DRAFT

2017-2020 Area Plan

Multnomah County Aging, Disability, & Veterans Services Division

August 18, 2016: Version 1

MULTNOMAH COUNTY
AGING, DISABILITY, & VETERANS SERVICES DIVISION
2017-2020 AREA PLAN

Table of Contents

Section A: Area Agency Planning and Priorities

A-1: Introduction

Multnomah County Aging, Disability, and Veterans Services Division (ADVSD) is the designated Area Agency on Aging for the County and a division of the County's Human Services Department, which also includes Developmental Disabilities and Youth and Family Services. ADVSD provides services to low-income seniors and people with disabilities at five District Centers, nine Enhancing Equity providers, and five Medicaid Long Term Services and Supports offices throughout the County. In addition, Adult Protective Services, Adult Care Home Licensing, and Public Guardian/Conservator programs offer targeted assistance to those who are most vulnerable and at risk. ADVSD offers clients seamless entry to services to ensure that they receive appropriate help regardless of where they enter the system, and to further that aim, three of the five District Centers are co-located with Medicaid offices and all Medicaid sites serve both older adults and people with disabilities.

ADVSD's primary goal is to help elders and adults with disabilities live as independently as possible and it provides a range of services—some directly and others under contract with community agencies—to achieve that end. Complete lists of key services can be found in **Section B-3, AAA Service and Administration** and **Section D-2 Services Provided to OAA and/or Oregon Project Independence Clients**.

ADVSD has three Advisory Councils—Elders in Action Commission, the Disability Services Advisory Council, and Multicultural Action Committee—that make recommendations on important issues affecting seniors and people with disabilities and advocate for legislation and initiatives.

For questions or comments, please call (503) 988-3646 or areaplan@multco.us.

A-2: Mission, Vision, & Values

ADVSD's mission is to:

> **Promote independence, dignity and choice in the lives of older adults, people with disabilities and veterans.**

This mission springs from a vision that all older adults, people with disabilities and veterans thrive in diverse and supportive communities and that ADVSD will be a leader and catalyst in developing, promoting, and implementing options for these choices.

ADVSD's mission and vision are founded on the following organizational values:

- Put People First
- Act with Integrity
- Promote Equity, Empowerment and Inclusion
- Collaborate
- Pursue Excellence
- Accept Personal Responsibility
- Foster Creativity and Innovation
- Act as Change Agents
- We Bring Our Best Selves to Work

We provide services directly and in concert with multiple community-based partners. We leverage the strengths of these non-profit organizations to provide coverage across the county and to provide culturally responsive and culturally specific services. We coordinate activities that have regional impacts with neighboring counties, cities within Multnomah County, and with sister agencies across the state. We embrace innovation and learn from our peers across the nation and in communities across the globe. We are actively breaking silos within our program areas, across the Department of County Human Services, and between Multnomah County Departments to better utilize technology, change the dominant culture to promote social justice, and to create a future that empowers all of our aging residents to enjoy their lives with dignity, choice, and independence. Some of our partners include:

- African American Health Coalition
- Asian Health and Service Center
- Asian Pacific American Senior Center
- El Program Hispano Católico
- Elders in Action
- Friendly House
- Independent Living Resources
- Meals on Wheels People
- Native American Rehabilitation Center
- Native American Youth and Family Center
- Neighborhood House
- SAGE Metro Portland

- Hollywood Senior Center
- Immigrant and Refugee Community Organization
- Impact NW
- Store to Door
- Urban League of Portland
- YWCA
- 211

A-3: Planning and Review Process

Scope of Need

ADVSD is continually gathering information about the needs of older adults and people with disabilities and tracking success in meeting those needs, using both quantitative and qualitative methods. We consistently find that as people age, there is a compounding effect on marginalized communities that contributes to disparities in health, income, safety, and connection to resources. We are necessarily focusing on the needs of marginalized communities and the strengths we can leverage to create equitable and culturally specific and culturally responsive programs and services. A few of the issues facing people in our community:

- Older adults, people with disabilities, and low-income minorities are being displaced by rising housing costs at a disproportionate rate
- There is a lack of affordable and reliable transportation, which is a critical component to receiving quality health care, preventing abuse and social isolation, having access to nutritious foods, and connecting to other community-based services
- People aging with HIV and AIDS Long-term survivors were more likely to experience social isolation, depression, and substance use disorders
- Racial, ethnic, and cultural minority elders were less likely to access services or have awareness of resources available
- People experiencing chronic conditions or disability want more health education and support specific to their needs
- Language is a barrier for non-English speakers navigating health, transportation, and other systems; many rely on community-based organizations or other informal networks of support to fill their needs.
- More information and outreach is needed to and for people who are deaf-blind
- LGBT older adults feel a lack of safety in their homes, at senior centers, and in other places throughout the community

- Immigrants and refugees rely heavily on staff to organize and provide transportation to community-based organizations that serve them

Community Listening Sessions

An equity lens was applied throughout the community engagement and area plan development process. In January 2016, we convened a group of 20 AAA advisory council members and stakeholders to approve our draft community engagement plan. In small groups they discussed the types and format of data and information that should be provided to consumers during the process; methods for outreach and specific populations to reach; ways to incorporate the feedback received; removing possible barriers to inclusion in the process, and ways for advisory council members to meaningfully engage throughout the process.

In April - June 2016, ADVSD conducted 18 public listening sessions in locations across the county. The methods used during the sessions were vetted by our knowledge of the equity lens and as the process went on we adjusted our methods according to what we observed and what participants expressed was successful or unsuccessful.

Attendees were asked three questions about nine focus areas that were developed using the State Area Plan guidance, the Multnomah County and Portland Age-Friendly Action Plan domains, and other Department-wide issues of interest. The nine focus areas were: Behavioral Health; Caregiver Respite, Support and Education; Case Management and Options Counseling; Emergency Services and Gap Programs; Healthy Aging; Nutrition Services; Outreach, Information, and Referral; Safety and Abuse Prevention; and Transportation Coordination and Resources. Participants were asked the following questions, in relation to each of the above listed focus areas:

1) What is important to you?
2) What is working well?
3) What do you need more of?

The listening sessions drew 474 people and solicited 2,348 comments. Some 68 percent of attendees were non-English speakers and 89 percent were from non-mainstream groups including the LGBT community. Participant comments were coded using an inductive, qualitative process and results are available in an interactive web-based file that can be found at www.multco.us/ads. Additional outreach is being conducted to Multnomah County Library Books by Mail delivery program participants.

Advisory Council members and staff worked together on July 21, 2016 to review the listening session data and further refine and develop draft area plan goals and objectives.

ADVSD Community Services RFPQ Workgroups

In May 2015, ADVSD Community Services convened a Request for Programmatic Qualifications (RFPQ) planning workgroup, in preparation for releasing an RFPQ for OAA funded services beginning in 2018. This workgroup helped establish five foundational assumptions for OAA funded services: 1) *Maintain a regional and culturally specific approach to service delivery; 2) Maintain the major service areas; 3) Maintain commitment to funding culturally specific services; 4) Be participant-centered and participant-directed; and 5) Build on recent service system changes.*

The RFPQ workgroup also provided recommendations that led to the formation of an Equity and Allocations Workgroup and a Contractor Feedback Workgroup to examine resource allocation and system structure; access and service integration; service gaps and program review; and ADVSD system and program outcomes. The Equity and Allocations Workgroup studied key demographic and service data and will provide guidance related to the RFPQ process and funding allocations for Culturally Specific and Culturally Responsive service providers.

The Contractor Feedback Workgroup focused largely on internal operations that can improve our customer service to contractors and quality of programming offered to consumers via those contracts.

Multnomah County Culturally Specific Workgroup

In the spring of 2015, Multnomah County's Culturally Specific Workgroup was convened to review best practices, solicit local and national advice and create a common, county-wide definition of culturally specific and culturally relevant services that follows applicable state and federal laws. ADVSD will be using the technical guidance created by this Workgroup for programs procuring culturally specific services

Other Resources Used

Recommendations provided in the 2010 report issued by the Coalition of Communities of Color entitled "Communities of Color in Multnomah County: An Unsettling Profile," have helped shape the Area Plan community engagement process and have reinforced strategic efforts to address disparities. Several other resources have been useful for

planning purposes and developing the 2017-2020 Area Plan. Some of these include an ADVSD-directed Community Services Consumer Satisfaction survey and subsequent workgroup recommendations developed in October 2015; a County-Wide Age-Friendly Multnomah County Employee Survey report completed in September 2015 and most recently, results from the Healthy Columbia Willamette Collaborative Needs Assessment.

