South Shore
Elder Services, Inc.

Area Agency on Aging
Area Plan 2014-2017

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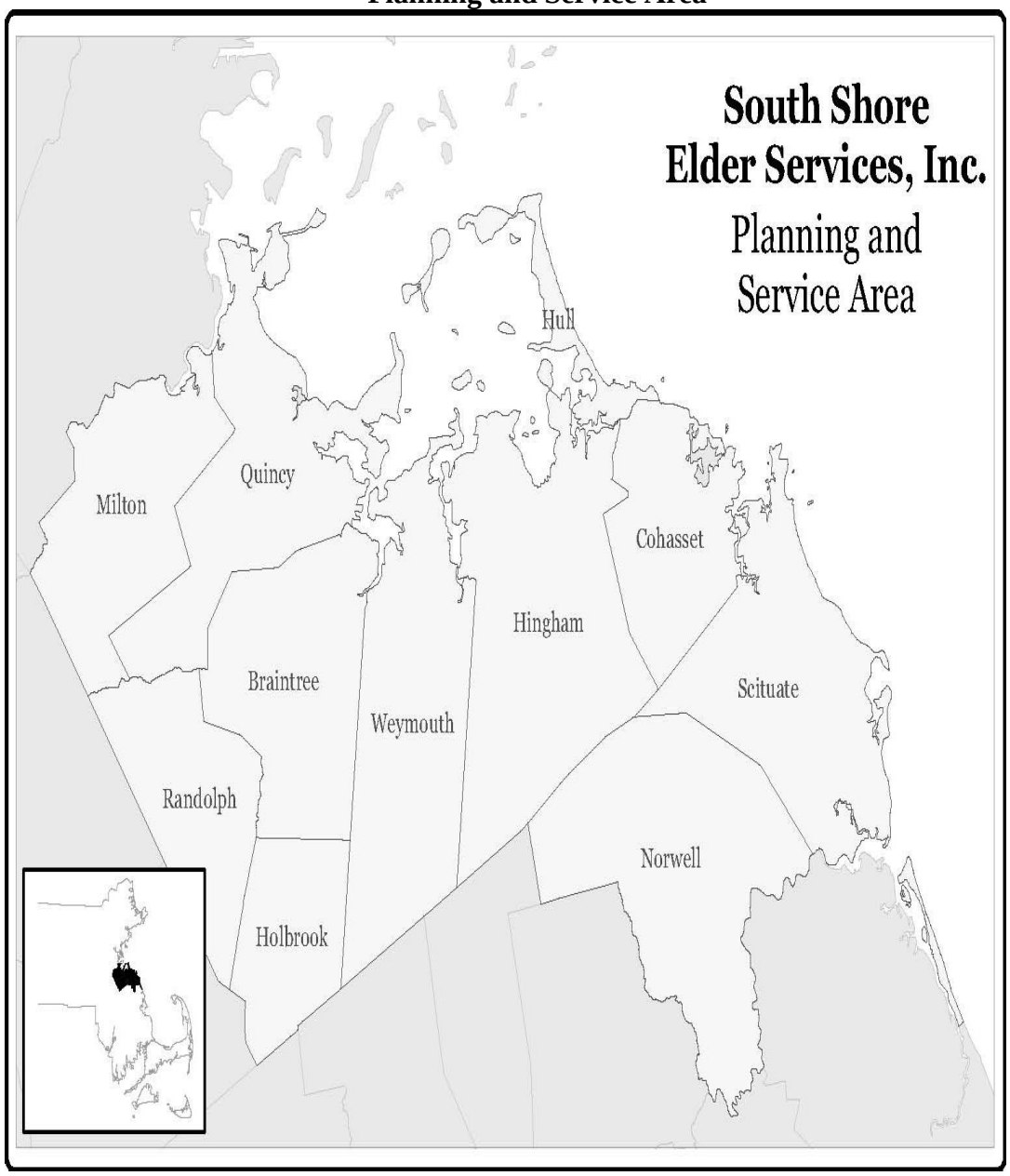

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Introduction
South Shore Elder Services, Inc.
Area Plan on Aging 2014-2017

Executive Summary

South Shore Elder Services, Inc. (SSES) is a private, non-profit agency established in 1977. The agency serves nine towns (Braintree, Cohasset, Hingham, Holbrook, Hull, Milton, Norwell, Randolph, and Scituate), and two cities (Quincy and Weymouth). Although SSES is not considered rural according to the U.S. Census (an area which contains less than 100 persons per square mile), there are some communities within the SSES Planning and Service Area (PSA) which are more "rural" than others (e.g. some communities can access resources easier than others such as community transportation).

SSES provides a broad range of programs and services to people age 60 and over to promote elder independence and services to caregivers. SSES also provides information, resources, and support to caregivers who may be under the age of 60 years old and caring for someone 60 years of age or older. A Board of Directors representing all eleven communities governs the agency through planning, policy development, and oversight of the programs and services it delivers. An Advisory Council advises the Area Agency on Aging according to the needs of elders and caregivers in the PSA.

Since 1978 SSES has served as an Area Agency on Aging (AAA). In this role, our mission and purpose is driven by the vision of Executive Office of Elder Affairs (EOEA) and the Administration for Community Living (ACL) to work closely with local Councils on Aging and other agencies and organizations to develop a comprehensive, coordinated and cost-effective system of home and community-based services that help elderly individuals maintain their health and independence in their homes and communities while having the supports necessary to maintain their wellbeing and dignity.

ACL Focus Areas:
In addition to the Title III funded service goals, the SSES also works as a partner with various organizations in seeking to address the focus areas established by the ACL. Specifically, SSES seeks to address the needs of target elders in relation to Older Americans Act (OAA) core programs: ACL discretionary grants, participant-directed/person-centered planning, and elder justice. We do so by requiring responding agencies to specify their plans for providing identified services to target group elders in the region. This Area Plan provides a detailed explanation of our efforts to address the established focus areas; either directly with Title III funded programs and services, and/or indirectly with administrative support to other agencies and programs working on these areas.

Needs Assessment:
Part of our responsibility as a AAA is to maintain a comprehensive understanding of the greatest unmet or under - met needs of elders who reside in the region. This is accomplished through various means, including surveys of provider agencies and older people. Our most recent

2013 elder needs assessment project identified the following as significant needs and service priorities for elders in our region. (See attachments 1-7)

1. Transportation
2. Mental Health Care
3. Financial Concerns
4. Language Barriers
5. Socialization and Support groups for both elder and caregiver
6. Education and Information

Our request for proposal process establishes minimum standards for addressing specific target group service provision requirements, and outlines goals for responding agencies in meeting the service requirements for the region. During our needs assessments, it has been determined that that our priorities have not changed and SSES is extending contracts to our current providers for another fiscal year.

