SeniorCare Direct Consumer Services

Information and Referral Department Services

The Information and Referral Department has the responsibility of being the point of entry for all referrals and inquiries for the whole of the Agency. It is the responsibility of the Specialist to determine the needs of the caller in an efficient and winsome manner and ensure that to the best of our ability we answer the questions, complete the referrals and otherwise see to it that that caller's needs are met within the realm of elder and now disability services.

Accepts calls from individuals with questions on available resources to include any and everything related to senior services, and more. Sends out requested information, resources, to include an array of brochures and pamphlets specific to the caller's need. Keeps an inventory of these materials. **Conducts follow-up calls to determine if the information was helpful, correct, and acted upon.** If determined that the Elder is incapable of making the calls independently, the Specialist will assist that caller. This is in fulfillment of the state regulation relative to advocacy. Some of the most common requests for information would be: Long Term Care facilities, Medication, Elder Law Attorney's, in home services such as hairdressers, homemakers, personal care workers and transportation resources

The Specialist maintains this extensive and ever growing database of resources for seniors and those with disabilities, which must be reviewed annually for accuracy.

Accepts and records all HC Intakes from outside sources such as; medical offices, agencies, hospitals, skilled nursing facilities, family, friends, and housing. Acknowledges these referrals by written thank you to the reporter. Schedules the home care intake visits utilizing a master calendar of available Care Managers. The **Specialist attends Interdisciplinary meetings** to present the Intakes and ensure all the information is appropriately and accurately related to the HC team for follow through. Topics such as urgency, special circumstances, allergies, other in place services, contact or point person, and discharge dates are highlighted.

Accepts and records all Nutrition, Nursing Home Screens, Option Counseling, Elder Care Advice, Caregiver Support Referrals, and Housing Referrals, recording each and sending the appropriate activity to the designated department for action.

Takes Protective Services reports, sends mandated reporter form requests. Processes through a separate database, Adult Protective Services. Specialist will review the Intake with the Protective Service Supervisor as a final step in the intake process.

Every call for any reason is processed through the intrastate database: SIMS/SAMS, to include identifying information, and journal notes specific to that call. The department receives approx. 4500 calls per year, incoming, and an equal number of outgoing or follow-up calls are completed.

The Specialist is trained in the use of the TTY apparatus for use with the Deaf, and **Mass Relay** for other disabilities that might prevent the use of a conventional phone, and **is able to access interpretation services when needed.**

The Specialist retrieves and answers calls to the state's 1-800-Age-Info helpline (a secure line) for our catchment area. **The Specialist also reviews the 2 incoming SeniorCare email sources**, sorts and distributes the contents to the appropriate staffers.

The Specialist is required by the State to receive 40 hours of training relative to their position as an information/resources specialist. The **State also requires that there is at least 1 AIRS certified staffer present in the Agency during normal business hours.**

With the addition of the Cummings Center office, **the Specialist will develop a monthly "feature" displaying a particular event, or SeniorCare Dept, or recognizing a celebrated day or month** which will occupy the reception area of that office.

Field education and outreach. The Specialists have brought their resources and Home Care knowledge into the field to provide education to the general public for purposes of outreach and exposure to the realm of elder services. I & R are hoping to reach the underserved or undereducated in the area of senior services.

Home Care Programs

SeniorCare is charged by the state with the implementation of the various state home care programs described below. There are both MA Health programs and non MA Health programs which are offered.

Choices Program

SeniorCare, Inc. offers the Community Choices Program to eligible consumers who have MA Health Standard and who are clinically eligible for the home and community based waiver. Community Choices has been designed to provide intensive services to Waiver clients who are at imminent risk of nursing facility placement and whose needs cannot be adequately met in the Home Care Program. The ASAP RN conducts a determination of clinical eligible criteria for nursing facility services and would like to receive services in the community through the home and community based waiver. The projected cost of the service package must be at least two times the current monthly Home Care Program purchased services rate, currently $266.00. An in person on site assessment must be completed at least quarterly by either the CM or RN. Annual eligibility re-determination by the RN for the waiver must be completed no later than every 365 days.

Waiver services under Community Choices or HCB/W program: *Homemaker, Home Health Aides, Personal Care, Respite Care, Environmental Accessibility Adaptations (Adaptive equipment), Skilled Nursing, Transportation, Chore Services, Companion Services, Supportive Home Care Aide*

(specially trained to work with consumers with Dementia or Mental Health issues), Supportive Day Program, Laundry Service, Grocery shopping and Delivery, Home Delivered Meals, and Transitional Assistance (to assist consumers back into the community setting from a nursing facility – may include security deposits, essential furnishings, moving expenses, etc.)

Enhanced Community Options Program (ECOP)

The Enhanced Community Options Program was implemented in 1993 to provide a higher level of service in the community to elders who are ineligible for MA Health Standard and meet the requirements for nursing facility services as determined by the ASAP RN. The goal of the program is to address the needs of nursing facility eligible elders who require enhanced service plans to live safely and independently at home. The projected cost of the service package must be at least two times the current monthly Home Care Program purchased services rate, currently $266.00. An in person on site assessment must be completed at least quarterly by either the CM or RN.

Purchased services options under ECOP or HCB/NW program: *Homemaker, Home Health Aides, Personal Care, Respite Care, Environmental Accessibility Adaptations (Adaptive equipment), Skilled Nursing, Transportation, Chore Services, Companion Services, Supportive Home Care Aide (specially trained to work with consumers with Dementia or Mental Health issues), Supportive Day Program, Laundry Service, Grocery shopping and Delivery, Home Delivered Meals, and Transitional Assistance (to assist consumers back into the community setting from a nursing facility – may include security deposits, essential furnishings, moving expenses, etc.) Behavioral Health services, Medication Dispensing Systems, Personal Emergency Response System (PERS), Occupational Therapy, Alzheimer's Coaching/Habilitation Therapy*

Home Care Program – waiver and non waiver

The Basic Home Care and Respite Over Income Programs provide a basic level of service to those consumers who meet the functional impairment level as determined by an assessment by the care manager. The projected cost of the service package is approximately $266.00/month. Consumers are contacted quarterly; phone calls are allowable for two of the contacts with two on site assessments at no greater than six month intervals.

Group Adult Foster Care:

GAFC is the only program administered by SeniorCare that provides service to consumers who are under age 60. GAFC provides personal care services to individuals age 22 or over, who are on Mass Health (Standard or Commonhealth), live in elderly or disabled housing and who are in imminent risk of institutional placement. An assessment is completed by the ASAP RN and eligibility is determined by Coastline Elderly Services. Reimbursement is at a per diem rate of $42.41 per day for personal care only. Currently these participants live in a variety of housing complexes in SeniorCare's catchment area including 17 nuns residing at the St. Julie Billiart Residential Care Facility, Sisters of Notre Dame in Ipswich. Visits are completed monthly and alternate between the CM and the RN.

Other Home Care Programs with Community Partners

The SeniorCare Home Care Department also collaborates with other agencies for the implementation of home care services. This includes but is not limited to the Adult Foster or Family Care (AFC) Program where a caregiver (family and non-family) is paid by MA Health to care for a Consumer on a 24/7 basis with some caregiver respite provided by SeniorCare. Another program is the Personal Care Assistance Program (PCA) whereby MA Health consumers may hire their own workers to assist them with their daily living needs. SeniorCare will refer out for the PCA program and will sometimes provide additional services that are not duplicative of what the Personal Care Attendant is providing. SeniorCare also collaborates with Veteran agencies in assisting Consumers to access benefits including at times, in home care or eligibility for adult day health programs.

Consumer Directed Programs

SeniorCare offers consumer directed programs in both the State Home Care Basic and ECOP Programs. Instead of utilizing the traditional provider network, Consumers may hire their own caregiver such as a friend, neighbor, family member, partner, and others including a spouse in some cases. The Consumer (or a Surrogate) is responsible for hiring, training, supervising, firing if needed, and generally managing their own care with the Care Manager assisting only as needed or requested. In the ECOP Independence Plus Program, Consumers may find their own workers as described above but can also utilize the money available from ECOP for other targeted needs they may have such as paying for medications, transportation, and much more.

Protective Services Department

Protective Services (PS) is the department within SC that is responsible for receiving and responding to all reports of abuse/neglect or exploitation of any elder residing in any of our nine communities. The types of reportable conditions that Protective Services investigates are: Physical Abuse, Emotional Abuse, Sexual Abuse, Caregiver Neglect, Self-neglect and Financial Exploitation. When a report is received it is screened by a Supervisor to determine if there are reportable conditions. When appropriate the report is screened in and assigned to a Protective Services Caseworker (PSW) who attempts to conduct a thorough investigation to determine if there is reasonable cause to substantiate the reported allegations. If substantiated, the case is “opened for ongoing services”, a service plan is developed, which may include many different types of interventions designed to mitigate the risks and alleviate the conditions of abuse or neglect. PS interventions are always aimed at being least intrusive, least invasive, and least disruptive to the elder, with the goal being to assist the elder in remaining safely in the community.

