ELDERLY SERVICES IN HEALTH CENTERS:

A Guide to Position Your Health Center to Serve a Growing Elderly Population
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for the

National Association of Community Health Centers, Inc.

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This Guide shares the experience and expertise of the authors in developing and operating a geriatric program at LifeLong Medical Care’s Over 60 Health Center as well as working with numerous other health centers through NACHC’s Elderly Sub-committee.

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. Those 85 years of age and older will grow from 2% of the population now to 5% by 2030 (U.S. Administration on Aging) . . . . . . . This Guide discusses issues for health centers to consider to meet elders’ health care needs and to take advantage of opportunities the growing elderly population affords.

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I. INTRODUCTION & RECOMMENDATIONS

Most of us are personally aware of the aging of the population in the United States. We may have parents, grandparents, aunts, uncles, or other family members to whom we help give care. Many of us are aging and some of us may be directly feeling the health and functional effects.

- **Our communities are aging.**

  Health centers once could concentrate on serving the “moms and kids’’ population with a sprinkling of elders. Now, health centers are challenged to serve an increasingly elderly population. Between 2005 and 2030, the over-65 population will double from 35 million to over 70 million and the oldest old, those 85 years of age and older, will grow from 2% of the population to 5%. ([http://www.aoa.gov/prof/statistics/future_growth/future_growth.asp](http://www.aoa.gov/prof/statistics/future_growth/future_growth.asp)).

- **In our health centers, we feel the effects of aging.**

  UDS data provided to the federal government by all community health centers shows that health centers have already begun to experience growth in their elderly patient populations. Number of elders served by health centers has grown by 47% between 1998 and 2005 to almost 1 million users. The age group from 45 to 64 years of age has grown by 87% indicating much more growth to come if health centers are able to retain those users as they reach 65 years of age. ([National Association of Community Health Centers [NACHC], 2006. Based on the Bureau of Primary Health Care, Health Resources and Services Administration [HRSA], Department of Health and Human Services [DHHS], 2005 Uniform Data System.])

- **Those over-85 elders will have a number of chronic diseases and functional disabilities.**

  In the over-85 group, more than a third need assistance with their disabilities. At the same time, this age group has fewer economic resources to pay for such help. ([http://www.census.gov/prod/2006pubs/p23-209.pdf](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.
- Many elders will live in the inner city urban areas and rural areas served by health centers.

Increasing numbers will be minorities such as Latinos and Asian-Americans. Many are also 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 will not be the affluent golfers of the TV commercials.

We are familiar with elders living on fixed incomes in our community. Over half 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 also will need help determining their eligibility 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.

This Guide presents issues for health centers to consider as they work to meet this growing community need and take advantage of the opportunities that the growing elderly population affords.
Authors’ Recommendations for Positioning Health Centers

- Understand the elderly demographics and market of your community.

- Look for collaborative opportunities with other community organizations that serve the elderly.

- Do careful and conservative business planning for any significant new service.

- If resources are tight, start slow. Significant expansions will stretch cash and infrastructure resources.

- Assure that staff members are trained in elder cultural competence and that clinical staff have some geriatric training, especially on physiological differences for the elderly including medication issues.

- Understand health literacy and communication issues for elderly populations.

- Plan to have social work case management capacity to work with medical providers.

- Plan to learn how to take full advantage of Medicare Federally Qualified Health Centers (FQHC) and Medicaid FQHC reimbursement including qualifying elderly patients for Medicaid.

- Explore special elderly programs such as adult day health care and Medicaid waiver programs for home and community-based services.

- Be sure you are sophisticated in terms of elder services and business infrastructure before taking on more complex programs like PACE.

- And do plan for the growing elderly members of your community and how you will serve them.
II. ELDER SERVICES CURRENTLY PROVIDED BY COMMUNITY HEALTH CENTERS

A. Core Primary Care Services
B. Adult Day Health Care
C. Program of All-Inclusive Care for the Elderly
D. Medicaid Home and Community-Based Services
E. Area Agencies on Aging and State Departments of Aging
F. Housing and Housing-Linked Services
G. Skilled Nursing Facilities and Assisted Living Facilities

A. Primary Care Services

Almost all health centers provide at least some elderly primary care services in their family practice clinics using family practice physicians, nurse practitioners, or physician assistants.

- Even health centers without an elderly focus may also have adult clinics and a staff of internal medicine physicians who serve adults and elders.

- Health centers may also provide some geriatric services in their dental clinics including providing dentures or partials.

- Integrated behavioral health models that incorporate mental health services may also serve elders.

- In addition to basic core services that serve the elderly as part of the broader clinic population, at least some health centers now provide separate geriatric primary care clinics or behavioral health programs specifically for the elderly. These clinics may operate on separate days of the week or in a separate facility dedicated to the elderly and use providers with special training in geriatric medicine or geriatric mental health. Some clinics employ physicians who are sub-boarded in geriatrics.

Other Support Services

In addition to core services a number of health centers now operate specialized programs for the elderly. Many of them speak to elders’ clear preference to remain in their own homes and communities even when faced with serious health problems and difficulties. Remaining at home can significantly improve elders’ quality of life and emotional health if necessary support services are available. These include:
B. Adult Day Health Care (ADHC)

ADHC is a community-based health and long term care service aimed at elders or individuals who are 55 years of age or older with functional limitations severe enough to be in a nursing home or at risk of nursing home placement. Participants live at home and are brought into the center from 3 to 5 days a week.

The service may vary from state to state but typically includes an assessment and care plan with nursing services, physical therapy, occupational therapy, speech therapy, socialization, transportation, social work case management, behavioral care, meals appropriate for the health condition of the participant, and personal assistance services related to toileting, 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). ADHC does not include medical care, which is provided through the health center’s primary care clinic, or, in some cases, through a private physician in the area.

This service is not covered by Medicare but is a Medicaid benefit, either as a state plan option or a waiver service, in many states. ADHC may be paid for either through fee-for-service reimbursement or FQHC prospective payment system rates. When coordinated with other health center services, particularly primary care, ADHC can be critical in allowing elders to avoid nursing home placement and helping families continue to provide care over an extended period.

C. Program of All-inclusive Care for the Elderly (PACE)

Several community health centers operate a PACE program, another home and community based service that allows elderly individuals with functional limitations and who are eligible for nursing home placement to remain in the community.

PACE is usually based in an adult day health center 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 including 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 elders with significant functional limitations. It 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 over 37 operational PACE programs around the country. Five are
operated by community health centers. (http://www.npaonline.org).

D. Medicaid Home and Community-Based Services (HCBS)

As an alternative to nursing home care, many states offer Medicaid HCBS waiver services,
often under a 1915c waiver. These services can vary greatly but are aimed at keeping elders
eligible and at-risk for nursing home placement in the community.

These waiver programs are also required to demonstrate cost-effectiveness, that is, serving
certain elders in the community would save money over the amount potentially spent on nursing
home care. A typical example would be a case management program where case managers are
paid through the waiver program and where these case managers assist elders and their families
to set up a range of necessary home and community services with the goal of the elder being able
to remain in their home.

E. Area Agencies on Aging and State Departments on Aging

Health centers and their elderly patients may also seek services at the county or regional level
from area agencies on aging that provide information and referral and also fund home and
community services. Health centers may also apply for limited funds from these area agencies to
deliver a variety of services. Area agencies also have the responsibility for planning and
advocating for elder services under the federal Older Americans Act (http://www.aoa.gov/about/about.asp). State departments on aging perform similar functions
at the statewide level.

F. Housing and Housing-Linked services

Some health centers have taken advantage of public housing dollars (such as federal Department
of Housing and Urban Development [HUD] section 202 funds) to build low-income senior
housing for their community and/or their patients (http://www.hud.gov/offices/hsg/mfh/progdesc/eld202.cfm). Others partner with local non-
profit or for-profit housing developers on such developments. In either case, the health center
provides services to any resident who wants them either at a nearby clinic location or by
bringing some level of services on-site (such as by using a half-day a week nurse practitioner
clinic, licensed clinical social worker services, or case manager services). As residents age, the
Health centers may increase the amount and intensity of services provided on-site to, in effect, accomplish an assisted living type of service for low income members of its community. Although housing residents can’t be required to use health center services, they often form a core of elderly users through convenience or through the delivery of services by the center that would not be available from private providers.

Health centers may also put services into very low income housing, such as residential hotels, which often house elders who have been homeless or marginalized. Residential hotels for seniors encompass not only medical services, but mental health and substance abuse services as well, all with the goal of keeping a complex population of elders housed.

Like PACE, developing or operating housing requires health centers to become familiar with a whole different range of funding sources and regulations, such as HUD, tax credit financing, and other development issues. Even providing services in housing requires health centers to become familiar with Medicare and Medicaid FQHC rules for providing services outside of the clinic site, in people’s homes, or in intermittent clinics which may be placed at housing sites. Providing on-site services for complex populations also require familiarity with regulations on allowable frequency of services and allowable costs. Medicare and Medicaid regulations are not coordinated with, and may conflict with, regulations associated with HUD funds or with state licensing or service delivery regulations. Nonetheless, housing and housing-linked services can be extremely helpful for low-income elderly communities and can benefit from service, financial, and organizational infrastructure that the health center has developed.

G. Skilled Nursing Facilities (SNF) and Assisted Living Facilities

Some health centers also either own or partner with SNFs or assisted living facilities. Skilled nursing facilities and other “nursing homes” provide institutional care for the disabled of all ages and are heavily regulated by federal and state government.

Assisted living facilities provide a residential alternative to SNFs, provide fewer medically-oriented services, and vary in the regulations applied to them. In rural areas, supporting local residential facilities may give the health center options in keeping disabled elders in their local community. Health center relationships may vary from ownership to simply having an agreement for one of their physicians to serve as medical director of the facility, or to providing medical services on site to residents.

Once again it is important to understand reimbursement and regulatory issues for health centers providing services off-site in either facilities or patients’ homes. Federal Tort Claims Act malpractice coverage, which is provided to health center providers practicing on-site, will not cover a health center physician serving as medical director of a nursing home. In this case, a contract with the health center should require the nursing home to provide malpractice coverage.
III. CLINICAL AND OPERATIONAL ISSUES RELATED TO ELDERLY SERVICES

A. The Service Package for Elders
   1. Community Outreach
   2. Health Promotion/Education
   3. Integration of Medical and Social Services
   4. Intensive Case Management
   5. Home Primary Care Visits
   6. Specialty Care Services
   7. Pharmacy Services
   8. Coordination with Hospital Care
   9. Neuro-Psychological Assessment and Alzheimer’s Care
   10. Nursing Homes
   11. End of Life Care

1. Community Outreach

Elders can be difficult to attract to health centers if they are not accustomed to receiving care in that setting. They may have a regular doctor through their Medicare coverage and be reluctant to change given chronic health problems and ongoing care needs and relationships. Health centers may, however, have numerous opportunities to reach community elders by cooperating with local agencies and churches or synagogues.

Local churches attended by board members or younger health center users often have a special committee or service group dedicated to the elderly in their congregation. Churches are sometimes willing to include announcements about community services in their Sunday services and bulletins.

Some elderly populations may respond to local ethnic media outlets and health centers should include elders in their media plans.

