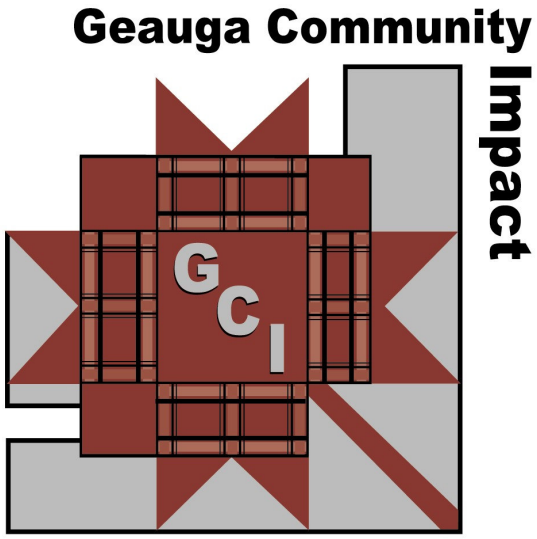

GEAUGA COMMUNITY IMPACT

Homebound Senior Strategy and Resource Plan

Final ~ July 28, 2008

Developed By:
Geauga Community Impact Homebound Task Force

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GCI Homebound Seniors Initiative
Strategy and Resource Plan: July 2008 – December 2010
Final ~ July 28, 2008

TABLE OF CONTENTS

Priorities……..2

Program Rationale……...……2

Initiative Elements by 2010……...…..…8

Theory of Change…….…….13

Lead Agency and Organizational Structure……...…14

Implementation……...……...18

Budget…….…...20

Supporting Forces and Challenges...…….….22

References……..……....23

Attachment..……...24

GCI Homebound Senior Task Force Members..……...27

Geauga Community Impact
Homebound Seniors Initiative

Strategy and Resource Plan
FINAL – July 28, 2008

Priority

Develop and implement a system of services for homebound elderly in Geauga County.

Program Rationale

Researchers are mixed on future service needs of older adults based on the babyboomers coming of age.

As described in the report, *Home Health Care*, (MCS, 2007): "there is considerable debate among experts concerning the issues and challenges facing America's home health care system, especially as it will be impacted by the aging of the population (Applebaum, Straker, Mehdizadeh, Warshaw & Gothelf, 2002). Researchers disagree about the number of elderly who will require care, what aging means, and the implications for policy at federal and state levels. For some researchers, there is the perception that disabilities among older persons will increase and drive up the need for more home and nursing care. The implication is that the absolute numbers of persons needing care will continue to increase, prompting a shortage of resources (Even, Ghosal, & Kunkel, 1998) (Applebaum et al., 1997; 2002).

"Others believe that the baby-boomer-driven demand for long-term supportive services is not likely to increase substantially until 2020—roughly 20 years or more from now—if at all (Redfoot & Pandya, 2002). Knickman and Snell (2002) are optimistic about future demand, citing the National Long-Term Care study's finding that the disability rate for all elderly Americans is dropping despite population growth. In short, they believe that the assumption that increased numbers and longevity deterministically relate to higher rates of disability, increased usage of institutional or non-institutional long-term supportive services, and the need for more staff is clearly wrong.

> To the contrary, longevity gains over the past decade and a half have been accompanied by declining disability rates and declining use of nursing home services. Whether one anticipates major demand for long-term supportive services or relatively modest increases depends to a large degree on one's assumptions about whether or not these trends will continue. As past experience indicates, accurate projections of future demand for long-term supportive services cannot be derived by simply projecting current utilization patterns onto future cohorts. Demography is not destiny. (Friedland and Summer, 1999)

"Despite these disagreements, most agree that the current system requires modifications if it is to meet the increasingly complex needs of consumers in a rapidly changing society."

It is from this starting point that Geauga Community Impact's Homebound Task Force set out to design a plan for a more responsive service delivery system for homebound seniors in the county to enable them to live independently in the community as long as possible. It is a fact that the babyboomers are coming of age; and the projections are that there will be more among them that join the ranks of the "disabled." It is also a fact that most older adults prefer to age in their own homes and communities and that nursing home utilization is on the decline. However, it is not as clear that aging babyboomers will use the health and social service system in the same way as their parents and grandparents. Already, they are designing alternative self-help models for "aging in place" as is evidenced in models like Beacon Hill Village in Boston, a one-stop solution which was created by members of the neighborhood community with a goal of helping members with whatever they need to let them stay living in their homes. The model is being replicated across the country in various settings. (Nyberg, 2007)

What has become clear to the Task Force are the needs to simplify the process of accessing the service delivery system, to provide greater supports for caregivers of homebound older adults, and to develop a high touch/high tech infrastructure whereby professionals who work with homebound seniors can work more cooperatively and efficiently.

The Task Force is also of one mind philosophically that Geauga Community Impact's program for homebound older adults and their caregivers is founded on the principle that older persons have the right to live their lives the way they want as long as they are safe as defined by generally accepted professional standards. Therefore, the program presented in this plan is consumer-centered, provides choices, and supports consumers in making informed decisions about their care options ranging from community-based to institutional care.

Geauga County considers itself a community that takes care of its own residents. In the spirit of this, its residents have been very generous by voting in a 1 mill senior levy three times. This amounts to approximately $2 million annually; the next levy will be up for passage by the voters in 2009. The senior levy offers great flexibility to provide the services needed for the senior population at a given point in time and to modify the direction as needs change.

Homebound seniors are defined broadly.