In MA, Protective Services is a voluntary program. This means that unless PS has good reasons to question the Elder’s ability to provide informed consent to our involvement, the Elder must consent to our involvement. We cannot force our services on any competent Elder.

PS works closely with many diverse professionals and families. PS uses a Consulting Attorney as needed, to petition the courts for Orders of Protection, and to seek Guardianships and Conservatorships as needed. SeniorCare is also involved at times with District Court, Housing Court, and Superior Court. Serious cases of physical abuse, sexual abuse, financial exploitation or other situations are sometimes referred to the District Attorney’s office for potential prosecution. SeniorCare

PS Department maintains an ongoing collaborative relationship with many law enforcement agencies, most notably the local Police Departments of our nine communities.

PS has 24/7 coverage and maintains one staff who is on call on weekends, holidays, and after business hours. Referrals may be received during such times through the statewide Elder Abuse Hotline.

PS collaborate with the Home care staff and all other Departments within SeniorCare. Routine collaborations also occur with medical providers, Attorneys, Nurses, Hospital and rehab staff, Social Workers and many other types of professionals.

Protective Services is designed to respond to acute situations, make appropriate referrals to get Elders the care they need, ensure an effective long term care plan is in place and to terminate our services as soon as not needed.

Often Protective Services get the call at 4:30pm of a Friday afternoon, before a holiday weekend, from a desperate care provider or family member that does not know what to do next. The PS staff at SeniorCare is a highly trained, seasoned, caring, and compassionate team that maintains the respect of their peers and community partners.

Hoarding Harm Reduction Program

The Harm Reduction Model for hoarding intervention is for consumers who hoard and are willing to engage in working on their hoarding issues. Hoarding is a chronic condition and requires not only skills training, but also on-going support and accountability to maintain one's success. The primary goal of this intervention is to reduce the risk to the consumer, rather than clean out all of their belongings or completely stop the hoarding behavior. A training has been developed by this agency (staff specially trained in hoarding intervention) for home care workers of contracted vendors to prepare them to work with this population in a supportive manner but also brings a level of accountability. This Harm Reduction Model uses a team approach to include the consumer at the center, as well as family members, landlords, medical providers, SeniorCare staff and any others that may be involved. A contract that the consumer helps to write is drawn up with measurable goals after identifying the areas of the home that pose the greatest risk. As hoarding is a risk to the public as well as the person who hoards, emergency personnel, landlords and/or neighbors all have a vested interest in the success of the program. For example, fires that begin in a hoarder's home are more difficult to extinguish and make it more difficult for emergency personnel to reach the person inside the dwelling. As recently as March 2012 a Massachusetts elder perished in a fire because firefighters were not able to reach him in time due to the amount of clutter and hoarded items blocking their access.

Hoarding poses a significant risk to elders as having large amounts of clutter with increased dust, mold and pest infestation as well as instability of the structure of their living spaces due to excess clutter, makes for a very unhealthy living situation. Hoarding also increases the danger of falling due to cluttered pathways. As a result hoarding behavior poses an important health risk to its sufferers, particularly in the elderly population. Additionally, a significant risk to elders who hoard is eviction as

hoarding is actually one of the leading causes of eviction besides non-payment of rent ("Hoarding Resources," 2012).

According to some estimates, 2-5% of the adult population suffer from hoarding, which increases as the population ages. This becomes an important issue facing communities whose older adult population is also on the increase. Nationwide there was an increase of 15% in the population of people age 65 and older from 2000 to 2010. This is expected to increase to 36% between 2010 and 2020. By 2030 there is expected to be 72.1 million older adults nationally – almost twice the number in 2008 (US census). In SeniorCare's area, the 60 and older population makes up 20 percent of the population with Cape Ann's percentage running about two percent ahead of the state average. Those 85 and older make up 2.19 percent of the population with Gloucester, Rockport, Beverly and Ipswich being the towns with the highest concentration. (SeniorCare Area Plan, 2006).

The need is great and we have been staffing the Harm Reduction Model for Hoarding Intervention with Masters in Social Work Interns from Boston University and Salem State under the direct supervision of the Director of Home care who is a MSW, LICSW and a Protective Services Supervisor as there are currently no funds to provide permanent staff for this program. This is an area that is in need of funding. Often these elders are referred to SeniorCare through the Protective Services Agency at a point of crisis.

Care Management Services

The Care Manager is part of an interdisciplinary team responsible for the provision of client-centered assessment, service authorization, service coordination, reassessment and monitoring of services provided to assist elders to live independently in the community. The Care Manager must work cooperatively, coordinating service plans and maintaining ongoing communication with a variety of vendors and service providers to maintain consistent and appropriate levels of service.

It is impressed upon the care management staff the importance of "person centered" care planning as it is important for the services to meet the needs expressed by the consumer. The care management staff must become familiar with the wide range of services and be able to determine which services are covered under particular programs and which services will best meet their consumer's needs, all staying within the budgetary constrictions of each program.

In assessing consumers' needs, Care Managers may provide information and referral, follow-up and advocacy services. They work in close collaboration with other service providers to ensure that authorized and/or required services are being provided in accordance with the client's individual service plan and to maintain independent living. It is important for the Care Managers to know about community resources and service providers as most often they are the link to these for the consumer and/or the family.

One important are of collaboration is with nursing facilities around the area of discharge planning. The ASAP RN and the Care Manager are an integral part of the discharge planning process as often those consumers returning to the community require extensive and complicated service packages from a variety of vendors and service providers.

The Care Manager is often the first face to face contact person that a consumer encounters. After the Information and Referral Department takes a home care referral it is assigned to a Care Manager for an Intake Assessment. The Care Manager is responsible for assessing the consumers' functional impairment level as well as income status to determine eligibility for services. It is from this initial assessment that the service plan is developed and services are implemented. During this assessment, the Care Manager may identify any number of issues that may need to be addressed, both through SeniorCare and through other agencies.

On a daily basis Care Managers field many calls and questions about a variety of issues. Families call with a myriad of questions and concerns. They may just need to reach out to someone who can provide a listening ear. Care Managers become a conduit for information, advice, referrals, and advocacy around a variety of issues. One of the challenges that they all face daily is "interruptions" from phone calls from families, consumers, vendors, other service providers and co-workers or supervisors.

Proper, complete and professional documentation is a major task of the Care Manager who must complete paper work after each in home visit as well as document the many phone calls and meetings that happen throughout the day. It is a constant challenge to get everything complete in a timely manner.

We have a very dedicated staff that works hard to meet the needs of our consumers. It is a very busy and very rewarding job.

Nursing Department Services

The SeniorCare Registered Nurses (RN's) implement the state Clinical Assessment & Eligibility (CAE) procedures which include a number of different functions described below. The RN's do not provide skilled services such as RN's in a hospital or rehab setting or as in a Visiting Nurse Association.

The RN's conduct community assessment for Consumers who receive personal care from SeniorCare's contracted provider system. The RN's determine the need for personal care which might include assistance with bathing, dressing, transferring, ambulating, etc… If a Consumer is determined to need a personal care worker by the RN, the RN develops the personal care plan and faxes to a contracted provider who are responsible for implementing the plan as written. During the home assessment by the RN, the RN also evaluates the need for any adaptive equipment that might be needed by the Consumer. This may include such things as grab bars in the bathroom, shower chairs, raised toilet seats, and other devises to assist the consumer in their daily personal care tasks.

The RN's are also responsible for determining the clinical eligibility of Consumers for the waiver CHOICES Program and State Home Care Basic Waiver Program. RN's are also responsible for determining the clinical eligibility for the Enhanced Community Options Program (ECOP). The eligibility for such programs is determined by state regulations which the RN's determine. In addition, the RN's conduct assessments for the Group Adult Foster Care Program (GAFC) eligibility.

Another function of the CAE Program is the implementation of several nursing home diversion programs including the Comprehensive Screening & Service Model (CSSM), Section Q assessment, and the Money Follows The Person (MFP) Program. In essence and based on collaboration with the nursing facility (i.e. nursing homes and rehabs) providers, the RN identifies Consumers who are appropriate to return to the community with services and they take steps with other SeniorCare staff such as the Options Counseling / Care Transitions Coordinator to assist the consumer and any family or other informal supports.

Another responsibility through the CSSM program is for the RN to conduct a weekly visit to the seven SeniorCare nursing facilities to conduct screenings for MA Health recipients in order for the Consumer to have their nursing facility stays covered under MA Health. This can either be for a short term approval of 30 days or more, or approvals for a Consumer to stay long term at the facility.