Quality Management and Practices for Funded Programs and Consumers:
All Title III funded programs are required to maintain a level of performance and service that is monitored on an ongoing basis by SSES. Monitoring is accomplished by quarterly grantee meetings, ongoing contact with grantee, review and analysis of monthly program performance reports, funding requisition requests, and annual site visits. With this system, we monitor and track program performance in relation to the agency proposal and SSES's expectations for performance. Additionally, any consumer of AAA services that is not satisfied has the right to file a grievance or complaint over any issue that arises during the course of receiving services. (See Grievance and Complaints Policy, Attachment 8)

During FFY2013, SSES provided the following:

- 11,636 information services through the Information, Outreach and Referral Department
- 2,856 Nursing Home visits through the Ombudsman Program
- 44,040 congregate meals through the Nutrition Program
- 347,659 home delivered meals through the Nutrition Program
- Received 286 referrals for the Family Caregiver Support Program
- Assisted 1,300 Asian elders and caregivers through the Asian Outreach Program

Through working with other community organizations, SSES not only receives referrals for services, but SSES also provides information on the variety of community organizations as service options for elders and caregivers in the PSA. SSES has partnered with these community organizations to develop specialized services for elders and caregivers such as healthy eating support groups, the South Shore Caregiving Collaborative, Mental Health Coalition, Southern Mass ADRC, Greater Boston ADRC, and Asian Outreach Support services at Quincy Asian Resources, Inc. The agency uses federal funds available through Title III of the Older Americans Act to initiate or expand community programs and to develop long-term community capacity to meet the needs of elders.

The Older American's Act is a governing document for the AAA, which promotes the well-being of elders and caregivers. It is divided into several Titles, and they are as follows: Title I (Declaration of Objectives and Definitions), Title II (Administration on Aging), Title III (Grants for Community Programs on Aging), Title IV (Training, Research, and Discretionary Projects &

Programs), Title V (Community Service Employment for Older Americans), Title VI (Grants for Native Americans), and Title VII (Allotments for Vulnerable Elder Rights Protection Activities). Since it was signed into law on July 14, 1965, the Older Americans Act has been periodically amended to include additional programs/services for elders.

Funding for SSES comes from federal sources (primarily Title III) and from the Commonwealth of Massachusetts, through the Executive Office of Elder Affairs. Contributions from individuals, area businesses, and community organizations are welcomed and needed.

Area Plan on Aging 2014-2017 Narrative

Administration on Aging Focus Areas Plan

Focus Area #1: Older Americans Act Core Programs/Title III &Title VII and Focus Area #4: Elder Justice: ***Vulnerable Elder Population***

Some of the goals addressed in this section of the narrative include: financial concerns, socialization for elders and caregivers, education and information, and developing operational improvements that provide better service, quality and efficiency.

South Shore Elder Services (SSES) does not have any known ***Native Americans*** in the planning and service area (PSA), and therefore cannot address this focus area. While we have had a few individuals identify themselves as such, we do not work with any tribal council.

SSES continues to prioritize protecting elders and their rights. The results of our most recent focus groups establish that the supportive services provided by SSES are identified as a primary emphasis needed to meet the needs of elders and their caregivers to promote their independence and wellbeing. SSES will continue to address this in a variety of ways including programs offered at SSES as well as partnering with community organizations.

The SSES Ombudsman Program protects the rights of residents in Nursing Homes and Rest Homes. The Ombudsman Program Director conducts resident's rights trainings with Nursing Home staff, SSES staff, and Nursing Home residents on a regular basis in order for them to be aware of the rights of residents in Nursing Homes. The Ombudsman Program also conducts trainings on abuse for Nursing Home staff. Additional community trainings are offered upon request and are tailored to meet the needs of the audience.

A Long Term Care Ombudsman will meet with the residents of Nursing and Rest Homes on a regular basis in order to ensure that their rights are protected, and they will advocate on behalf of the residents as needed. The Ombudsman will also periodically consult with Greater Boston Legal Services (GBLS) on any legal issues that may arise. Greater Boston Legal Services Attorney meets with the Ombudsman staff annually to update staff on any new issues that may arise due to changes in regulations or laws. The Ombudsman staff also work collaboratively with the Department of Public Health during the investigation process when complaints of that nature occur. They also meet with the survey team annually when they visit a facility for inspection. The Ombudsmen also receive on-going trainings on a regular basis on such topics as the nursing home rating system, case resolution, guardianship, culture change, resident's rights, etc. An Ombudsman undergoes extensive 3-day training before becoming a part of the program and visiting residents on Nursing and Rest Homes.

In the future, the Ombudsman Director would like to continue to promote the concept of "culture change" with nursing homes in order to ensure that they are meeting all of the needs of all of the residents. Some Nursing Homes in the SSES PSA have introduced this concept to make service delivery less institutionalized and more personalized (and home-like) for residents. The program also plans to collaborate on a community education program with the Family Caregiver Support Program to educate caregivers on nursing homes. Additional educational and learning

opportunities were identified as a need by caregivers during the most recent focus group meetings. The Ombudsman Director and Assistant Director also plan to meet with the Council on Aging Directors and/or Outreach Workers as part of their future outreach to discuss the Ombudsman Program, and how it can help nursing home residents and their families. Trainings on care plans and sensitivity are also a future goal of the program.

SSES also allocates Title IIIB funding to a legal service organization (GBLS), which provides information, education, and legal support to elders in the SSES PSA. The staff at the legal service organization have focused some of their advocacy efforts on elder consumer protection (specifically from debt collectors), and they have begun to help elders develop health care proxies and Power of Attorney documents. The staff has also conducted legal service community education programs at Councils on Aging to help inform the public of their legal rights. This will continue in the future. GBLS staff have also advocated for elders through legislative work, and most recently they have worked on the following legislative advocacy: an act to protect elders from credit collection communications, an act to reform debt collection practices, an act to establish public guardianship, and an act to restore the personal needs allowance for Nursing Home Residents. GBLS will continue its legislative advocacy in the future based on the needs of elders. Staff is also available to consult on cases and provide legal advice to elders as needed. SSES will continue to provide Title IIIB funding to a legal services organization during the next four years.

The SSES Protective Service Advocates (PSA) are specially trained to assist elders and their families with sensitive situations that may contain physical abuse, emotional abuse, sexual abuse, financial exploitation, neglect or self-neglect. All PSAs take a non-judgmental approach and look to protect the well-being of the elder with the ultimate respect for his/her right to make decisions for him/herself. The goal of the Protective Service (PS) department is to make resources available to elders and their families which will allow the elder to remain safely in the community. Each advocate works with the elder and his/her family to offer the least restrictive intervention possible with the purpose of having the least amount of disruption to the elder's life. Some of the services offered may include: crisis intervention, safety planning, case management, home care services, referrals to appropriate resources such as counseling and support groups, alternative housing, family intervention, legal intervention, and advocacy. Protective Services are available 24 hours a day. Protective Service staff is also available to consult on a situation where abuse or neglect is suspected.

The SSES Protective Service Department continues to conduct community education for mandated reporters and community members about the topic of elder abuse and neglect. For instance, the Clinical Director of SSES and the Protective Service Program Director of OCES presented Protective Services from A-Z: A Presentation on An Elder's Right to Self Determination at the Senior Networking Conference. This was a 1.5 hour seminar offered to professionals reviewing the many facets of the program which included the elder abuse reporting law and the role that Mandated Reporters play in assisting elders who may be a victim of abuse. Another example of community outreach that is done annually to raise awareness of this critical issue is done in honor of Elder Abuse Awareness Day. Specifically, the Protective Service Program hosts a program for both community members and mandated reporters to learn more about elder abuse. Attendees were provided with statistics, case examples and an opportunity to

meet the advocates on the front lines. Outreach is also done on an annual basis with the local Police, Fire, COAs and Visiting Nurse Associations and contracted providers of SSES.

