-Neglect

Form section B containing fields for name of suspected abuser, care custodian, health practitioner, address, and physical characteristics.

C. REPORTING PARTY: Check appropriate box if reporting party waives confidentiality to:

Form section C containing fields for reporting party name, signature, occupation, agency name, and contact information.

D. INCIDENT INFORMATION - Address where incident occurred:

Form section D containing fields for date/time of incident and place of incident.

E. REPORTED TYPES OF ABUSE (CHECK ALL THAT APPLY).

Form section E containing multiple checkboxes for types of abuse such as physical, self-neglect, and financial abuse.

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM?

G. TARGETED ACCOUNT

Form section G containing fields for account number, type of account, and power of attorney.

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. (family, significant others, neighbors, medical providers and agencies involved, etc.)

Form section H containing fields for name, address, telephone number, and relationship of the other person.

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. (If unknown, list contact person).

Form section I containing fields for name, address, city, zip code, telephone, and relationship of the responsible person.

J. TELEPHONE REPORT MADE TO: Local APS, Local Law Enforcement, Local Ombudsman, Calif. Dept. of Mental Health, Calif. Dept. of Developmental Services

Form section J containing fields for name of official contacted and telephone number.

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

Form section K containing fields for agency name, address, and date of report.

L. RECEIVING AGENCY USE ONLY Telephone Report, Written Report

Form section L containing multiple checkboxes and fields for report received, assigned, approved, and cross-reported information.

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. "Elder," means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). "Dependent Adult," means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c) As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1) Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than \$1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to \$5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

- (1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
- (2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- (3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- (4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

- (1) The mandated reporter is aware that there is a proper plan of care.
- (2) The mandated reporter is aware that the plan of care was properly provided and executed.
- (3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
- (4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

Caregiver Strain Questionnaire

I am going to read a list of things which other people have found to be difficult in helping out after somebody comes home from the hospital **Would you tell me whether any of these apply to you?** (GIVE EXAMPLES)

	Yes = 1	No = 0
Sleep is disturbed (e.g., because . . . is in and out of bed or wanders around at night)		
It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help)		
It is a physical strain (e.g., because of lifting in and out of a chair; effort or concentration is required)		
It is confining (e.g., helping restricts free time or cannot go visiting)		
There have been family adjustments (e.g., because helping has disrupted routine; there has been no privacy)		
There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation)		
There have been emotional adjustments (e.g., because of severe arguments)		
Some behavior is upsetting (e.g., because of incontinence; . . . has trouble remembering things; or . . . accuses people of taking things)		
It is upsetting to find . . . has changed so much from his/her former self (e.g., he/she is a different person than he/she used to be)		
There have been work adjustments (e.g., because of having to take time off)		
It is a financial strain		
Feeling completely overwhelmed (e.g., because of worry about ...; concerns about how you will manage)		
Total Score (count yes responses)		

[Home](#) > [Tools](#) > [Evaluation Tools](#) > [Clinical Quality](#) > [Caregiver Burden Scale](#)

Tools
NPO Products
Resources
Grantees
Workgroups
National Office

Caregiver Burden Scale

Instrument Name:

Caregiver Burden Scale

Description:

A tool to numerically calculate the burden experienced by caregivers caring for a loved one.

Category:

Evaluation Tools - Clinical Quality

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References:

Montgomery RJV, EF Borgatta & ML Borgatta. (2000). "Societal and Family Change in the Burden of Care." In *Who Should Care for the Elderly? An East-West Value Divide*, edited by WT Liu & H Kendig. Singapore: The National University of Singapore Press. (Reprint in PDF format available at website.)

Montgomery RJV, Gonyea JG and Hooyman NR. Caregiving and the Experience of Subjective and Objective Burden. *Family Relations* 1985;34:19-26.

Keywords:

caregiver survey, caregiver perception of care, emotional well-being, impact of care

To use this tool:

No permission is required to use this tool.