Each region in the country is served by an Older Americans Act sponsored Area Agency on Aging (http://www.aoa.gov) which can be a point of contact to find out where senior centers, meals programs and other service programs are located.
Senior centers, meals programs, and churches are often happy to work with health centers if they are willing to provide some health promotion activities, such as health education, blood pressure checks, or flu shot clinics. These agencies are also happy to hear about resources for low income seniors and usually are happy to include health centers in their information and referral data bank.

For the elderly, who are wary of advertising and who fear being taken advantage of through financial scams, word of mouth from a friend or family member can be the most important method of outreach. Health centers can reach out by assuring that current elderly users are satisfied with services and asking them to tell their friends about the health center. Health centers can also ask younger patients to tell their older family members about new elder-focused services that are now available to them.

2. Health Promotion/ Education

Health centers may wish to offer talks by their providers at a luncheon event, either sponsored at the center or at senior meals programs. This is a way to both provide health information and an opportunity for prospective patients to meet and speak with providers from the health center.

Health promotion/education activities will be more successful if “prescribed” and encouraged by a physician who is providing ongoing primary care.

Health promotion activities for the elderly must be sensitive to real world concerns such as security, transportation needs, child care responsibilities for other family members, and other such concerns.

Senior programs are interested in having health promotion programs that focus on chronic diseases such as diabetes, hypertension, heart disease, etc. Some elders are interested in chronic disease management skills, doing gentle exercise, yoga, life history discussions, and other positive activities. For existing health center patients, the peer support and education offered in chronic disease group visits are particularly helpful as they can be with younger users.

Many elders are uncomfortable leaving their homes at night or, if they drive, may also be less comfortable driving outside of daylight hours. In general health promotion and education activities should use communication strategies that are clear and easily understood by the population using them.

3. Integration of Medical and Social Services

Many elders have complex medical problems, some have functional limitations, and many also have the same psychosocial problems that beset our younger patients. Given these
problems it is important to understand that, like other complex populations such as people with HIV/AIDS or the homeless, it is impossible to provide medical services in a vacuum. A small example may help explain the problem. One of the authors remembers in his early years in a geriatric health center when a patient had her gas and electricity turned off. One of my elderly board members asked me, “How much do you think they will be paying attention to their blood pressure medicine until we can help them get their PG&E services back on?” The point is a simple one but reminds us that low income elders often have a number of very basic survival needs that must be met in order for them to act as a full partner in their health care activities.

The health center must be aware that helping a patient find housing, security, a source of food, or deal with an abusing or difficult family member, may be just as important if not more, than gaining compliance with their doctor’s instructions. Given these needs the health center, if it is to be more than a physician’s office, must be able to provide some type of social work case management services to its elderly population. In the world of fee-for-service Medicare these services may be allowable as costs but are not billable and may be difficult to support.

4. **Intensive Case Management**

Serving an elderly population requires special services. While a healthy 65 year old may have no special needs, certainly a person over 85 or a 65 year old who has been homeless for some time is likely to have complex problems. Case management services can refer to a range of activities. Elders are likely to require two different types of assistance.

**Nurse Case Management**

Given the presence of serious medical problems for many elders, it is helpful to have access to nurse case management to assist the physician or other provider in arranging for special medical needs whether it be working with specialists, arranging home health services, ordering durable medical equipment, coordinating post-hospital care, or simply working with the patient or their family as crises arise. A skilled and experienced registered nurse can handle this function, although in some cases it has been helpful to use a nurse practitioner with greater clinical sophistication who can see the patient for an acute problem when a clinic visit is necessary but the physician is not available.

**Social Worker Case Management**

The second type of case management is that provided by a social worker to assist the patient with functional and independent living needs and to work closely with the physician and the nurse manager. The social worker may be either at the Master degree level or have a Bachelor’s degree plus experience. The social worker often performs in-home assessments to understand how well the patient is
functioning in the home and whether he or she needs assistance with activities of
daily living (toileting, eating, bathing, getting in and out of bed, dressing) or
instrumental activities of daily living such as cooking, shopping, taking
medications, etc. Typically this type of case management includes an assessment, a
care plan, coordinating and monitoring delivery of necessary community-based
services, and reassessing as needed. The social worker case manager is a critical
part of a multi-disciplinary approach to care for the elderly and is able to assist the
patient with services critical for day-to-day life.

5. **Home Primary Care Visits**

Some health center may wish to provide primary care in the home (house calls) for
patients who cannot easily make it into the clinic or may require medical transportation to
reach the clinic. It is probably more practical and cost effective to provide primary care
home visits by using a nurse practitioner or physician assistant since it is impossible to see
as many patients as can be seen in the clinic (unless a number of patients can be seen at a
congregate housing facility without requiring travel from place to place). Again health
centers should pay close attention to Medicare and Medicaid rules related to home visits.

6. **Specialty Care Services**

Large health centers may be able to employ or contract with key specialists such as
Gastro-Intestinal (GI) or Cardiology to come into the clinic and see patients on-site. Any
health center serving the elderly will need a full panel of specialists in the community to
whom they can refer their patients for services. Finding specialists who work with the
elderly, communicate well with in-house physicians, and are supportive of community
health centers is critical to good patient care.

Similar to finding specialty care for our younger uninsured patients, there may be a
shortage of certain types of specialists willing to see low income elders. We have worked
to assure that elder-friendly specialists are on the panel of our health center network’s
specialty panel and conversely our network has been able to find some hard-to-find
specialists to serve the whole network, including elders.

7. **Pharmacy Services**

Since medications are critical to caring for the elderly, a relationship with either an in-
house pharmacist or a contract pharmacist is critical to the health center. Medical
providers trained in geriatrics will understand different dosage requirements and contra-
indications for older patients, but a good pharmacist can help both providers and patients
to better work with medication regimens.
This service is even more important with the many requirements of Medicare Part D drug plans including quantity limitations, progressive regimens required in order to cover certain drugs, and substitution of covered drugs for non-covered ones in the patient’s treatment plan.

Electronic prescribing or drug information software on hand-held devices may be helpful as well. A nurse manager is a critical link among patient, family, pharmacist, and physician in pharmacy related matters. The nurse can also help explain medications in a way that elderly patients can clearly understand them.

8. **Coordination with Hospital Care**

Our older patients are likely to be hospitalized substantially more often than younger adults or children and thus relationships with hospital services are important. The direction of much of the medical care system to use “hospitalists” to provide care to patients in the hospital is at odds with the desire of patients to have a familiar primary care provider who they know and trust coordinating their care at these difficult times.

Depending on the community where the health center is located, health center physicians may admit and follow their own patients in the hospital, with the likelihood of better continuity of care. On the other hand, some health plans require the use of hospitalists (or house staff at academic medical centers) when an older patient is hospitalized. In the later case, health centers should work hard to assure close communication with hospitalists and hospital discharge planners to assure high quality inpatient and post-hospital care. Health centers may even choose to make courtesy visits to their older patients who are hospitalized to assure continuity and coordination of care.

9. **Neuro-Psychological Assessment and Alzheimer’s Care**

Since there is a significant amount of Alzheimer’s and dementia in the elderly population, health centers must be prepared to respond to these problems either through referrals or with in-house services.

Clinical psychologists trained in geriatrics are able to offer neuro-psychological assessments to help distinguish between dementia and normal memory loss. These services, when offered by a licensed doctoral level psychologist, can be reimbursed under FQHC Medicare.

Health centers should also be aware of specialized Alzheimer’s assessment programs in their area so that they can refer to these services. Health center case managers and elderly-serving physicians would be expected to be familiar with dementia patients and work with them and their families to manage both the dementia and other health problems that may become more difficult to manage given the patient’s cognitive status.
Familiarity and comfort level with these problems can help attract additional elderly patients from agencies who also serve dementia patients.

10. **Nursing Homes**

Health center patients may require nursing home care and the health center must decide if its physicians will provide that care. A significant challenge arises in choosing which nursing homes are practical for health center staff to visit and whether these can include nursing homes that serve most of the health center’s patients.

Nursing home regulations require the patient to be visited by the medical provider at least once every 30 days. In the authors’ health center, staff divided a limited number of nursing homes among clinic physicians to balance the provision of as much continuity as possible with the practicality of only being able to visit and maintain relations with a certain number of facilities. Expectations by patients and family members for the health center physicians to visit their patients in nursing homes may vary from community to community.

11. **End of Life Care**

A key aspect of geriatric care is discussing patients’ wishes regarding the use of high tech medical care at the end of their lives. Our health center physicians work to discuss the patient’s wishes (Advance Directives) with them early in their care relationship and long before such directives may be needed. This discussion is documented carefully and prominently in the medical record.

Providers also encourage patients to complete a durable power of attorney for health care, documenting their wishes and choosing someone who may represent them if they are unable to express their own wishes.

Geriatric care requires physicians to work with patients and their families to make difficult and heart wrenching decisions at the end of life. Our geriatric clinics now hold quarterly memorial services during their multi-disciplinary team meetings where staff can remember patients who died that quarter and provide support for each other in what can be a difficult aspect of caring for elderly patients. Staff also encourage patients and families to work with the local hospice and to receive counseling and palliative care at the end of their lives.
B. Visit Issues

1. Extended Visits Required By Elderly Patients
2. Intake Coordination
3. Urgent Care for Elders
4. Chronic Disease Self-Management Education Visits
5. In-House Referrals
6. Outside Referrals

1. Extended Visits Required By Elderly Patients

Visits to the doctor for elders tend to be more complicated than for the average adult. An elder may present with apparently minor complaints that could represent the beginning of a more serious condition warranting a complete and thorough investigation. For example, a cough in an elder may indicate something much more serious than a simple cold.

Elders sometimes feel tired most of the time and may not notice the decrease in energy or a subtle fever that does not get as high as it would in a younger adult. Elders become sicker than younger adults from urinary tract infections and sometimes need to be hospitalized. In younger adults, a urinary tract infection almost never leads to hospitalization. So, in essence the normal fifteen-minute visit for the younger adult can turn into a much longer visit for an elder.

Elders may wait to go to the doctor until they have multiple symptoms that require an extensive amount of time for the doctor to get a definitive diagnosis. Other contributing factors to longer visits are language barriers, hearing deficiencies and difficulty understanding or comprehending. Health literacy and clearly understanding physician instructions can be challenging for all health center patients, especially the elderly.

Because the elderly have complicated health problems and long health histories, initial and return visits are expected to be longer than for a younger adult population. The authors’ health center schedules 40 minutes for an initial visit and 20 minutes for a return visit. If necessary issues can’t be covered in the initial visit, providers expect to bring the patient back for a follow-up visit soon after the first visit.

Given complex histories, it is more important for elderly patients to have medical records from previous providers transferred to the health center prior to the first visit. Even with slightly longer visit times, providers must prioritize issues and use nurse and social work supporters if they are to remain on their schedule.

2. Intake Coordination

It is also helpful to have social service staff review psycho-social issues and functional abilities, if possible, before the physician sees the patient for the first time. Some
physicians and health plans routinely use a brief risk assessment questionnaire for their new elderly patients to maximize the chance of identifying high risk patients early.

3. Urgent Care for Elders

The elderly, like any clinic population, require urgent care availability either with the patient’s primary care provider or with another provider. Some of this urgent care capacity can be in same or next day appointments, but it is helpful to have at least some walk-in capacity for urgent issues. For the elderly, the urgent care providers must be aware of the myriad of chronic health problems present when treating an urgent problem.

