Empowering Older Adults to Live with Dignity and Choice.
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In 2018 Senior Connections gave considerable attention to transforming the Agency’s popular Mature Life newsletter that was first published in November 1977. The Mature Life newsletter, mailed quarterly to over 15,000 households, has kept community members up-to-date on issues important to older adults and their caregivers for over 40 years. In an effort to continue our Transforming Perspectives theme of presenting the positive aspects of aging as part of the important work we do, the decision was made to change the newsletter’s title to Engage at Any Age. In addition, to expand the newsletters reach, Senior Connections partnered with The Beacon Newspapers, a family-owned business dedicated to providing well-written, useful information of interest to people 50 and older and their families. The Beacon’s award-winning content covers health, financial, career, housing, travel and arts topics, as well as local events and feature stories. In 2018, the Engage at Any Age newsletter became a four page pull-out section of The Beacon’s Fifty Plus Richmond publication. The Engage at Any Age newsletter now reaches over 65,000 readers and is distributed to over 350 locations throughout the eight localities served by Senior Connections.
We are excited to have many success stories to share with program participants, community friends, supporters, funders and partners as part of this Impact Report. As we reflect on the last two successful years (2018 and 2019), we are extremely pleased to look ahead to the celebration of the rich 50 year history of Senior Connections, The Capital Area Agency on Aging. The years since 1973 have been historic and impactful. As we reflect back, celebrate now and look ahead, we are grateful for the thousands of older adults and caregivers who have given us the opportunity to assist them with services, information and advocacy. We are grateful for the thousands of volunteers who support our mission of “empowering seniors to live with dignity and choice” and our vision for a region that has “seniors with improved quality of life.” We wish to thank all program participants and volunteers.

The Agency’s history is greatly enriched by the hundreds of community partners who collaborated with us on ideas and resource sharing. Our journey is enhanced with assistance and guidance from a multitude of funders at the state, local and national levels and by generous private contributions that include donations and fees from many program participants. We continue to enjoy tremendous leadership from numerous individuals who serve on our Board of Directors, Advisory Councils and Planning Groups. Throughout the Agency’s 50 year history, numerous passionate, knowledgeable and skilled staff have managed programs and delivered services. This tradition makes the Agency strong and capable. We wish to thank all leaders, community partners and staff.

As we reflect on the past two years and celebrate current successes, we also look ahead to the Agency’s future. We have an updated five year Strategic Plan with goals to address today’s trends and the future through 2023. The Agency’s 50 year history has been impacted by the provision of important services and programs that enhance the health and wellness of the community, people and places. These important programs and services range from the recently transformed Engage at Any Age newsletter to the Home Delivered Meals program in collaboration with Feed More, the Benefits Enrollment Center (BEC) with several locations throughout our service area, the Hospital to Home Care Transitions program and Ride Connection with numerous supporters. While these services are being highlighted in this Impact Report, all of our home and community services help older adults live with dignity and choice along with health and wellness. We are grateful for these opportunities.

With our thanks to all.

Thelma Bland Watson, Ph.D
Executive Director

Michelle Johnson
Chair, Board of Directors

Carol Young
Chair, Advisory Council
## By the Numbers: Financial Statement

### SUPPORT AND REVENUE

<table>
<thead>
<tr>
<th>Source</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Americans Act (Federal)</td>
<td>$3,351,900</td>
<td>$3,641,217</td>
</tr>
<tr>
<td>Other Federal Funds</td>
<td>$507,607</td>
<td>$561,808</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>$1,992,635</td>
<td>$2,094,957</td>
</tr>
<tr>
<td>Other Grant Funds</td>
<td>$238,120</td>
<td>$346,166</td>
</tr>
<tr>
<td>Donations &amp; Participation Fees</td>
<td>$400,622</td>
<td>$387,175</td>
</tr>
<tr>
<td>Noncash &amp; Other Income</td>
<td>$105,673</td>
<td>$40,553</td>
</tr>
<tr>
<td><strong>Total Support and Revenue</strong></td>
<td><strong>$6,596,557</strong></td>
<td><strong>$7,071,876</strong></td>
</tr>
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### EXPENSES