To view this tool:

http://www.nysaaa.org/Caregiver_Forum/CaregiverForumErieHandout09.pdf (PDF)
Information about using the scale is available at
http://www.uwm.edu/Dept/SSW/facstaff/bio/Burden_Scale.pdf (PDF).

type:clinical_quality

[Return to top](#) 

Promoting Excellence in End-of-Life Care was a national program of the [Robert Wood Johnson Foundation](#) dedicated to long-term changes in health care institutions to substantially improve care for dying people and their families.

Am I a Safe Driver?

Check the box if the statement applies to you.

- I get lost while driving.
- My friends and family members say they are worried about my driving.
- Other cars seem to appear out of nowhere.
- I have trouble seeing signs in time to respond to them.
- Other drivers drive too fast.
- Other drivers often honk at me.
- Driving stresses me out.
- After driving, I feel tired.
- I have had more “near misses” lately.
- Busy intersections bother me.
- Left-hand turns make me nervous.
- The glare from oncoming headlights bothers me.
- My medication makes me dizzy or drowsy.
- I have trouble turning the steering wheel.
- I have trouble pushing down on the gas pedal or brakes.
- I have trouble looking over my shoulder when I back up.
- I have been stopped by the police for my driving recently.
- People will no longer accept rides from me.
- I don't like to drive at night.
- I have more trouble parking lately.

If you have checked any of the boxes, your safety may be at risk when you drive. Talk to your doctor about ways to improve your safety when you drive.

California Advocates for Nursing Home Reform

CANHR Fact Sheets: Planning for Long Term Care

http://www.canhr.org/factsheets/fs_planningLTC.htm

Planning for Long Term Care (LTC) is vital to save time, money, and stress. Such planning can seem intimidating. It will seem less so if you and your family approach it one step at a time. Use the following checklist to aid you in your planning.

Healthcare Needs

- ❑ Determine the appropriate level of care.
 - In other words, where should the person be? Should the person receive care at home, in a Residential Care Facility for the Elderly (RCFE), in a nursing home, or some other facility?
 - The person's physician should give guidance as to the appropriate level of care. Remember, physician's orders are a prerequisite to nursing home admission.
- ❑ Find the appropriate placement.
 - For RCFE placement, information, and resources, contact CANHR. You can also search for RCFEs on our ResidentialCareGuide.org website.
 - For nursing home placement, consult our nursing home guide website, www.nursinghomeguide.org. Here, you can search for nursing homes by name, location, acceptance of Medicare/Medi-Cal, and specific medical need. You can also view the disciplinary record for each facility.
- ❑ Educate yourself.
 - Start with CANHR's website. In addition to nursing home and residential care information, our website contains a consumer links section with many useful resources.

Financial Considerations

- ❑ Obtain a complete financial picture.
 - Inventory all assets in the person's estate: cash, investments, annuities, CDs, IRAs, and work-related pensions. If the person owns real property, determine the nature of ownership (sole ownership, joint tenancy, etc.). If the person has life insurance, determine the cash surrender value, if applicable. Determine the person's monthly income.

- ❑ Determine how to pay for LTC.
 - The average cost of nursing home care is between \$4000 and \$5000 per month. While this is steep, privately paying for even a short time can increase the chances of admission.
 - Medicare may cover up to 100 days of skilled nursing care. HMOs and other health plans may offer LTC coverage. Purchasing LTC insurance may also be an option. For questions about Medicare, HMOs, and LTC insurance, contact HICAP (Health Insurance Counseling and Advocacy Program).
 - Medi-Cal, California’s Medicaid program, can help cover the cost of care at home or in a nursing home. Note that it does not cover the cost of RCFE care. The IHSS (In Home Supportive Services) program can help pay for a caregiver at home. Contact CANHR for information about Medi-Cal and IHSS eligibility requirements.