Urgent care and walk-in appointments are also crucial for elders as there are socio-economic factors contributing to the use of these types of appointments. Many elders today live alone and may have difficulty arriving on time, or even at all, to routine appointments. In addition, elders face financial problems. The majority of elders served by community health centers live on fixed incomes below 200% of the federal poverty level and must perform balancing acts with their finances from month to month.

Also, relating back to the subtleness of some symptoms felt by elders, patients may not feel that anything is wrong until they need immediate care and by that time they are in crisis, with the limited options of using urgent care or walk-in appointments.

4. Chronic Disease Self-Management Education Visits

Self-management is becoming a best practices standard in the United States. As early as 1999, a collaborative study done by the Center for the Advancement of Health (CAH) and the Milbank Memorial Fund showed improved outcomes and lower costs for patients who were involved with self-management of chronic diseases. The study cautioned, however, that effective patient involvement requires more than just telling patients what to do and what to avoid. “Services that enhance patient self-management of chronic conditions can improve how they function and reduce pain and suffering,” the report noted, “in some cases, these services can also reduce the direct costs of medical care by eliminating unnecessary and wasteful doctor and emergency room visits, hospitalizations, and medication use, and by reducing the costly consequences of poorly treated conditions. Specifically, this study concluded, “By helping people change their behaviors and adapt to their conditions, self-management programs often increase people’s adherence to medical treatments, strengthen their control of pain and symptoms, and improve overall emotional well-being.” “Self-care is a crucial element in facing illness and maintaining function as well as morale and encompasses activities related to health promotion, disease prevention, illness and injury treatment, chronic disease management and rehabilitation (http://www.milbank.org/reports/990811chronic.html).

As with any chronic disease population, it is helpful to have either individual self-management counseling and education visits or group visits available to allow patients to learn about their disease and take advantage of peer support (http://www.cfah.org/pdfs/Essential_Elements_Report.pdf). Most elders do not have a
lot of family or outside communication with others so group encounters are useful in many ways. Group visits allow elders to have the social interaction that they may not have on a normal basis, as well as give them an outlet to express their feelings about their health condition or related problems. Groups also give elders the opportunity to see and hear that others elders are having some of the same issues allowing for the development of a support system. Groups also allow the elder to discuss physician instructions, which he or she may not have understood during a one-on-one visit.

5. In-House Referrals

The elderly population has been shown to be even more reluctant to take advantage of mental health services than the adult population. Willingness to use mental health services also varies with racial and ethnic grouping. We have found that having the medical provider physically introduce the patient to a licensed clinical social worker, clinical psychologist, or psychiatrist provides the best chance of the elderly patient accepting such a referral.

6. Outside Referrals

Most outside referrals made for specialty medical care and for elders with functional limitations or dementia require more staff assistance than for a younger population since the patient may not be able to make arrangements for the visit and may need extra assistance. Assuring that the specialist office and the patient or family connect and follow through on the appointment is a time intensive process.

C. Customer Service – Culture and Age Differences

1. Age Issues
2. Cultural Expectations
3. Phone Issues

Patients today have a very different expectation of their interactions in a doctor’s office than did patients in previous years. In the past, patients held doctors to a different standard and most were just grateful that a doctor would see them, especially if they were not well insured or financially independent.

With the rise in healthcare costs and decrease in payments to doctors and hospitals, patients are becoming much more aware of how important the patient is to the success of a health care organization. Older patients now have developed higher expectations for good customer service. Becoming culturally proficient will lead to excellent customer service.
Elders, like people of all ages and racial backgrounds, appreciate being treated with respect. Unless older patients ask to be called by their first name, we try to address them as Mr. or Ms. Older patients should not be addressed with diminutives like “dear” or “honey”.

In 2002, a Commonwealth Fund funded research project by Betancourt, et al http://www.cmwf.org/publications/publications_show.htm?doc_id=221320 (Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches, Joseph R. Betancourt, M.D., M.P.H., Alexander R. Green, M.D., and J. Emilio Carrillo, M.D., The Commonwealth Fund, October 2002) stated, “Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular”. The study defined cultural competence in health care.

“Cultural competence in healthcare describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.”

Experts interviewed for this study describe cultural competence as:
- A vehicle to increase access to quality care for all patient populations and
- A business strategy to attract new patients and market share.

1. **Age Issues**

Being aware of age differences is another important aspect of dealing with patients effectively and efficiently. All staff relating to elders should have knowledge of the basic competencies needed to care for elder patients.

Staff should be able to understand the complexities that come with disabilities and impairments suffered by elders as they age, as these things may cause behaviors that otherwise would not be present. If staff can see these behaviors as related to the patient’s health problems, they become easier to deal with effectively.

2. **Cultural Expectations**

Communication skills are key to a successful relationship with an elder, where again the all-important cultural competency comes into play. Elders from various cultures have different expectations about how they should be treated, so having a very basic knowledge of these cultural expectations is always helpful. Health centers that primarily deal with elders may want to invest in additional training surrounding culture and age differences. One example of being respectful is asking physically disabled elders if they want assistance before automatically helping them.
3. **Phone Issues**

Our older patients seem to prefer speaking with a live phone operator rather than dealing with auto-attendant phone systems. There seems to be a sense of comfort for an elder to actually speak to a live person as opposed to leaving a message on a machine.

As stated earlier, elders tend to wait until things are of an urgent nature before they seek help; having the satisfaction of speaking to a live person reassures them that their needs will be taken care of in a timely manner.

There may be hearing impairments that prevent an elder from working successfully with an auto-attendant system as well as discomfort with electronic technology. This is an area where it is important to acknowledge age cohort differences. Young seniors may be familiar with using an auto-attendant system but elders over 85 are much less likely to be comfortable with these systems ([http://taylorandfrancis.metapress.com/(hgn4ib45u1f413rk2r4xgb2c)/app/home/contribution.asp?referrer=parent&backto=issue,3,8;journal,30,67;linkingpublicationresults,1:100652,1](http://taylorandfrancis.metapress.com/(hgn4ib45u1f413rk2r4xgb2c)/app/home/contribution.asp?referrer=parent&backto=issue,3,8;journal,30,67;linkingpublicationresults,1:100652,1)).

D. **Facility Issues**

1. Integrated With Other Ages or Not?
2. Layout and Access Issues
3. Transportation

1. **Integrated With Other Ages or Not?**

Some elders prefer not to receive their care in a busy family practice facility with kids running around under foot. Others really prefer to be around children and younger people. It makes them feel a part of their community. There is no right answer to the question of having separate times and/or locations for senior clinics. The answer will probably depend on the number of elders in the practice, where they live, and the logistics of running the health center as well as working to satisfy the preferences of the senior patients at the health center.

2. **Layout and Access Issues**

Since the passage of the Americans with Disability Act, most health center facilities should be accessible to elders. There are several things to remember about office layouts.

- More elders are likely to have walkers, canes, and wheel chairs. They also may move slowly. This tends to clog up hallways unless the facility is built to accommodate this flow. This can be a particular problem if patients have
to move in both directions down a long narrow hallway and may be using assistive
devices or being assisted by a staff member or family member.

- It is helpful for bathrooms to have call buttons.

- Elders appreciate hand rails in corridors and grab bars and step stools to help them
get on exam tables.

- Health centers should have at least one fully accessible disability friendly powered
exam table that allows easy transfer from a wheel chair to the table.

- Elders with physical limitations should not be asked to perch on exam tables while
the provider or medical assistant takes medical history.

- Given the necessary dialogue and listening that must go on between provider and
elders with chronic problems, both should have a comfortable place to sit in the
exam room. Relaxed face-to- face communications may also mitigate some hearing
problems.

- Health centers designing or renovating facilities for the elderly may also wish to
consult with color experts about which colors are best seen by elders. Earth tones
are usually a solid choice.

### 3. Transportation

It is important for health centers to provide or arrange for transportation to visits and
groups for elderly who may not drive or may need disability accessible vehicles. The
ability of the health center to provide transportation from senior congregate residences
also may help build up an elderly practice.

- At a minimum, health center social services staff must be familiar with para-transit
programs, taxi vouchers, senior vans, and accessible public transportation to help
the elderly patient get into the center. Staff and providers should also be sensitive
to problems with para-transit or ride services and realize that patients may be late
or early because of problems with transportation and may also have to leave the
center at a certain time in order to catch a pre-arranged ride.

- Health centers should adjust their late arrival policies so that elders are not forced
to return on another day or make a new appointment if they experience
transportation problems.

- Transportation is also an issue in terms of being able to provide lab services and
pharmacy at the time of a visit. Health center pharmacies can deliver prescription
drugs to their elderly users or use mail order approaches when security allows.
E. Staff Issues

1. Provider Training

Training for all who work with elders should follow an interdisciplinary and multicultural approach that recognizes cultural and ethnic differences of patients.

- Staff should be knowledgeable in diagnosis and treatment in the various care settings (i.e. outpatient, home, assisted living facilities, hospital, sub-acute settings, nursing homes, and others) and transitional care across sites.
- Both the physicians and mental health providers need to be well versed in ethical and legal issues as well as end of life issues.
- There has to be strong collaboration among all concerning psychosocial issues.
- Staff need to be very knowledgeable in teaching, guiding, and communicating with the elderly.
- Staff must understand health literacy challenges faced by patients in understanding provider instructions.
- Health centers may want to invest in continuing education for their providers in geriatric competencies.

2. Staff Needs to Address Death and Dying

It is very important to have a program in place to help staff cope with the deaths of patients. Support staff spends as much or more time communicating with elder patients than the physicians or other professional staff. They establish relationships with patients that are sometimes very strong, so it is important to have an outlet for staff to express their feelings. This can be done by way of a monthly or quarterly memorial service as part of staff meetings. This type of program not only allows staff (including providers) to discuss some of their grief, it also serves as a good internal customer service tool for staff. It signals to them that their feelings are important and that you as a health center are concerned about all of them and their well-being. (For general information about death and dying, including staff support, see: http://www.abcd-caring.org/.
F. Hours of Operation

1. Daylight Hours
2. On Call System

1. Daylight Hours

Most, although not all, elders will prefer to use clinic services during daylight hours when security and driving issues are less problematic. Health centers should be sensitive to such needs. These problems will be more acute in winter when late afternoon appointments may not be desirable if they force the older person to return home after dark. External programs offered in conjunction with senior programs often can be scheduled around a congregate lunch so that elders only have to travel once.

2. On Call System

A health center may want to consider having an on-call system in place for its elderly patients. It is difficult to contract with an outside source to take call for elder patients. One issue is the complexity of the patients’ conditions, but more has to do with the patients feeling comfortable with the on-call physicians. Elder patients are much more complicated in terms of relationships and they may not like change. Having a consistent group of people to communicate with makes them feel safer and more open to discussing potential problems.
IV. BUSINESS ISSUES

Business and financial issues related to serving this population can be divided into operational issues and broader market and strategic planning questions.