In an effort to strengthen and expand our relationships within the community and within our network, a representative from SSES protective service team participates in several collaborative meetings. For example, PS has become involved with the Plymouth DA's attempt to foster better communication between police officers, DPPC, adult protective services and the DA office in order to provide better intervention once abuse has been identified. Another collaborative group has been arranged by Melissa Bickler, a Mental Health Clinician at Quincy Police Department in order to strengthen ties between local agencies (mental health agencies, housing authorities, shelters, police and protective services) in order to assist individuals with mental health issues struggling in the community. These meetings are held quarterly.

Finally, the supervisory team seeks to raise awareness and education about the various community programs available to elders. This is done so by hosting guest speakers during the Team meetings on a monthly basis. These trainings provide an opportunity for the community programs and the Protective Service Department to learn about what each respective program offers to consumers.

The SSES Money Management Program (MMP) is a program for elders and younger disabled individuals whose independence is at risk due to difficulty managing their finances. The MMP is jointly sponsored by AARP, Massachusetts Home Care, the Executive Office of Elder Affairs, and SSES. AARP has established income and asset guidelines based on HUD Annual Low-Income limits as the basis for program eligibility.

Because of the MMP, many consumers can live at home longer with the security of knowing that their bills are being paid. This program will continue in the future with plans to increase the number of educational seminars offered in the community on the topics of budgeting and basic money management.

The population currently being served is predominately 60 years and older (***are sometimes socially isolated***), an increased number of ***Protective Services clients***, and a ***few younger disabled consumers***. It is anticipated that with the growing collaboration of ADRCs we will be ***serving an increased number of younger disabled consumers in the future***.

The MMP Coordinator will periodically consult with Greater Boston Legal Services, or refer consumers to several elder law attorneys or elder care planners. The Coordinator also remains proactive for our consumers as their needs change and may refer high debt consumers to several non-profit debt counseling services, as well as over asset consumers to several private pay money managers.

The Money Management Program utilizes a team of volunteer monitors, who audit client records on a quarterly basis. In addition to our volunteers, the program also has a volunteer Advisory Board, which meets 2-3 x/ year. Our members represent banking, elder law and elder care planning, Councils on Aging, Social Security Administration, and volunteer bill payers.

Many times an elder's rights can be protected through altering their living situation or obtaining the paid assistance from another professional organization. Many elders are ***low income*** and do not have the financial means in order to access these types of supportive services. As an agency, SSES has also recognized the financial assistance needs of elders (and caregivers) in the community. SSES has a *"Special Needs Fund"* that provides financial assistance for a service or a product that can't be paid for by other means. ***The program is available to anyone in the SSES PSA.*** SSES has conducted annual fund raising efforts to raise money for the fund which will continue in the future. SSES has noticed an increase in financial needs over the last several years, and it has become a challenge to meet those needs in the community when other funding sources have received fiscal cuts in their programs. As a result, SSES has made it a priority to provide some financial assistance and to research other potential financial assistance programs for individuals in need. Some of the financial assistance provided has gone towards utility bills, moving expenses, and other daily living expenses.

In recent years, a large portion of funds has been utilized for the purchase of heat/oil as several programs previously available for financial aid have lost their funding. SSES will continue to look for creative ways to obtain additional funding for the *"Special Needs Fund"* (e.g. through fund raising, private donations, and applying for grants) over the next four years. Part of SSES's *annual "Aging is Everyone's Future"* conference this year will include a raffle fundraising specifically for the Special Needs Fund. In the last 2 years, South Shore Elder Services has been designated as one of the recipients of The Visiting Angels *"Dancing with the Angels"* fundraising event where staff have participated in the dancing competition at the event. We hope to continue this event as it has been a great success, and this year included the Plymouth Philharmonic as well. SSES staff have volunteered to assist with the coordination to ensure the success of the event.

This was the eighth year of the *"Aging is Everyone's Future"* conference and the focus was on the importance of *"The Power of Positive Humor."* Each conference has provided education to individuals on areas of aging that may not be needed presently, but may be needed in the future. The conference's goal has been to let attendees know about resources and information before it is needed so that people are more prepared when a "crisis" may occur. This program will continue over the next four years and each year will have a different focus based on identified needs for aging "Baby Boomers".

Affordable housing has become increasingly important during the difficult economic times of the state and the country. This was an identified need during the most recent focus group meetings and the increase in the type and number of phone calls and assistance needed is supported through the Intake, Outreach, and Referral (IOR) and Housing Departments of SSES.

Our Housing Department and IOR staff have received an increase in the number of telephone calls looking for and needing affordable housing on the South Shore. This has been a challenge for many reasons: primarily, there is simply not enough housing on the South Shore and the housing programs that do offer some availability have strict qualifying guidelines that must be followed. The SSES Housing Department and the SSES Information Outreach and Referral Department have a list of housing options on the South Shore. SSES has a Congregate and Supportive Housing Team who look for individuals that meet the criteria for those specific living arrangements as they are affordable and provide the socialization which many people need as

they get older. SSES has aimed to take steps towards ***helping individuals who are in their homes to remain in their homes (as long as they are safe), by providing some financial assistance (particularly related to home heating).*** SSES staff work closely with local Housing Authorities and other community agencies to develop strategies and solutions to find housing options for elders in the SSES PSA and this will continue over the next four years. ***SSES has also provided funding to a local homeless shelter in Quincy (Father Bills & MainSpring) to provide daily nutritious meals to homeless elders on the South Shore.*** This collaboration has strengthened SSES's working relationship with Father Bills & MainSpring. SSES seeks to continue this partnership with them in the future as it is critical for both agencies work on decreasing the number of homeless elders in the SSES PSA and develop creative solutions to the need for additional affordable housing.

Our program goals over the next four years are to: to strengthen relationships with housing authorities on the South Shore, to acquire and build working relationships with private subsidized housing options, and to continue to acquire and strengthen housing resources.

Focus Area #1: Older Americans Act Core Programs/Title III &Title VII, Focus #2: ACL Discretionary Grants

Some of the goals addressed in this section include: education and information, socialization for elders and caregivers, programs that support community living, programs that promote the well-being of seniors and allow them to remain in their own homes with a high quality of life.

Outreach to faith-based organizations will continue over the next four years as they offer an invaluable resource to reach elders and caregivers in the community regarding the resources and services that are available. In the past, faith based communities have hosted educational programs through the Family Caregiver Support Program, and the SSES Volunteer Coordinator has worked closely with faith based communities in order to recruit volunteers and successful stable nutrition sites. This type of successful recruitment has expanded into the nutrition program and will continue during the next four years. Six of SSES nutrition meal sites are located in churches and synagogues and as we explore expansion of services in the next four years, we will continue to use this faith based program model.