<table>
<thead>
<tr>
<th>Category</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs</td>
<td>$6,209,186</td>
<td>$6,566,406</td>
</tr>
<tr>
<td>Management and General</td>
<td>$208,396</td>
<td>$221,877</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>$9,262</td>
<td>$9,991</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$6,426,844</strong></td>
<td><strong>$6,798,274</strong></td>
</tr>
</tbody>
</table>

Change in Net Assets $169,713 $273,602

Net Assets, Beginning of Year $1,522,611 $1,692,324

Net Assets, End of Year $1,692,324 $1,965,926
### By the Numbers: Programs and Services

<table>
<thead>
<tr>
<th>Program</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Delivered Meals</strong> - Providing Support to Help Older Adults Age in Place</td>
<td>83,849 Meals Provided</td>
<td>90,214 Meals Provided</td>
</tr>
<tr>
<td><strong>Ride Connection</strong> - Connecting Older Adults to their Community</td>
<td>695 Individuals Served</td>
<td>825 Individuals Served</td>
</tr>
<tr>
<td><strong>Benefits Enrollment Center (BEC)</strong> - Connecting Medicare Beneficiaries to Cost Saving Benefits</td>
<td>The BEC Program launched on March 1, 2019</td>
<td>358 Benefit Applications Completed</td>
</tr>
<tr>
<td><strong>Care Transitions</strong> - Reducing Hospital Readmissions</td>
<td>7.9% Readmission Rate</td>
<td>7.6% Readmission Rate</td>
</tr>
<tr>
<td><strong>No Wrong Door</strong> - Connecting People to Programs and Services</td>
<td>3,751 Individuals Served</td>
<td>3,838 Individuals Served</td>
</tr>
<tr>
<td><strong>Empty Plate Luncheon</strong> - Supporting Critical Needs</td>
<td>$148,000 Raised</td>
<td>$160,000 Raised</td>
</tr>
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</table>

The BEC Program launched on March 1, 2019.
Home Delivered Meals

Senior Connections’ Home Delivered Meals program connects older adults who are homebound and unable to meet their basic nutritional needs to a healthy diet, a friendly face, and a safety check. The Home Delivered Meals program sponsors older adults who are unable to cover the cost of the meal service. By providing nutritious, diet-specific meals and social interaction, the Home Delivered Meals program helps keep older adults independent and safe in their homes for as long as possible. For over 40 years, Senior Connections has partnered with Feed More, our local Meals on Wheel provider. Through this partnership, both agencies are better able to reach those in need within the community. Referrals and Information are exchanged between Senior Connections and Feed More through Virginia No Wrong Door, giving both agencies the ability to respond quickly and efficiently to individual needs. Program volunteers, who provide meal recipients with a friendly smile and important safety check, are key to the program’s success. As the eyes and ears providing social contact, volunteers extend the program beyond a simple meal.

Impact Story
Elliott lacked the energy and stamina he needed to take care of his every day needs when he was referred to the Home Delivered Meals program. Before enrolling in the program, Elliot was having his meals delivered to him from various local restaurants. He was not following a healthy diet plan and incurring additional expenses, such as delivery cost. Shortly after being enrolled in the program and maintaining a healthy diet, Elliot noticed a change in energy level. He found he had the energy to move about more and to take better care of himself. Elliot’s overall health improved, impacting his quality of life in a positive way. Elliot’s family is thankful for the peace of mind that comes with knowing their loved ones nutritional needs are being met and are happy to see the improvement in his overall well-being.
Support to Stay at Home

Mobility Management and the Ride Connection Program

Access to safe, supportive and reliable transportation services are fundamental building blocks of a healthy, connected community and healthy, connected individuals.

Mobility Management is an innovative, person-centered approach for managing and delivering coordinated transportation services to low income older adults and individuals with disabilities. Ride Connection provides older adults, their caregivers, and individuals with disabilities with information about and access to transportation resources to help them age in place and remain in their own community. Ride Connection counselors educate community members on the public and private transportation options available in their community. Ride Connection counselors also provide travel training, giving community members the information needed to best meet their transportation needs. Most importantly, the Ride Connection program provides eligible individuals with transportation to their medical appointments.

What our Riders Say:

• 100% of survey respondents said Ride Connections helps improve their access to medical care.