A. Operations Level Business and Financial Issues

1. Visits and Productivity
2. Ability to Fill Clinics for Providers on Sick Leave or Vacation
3. Eligibility Assistance
4. Medicare Part D
5. FQHC-Related Risks
6. Non-Billable Visits

1. Visits and Productivity

The extended visits discussed above, the complex problems of elders, and extra follow-up and paper-work time all mean that the geriatric provider will not be as productive as a normal family practitioner. Administrators cannot expect physicians with a geriatric practice to see 4,200 patient visits per year and panel sizes will also be much smaller as geriatric patients are more likely to use additional visits.

The authors’ health center averages about 7 medical visits per year for an elderly patient.

This will vary depending on the age and complexity of the senior population served.

The authors have not seen any hard and fast numbers on geriatric productivity goals but think that approximately 3,500 visits per year may be appropriate.

For federally funded health centers with a large elderly population, productivity levels will drive down medical team productivity reported on the UDS and may need to be explained.

2. Ability to Fill Clinics for Providers on Sick Leave or Vacation

Elders are most often seen for chronic problems and establish a relationship with their primary care providers. Most would rather wait for their ongoing chronic care visits until they can see that regular provider. It is therefore difficult to use fill-in physicians for regular medical providers and expect anywhere near normal productivity.
It may be better to budget for vacation and sick time and only expect to use fill-in physicians for part of the regular physician’s schedule in order to handle urgent care needs.

3. Eligibility Assistance

Working to qualify low income elderly users for Medicaid, Medicare Savings programs, or providing assistance to elders in seeking Medicare Part D subsidies can all be time consuming for health center staff and require a different set of member services skills and knowledge than needed to qualify children or younger adults for coverage. Health centers may be able to use Medicare benefits counseling programs in their area for some assistance. Because many health centers have not focused on the elderly population and because there are fewer public and philanthropic resources aimed at the elderly population, this can be a difficult issue.

Working with these eligibility issues can be critical for the patient and for the financial well-being of the health center.

For the patient, qualifying for Medicaid or a Medicare Savings Program (http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#) can mean:

- Not having to pay the Medicare Outpatient Part B premium every month from his or her Social Security check -- for a person living on a low fixed income, this extra $88.50 per month (in 2006, projected to rise to $93.50 in 2007) may mean the difference in eating adequately or taking part in some favorite activity that improves the quality of life;

- Coverage for additional services such as long-term care or adult dental (in some states) and avoids the cost of Medicare co-payments and deductibles;

- Elimination of most out-of-pocket costs for Part D-covered drugs.

For the health center, Medicaid eligibility can make a significant difference in health center revenues because it:

- Brings a higher reimbursement rate in many states (if the state pays a wrap-around payment for Dual Eligibles);

- May bring reimbursement for other services not previously covered such as dental care.
4. Medicare Part D

Part D can provide drug coverage to elders not previously covered through the low-income subsidy, thus allowing the health center to save costs previously spent on elders with no drug coverage. Health centers that operate their own pharmacies must negotiate agreements with Part D drug plans for dual eligibles who were covered by Medicaid in the past. Health center patients may also have lost the benefits associated with certain specific pharmaceutical patient assistance plans and need help from the health center to get through newly required deductibles, copays, and loss of coverage in the so-called donut hole. Please refer to NACHC issue briefs on Part D to understand how these issues may affect your health center (http://iweb.nachc.com/downloads/products/76.pdf).

5. FQHC-Related Risks

Certain services required in serving the elderly such as the intensive social work case management described above may or may not be allowed as FQHC costs under Medicare or Medicaid. Although such costs are clearly a part of the overall team approach to care, some Medicare or Medicaid auditors may try to disallow them claiming that they are not appropriate medical care services. Such disallowances can lead to lower FQHC rates and the inability of the health center to meet its true costs and a tendency to provide fewer case management services than required by the patients. To date NACHC legal counsel has not been able to point to clear legislative or regulatory language that requires these costs to be allowable. They therefore remain in a gray area and health centers can be at financial risk if these costs are disallowed.

6. Non-Billable Visits

Health centers may choose to provide certain preventive or educational activities, same day services, or services from providers who are non-FQHC billable. These services may be a key part of an elderly service package but their costs must be borne through grants or contracts or through clinic surplus generated from services that are reimbursed.
B. Strategic Financial Questions

1. Business Planning

Any health center considering opening new sites or programs for the elderly should go through a detailed business planning process.

- What is the market in terms of potential elderly business?
- How long will it take to attract new patients, using conservative projections?
- How long will it take for patient ramp-up as well as phasing in necessary staff and assuring that there are available start-up funds, the loss of which will not put the other health center services or programs in jeopardy?

At a minimum, have such projections reviewed by outside consultants familiar with elderly services and the local community. Remember that elderly patients do not necessarily switch providers easily and it may take some time to build up a new service. Of course a health center may have the opportunity to jump-start its elderly services if it has the opportunity to take on a private physician practice with a large elderly population. Perhaps an existing elder program such as adult day health care could merge into the health center. In both of these examples it is still necessary to fully understand the new business and carefully project the impact on the health center, its culture, and its financial performance. It is also possible to grow elderly business without major up-front costs, by using existing facilities and staff and slowly integrating new elderly patients into existing structures. The more complex and risky the program (e.g. PACE), the more carefully the health center should examine the opportunity and assure that cash reserves are adequate and infrastructure is strong enough to take on a new program.

- Given demographic changes in the health center’s community, can the CHC afford not to participate in some way?
- Will the health center lose a significant part of its patient base or its potential community if it does not expand its elderly service capacity?

2. Infrastructure

Health centers should carefully assess their infrastructure in terms of being able to support a new service. These are important questions for a health center to answer before taking on significant new programs.
• Does the billing and accounting function have to build up substantial new expertise in order to handle Medicare billing and Medicare cost reporting requirements?
• Does member services staff understand elderly eligibility issues?
• Can Information Technology staff support necessary chronic disease module expansion?
• Does clinical staff have the necessary expertise available?
• Are new facilities or upgrades to existing facilities required?
• Does the management team have the energy and expertise to take on a new type of business?

Health centers should be familiar with FQHC Medicare regulations.

• Medicare pays FQHCs a capped cost-based fee-for-service payment for allowable visits. The maximum FQHC rate varies between urban and rural areas. Approximately two-thirds of health centers have costs higher than these allowable rates.
• Health centers will be paid 80% of their approved rate for medical services and approximately 50% to 60% of that rate for mental health services.
• A medical and mental health visit may be provided on the same day for two different diagnoses.
• Medicare does not pay for dental care or for adult day health care.
• Medically necessary limitations apply and the Medicare fiscal intermediary can deny certain visits, such as for podiatry care, if they are not deemed medically necessary.
• Medicare pays FQHC rates for services provided in the clinic and in the patient’s home but not in the hospital.
• Health centers must bill standard fee-for-service Medicare for hospital visits provided when rounding on elderly patients.
• Medicare also requires separate clinic provider numbers for every physical clinic location including intermittent or satellite clinics. NACHC has successfully negotiated a streamlined process for existing health centers to apply for provider numbers for new sites.
• Given that Medicare pays a percentage of costs and that allowable costs are capped, health centers will usually be paid less than they would be for comparable services under a Medicaid FQHC system. Any business planning process must provide for making up the difference and since these are usually low-income elderly patients, the health center will usually put co-payments on a sliding scale and should not count on making up the difference from patient revenue.
3. **FQHC Medicaid Reimbursement**

- Some states provide a wrap-around payment to health centers for Dual Eligibles up to the Medicaid rate. Health centers should check with their state primary care association or with other health centers in their state that serve an elderly population to understand this reimbursement mechanism as it has the potential to make a substantial difference in revenues.

- State Medicaid programs may also cover other services such as dental and various home and community-based services which the health center can provide and receive payment for at the state level.

- It is especially important to understand Medicaid waiver program services that vary from state to state and may better enable the center to care for disabled elderly patients.

4. **Medicare Advantage**

Medicare Advantage (MA) is the private health plan option for Medicare and includes Health Maintenance Organizations (HMOs) Preferred Provider Organizations (PPOs), and private fee-for-service plans, all offered outside of the traditional Medicare program. Health centers may contract to be providers under these plans and retain the right to receive a wrap-around payment up to their Medicare FQHC rate. See NACHC Issue Brief #85 for requirements for wrap-around payments (http://iweb.nachc.com/downloads/products/85.pdf).

Medicare Advantage plans can create opportunities and threats for health centers. In the past Medicare HMO plans have been concentrated in several urban areas of the country and affected only health centers in those areas. Health plans usually did not try to enroll the low-income dual eligible patients who make up the core of health center elderly business. Under the Medicare Modernization Act, health plans are receiving enhanced rates to encourage them to get back into the market. In addition, Medicare is trying to make some private plan option available in every part of the country, even in rural areas that in the past have not been affected by Medicare health plans.

The Medicare Modernization Act also established a Special Need Plan (SNP) designation to allow for health plans wishing to specialize in the enrollment of dual eligibles, institutionalized elders, or people with a certain high-risk chronic condition such as diabetes. A number of plans are now beginning to market to dual eligibles in several areas of the country and 470 SNPs, most proposing to serve dual eligibles, have been approved by the Centers for Medicare and Medicaid Services (CMS) for operation. We can expect to see much more activity in this area in coming years.

Some health centers already hold contracts with Medicare Advantage plans either directly or through a sub-contract arrangement and health plans are beginning to learn about health centers as providers of care to the elderly. This can present opportunities if the health plan is able to bring enrollment to a contracted health center and if the health center is able to negotiate bonus payments if they successfully manage care for their
patients. There may also be opportunities for health center networks to contract with plans on behalf of their member clinics and to thus share risk and potential rewards over a greater number of members.

There are also, however, threats as health centers could potentially lose elderly patients who choose to enroll in a plan with whom they don’t contract. Health centers should also be aware that some health plans may wish to contract with them in order to get the health center to encourage its members to enroll in a particular plan. If contracting terms are favorable this could present opportunities for the health center but certainly would also allow the plans to gain enrollment without having to spend normal marketing dollars in the effort.

Our belief is that health centers wishing to engage in elderly services should explore contract options that are favorable, but should certainly proceed with great care and use technical and legal counsel in negotiating agreements.

An added complication with Medicare Advantage plans is that some health center users may accidentally enroll in them when picking a Part D plan without understanding that they may no longer be able to use health center services.

5. Public Awareness of Elderly Services

Most elders and their families are familiar with physician services and may be willing to receive those services at a health center. Health Centers should be aware, however, that the public is less familiar with other types of elder services discussed above such as adult day health care, PACE, Medicaid waiver programs, and other community-based services. If the Center chooses to offer some of these helpful services it may need to educate the public and referring agencies about the service and its benefits.

As the population ages, we believe that the public will become more familiar with services which allow disabled elders to remain in their communities.
V. UPCOMING POLICY ISSUES

Payment Limits under Medicare

The Medicare FQHC program pays only a capped fee for service payment to health centers despite their actual costs. For several years NACHC has been gathering data on the number of health centers that lose money because of this capped payment with the latest data showing that nearly two-thirds of health centers have costs higher than the capped rate. NACHC will continue to work toward either readjusting this rate or removing the cap so that health centers can serve Medicare patients without losing funds.

A. Mental Health Providers

Health centers that offer integrated primary care and mental health services are hurt by restrictions on types of licensed mental health providers who can be billed to Medicare. Licensed mental health professionals such as marriage and family counselors or licensed professional counselors cannot be billed under the Medicare FQHC program (and sometimes under Medicaid as well). This makes it difficult to recruit billable providers to offer mental health services especially in rural and under-served areas.

