November 1, 2007

MEMORANDUM

To: The Honorable Timothy M. Kaine
Governor of Virginia

The Honorable Vincent F. Callahan, Chairman
House Appropriations Committee

The Honorable John H. Chichester, Chairman
Senate Finance Committee

From: William S. Massey
Chief Executive Officer
Peninsula Agency on Aging, Inc.

Subject: Report on Success of the Senior Outreach to Services Pilot

The enclosed report is submitted pursuant to Item 280(m) of the 2006 Appropriation Act, which authorized the Peninsula Agency on Aging to use existing funding provided for care coordination for the elderly to conduct a pilot program providing mobile, brief intervention and service linking as a form of care coordination. The Agency shall report on the pilot project including the design of the program, the cost of the program, staffing, the number of individuals served, and the impact on overall care of individuals in the program. The Agency shall report on the pilot program to the Governor and Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2007.

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Item 280(m) of the 2006 Appropriations Act authorized the Peninsula Agency on Aging (PAA) to use existing Case Management for Elderly Virginians funding in the amount of $101,797 to provide a mobile, brief intervention and service linking form of care coordination. Staffing consists of 3 FTE Social Workers, 1 FTE Administrative Assistant and .5 FTE Supervisory Staff. This approach, Senior Outreach to Services (S.O.S.), has proven highly effective in linking seniors with existing services.

S.O.S. focuses on literally taking care coordination to the senior and reduces the intake form to one piece of paper, albeit both sides are used (see Attachment A). Success is judged by the number of services implemented based on assessed need compared to referrals for service. The S.O.S. success rate in fiscal 2007 was 90.6%. There was also a 400% increase in seniors served (873) compared to fiscal 2006 at no additional cost to the Commonwealth (see Attachment B for full details).

Background:

The S.O.S. model was developed in 2003 in collaboration with senior service providers serving the Virginia Peninsula and with a $100,000 grant from the Newport News based Bernardine Franciscan Sister's Foundation.

Senior Outreach to Services (S.O.S.) is a mobile, brief intervention, and service linking form of care coordination. S.O.S. provides an aggressive information and assistance/outreach service to seniors living in the community. The objective of S.O.S. is to link as many eligible seniors as possible with existing services. To promote independent living, S.O.S. assists seniors with paperwork, makes calls on their behalf, follows up with the senior and the service provider, brings resource/education programming to congregate housing

sites and regularly meets with seniors on their home territory. S.O.S. utilizes evaluation tools developed by Virginia Commonwealth University during the development phase of the S.O.S. Pilot to provide data in support of community needs assessment and community planning activities (see Attachment C for comprehensive service description).

After two years operating S.O.S. as a grant-funded project, the effectiveness of this streamlined approach to linking seniors with services was clear. Armed with evaluation data complied by the Department of Gerontology at Virginia Commonwealth University, PAA approached Delegate Phillip Hamilton and requested his assistance in gaining approval to pilot S.O.S. using existing Case Management for Elderly Virginians funding. Delegate Hamilton agreed to sponsor our request and as noted earlier in this report, permission was granted in the 2006 Appropriations Act.

A service standard for S.O.S. was developed by the Virginia Department for the Aging and PAA began expanded use of the S.O.S. Model in October of 2006. The past twelve months have only served to further validate PAA's belief that a streamlined approach to care coordination is effective and will serve the Commonwealth well as we gird for the onslaught of baby boomers.

Evaluation:

S.O.S. staff complete written assessments/intake forms. A specially designed ACCESS database tracks client data/services monthly. Quality assurance and assessment of impact of service on overall care of individual being served also occurs through client surveys.

Results of 46 Responses on S.O.S. Satisfaction Survey (phone calls) April and May 2007

74% stated they learned a great deal
96% stated they would call the S.O.S. worker again

Results of 47 Responses (86 sent) Impact Survey (mailed) Spring 2007

85% received help that improved their health
83% gained greater knowledge of services in community

Results of 51 Responses on Seminar Evaluations

78% rated information as excellent
11% rated information as good.