SSES's most recent faith based collaboration included the development of the LGBT meal site located in a Unitarian Universalist church in Braintree, ***a culturally isolated population.*** SSES will also be looking at collaborating with faith-based communities to develop a second LGBT meal site in the future through the SSES Nutrition Program. Most recently SSES partnered with the LGBT (Lesbian, Gay, Bi-sexual and Transgender) Aging Project to find a location in the community for the LGBT Aging Project to host a ***LGBT bereavement support group***; one of the churches in Milton that SSES has worked with in the past will be hosting this program.

The Volunteer Program at SSES is made up of multiple components that are integrated into our support services as well as our outreach efforts into the community. The strength of our Meals on Wheels Program, our Friendly Visitor Program, as well as our MMP is due to the success and ongoing recruitment of volunteers. Recruitment remains vital to the expansion and success of these services. All volunteers are CORI checked and trained by the Volunteer Coordinator

before being placed. Quarterly training on relevant topics is offered by SSES for all volunteers. In anticipation of a ***growing population of frailer elders, younger disabled and minority ethnic consumers,*** volunteer trainings are being updated in order to better prepare our volunteers to serve these populations.

SSES Friendly Visitor volunteers are matched with ***isolated seniors who have little or no informal supports*** for social companionship. Consumers involved in this program are also receiving case management services through SSES. Volunteers make weekly visits for about 1 hour. Depending on the identified need, services include reading as well as taking the consumer out for a walk or drive even if the consumer is able to do so unassisted.

SSES Volunteer Coordinator will plan to reach out to faith based communities in the future in order to recruit additional volunteers for the SSES programs, particularly the Nutrition Program in order to identify volunteers who would be available to deliver meals to homebound elders in emergency situations on a one time only basis. ***This initiative not only helps the current consumers at SSES but also offers a socialization opportunity for active elders and caregivers in the SSES PSA.***

Over the next four years, SSES will continue its efforts to increase collaboration with faith-based communities to offer information, resources, and support to its members, and to share resources in order to serve elders and caregivers in the community. In addition to these efforts, our volunteer recruitment efforts will expand to increasing our visibility on social media and using it to recruit a new generation of volunteers. We will also continue to utilize traditional recruitment methods such as word of mouth, local media, volunteer websites, and outreach to civic organizations.

Connecting ***elders to employment and volunteer opportunities is also a goal of SSES as part of healthy aging.*** The SSES Advisory Council has a member who works for the South Coastal Workforce Investment Board; this Advisory Council member helps keep SSES informed of workforce needs for elders in the SSES PSA and trends that are taking place across the state. The SSES Information, Outreach and Referral Department also has a stipend staff person from Senior Community Service Employment Program of America (out of National Asian Pacific Center on Aging), and the Nutrition Program is working on obtaining a staff person from this organization to help in the Nutrition Department in the future.

Transportation was identified as a need in the most recent needs assessment data gathering process conducted with elders. Transportation has always come up as a need during focus groups and surveys in the past and this past year was no exception. The SSES PSA is unique in that some of the communities in the PSA have more access to public transportation than others, which makes the lack of transportation compounded in some communities, for example a city such as Quincy has access to the "T" whereas many of the towns in the PSA have very limited public transportation options. SSES has continued to provide Title IIIB funding to Councils on Aging for the MAP Program (Medical Access Program) which provides out of town medical transportation to individuals who are 60 years of age or older. Although the funding is limited, the Councils on Aging are able to access this resource when they can't provide the needed transportation utilizing their own Council on Aging vans. This will continue over the next four years.

The SSES Information, Outreach and Referral Department also provides transportation resources to anyone who calls looking for information regarding transportation services, and this will continue over the next four years.

Focus Area #2: ACL Discretionary Grants and Focus Area #3 Participant – Directed/Person-Centered Planning

Some of the goals addressed in this section include Health Care System Coordination, a degree of choice and control over the long-term services and supports needed to live at home, services designed to access services and assist in overcoming language and cultural barriers, strengthening housing with supports options, and increasing supports available to informal caregivers.

Health care concerns for elders were an identified need during the most recent focus group meetings. SSES has three hospitals in the PSA, and SSES works closely with each of them. SSES is a member of two of the hospitals STAAR Initiatives Team and actively involved in reducing hospital readmissions. SSES is also actively involved in community partnership development with local accountable care organizations to streamline patient access to medical care and meeting the needs in the community.

The IOR Department receives discharges from South Shore Hospital (electronic discharges also known as e-discharges) of elders who will need home-based services. ***This has proven to be a helpful transition for elders who need services in the home after a hospitalization*** and SSES will continue this effort as well as work to expand this streamlined method of communication with the other two hospitals in our catchment area over the next four years.

SSES also works closely with two of the Visiting Nurse Associations in the PSA (Norwell Visiting Nurse Association and Hospice, Inc. and South Shore Visiting Nurse Association and Hospice, Inc.). SSES has provided Title III funding to each of them in order for them to conduct community health education programs and to provide support services to elders and caregivers in the PSA.

Options Counseling was launched in 2008, and is a free, short-term counseling service for ***elders, as well as young and disabled persons.*** The program began with one staff person and is now increased to three, better preparing our region to address the needs of the older as well as the younger disabled population. Options Counseling provides consumers with information about long-term supports, as well as consumer directed decision support to help evaluate service options. This service is an interactive process whereby ***consumers, family members, and/or significant others are supported in their deliberations to determine long-term care choices in the context of the consumer's needs***, preferences, values, and individual circumstances.

As part of the Massachusetts Aging and Disability Resource Consortium (ADRC), South Shore Elder Services plans to conduct more outreach for Options Counseling. Maintaining relationships within the community is crucial to the ADRC's "no wrong door" policy. Options Counseling will establish an outreach plan, which identifies specific hospitals, rehabilitation facilities, nursing facilities, community agencies and other providers for outreach efforts to

heighten awareness of Options Counseling services and generate referrals. Thus far, Options Counseling is conducted, on a regular basis, at a local medical practice, as well as at a local elderly housing complex.

Options Counseling will push to increase its service to the ***young and disabled population*** (ages 22-59). South Shore Elder Services will also strive to collaborate more closely with the ILC's (Independent Living Centers)

The Senior Care Options Program (SCO) joins forces with Medicare and Medicaid to provide a comprehensive care plan to the meet the needs of ***low-income seniors***. In doing so, the SCO program does a thorough psychosocial assessment, which then leads to the development of an integrated care plan. This allows for seniors to remain in the community. South Shore Elder Services currently holds a contract with Senior Whole Health, United Health and the Navi Care. South Shore Elder Services began a contractual relationship with Navi Care in January 2013. South Shore Elder Services currently serves 709 members Senior Whole Health Members, 325 United Health Members and 16 Fallon Navi Care members. In order to be eligible for the SCO program, an individual must be 65 years of age, eligible for MassHealth Standard, live within the SCO service area and receive medical care from within the SCO network exclusively.

South Shore Elder Services has developed strong relationships with each of the SCO Programs. It is imperative for effective service delivery that South Shore Elder Services works collaboratively with each program to meet the individual needs of the members. South Shore Elder Services has seen tremendous growth in the last four years that has required the hiring of additional staff. From 2008 until now, South Shore Elder Services went from 2.5 Geriatric Support Services Coordinators (GSSC) to a total 8. With the widespread growth that has taken place, South Shore Elder Services has recently restructured one of the Geriatric Services Support Coordinator Position into strictly a Team Leader Position. The Team Leader not only oversees the daily operations of the program, but also provides direction and support to the GSSC staff. As the numbers continue to grow, South Shore Elder Services will continue to monitor caseloads so that the necessary adjustments can be made to meet the growing demands of the program.