Capacity Considerations

- ❑ Determine the person’s mental capacity.
 - Can the person make his or own decisions? If the person’s mental capacity isn’t obvious, seek the opinion of a physician.
- ❑ Obtain DPAs or a conservatorship.
 - If the person still has mental capacity, consider arranging for a Durable Power of Attorney (DPA). A DPA ensures that someone can make legal decisions for a person in the case of incapacity. There are two main kinds of DPAs: the DPA for Finance and Property, and the DPA for Healthcare (called an Advanced Healthcare Directive).
 - If the person does not have mental capacity, consider arranging for a conservatorship. A conservatorship is a procedure whereby a court appoints someone to manage the person’s affairs. Conservatorships can be costly; if possible, DPAs should be obtained before loss of capacity.
 - In some situations, a living trust can empower a person to act as an individual’s agent. For questions about these issues, talk to your attorney, or contact CANHR for a referral.

Legal Considerations

- ❑ Plan the estate.
 - Planning for LTC is a chance to plan the estate. Make sure that any wills, trusts, and other legal documents are up-to-date and applicable. CANHR staff can help answer questions about financial options, but we cannot plan your estate.
 - If you wish to plan and protect your estate, CANHR can refer you to a qualified lawyer in your area. Call 800-474-1116 for the only State Bar certified Lawyer Referral Service in California specializing in long term care.



National Coalition for the Homeless

2201 P. St. NW • Washington, DC 20037

Phone: (202) 462-4822 • Fax: (202) 462-4823

Email: info@nationalhomeless.org | Website: <http://www.nationalhomeless.org>

Federal Housing Assistance Programs

NCH Fact Sheet #16

Published by the National Coalition for the Homeless, August 2007

SECTION 811 SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES PROGRAM

The purpose of this U.S. Department of Housing and Urban Development (HUD) program is to provide funding for supportive housing for very low-income persons with disabilities who are at least 18 years of age. Capital advance funds are available for use in constructing, rehabilitating, or acquiring structures to be used for housing. These funds can be used to develop small group homes, independent living projects and units in multifamily housing developments, condominiums, and cooperative housing. Repayment of the capital advance is not required as long as the housing is available for at least 40 years. Section 811 project rental assistance contracts are also available to cover the difference between what a tenant can pay in rent (30% of income) and the cost to operate the project, and each project must have a supportive services plan. The initial term of the project rental assistance contract is 5 years and can be renewed if funds are available.

Any nonprofit organization with a 501(c)(3) tax-exempt status is eligible to receive Section 811 funds. HUD encourages prospective applicants to attend local HUD office workshops, which detail the application process, as well as local market conditions, building codes and accessibility requirements, preservation, displacement and relocation, and housing costs, but workshop attendance is not mandatory. In order to live in Section 811 housing, a household that may consist of a single qualified person must be very low-income (within 50 percent of the median income for the area) and at least one member must be 18 years old or older and have a disability, such as a physical or developmental disability or chronic mental illness.

SECTION 202 SUPPORTIVE HOUSING FOR THE ELDERLY PROGRAM

This HUD-administered program provides supportive housing for very low-income persons age 62 and older. Capital advances are available for the construction or rehabilitation of a structure, or the acquisition with or without rehabilitation of structures that will serve as supportive housing. The Section 202 program helps expand the supply of affordable housing with supportive services for the elderly. It provides very low-income elderly with options that allow them to live independently but in an environment that provides support activities such as cleaning, cooking, transportation, etc. Capital advances do not have to be repaid, provided the housing remains available for at least 40 years. Section 202 project rental assistance contract

funds are available to cover the difference between what the renter can pay, and the cost of operating the project.

All private nonprofit organizations and nonprofit consumer cooperatives are eligible to apply. HUD encourages prospective applicants to attend local HUD office workshops, but attendance is not mandatory. Occupation is restricted to household that included at least one person who is 62 years old or older with incomes at or below the HUD-determined Very-Low Income Limit (50% of area median income (AMI)). Between 20-25% of Section 202 funding nationwide must be set aside for use in non-metropolitan areas.