Case Example:

Ethel moved from New Jersey to a S.O.S. complex to be closer to her son as she was homebound. She called PAA about receiving Meals on Wheels. In addition to arranging Meals on Wheels, the S.O.S. social worker worked with her to help her qualify for Medicaid. Ethel was hearing impaired and the Social Worker visited her at home to help her through the phone interview for food stamps. The senior also received a free fan during the heat of the summer.

Recommendations:

Virginia's Area Agencies on Aging have been kept abreast of progress with the S.O.S. pilot and several have expressed interest in replicating the model. One Area Agency

on Aging has begun to replicate S.O.S. utilizing grant funding. Given the foregoing, PAA recommends the General Assembly grant authority to all Virginia Area Agencies on Aging to utilize existing Case Management for Elderly Virginians funding to replicate the S.O.S. form of care coordination at their discretion. It is also recommended that Area Agencies on Aging be authorized to use other appropriate funding to support S.O.S.

Peninsula Agency on Aging

SOS Intake / Referral Form

Date: _____

CLIENT NAME: _____

PHONE #: _____

Case Worker: _____ ☐ **Own Home** ☐ **Congregate Housing Site** _____

√	*Current formal services/benefits*	**Info Only**	**Referrals**			Non-Implemented
	Services	Date	Date	Provider	Implemented Date	Code / Date
	Adult Day Care					
	Adult Protective Services					
	Chore/Companion/Homemaker					
	Congregate Meals/ Senior Centers					
	Dementia Services					
	Dental Services					
	Disaster Preparedness					
	Durable Medical Equipment					
	Emergency Assistance (utilities,food,RX)					
	Emergency Response System					
	Energy Assistance (fuel, cooling, fans)					
	Fan Care					
	VDA/Cooling Assistance					
	Energy Share					
	Heating Asst (Social Services)					
	Eye and Ear Care					
	Financial Management/ Counseling					
	Food Stamps-Certification/Recertification					
	Friendly Visitor/Telephone Assurance					
	Health and Wellness					
	Holiday Assistance / Special Help					
	Home Delivered Meals/Supplement					
	Home Health / Therapy / Hospice					
	Home Repairs / Ramps / Yardwork					
	Housing					
	Med Mgmt					
	Medicaid-Certification / Recert / CBC					
	Medical Supplies (diabetic/incontinent)					
	Medicare (not Medicare D)					
	Nutrition Counseling					
	Personal Care					
	Physician Linkage					
	Rx Assistance / Medicare D / Extra Help					
	Safety at Home					
	Support Groups/Caregiver Support					
	Transportation					
	Other:					
	Other:					

Emergency Contact: _____ **Relationship** _____ **Phone #** _____

☐ Consent on File ☐ UAI on file

VIRGINIA SERVICE – QUICK FORM

Today's Date _____/_____/_____

Updated _____/_____/_____

Client Name & Demographic Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street)

_____
(City) (State) (Zip)

Phone: (____) _____ County or City of Residence: _____

Social Security Number: _____-_____-_____ Is There a Caregiver? Yes ____ No ____

Birthdate: _____/_____/_____ Gender: ____ Male ____ Female
(Month) (Day) (Year)

Race Status:

____ White or Caucasian Only
____ Black / African American Only
____ American Indian or Alaskan Native Only
____ Asian Only
____ Native Hawaiian or Pacific Islander Only
____ Some Other Race Only
____ Two or More Races Combined
____ Race Unknown or Unreported

Hispanic Origin:

____ Hispanic or Latino Origin **OR** _____ **Not** Hispanic or Latino Origin **OR** _____ Hispanic Ethnicity Unknown

Physical Environment

_____ No one else lives in my home

_____ Yes, I live with someone

Financial Resources

Number of members in immediate family: _____

Total monthly income of immediate family: $ _____

In Federal Poverty? Yes _____ No ____

Sliding Fee Scale Level? A____ B____ C____ D____ E____ F____ G____
(If applicable)

For Office Use Only
Services Requested:

_____

_____

Services Provided:

_____

_____

Agency / Provider: _____ PSA No. _____

NOTE: At a minimum, this form must be updated annually in order for a client to continue service.