The Task Force also defined the term "homebound" very broadly by going beyond the Medicare definition. Generally speaking, Medicare beneficiaries are considered homebound if they have an illness or injury that restricts their ability to leave their residence except with the aid of supportive devices (canes, wheelchairs and walkers), special transportation or another person. (Baker, 2001). Beneficiaries with conditions for which leaving home is medically contraindicated are also considered homebound. The following are examples of homebound patients that meet the Medicare definition:

- Beneficiaries paralyzed from a stroke and confined to a wheelchair or requiring crutches to walk;

- Blind or senile beneficiaries who require another person's assistance to leave their residence;
- Beneficiaries who have lost the use of their upper extremities and are unable to open doors, use stairway handrails, etc., and therefore require another person's assistance to leave their residence;
- Beneficiaries recently released from the hospital following surgery, who may be suffering from resulting weakness and pain, and whose activity is restricted by their physician to certain specified, limited activities (such as getting out of bed only for a specified period or walking stairs only once a day);
- Beneficiaries with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity;
- Beneficiaries with a psychiatric problem that is manifested in part by a refusal to leave their home environment or that makes it unsafe for them to leave their home unattended, even if they have no physical limitations

While these examples are included in the GCI Homebound Seniors Initiative's definition of homebound, it does not stop there. Thus the primary consumers of the Homebound Senior Initiative are older adults 60+ of all economic strata who are at risk of disability or already moderately/severely disabled and thus dependent on others to meet one or several activities of daily living (ADL) on a short or long term basis.

The number of older adults with disabilities in Geauga County is projected to increase by 2020.

While predicted for several decades, the aging of the babyboomers is now a reality in Geauga County and will have impact on the county's health and human services industry. According to the 2000 U.S. Census, the population age 60+ in Geauga County was 14,909. The Scripps Gerontology Center projects that the county's oldest population will increase consistently through 2020 to 25,962, a 174 percent increase. A sub-population of the county's senior cohort that is also expected to increase in the next 10 to 30 years (although at slightly lower rates) consists of moderately and severely disabled older persons 60 years and older.[1] Scripps projects a 169 percent increase in the moderately disabled from 2,411 in 2000 to 4,077 by 2020 and a 167 percent increase in the severely disabled from 1,197 to 2,003 during the same time period. (See Table 1.)

[1] *Moderate disability* is defined as received help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation.

Severe disability is defined as receiving help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment.

Table 1: Projection of 60+ Population with and without Disabilities in Geauga County: 2000-2020

Year	Total Population 60+	No Disability 60+	Moderately Disabled 60+	Severely Disabled 60+
2000	14,909	11,301	2,411	1,197
2005	16,813	12,729	2,706	1,378
2010	19,464	14,828	3,080	1,556
2015	22,446	17,174	3,519	1,753
2020	25,962	19,882	4,077	2,003

* Source: Mehdizadeh, S. (2004). Profile and projections of the 60+ population: Geauga County, Ohio. Scripps Gerontology Center.

The needs of older adults in rural communities may differ from those in urban settings and thus require differentially sensitive models of services specific to a rural senior population.

In a study entitled *Homebound Seniors in Rural Communities: Recruitment Challenges & Emerging Themes,* Kalavar and Rapano (2000) reported that numerous homebound elderly perceive their situation negatively and that this was not surprising since many studies have shown that rural elders experienced more symptoms of depression and loneliness (Nyman, Sen, Chan & Commins,1991), higher suicide rates (U. S.Congress, 1990); and higher rates of cognitive impairment (Blazer, George, Landerman, Pennybacker, Melville, Woodbury, Manton, Jordan & Locke,1985) than their urban counterparts. The authors reflected that this may not only reflect isolation experienced in rural communities, but also the continuing emphasis on service recipients as "needy people." Many respondents to the authors' survey stressed loneliness, depression, and lack of mobility as a result of being homebound.

The report of key informant interviews noted previously (MCS 2007) noted that "there are many older adults in the county who are socially isolated and do not have the support system to meet their psychosocial needs. In addition, there are many older adults (and even 50 to 60 year olds) who reside in the county, but are not safe in their homes because they do not have the support systems to meet their basic needs."

Kalavar and Rapano (2000) furthermore noted that research on rural seniors has also shown that they often exhibit special needs and are not aware of services that are available to them. According to Neese & Abraham (1997), even though the need for services is high among rural seniors, their service utilization rates tend to be low. The multitude of service providers, with separate organizations providing care management, home-health services, in-home services, home delivered meals, and volunteer services appear to foster this perception.

The authors conclude that if we are to maintain elderly adults in the community, the challenge from a service delivery perspective is to provide appropriate services that directly address their needs. That is, differentially sensitive models of rural service programs must be developed. Such a partnership should not only serve the care recipient but also utilize the assets of the rural homebound individual as a contributing member of the community.

Geauga County's older adults verbalize a spirit of independence and self-sufficiency, but are less confident that their family and friends will be there for them as they age.

The Western Reserve Area Agency on Aging conducted a survey of persons 55+ in Geauga County in January 2006. Their responses reflected a great spirit of independence and self-sufficiency. When asked if they needed help with activities of daily living such as grocery shopping, running errands, cooking, cleaning, dressing, bathing, getting around inside their home, 87 percent responded that they could do it on their own. Ninety-five percent said they had no problem getting the help to stay independent and the remaining 5 percent said that getting help was only a minor problem. When asked whom they would go to if they needed help, the responses were overwhelmingly that they would go to family; only 10 percent reported that they would turn to community agencies. However, when asked if they thought their family and friends would care for them as they got older, only 57 percent agreed.

There are indications that there are specific service gaps for homebound seniors in Geauga County including the lowest income seniors and those needing intermediate level of care.

In the *2007 Community Needs Assessment of Services for Homebound Seniors in Geauga County* (MCS 2007) e-survey respondents reflected an opinion that the following five services were important, but that the community's capacity to provide them was low: Errand Running/Shopping Assistance, Homemaker Assistance, Transportation Expense Assistance, Home Based Mental Health Services, and Yard Work. Interestingly, the key informants interviewed for GCI (MCS 2007) also noted In Home Assistance, In Home Mental Health Service, and Transportation as gaps for homebound seniors. These findings are furthermore confirmed by a report of Geauga 211 Homebound Service requests for the period January 2005 through September 2007 which states that two of the three services with the largest numbers of unmet needs (defined as being unable to make a referral) were Transportation Expense Assistance and Yard Work.