Public Comment

Two public hearings were held by the Senior Advisory Council in August 2016, one in Gresham and one in downtown Portland. These were advertised in local newspapers, in community calendars, and distributed via web calendars and email lists. Participants in area plan listening sessions were also invited to attend. The meetings were recorded and posted at www.multco.us/ads. We provided ASL interpretation, amplified sound and closed loop system, and language interpretation upon request. Public comment was invited via email, postal mail, voice recording in any language, and at the public hearings.

A-4: Prioritization of Discretionary Funding

Whenever funding limitations require it, ADVSD will direct our District Center partners to place any newly referred individuals on a waitlist.

- OPI in home services and support:
  - OPI Risk Assessment Tool (RAT- 287j form) is completed and clients are prioritized with those most at risk for nursing facility placement being put at the top of the list. Other factors, such as the risk of self-neglect or of abuse/neglect by others are considered in priority ranking.
  - Options Counseling provided
- Transportation assistance:
  - For waitlisted individuals who have a case manager, risk and need is assessed to determine prioritization.
  - Those clients without a case manager will receive information and assistance notifying them of other resources in the community for transportation.
- Family Caregiver Support Program:
  - The family caregiver if offered Options Counseling and referred accordingly.

- The family caregiver is informed of other services such as support groups, education and training and respite options such as Adult Day Services.

ADVSD is currently reviewing the funding formula applied for programming through our RFP process. As we change and update our funding formula and program model we are applying the equity and empowerment lens and involving community engagement opportunities, including conversations with communities of color and the LGBT community to inform our decision.

In all cases we strive to prioritize services for those at highest risk and those in most need, utilizing assessment tools and census/demographic data to guide our decisions. We also prioritize funding for programs and services that are evidence based or that are proven to have a positive impact on the community being served, again, applying an equity and empowerment lens and being informed by communities of color.

Section B: Planning and Service Area Profile

B-1: Population Profile

The large baby boom generation coupled with historical increases in longevity have resulted in tremendous growth in the 60+ population in recent years. The Census Bureau, through the 2014 American Community Survey has estimated the county's 60+ population at over 140,000, a growth of 21% over 2010 figures. This cohort now represents 18%, or nearly 1-in-5 of the county's residents. In our county, considerable concentrations of older adults are located in mid and east county, areas with a greater supply of affordable housing and retirement communities. Map 1 (page) shows the county's 60+ population by census tract, using American Community Survey's 2014 5-Year estimates.

Since 2010, we've seen the population of those aged 60-74 years old grow an astonishing 29.4%. We have also seen a 5.9% growth of our 85+ population, a cohort often in great need of supports and services. According to 2014 figures, this population measures at 13,285 individuals or 9.5% of those aged 60 years or greater. Map 2 (page) shows the county's 85+ population by census tract, using American Community Survey's 2014 5-Year estimates. Somewhat like the County's 60+ population, those aged 85 or greater are more concentrated our Mid County district.

In Multnomah County we are seeing a more ethnically and racially diverse aging population. It is estimated that for 2014, minorities make up 17% of the aging population, compared with 16% in 2010. Minority elders make up a greater proportion of those aged 65 or greater in our Mid and N/NE regions. Multnomah County's minority populations are not homogenous and racial/ethnic groups tend to be clustered more in certain regions. For example, Black/African-Americans, while making up about 22% of minorities in Multnomah County, they make up roughly half of those living in our N/NE region. Our elder Asian population makes up two-thirds of our minority population in both Mid and SE regions. Map 3 (page) shows the dispersion of our aging minority populations.

Of those that are aged 60 years or greater, 8.6% report limited english proficiency, defined as either not speaking english at all, or speaking english less than very well. Nearly 5% of people in Multnomah County, aged 60+ are linguistically isolated, which means that no one in their household over the age of 14 speaks only english, or speaks english "very well". Reaching these populations with mass marketing techniques prove to be a challenge and underscores the need to provide inclusive services that provide materials in languages other than English. Approximately 14% of our county residents aged 60+ were born outside of the US. Multiple tribes constitute Multnomah County's Native American elders, those in federally recognized and recorded tribes represent less than 1% of Multnomah County's 60+ population and 4% of its minority 60+ residents.