CAE RN's also conduct community screens as well for such programs as PACE, Adult Day Health eligibility, and others.

The RN's conduct home-visits at regular intervals in the CHOICES program, ECOP program, GAFC program and others. Depending on the program enrollment and needs of the consumer and the particular program they are in, home-visits may occur monthly, every other month, or semi-annually. The RN's work in close collaboration with the Care Managers implementing the interdisciplinary team process.

Options Counseling / Community Care Transitions Department

Options Counseling

This program is intended to be short-term and informative with the goal of educating an individual on their care options in the community. We provide unbiased information to assist those making an informed decision for their own or some else's care at home, in a rehab or a long-term care facility.

Typically the goal is to remain independent in their home, but at times a more supportive living environment is being sought. Referrals are often received from people seeking services for themselves, children for parents, or stressed caregivers seeking additional support.

Options Counseling is available to those over the age of 60, whether the caller or the intended recipient, and to those over age 22 and disabled.

Counseling is offered in person, by telephone or by email, and can be provided in any setting.

We provide a wide range of information and support. Our goal is for the consumer to be able to take the next step whether it is to seek assistance from their local Council on Aging, to accessing transportation networks, or obtaining Home Care Services, and much more.

Coleman Coaching

This program is intended to provide short-term support for people with a goal of reducing or avoiding an unnecessary hospital stay. Over four weeks this program provides the following: a visit from a coach after a discharge, a personal health record designed to help manage conditions/organize medications, and three follow-up phone calls from the coach to provide support during the transition from the health care facility to their home. Dr. Eric Coleman from the University of Colorado developed this evidence based approach to empowering and teaching/coaching consumers to act on their own behalf in navigating the health care system. Coaching focuses on the Coleman "four pillars" which include medication reconciliation, the use of a personal health record, preparing for medical appointments which PCP's and specialists, and knowledge of the consumers "red flags" specific to their medical conditions.

Money Follows the Person

This Mass Health/Medicaid program provides assistance to an individual wishing to return to their community after residing in a long-term care facility. Often the individual has had to give up their apartment and/or possessions, and is financially unable to outfit their new home. This federal program allows the preparation of their new home to begin before discharge. Our support then

continues in the form of services to help the individual transition back into the community with greater ease.

Evidence Based Programs:
My Life, My Health
This Chronic Disease Self-Management Workshop, a Stanford University Self-management program, is six-week course to help people with chronic illness explore healthy ways to live with a physical or mental condition. Each week participants learn, discuss, share, and laugh as they explore the materials. Each session is varied; participants work in a group, in a pair, or brainstorm as a group together. Topics are varied each week and are centered on several basic tenets such as; problem solving and action planning.

A Matter of Balance
An eight-session program to help older adults reduce their fear of falling thereby enhancing activity levels. This course is conducted over four weeks with two 2-hour sessions per week. Participants learn to challenge their concerns about falling. They do this by learning to view falls and fear of falling as controllable; to set realistic goals for increasing activity, to change their environment to reduce fall risk factors and to promote exercise to increase strength and balance. They get to exercise too!

Title III Services

The Older Americans Act was signed into law in 1965. It was proposed by policy makers in response to the lack of community social services for older persons and to assist them in maintaining their dignity and personal welfare. The Act was considered the major vehicle for organizing and developing social and nutritional services to older adults and caregivers. The Act has been reauthorized several times over the years and targeted populations, services and granted opportunities have been added.

An Administration on Aging (AOA) was created in 1965 to administer the Act through designated State Units on Aging to provide state level coordination of the structure. And in 1973 the Area Agencies on Aging were created to work on a localized/regionalized level to identify and maintain the uniqueness that was, and is, characteristic of communities nationally. SeniorCare became a state designated Area Agency on Aging at the time.

The AAA is advised locally by an Advisory Council which reports to SeniorCare's Board of Directors. The Council members are viewed as the specialists in matters pertaining to Title III programming and funding and the Council members play a vital role as a link to the communities that they represent. A representative from the Advisory Council attends meetings of the Board of Directors as a liaison.

As an AAA SeniorCare performs three major functions for older Americans:

1. creates a 4-year area plan through conducting an area wide needs assessment; addressing the designated goals from AOA and the state Executive Office of Elder Affairs; and maintaining a community-based locally focused plan through familiarity with the characteristics of the communities it serves.
2. provides information to elders through Information and Assistance, presentations, events, focus groups and other activities; by contracting with outreach/legal and other service

providers and through Title III programs such as Ombudsman, Health Promotion and Caregiver Support programs; also by participating on local planning committees and boards along with advocating, on many levels, for improved services for elders and their caregivers.

3. coordinates funding through access services such as transportation, I&R, SeniorCare's volunteer transportation program; in-home services including home-delivered meals, mental health and money management services ; community based services including congregate meals; legal services through protective services and one-on one counsel for area elders; and vulnerable elders through money management, protective services and LTC Ombudsman.

Eligibility for AOA/AAA services requires that a person is sixty or over, or a spouse or caregiver, of an older adult; focus is on those of greatest social and economic need, minority individuals, older adults with limited English proficiency, LGBT populations and minority religions, those at risk of institutional placement; and those with dementia and/or Alzheimer's disease.

Funding is distributed through grants from AOA, through the local State Unit on Aging (EOEA) to SeniorCare as the AAA. Through the process of needs assessment; local involvement and knowledge; consumer feedback and requests; planning and discovery; and quality assurance, evaluation and outcome measure; a plan for contracted and waivered services is designed.

The Title III-A dollars are for administration of the plan; Title III-B provides funds for supportive services; Title III-C-1 and C-2 for nutrition services; Title III-D for health promotion; III-E for caregiver support; funding for the Ombudsman program.

Presently the services provided through Title III vendors are transportation, outreach, legal and mental health services. Other services are provided through the waivered services such as nutrition, money management and I&R. An RFR process is required for the service provision and vendor selection annually with potential rollover of contracts for one year. Public hearings are held; technical assistance is provided; and after initiation of contracts reporting is required and annual monitoring is conducted. The utilization of local vendors, such as the Councils on Aging, allows for uniquely focused services to address specific needs and diverse populations.

Over the years there has been much discussion about the similarities in service provision and delivery for the aging population and those with disabilities. The focus often referred to a fragmented system of policies and procedures. To address this concern, in 2012 the Administration for Community Living was established which brought together the AOA, the Office of Disability and the Administration of Developmental Disabilities to achieve several important objectives including but not limited to; reducing the fragmentation that exists in federal programs; addressing the community living services and supports needs of both the aging and disability populations; enhancing access to health care services; and promoting consistency in federal policy.

The AOA through its network of providers, partners and collaborators, looks to strengthening its critical programs and further building the capacity of the national aging services network to continue to deliver high-quality services that improve the health, safety, and well-being of older Americans and the AAA's are major contributors in coordinating, advocating and providing for the needs of older adults, their caregivers and others. The network of 56 State agencies, such as the Executive Office of

Elder Affairs in Boston, 629 Area Agencies on Aging, such as SeniorCare, Inc. and 246 Tribal organizations provide services and support to 1 in 5 seniors to help them remain independent and in their communities. It is an infrastructure that supports 11 million older adults and caregivers and through the inclusion of the Administration for Community Living with the disabilities communities its expansion will be far reaching.

Family Caregiver Support Program

In 2000 the Federal and State governments began an effort to recognize and address the growing number of family caregivers in the U.S. Out of that effort came the Family Caregiver Support Program. Currently nearly 7.5 million individuals provide unpaid help to disabled older people living in community.

Caregiving can last as long as 40 years. Both genders devote time to caregiving, in nearly equal measure.

Most caregivers are not retired, and struggle to balance work, family, child rearing and caregiving.

The overall mission is to provide services to support friends and family members who provide care to seniors and individuals with disabilities.

Qualifications for the program are:

- The Caregiver is 18 years of age or older.
- A Caregiver is providing DAILY CARE to an elder on an ongoing basis
- The caregiver either lives with the elder or is a relative of the elder.
- The person receiving the care must be 60 or older, or have a medical diagnosis of Alzheimer’s disease.
- Grandparents of minors under the age of 18, who fit the above description of a caregiver may also be eligible.

We offer an in home assessment of the caregiver’s needs, to assist in planning for the loved one’s current and future challenges. And in the process the Specialist provides emotional support along with information which spans the many topics related to the caregiving role.

Often referrals to elder law attorneys, Medicaid advisors or SHINE workers, referrals to Home Care, adult day care, private pay resources, support groups, or alternative living environments are initiated as a result of the Specialist’s assessment and knowledge of available services.

The Specialist may offer and conduct family meetings in an effort to respond to the entire spectrum of care providers and encouraging the engagement of all available caregivers.