In addition, GCI needs assessment survey respondents noted that the capacity of the community to serve homebound seniors decreased with the age of the senior and they believed there was sufficient capacity for high income persons. However, they believed that there was insufficient capacity for the lowest income seniors and those needing intermediate level of care.

There is a perceived need for a more coordinated network of care for homebound seniors in the county that includes informal and formal caregiving providers as well as systems of care.

As summarized from the comments of key informants (MCS 2007), a coordinated network of care for homebound seniors should operate on three levels which the plan described herein attempts to incorporate:

- Level 1: An informal coordinated network of care that involves family members, friends, members of their faith-based communities, and neighbors;
- Level 2: A formal coordinated network of care that involves formal caregivers (medical professionals, home health care agencies, etc.) plus the informal network in coordination of services; and

- Level 3: A coordinated system of care across provider agencies and organizations.

Initiative Elements

There are three primary purposes of the Geauga Community Impact Homebound Seniors Initiative:

1. To ensure that all homebound seniors in Geauga County are offered choices about available services.
2. To expand the capacity of Geauga County to provide services to frail and dependent older adults who live in the community by:
    - Designing a care managed multi-point of entry service delivery model; and
    - Initiating a holistic geriatric assessment.
3. To enhance the quality of life of frail and dependent Geauga County residents 60 years and older who live in the community by:
    - Helping them access needed benefits and services;
    - Assisting their family caregivers; and
    - Enhancing the information base for professionals and paraprofessionals who work with them.

The intention is to design and pilot a model in the next three years that is supported by multiple community resources for the short term and is sustained for the long term.

Strategy 1: **Ensure that all homebound seniors are offered the opportunity to make informed choices about available services.**

Action Steps:

- Meet with the health care leadership to request practices that ensure a level playing field of fair competition, integrity, and most importantly what is in the best interest of the patient: informed client choice. Note that client choice is also mandated by the Centers for Medicare and Medicaid.
- Hold annual dialogues between the leadership of the GCI Homebound Senior Initiative, leaders of long term care, and health care providers to ensure that these practices are being adhered to.
- Model this philosophy in all GCI efforts for homebound seniors.
- Develop and use a form signed by patient or caregiver that s/he received information about available services in Geauga County.

Strategy 2: **Develop a person-centered, multiple points of entry system of care for homebound seniors. (See Figure 1.)**

> ***Sub-Strategy 2a:*** **Strategically disseminate information to older adults and their caregivers to help them make informed choices.**
>
> **Action Steps:**

- Design and widely disseminate a general information packet on how to access benefits and services throughout the county. (GCI General Information Packet)
- Develop a screening tool focused on the activities of daily living and the instrumental activities of daily living that can be used by older adults and their caregivers to determine whether they need assistance from the formal social service delivery system; distribute it through service providers. (GCI Screening Tool)
- Provide a customized information packet to older adults and their caregivers upon completion of a geriatric assessment. (GCI Customized Information Packet)

Sub-Strategy 2b: **Ensure that there is capacity and continuity across the provider network to inform consumers and professionals about service options and make referrals to appropriate providers.**

Action Steps:
- Utilize 211/First Call for Help (211geauga.org) as the comprehensive information and referral service provider.
- Recognize the Department on Aging as the specialized information and referral provider.
- Build the capacity of the entire community-based and facility-based provider network to provide information to service consumers who enter the system through their "front door."

Sub-Strategy 2c: **Formalize a network of interventions within and across service organizations for persons with no or moderate disabilities as a "soft entry" into the care system.**

Action Steps:
- Encourage older adults to become involved in senior centers, community volunteer programs, faith-based organizations, library programs, safety programs, chore and home repair programs, health and wellness programs, etc. as ways to stay connected to the formal service delivery system.
- Initiate a formal process and form for referral to other service providers.

Sub-Strategy 2d: **Develop the county's capacity to provide full geriatric assessments with a view on the whole person and conducted in the home when possible.**

Action Step:
- Based on previous geriatric assessments available in the community, review the model with the assessment provider to agree on elements to be included and a referral process.

