



COMMONWEALTH of VIRGINIA
Department for the Aging

[Click here to go to the Virginia Department for the Aging Home Page](#)

TABLE OF CONTENTS
ADDENDUM TO AAA TUESDAY E-MAILING
August 23, 2011

SUBJECT	VDA ID NUMBER
<u>Care and Coordination and CCEVP Service Standards</u> (Kathy Miller)	11-202
<u>Caregiving</u> (Ellen Nau)	11-203
<u>Aging Services Provider Information</u> (Ellen Nau)	11-204

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11-202

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM (ADDENDUM)

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: August 23, 2011

SUBJECT: Care Coordination and CCEVP Service Standards

In the Biennium budget passed by the General Assembly for FY 10-11 and FY 11-12, VDA was tasked to collaborate with the AAAs that are authorized to use funding for the Care Coordination for Elderly Virginians Program (CCEVP) to examine and analyze existing state and national care coordination models to determine best practices. To carry out this directive, VDA convened a work group to examine care coordination models. District Three Senior Services, Prince William AAA, Rappahannock-Rapidan CSB, Central Virginia AAA, Rappahannock AAA and Crater District AAA served on the work group.

As a result of the work group's efforts, four models of support coordination are now approved as options that can be implemented under CCEVP funding. These are Service Coordination Level One, Service Coordination Level Two, S.O.S. and Options Counseling. Attached for your review are the draft service standards for Service Coordination Levels One and Two and S.O.S. The Options Counseling Service Standard has been developed by a separate work group made up of AAA-CIL teams under the AoA Options Counseling Grant.

In addition, VDA has also revised the Care Coordination Title III-B and III-E Service Standard to allow increased eligibility under the OAA definitions of "frail" and "case management."

Please review the draft standards. If you have comments or questions, please send them to Ellen Nau at ellen.nau@vda.virginia.gov no later than **September 15th**.

Title III B and E CARE COORDINATION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Care Coordination is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.¹ Care Coordination is a distinct and comprehensive service. It entails investigating a person's needs and resources, linking the person to a full range of appropriate services, using all available funding sources, and monitoring to ensure that services specified in the care plan are being provided.

Eligible Population

Care Coordination shall be targeted to those older persons, age 60 years and over, who are frail, or have disabilities, or who are at risk of institutional placement. This includes individuals who are determined to be functionally impaired because they are unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or they have a cognitive or other mental impairment that requires substantial supervision because they behave in a manner that poses a serious health or safety hazard. Priority shall be given to older persons who are in the greatest economic or social need and/or residing in rural and geographically isolated areas with particular attention to low-income minority individuals and individuals with limited English proficiency.² Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis.

Service Delivery Elements

Care Coordination providers must perform all of the following:

Outreach:

Outreach is the proactive seeking of older persons who may be in need of care coordination. It involves defining and identifying a target population, and devising an outreach mechanism for educating this population about the program. Outreach makes the service known to other providers and helps assure proper referrals and coordination of care.

Intake/Screening:

Intake/screening is an initial evaluation of a person's needs for care coordination and/or another service. The purpose is to obtain enough information to determine the person's likelihood of needing care coordination or another service and whether a full assessment is needed. The information obtained includes the reason for the referral for the individual seeking help, the informal and formal supports already available, and basic information

¹ National Aging Program Information System Reporting Requirements – State Program Report Definitions

² Older Americans Act of 1965 as amended 2006. Section 306(a)(4)(A)(i)

such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities, in the older person's residence or by telephone.

Assessment:

The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers. The assessment is conducted prior to provision of any further care coordination services. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for care coordination services and a full Uniform Assessment Instrument is completed.

- A nutritional screening shall be completed on each client.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Cost sharing is prohibited in Title III Care Coordination

Care Planning:

The care plan is the link from the assessment to the delivery of services. Working with the person and the caregivers, the Care Coordinator develops a plan to address the problems and strengths identified in the assessment; the establishment of desired client-specific goals; the development of a complete list of services to achieve these goals, the responsibilities of the Care Coordinator, client, and informal and formal supports; and the payment sources for services. The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of denial into care coordination shall be mailed within five (5) working days of completion of the plan of care.

Service Delivery:

Service delivery is the process through which the Care Coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided by outside agencies through collaboration, formal request, or the use of purchase-of-service agreements; coordinating help given by family, friends, and volunteers; and requesting services provided directly by the care coordination agency.

Monitoring:

Monitoring is the maintenance of regular contact with the person, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate,

of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs change. Contact must be made monthly with the client for purposes of monitoring the implementation of the care plan.

Reassessment:

Reassessment is the formal review of the client's status to determine whether the person's situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs have changed, the care plan is adjusted. This review is done at least every six months while the individual remains open to care coordination or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s). If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the client. The change should be noted on the care plan and in the care coordination progress notes. The Care Coordinator should make two copies of the revised care plan, mailing one to the client and retaining the other in the client's electronic file.

Termination:

Care Coordination services can be terminated at the discretion of the service provider or the client. Written notification of termination of care coordination services shall be mailed to the client 10 business days in advance of the date the action is to become effective.