B. Medicare Advantage Payment Rates

Higher payments to Medicare health plans create an incentive for health plans to enroll more elders and to create attractive benefit packages. These payments may direct patients away from health centers. It is unclear whether Medicare will maintain these higher payment rates in years to come. A recent Commonwealth Fund study indicated that Medicare Advantage plans get paid 12% more than traditional Medicare spends for equivalent patients. (See --The Cost of Privatization: Extra Payments to Medicare Advantage Plans, Brian Biles, Lauren Hersch Nicholas, and Barbara S. Cooper, The Commonwealth Fund, Updated December 2004.) Medicare is also switching health plans to risk-adjusted capitation rates, which may mean that more complex health center patients have additional dollars attached to them and thus may be more attractive to health plans if the plan believes it can manage the risk.

C. Medicare Part D

The Medicare Part D drug benefit is still in its early days of implementation. It is unclear how the Part D benefit will develop in the future and how it will affect health centers. A change in administration could result in significant changes in Part D.
D. Medicaid Managed Care for the Elderly and Disabled

A number of states have moved their moms and kids into mandatory managed care. Now, a number of states are considering moving elderly and disabled Medicaid recipients into managed care. Again, the effect on health centers is unknown, but progress should be monitored closely at the state and regional association level.

E. Entitlement Programs

On a larger scale major entitlement programs like Medicare and Social Security are under attack by conservatives as unsustainable as the baby boomers age. Both programs will require tweaks in tax rates or benefit structures over the coming years in order to remain solvent. Health centers will wish to monitor and be active both from an advocacy perspective for their patients as well as from a business perspective in terms of understanding changes in existing entitlement benefits.

F. Medicare Privatization

The current Administration is in favor of private sector solutions to public problems and thus has been moving toward privatizing Medicare, as shown by increased reliance on private health plans as well as the private insurance structure of the new Part D benefit. Continued movement in this direction could threaten health center reimbursement structures as well as threaten current levels of care being provided to health center patients. Again health centers will want to both monitor and be active in advocating on behalf of their patients and the health center movement.

G. Long Term Care Coverage

Despite the aging of the baby boomers, current health and long term care policy and service delivery is extremely fragmented, which creates access problems for seniors. There is only incremental progress in expanding some Medicaid waiver programs and providing tax credits for purchasing private long term care insurance. This later private option is not available to low income health center patients. Some observers feel that government will have to improve the availability of community-based non-institutional long term care coverage as the population ages. If such improvements in coverage take place, health centers may very well benefit from being positioned as service providers for the elderly population.
VI. RECOMMENDATIONS:

Based on more than 27 years working with elderly people, community-based health care delivery systems, and providers, the authors recommend the following as essential issues for health center to consider when serving elderly people.

- Understand the elderly demographics and market of your community.
- Look for collaborative opportunities with other community organizations, which serve the elderly.
- Do careful and conservative business planning for any significant new service or service expansion.
- If resources are tight, start slow. Significant expansions will stretch cash and infrastructure resources.
- Assure that staff members are trained in elder cultural competence and that clinical staff has some geriatric training especially on physiological differences for the elderly including medication issues.
- Understand health literacy and communication issues for elderly populations.
- Plan to have social work case management capacity to work with medical providers.
- Plan to learn how to take full advantage of Medicare FQHC and Medicaid FQHC reimbursement including qualifying elderly patients for Medicaid.
- Explore special elderly programs such as Adult Day Health Care and Medicaid waiver programs for home and community-based services.
- Be sure you are sophisticated in terms of elder services and business infrastructure before taking on more complex programs like PACE.
- DO plan for the growing elderly members of your community and how you will serve them.
Attachments

1. Advance Directive Example
2. Social Services Brief Assessment
3. Case Management Check List
4. Over 60 Health Center Client Assessment Form
5. Initial Mental Health Assessment
6. Depression Screeners, PHQ2 & PHQ9
7. Mini Mental Health Status Evaluation
8. Information for Mental Health Clients
9. Substance Abuse Initial Client Assessment
10. Patient Satisfaction Survey
#1 Advance Directive Example

Over 60 Health Center
My Health Care Wishes

The California Medical Association's

Advance Health Care Directive Kit

For more information on Advance Health Care Directives, see www.cmanet.org

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After you have completed your Advance Health Care Directive form (included in this kit), you should give copies of the form to the people you have appointed as your agent and alternate agents, to your doctor(s) and health plan, and to family members or anyone else who is likely to be called if there is a medical emergency. You should also take a copy with you if you are going to be admitted to a hospital, nursing home or other health facility.

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Introduction to Advance Health Care Directives

California law gives you the ability to insure that your health care wishes are known and considered if you become unable to make these decisions yourself.

The following are answers to commonly asked questions about Advance Directives. For more information on Advance Health Care Directives, see www.cmanet.org.

What is an Advance Health Care Directive?

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. Completing a form called an "Advance Health Care Directive" allows you, under California law, to do either or both of two things:
First, you may appoint another person to be your health care "agent." This person (who may also be known as your "attorney-in-fact") will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself.
Second, you may write down your health care wishes in the Advance Health Care Directive form—for example, a desire not to receive treatment that only prolongs the dying process if you are terminally ill. Your doctor and your agent must follow your lawful instructions.

Even though you do not have to appoint a health care agent, the California Medical Association (CMA) recommends that you do so. Then there will be someone you trust to actively participate in the decisions surrounding your health care.

Is an Advance Health Care Directive different from a "Durable Power of Attorney for Health Care"?

The Advance Health Care Directive has replaced the Durable Power of Attorney for Health Care (or "DPAHC") as the legally recognized document for appointing a health care agent in California. The Advance Health Care Directive allows you to do more than a DPAHC. An Advance Health Care Directive permits you not only to appoint an agent, but to give instructions about your own health care. You can now do either or both of these things.

What if I have already executed a Durable Power of Attorney for Health Care or a Natural Death Act Declaration. Is it still valid? Do I have to complete a new Advance Health Care Directive?

All valid Durable Powers of Attorney for Health Care (DPAHC) and Natural Death Act Declarations remain valid. Thus, unless your existing DPAHC has expired, you do not have to complete a new Advance Health Care Directive. A DPAHC executed before 1992 has expired and should be replaced.

Because the new Advance Health Care Directive gives you more flexibility to state your health care desires, you may wish to complete the new form even if you previously completed a DPAHC or Natural Death Act Declaration. At a minimum, you should review your existing DPAHC or Natural
Death Act Declaration to make sure it has not expired and that it still accurately reflects your wishes.

**Who can complete an Advance Health Care Directive?**

Any California resident who is at least eighteen (18) years old (or is an emancipated minor), of sound mind, and acting of his or her own free will can complete a valid Advance Health Care Directive.

**Do I need a lawyer to complete an Advance Health Care Directive?**

No. You do not need a lawyer to assist you in completing an Advance Health Care Directive form (such as the form supplied in this kit). The only exception applies to individuals who have been involuntarily committed to a mental health facility who wish to appoint their conservator as their agent.

**Who may I appoint as my health care agent?**

You can appoint almost any adult to be your agent. You can choose a member of your family, such as your spouse or an adult child, a friend, or someone else you trust. You can also appoint one or more “alternate agents” in case the person you select as your health care agent is unavailable or unwilling to make a decision. (If you appoint your spouse and later get divorced, the Advance Health Care Directive remains valid, but your first alternate agent will become your agent.)

It is important that you talk to the people you plan to appoint to make sure they understand your wishes and agree to accept this responsibility. Your health care agent will be immune from liability so long as he or she acts in good faith.

The law prohibits you from choosing certain people to act as your agent(s). You may not choose your doctor, or a person who operates a community care facility (sometimes called a “board and care home”) or a residential care facility in which you receive care. The law also prohibits you from appointing a person who works for the health facility in which you are being treated, or the community care or residential care facility in which you receive care, unless that person is related to you by blood, marriage, or adoption, or is a co-worker.

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**Can I appoint more than one person to share the responsibility of being my health care agent?**

The California Medical Association (CMA) recommends that you name only one person as your health care agent. If two or more people are given equal authority and they disagree about a health care decision, one of the important purposes of the Advance Health Care Directive—to identify clearly who has authority to speak for you—will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be the agent, and list the others as alternate agents.

**I want to provide more specific health care instructions than those included on this form. How do I do that?**

You may write detailed instructions for your health care agent and physicians(s). To do so, simply attach one or more sheets of paper to the form, write your instructions, write the number of pages you are attaching in the space provided at the end of Section 3, and sign and date the attachments at the same time you have the form witnessed or notarized. For examples of more specific instructions, including specific instructions for organ and tissue donation, go to the California Medical Association’s website at www.cmanet.org.

**How much authority will my health care agent have?**

If you become unable to make your own health care decisions, your agent will have legal authority to speak for you in health care matters. Physicians and other health care professionals will look to your agent for decisions rather than to your next of kin or any other person. Your agent will be able to accept or refuse medical treatment, have access to your medical records, and make decisions about donating your organs, authorizing an autopsy, and disposing of your body should you die.

If you do not want your agent to have certain of these powers or to make certain decisions, you can write a statement in the Advance Health Care Directive form limiting your agent’s authority. In addition, the law says that your agent cannot authorize convulsive
treatment (i.e., electroconvulsive therapy or ECT), psychosurgery, sterilization, abortion, or placement in a mental health treatment facility.

The person you appoint as your agent has no authority to make decisions for you until you are unable to make those decisions yourself. Unless you choose to allow your agent to make those decisions for you immediately.

When you become incapacitated, your agent must make decisions that are consistent with any instructions you have written in the Advance Health Care Directive form or known in other ways, such as by telling family members, friends or your doctor. If you have not made your wishes known, your agent must decide what is in your best interests, considering your personal values to the extent they are known.

What should I tell my family, my health care agent, and my doctors?

One of the most important parts of completing an Advance Health Care Directive is the conversations you have about it with your loved ones and your physician. You should talk about: your personal values and what makes living meaningful for you; your current medical condition and decisions you may foresee in the future; specific concerns or wishes you may have regarding life support or aggressive interventions; hospice or long-term care; what concerns you most about death or dying; and how you would want to spend the last month of your life. It is recommended, although not always possible, that such a discussion include both your physician(s), and your health care agent (and alternate agent(s)).

Tell your loved ones that you have completed an Advance Health Care Directive and what you have said in it, especially if you have selected a health care agent. Your Advance Health Care Directive will likely go into effect during a period of crisis for them. It can help ease their burden to know that you have made some of these decisions in advance. In addition, they should know in advance who is to speak for you in making medical decisions and where copies of your Advance Health Care Directive can be found. Remind them that their role is to make sure that your wishes are communicated and that those wishes guide their decision making.

Will my health care agent be responsible for my medical bills?

No, not unless that person would otherwise be responsible for your debts. The Advance Health Care Directive deals only with medical decision making and has no effect on financial responsibility for your health care. Please note, however, that unless you have made other arrangements, your agent may be responsible for costs related to the disposition of your body after you die. Consult an attorney regarding how your financial affairs should best be handled.

For how long is an Advance Health Care Directive valid?