Specialist conducts support groups in various communities and in the work place as a vehicle of disseminating information, educating and supporting the caregiver. Many times the relationships that are established can be both short term and long term spanning years, as the care recipient’s needs grow and change.

The program offers education and information sessions through various community outlets, such as the COAs, libraries, and nursing facilities, to reach a broader audience with the support services that are available to them in their area.

A lending library of resources is developed and maintained including: books, pamphlets, and websites specifically related to the caregiver's needs and concerns are made available to all caregivers.

All of these services are available at no charge to the Caregiver.

Our current staffing is one ½ time Support Specialist, with supervision provided through the information services department.

As with any funded service we are required to keep statistics and record our work in the intra state database.

Money Management Program

The Money Management Program was established by AARP in the late 1980's and here at SeniorCare in 1995. The 20th anniversary of Massachusetts Money Management Program was celebrated in May 2012 at the State House in Boston. It is sponsored by AARP, the Executive Office of Elder Affairs and Mass Home Care and is a Title III program. Over 1500 clients have been served in Massachusetts this year and this free service is available in every city and town.

The Money Management Program recruits and trains volunteers to provide consumers with help monthly to organize bills for payment, write out checks to be signed and balance the checkbook register with the bank statement. This enables them to remain living independently and as part of the community.

The consumers must be 60 or over and have an income less than $45,100 for an individual, $51,500 for a couple. These figures are based on federal low income guidelines for Massachusetts. And the most important guideline is for the consumer to be able and willing to cooperate with the volunteer and wanting to receive the services.

SeniorCare's program currently serves 32 consumers matched with volunteers. All meet the guidelines. There a number who are visually impaired, some are disabled, others homebound, some just a bit forgetful, and most have no other family to help.
There are 47 volunteers trained for the program. Most are professional either still working from the fields of finance, banking, accounting, teaching, nursing, law, or business. One is   just now in completing a business degree in graduate school and is an artist in the process of opening her studio. All are building long term relationships with their consumers. And both consumer and volunteer benefit from the circle of giving and receiving that this program fosters.

All volunteers submit an application with three references and agree to a background CORI check. They have an interview with the program manager and an initial training of three hours. They are asked to commit to at least a year of service and agree to attend ongoing in-service trainings held bi-monthly throughout the year.
The three roles of the program are Bill Payer, Representative Payee, and Monitor. All current consumers have Bill Payers that prepare the checks for the consumer's signature. The consumer remains in charge of the checking account. The program offers the role of Representative Payee that is administered by the Social Security Administration for those unable to manage their social security income due to impairment of function either mentally or from addictive behaviors. In this case the volunteer opens the account and signs the checks to successfully manage their income. There are no Representative Payees currently in the program. The third role of Monitor is very important to ensure the liability of both the consumer and the volunteer, especially since this service is performed in the home. They monitor the monthly reports required of the volunteers that include a copy of the bank statement with copies of the processed checks. This is to verify that the consumer is the one signing the checks and that there are no large expenses out of the ordinary.
These are a few of the success stories. One volunteer has been matched for over twelve years with a legally blind consumer helping her stay living independently. The last Representative Payee in the program helped her consumer with no family for almost 15 years until her death. And the consumer who through the volunteer's efforts and advocacy has over a five year period successfully paid off credit card debt incurred in her name by another family member.
The administration of the program includes maintaining client and volunteer files and the monitoring schedule. There is ongoing supervision of the volunteers. Monthly reports are made to the Advisory Council of which three per year are presented in person. Attendance at the three statewide Massachusetts Money Management Program is required. And the outreach and promotion of the program is ongoing throughout the year.

Nursing Home Ombudsman Department
(The Long Term Care Ombudsman)

Definition:

Ombudsman is a medieval Swedish word which means a representative for the people and receives and looks into concerns from the public regarding an institution and through various dispute resolution techniques, attempts to develop a cooperative resolution. The Long Term Care (LTC) Ombudsman Program was established by the federal government in 1973. Every state in the country offers this federally funded program. These programs provide a mechanism outside the official regulatory apparatus for addressing concerns of individual nursing home residents or their families and friends.

Autonomy:

The ability of the LTC Program to carry out its responsibilities rests to a large extent on the degree of independence or program autonomy. Mechanisms are developed to hold the program accountable to fulfill the public trust, including potential or actual conflicts of interest, statutory/mandated requirements, political influence, and systems level advocacy.

The Specifics for SeniorCare, Inc.:

Where do LTC Ombudsmen go?

Between the four walls of a medical nursing, rest home, transitional care unit, or rehab center while it annually fulfills its licensure regulations to operate as set by the Commonwealth's Executive Office of Health and Human Services.

Why a LTC ombudsman?
The LTC Ombudsmen, at SeniorCare, Inc., consists of a corps of dedicated volunteers who are watching out for their neighbors in these homes. It's a statutory right of access and community presence. Often tolerated by the nursing homes administration and the unit staff, the ombudsmen build mutually productive working relationships with the provider groups, government agencies, and academic researchers.

What do the volunteers accomplish?
They walk, talk, visit, observe, and empower the multiple stakeholders. The certified ombudsmen follow a strict protocol as representatives of the State Ombudsman's Office in Boston. Individually, the LTC ombudsman visits with nursing home residents at one assigned home four times a month and honors the preferences of the resident once their informed consent is given on quality of life and the patient bill of rights and responsibilities. The qualifications and training are demanding and require a wide range of abilities, knowledge, and characteristics. The environment may be unfriendly, the LTC volunteer ombudsman works alone, and may have to persevere in order to obtain patient-centered satisfaction and control within a therapeutic environment.

Data and information collecting, analysis, and dissemination:

LTC ombudsmen are agents of change, individually and on a collective basis. If done well, the proprietary data and information give a strong scope and impact for this vulnerable population to the Congress of the United States. Nationally, industry behavior, trends, structural design, and economies of scale are monitored along with acts of social injustice. Locally, identification of institutional profiles that characterize a pattern of reported grievances could be made. The foundation of the program is legal in scope. Industry and federal initiatives are communicated to SeniorCare's volunteer corps by E.O.E.A.'s representative/program director at the required staff meetings. The designation of this contract is awarded on an annual basis and receives no state funding.

Education and Information:

These are important components of the LTC ombudsman employee and volunteer staff. The program is prepared to receive inquiries regarding nursing home placement. The program provides general information about long term care issues and options and specific information concerning licensed homes in SeniorCare's nine communities. The aim is to foster an informed comfortable transition through advocacy and support during the individual's own decision making.

RSVP Volunteers of the North Shore

Established in 1971 by Congress, and now one of the largest senior volunteer organizations in the nation, RSVP engages more than 296,000 people age 55 and older in a diverse range of volunteer activities to meet important, local community needs.

Previously known as the Retired Senior Volunteer Program, RSVP is funded and administered federally by the Corporation for National and Community Service (www.nationalservice.gov) in Washington, DC.

RSVP volunteers choose how, where, and how often they want to serve, with commitments ranging from a few hours to 40 hours per week.

2012 RSVP Statistical Highlights*

- Volunteers: 320,100 million
- Hours Served: 60 million
- Number of Chapters: 685
- Organizations Supported: 65,000
- Elderly Adults Served: 742,000

"Today, more than ever, communities need the talents and skills of all citizens to help solve our most pressing challenges," said Wendy Spencer, CEO of CNCS. "Americans age 55 and over are a powerful resource to help communities achieve real change. RSVP grants provide the bridge to connect seniors to meaningful service opportunities, so that they may deliver the enormous social and economic benefits we know are good for our nation." While serving, RSVP volunteers also improve their own lives, by staying active and civically engaged.

RSVP Volunteers of the North Shore was first sponsored locally by Action, Inc. of Gloucester and in 2001 SeniorCare took over the program. It functions in all of SeniorCare's towns and cities as well as Danvers, Peabody, Salem and Marblehead.

From a few hours a month to several days a week, RSVP volunteers serve in many capacities at nonprofit and government agencies all over Cape Ann and the North Shore. It is a wonderful way for them to meet new friends, invigorate their spirits and raise their own self esteem while helping their neighbors in needed services.

Older Americans bring a lifetime of skills and experience as parents, workers, and citizens that can be tapped to meet challenges in the communities. Given the many social needs facing communities – and the growing interest in service by 55+ American citizens – this is a moment of unprecedented need and opportunity for volunteer programs to take advantage of an extraordinary wave of human capital that has the potential to transform our nation.

SeniorCare Nutrition Program: Meals on Wheels & Congregate Dining

The Nutrition Department provides hot, flavorful, nutritionally balanced meals to older adults in the nine cities and towns SeniorCare serves. Our meals are served at congregate dining sites where older adults can socialize and eat with their peers or delivered by caring, committed drivers to the homes of those who unable to adequately provide meals for themselves.