• 100% of survey respondents felt they would miss important medical appointments without the support they received from Ride Connections.

• 92% of survey respondents said Ride Connections helps them manage their overall health care costs.

Human Services Transportation Coordination Entity

As a sign of Senior Connections’ critical role in transportation services and leveraging our collaborative spirit, Plan RVA designated our agency as greater Richmond’s Human Services Transportation Coordination Entity (HSTCE). The HSTCE works with community partners to promote, facilitate, educate, and help coordinate regional transportation efforts to improve the quality of life in our area. In May 2019, we hosted community partners, consumers, advocates, and service providers to complete A Framework for Action, a self-assessment tool for communities working towards a coordinated human services transportation system. From that symposium, the HSTCE has begun work on a strategic plan to improve access to transportation in order to reduce health disparities.
Benefits Enrollment Center (BEC)

Launched in 2019, the Benefits Enrollment Center (BEC) was created to help low-income Medicare beneficiaries access programs that pay for healthcare, food, and more. The Benefits Enrollment Center is supported by a grant from the National Council on Aging (NCOA). Through this program Medicare beneficiaries receive enrollment and application assistance with the following core programs:

- Low Income Subsidy (LIS)/Extra Help
- Medicare Savings Programs (MSPs)
- Medicaid
- Supplemental Nutrition Assistance Program (SNAP)
- Low-Income Home Energy Assistance Program (LIHEAP)

The BEC at Senior Connections officially began accepting referrals in March 2019. As of September 30, 2019, the BEC has assisted 171 Medicare beneficiaries with completing 358 benefit applications. The total value of benefits applied for by our Benefits Outreach Specialist exceeds $1.2 million.

BEC Locations:
- Senior Connections, The Capital Area Agency on Aging
- Hanover Community Resources
- VCU Health Hub at 25th
- Powhatan Department of Social Services
- Goochland Cares
- Chesterfield Department of Social Services

Impact Story:
The BEC received a referral from the Richmond Department of Aging and Persons with Disabilities for a gentleman who moved to the Richmond area from another state. The gentleman had Medicare, Medicaid and SNAP from the state he lived in previously but he needed to reapply in order to get those benefits in Virginia. He relied on the benefits for his general well-being and he could not afford a long delay in receiving them. A Benefits Outreach Specialists from the BEC helped the gentleman apply and get approved for each one with minimal interruption. As a result, he did not miss a meal or a medical appointment and he was able to get settled in his new place with minimal stress.
Care Transitions Program

Confidence in managing one's own health care after a hospitalization is essential to reducing the risk of hospital readmission and ensuring the best possible recovery. Patients returning home after a hospitalization may find themselves vulnerable to hospital readmissions if they are not certain of the steps they need to take when making the transition to their home after being discharged from the hospital.

Care Transitions Intervention® is an evidence-based program proven to reduce hospital readmissions. Our trained Health Coaches receive referrals on older adult patients from VCU Health and Bon Secours Mercy St. Mary's, the local area hospitals participating in the Care Transitions program. Our Health Coaches also provide CTI® services on behalf of VAAA Cares, managed by Bay Aging.

The Care Transitions program is introduced to the patient and their family members at the hospital and includes a home visit shortly upon the patients discharge from the hospital. Over the 30 days following the discharge, a Senior Connections Health Coach works with the patient by reviewing their progress, answering questions, and encouraging them to have confidence in managing their health care. Our Health Coaches ask questions and listen to see what other needs the patient may have. After assessing those needs, our Health Coaches make referrals to community programs with resources to meet the individuals' unmet needs. Referrals are made to programs such as Home Delivered Meals, Telephone Reassurance, and the Benefits Enrollment Center (BEC).