SECTION 8 HOUSING CHOICE VOUCHER PROGRAM

This is the federal government's major program for assisting very low-income families, elderly and disabled individuals to afford housing on the private market through various voucher options. The program is federally funded, but a network of 2,600 state, regional, and local housing agencies distributes vouchers. Participants in Section 8 are responsible for finding their own housing. They can choose anything that meets the requirements of the program and are not limited to subsidized housing projects.

HUD administers Section 8 funds to Public Housing Agencies (PHAs) that deliver the vouchers to eligible families and individuals. The PHA directly pays the rental subsidy to the landlord and the residents pay the remaining difference. The Homeowners Voucher also gives families the opportunity to purchase their first home and helps with homeownership expenses. In order to be eligible for Section 8 subsidies, a participant's income cannot exceed 50% of the median income for the county or metropolitan area in which they choose to live. A housing voucher family must pay 30% of its monthly-adjusted gross income for rent and utilities. Long waiting periods are common of the voucher program due to high demand and limited housing resources. If the PHA of any given locality administers Section 8 vouchers and public housing, applicants can ask to be placed on both waiting lists.

SECTION 8/SINGLE ROOM OCCUPANCY (SRO)

This program provides funding to moderately rehabilitate existing structures to create SRO housing for homeless *individuals* of very low income. A typical SRO structure is a residential building with small private rooms for a single individual. Shared space typically includes bathrooms, kitchens, living spaces, laundry rooms, and occasionally meeting rooms. These PHAs make Section 8 rental assistance payments to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between a portion of the tenant's income (normally 30%) and the unit's rent, which must be within the fair market rent (FMR) established by HUD. Rental assistance for SRO units is provided for a period of 10 years. Owners are compensated for the cost of some of the rehabilitation (as well as the other costs of owning and maintaining the property) through the rental assistance payments.

Many rehabilitated SROs were formerly residential hotels or YMCA/YWCA's acquired by a sponsor through local government donation or tax delinquencies or condemnation. SRO project sponsors draw on several funding sources such as local government (34%), private lenders (30%), and state government (18%). Section 8/ SRO contract rents must be equal to or less than 75% of the fair market rent for an efficiency unit/studio apartment. The average operating cost of an SRO is \$298 monthly, \$3,570 yearly. It is not required but 47% of sponsors provided some support services, i.e. health exams, substance abuse counseling, job counseling, and literacy

training. SRO also gives residents a fixed address to which essential benefits and other information can be sent.

The typical resident of an SRO is low-income, middle-aged, unemployed or unemployable male, formerly living in the streets or a shelter. The gender ratio is 70/30 male to female, which is typical of the overall ratio of single men and women without dependants experiencing homelessness. The resident selection process can be very lengthy. Many sponsors are concerned about the lack of preservation policies for Section 8/ SROs. According to numerous sponsors the presence of the aforementioned support services are critical to the success of an SRO.

HOPE VI

This program provides grants to PHAs to destroy severely distressed public housing units and replace them with new units or dramatically rehabilitate existing units. The transformation process includes physical improvements, management improvements, and social and community services to address the needs of residents. It hopes to relocate residents in order to integrate low and middle-income communities. The program replaces dilapidated housing units with apartments or townhouses designed to "blend" into the community. This mixing of different economic classes is a major goal of Hope VI in order to lessen concentrations of poverty in the area.

Non-public housing residents and public housing residents live side by side in the newly erected or rehabilitated structures. Market-rate rentals, market-rate homeownership units, and low-income housing tax credit units all share the same Hope VI buildings. The program also provides support services to help residents get and keep jobs. Often, families have to agree to counseling and employment services to qualify for residency and individuals go through an intensive screening process. The main problem with Hope VI is the lack of one-for-one replacement of demolished housing and most displaced residents are given Section 8 vouchers. However, Section 8 housing is so scarce and has long waiting lists so they are often useless. Another possibility for displaced tenants is to move into other public housing in the area.