Poverty data are shown for the 60+ age group in Table 1. *S*ixteen (16) percent of the 60+ population lives below the Federal Poverty Level (FPL) which in 2014 was $19,790 for a family of three. Because the cost of living in Multnomah County, and much of the county is higher than the guidelines suggest, many programs have established eligibility thresholds based on earning less than 185% of the FPL (36,611 for a family of 3), and often have even higher thresholds. Roughly 4-in-10 people over the age of 60 have earnings less than this threshold, Map 4 (page) shows poverty prevalence throughout the county for those aged 65+. Concentrations of poverty for our older population exists primarily in Mid and East County, with dispersed but sizeable pockets in the N/NE and West (Downtown) district area as well. These areas continue to see lower income individuals move or retain housing in these areas due in part to housing availability, and subsidized living options.

Almost 65,000 individuals aged 18 to 64 years report having a disability, the Census Bureau no longer publishes 1-Year estimates by Census Tract, so Table 1 shows the distribution of this population based on 5-Year estimates. As our population ages and more people live longer, the number of people with disabilities also grows. Of those that are aged 60+ in Multnomah County, nearly 30% report having a disability.

Table 1: Population Profile

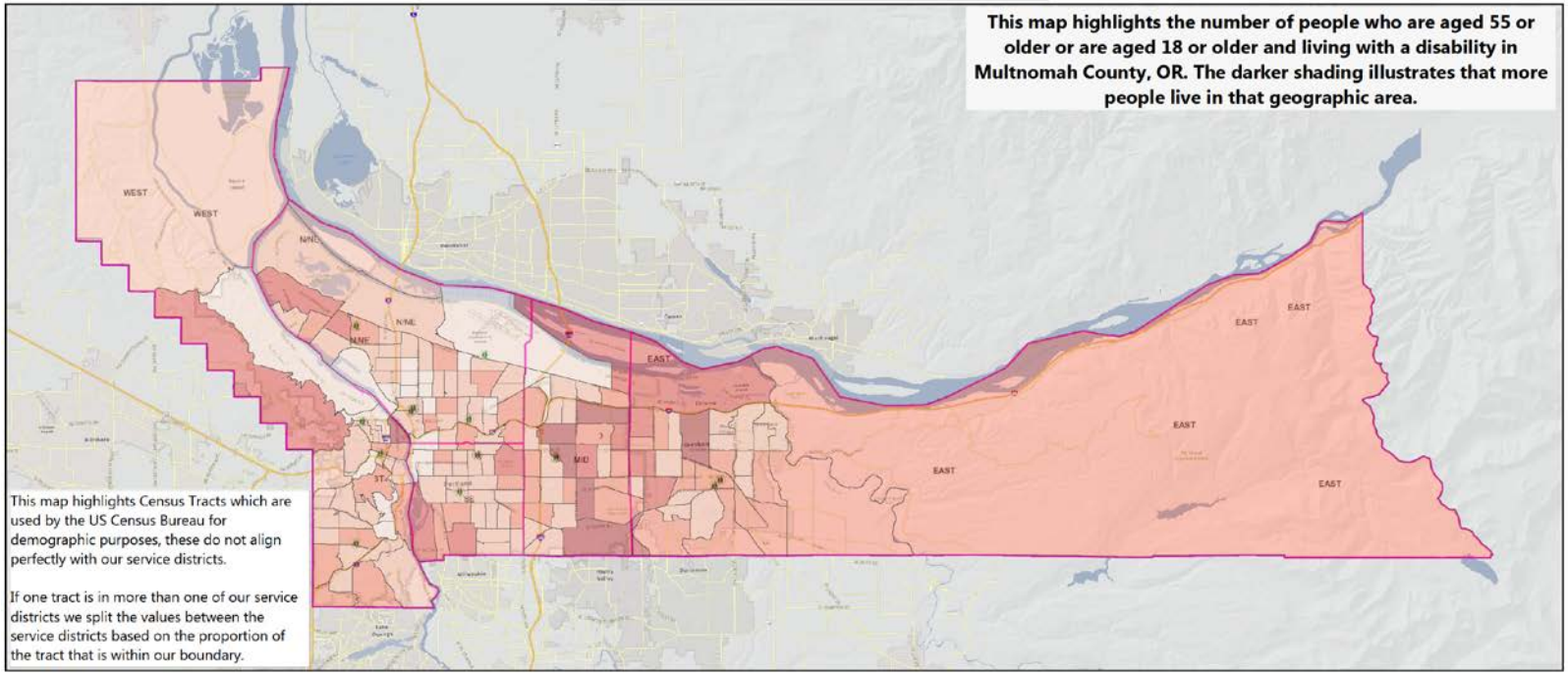
All estimates are based on populations 60+ unless otherwise noted. Estimates based on Census Bureau American Community Survey Data (2014, 1-Year) and/or Minnesota Population Center, University of Minnesota, 2014 Integrated Public Use Microdata Series (IPUMS). Multnomah County estimates are derived by using IPUMS proportional data and applying that to Census Bureau 60+ population estimates.