Impact Story:
A Senior Connections Health Coach visited Barbara, a 68 year old woman, in the hospital’s ICU. She was receiving care for complications due to diabetes. Barbara was to be discharged that day, and a Care Transitions home visit was scheduled for the following day. Barbara lives alone in a small, neat apartment. At the home visit, she and the Health Coach reviewed the Personal Health Record, in which Barbara recorded each of her medications. Barbara had a question regarding the proper dosage for one her meds and was unsure about who to call and the right questions to ask. Instead of calling on the patient’s behalf, the Health Coach helped Barbara clarify her question and role played how the phone call to the pharmacy might go. Barbara made the call during the home visit and obtained the answer to her dosage question. Barbara stated she received medical transportation assistance from friends at her church. She and the Health Coach reviewed potential red flags regarding her condition and what to do in case any of those occurred. Barbara agreed it would be best to call her primary care physician when symptoms first arise. The Health Coach followed up with Barbara by phone over the following three weeks. Barbara continued to recover and remained out of the hospital during that time.
There is literally no wrong door to begin the process of finding help when needed with Virginia No Wrong Door (NWD). NWD empowers individuals to make informed decisions, exercise control over their long-term support needs and to achieve their personal goals and preferences.

The cornerstone of NWD is Person-Centered Thinking. Treating people with dignity and respect. Recognizing strengths as well as needs. Supporting the person’s own goals and preferences.

Senior Connections and our NWD partners help individuals understand what resources are available and provides them with quicker access to those resources. For example, if a caregiver calls Senior Connections after a loved one experiences a stroke, our Care Coordinators are able to connect them to one of our many partners to help with things such as home modifications, in-home respite and legal services.

NWD: By the Numbers FY2018-19
Senior Connections made approximately 2,400 referrals each year (2018 and 2019) to partner agencies who provide over 189 unique services. By connecting individuals to needed resources through NWD, partner agencies are able to respond quickly and efficiently to the needs of community members and there is a reduction in duplication of efforts among providers.

No Wrong Door Certified Partners:
- Alzheimer's Association Greater Richmond Chapter
- Bon Secours
- Circle Center Adult Day Services
- CA
- Department for Aging and Rehabilitative Services
- Family Lifeline
- FeedMore
- InnovAge Virginia PACE
- Jewish Family Services
- Open Door Resource Center
- Project:HOMES
- Rebuilding Together Richmond
- Resources for Independent Living
- South Richmond Adult Day Care Center
- Virginia Poverty Law Center
Senior Connections’ collaborates with other community organizations and groups to better support older adults and individuals with disabilities in our community. We are thankful to all who work in partnership with us as we strive to empower seniors to live with dignity and choice.

- Better Housing Coalition
- Bon Secours
- Circle Center Adult Day Services
- Feed More
- Glen Allen Cultural Art Center
- Greater Richmond Age Wage Coalition co-partnered by VCU Department of Gerontology and Senior Connections
- Guardian Place Retirement Community
- Hanover Adult Center
- Hanover Senior Rides
- Lucy Corr Adult Day Center
- Project: HOMES
- SOAR365
- South Richmond Adult Day Care Center
- United Way of Greater Richmond and Petersburg
- The Valentine
- VCU Health
- Visual Arts Center of Richmond
- Westminster Canterbury
- YMCA
Senior Connections’ Annual Empty Plate Campaign and Awards Luncheon raises funds to support the critical needs of older adults and caregivers in our community. As a result of the contributions we receive through this annual campaign, we are able to provide assistance with essential needs such as nutrition, emergency services, transportation, and social interaction. As the cost of living continues to rise and the number of older adults in our area increases, financial support from the community is more important than ever. We are thankful for the contributions made over the past two years that allowed us to raise $148,000 in 2018 and $160,000 in 2019. We are grateful for each and every donation we receive to support older adults in our area.

**Major Sponsors in 2018 and 2019:**

- Dominion Energy
- Genworth
- The Barrington Family Foundation
- Publix Super Markets Charities
- UnitedHealthcare
- Bon Secours Mercy Health

**Presenting Sponsor**
The Honorable Eva T. Hardy
Chair, Empty Plate Luncheon Steering Committee

**Program Sponsor**
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  Charles City County

- **The Honorable Carson Tucker**  
  Board of Supervisors  
  Powhatan County

- **Ms. Jelisa S. Turner**  
  Henrico County Division of Fire  
  Henrico County
Our Vision: Seniors with improved quality of life.

Our Mission: Empowering seniors to live with dignity and choice.

Serving the City of Richmond and the counties of Charles City, Chesterfield, Goochland, Hanover, Henrico, New Kent and Powhatan.