In maintaining a collaborative relationship with of the SCO programs, South Shore Elder Services, participates in quarterly clinical meetings with each program to ensure effective communication and service delivery. Specifically, the discussion may focus needs of specific members' as well programmatic issues. Each SCO seeks to provide staff development in clinical development such as conducting assessments with the use of motivational interviewing and computer training. It is imperative for South Shore Elder Services GSSC staff not only attend trainings set by each SCO but also to maintain a working knowledge of each computer program utilized by the individual SCO programs. This allows for SSES to keep up with the growing demands of each program and provide optimum services to the each member.

With the many changes facing the pre-existing health care system and the rising cost of health care, it can be very confusing to find the appropriate health care coverage options. SSES is fortunate to have SHINE (Serving the Health Information Needs of Elders) volunteers at the agency once a week who can meet ***with aging individuals, families and caregivers*** to present them with the best health care coverage options for them to choose based on their individual needs.

In addition to the two volunteer SHINE workers, SSES also has two full-time employees that have been trained as SHINE workers who are able to assist staff members navigate the intricacies of the health care system.

The SHINE program is managed through the regional office located at HESSCO. The SHINE workers also help ***elders and caregivers*** understand state and federal benefits, as well as long-term care options. The IOR and Options Counseling Departments can also assist in providing information on local medical professionals and organizations that provide health related information/resources. These types of calls and the need for updated information remains steady and our services will continue to provide guidance to our community over the next four years. South Shore Elder Services currently is working on establishing a Memorandum of Understanding with Granite Medical and South Shore Medical Center to provide SHINE Counseling Services to consumers on a monthly basis.

SSES has also identified the ***continued increase in the population of Asian elders and caregivers*** in the PSA. ***To help address the needs of this population, SSES has an Asian Outreach Worker who speaks Cantonese and understands the Chinese culture. He will continue to spend time with Asian elders and caregivers in the community to help connect them to resources, services and support in the community.*** The Asian Outreach Worker has advocated for the needs of these elders and caregivers in the SSES PSA. Some of the needs identified include: lack of classes in the community that can teach basic English, information, resources and support offered in the Chinese language, translation/interpretation needs, and assistance with medication management. Some of the services that have been funded through Title III grants include: information, outreach and referral services, community health education programs, social and recreational programs, translation services, caregiver support programs, and services that connect individuals to appropriate resources in the community (similar to case management work).

Another program that was funded through a Title IIIB grant was a survival English class that teaches participants basic English words and phrases in order to successfully communicate in the community (e.g. on public transportation, in stores or community centers, at the physician's office, etc.).

The Asian Outreach Worker has been very helpful in setting up ethnic meal sites with the SSES Nutrition Program as well as working with local Councils on Aging to include ***Chinese programming in the local communities***. Over the next four years, SSES will continue to have an Asian Outreach Program, work collaboratively with the Councils on Aging in the PSA, offer Title III grants to community organizations to develop programs and services for ***Chinese speaking elders and caregivers***, and increase collaborations with Asian service organizations in the community.

SSES continues to expand its partnership with the local Asian service provider community with translation services, promotion of educational and outreach services, and identifying new communities and their needs in our catchment area.

Our ongoing partners include the local libraries such as the Thomas Crane Library where we host ongoing seminars, local hospitals and COAs. Together we promote community center activities for Asian residents, expanding new monthly gathering groups such as one at the Simon C & Fireman Community in Randolph where ***participants include Asian, Japanese, Haitian, and Jewish seniors.***

SSES has also provided Title IIID funding to Quincy Asian Resources, Inc. to provide information and assistance with health related questions to Chinese elders and caregivers who may have questions and need assistance due to language and cultural barriers. Quincy Asian Resources, Inc. will provide written health information in Chinese and will refer Chinese speaking elders and caregivers to other service providers based on their identified need(s). The SSES Outreach Worker will continue to collaborate with our local Asian service provider agencies to conduct monthly community education programs on healthy living. The programs are offered in Cantonese/Mandarin and are open to community members to attend.

As elders, caregivers, and those coming of age need health care services, it is important to inform them of the resources and services available in the community. As has been discussed in this document, SSES's annual *"Aging is Everyone's Future"* conference helps link individuals to such services.

SSES Case Managers and the Clinical Assessment and Eligibility team also work with consumers to connect them to resources and information based on their healthcare questions and needs; this will continue over the next four years.

The Home Care Program is a state sponsored program that provides interdisciplinary case management and home care services to ***fixed income elders*** who have functional needs. It provides this help at a very reasonable cost determined by a State established co-pay schedule. Services are arranged through contracted Provider agencies and include PERS (personal emergency response system), personal care (help with showering, etc.), homemaking (assistance with laundry, shopping and meal preparation) and transportation for medical appointment purposes. Service plans may also include attendance at Adult Day Health or Behavioral Health Counseling. The goal is to assist consumers to remain as independent as possible for as long as possible.

Case Managers conduct a comprehensive health and psychosocial assessment through interviewing the applicant/other(s) present and making visual observation of the applicant's physical and cognitive condition and his/her environment. The consumer/representative is encouraged to participate in the discussion of how they feel their needs can best be met and to participate in the development of an initial service plan. The plan is developed in conjunction with a supervisor and input from Protective Services and Registered Nurses as needed with consideration given to the applicant's support system including family, friends, medical community and benefits available.

The Medicaid Team/CSSM (Comprehensive Screening and Service Model) has assisted caregivers and their families to maintain consumers in the least restrictive setting by enrolling consumers who have MassHealth Standard and meet clinical eligibility into Home and Community Based Services Waiver Program (HCBSW). As their needs have increased,

consumers are enrolled in Community Choices Program. A team approach has been developed with the RNs, Case Managers, NF Social Workers, consumers and their caregivers to assist with nursing home consumers' return to the community with increased services that enable them to receive the appropriate care and supports necessary to ensure that their discharges are successful. This approach has increased the Community Choices enrollment. Plans of Care are developed to meet the consumer's individual needs as well as to provide respite for their caregivers.

The Medicaid Team takes an interdisciplinary approach and reviews all care plans for those consumers enrolled in HCBSW. This collaborative approach is to ensure that each care plan developed appropriately responds to the individual needs of the consumer in order for them to remain in the community. The development of care plans for consumer's enrolled in the Community Choices Program including Nursing Home Discharge (Planning) Consumers has resulted in multiple service plans exceeding 42 hours of personal assistance services (Home Health Aide, Personal Care, Supportive Home Care Aide, Homemaker and Companion) per week or the Extended Service Plan.

The SSES Information Outreach and Referral Department Manager has developed informational flyers in the past on a variety of topics (such as a guide to fuel assistance, weatherization and conservation resources, preparing for a winter weather emergency, and a hurricane disaster supply kit checklist) and distributed the information to community members as well as to Councils on Aging. Developing information on health related topics to be distributed in the community will also be explored over the next four years.

