Service Coordination Level Two
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Service Coordination Level Two (2) is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.[1] It entails investigating a person's needs, preferences, and resources, linking the person to a full range of appropriate services and supports, using all available funding sources, and monitoring to ensure that services specified in the support plan are being provided.

Eligible Population

Service coordination shall be targeted to those older persons, age 60 years and over, who are frail, or have disabilities, or who are at risk of institutional placement. Priority shall be given to older persons who are in the greatest economic or social need and/or residing in rural and geographically isolated areas with particular attention to low-income minority individuals or individuals with limited English proficiency.[2] Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis; shall be dependent in two (2) or more activities of daily living; and have significant unmet needs that result in substantive limitations in major life activities.

Service Coordination Level Two is part of the state-funded Care Coordination for Elderly Virginians Program and is not an entitlement program. Service Coordination Level Two shall be available to the extent that state appropriations allow.

Service Delivery Elements

Service Coordination Level Two providers must perform all of the following:

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

Intake/Screening:
Intake/screening is an initial evaluation of a person's needs for service coordination and/or another service. The purpose is to obtain enough information to determine the person's likelihood of needing service coordination or another service and whether a full assessment

[1] National Aging Program Information System Reporting Requirements – State Program Report Definitions
[2] Older Americans Act of 1965 as amended 2006, Section 306 (a)(4)(A)(i)

is needed. The information obtained includes the reason for the referral or for the individual seeking help, the informal and formal supports already available, and basic information such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities, in the older person's residence or by telephone.

Assessment:
The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning, as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers.

The assessment is conducted prior to provision of any further care coordination services. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for care coordination services and a full Uniform Assessment Instrument is completed.

- A nutritional screening shall be completed on each client.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Service Planning:
The care plan is the link from the assessment to the delivery of services. Working with the individual and the caregiver(s), the service coordinator develops a plan to: address the problems and strengths identified in the assessment and reflect the person's values and preferences; establish desired person-specific goals; develop a complete list of services and supports to achieve these goals, outline responsibilities of the service coordinator, individual, and informal and formal supports; and identify payment sources for services.

The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of denial into service coordination shall be mailed or conveyed by electronic communication within five (5) working days of completion of the plan of care.

Service Delivery:

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

Monitoring:
Monitoring is the maintenance of regular contact with the individual, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs and preferences change. Contact must be made monthly with the individual for purposes of monitoring the implementation of the care plan.

Reassessment:
Reassessment is the formal review of the individual's status to determine whether their situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs and preferences have changed, the care plan is adjusted. This review is done at least every six months if the individual remains open to care coordination or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s).

If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the individual. The change should be noted on the care plan and in the Service Coordination Level Two progress notes. The service coordinator should make two copies of the revised care plan, mailing one to the individual and retaining the other in the individual's support record.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Termination:
Service coordination can be terminated at the discretion of the service provider or the individual. Service coordination should be terminated when the individual's service goals are met. Written notification of termination of service coordination shall be mailed to the individual by the agency 10 business days in advance of the date the action is to become effective.

Administrative Elements
The area agency on aging shall have a written Policies and Procedures Manual for service coordination.

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

Staff Qualifications:

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

- Skills: Service coordinators should have skills in negotiating with consumers and service providers; observing, documenting and reporting behaviors; identifying and documenting a consumer's needs and preferences for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs and preferences; coordinating the provision of services and supports by diverse public and private providers; analyzing and planning for the service needs of older adults and individuals with disabilities, and assessing individuals using the Uniform Assessment Instrument (UAI).

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

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

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

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

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and

- A current description of the minimum entry-level standards of performance for each job.

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

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

Program Reports: Aging Monthly Report (AMR) to VDA by the twelfth (12^{th}) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.

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

Organizational Structure:
Service Coordination Level Two is a separate and discreet service of an area agency on aging. Service coordinators must be organizationally separate from management of services provided by the agency that the service coordination clients might receive.

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

- Cost Sharing/Fee for Service: Cost sharing/fee for service is permitted for Care Coordination for Elderly Virginians Program Service Level Two Clients.

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation in non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is

at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services. [3]

Quality Assurance:

Criminal Background Checks:

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

Staff Training:

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

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

Caseload Size:

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

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

Supervision/Case Review:

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

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service and use this analysis to improve the quality of service planning and delivery.

Anonymous client surveys of the service shall be done annually. At least 10% of the clients shall be surveyed. Surveys should be maintained in an agency file with a summary of the survey results.

[3] Older Americans Act of 1965 as amended 2006, Section 315(b)

Complaint and Appeals:
Service coordination agencies shall have in place a written Complaint Procedures and Appeals Process.

Client Bill of Rights:
Service coordination agencies shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving service coordination and includes basic tenets that should be followed in providing the service. Individuals should receive copies of the bill of rights on commencement of Service Coordination Level Two, and a signed, dated copy must be kept in the individual's support record.

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

- Consent to Exchange Information Form – signed by the client
- Full Uniform Assessment Instrument (UAI)
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation.
- Care Plan (original and revisions) – signed by the client
- Monthly Progress Notes
- Care Coordination Outcome Report Closing Summary
- The Client Fee recorded in the progress notes
- The Gap Filling Service Form information recorded in the progress notes.

The Area Agency on Aging will maintain:

- A copy of the Denial or Termination of Service Coordination Services Letter
- A signed copy of the Client's Bill of Rights/Service Appeals/Termination Policy
- The Client Fee Form
- The Gap Filling Service Form