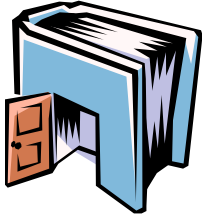


Welcome to *Information Portal*, a newsletter that encourages project communication and networking and celebrates success. We've captured your ideas and implementation practices to support project development and communication. Find *Information Portal* at www.unr.edu/sanford (click on Affiliates; click on Single Point of Entry Project); printed newsletters are mailed to those without Internet access. To submit information, e-mail Bill Murphy-Sharp no later than the **20th of each month** at wsharp@unr.edu (all attachments in Microsoft Word, please) or fax text to (775) 784-1814. We welcome your feedback.

SPE Enhances Service Delivery: A Personal Story



An alarming voice mail left one evening on the Caregiver Assistance Helpline (1-800-243-3638) described a woman in Las Vegas that needed help. By the next morning, Diane Ross (The Continuum, Reno) secured permission to forward contact info to the Economic Opportunity Board Community Action Partnership (EOB) where Martha Pilgrim, LCSW, began an initial screening with a 76-year-old woman in crisis.

"She was panting while we spoke," said Pilgrim. An untreated heart condition left her debilitated. She was out of medication, very low on food, unable to manage finances — and rent was due. Although her son managed her affairs, he'd been in a diabetic coma for three weeks. She had no other family or support network.

EOB, a mandatory reporting agency, contacted Senior Protective Services (SPS). An immediate site visit with the Las Vegas Metropolitan Police Department secured permission to coordinate medical intervention and deliver a rent check.

When Pilgrim's follow up phone call came days later, the

son answered. He'd emerged from the coma, left the hospital (against medical advice), and returned to care for his mother. Ironically, she'd been hospitalized with kidney failure (a condition that may have remained untreated without assistance from Helpline, EOB and SPS). He still needed medical attention but refused treatment until his mother was stable and safe. She was discharged three weeks later with necessary treatment plans, appointments, and the oxygen, wheelchair, and other essential medical equipment.

Unfortunately, the son's deteriorating health left him unable to care for his mother, and she required relocation to a skilled nursing facility. EOB staff continue to monitor the son's situation.

Clearly, each case is unique; however, both seniors (and caregivers or families) in crisis and providers share commonalities. A Single Point of Entry (SPE) integrated information sys-

tem reduces redundancy; increases response time; and improves the quality, coordination, and effectiveness of service delivery. And, it begins with first contact.

Initial contact is maintained locally to prevent the hours it may take to secure permission to forward contact information. Personal intake interviews begin immediately further reducing time wasted in returning voice mail and data captured (i.e., eligibility, service enrollment, provider referrals, etc.) is entered directly into a database. Providers with 24-hour coverage could alert appropriate emergency responders when necessary or begin pre-screening interviews for follow up referrals.

A centralized database facilitates the access to information from all involved providers — caregivers and hospital discharge planners to therapists (once authorized) — much like online banking is conducted. SPE intake and referral sites (like EOB) may monitor the online database to confirm follow up activities or track changes in medical services,

Stakeholder Announcements

The Nevada Association of Latin Americans, Inc.'s Arturo Cambeiro Senior Center is pleased to announce they have a Medicare Counseling volunteer, Carlos Valdivia, to work with senior's Medicare applications, help prepare appeals and answer questions. Carlo's job will include help in deter-

mining Medicare and supplemental coverage benefits and the amount of out-of-pocket expenses a senior will pay. These services are offered at the Center, by appointment, on M-W-F mornings. For more information, please call the Center at (702) 382-6252 ext.

Information Portal is funded in part by a National Family Caregiver Support Program (NFCSP) grant and is administered by the Nevada Division for Aging Services. This newsletter is a project of the Sanford Center for Aging and Nevada Cooperative Extension and does not necessarily reflect opinions of the Nevada Division for Aging Services or NFCSP.

Geriatric Resource Team: Extra Special Service Delivery

outcomes or treatment plans.

The Single Point of Entry integrates information and referral (I&R) services with medical care planning and evaluation of community-based services. It also supports innovative programs such as the Geriatric Resource Team (GRT) developed by the Office of Geriatric Medicine, Chronic Illness and Disability Management at the University of Nevada School of Medicine.

A geriatrician, nurse practitioner, registered nurse, and social worker comprise this interdisciplinary team; other providers participate as needed to meet the individual needs of Medicare-eligible clients. "GRT client evaluations may result in referrals that range from medical treatment to homemaker services," said Program Administrator Priscilla Bender, M.S.W. "We strive to identify solutions that improve quality of life."

An emphasis on education empowers elders and/or caregivers to make choices that encourage independence. "We don't see them in the emergency room, but in their homes," explained Bender. The key is timely contact. GRT referrals occur through various sources. Physicians, caregivers, even concerned neighbors or mail carriers

may request an evaluation of an at-risk elder.

No cost screenings throughout Northern Nevada and designated rural communities begins with consultation with the client's primary care physician and a brief survey that determines what level of care may be needed. Then, the GRT develops an individual's Medical Action Plan (MAP) that identifies specific needs, recommends services (e.g., physical therapy, home health care, emergency etc.) thus contributing to effective health care management. A care manager follows up with clients or caregivers to document and evaluate progress.

Program Administrator Diane Bush, R.N., M.P.H. believes that GRT serves a client's care management needs. "The complexities of chronic illness or disability challenge clients or caregivers," she said. "GRT helps resolve care management issues by identifying needs and anticipating solutions that prolongs independence by supplementing with supportive community resources."

For more information about GRT or to schedule a free screening, please contact the Office of Geriatric Medicine Chronic Illness and Disability Management at the University of Nevada School of Medicine, Reno (775)

327-2283 or visit their website at <http://www.unr.edu/ogm>.