In addition to IOR phone assistance, SSES has also recognized the importance of disseminating written information into the community. SSES now maintains a resource library with community information available for anyone to take home with them. It is through all of these collaborations that agencies help prevent duplication of service and maximize the resources available to elders and caregivers. Efforts will continue to be made to increase the number of community collaborations over the next four years.

<u>Focus Area #2: ACL Discretionary Grants and Focus Area #3: Participant –Directed/Person Centered Planning Healthy Aging/Fall Prevention Programs</u>

Some of the goals addressed in this section of the narrative include: education and information, socialization for elders and caregivers, attain and sustain the best possible physical, cognitive, and mental health, and expand capacity and availability of and enhance the quality of community based long term services and supports, increase supports available to informal caregivers.

Healthy eating and living as an individual ages has been very visible in the media. SSES hired a nutritionist who has been conducting nutritional educational programs in the community on such topics as reading food labels and the importance of Calcium and Vitamin D. SSES has also partnered with South Shore Visiting Nurses Association (SSVNA) AND Greater Boston Chinese Golden Age Center (GBCGAC) to conduct the *"Healthy Eating Initiative*". This initiative includes partnering with three Councils on Aging in the PSA who conduct the community education programs. SSES has also provided Title IIIB and Title IIID funding to community organizations that conduct weight loss support programs, diabetes support groups, chronic

disease self-management programs, and healthy eating programs. This will continue over the next four years.

The SSES Nutrition Program looks at ways in which the menu for home delivered meals and congregate meals can incorporate healthy foods and health education opportunities. These opportunities may come through health education information posted on the SSES menu and through health education information offered at congregate meal sites. SSES recently hired a new Nutrition Program Director who will look at creative ways to continue this over the next four years. Plans for future expansion of home delivered meals include home delivered Asian ethnic meals.

Our Volunteers continue to be the primary kitchen helpers and deliverers for the Meals on Wheels program. Each meal site has its own roster of volunteers, mostly seniors, who work Monday-Friday and the Volunteer Coordinator keeps a current database of all volunteers. SSES has partnered with 10 different Special Education/Work programs to establish Meals on Wheels delivery teams. Examples include The Higashi School, The May Institute, St. Colletta's, WORK, Inc., and Road to Responsibility. These continue to be very successful working relationships and volunteer recruitment for this program will continue to remain a priority.

During FFY13 SSES has provided Title IIID funding to Norwell Visiting Nurses Association (NVNA) in order to promote, *"A Matter of Balance"* where the agency is able to conduct fall prevention screenings and educational programs in the community for consumers who receive cluster services. Many of these educational programs have been conducted at Councils on Aging or at senior housing locations. After the community education program, participants are encouraged to have a home safety assessment in order to identify any areas in their home that could potentially cause falls. SSES will continue to work with local Visiting Nurse Associations and other health care providers to provide community health education opportunities. Fall prevention in the home health setting is defined as a strategy that uses specific interventions to help specific patient or all patients avoid the risks of falling in an effort to reduce hospitalizations. NVNA utilizes the Four C's approach ---Consistent, Cross Discipline, Coordinated, and Culture. Their Care Team is interdisciplinary and consists of experienced nurses, physical therapists, occupational therapists, and HHA representatives. The services provided through this funding includes: individual Fall Risk Assessments, client/caregiver participation in the development of a personal fall prevention plan, evidence based fall prevention care pathways, intensive patient/caregiver education both verbally and in writing, outcome measures are defined and monitored, ongoing processes and systems to ensure there is equity for all individuals related to fall prevention assessment, harm reduction and interventions, ongoing benchmarking regarding Adverse Event related to Falls.

SSES also provided NVNA with a pilot funding for Congestive Heart Failure (CHF) Telehealth Program designed to reach out to ***newly diagnosed elders*** or those who have had a recent exacerbation of CHF symptoms. This program then expanded in its' scope to elders with cardiac and respiratory chronic diseases. The goal of this new program is to offer education and Telehealth technology to work with our seniors to help manage and keep chronic symptoms under control. The proactive program utilizes technology, data, and clinical expertise to oversee and improve care for elders living with CHF, COPD, emphysema and other respiratory conditions. Offered to elders over age 60 who are not homebound, the program runs for a 30-day

period during which lifestyle changes and positive behaviors are incorporated to enable the person to self-manage their disease. A Telehealth telemonitoring unit is installed in the elder's home to transmit biometric readings for 30 days to the central monitoring station at NVNA and Hospice. These readings include blood pressure, pulse rate, pulse oximetry and weight. During that 30-day monitoring period, the NVNA clinical team intervenes at teachable moments to coach and encourage the person.

SSES has provided funding to SSVNA and GBCGAC for Chronic Disease Self-Management Education Programs, designed by researchers from Stanford University. This is a six-week program offered to all South Shore residents living with the challenges of ***one or more chronic conditions*** either themselves or someone for whom they care. The program teaches strategies to improve quality of life, communication with doctors, and ability to handle stress. Funding under this initiative has also been made available to the ***Asian population through the program at GBCGAC***. The program leaders help participants set and meet personal goals, make good choices about one's health, and identify simple techniques that increase energy level.

We look forward to evaluating these new programs which support community living and enable our seniors to remain in their own home with a high quality of life. These programs are a benefit to our seniors and as they are new initiatives, their outcome measures will describe the impact made and expected to make as we plan for the next four years.

SSES provides funding and supports outreach activity to two very difficult to reach populations: the visually impaired and the deaf and hard of hearing. The *"Images Program",* a program in its twelfth year, is part of SSES outreach and provides a social opportunity for visually impaired elders to interact with others who have also experienced a loss in their vision as a result of macular degeneration or other health complications. The Images group is very cohesive, meets monthly, and collectively decides what events they will participate in during the upcoming calendar year. The strength of the relationships amongst the group members has allowed for them to find trust and support in one another.

The South Shore Elder Services assists in funding the New England Homes for the Deaf, Inc. (NEHD) satellite location at the Senior Center in Quincy. There are twenty one identified deaf seniors living in the South Shore service area. All twenty-one receive services including information/referral and weekly recreational opportunities. The program has achieved its goals by providing communication, accessibility, recreation, information and referral, as well as outreach activities to deaf and deaf- blind seniors. Also, every third Saturday of the month is "Community Bingo Night." Deaf seniors from the South Shore area have enjoyed weekly recreation sessions at all 3 NEHD satellite locations, information and referral related to upcoming events, social opportunities and a quarterly newsletter. Seniors have enjoyed several field trips including a Train Ride through the foliage of New Hampshire, Berkshires, New York and a trip to Foxwoods. In addition, the Volunteer Center Coordinator provides transportation and interpretation for shopping trips and doctor visits on a weekly basis. Attendance at the three centers averages 160 per week with many seniors traveling to more than one center throughout the week.

Program monitoring continues through semi- annual (or more often as needed) meetings of the Round Table. Each center chooses two delegates and two observers to attend a full day meeting

to discuss program goals and performance. They are then expected to return to their centers to share information. The South Shore Seniors are active participants at these meetings often providing solutions to problems. The program has a positive impact on this unique population and NEHD will strive to maintain and improve the program with close partnership with other agencies and organizations.