An Advance Health Care Directive is valid forever, unless you revoke it or state in the form a specific date on which you want it to expire.

What should I do with the Advance Health Care Directive form after I fill it out?

Make sure that the form has been properly signed, dated, and either notarized or witnessed by two qualified individuals (the form includes instructions about who can and cannot be a witness). Keep the original in a safe place where your loved ones can find it quickly. Give copies of the completed form to the people you have appointed as your agent and alternate agent(s), to your doctor(s) and health plan, and to family members or anyone else who is likely to be called if there is a medical emergency. You should tell these people to present a copy of the form at the request of your health care providers or emergency medical personnel.

Take a copy of the form with you if you are going to be admitted to a hospital, nursing home or other health care facility. Copies of the completed form can be relied upon by your agent and doctors as though they were the original.

In addition, you should fill out the contact list provided on the inside front cover of this kit. This will enable you to communicate any changes you make to your directive. Make sure you include the name, address, and telephone and fax numbers for each person or facility to whom you have given a copy of your Advance Health Care Directive form.
What if I change my mind after completing an Advance Health Care Directive?

You can revoke or change an Advance Health Care Directive at any time. To revoke the entire form, including the appointment of your agent, you must inform your treating health care provider personally or in writing. Completing a new CMA Advance Health Care Directive will revoke all previous directives. In addition, if you revoke or change your directive, you should notify every person or facility that has a copy of your prior directive and provide them with a new one.

You should complete a new form if you want to name a different person as your agent or make other changes. However, if you need only to update the address or telephone numbers of your agent or alternate agent(s), you may write in the new information, and initial and date the change. Of course, you should make copies or otherwise ensure that those who need this new contact information will have it.

You should make a list of the people and institutions to whom you give a copy of the form so you will know whom to contact if you revoke the Advance Health Care Directive, update contact information, or make a new one. The inside front cover of this kit provides a place for this list.

How will emergency personnel (such as paramedics) find my Advance Health Care Directive form in the event of an emergency?

On the back cover of this kit you will find two Advance Health Care Directive Wallet Identification cards. You should complete both cards. Keep one for yourself and give one to your spouse or someone who is likely to be contacted should you be in an emergency situation. The cards should be kept where emergency health care personnel will find them, such as in a wallet.

I have reached a point in my life that I don’t want the paramedics to give me CPR. Will this Advance Health Care Directive keep this from happening?

If the paramedics see your Advance Health Care Directive before they start resuscitative efforts, and the Advance Health Care Directive clearly instructs them not to start these efforts, they probably will not start resuscitation. The best approach is to complete the "Prehospital Do Not Resuscitate (DNR)" form and obtain a "Do Not Resuscitate- EMS" medallion approved by California’s Emergency Medical Services Authority. You may order copies of the DNR form (which includes instructions on ordering the medallion) from CMA publications. Please see the inside front cover of this kit for ordering information.

Is my Advance Health Care Directive valid in other states?

An Advance Health Care Directive that meets the requirements of California law may or may not be honored in other states, but most states will recognize an Advance Health Care Directive that is executed legally in another state. If you spend a lot of time in another state, you may want to consult a doctor, lawyer, or the medical society in that state to find out about the laws there.

Can anyone force me to sign an Advance Health Care Directive?

No. The law specifically says that no one can require you to complete an Advance Health Care Directive before admitting you to a hospital or other health care facility, and no one can deny you health insurance because you choose not to complete an Advance Health Care Directive.

Can I get more information about the Advance Health Care Directive?

Yes. Your doctor probably can provide you with more information. However, you should talk to a lawyer if you want legal advice.

For more information about end-of-life medical decisions, go to www.finalchoices.calhealth.org, the website for the California Coalition for Compassionate Care.

Sacramento Healthcare Decisions' booklet "Finding Your Way" is a useful guide to thinking about and discussing these issues. To order a copy, send a $1.50 check (payable to "Finding Your Way") to CAHHS Sales Center, PO Box 340100, Sacramento, CA 95834-0100.
ADVANCE HEALTH CARE DIRECTIVE
Including Power of Attorney for Health Care Decisions
California Probate Code Sections 4600-4805

MY HEALTH CARE WISHES

This form lets you give instructions about your future health care. It also lets you name someone to make decisions for you if you can't make your own decisions. It's best if you fill out the whole form, but, as long as it is signed, dated and witnessed or notarized properly, you may choose only to appoint an agent (section 1) or provide health care instructions (section 3). If there is anything in this form you do not understand, read the booklet that comes with this form and the italicized instructions on the form, or ask your physician, other health care professional or an attorney for help. You may also review additional information and instructions concerning advance health care directives on the California Medical Association’s website, www.CManet.org. Internet access is available at your local public library.

1. APPOINTMENT OF HEALTH CARE AGENT

☐ Option 1. I. ____________________________, wish to appoint a health care agent.

(Print your full name and date of birth)

Fill in below the name and contact information of the person(s) (your agent and alternate agent(s)) you wish to make health care decisions for you if you are unable to make them for yourself. You may appoint alternate agents in case your first appointed agent is not willing, able or reasonably available to make these decisions when asked to do so.

Your agent may not be:

A. Your primary treating health care provider.

B. An operator of a community care or residential care facility where you receive care.

C. An employee of the health care institution or community or residential care facility where you receive care, unless your agent is related to you or is one of your co-workers.

If you choose to name an agent, you should discuss your wishes with that person and give that person a copy of this form. You should make sure that this person understands your wishes and this responsibility and is willing to accept it.

OR

☐ Option 2. I. ____________________________, do not wish to appoint an agent at this time.

(Print your full name and date of birth)

If you choose not to name an agent, initial the box above, print your name on the line in the space provided, draw a line through the rest of this page, then continue to Section 3.

I hereby appoint as my agent to make health care decisions for me:

Name ____________________________

(agent’s name)

Address ____________________________

(street address, city, state, zip code)

Home Phone (____) __________________ Work Phone (____) __________________

Cell phone/Pager (____) __________________ Fax (____) __________________ e-mail __________________

I understand this appointment will continue unless I revoke it as explained in Section 5.

If I revoke my agent’s authority or if my agent is not reasonably available, able or willing to make health care decisions for me, I appoint the following person(s) to do so, listed in the order they should be asked:

OPTIONAL: 1st alternate agent: Name ____________________________ e-mail __________________

Address ____________________________

(street address, city, state, zip code)

Home phone (____) __________________

Work Phone (____) __________________ Cell phone/Pager (____) __________________ Fax (____) __________________

OPTIONAL: 2nd alternate agent: Name ____________________________ e-mail __________________

Address ____________________________

(street address, city, state, zip code)

Home phone (____) __________________

Work Phone (____) __________________ Cell phone/Pager (____) __________________ Fax (____) __________________

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2. AUTHORITY OF AGENT

Your agent must make health care decisions that are consistent with the instructions in this document and your known desires. It is important that you discuss your health care desires with the person(s) you appoint as your health care agent, and with your doctor(s). If your wishes are not known, your agent must make health care decisions that your agent believes is in your best interest, considering your personal values to the extent they are known.

If my primary physician finds that I cannot make my own health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any health care instructions set forth below. My agent will have the right to:

A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).

B. Choose or reject my physician, other health care professionals or health care facilities.

C. Receive and consent to the release of medical information.

D. Donate organs or tissues, authorize an autopsy and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, or by some other written method.

I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

OPTIONAL: I want my agent’s authority to make health care decisions for me to start now, even though I am still able to make them for myself. I understand and authorize this statement as proved by my signature ________________________________

3. HEALTH CARE INSTRUCTIONS

You may, but are not required to, state your desires about the goals and types of medical care you do or do not want, including your desires concerning life support if you are seriously ill. If your wishes are not known, your agent must make health care decisions for you that your agent believes is in your best interest, considering your personal values. If you do not wish to provide specific, written health care instructions, draw a line through this Section.

The following are statements about the use of life-support treatments. Life-support or life-sustaining treatments are any medical procedures, devices or medications used to keep you alive. Life-support treatments may include: medical devices put in you to help you breathe: food and fluid supplied artificially by medical device (feeding tube); cardiopulmonary resuscitation (CPR); major surgery: blood transfusions; kidney dialysis: and antibiotics.

Sign either of the following general statements about life-support treatments if one accurately reflects your desires. If you wish to modify or add to either statement or to write your own statement instead, you may do so in the space provided on a separate sheet(s) of paper which you must date and sign and attach to this form.

OPTIONAL: The statement I have signed below is to apply if I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support treatments are needed to keep me alive.

A. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician(s) allows me to die as gently as possible. I understand and authorize this statement as proved by my signature ________________________________.

OR

B. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

I understand and authorize this statement as proved by my signature ________________________________.

OPTIONAL: Other or additional statements of medical treatment desires and limitations: ________________________________

For additional Advance Health Care Directive options, go to the California Medical Association’s website at www.cmanet.org.

OPTIONAL: I have added _____ page(s) of specific health care instructions to this directive, each of which is signed and dated on the same day I signed this directive.
4. ORGAN AND TISSUE DONATION
I wish to be an organ donor. I understand and authorize this statement as proved by my signature ________________________________.

I have indicated this on □ my driver’s license and/or □ an attached page.

If you do not wish to be an organ donor, draw a line through this Section 4 and initial it.

For additional information concerning organ and tissue donation, go to the California Medical Association website at www.cmanet.org.

5. PRIOR DIRECTIVES REVOKED
I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

You may revoke any part of or this entire Advance Health Care Directive at any time. To revoke the appointment of an agent, you must inform your treating health care provider personally or in writing. Completing a new California Medical Association Advance Health Care Directive will revoke all previous directives. If you revoke a prior directive, notify every person, physician, hospital, clinic, or care facility that has a copy of your prior directive and give them a copy of your new directive, if you execute one.

6. DATE AND SIGNATURE OF PRINCIPAL
I sign my name to and acknowledge this Advance Health Care Directive:

__________________________________________
(signature of principal)

__________________________________________
(date of birth)

__________________________________________
(date of signing)

7. STATEMENT OF WITNESSES
This Advance Health Care Directive will not be valid unless it is either (1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature or (2) acknowledged before a notary public in California. If you use witnesses rather than a notary public, the law prohibits using the following as witnesses: (1) the persons you have appointed as your agent or alternate agent(s); (2) your health care provider or an employee of your health care provider; or (3) an operator or employee of an operator of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to you by blood, marriage or adoption, or be named in your will, or by operation of law be entitled to any portion of your estate upon your death.

Special Rules for Skilled Nursing Facility Residents
If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign as a witness and sign the Statement of Patient Advocate or Ombudsman. (See following page.) You must also have a second qualified witness sign below or have this document acknowledged before a notary public.

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence (“see next page), (2) that the individual signed or acknowledged this Advance Health Care Directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this Advance Health Care Directive, and (5) I am not the individual’s health care provider or an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

First Witness:

__________________________________________
(date)

__________________________________________
(name printed)

__________________________________________
(signature)

Residence Address: ____________________________________________________________

Second Witness:

__________________________________________
(date)

__________________________________________
(name printed)

__________________________________________
(signature)

Residence Address: ____________________________________________________________

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION:
I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the individual’s estate upon his or her death under a will now existing or by operation of law.

Date: __________________________ Signature: __________________________
FOR SKILLED NURSING FACILITIES: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses above, and must also sign the following declaration.