Administrative Elements

A written Policies and Procedures Manual must be maintained for the service.

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 form or supporting documentation, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Care Coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct client assessments (including psychosocial, health and functional factors) and use them in care planning; interviewing techniques; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of file documentation, and service planning process and the major components of a service plan.

- Skills: Care Coordinators should have skills in negotiating with consumers and service providers; observing, filling and reporting behaviors; identifying and documenting a consumer's needs for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of elderly and/or disabled persons, and assessing individuals using the Uniform Assessment Instrument (UAI).
- Ability: Care Coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining 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 to communicate with different types of persons from diverse cultural backgrounds, and interview.

It is required that an individual complete training on the UAI prior to performing care coordination.

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.

Job Description: For each paid and volunteer position an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and
- A current description of the minimum entry-level standards of performance for each job.

Units of Service:

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

- Hours (All hours relating to care coordination services, including travel time. Assessment time is included in hours, if this process leads to care coordination. An hour or part of an hour in 15-minute increments is a unit of service.)
- Persons served (unduplicated)

Program Reports:

- Aging Monthly Report (AMR) to VDA by the twelfth (12th) 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 or PeerPlace client level data transmitted to VDA by the last day of the following month.
- A completed and properly maintained electronic/digital full Uniform Assessment Instrument (UAI) is a mandatory requirement.
- The question “Client in Federal Poverty?” (answer Yes or No) must be asked and recorded.

Organizational Structure:

Care Coordination Services are separate and discreet services of an area agency on aging. Care Coordinators must be organizationally separate from management of services provided by the agency that the care coordination clients might receive.

Consumer Contributions/Program Income:

The Area Agency on Aging shall formally adopt written policies and procedures, approved by the governing board, regarding the collection, disposition, and accounting for program income.

- Cost Sharing/Fee for Service: Cost sharing/fee for service is prohibited in Title III Care Coordination.³
- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation is non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.⁴

Quality Assurance:

Criminal Background Checks:

- VDA requires that the agency and its contractors protect clients by conducting criminal background checks for staff providing any service where they go to or into a client’s home.

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client’s rights’ characteristics and resources of the community; and techniques for conducting the assessment, care planning, arranging services, and monitoring.

³ Older Americans Act of 1965 as amended 2006, Section 315(a)

⁴ Older Americans Act of 1965 as amended 2006, Section 315(b)

- Each staff person must participate in eight (8) hours of in-service training per year. Content should be based on the Care Coordinator's need for professional growth and upgrading of skills.

Caseload Size:

The ratio of clients to Care Coordinator must be reviewed annually and is dependent on the following:

- characteristics of the target population served (e.g., very frail, disoriented, without family support);
- complexity of the care plan;
- geographical size of the area covered, taking transportation difficulties into account;
- availability of community-based services; and the extent of responsibility and control over funds that is exercised by the Care Coordinator.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service. The Case Monitor Section for this service must be utilized in the approved Virginia Department for the Aging electronic data system.

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service.

Anonymous client surveys of the service shall be done annually. Surveys should be maintained in an agency file with a summary of the survey results.

Complaint and Appeals:

Care Coordination agencies shall have in place a written Complaint Procedures and Appeals Process.

Client Bill of Rights:

Care Coordination agencies shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving care coordination services and includes basic tenets that should be followed in providing the service. Clients should receive copies of the bill of rights on commencement of care coordination, and a signed, dated copy is to be kept in the client's record.

Client Records:

Records must be maintained for all recipients of services. The approved Virginia Department for the Aging electronic record system must contain:

- Consent to Exchange Information Form
- Full Uniform Assessment Instrument (UAI)
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation.

- Care Plan (original and revisions)
- Monthly Progress Notes
- Care Coordination Outcome Report Closing Summary
- A Caregiver Form, if this service is funded by OAA Title III E.

The Area Agency on Aging will maintain:

- A copy of the Denial or Termination of Care Coordination Services Letter
- A signed copy of the Client's Bill of Rights/Service Appeals/Termination Policy

DRAFT



COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen M. Nau, Program Coordinator

DATE: August 23, 2011

SUBJECT: Caregiving

Grandparents Rally

The Fourth National GrandRally will be held on September 15 at 1:00 P.M. on the Grounds of the U.S. Capitol in Washington, D.C. The rally is designed to promote the realities of challenges that relative caregivers must overcome and the contributions they make to the lives of the children that they parent.