Meals are a tangible, direct service.

- Serve more than 600 meals per day.

- Meals are easily recognized, identifiable service. In a recent survey conducted by Meals on Wheels of America, 92% of respondents were familiar with Meals on Wheels and 98% of those gave MOW a favorable rating.

- The meals program is an excellent entry point to introduce SeniorCare to both older adults and the community at large. Congregate dining program reaches active, mobile older adults. Special meals such as St. Patrick's Day or Thanksgiving can reach wide audiences. Over time consumers often move from congregate to home delivered meals. Positive experience with meals program can leave consumers receptive to other services.

- Home delivered meals can be the first service older adults will accept.

- Meals served five days per week, except holidays

Eligibility: There are no income requirements for meals.
Congregate Dining: any individual 60 years of age or older and their spouse of any age is welcome to dine at any site in our service area.
Home delivered meals, individuals must be 60 years of age and older or the spouse of an eligible person receiving meals and:

- Unable to prepare a balanced meal because of physical, mental, or emotional limitations,
- Without sufficient assistance from family, friends, or neighbors, to prepare a balanced meal, and
- Unable to comfortably or safely participate in the Congregate Dining program

A meal and more:
Congregate: Eating with others is linked to increased food consumption; at community dining rooms, diners have the opportunity to socialize while enjoying a flavorful, balanced, nutritious meal. Congregate programs provide easy way to inform older adults and provide link to other programs and services.
Home Delivered:
Drivers provide daily contact.
Meal delivery provides backup safety check. (Note: Does not replace the importance of family or other checks on well being.) If consumer does not answer when driver attempts delivery, follow-up protocol put into place; site manager or nutrition office notified; follow up calls to consumer, care manager, emergency contact notification or wellness checks, as necessary.
To date in FY2013 two consumers have been found by drivers who alerted 911.
Nutrition Program: Background
Multiple Funding Sources

- Federal: Older Americans Act, USDA

- State – home care purchased service, State Elder Lunch

- Local – direct payments from cities and towns, in-kind meal sites located in Senior Centers/Councils on Aging at no cost to nutrition program

- Other: Private, Corporate, Grants, Fund Raising

- Participant Donations – important funding

Meal Cost/Donations

- Contracted per meal cost for each meal purchased from caterer (Sidekim Foods)

- Actual cost per meal – currently estimated at $7.15 per meal. This includes employee salaries and benefits, supplies, mileage reimbursement, utilities, administrative overhead, etc.
- Donations – requested donation $2.00 per meal
- Required to request donation (Federal policy). Donations must be voluntary and confidential.
- Home delivered - donation statements sent to consumers monthly, based on meals utilized during month. Significant percentage (approximately 40%) of consumers cannot be asked for donation because they are enrolled in Mass Health programs.
- Home delivered – FY2012 donations – actual donation .67 cents per meal.

Nutrition Program Staffing:

- In House – care manager, congregate site coordinator, program supervisor, program director, registered dietitian (currently program director)
- Unique for agency - most staff off site. Seven paid site managers, (paid site manager at seven sites), 76 drivers – 9 paid, 67 volunteers.
- Paid Drivers: advantages - work five days per week, steady, year round; disadvantages – cost.
- Volunteer – advantage - cost savings, increases range of people aware of SeniorCare and Meals on Wheels program; drawbacks – generally higher turnover, time commitment for recruiting and training; scheduling   Typically deliver one or two days per week resulting in multiple drivers for single route.
- Contracted: Bridgewell, Bass River Salem, Bass River Beverly. Human service agencies that work with developmentally challenged adults. Contract to deliver meals.
- Corporate Drivers – Electric Insurance Company (EIC). Provides two drivers for one route per week.

Caterer

- Food (except Topsfield) provided by Sidekim Foods, Lynn, MA. Small business; president is hands-on and on-site. Sidekim Foods has commitment to high quality food, use fresh vegetables when possible, local foods when possible. Very strong emphasis on food safety. SeniorCare dietitian inspects facility twice per year; also inspected by city, state, federal. Works backward so that food spends minimum amount of time between cooking and delivery to sites to promote integrity of food.
- Five year contract. In fourth year. Program must go out to bid in 2014.

Menu

Multiple Strict Guidelines

- Must meet standards set by Administration on Aging and MA Executive Office of Elder Affairs
- Oversight by SeniorCare registered dietitian
- Meals must provide 1/3 of the Dietary Reference Intakes for Older Adults (male age 71+)
- EOEA Standards lengthy and very specific

- USDA commodities used to control food cost
- Overall menus are planned to control sodium and sugar, minimize harmful (saturated and trans) fats, emphasize vegetables and fruits (two or more servings per meal), whole grains, protein (entrée must be good source of protein), 8 ounces milk must be served with each meal.
- Currently completing nutrient analysis for all recipes currently being used

Menu Planning

- Team – SeniorCare Nutrition director/dietitian, caterer representatives, caterer dietitian.
- Menu planning considerations include: menu requirements, overall nutrient composition, consumer satisfaction, flavors, variety, balance (texture, color), appearance, aroma, etc.
- Consumer input: annual survey, spot checking via calls to HDM consumers, consumers asked about meal satisfaction at 6 month telephone assessment, daily congregate consumer comment sheet, test meals. Both positive and negative responses incorporated into future meals.

Meals

- Congregate – sent in bulk, portioned at sites.
- Home delivered. Generally hot meal in 2 or 3 part tray with accompanying cold pack containing bread, milk, condiments and dessert.
- Additional meal types to meet special needs: modified, cardiac, mechanical soft, puree.
- Cold suppers, weekend frozen meals available for those needing more than one meal per day. Due to funding constraints generally only available for consumers who have home care services
- Congregate specials – themed monthly meal. Traveling Chef – special set menu, changes monthly, site chooses day for special. Food partially cooked on site. Promote participation; COAs often build on special menus for parties.
- Emergency meals – provided to at-risk consumers at beginning of each winter to use if site must close due to weather or other conditions that make delivery difficult or dangerous. All consumers called if meal service is cancelled.

Delivery Process

- Decentralized. Caterer brings food to sites in each city and town (except Topsfield which is under separate contract with school). Each site has multiple meal delivery routes. Site manager oversees packing routes; paid and volunteer drivers pick up food at site, deliver, return to site and report any missed deliveries.
- Follow-up on missed deliveries by site manager and office staff.

Additional Services:

Nutrition Education, Registered Dietitian Services

- Nutrition education offered at least twice per year at sites; planned and provided by registered dietitian.

- Monthly nutrition education on menu backs distributed to all participants.
- Consumers have telephone access to registered dietitian for questions or concerns. RD provides information and educational materials to agency staff on as-needed basis.

Mobile Markets

- Collaboration with Open Door, Rockport and Gloucester Councils on Aging, SeniorCare Nutrition. Monthly distribution of groceries to income-eligible participants. Specialized foods when possible – lower sodium canned goods, higher fiber, low sugar cereals, etc. Choice of fresh produce, one or more high protein frozen food item per distribution.

Farmers' Market

- Department of Agriculture. Eligible elders can receive $25.00 in coupons redeemable for produce at Farmers' Markets for mobile individuals. Homebound receive freshly harvested produce three times per summer through collaboration with The Food Project.

Outreach/Communication with Homebound

- Information from SeniorCare, COAs, others provided to homebound with meal
- Title III Care Manager brings packet of resource information at initial and follow up visits

Today and Tomorrow
Fiscal Year 2012: 176,176 meals served

Quality Survey Results

- 94% of congregate diners and 85% of home delivered meals consumers rated the meals as good or excellent
- 98% of respondents would recommend the program to others.
- Congregate: 70% respondents state meals improve their health; 63% report eating better
- Home Delivered: 79% respondents report HDM is their main meal of the day; 59% feel meals have improved health

Challenges:
Budget - changes in funding formulas resulted in decreased Federal and State funding. Federal funding subject to sequestration mandated cuts. Realize steady cost increases in food, fuel, labor, etc. and an aging population while funding is level or cut.
Demographics – Increases in population of older adults/no increased funding; will be asked to do same with less, particularly for home delivered program. Congregate program faces different challenge as older adults work longer and have different view of aging. Many look at congregate dining as programs for "old people."

Benefits:
Consumer Benefits Include:

- Health benefits from eating better

- Meals can be critical link to being able to remain in home (Brown University study summary attached)

- Driver contact – reassurance to consumers and their families/caregivers

- Reduction in food insecurity – provide a meal with no stigma; no income eligibility means we can serve those who cannot be served by other programs. ***No older adult in our service area should go without a nutritious meal because they lack the means of providing one for themselves.***

Benefits to SeniorCare and Others

- Link to COAs. SeniorCare nutrition staff in COAs work with COA staff, build positive relationships

- Cities and Towns use meals served information in their annual statistics

- Links to community – examples – Endicott College students make Halloween Treat Bags to distribute with Beverly Meals on Wheels; schools and youth groups make Valentine, Thanksgiving, and holiday cards.