S.O.S. Intakes/Referrals/Implementations October 2006 - September 2007

	Referrals														
Service	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**TOTALS**	**INTAKE TOTALS**	
Adult Day Care	4	4	2	4	2	2	3		2	4			**27**	Oct-06	**253**
Adult Protective Services	2	2	1	1	3		1	1	1			1	**13**	Nov-06	**73**
Chore/Companion/Homemaker	3	4	3	2	3	7	6	8	9	10	6	4	**65**	Dec-06	**51**
Dementia Services	3	1	1	6	3	1	2	3	3	7	3	1	**34**	Jan-07	**35**
Dental Services			5			3	2	1	3			1	**15**	Feb-07	**36**
Disaster Preparedness	7	12	8	7	11	4	10	12	7	2	4	8	**92**	Mar-07	**48**
Durable Medical Equipment	1	2		3	5	4	6	4	3	3	4	4	**39**	Apr-07	**32**
Emergency Assistance	18	6	2	1	2			3		5		2	**39**	May-07	**36**
Emergency Response System	16	16	20	17	18	6	12	18	10	17	5	14	**169**	Jun-07	**126**
Employment/Job Counseling					1						1		**2**	Jul-07	**69**
Energy Assistance	46	21		1		1			226	28	113	58	**494**	Aug-07	**78**
Eye/Ear Care	1	23	3			1	3	4	3	4	1		**43**	Sep-07	**36**
Financial Mgmt/Counseling		1	1		2	1	5	1	2	2	2	2	**19**	**TOTAL**	**873**
Food Stamps		2	4	3	7	3	1	2	6	1			**29**		
Friendly Visit/Telephone Assurance	10	9	8	7	10	6	7	7	5	10	7	4	**90**		
HDM/Supplement	29	15	21	9	5	2	6	11	27	43	38	25	**231**		
Health/Wellness	44	6		3	2	4	3			4	2	5	**73**		
Holiday Assistance/Special Help	198	31	40							1			**270**		
Home Health/Therapy/Hospice	12	1	1							1	1		**16**		
Home Repairs	1	2	3	2	2	3	4			3			**20**		
Housing			1		1		6	2	3	1			**14**		
Legal Assistance						1		4		3	3		**11**		
Med Mgmt	13	7	11	10	13	9	17	15	14	22	23	16	**170**		
Medicaid	2	3	3	2	4	3	2	3	6	1	2	1	**32**		
Medical Supplies	2		1		3	5	5	1		1	6	2	**26**		
Medicare	1	1	3	1	3		1	1	1		1	1	**14**		
Mental Health	1				2		2					1	**6**		
Nutrition Counseling											2		**2**		
Personal Care	9	3	10	6	9	19	16	9	13	12	9	15	**130**		
Physician Linkage	10	3	3	5	1	1	2	4	3	2	1	2	**37**		
Rx Assistance/Medicare D	4	3	6	1	3	3	3	1	1		2		**27**		
Safety at Home				4	2				1	6	1	3	**17**		
SSA/SSI					1	1					2		**4**		
Support Groups		1	1	2		12		1		1	1		**19**		
Tax Assistance	1	1		1		4	2		2				**11**		
Transportation	6	8	9	8	7	6	13	9	8	14	8	7	**103**		
Veterans Benefits		1						1	1		1	2	**6**		
Websites								1		1	2		**4**		
Other	2	2								4	2	1	**11**		
Other: Auxillary Grant				1									**1**		
Other: Discount Phone Service				2	4	1	1				1		**9**		
Other: DNR										1			**1**		
Other: Caregiver Grant				13			1						**14**		
Other: Caregiver Newsletter				2			1	1	3	1	2	1	**11**		
Other: Caregiver Support							3	1	3				**7**		
Other: Family Coordination					1								**1**		
Other: Do Not Call List												7	**7**		
Other: Medicare Respite					1								**1**		
Other: Medicare Respite Benefit					1								**1**		
Other: Project Lifesaver					1								**1**		
Other: Rehab					1								**1**		
Other: Hair Care						1			1				**2**		
Other: Computer Training									1				**1**		
Other: Foster Grandparents									1				**1**		
Other: TTY Machine						1							**1**		
Other: Furniture				1	1								**2**		
Totals	**446**	**191**	**171**	**125**	**135**	**115**	**146**	**129**	**369**	**215**	**256**	**188**	**2486**		