Typically the residents who are forced out of Hope VI housing are of lower income than those who remain. One major repercussion is that displaced families generally move into communities with already high concentrations of poverty and make them even higher. Ultimately, the Hope VI attempt at income-based class integration tends to lead to more economic stratification. Every year the Administration requests no funding for the Hope VI and Congress restores funding and reauthorizes the program.

PUBLIC HOUSING

The goal of this program is to provide rental housing for low-income families, elderly and disabled individuals. Several million households in the United States live in public housing. HUD administers federal aid, in the form of annual grants, to local public housing agencies (PHAs) that manage housing for lower income residents at rents they can afford and provides them with technical and professional assistance. Rent is paid based on the highest of: 1) 30% of a resident's monthly adjusted income, 2) 10% of their monthly gross income, 3) their welfare shelter allowance, 4) a PHA-established minimum rent of up to \$50. Eligibility for public housing is also based on a given individual or family's status as either a family, or a disabled or elderly individual, and qualification as a U.S. citizen or eligible immigrant. HUD allows PHAs to exclude from annual income certain allowances for dependents or elderly or disabled individuals.

People applying for public housing commonly experience long waiting periods, in many large cities, the wait can be up to 10 years. Generally, once residents are accepted into public housing they can stay as long as necessary provided they comply with their lease. According to public housing policy no resident will be forced to move, regardless of income increases, unless there is affordable housing available for them on the private market.

HOME: HOME INVESTMENT PARTNERSHIPS PROGRAM

This program provides formula grants to states and localities that communities use to fund a range of activities that build, buy, or rehabilitate affordable housing units for rent or ownership. HOME is authorized under Title II of the Cranston-Gonzales National Affordable Housing Act and is the largest block grant to State and local governments exclusively to create affordable housing for low-income households. It provides direct rental assistance for such households often in partnership with local non-profit groups.

HOME is designed to reinforce several principles of community development. It encourages flexibility by authorizing people to utilize housing strategies that work with their own needs and priorities. In order to strengthen partnership among different levels of government and the private sector, HOME emphasizes the need for consolidated planning. Additionally, the program expands the capacity of community-based nonprofit housing groups. A very important aspect of HOME is its requirement that all participating jurisdictions match twenty-five cents of every dollar granted with non-federal sources, including donated labor and materials. HOME establishes Home Investment Trust Funds for each grantee providing a line of credit that each jurisdiction can draw upon as needed. States are automatically eligible for HOME funds and receive either their formula allocation or 3 million dollars; whichever is greater. Local jurisdictions are eligible for at least \$500,000 under the formula can also receive an allocation.

Individual communities can qualify for separate allocations or can join one or more neighboring communities in a legally binding consortium. The formula used by HOME considers the relative inadequacy of each jurisdiction's housing supply, its incidence of poverty, fiscal distress and other factors. According to HUD, the eligibility of households for HOME assistance varies with the nature of the funded activity. For rental housing and rental assistance, at least 90% of benefiting families must have incomes that are no more than 60% of the HUD-adjusted median family income for the area. In rental projects with five or more assisted units, at least 20% of the units must be occupied by families with incomes that do not exceed 50% of the HUD-adjusted median. The incomes of households receiving HUD assistance must not exceed 80% of the area median.

SECTION 502 RURAL HOME OWNERSHIP DIRECT LOAN PROGRAM

Administered by the Rural Housing Service (RHS), an agency in the United States Department of Agriculture (USDA), Section 502 makes loans to low and very low income households (defined as those with income up to 80% of area median) in rural areas to build, repair, renovate, or relocate houses, including mobile/manufactured homes. Section 502 funds can be used to purchase and prepare sites and to pay for necessities such as water supply and sewage disposal. There is no down payment required and interest rates are subsidized. At least 40% of appropriated funds must be used to assist families with incomes less than 50% of the area median income (AMI). Families must be without adequate housing, but be able to afford the mortgage payments including taxes and insurance. Loans are given for up to 33 years.