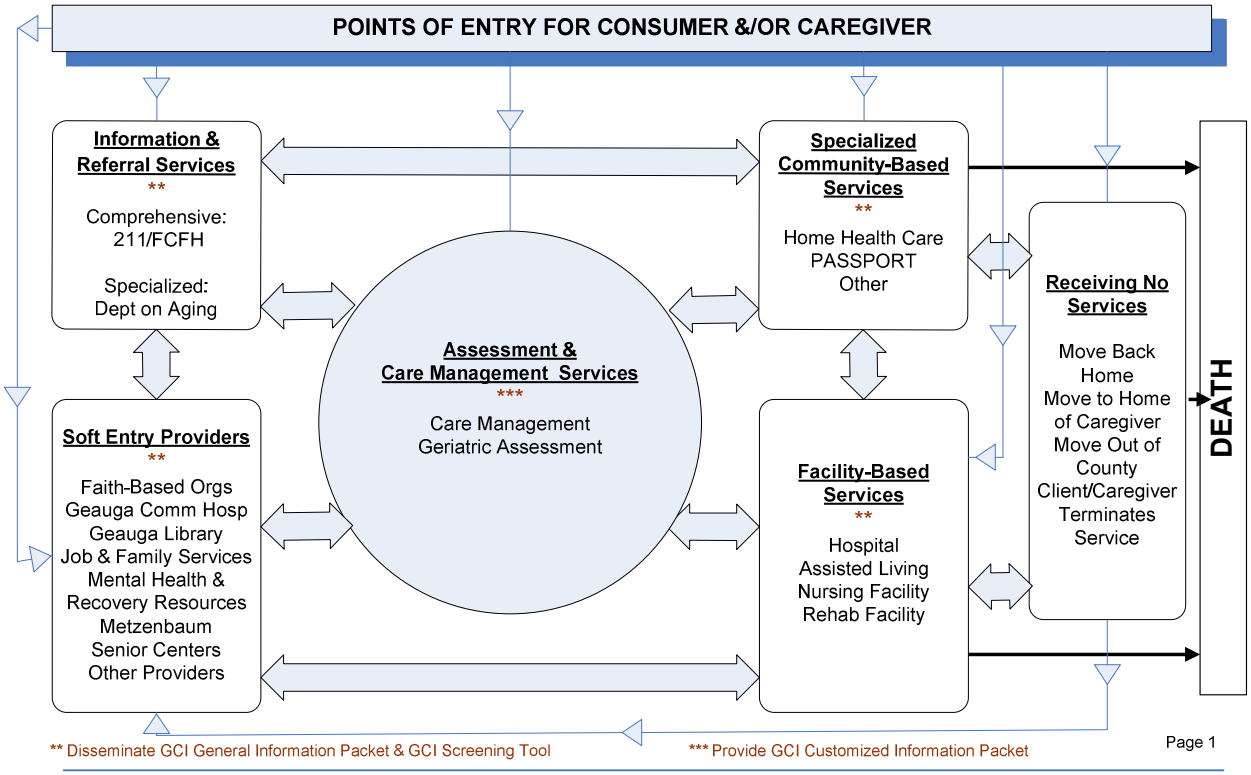
Sub-Strategy 2e: **Expand the county's capacity to provide care management service for homebound older persons with complex circumstances by a neutral organization.**

Action Steps:

- Generate the resources to hire a professionally qualified Coordinator/Care Manager to manage the Initiative and additional professionally qualified Care Managers to help homebound seniors link to services as needed.
- Establish a sub-committee to establish expectations about quality of services and a process for measuring client satisfaction.

Figure 1
Geauga Community Impact (GCI)

A Person-Centered, Multiple Points of Entry System of Care for Homebound Seniors



Strategy 3: **Assist the family caregivers of homebound seniors.**

Action Steps:

- Offer caregiver orientation programs to:
    - Educate them about how to access services through the county's person-centered, multiple points of entry system of care for homebound seniors before there is a crisis.
    - Inform them about how to use other available resources, services and benefits.
    - Provide content information about health conditions and functional limitations.
    - Promote the availability of respite for caregivers (one hour to overnight) to provide backup care and support groups to prevent and/or reduce isolation, stress, and burnout.
    - Promote awareness that it's okay to ask for help, of the importance of maintaining a close bond with other family members where possible, and of sharing their positive experiences as a caregiver.
- Provide a range of ongoing caregiver outreach activities such as quarterly forums, online chat rooms, regular mailings and/or newsletters, and drop-in centers.

Strategy 4: **Enhance the information base for professionals and paraprofessionals who work with homebound seniors.**

Action Steps:

- Offer professional and paraprofessional orientation programs to:
    - Educate them about how consumers can access services through the county's person-centered, multiple points of entry system of care for homebound seniors.
    - Inform them about how to use specific resources, services and benefits.
- Develop the infrastructure to enable professionals to engage in more inter and intra-department/agency collaborations around consumer needs.
- Conduct a feasibility study to determine if it is possible to eliminate duplication of information collected on the same consumer by multiple service providers in a way that is compliant with HIPAA, the Ohio Revised Code, and other regulatory bodies. Elements would include:
    - A universal intake form to be completed by the point of entry organization;
    - A coordinated assessment process with the potential to include multiple agencies;
    - A common format for care plans to be shared with other departments/organizations involved with the care of a particular consumer;
    - Appropriate software that can be used by professionals to share the intake, assessment, and care plans with other departments/organizations involved with the care of a particular consumer as well as with the service consumers. This can include consumer information that is universally available and some that is confidential and only available to a specific service provider.

***Strategy 5*: Educate community residents about successful aging and choices in community-based and facility-based care.**

Action Steps:

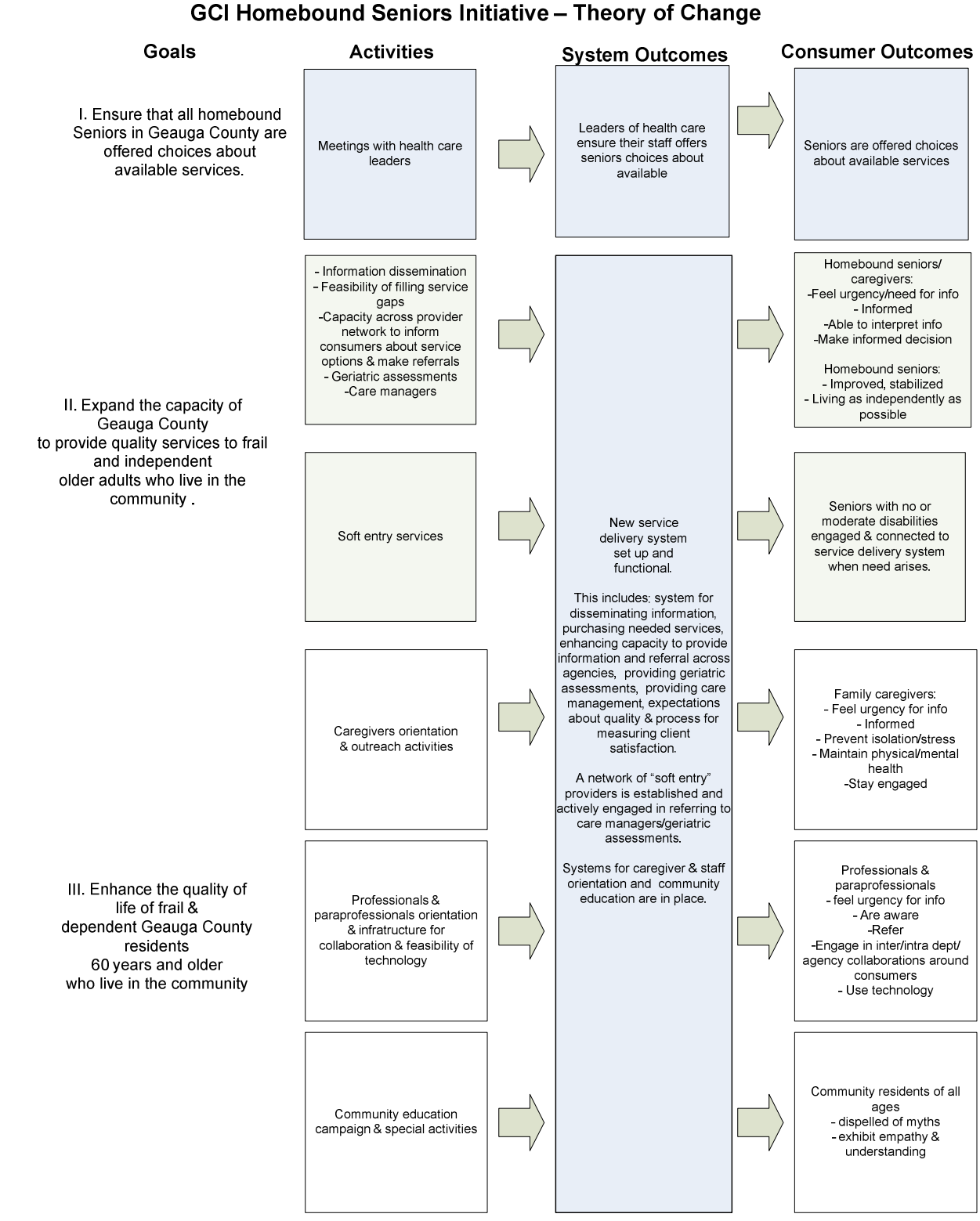
- Conduct a community education campaign to dispel myths about long term care, to discuss trends and choices in community-based and facility-based care, to educate about the role of the Long Term Care Ombudsman, and to promote respite care for caregivers.
- Engage in special activities such as a myth-buster-type program or "I love seniors" programs for children and youth to encourage community residents of all ages to exhibit deeper empathy for older adults and to gain understanding that homebound seniors are not an invisible part of the community.

***Strategy 6:* Explore the feasibility of building service alliances where gaps have been identified.**

Action Steps:

- Build capacity for in home mental health services, in home assistance (personal care and homemakers), errand running/shopping, and yard work.
- Stay informed on the progress of the planning collaborative between Geauga County Transit and Portage Area Regional Transportation Authority (PARTA) and advocate for transportation services for homebound seniors.
- Ensure that care managers inform homebound seniors and/or their caregivers of all service options, including PASSPORT for those who are potentially eligible.
- Explore the possibility of initiating community based, consumer driven alternative network of service village or co-housing models that are complementary to social service models, particularly in areas where there are seniors living in fairly close approximation to each other.

Theory of Change



Lead Agency and Organizational Structure

Lead Organizations: Catholic Charities Community Services of Geauga County; Geauga County Department on Aging; University Hospitals Extended Care. See Attachment A for descriptions. Catholic Charities will function as the fiscal agency.

Responsibilities of the Lead Organizations:

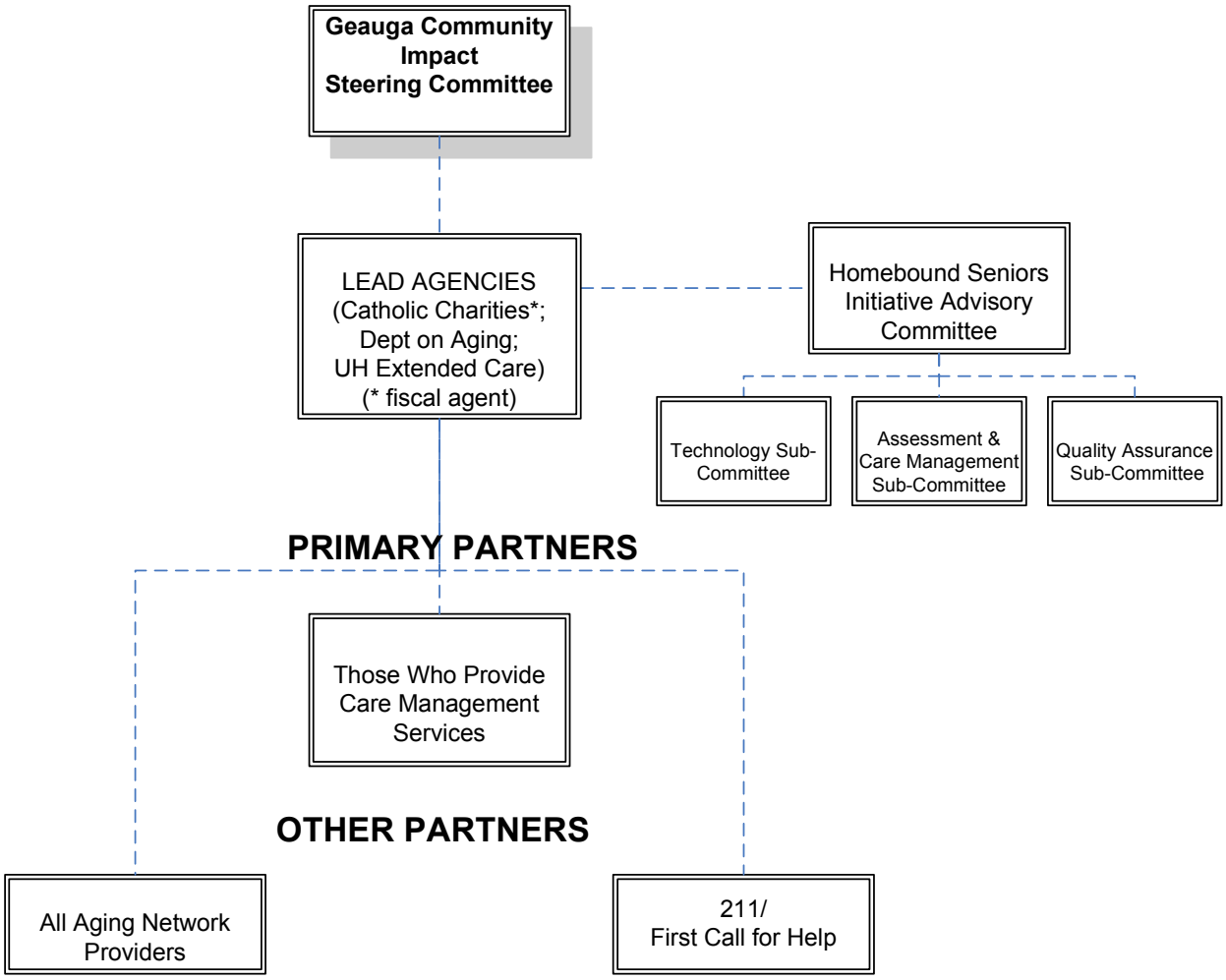
- Provide leadership for the initiative through implementation of the Strategy and Resource Plan, including oversight and coordination of all activities.
- Hire the staff and/or consultants who will implement the initiative in collaboration with stakeholder committees.
- Develop and foster agreements with specific partner organizations to carry out parts of the initiative.
- Report to the Geauga Community Impact Steering Committee on implementation, progress toward intended outcomes, supports/challenges, and proposed modifications of the Strategy and Resource Plan.
- Seek additional funding from other resources as needed with support from the Geauga Community Impact Steering Committee.
- Establish a communications, marketing and public relations protocol to ensure that the Geauga Community Impact philosophy and brand remains intact.
- Oversee outcome data collection for the initiative across all partner agencies/organizations through United Way's Internet-based e-fund application.
- Develop and implement a plan to sustain the initiative.