Part of SSES's annual *"Aging is Everyone's Future"* conference includes fundraising specifically for the "***Special Needs Fund".*** We recognize that many elders do not have the financial means to always pay for some of their critical needs such as medicine, food, and very often fuel. This financial commitment to the seniors and disabled in our community remains a priority for us as an agency. As we begin to expand our services to a younger disabled population and as our senior population continues to live longer, the need for this fund remains crucial.

During FFY12, the SSES *"Aging is Everyone's Future"* focused on *"Am I Having a Senior Moment or Is It More?"* which provided on how to care for a loved one with Alzheimer's and how to recognize signs of dementia vs. common forgetfulness. The conference's goal has been to let attendees know about resources and information before it is needed so that people are more prepared when a "crisis" may occur. Our FFY13 conference focused on humor and Mental Health Issues. Additionally, the conference has vendors representing different services or products that individuals may need as they age such as fitness organizations, home care services, in-home meal preparation services, etc. The annual conference will continue over the next four years and each year has a different focus based on identified needs for aging "Baby Boomers".

As the "Baby Boomers" age, SSES has noticed their increased interest in more recreational and social programs in the community as well as their focus on health issues. SSES has begun to see some of the Councils on Aging in the PSA begin to offer programs during the evening (for individuals to attend after work) and activities that appeal to a younger aging population such as yoga classes, journal writing, cooking programs, health education programs, etc. SSES supports the Councils on Aging in this effort and will provide information obtained from needs assessments to help the Councils on Aging develop future programming.

The Family Caregiver Support Program (FCSP) provides support, education, counseling, and resources for caregivers. This includes individuals who care for a person age 55 and over, individuals who care for a person with Alzheimer's disease, a grandparent or other relative over the age of 55 who is raising a child under the age of 18, or individuals who are 55 and over who are caring for an adult with developmental disabilities. Services provided by the FCSP include telephone consultation, in-home assessments, long term planning, and links to community resources.

The FCSP will strive to conduct more outreach by providing educational trainings at local Councils on Aging, local libraries, hospitals, Adult Day Health programs, Public Health Departments, and skilled nursing facilities in the area. FCSP will focus on reaching specific groups of people that populate the South Shore Elder Services catchment area- such as the "baby-boomer" population and the Asian population.

The FCSP will reach the public by utilizing the media, including local radio broadcasts and local cable access television. Special events will be posted on SSES website, Facebook, Twitter and Pinterest. The program's trained Caregiver Specialists will provide ongoing educational programs such as Caregiver 101, Holidays Tips, How to communicate with someone who has Alzheimer's Disease or Related Dementia, as well as a yearly program which The South Shore Caregiving Collaborative sponsors. The FCSP will also strengthen its collaboration with agencies that specialize in Alzheimer's care and education.

The FCSP will continue to work with the South Shore Alzheimer Partnership and attend the yearly Alzheimer educational event. Furthermore, the FCSP will attend the yearly walk to raise money to support caregivers who are dealing with the daily challenges of a loved one who has a diagnosis of Alzheimer's or related dementia.

The FCSP will continue to provide ongoing outreach in the area of special events as well as local Support Groups in the SSES catchment area. As has been typically done in the past, SSES will direct special attention to the Family Caregiver Support Program outreach efforts during National Caregiver Month- which is November. During this time, a celebratory event will be held to recognize caregivers and provide education to the public. Outreach will be done to advertise this event and caregivers will be invited to learn more about all that the FCSP has to offer.

Respite Services include the provision of one or more Home Care Program services to temporarily relieve the ***caregiver of a consumer*** in emergencies or in planned circumstances. The purpose of these services is to relieve the caregiver of the daily stresses and demands of caring for a consumer and strengthen or support the consumer's informal support system. In addition to services available under the Home Care Program, Respite Care services may include short-term placements in Adult Family Care, Nursing facilities, Rest Homes, or Hospitals.

A caregiver is defined as a family member regardless of place of residence or a non- family member **living in the same residence**, who is age 18 or older and who provides daily care to the consumer without receiving payment for providing such care. SSES strives to meet the needs of the caregiver and makes it a priority to assess the stresses and issues during each visit or telephone conversation. The CM discusses if the services are meeting the needs of the caregiver and if not, they will consult with their supervisor to make necessary changes in the care plan. Case Managers also assist the caregiver in coordinating community services that may supplement the SHC Program services.

South Shore Elder Services has recognized the importance of working with organizations serving the ***disabled community*** and is a member of the Aging and Disabled Resource Consortium. The primary goal of the ADRC is to provide a "no wrong door" model to working with individuals, allowing for a streamlined ***transition for individuals from the disability network to the aging services*** and to provide appropriate resources to individuals.

SSES is a member of two ADRCs. South Eastern/Southern Mass. ADRC includes collaboration with Independence Associates, Bristol Elder Services, Old Colony Elder Services, Coastline Elderly Services, and Southcoast Independent Living. The Greater Boston ADRC includes collaboration with Boston Center for Independent Living, Ethos, South Shore Elder Services,

Minuteman, Springwell, HESSCO, and Mystic Valley Elder Services The service that the ADRC provides is Options Counseling, a shared program of each member of the ADRC to promote the ability of streamlined access to meet the ***specific self-identified needs of all individuals in the community***. SSES continues to function as a member of the SEISM ADRC to collaboratively enhance partnerships, resources, and ***services to meet the needs of both elders and the young and disabled populations.*** SSES participated in consistent cross training with staff and members of the ADRC to enhance the knowledge of the ***aging disabled populations***.

The IOR Department continues to develop and enhance existing resource databases for the aging and disabled populations. A new hire orientation training on the ADRC disabled populations has been developed for new staff and on-going cross training from our local disability organizations will continue annually.

Money Follows the Person (MFP) is a demonstration grant awarded to Mass Executive Office of Health and Human Services from CMS. The demonstration will support the state's efforts to rebalance the long-term care support system, assist in transitioning individuals from long term care facilities to the community, and improve the long term care system overall. MFP allows for the consumer to receive enhanced support to assist them in moving out of long term care facilities. During pre-transition, the consumer will also work with the interdisciplinary discharge planning team that will assess their needs and facilitate the development of a comprehensive person-centered plan of care for the community. Post-transition, the consumer will receive 24-hour support, including a backup plan to ensure their needs are met and to prevent re-institution.

If a consumer is in NF for rehabilitative services only, care is considered daily if it is provided 5 or more times a week. *Alternatively, all MassHealth-paid days count towards the 90-day requirement.* To be eligible for MFP the consumer must meet the following criteria: 1. Have resided in a nursing facility (NF) for at least 90 days, or will have resided in NF for at least 90 days before discharge, excluding "rehabilitative days" defined as: the period of time in a NF during which the consumer receives daily rehabilitative therapies such as physical therapy, occupational therapy, speech therapy, and/or audiology services that are provided for a medical condition that was treated during a qualifying 3 day hospital stay, 2. Consumer must be eligible for MassHealth (or will be eligible for MassHealth prior to discharge); AND be eligible for Community MassHealth on discharge, 3. MassHealth has paid (or will have paid before discharge) for at least 1 day of NF services (a NF screening is completed), **4**. Consumer must transition to a qualified residence defined as: a home owned or leased by the consumer or his/her family, an apartment with an individual lease, with lockable access and egress and which includes living, sleeping, bathing and cooking areas over which the consumer or his/her family have domain and control. This may include Assisted Living Residence provided it meets all of the requirements; a community based residential setting in which no more than 4 unrelated individuals reside and, 5. Consumer must sign the Informed Consent.