Households with adjusted incomes between 80% and 100% of median income (as defined by HUD) are eligible for the Section 502 single-family housing guaranteed loan program. Through this program banks or savings and loan institutions rather than the RHS make loans.

SECTION 515 RURAL RENTAL HOUSING LOANS

This program provides direct, competitive mortgage loans to provide affordable multifamily rental housing for very low, low, and moderate-income families, and elderly and disabled individuals. Section 515 is primarily a direct mortgage program but funds can also be used to buy and improve land and water and waste disposal systems.

According to the National Low Income Housing Coalition, while dramatic improvements have been made in rural housing quality over the last few decades, problems persist and many of rural America's 55.4 million residents experience acute housing problems that are often overlooked while public attention is focused on big-city housing issues. They also mention that nearly 30% of non-metro households experience at least one major housing problem: high cost, physical deficiencies, or overcrowding. These problems are found throughout rural America but are particularly pervasive among several geographic areas and populations, such as the Lower Mississippi Delta, along the U.S.-Mexico border, and Central Appalachia, and among farm-workers and Native Americans. More than one-third of rural renters, about 1.9 million households, are cost burdened, paying more than 30% of their income for their housing. One in every ten rural rental households lives in either severely or moderately inadequate housing.

Very low income is defined as below 50% of the area median income (AMI), low income is 50% to 80% of the AMI, and moderate status is capped at \$5,500 above the low-income limit. Those living in substandard housing get top priority; next preference goes to very low-income households. Loans are for up to 50 years at 1% interest rate. Tenants pay whichever is greater, basic rent or 30% of their adjusted income.

Individuals, partnerships, limited partnerships, for-profit corporations, non-profit organizations, limited equity co-ops, Native American tribes, and public agencies are eligible to apply. For-profit borrowers can only operate on a limited-profit basis. Currently, Section 515 loans are made available on a competitive basis, using a national Notice of Funding Availability (NOFA). The program is administered by the United States Department of Agriculture (USDA) and is administered at the state and local level.

SECTION 514/516 FARM LABOR HOUSING LOANS AND GRANTS

These loans and grants are used to buy, build, improve, or repair housing for farm laborers, including persons whose income is earned in aquaculture (fish and oyster farms) and those involved in on-farm processing. Funds can be used to purchase a site or a leasehold interest in a site, to construct or repair housing, day care facilities, or community rooms, to pay fees to purchase durable household furnishings and pay construction loan interest. Loans are made to farmers, associations of farmers, family farm corporations, Native American tribes, non-profit organizations, public agencies, associations of farm workers and limited partnerships in which the general partner is a nonprofit entity.

Grants are made to farm worker associations, non-profit associations, non-profit organizations, Native American tribes and public agencies. Funds may be used in urban areas for nearby farm labor. Eligible tenants are domestic farm laborers who receive substantial portions of their incomes from farm labor. Eligibility is limited to citizens, or persons legally admitted for

permanent residence. Legally admitted temporary laborers are not eligible. Retired or disabled farm laborers can remain as tenants if they were initially eligible.

Loans are for 33 years at 1% interest. Grants may cover up to 90% of development costs.

RESOURCES:

Center on Budget and Policy Priorities (CBPP) Housing Policy. Available at:

<http://www.cbpp.org/pubs/housing.htm>

Housing Assistance Council (HAC) Information Sheets. Available at:

<http://www.ruralhome.org/info.php>

National Low Income Housing Coalition (NLIHC) Publications. Available at:

<http://www.nlihc.org/pubs/index.htm>

U.S. Department of Housing and Urban Development (HUD) Public and Indian Housing.

Available at: <http://www.hud.gov/offices/pih/programs/hcv/index.cfm>