For further information and to register, go to:

http://cdf.childrensdefense.org/site/PageServer?pagename=grandrally_home

Virginia Caregiver Coalition

The next meeting of the Virginia Caregiver Coalition will be held on Friday, September 16, 2011 at 9:30 A.M. The meeting will include a presentation by Kelly Stuart, MD, MPH of the Bon Secours Health System on *Ethical Decisions: A Conversation Around the Issues in Caregiving*. Attendees for this meeting are welcome at the Virginia Department for the Aging and at various video conference sites throughout the Commonwealth. For further information, contact Ellen.Nau@vda.virginia.gov

Dr. Stuart is Medical Director of Clinical Ethics at Richmond Bon Secours and Medical Director of the Center for Healthy Beginnings. She has a Bachelor of Science Degree in Scientific Nutrition from Texas A&M, a Medical Doctor degree from Eastern Virginia Medical School, a Master of Public Health Degree from the Uniform Services University, and is studying for a Master of Arts in Theological Studies at Baptist Theological Seminary. Dr. Stuart did postgraduate medical training at Walter Reed Army Medical Center and the National Naval Medical Center. During her military service, she served

as staff neonatologist at Landstuhl Regional Medical Center, staff pediatrician, Langley Air Force Base, and staff neonatologist at the Naval Medical Center Portsmouth.

Dr. Stuart is married to Dr. J.E.B. Stuart V, MD and is the mother of three children.

If you would like to submit a question for Dr. Stuart to answer during her presentation, Please contact VCC Education Committee Co-chair, Kathleen Fogerty at 804-213-0919.

Advance Notice!

New River Valley Area Agency on Aging announces:

“Caring Connections” Fourth Annual Caregiver Conference and Resource Fair

October 15, 2011 8:00 A.M. until 3:30 P.M. 117 Edwards Hall at New River Community College in Dublin, Virginia

Featuring Teepa Snow, a highly engaging and sought-after presenter, nationally recognized for her work in Dementia Care & Dementia Education.

For further information or to register, contact 540-980-7720

Family Caregiver Alliance - Survey For Family Caregivers

Family Caregiver Alliance is partnering with several other caregiver organizations and experts to focus on assistive technologies and is administering a survey on the topic. Assistive technologies are defined as a piece of equipment, training, or intervention that promote greater independence by enabling individuals to perform task that they were formerly unable to accomplish or had great difficulty accomplishing. The anonymous survey takes about five minutes to complete and participant responses will help guide FCA and other provider organizations on what types of technology are most helpful for family caregivers and their loved ones. To participate in the survey, visit:

https://www.surveymonkey.com/s/Survey_FCA

Family Caregiver Alliance – Gilbert Awards

Three awards of \$20,000 each will be awarded to *nonprofit organizations, government agencies or universities* responding to a community need with a program or project which focuses primarily on *family/informal caregivers of adults with Alzheimer's disease and related dementias*.

The deadline has been extended for the Awards until September 16. For further information go to:

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=2188

Grandparent Research Project

Kathy Dial of Catholic Charities of Eastern Virginia and member of the Kinship Care Initiative Statewide Task Force is seeking grandparents to participate in her PhD. research project. The survey will take one hour and the personal information on grandparents and their grandchildren is kept strictly confidential. If you know of someone who would like to participate contact Kathy at grandparent.study@cox.net or 757-905-4546. Participants will be awarded \$15 Wal-Mart Gift Card.



11-204

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Program Coordinator

DATE: August 23, 2011

SUBJECT: Aging Services Provider Information

Medicaid Fraud – Be Alert!

The federal government's recovered a record \$4 billion last year from people who attempted to defraud seniors and taxpayers. This fraud is despicable and inexcusable. CMS recently announced that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Medicaid recipients can be educated to identify and report suspected fraud. Help your clients access the **CMS Fraud Prevention Toolkit** on the web at https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp#TopOfPage.

The Quality Care Finder

The Centers for Medicare & Medicaid Services just launched the Quality Care Finder designed to help beneficiaries and their caregivers find better health care options. To find health care providers, facilities, health and drug plans, and equipment suppliers, and to make "apples-to-apples" comparisons of their quality, patients and their caregivers can go to www.Medicare.gov/QualityCareFinder or call 1-800-MEDICARE (1-800-633-4227) or TTY call 1-877-486-2048. For further information,

MindAlert Award

The application process for the American Society on Aging's 2012 MindAlert Award is now open! Sponsored by the MetLife Foundation, MindAlert Awards are available in the following three categories:

1. Lifelong Learning/Third Age educational programs
2. Mental Fitness Programs for the general population of older adults.
3. Mental Fitness Programs for early stage cognitively-impaired older adults

Each Awardee will receive:

A cash awards of \$1,500

One complimentary Aging in America conference registration

A one-year complimentary membership in ASA

Go to: <http://www.asaging.org/mindalert-award> for more information and an application.

Expiration of SSI Benefits for Elderly Refugees

On April 21, 2011, the Office of Public Engagement (OPE) hosted a two part national stakeholder teleconference specific to issues affecting refugees, asylees and other non-citizens. The first portion of the stakeholder call focused on the expiration of Supplemental Security Income (SSI) benefits for certain refugees and other non-citizens. Information from the stakeholder teleconference can be accessed at:

<http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=33d10d96eb591310VgnVCM100000082ca60aRCRD&vgnnextchannel=994f81c52aa38210VgnVCM100000082ca60aRCRD>

Also, to learn more about the citizenship application process and what tools USCIS offers for citizenship preparation, please visit the USCIS Citizenship Resource Center by visiting the link identified below.

Link: <http://www.uscis.gov/portal/site/uscis/citizenship>