I further declare under penalty of perjury under these laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by Probate Code 4675.

Name/Title Printed ___________________________ Signature: ___________________________

Date: ______________________ Address: ___________________________

8. CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Acknowledgment before a notary public is not required if two qualified witnesses have signed on page 3. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses on page 3 and the Statement of Patient Advocate or Ombudsman above, even if you also have this form notarized.

State of California

County of ____________________________ ss.

On this _______ , before me, ____________________________ ,

(Date) (Name and Title of Officer)

personally appeared ____________________________________________ .

(Name(s) of Signer(s))

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

__________________________________________________________ (Signature of Notary Public) Notary Seal

9. COPIES

My agent and others may use copies of this document as though they were originals.

Your agent may need this document immediately in case of an emergency. You should keep the completed original and give copies of the completed original to (1) your agent and alternate agents, (2) your physician(s), (3) members of your family and others who might be called in the event of a medical emergency, and (4) any hospital or other health facility where you receive treatment. Instruct your agent(s), family, and friends to provide a copy of your directive to your physician(s) or emergency medical personnel on request.

Additional forms can be purchased from:
CMA Publications, P.O. Box 7690, San Francisco, CA 94120-7690
Phone: 1-800-882-1CMA • Fax: (415) 882-5195 • Internet: www.cmanet.org

*EVIDENCE OF IDENTITY: The following forms of identification are satisfactory evidence of identity: a California driver’s license or identification card or U.S. passport that is current or has been issued within five years, or any of the following if the document is current or has been issued within 5 years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number: a foreign passport that has been stamped by the U.S. Immigration and Naturalization Service; a driver’s license issued by another state or by an authorized Canadian or Mexican agency; an identification card issued by another state or by any branch of the U.S. armed forces, or for an inmate in custody, an inmate identification card issued by the Department of Corrections. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.
ADVANCE HEALTH CARE DIRECTIVE WALLET IDENTIFICATION CARD

These wallet cards are provided for the purpose of alerting emergency medical personnel that you have an Advance Health Care Directive in the event that you require medical treatment and are unable to talk. You should complete the cards by filling in the names and telephone numbers of your health care agent(s) or others who have a copy of your Advance Directive. Carry one of these cards with you at all times. Give the other to your spouse or other person who is likely to be contacted in the event of an emergency.

INSTRUCTIONS

1. On the top half of each card, print your full name and date of birth in the space provided.

2. On the lower half of each card, print the names and telephone numbers of the person(s) you have appointed as your health care agent and alternate agent(s) in the spaces provided. (Make sure the names and telephone numbers are the same as those listed in your Advance Health Care Directive form. Where the person has more than two phone numbers, use the numbers where the person is most likely to be reached in an emergency.) Space is also provided on the card to write in the name and telephone number(s) of a person who has a copy of your Advance Health Care Directive form. If you have not named alternate agents (or if you have not named an agent at all), you should list any other person who has a copy of your completed form. If more than three people have a copy, list the people who are most likely to be available by phone in the event of an emergency.

3. Carefully cut each card along the perforated lines, fold it in half, print sides showing, and place it in a conspicuous place in your wallet or billfold. Be sure to update the information on the card if there is a change in the telephone number(s) of any of the people you have listed on it, or if you subsequently complete a new Advance Health Care Directive form in which different individuals are designated to act as your agent and/or alternate agent(s).
1. **Change in health status** (How has your health been lately? Have you been hospitalized in the last 6 months?)

2. **Dementia** (Have you noticed any changes in your memory lately?)

3. **Transportation** (How do you get out for doctor’s appointments or errands? Do you have problems with transportation? Do you have Paratransit?)

4. **Housing Issues** (Where are you living now? How long?)

5. **Financial Issues** (Do you pay your own bills or does someone help with that? Do you run out of money before the end of the month?)

6. **Meals** (Do you cook for yourself? Do you have delivered meals?)

7. **Caregiver Issues** (Who else lives w/you? Who helps you the most? List contact info)

8. **In an emergency, whom should we contact?** (name/address/phone/relationship)
9. **Mental Health** (Have you been feeling sad or down lately? Include psych history)

10. **Violence/Domestic Violence** (Is anyone hurting you at home? Do you feel unsafe?)

11. **Are there weapons in your home?** (If yes, whose, are they in a secure place?)

12. **Other Community Services** (Do you have help from a social worker or therapist?)

**Referral to Social Service?**

Y (list issues)

N

I & R only (list)

Signature: _______________________________________

Co-Sign:
3. Case Management Checklist

Over 60 Health Center

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<tr>
<th>SERVICE</th>
<th>DATE REF'D</th>
<th>OUTCOME</th>
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<td>(Paratransit, Taxi Scrip)</td>
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<td>Food (Meals on Wheels, Congregate Meals,</td>
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</tr>
<tr>
<td>Management)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCOME: $_________/mo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source: _________ Source: _________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount: _________ Amount: _________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Safety (rugs, smoke alarms, grab bars,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>shower bench, handheld shower)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services (PHP, therapy,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychiatry, support groups)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Services (smoking cessation,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>counseling)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### End of Life Decisions
(burial plans, DPA-HC, DPA-F, Code Status – DNR)

### Durable Medical Equipment
(walking aides, bathroom, incontinence supplies)

<table>
<thead>
<tr>
<th>ADL/IADL</th>
<th>ADL#</th>
<th>IADL#</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE</td>
<td>Date</td>
<td>Score</td>
</tr>
<tr>
<td>GDS</td>
<td>Date</td>
<td>Score</td>
</tr>
<tr>
<td># of hospitalizations in past 6 mos</td>
<td>Date</td>
<td>#</td>
</tr>
</tbody>
</table>

**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:**
4. Client Assessment Form

Over 60 Health Center

Interviewer: ___________________________ Date: ______________

1. CLIENT IDENTIFICATION

Name ____________________________ Tel. _______________ If none, nearest tel. ________________

Social Security no. _________________ Date of Birth ________ Sex __ Religious Pref. ____________

Address _______________________________________________________ Zip Code __________

Apt. no. _____________________

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Ethnicity</th>
<th>Limited English Speaking</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>_ Single</td>
<td>__ Native American</td>
<td>__ No</td>
<td>__ Apt. - Private</td>
</tr>
<tr>
<td>_ Married</td>
<td>__ Asian/Pacific</td>
<td>__ Yes</td>
<td>__ Apt. - Public Housing</td>
</tr>
<tr>
<td>_ Separated</td>
<td>__ Black - Not Hispanic</td>
<td>__ If yes, list main language:</td>
<td>__ Sr. Housing (AL/RCFE)</td>
</tr>
<tr>
<td>_ Divorced</td>
<td>__ Hispanic</td>
<td></td>
<td>__ One Family House</td>
</tr>
<tr>
<td>_ Widowed</td>
<td>__ White</td>
<td></td>
<td>__ Multi-family House</td>
</tr>
<tr>
<td>date ______</td>
<td></td>
<td></td>
<td>__ Furnished Room</td>
</tr>
</tbody>
</table>

Past Profession: ___________________________

Limited English Speaking: __________

Housing: __________

Household Composition

<table>
<thead>
<tr>
<th>Lives alone</th>
<th>Lives with others:</th>
</tr>
</thead>
</table>

Household Composition

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                |                |

2. FAMILY CAREGIVER / PRIMARY CONTACT

Name ___________________________ Relationship ___________________________

Address _______________________________________________________________ Zip Code __________

Home phone _____________________________________ Work phone _______________________________

3. SOURCE OF REFERRAL AND PRESENTING PROBLEM

Name ___________________________ Telephone ________________

Presenting Problem:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
4. **FORMAL SUPPORTS, OTHER AGENCY INVOLVEMENT**

<table>
<thead>
<tr>
<th>Daily Schedule (Hours)</th>
<th>Name</th>
<th>Agency</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help at Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid Caregiver(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Agcy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeline/Vital Link</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly Visiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone Reassurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Center/ADHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. **INFORMAL SUPPORTS AND EMERGENCY CONTACTS**

Relatives, Friends, Neighbors Not Living With Client:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Landlord / Property Manager:

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **FINANCIAL STATUS**

**Source and Amount of Monthly Income**

- Social Security $ _____
- S.S.I. $ _____
- Pension (indicate source below) $ _____
- Veteran’s Assistance $ _____
- Interest / Dividends $ _____
- Other (specify on lines below) $ _____

**Monthly Expenses**

- Rent / Mortgage $ _____
- Utilities $ _____
- Telephone $ _____
- Taxes $ _____
- Health Insurance Premiums $ _____
- Medical Expenses $ _____

**TOTAL** $ _____

53
TOTAL $_______

 Assets
 Savings ____________________________  ____________________________

7. ENTITLEMENTS

<table>
<thead>
<tr>
<th></th>
<th>Client</th>
<th>Spouse</th>
<th>Total/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Stamps No. __________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare No. ___________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A ___</td>
<td>B ___</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal No. ____________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IHSS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 8 Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Health Insurance Coverage:
Carrier __________________________ Policy No. __________________________ Tel. __________________________

8. PHYSICAL STATUS AND HEALTH CARE

Medical care usually obtained from: Doctor _____ Hospital _____ Clinic _____
Name __________________________ Telephone __________________________
Address _____________________________________________________________________________

Name __________________________ Telephone __________________________
Address _____________________________________________________________________________

Visits doctor on a regular basis: Yes _____ No _____ Frequency __________

Last time doctor seen ___________ Why? __________________________

Hospitalization within last year (date and reason) __________________________________________
____________________________________________________________________________________

____________________________________________________________________________________
Current health problems ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
(Circle if present) Vision Impairment    Hearing Impairment    Literacy Issues

9. **ACTIVITIES OF DAILY LIVING**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Client’s Report of Help Needed</th>
<th>Interviewer’s Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Heavy housework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Light housework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Shopping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Getting to doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Meal Preparation (can cook or reheat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Washing / Bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Grooming / Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Cutting toe nails</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Getting in / out of bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Getting around the house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Walking stairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Going outdoors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Picking up mail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Taking medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Using Telephone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 10. MOBILITY AND OTHER AIDS

<table>
<thead>
<tr>
<th>Has</th>
<th>Needs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair, Manual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair, Electric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grab Bars - Toilet / Bath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower Hose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egg Crate Mattress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Door Locks (for wandering)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 11. LIVING CONDITIONS

<table>
<thead>
<tr>
<th>Safety Concern</th>
<th>Check if unsafe</th>
<th>Recommended Action</th>
<th>Date Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adequate: Yes ____ No ____ Adequate: Yes ____ No ____ Adequate: Yes ____ No ____
Rugs, carpet
Floors
Plumbing
Expired medication
Adequate lighting
Smoke alarms
Other

12. BURIAL INFORMATION

Funeral Home: ________________________________ Phone: ________________________________
Address: ___________________________________

Will / PoA - HC / PoA - F / DNR/ Organ Donation (circle which ones)

13. MENTAL STATUS  If interviewer notes problem or behavior, check item and give examples.

<table>
<thead>
<tr>
<th>Check if Yes</th>
<th>Observation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>looks fearful or apprehensive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>looks mournful or depressed, sad, tearful, sighed a lot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>is uncooperative, objects to interview, looks angry, expresses contempt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>laughs excessively, unduly euphoric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>restless (fidgets, squirms, moves about)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bizarre behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>talks to self</td>
<td></td>
</tr>
<tr>
<td></td>
<td>has difficulty concentrating</td>
<td></td>
</tr>
<tr>
<td>Evidence of Substance Abuse</td>
<td>Memory Loss</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Disorientation, Confusion</td>
<td>Forgetfulness</td>
<td></td>
</tr>
<tr>
<td>Inability to Cope</td>
<td>Anxiety/Panic Attacks</td>
<td></td>
</tr>
<tr>
<td>Agitation (Verbal or Physical Aggression)</td>
<td>Hallucinations, Delusions</td>
<td></td>
</tr>
<tr>
<td>Sleeping Problems</td>
<td>Hides Valuables</td>
<td></td>
</tr>
<tr>
<td>Boredom</td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Other (Describe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Testing Done: MMSE (Score): GDS (Score):

**Psychosocial Stressors**

Developmental and Family History: (Relationships, children, pregnancies, childhood trauma, losses)

Recent losses/stressors:
History of suicidal ideation/attempts:

Abuse potential: Physical (including domestic violence), emotional, fiduciary, alcohol/other drugs

14. ACTIVITIES OF INTEREST (Interviewer should list all events that could be considered to provide some social stimulation.)