Staff will administer the Quality of Life (QoL) Survey. RN will administer the survey to the consumer before discharge and by CM at 11 months and 24-month post discharge. The pre-transition survey will ideally be administered no more than 30 days prior to discharge. However, if the discharge is delayed, staff will not need to administer the survey a second time while the consumer resides in the nursing facility. Also if it is not possible to administer the survey prior to

discharge, staff may conduct it up to 10 days after discharge. If the initial survey is not administered to the consumer, staff will not need to schedule follow up surveys. Consumers do have right to refuse to participate in the QoL survey. MFP has continued to exceed the annual goals set for this program and the expectation is that this trend will continue. Many of the consumers enroll in MFP have resided in a nursing facility for well over 1-3 years and have successfully returned to the community with enhanced services through Choices Program.

In 2008, SSES partnered in a subcontract to offer care management under the auspices of Old Colony Elderly Service's Personal Care Attendant (PCA) Program. The PCA Program is a ***consumer directed care program*** overseen by Mass Health. This is an excellent resource for consumers and many caregivers. ***This program provides support to consumers allowing them to remain in the community rather than placement in a long-term care facility.*** The PCA program is consumer driven which means the consumer is responsible for hiring, scheduling and supervising workers. The consumer will work with a Skills Trainer who will assist the consumer with managing the many facets of the program. The Skills Trainer will explain the parameters of the program; answer questions and fill out the paperwork in order to get the program started. The consumer will collaborate with the Skills Trainer to develop a service agreement which specifically outlines the consumer's role and PCA under the program.

In order to qualify for the benefit, a person must be on Mass Health Standard and have a disability or illness that is expected to last at least six months. Additionally, the recipient has to require daily hands on assistance with at least two of the following tasks: mobility and transfers, taking medications, bathing and grooming, passive range of motion exercises, eating and continence management. A nurse practitioner or doctor must prescribe the services.

Over the last several years, South Shore Elder Services has experienced tremendous growth in the PCA Program. There are currently 174 consumers in the South Shore Elder Services catchment area. South Shore Elder Services currently has two full-time Skills Trainer. As South Shore Elder Services continues this partnership with OCES, SSES works collaboratively meet the needs of the consumers. This is done so with regular communication between both agencies. South Shore Elder Services works closely with the PCA Program Supervisor. Monthly unit meetings are held to ensure compliance and programmatic operations are achieved. South Shore Elder Services will work with OCES with regards to marketing the program and conducting community outreach. South Shore Elder Services also is undergoing the readiness review in preparation for the Integrative Care Organizations.

In 2009, South Shore Elder Services developed a contractual relationship with South Bay Mental Health. With this collaboration, South Shore Elder Services has been able to deliver ***therapeutic services to consumers in their home and the community***. The private contractual agreement initially began by offering South Bay Mental Health Day Program and home visits with clinicians to consumers. The contract allows the consumer to be seen for three visits without needing to provide their insurance information. The first visit is also referred to as the diagnostic service where an initial assessment is completed by the clinician to determine the needs of the consumer. If the clinician feels the consumer would benefit from additional visits beyond the initial three, the clinician will then work with the consumer to obtain the consumer's insurance information and transfer the billing to the insurance company. If the consumer does not have an accepted insurance plan, the additional visits may be approved at the discretion of

the Supervisor. When working with consumers to address concerns of hoarding, the clinician may schedule 4 visits with the consumer allowing an opportunity to complete the necessary assessments and establish rapport with the consumer. The clinician works towards identifying appropriate resources that will complement the therapeutic services.

South Shore Elder Services may request training in areas related to mental health topics. In the September 2012, South Bay Mental Health provided training to SSES contracted providers related to working with difficult clients in addition to reviewing staff safety during home visits. South Shore Elder Services will collaborate more with South Bay Mental Health in the future to develop staff awareness about topics related to mental health.

In 2010, the contractual agreement was expanded to include a South Bay Mental Health Clinician to attend weekly in the Home Care Team and monthly Protective Service interdisciplinary case conferences. This addition to the contract has been an asset for the staff. The Clinicians bring a different perspective and have been helpful in making suggestions to staff. Suggestions include offering resources available in the community, to whom to approach a volatile situation involving a victim of domestic violence. South Bay Mental Health Staff are also accessible to for case consultation over the phone on difficult cases as needed.

As the relationship with South Bay Mental Health has unfolded, both parties have been working towards thinking creatively when working with ***difficult consumers. As result, bridge visits and family case conferencing visits*** have been developed. ***Bridge visits are utilized when a consumer is in a restricted environment such as a nursing facility or hospital prior to discharge. The clinician will meet with the consumer to discussion the consumer's transition back to the community with service in place.*** The consumer's family may or may not be present. The initial first meeting is to gather information and to engage the consumer. When using a Family Group Conference, a clinician will facilitate a family meeting in which all parties are present to discuss topics related to the goals and needs of the consumer. The clinician will facilitate the discussion to formulate a plan for after care.

South Shore Elder Services will work towards identifying consumers on Mass Health that would be appropriate for the Community Support Program (CSP). The CSP has the ability to work with consumers who have more specialized needs that beyond the scope of what South Shore Elder Services can provide. For example, a consumer with a high level of anxiety may be unable to complete regular trips to the pharmacy or a department store. A referral to the CSP would provide an assessment and coordination to meet the needs of the consumer. Specifically, the consumer would be able to receive a higher level of case management and transportation. South Shore Elder Services will look to identify consumers and collaborate with South Bay Mental Health in order to provide effective and efficient services to these consumers.

South Shore Mental Health and South Shore Elder Services have regular communication to discuss the contractual relationship and to resolve concerns that may arise. Meetings are held every other month to monitor the contractual relationship with South Shore Elder Services and plan for future development as appropriate. Both parties agree to maintain the highest standards of ethical conduct in this working partnership with one another to offer quality services to consumers.

Focus Area #3 - Disaster Preparedness

Some of the goals addressed in this section include education and information.

In response to the disasters that have taken place over the last few years, community members are much more aware and interested in what they need to do to prepare for such events. As an Area Agency on Aging, SSES has developed a disaster preparedness protocol, and will continue to work towards educating the community on what they need to know and what they need to do in the event of a disaster. (See attachment 9)

During 2014-2017 SSES will look at additional ways to increase public awareness of disaster preparedness, and to continue to coordinate efforts with community and governing agencies to help plan and prepare for any kind of disaster or emergency.

SSES has recognized that consumers' and caregivers' needs continually change and as an organization, SSES must adapt to address those needs. SSES will continue over the next four years to identify community needs and work to address the needs through program and resource development, and collaboration with our new community partners such as the ADRCs as well as existing partner organizations. SSES will also continue to restructure and reorganize the staff to maximize the utilization of staff time and resources to work towards meeting the needs of seniors, disabled, and caregivers in the SSES PSA.