Collaborations and Partnerships: Due to the comprehensiveness of this initiative the Lead Agencies are encouraged to collaborate and partner with other entities to carry out specific components of the initiative. Major partners include providers who currently offer case management services and have the capacity to provide the macro geriatric care management needed for this initiative for their clients who use the geriatric assessment during the start-up phase. Other partners include the provider agencies and faith-based organizations involved in serving homebound seniors, 211/First Call for Help, and the Long Term Care Ombudsman Program.

In addition, a Homebound Seniors Initiative Advisory Committee will be established by the lead agencies to advise on the initiative. Current task force members may wish to remain as committee members. Other committee members will include lead agency staff, GCI project manager, staff, agencies with key roles, consumers, and other stakeholders as appropriate. The Committee may have subcommittees to oversee the work of the initiative when appropriate, one of which is a Technology Committee to guide the design of the common database and software as described in the plan.

Oversight: The lead agencies are under the supervision of the Geauga Community Impact (GCI) Steering Committee. A memorandum of agreement will be developed between GCI and the lead agencies that will spell out roles, responsibilities, and reporting requirements. (See organizational chart on the following page.)

Organizational Structure



Role Descriptions

Homebound Seniors Initiative Advisory Committee

- Act as an advisor to the lead agencies.
- Provide oversight to the Initiative.
- Offer guidance and direction to the lead agencies as needed.
- Make reports to GCI Steering Committee.
- Conduct quarterly meetings.
- Identify and recruit chair and members of Technology Committee.

Note: The committee will consist of 3 members each from the 3 lead agencies plus 3 additional at large members. In addition, other community representatives will be actively involved in sub-committees based on their areas of expertise.

Assessment & Care Management Sub-Committee

- Assist with developing the protocols for the care management component of the Initiative, screening tools, and other information pieces.
- Provide feedback on the geriatric assessment.

Quality Assurance Sub-Committee

- Assist with developing expectations for quality services (care management and geriatric assessment) and a process for measuring client satisfaction.

Technology Sub-Committee

- Assist with developing a tracking system for output/outcome indicator collection in the short term.
- Assist with developing approaches to assessment forms and other client records.
- Develop a client satisfaction survey.
- Explore options for a web-based, care-management software program capable of sending and receiving data across departments/agencies regarding intake data, assessment, care plan, and other relevant data.

Other Sub-Committees

- As needed.

Coordinator/Care Manager

- Oversee and implement all operations of the initiative.
- Coordinate and provide care management services.
- Collaborate with partner agencies on operations.
- Provide staffing to develop and consummate agreements with partner agencies.
- Provide staff support to the Homebound Seniors Initiative Committee and its Sub-Committees.
- Implement the person-centered model of care for homebound seniors, the caregiver support program, and the professional support services.
- Collect output and outcome indicator data from all participating organizations.
- Develop proposals to raise funding for the initiative, if necessary.
- Develop and initiate implementation of a plan for sustainability.
- Convene aging network staff as needed.
- Interface with the GCI Steering Committee as appropriate.

Administrative Assistant

- Provide administrative support to the Coordinator and initiative.
- Implement specific activities of the initiative.

Partners

Partner Agencies/ Those Who Provide Care Management

- Collaborate on design and implementation of the care management component of the service delivery model.
- Make macro geriatric care management services available for their clients who receive a geriatric assessment during the start-up phase.
- Contribute output and outcome indicator data as appropriate.

Partner Agencies/ All Aging Network Providers

- Collaborate on design and implementation of the care management component of the service delivery model.
- Disseminate broad information pieces plus the screening tool.
- Refer for geriatric assessments.
- Participate in design of cross department/agency database and software.
- Participate in appropriate training activities.
- Contribute output and outcome indicator data as appropriate.