- Links to Business – EIC delivers meals weekly, donates money for emergency meals and donates for other special events.

- Visibility. Easy for community to understand program. “Feel good” program. Program like Mayors for Meals where state and local officials deliver meals one morning provides firsthand experience with SeniorCare and the people we serve.

- **SeniorCare Nutrition Program: Community Dining Sites**

Beverly	**Beverly Council on Aging** 90 Colon St. Serves Monday through Friday excluding holidays
Boxford	**Boxford School/COA** Elm St. Serves Monday through Friday when school is in session
Essex	**Council on Aging** 17 Pickering Street Serves 1st and 3rd Thursday of every month
Gloucester	**Rose Baker Senior Center** 6 Manuel Lewis Ave. Serves Monday through Friday excluding holidays
	McPherson Park Apartments 31 Prospect St. Serves Monday through Friday excluding

	holidays
Hamilton	**Hamilton Apartments/Lamson Hall** 129 Railroad Ave. Serves Monday through Friday excluding holidays
Ipswich	**Whittier Apartments** Caroline Avenue Serves Monday through Friday excluding holidays
	Council on Aging 25 Green Street Contact the COA for monthly meal information
Rockport	**Rockport Community House/Rockport COA** 58 Broadway Serves Monday through Friday excluding holidays
Topsfield	**Topsfield COA/Town Hall** 8 West Common St. Contact COA for monthly meal information

Housing Advocate/Coordinator Services

The Housing Advocate assists elders in the North Shore area with a variety of housing issues, ranging from locating safe and affordable housing to advocating for the individual in maintaining their current tenancy.

The majority of consumers seeking assistance from the Housing Advocate are living on fixed incomes which require the housing search be limited to Local Housing Authorities and privately managed, HUD subsidized developments.

With a limited stock of subsidized housing, the expected wait time for a subsidized apartment may be six months to a year, sometimes longer for some of the smaller subsidized developments. Often, the rent burden of market rate apartments leave the elder with little resources to afford other basic necessities. This rent burden attributes to the increasing number of elders receiving thirty day notice to quit, which often leads to Housing Court Summons and eviction proceedings.

Neighborhood Legal Services and the Law Project of North Shore Community Action Programs have represented our consumers through mediation and trial proceedings in the Northeast Housing Court. Some cases may only require a onetime consultation, while other cases have been litigated over long periods of time. This service provides our consumer with quality legal representation, which they may otherwise be unable to afford.

The long wait for housing may also be exacerbated by the consumers housing and credit histories. In the cases of housing authorities' denial of housing, the housing advocates appeals and advocates for

the consumer and authorities to agree to a specific plan to assist consumer in being a successful tenant. Home Care Services and Money Management are services offered and used successfully with housing authorities to assist consumers in obtaining housing.

Housing assistance for the homeless and those living in unsafe conditions is addressed with Emergency applications and advocacy; assisting consumers in gathering required verifications, secure deposits, and finding resources to pay rental arrears and furnish apartments. The Housing Advocate also provides assistance to SeniorCare nursing home diversion programs such as Money Follows the Person, Section Q, and the Comprehensive Service and Screening Model, all in collaboration with the Nurses, Options Counselors, and Care Transitions Coordinator. The Housing Advocate also assists the Protective Services Department as indicated in housing related situations.

Community resources and collaboration is key to successful housing advocacy, and many services are called upon to help achieve and maintain safe housing for our consumers. Housing Advocacy is a unique service offered to our community and is successful with agency wide support and cooperation.

Pawsitive Connections Program

The Pawsitive Connections program provides information, referral and services for elders and disabled adults who share their lives in the company of animals.

Some of the issues we confront and assist with regularly in this program are:

- Referrals for veterinary, grooming, boarding, training or other pet services
- Pet bereavement issues
- Renting with pets
- Therapy and service animals
- Advance planning for the care of a pet
- Adoption counseling
- Pet relinquishment (we do not find homes for unwanted pets, but can offer referral to shelters or breed rescues, and will assist an elder or disabled person to create an online listing, or make a flyer for posting at their vet's office, etc.)
- Financial hardship (we have a donor funded grant that consumers can apply for, and that our care management and protective staff can access for their clients)
- And more…

We can provide a speaker for various groups on topics such as:

- Pets and the Elderly or Disabled Consumer
- Bite prevention for home care workers/police/fire/EMT, etc.
- How animals can help social workers assess people's functional impairment
- Therapy and service/assistance animals
- Responsible pet ownership for seniors and disabled adults

SeniorCare External Collaborations Providing Direct Client Services

Title III Programs

Through AOA funding for AAA's support services, legal services, access and in-home services are offered to older adults in SeniorCare's Planning and Service Area (PSA) through contracted services with local providers. These services include:

Transportation: Three contracted vendors provide rides to elders within SeniorCare's (PSA). CATA out of Gloucester provides bus service to Gloucester, Rockport, Ipswich and Essex. Rides are available to Title III qualified adults for a suggested donation per trip. The purpose of the trips is determined by the riders' needs. Dial-a-Ride services are also available to seniors for door-to-door appointments. Beauport Ambulance provides rides to older disabled adults within the PSA who require skilled medical transportation to adult day services and medical appointments. Trips can also be arranged, by appointment, for elder groups to utilize the bus. Topsfield COA provides additional transportation services on Fridays for older adults for a variety of transportation needs.

Outreach Services: Five COA's provide outreach services through Title III contracts. Beverly, Essex, Gloucester, Hamilton and Wenham have qualified outreach workers on staff or utilize volunteers to outreach to local older adults to inform them of available services and opportunities and how to access them. Hundreds of older adults are contacted yearly.

Legal Services: Neighborhood Legal Services advise and represent older adults for certain legal matters such as government program benefits, tenants' rights and consumer problems. The highest percentage of elders served receive services related to housing such as imminent eviction, utilities termination, tenant issues and other issues related to maintaining appropriate shelter.

Mental Health Services: Mental Health in-home counseling has been provided for the past 12 years through a program piloted by SeniorCare. Elders have been seen in their homes, individually and in group settings, to allow them a venue in which they may address issues of personal concern for emotional healing and to maintain independence.

Aging & Disability Resource Consortium of the Greater North Shore, Inc.

SeniorCare is a Board member of the ADRCGNS, Inc. which also includes Board members from North Shore Elder Services, Greater Lynn Senior Services, and the Independent Living Center of the Greater North Shore and Cape Ann. Other leadership agencies on the board include North Shore Career Center and Elder Service Plan of the North Shore. There are also many community based organizations that comprise the "partners group".

The primary goal of the Aging and Disability Resource Consortium of the Greater North Shore (ADRC of GNS) is to create a single, coordinated system of information and access for all persons seeking long-term services and supports, regardless of age, disability or income.

Key Aspects of the ADRC Model

- Partnership between aging service agencies and independent living centers/disabilities services
- No "Wrong Door" approach versus "Single Entry Point"

- Cross-Training of ASAP and ILC staff to enhance service delivery
- Coordination and streamlining of key functions within existing organizations
- Involvement of consumers and community stakeholders as advisors
- Provide aging and independent living center/disability services staff with increased collaboration and knowledge of cross-age and cross-disabilities long term services and supports

Who does the ADRC Serve
- Persons of any age who have any type of disabilities
- Persons age 60 and over
- Family members and caregivers
- Private pay consumers (e.g. persons not eligible for public programs or individuals planning for their future long term care needs)

What are the Benefits of the ADRC?
- Minimize consumer and provider confusion
- Streamline access to long-term services and supports
- Streamline service coordination
- Enhance individual choice
- Support informed decision-making
- Increase the cost-effectiveness of the long-term supports system
- Reach under and un-served populations

SeniorCare Contracted Vendors/Providers

SeniorCare has contracts with a variety of vendors that provide the following services: Homemaker, Home Health Aides, Personal Care, Respite Care, Environmental Accessibility Adaptations (Adaptive equipment), Skilled Nursing, Transportation, Chore Services, Companion Services, Supportive Home Care Aide (specially trained to work with consumers with Dementia or Mental Health issues), Supportive Day Program, Laundry Service, Grocery shopping and Delivery, Home Delivered Meals, and Transitional Assistance (to assist consumers back into the community setting from a nursing facility – may include security deposits, essential furnishings, moving expenses, etc.) Behavioral Health services, Medication Dispensing Systems, Personal Emergency Response System (PERS), Occupational Therapy, and Alzheimer's Coaching/Habilitation Therapy

The Medical Group of Beverly

The Medical Group is a seventeen Physician practice near Beverly Hospital. Since September of 2010 and in collaboration with North Shore Elder Services, SeniorCare provides onsite Options Counseling to patients and caregivers as referred by the providers of The Medical Group. SeniorCare is onsite at the Medical Group 2-3's per week for approximately 2-3 hours per day. Consumers may make appointments to see an Options Counselor, may be referred at the time of their medical appointment, or may be called to initiate options counseling. Follow-up home-visits may occur if needed as well as referrals to SeniorCare or North Shore Elder Services or to our many community partners.