S.O.S. Intakes/Inplementations October 2006 - September 2007

	Implementations												
Service	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**TOTALS**
Adult Day Care	1	2	3	2	1	2	1	2		2			**16**
Adult Protective Services	2	1	1	1	2	1	1		2			1	**12**
Chore/Companion/Homemaker	1	1			1	2	7	7	11	10	4	3	**47**
Dementia Services	3		1	6	1	2	2	3	4	4	4	1	**31**
Dental Services	4	1				4						3	**12**
Disaster Preparedness	6	12	8	8	9	6	14	11	20	2	4	8	**108**
Durable Medical Equipment		2	1	3	5	2	8	3	1	4	4	6	**39**
Emergency Assistance		3	17	6	2			2		5		10	**45**
Emergency Response System	13	17	15	19	16	7	11	12	16	16	5	11	**158**
Employment/Job Counseling					1						1		**2**
Energy Assistance	3	2	21	38		1		1	84	137	116	4	**407**
Eye/Ear Care		2	22	1		1	2	2	1	1		1	**33**
Financial Mgmt/Counseling				1	1	3	3	2	3		2	2	**17**
Food Stamps		1	4	1	1	2	1	3	1	4	1		**19**
Friendly Visit/Telephone Assurance	8	6	8	5	9	7	6	5	7	9	7	4	**81**
HDM/Supplement	22	12	20	9	5	2	3	10	18	44	38	24	**207**
Health/Wellness	43	6		2	1	6	1	1		3	3	5	**71**
Holiday Assistance/Special Help	53	1	201	4						1			**260**
Home Health/Therapy/Hospice	9	3	1				1			1	1		**16**
Home Repairs		2	1		2	2			1		1	1	**10**
Housing			1				6		3	1			**11**
Legal Assistance						1		3		2	4		**10**
Med Mgmt	13	7	10	11	13	9	15	16	14	23	24	16	**171**
Medicaid	1	3	2	1	1	3	2	3	1	2	3		**22**
Medical Supplies		2		1	3	5	5	1		1	5	3	**26**
Medicare		2	3	1			1	2	1				**10**
Mental Health		1			2		2					1	**6**
Nutrition Counseling											2		**2**
Personal Care	3	3	6	9	5	18	15	7	10	13	12	11	**112**
Physician Linkage	6	5	3	6	1	1	1	2	4	2	1	2	**34**
Rx Assistance/Medicare D	2	4	5	2	1	3	2	2	1		2		**24**
Safety at Home				2	2	28			1	2	5	3	**43**
SSA/SSI						1				1	1		**3**
Support Groups		1		3			1		2	1	1		**9**
Tax Assistance	1			1		2	3		2			1	**10**
Transportation	7	2	11	8	5	6	8	12	9	13	10	7	**98**
Veterans Benefits		1							2		1	2	**6**
Websites										1	2		**3**
Other		2	3		3		3	4		1	4	1	**21**
Other: Auxillary Grant													**0**
Other: Discount Phone Service				1	2	1	1				1		**6**
Other: DNR				2						1			**3**
Other: Caregiver Grant													**0**
Other: Caregiver Newsletter				2			1		3	1	2	1	**10**
Other: Caregiver Support							3	1	3				**7**
Other: Family Coordination					1								**1**
Other: Do Not Call List											1	7	**8**
Other: Medicare Respite Benefit													**0**
Other: Project Lifesaver					1								**1**
Other: Rehab					1								**1**
Other: Hair Care							1						**1**
Other: Computer Training									1				**1**
Other: Foster Grandparents													**0**
Other: TTY Machine													**0**
Other: Furniture					2								**2**
Totals	**201**	**107**	**368**	**156**	**100**	**128**	**131**	**117**	**226**	**308**	**272**	**139**	**2253**

SENIOR OUTREACH TO SERVICES (S.O.S.)

Definition

Senior Outreach To Services (S.O.S.) is designed to be a mobile, brief intervention, and service linking form of care coordination. S.O.S. will provide an aggressive information and assistance/outreach service to seniors living in the community. The objective of S.O.S. is to link as many eligible seniors as possible with existing services. To promote independent living, S.O.S will assist seniors with paperwork, make calls on their behalf, follow up with the senior and the service provider, bring resource/ education programming to congregate housing sites and regularly meet with seniors on their home territory. S.O.S. will utilize the evaluation tools developed by Virginia Commonwealth University during the development phase of the S.O.S. model to provide data in support of community needs assessment and community planning activities.