Partner Agencies/ 211/First Call for Help

- Collaborate on design and implementation of the care management component of the service delivery model.

Implementation

Function	Activity	Year 1 7-12/08	Year 2 1-12/09	Year 3 1-12/10
Org. Roles	Establish Homebound Seniors Initiative Advisory Committee	7/08		
	Consummate a memo of understanding signed by the lead organizations and GCI Steering Committee	7/08		
	Hire a professionally qualified Coordinator/Care Manager		1/09	
	Hire Administrative Assistant		9/09	
	Work out agreements with partner agencies	7/08-12/08	Ongoing	Ongoing
Adherence to Philosophy of Choice	Conduct meetings between the GCI Homebound Seniors Initiative and the county's health care leadership	10/08	Ongoing	Ongoing
Person-Centered Model of Care for Homebound Seniors	Convene staff of the aging network to inform them of the plan and engage their involvement and participation in the "soft entry" part of the model	10/08	Ongoing	Ongoing
	Initiate the "soft entry" activities for those with no or moderate disabilities	10-12/08		
	Develop the information piece(s) for broad dissemination	9/08		
	Disseminate the information piece(s)	10/08	Ongoing	Ongoing
	Develop the screening tool for dissemination	9/08		
	Disseminate the screening tool	10/08		
	Develop the format for the customized information packet to be provided to consumers of the geriatric assessment	7/08		
	Reinstitute the geriatric assessment	7/08		
	Convene the care managers from partner agencies and design the expanded care management system	8/08		
	Pilot the expanded care management system	10-12/08	Ongoing	Ongoing
	Hire an additional Care Manager		As Needed	As Needed
	Bring Care Management Program to scale by hiring additional Care Managers			As Needed
Professional Support Program	Meet with 211/FCFH and other providers to enhance Information and Referral services for homebound seniors	9/08		
	Orient professionals to new model	10/08		
	Convene the Technology Committee			6-12/10
	Conduct feasibility of initiating cross organization information & software systems; involve care managers			6/12/10
Caregiver	Design content information piece(s)		9-12/09	

Function	Activity	Year 1 7-12/08	Year 2 1-12/09	Year 3 1-12/10
Support Program	Disseminate content information piece(s)			1/10
	Design caregiver orientation program			1/10
	Offer caregiver orientation program			4/10
	Determine the package of outreach services to be available to support caregivers			1/10
	Implement the outreach program			4-12/10
Community Residents Education	Design consumer education campaign		1-6/09	Ongoing
	Conduct campaign		1-6/09	Ongoing
Feasibility of New Service Development	Explore feasibility of new service development in areas where there are identified gaps			4-12/10

Budget

Older Adult Geriatric Assessment and Care Management
Combined Budget Summary Sheet

	FY09	FY10	FY11*
	7/08 - 6/09	7/09-6/10	7/10-12/10
Revenue			
Geriatric Assessment Program (UH Extended Care Campus)			
United Way Services of Geauga County	$26,946	$31,409	$18,286
Therapy Evaluations	$4,756	$5,914	$3,226
Home Assessments	$12,149	$15,108	$8,241
Program Fees	$14,375	$17,875	$9,750
Charity Care	-$7,188	-$8,938	-$4,875
Geauga County Department on Aging	$20,000	$20,000	$10,000
University Hospitals	$20,000	$20,000	$10,000
Total UH Revenue	**$91,039**	**$101,368**	**$54,627**
Older Adult Care Management (CCCS/Geauga) **			
United Way Services of Geauga County	$15,000	$30,000	$15,000
Geauga County Department on Aging	$12,000	$24,000	$12,000
Foundations & grants	$48,262	$99,313	$51,983
In-kind case management provided by referring agencies (25 cases x $80 per hour x 15 hours per case)	$15,000	$30,000	$15,000
Total CCCS/Geauga Revenue	**$90,262**	**$183,313**	**$93,983**
Community Education (Geauga United Way)	$13,054	$8,591	$21,714
Total Combined UH & CCCS/Geauga Revenue	**$181,301**	**$284,681**	**$148,610**
Expenses			
Geriatric Assessment Program (UH Extended Care Campus)			
Direct Expenses			
Salaries & Wages	$18,688	$23,238	$12,675
Other	$5,550	$7,700	$5,850
Total Direct Expenses	$24,238	$30,938	$18,525
Indirect Expenses			
Salaries, Wages & Benefits	$47,736	$49,646	$25,310
Plant Operations	$2,569	$3,195	$1,743
Marketing	$12,000	$12,000	$6,000
Overhead	$4,255	$5,290	$2,886
Bad Debt	$242	$300	$164
Total Indirect Expenses	$66,801	$70,430	$36,101
University Hospitals Total Expenses	**$91,039**	**$101,368**	**$54,626**
UH Net Income (Loss) from Program	**$0**	**$1**	**$1**

	FY09	FY10	FY11*
	7/08 - 6/09	7/09-6/10	7/10-12/10
Older Adult Care Management (CCCS/Geauga)			
Expenses			
I. Staff			
A. Salaries	$46,638	$94,880	$49,044
B. Payroll Related Expenses	$17,493	$35,840	$18,478
Total staff costs	**$64,131**	**$130,720**	**$67,523**
II. Operations			
A. Travel and Short-term training	$3,306	$7,044	$3,738
B. Consumable Supplies	$533	$1,081	$549
C. Occupancy Costs	$3,308	$6,766	$3,458
D. Indirect Costs	$1,850	$3,765	$1,915
E. Contract and Professional Services		$0	$0
F Other - Miscellaneous	$1,263	$2,532	$1,269
G. In-kind case management provided by referring agencies	$15,000	$30,000	$15,000
Total Operational Costs	**$25,259**	**$51,187**	**$25,928**
III. Equipment			
A. Equipment Subject to Depreciation	$200	$406	$206
B. Small Equipment purchases	$500	$650	$150
C. Leased and rented equipment	$173	$350	$177
Total Equipment Costs	**$873**	**$1,406**	**$533**
Total Catholic Charities Community Services Cost	**$90,262**	**$183,313**	**$93,984**
Catholic Charities Community Services Profit (Loss) from program	$0	$0	-$1
Community Education	$13,054	$8,591	$21,714
Total UH & CCCS/Geauga Combined Revenue	**$181,301**	**$284,681**	**$148,610**
Total UH & CCCS/Geauga Combined Cost	**$181,301**	**$284,681**	**$148,610**
Combined Profit (Loss) from program	**$0**	**$0**	**$0**