Lahey (Beverly Hospital & Addison Gilbert Hospital)

SeniorCare maintains office hours at Addison Gilbert Hospital two times per week for two hours. The office is staffed by an Options Counselor who conducts a similar function as described above for The Medical Group.

SeniorCare works closely with both hospitals relative to receiving referrals for services, working with the Social Work and other staff for hospitalized SeniorCare consumers, following up with Consumers who go to rehab from the hospital, and attending some meetings as well.

Through the ADRCGNS, Inc. described above, SeniorCare participated in the Administration on Aging and Center for Medicare / Medicaid Services "Navigating Across Care Settings" two year grant. SeniorCare provided Coleman Coaches, an RN Care Transitions Liaison, and participate in many meetings with Hospital staff.

Another area of involvement included participation in the hospital State Action on Avoidable Rehospitalizations (STAAR) initiative. This is an endeavor by the hospital to reduce avoidable rehospitalizations. SeniorCare and other community providers represent the community link to services that can sometimes mitigate the need to be hospitalized through home or other services.

SeniorCare and other members of the ADRCGNS, Inc. meet with the leadership of Lahey on an intermittent or as needed basis throughout the year.

Kiosk Project

SeniorCare is participating in the "Kiosk for Living Well" project as part of a grant in partnership with Greater Lynn Senior Services, North Shore Elder Services and the Aging and Disability Resource Consortium of the Greater North Shore, the member agencies of the Aging and Disability Resource Consortium of the Greater North Shore, Inc. (ADRCGNS, Inc.) Funding comes from the National Center on Senior Transportation and the New Freedom Initiative.

SeniorCare has been operating the Kiosk for Living Well at the Beverly Senior Center since November, 2012. The Kiosk is staffed with two trained Volunteer Advisors, a Travel Counselor from GLSS, and an Options Counselor from SeniorCare and a Career Counselor from the NS Career Center who assists visitors with problem-solving and connects them with resources around a variety of issues.

The interactive kiosk setting is designed to assist with mobility and travel options, chronic health self-management, and a host of fun learning games and modes of communication. The kiosk features an exciting touch screen computer called the IN2L which stands for "It's Never Too Late." The computer is easy for all ages to use and is designed to offer hundreds of different experiences. Presently there are three kiosks which are part of this grant, SeniorCare's at Beverly COA, the Longevity Connection at North Shore Elder Services and one opening soon sponsored by GLSS at the Lynn Library.

Senior Emergency Partnership Program

The Senior Emergency Partnership Program is a SeniorCare specific program and collaboration with the local catchment area Police Departments and Councils on Aging. The goal of the program is for SeniorCare to identify high risk Consumers who would be at risk during an emergency situation in their communities. There are internal steps to make contact with such Consumers or emergency

contacts during an emergency to assess their safety and to take any action needed to assist them. The Councils on Aging and Police Departments are provided with an Emergency Face Sheet on each Consumer so that the COA's can provide outreach if they choose, and if the Care Manager can't reach the Consumer or emergency contact, the Police would be asked to conduct a well being check. This program has been in effect since June 2011.

Beverly Congregate Housing

In collaboration with the Beverly Housing Authority and EOEA, congregate housing offers communal housing for elders and non elders who require further assistance to maintain their quality of life. Residents share common areas while maintaining their own bedroom space. There are three units at the site with four people per apartment. A Coordinator works at the site part time to assist with resident issues.

Beverly Safehouse Apartment

In collaboration with the Beverly Housing Authority, the SeniorCare Protective Services Department has maintained a safehouse apartment for over ten years for elders who are in need of relocating or escaping abuse. This temporary housing offers safety until the abuse is addressed through the work of the Protective Services staff.

Harborlight Properties Supportive Housing Models

SeniorCare provides a non state supportive housing model at Turtle Creek and Turtle Woods subsidized housing complexes in Beverly. SeniorCare provides a Care Manager Coordinator who works with one of our onsite vendors to provide services throughout the day at more frequent daily intervals that would not otherwise be available to our private community residence Consumers. The Coordinator works closely with the Turtle Creek staff to ensure that the home care residents receive services to meet their needs.

SeniorCare is currently in discussions with Harborlight to replicate this model at the Pigeon Cove Ledges in Rockport and the Rockport High School Apartments.

Nursing Facilities & Rest Home

As described above, SeniorCare provides Ombudsman, Nursing, Home Care, Options Counseling, Coleman Coaching, Care Transitions, and other services to consumers who reside in our seven nursing facilities and one rest home or who are in rehab waiting to return home in one of the facilities.

The Court System
District Attorney's Office, Probate Court, District Court, Housing Court, Superior Court, Probation Departments

The SeniorCare Protective Services Department and Housing Advocate/Coordinator are periodically involved in these court systems as described above.

Program For All Inclusive Care of the Elderly

PACE is an innovative model of care that enables eligible seniors to remain in their own communities rather than being placed in long-term care facilities. Based on a system of care that was begun in the early 1970's in San Francisco's Chinatown, the PACE model provides one stop comprehensive health and social services for its participants. SeniorCare and PACE make referrals to each other and SeniorCare provides meals to the PACE participants.

North Shore Career Center

The North Shore Career Center, chartered by the North Shore Workforce Investment Board (WIB), with offices in Salem, Lynn, and Gloucester is part of a statewide network of One-Stop Career Centers offering **a** wide range of no-cost services to meet the employment needs of job seekers, youth and businesses throughout our region. The North Shore Career Center is a leadership member of the Aging and Disability Resource Consortium of the Greater North Shore, Inc. and will be an instrumental partner with the onset of Integrated Care Organizations as well as in our present and future work with the younger disabled adult.

Caregiver Homes & Adult Foster Care of the North Shore

Adult Foster Care of the North Shore and Caregiver Homes are two Adult Foster Care providers in this area. This program provides private homes and caregivers for adults with disabilities or chronic illnesses. Often, consumers are already living with family members who are providing care, sometimes at the expense of being able to work outside the home. Adult Foster Care is a Mass Health funded program that provides a tax-free daily stipend to the adult caregiver with whom the consumer is living. This program is available to younger disabled adults 22 and over. SeniorCare makes referrals to both of these programs, receives referrals from both, and supplements the caregiver with some respite services.

North Shore Association for Retarded Citizens (NSARC), Independent Living Center of the Greater North Shore & Cape Ann, Northeast Independent Living Center

Similar to the AFC program is the PCA program. There are many providers in this area including but not limited to those listed above. This program is a consumer directed model for consumers who are on Mass Health and wish to hire their own personal care attendant. A fiscal intermediary handles the payroll but the consumer hires (and fires if necessary) and trains their own staff. The PCA provider completes and assessment to determine the allotted PCA hours per week. This program is available to younger disabled adults as well as those over 60.

Electric Insurance Company (EIC), Bridegwell, & Bass River

The Nutrition Department collaborates with several entities to deliver meals to clients. In May of 2007, a relationship was instituted with Electric Insurance Company (EIC) in Beverly. In addition to other significant support EIC provides to the Nutrition program, members of the EIC Community Involvement (CITE) team deliver meals in Beverly once per week. The nutrition director works with a liaison at EIC who recruits and oversees a team of approximately 16 volunteers each year. These volunteers work in pairs to deliver meals once per week. SeniorCare processes CORIs and motor vehicle checks, the EIC leader schedules teams and ensures new volunteers are trained. In addition to the service rendered through meal delivery, the program directly introduces EIC employees to SeniorCare, the meals program, and the older adults we serve. This is a corporate model we are seeking to replicate with other businesses.

The department also contracts with two community-based agencies, Bridgewell and Bass River (Salem and Beverly offices), that work with adults with developmental and other disabilities. The agencies provide a trained staff member who drives and supervises the meal delivery process. Currently a Bridgewell team delivers in Beverly Monday through Friday and an additional Bridgewell team delivers in Ipswich three days a week. Bridgewell is willing to take on extra routes, when necessary and, when possible, will even send a second van and driver to Beverly if a sudden need arises, providing important back up assistance for meal deliveries. Bass River delivers meals two days per week. These collaborations provide vocational support and training for those working through Bass River and Bridgewell while helping to contain delivery costs.