Eligible Population

Individuals are eligible for S.O.S if they are 60 years of age or older and living in the community.

Service Delivery Elements

Agencies providing S.O.S. must perform all of the following components:

Resource File: The utilization of accurate, up-to-date, and well-organized information systems on opportunities, services and resources available in the community, including detailed data on service providers.

Electronic Media: The process of receiving and soliciting information via the Internet and email. The use of electronic screening tools and web-based systems such as SeniorNavigator.com, BenefitsCheckUp.org, and SSA online screening tools are encouraged.

Outreach: Outreach is the proactive seeking of older persons who may be in need of S.O.S. assistance. Strategies for outreach include, but are not limited to:

- Resource/educational programming provided to congregate housing residents
- Home visits to individuals residing in single family homes and congregate housing

Information: The process of informing an older person of available opportunities, services, and resources.

Screening/Assessment: Screening/assessment, using the S.O.S. Intake/Referral Form is conducted with the older person and, if applicable and with the older person's permission, his or her caregiver(s). The interview is conducted in the person's residence or in a private portion of a congregate housing community room. Cost sharing does not apply to this service.

Attachment C (4 Pgs)

Referral/Assistance: The process of initiating an arrangement between the older person or caregiver and the service provider; advising older persons and their caregivers: providing information to older persons to link them with the opportunities, services, and resources available to meet their needs; assisting the person or caregiver to contact the appropriate community resource; and if necessary, advocating with agencies on behalf of older persons.

Follow-Up: The process of contacting individuals and the organizations to which they were referred to determine the outcome of the referral. Determining the quality and effectiveness of the referral and the service provided to the person referred. Additional assistance to the individual in locating or using needed services may be a part of the follow-up. Follow-up is an integral part of the S.O.S. model and must be completed whenever possible.

Planning and Evaluation: The process of aggregating and analyzing information collected through the use of the service utilizing evaluation instruments developed and tested by Virginia Commonwealth University.

Administrative elements

A qualified Care Coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the Care Coordinator's job application, or observable in the job or promotion interview.

Staff Qualification:

- Knowledge: Care Coordinators should have a knowledge of aging and/or the impact of disabilities and illness on aging; conducting client interviews; local human service delivery systems, including support services and public benefits eligibility requirements; effective oral, written, and interpersonal communication principals and techniques.

- Skills: Care Coordinators should have skills in negotiating with consumers and service providers; identifying and documenting a consumer's needs for services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers.

- Ability: Care Coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; maintain effective inter- and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and communicate with different types of persons from diverse backgrounds, and interview.

Individuals meeting all the above qualifications shall be considered a qualified Care Coordinator; however, it is preferred that the Care Coordinator will possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition it is preferable that the Care Coordinator will have two years of satisfactory experience in the human services field working with the aged or disabled.

* It is acceptable for administrative staff to coordinate the Resource/Educational program component of S.O.S.

Units of Service:
Units of service must be reported in AIM for each client receiving services. Service units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month

- Persons served (unduplicated)
- Referrals: the number of referrals made to service providers, including referrals for area agency on aging services.
- Implementations: the number of services implemented.
- Group Presentations: the number of presentations made to groups of seniors.

Program Reports:

- Aging Monthly Reports (AMR) to VDA by the twelfth (12^{th}) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.
- AIM client level data transmitted to VDA by the last day of the following month.

Quality Assurance:

Criminal Background Checks:

- VDA strongly recommends that the agency and their contractors protect their vulnerable older clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:

- Staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Care Coordinators should receive a minimum of 10 hours of in-service training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision/Case Review:
Consultation, supervision and case review shall be available to all staff providing the service.

Program Evaluation:
The agency should conduct regular systematic analysis of the persons served and the impact of the service utilizing the Virginia Commonwealth University evaluation tools.

Client Record:

Service providers must maintain specific program records that include:

- S.O.S. Intake/Referral Form (which incorporates the Virginia Service – Quick Form in its entirety).
- Consent to Exchange Information Form.
- Progress Notes or contact logs to document case activity.