*6 months only

**This will not start until 1/1/09

Supporting Forces and Challenges

Supporting Forces:

- Capacity within the county to initiate the pilot.
- Supportive provider network.
- Strong possibility for sustainable funding for the long term.

Challenges:

- Uncertainty of the national and regional economies.
- Limited funds available for elder care resources.
- Uncertainty of state and national funds.
- Gaining buy-in for design and implementation of a shared data collection system.

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Attachment

DESCRIPTION OF LEAD AGENCIES

Catholic Charities Community Services of Geauga County

Catholic Charities Health and Human Services helps people through 123 services at 64 locations. The Catholic Charities Annual Appeal provides basic operating support through the generosity of donors from parishes all across the eight counties of the Diocese of Cleveland, including Geauga County. With their help, the agency serves the hungry and homeless, children and families, the elderly and chronically ill, and people with disabilities.

Geauga County Department on Aging

The Geauga County Department on Aging has a full menu of services for older adults who reside in the county. These services are primarily funded by the Geauga County Senior Levy, the Older Americans Act, and donations. Among those that would be most beneficial to homebound seniors are the following:

- Chore and Home Maintenance whereby an assessment is done followed by work with the Department paying 100 percent of labor and the client paying 100 percent of materials. Currently the Department has an agreement with Lake Communities Development Corporation to provide these services for lower income seniors. Lake Communities also purchased a stock pile of hand rails, ramps, etc. which reduces the cost of materials for the client. As a result of education provided by the Department, Hambden Building Supply has conducted a seminar for builders and developers on universal design and is now a huge supporter of the concept.
- Nutrition:
  - Home delivered meals, typically available on weekdays
  - Emergency meals - in winter enrolled clients receive three stored shelf-stable emergency meals
  - Holiday Meals – delivered on the holiday for those who are 60+ and home alone; it consists of a full lunch and frozen meal supper
- Social Contact:
  - Friendly visiting and telephone reassurance
  - Girl Scout troops and other organizations making gifts; florists donating poinsettias, etc.
- Transportation:
  - Out of county medical transportation in adjacent counties paid by donations
  - Transportation vouchers for in county medical care – seniors receive a $20 pass for Geauga Transit if they are income eligible
  - The Department owns three vehicles and employs two drivers

- Safety Seminars in collaboration with specific townships.

University Hospitals Extended Care Campus

Founded in 1939, Heather Hill is now called University Hospitals (UH) Extended Care Campus which has a multi-level system of services including:

- *The Specialty Hospital (LTACH), including High-Observation (Critical Care) Unit* which serves the medically complex patient who would otherwise remain in the acute care setting. (56 beds)
- *Short-term and Outpatient Rehabilitation* which provides outcome oriented medical and rehabilitative care for persons who are too frail to return home following acute hospitalization but whose condition no longer warrants the resources of an acute hospital. Programs may be continued or initiated on an outpatient basis. (60 beds)
- *The Corinne Dolan Center for Memory and Aging* which serves persons in the early and middle stages of Alzheimer's through respite care, short-term overnight care and residential services. It was designed by architect Stephen Nemtin of the Frank Lloyd Wright Foundation to maximize independence and promote a high quality of life. (24 locked units)
- *The Liberty – Assisted Living* (70 apartments) which is an assisted living community featuring resort style living.
- *Outpatient Rehabilitation and Aquatic Center* which serves adults and adolescents recovering from head injury, stroke, spinal cord injury, amputation, orthopedic surgery, neuromuscular disease and other major illnesses.

Previously UH Extended Care Campus provided a full one-day outpatient geriatric assessment which focused on physical, psychological, and social functioning. Administered by a part-time social worker, the assessment consisted of a 3-hour interview at Heather Hill followed by an in home evaluation by an Occupational Therapist within the same week. Within two weeks of the assessment, the social worker met with the family to share results. A written report was also given to the family, referral source, and primary care physician. In total there were approximately 160 referrals and a total of 75 patients assessed (an average of two per week). (Note that as a result of the Initiative described in this plan, the geriatric assessment is being re-instituted.)

Homebound Senior Task Force Members

Susan Juris, Co- Chair
UH Extended Care Campus

Pat Schraff, Co-Chair
Schraff and King, L.P.A

Sally Bell, Geauga County Department on Aging
Joy Black, Emerald Rose and Joy's Place
Kristi Burr, BCCN
Dorothy Cheeks, Community Member
Vicki Clark, Ravenwood Mental Health Center
Jim Clements, Catholic Charities
Ron Cotman, Chester Township Trustee
Donald Goddard, MD, UH Extended Care Campus
Scott Hildenbrand, Geauga Sheriff's Office
Suzanne Joseph, Geauga County Board of MRDD
Cheryl Kanetsky, Alzheimer's Association
Therese Kovatch, Home Instead Senior Care
George Ohman, The Hills: Blossom, Briar and Holly
Liz Petersen, Care Corporation
Bob Reschke, Chagrin Valley Rotary
Susan Schwarzwald, Western Reserve Area Agency on Aging
Peggy Sherer, Geauga County Health Department
Christine Thwing, WellCare
Bonnie Weible, Senior Home Sitter Connection

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