Councils on Aging Nutrition Sites

Nutrition program collaborations with Councils on Aging and Senior Centers are mutually beneficial. At sites located within Councils on Aging (Beverly, Gloucester, Rockport), meals are one of the daily services that participants can utilize. Some participants may come specifically for the meal, drawing traffic into the COA. Others may come for a movie or Bingo at the COA and stay for the meal. The monthly and Traveling Chef specials are utilized by nearly all of the Councils on Aging in our service area. COAs can plan parties around the meals, adding entertainment and other extras. In turn these extras encourage local seniors to attend the meals. These collaborations build bridges between the COAs and SeniorCare. Additionally collaboration takes place through shared interests and opportunities such as coordinated volunteer efforts, special events planning, presentations, grant funded and contracted projects, and service provision.

Housing Authorities

SeniorCare works collaboratively with all Housing Authorities in our catchment area. This includes receiving referrals from HA staff, and the involvement of SeniorCare services as described above including a state funded Supportive Housing site at McPherson Park in Gloucester.

One Care Organizations

One Care Organizations is a MA demonstration grant for adults 21-64 who are dually eligible for both Medicare and MA Health. SeniorCare and the ADRCGNS, Inc. have a contract with Community Care

Alliance (CCA) One Care to provide mandated Long Term Support Services – Coordination (LTSS-C) services to its Consumers. One Care programs became effective on July 1, 2013 for voluntary enrollment with involuntary enrollment beginning in October 2013.

External Collaborations Providing Indirect Client Services

Executive Office of Elder Affairs

The state agency responsible for elder services throughout Massachusetts and SeniorCare's primary funding source and government oversight body.

Lifetime Group

The organizational members include Senior Care, Elder Services of Merrimack Valley, Greater Lynn Senior Services, Mystic Valley Elder Services, North Shore Elder Services, and Somerville Cambridge Elder Services. Lifetime's mission is to create choices that will enable elders to live independently and with dignity for as long as possible in their own homes. The agency is a private, tax exempt (IRS approved 501-c- (3)), not for profit corporation whose offices are located at 152 Sylvan Street, Danvers, MA, 01923.

The agency's focus and purpose includes but is not limited to:

Sharing of best practices

- Sharing of best practices and learning new ways to bring high quality, cost efficient, comprehensive services to the elders in the region, which includes 20% of the state's over-60 population and over 30% of the state's low income elder population.

Employee Benefits and Corporate Insurances

- Secure employee benefits and agency commercial and professional liability insurance

Marketing

- The launch of Physician Outreach across the region, first initiated by Elder Services of Merrimack Valley staff, was the outcome of collaboration between the Lifetime agencies' FCSP staff and the Director of Communications at Hospice of the North Shore, who has extensive expertise in this area.
- Lifetime video, which has been utilized both locally and across the region to highlight the FCSP and increase awareness of the program. To ensure that non-English speaking caregivers have access to information, the FCSP brochure and ECA educational panels have been translated into 5 languages.

Training

- Provide targeted training programs for members of the boards of directors and senior management staff.
- Specialized training on how to be a supervisor
- Regional SIMS training
- Coop Disaster Recovery Plan

- Clinical Capacity Committee developed and continues to deliver a Basic Case Management training curriculum for new and existing case management and supervisory staff

MA Home Care, Inc.

MA Home Care represents the 27 ASAP's throughout the state and conducts significant legislative advocacy as well as advocacy with the Executive Office of Elder Affairs. MA HC has monthly meetings with all the ASAP's throughout the state.

Gloucester & Beverly Hoarding Task Forces

The purpose of the tasks forces is to better understand hoarding and the individuals who engage in this practice, in an effort to better respond to the problems associated with the disorder. To that end both the Cape Ann and Beverly Task Forces hold monthly meetings to provide trainings, facilitate collaborations with other town boards and public safety departments, discuss case studies, and share information and resources.

Senior Care involvement with the hoarding initiative began with the Beverly Task Force as early as 2006. SC, in collaboration with the Beverly COA, was instrumental in bringing education and training on this topic to the North Shore. During its existence the Task Force has been active in arranging for "clutters support groups", and shredding days through the Beverly COA.
Currently Senior Care is the coordinator of the Beverly Hoarding Task Force whose activities often mirror those of the Cape Ann group and in future the Task Forces will combine their efforts around events and trainings.

With the inception of the Cape Ann Task Force, Senior Care was able to share our expertise and help arrange for trainings with some of the foremost Hoarding specialists out of Boston University. As an active participant in the Cape Ann Task Force representatives from several SC departments attend the meetings: Protective Services, Care Management, and the Hoarding Harm Reduction Team Members. SeniorCare was responsible for developing a brochure on "clutter's resources" and a list of who's who to contact from first responders to home organizers.

To better facilitate our own work with hoarders and better represent Senior Care on the various task forces, the Senior Care Harm Reduction Team received certification from Boston University's School of Social Work's Compulsive Hoarding project.

In 2012, Senior Care was invited to participate in the Elder Affairs Hoarding Round Table and has contributed to the State's best practices document which will be ready for distribution by late 2013.

The Hoarding initiative at SeniorCare will be applying for potential grant funding to help support the efforts of this initiative and make services available for in-home services.

Massachusetts Coalition for the Prevention of Suicide

The Protective Services Director, a member of the Northeast Coalition for the prevention of suicide. He is a certified QPR gatekeeper in suicide risk assessment and risk management. Steve attends quarterly meetings and provides training to Senior Care Staff and outside organizations upon request.

Gloucester Coalition for the Prevention of Domestic Abuse

A Protective Services Worker represents Senior Care as a member of the coalition. It meets once monthly in Gloucester and provides networking with other professionals and lay persons concerned with domestic abuse. The coalition provides education and training to first responders, and the general public in order to fulfill their mission to expose and prevent domestic violence and its resulting abuse.

Gloucester Help for Abused Women and Children (HAWC)

HAWC provides education, support, and advocacy services to women (and children) on the North Shore. It serves as a referral source for SeniorCare's Protective Services department and can offer in-home support, arrange translation services, and provide outreach specifically to older women in their homes through the Older Battered Women's Program.

Beverly Citizen's Advisory Committee

SeniorCare attends the Beverly Citizen's Advisory Committee to ensure that Beverly committee citizens including the Beverly Police Department are kept up to date on SeniorCare activities and services in Beverly and in order to be provided with feedback on community needs relative to those we serve.

Meals on Wheels Association of America

SeniorCare is a member of the Meals on Wheels Association of America (MOWAA), a national association of meals on wheels providers. Among other benefits, MOWAA offers a range of training opportunities including modestly priced or free webinars and other regional and national trainings; provides grant funding opportunities through direct grants such as awards for March for Meals and links to external grant databases; and provides a national voice for Meals on Wheels and other elder-focused issues on a national level. MOWAA initiated the Campaign to End Senior Hunger by 2020 and instituted the very successful Mayors for Meals campaign that encourages state and local officials deliver meals one day a year.

Get Fit Gloucester

Get Fit Gloucester! began in 2009 when the City of Gloucester was awarded one of 10 statewide Mass in Motion grants intended to promote wellness and prevent overweight and obesity in Massachusetts, with a special emphasis on importance of healthy eating and physical activity. The Nutrition Director represents SeniorCare for the Get Fit Gloucester! Partnership, a group that includes civic leaders, Gloucester city and school staff, community organizations, medical providers and

businesses working together to create a “Fit Friendly Gloucester.” Benefits of participating in the Get Fit Gloucester partnership include the opportunity to advocate for attention to areas that may be of particular interest to an older population and networking.

Nutrition Advisory Board

The Nutrition Director/Registered Dietitian serves on the Nutrition Advisory Board of the Open Door, a Gloucester-based agency that seeks to alleviate the impact of hunger in our community. The Open Door serves residents of Gloucester, Manchester, Rockport, Essex and Ipswich.

The Food Project, North Shore

The Food Project engages young people in personal and social change through sustainable agriculture. The program works with teenagers from diverse background who help to grow and harvest food and distribute it through farmers’ markets, community supported agriculture programs, and local hunger relief organizations. The collaboration with SeniorCare and the North Shore branch of The Food Project began when the Nutrition Department chose to use funding it receives for the homebound Farmers’ Market program to purchase produce from The Food Project, North Shore. (Through the homebound Farmers’ Market program, nutrition programs in ASAPs across the state receive funding from the MA Department of Agriculture to purchase fresh produce that is packed and delivered to eligible older adults with their home delivered meal on two or three occasions during the summer.) This initial idea grew into The Food Project using the SeniorCare congregate dining site and the Beverly Council on Aging as a site for one of their youth crews. Each summer a group of teenagers spend one day a week for six weeks at the Beverly COA, assisting with meal service, chatting with participants, and helping with other functions at the COA. At least one homebound produce distribution is scheduled during this time so that the youth group has the opportunity to help pack and distribute food they helped to grow and harvest to home delivered meals consumers.