15. CAREGIVER STRESS (Include health problems, depression, medications, social supports, outside interests and an assessment of caregiver’s attitude and perception of the situation.)

16. TREATMENT PLAN:
5. Initial Mental Health Assessment
Over 60 Health Center

Client Name: ____________________________  MR# __________

Date: ____________________

Referred by: ____________________________

Therapist: _____________________________

Brief description of client and presenting problem:

Medical Problems:

Mental Health History (diagnosis, ever hospitalized? Medication, therapy, other treatments? Suicidal, homicidal or violent behavior?)

Personal and Work History: (where born, significant family history, trauma or abuse, work and personal interests)

Substance Abuse History: (alcohol or drug use, prescription or street drugs, when did use begin, how often, etc)

Support Systems: (Include emotional and spiritual supports.)
Provisional Diagnostic Impression:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Initial Treatment Plan:

- Specify frequency and duration of therapy sessions; date to re-evaluate need for further services.
- Outline measurable goals for treatment and specific interventions

__________________________________________________________________________________________
Therapist Signature
6. Depression Screener PHQ2
Over 60 Health Center

LifeLong Medical Care IMPACT Program
PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

Name:                                                                        Date:
Chart #: 

Over the last 2 weeks, how often have you been bothered by
any of the following problems?
Please mark (X) the boxes to indicate your answer.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

For Staff Use Only

Intervention:

( ) None, place in Social Service Referral Box

( ) To Depression Care Manager for follow-up (place in SS Referral Box)

( ) Page on-call SW (801-0307) to provide patient more information about IMPACT
Over the *last 2 weeks*, how often have you been bothered by any of the following problems? Please mark the boxes to indicate your answer.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*add columns*  
TOTAL

<p>| 10. If you checked off <em>any</em> problems, how <em>difficult</em> have these problems made it for you to do your work, take care of things at home, or get along with other people? |
|---|---|---|---|---|
| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|                  |                  |                  |                      |</p>
<table>
<thead>
<tr>
<th>For Staff Use Only</th>
<th>WW: □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinks of alcohol ________ per D / W / M</td>
<td></td>
</tr>
<tr>
<td>MMSE _________ / 30</td>
<td></td>
</tr>
<tr>
<td>Type: Clinic Phone Home Rx:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Dosage:</td>
<td></td>
</tr>
</tbody>
</table>

10/27/06
# Mini Mental Health Status Evaluation

**Over 60 Health Center**

**Name:** ______________      **Examiner:** ____________

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the: (year) (season) (date) (day) (month)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where are we: (state) (county) (town) (facility) (floor)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REGISTRATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name three objects and have person repeat them back (immediately): <strong>House, Tree, Airplane</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give one point for each correct answer on the first trial.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ATTENTION AND CALCULATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
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<tr>
<td>Serial 7's. Count backwards from 100 by serial 7's. Stop after 5 answers. (93 86 79 72 65)</td>
<td></td>
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<tr>
<td>Alternatively spell &quot;world&quot; backwards. (D - L - R - O - W). One point for each correct answer.</td>
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<tr>
<td><strong>RECALL</strong></td>
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<td>3</td>
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<tr>
<td>Ask for the names of the three objects learned above. Give one point for each correct answer.</td>
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<tr>
<td><strong>LANGUAGE</strong></td>
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<tr>
<td>2</td>
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<tr>
<td>Name: a pen (1 point) and a watch (1 point)</td>
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<td>1</td>
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<tr>
<td>Repeat the following: &quot;No ifs, ands, or buts&quot;</td>
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<td></td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>Follow a three-stage command: &quot;Take this paper in your (non-dominant) hand, fold it in half and put it on the floor&quot;. (1 pt for each correctly performed)</td>
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<td>1</td>
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<tr>
<td>Read to self and then do: &quot;Close your eyes&quot;</td>
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<td></td>
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<tr>
<td>1</td>
<td></td>
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<tr>
<td>Write a sentence (subject, verb and makes sense)</td>
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<tr>
<td><strong>Visuospatial</strong></td>
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<td>1</td>
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<tr>
<td>Copy design (5 sided geometric figure; 2 points must intersect)</td>
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<tr>
<td><strong>Total Score</strong></td>
<td><strong>/30</strong></td>
<td><strong>/30</strong></td>
<td><strong>/30</strong></td>
<td><strong>/30</strong></td>
<td><strong>/30</strong></td>
<td><strong>/30</strong></td>
</tr>
</tbody>
</table>

Level of Consciousness (circle one)
Alert, Drowsy, Stupor, Coma

Interpretation:
25-30 Normal
21-24 Mild Intellectual Impairment
16-20 Moderate Intellectual Impairment
Close Eyes

(Patients are asked to write a sentence before closing their eyes.)
9. Information For Clients
Over 60 Health Center

Information About the Process of Therapy
Many people find it helpful to have a place to talk about their feelings and concerns; their problems, and their goals and hopes for the future. The process of therapy can offer a safe place to explore these issues. This process will involve effort on your part, a willingness to be honest with yourself and your therapist, and an investment of time and attention to the issues that you bring to the therapy. In many cases, the outcome of this process is improvement in relationships, a greater understanding of yourself and your experiences and a clearer idea of your problems and the steps you might decide to take to address them.

Confidentiality in Therapy
In order for therapy to be most helpful to you, it is important that you feel comfortable with your therapist and willing to open up to him/her. As your therapist I have a duty to keep what you talk about during your sessions confidential and not to release information about you or your sessions to anyone without your permission. The only exceptions to this rule of confidentiality are spelled out below:

1) If you threaten to harm someone else, and I believe that this threat is serious, I am required to take steps to protect people who are in danger. These steps include calling the person or people who are threatened with harm and notifying the police.
2) If you threaten to cause severe harm to yourself and I believe that the threat is serious, I am required to take steps to protect your safety. These steps may include talking with you about going to a hospital voluntarily, involuntarily or calling the crisis team or police.
3) If I suspect that a child, elderly person or dependent adult is or has been abused or neglected, I am required to report this to the appropriate county agency.

Billing Information and Missed Appointment Policy
Your insurance will be billed for our sessions. If you have a co-payment, it will be billed to you directly and you are responsible for prompt payment. Please speak with your therapist about any financial concerns that you may have before you sign the consent below.

If you are unable to keep your appointment, please call the main number, 601-6060 as soon as possible. You will be offered the next available appointment time. Missed appointments without prior notice may be charged a missed appointment fee.
**Emergency Contact Information**

If you need to reach me for any reason during business hours, you can call my direct number at _______________________. Please know that I am often away from my desk but check my messages frequently. I will return your call at my earliest convenience.

If you cannot reach me, or it is after business hours, please call the emergency room of the nearest hospital and ask for the mental health professional on call OR call the mental health crisis line for Alameda County at 800-491-9099.

**Acknowledgement**

In signing this form, you are acknowledging that you understand what you have read above, that you have asked any questions you may have, and that your questions have been answered to your satisfaction.

Client Signature_______________________________________________________  
Date:______________________________

Therapist Signature_____________________________________________________
Date:_______________________________
10. Substance Abuse Counseling
Initial Assessment
Over 60 Health Center

Client Name: ________________________________

Date: ________________________________

Counselor: ________________________________

**Brief description of client**: (include where born, early history, family history and any use of alcohol/other drugs by family members)

**Medical Problems:**

**Substance Abuse History**: (alcohol or drug use, prescription or street drugs, when did use begin, how often do you use, etc)

**Treatment and relapse history** (inpatient or outpatient, how recent):

**Mental Health History** (diagnosis, hospitalized? Medication, therapy treatments? Suicidal, homicidal or violent behavior?)

**Work History and Financial Issues**: (amount & source of income, insurance and benefits issues)

Social Security:
SSI:
Pension:
Other:

Support Systems: (Include emotional and spiritual supports. List name, relationship and contact info):

Initial Treatment Plan:

Problem:
Goal:
Intervention:

Problem:
Goal:
Intervention:

Problem:
Goal:
Intervention:

________________________________________________________

Signature, Substance Abuse Counselor
DATE: ______________

We would like to know how you feel about us. Your responses are kept confidential. Please circle the number that best rates your experience here in the last 12 months. Thanks!

IN THE LAST 12 MONTHS, RATE YOUR EASE OF GETTING CARE:

<table>
<thead>
<tr>
<th></th>
<th>GREAT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>DOES NOT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was it easy to be seen at our clinic?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Hours clinic is open?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Can you get through on the telephone <strong>during</strong> business hours?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Can you get through on the telephone <strong>after</strong> hours?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. If you were sent to an outside specialist (such as a heart doctor or allergy doctor), how easy was it to get an appointment?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>

IN THE LAST 12 MONTHS, HOW WAS YOUR WAITING TIME?

<table>
<thead>
<tr>
<th></th>
<th>GREAT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>DOES NOT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. In the waiting room?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. In the exam room?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

IN THE LAST 12 MONTHS, HOW DO YOU RATE OUR PROVIDER STAFF? (DOCTORS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS)

<table>
<thead>
<tr>
<th></th>
<th>GREAT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>DOES NOT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Listened carefully to you</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Explained things clearly</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

IN THE LAST 12 MONTHS, HOW DO YOU RATE ALL OTHER CLINIC STAFF?

<table>
<thead>
<tr>
<th></th>
<th>GREAT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>DOES NOT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Friendly and helpful</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

GENERAL:

<table>
<thead>
<tr>
<th></th>
<th>GREAT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
<th>DOES NOT APPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Please rate your overall satisfaction with the clinic.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. How would you rate your health now?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Would you refer your friends and relatives to us?</td>
<td>YES</td>
<td>NO</td>
<td></td>
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</tr>
</tbody>
</table>

14. Your sex? □ Female □ Male

15. What is your race/ethnicity?
   □ Asian/Pacific Islander □ American Indian/Alaska Native □ White (Not Hispanic or Latino)
   □ Black/African American □ Hispanic or Latino (all races) □ Other

😊 THANK YOU FOR COMPLETING OUR SURVEY! 😊