Characteristic	**Population Estimate**	**Percent of 60+ Population**
Total	140,097	100%
Below 185% FPL	59,435	7.6%
Minority	23,676	16.9%
Below 185% FPL minority	10,241	7.3%
Person with disability	39,409	28.1%
Limited English Prof.	12,048	8.6%
American Indian or Alaska Native		0.6%
Black / African-American	7,024	5%
Asian / Pacific Islander	9,962	7.1%
Other Race	1,326	0.9%
Two or More Races	1,871	1.3%
Hispanic	4,070	2.9%

Aging & Diversity Profile by Region

Multnomah County
Aging, Disability and Veterans Services Division

Figures based on 2014 American Community Survey 5-yr estimates by 2010 Census Tracts. Figures are estimates, boundaries are approximate.



Measures selected that result in map shading:

	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
Population AGE 55-59	9,743	9,542	10,866	8,387	10,044	48,582	6.41%
Population AGE 60-64	8,225	8,274	11,067	7,037	9,495	44,099	5.82%
Population AGE 65-74	9,940	9,559	10,269	7,611	10,834	48,213	6.37%
Population AGE 75-84	5,633	5,958	4,520	3,307	4,153	23,572	3.11%
Population AGE 85+	2,266	4,061	2,261	2,053	2,439	13,080	1.73%
DISABILITY (18-64)	12,985	13,474	12,586	9,188	7,523	55,756	7.36%
DISABILITY (65-74)	3,052	2,947	2,882	1,962	1,686	12,529	1.65%
DISABILITY (75+)	4,183	5,659	3,538	2,930	3,133	19,443	2.57%

More information about Multnomah County:

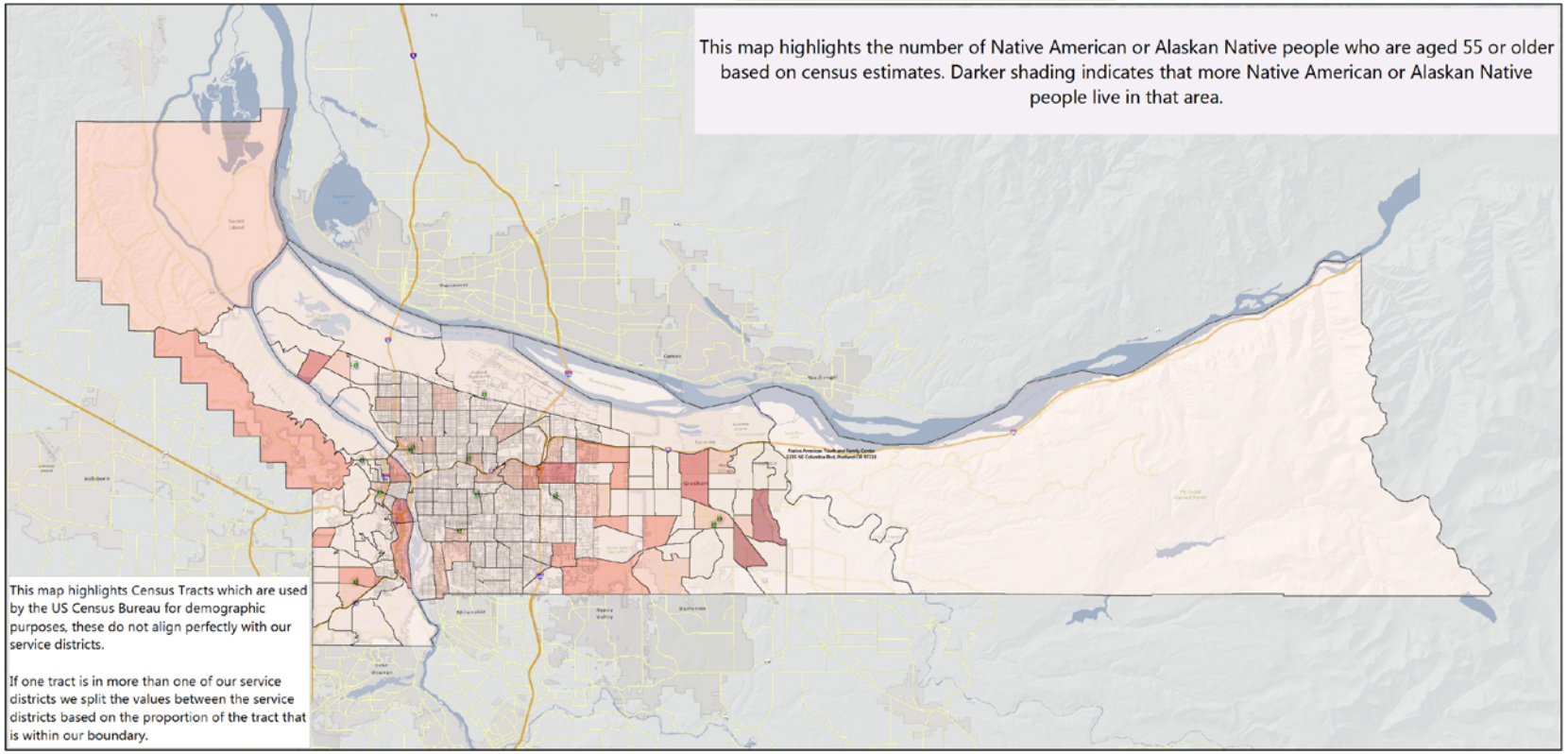
	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
60+ Population	26,064	27,852	28,118	20,008	26,922	128,964	17.03%
Population	153,863	159,114	184,868	126,962	132,564	757,371	100.00%
Median Age	30	28	30	26	32	29	100.00%
Disabled Adults	16,038	16,421	15,468	11,150	9,208	68,285	9.02%
Poverty (Below 185% FPL)	57,545	70,332	59,585	37,569	30,777	255,808	33.78%
HH with Person 60+ Receiving SNAP	769	952	1,573	1,043	1,019	5,356	0.71%
55+ Population	35,807	37,394	38,984	28,396	36,965	177,546	23.44%
55+ Poverty (Below 185% FPL)	9,008	12,298	11,760	7,636	7,425	48,127	6.35%
55+ Hispanic	1,455	1,270	1,993	914	970	6,602	0.87%
55+ African-American / Black	1,180	1,453	4,974	261	431	8,299	1.10%
55+ American Indian / Alaskan Native	302	326	280	132	263	1,304	0.17%
55+ Asian	2,697	7,481	2,798	3,904	1,789	18,669	2.46%
55+ Native Hawaiian / Pacific Islander	189	103	383	19	37	731	0.10%
55+ Other Race	436	595	722	415	521	2,689	0.36%
55+ Two or More Races	352	362	608	99	259	1,680	0.22%

Map 1

American Indian or Alaskan Native Aging Profile

Multnomah County
Aging, Disability and Veterans Services Division

Figures based on 2014 American Community Survey 5-yr estimates by 2010 Census Tracts. Figures are estimates, boundaries are approximate.



Additional Detail of the American Indian / Alaskan Native Population:

	EAST	MID	N/NE	SE	WEST
Multnomah County Population	153,863	159,114	184,868	126,962	132,564
Race: Part American Indian / Alaskan Native	4,289	4,099	4,714	2,690	2,834
American Indian / Alaskan Native ONLY	1,794	1,397	1,600	908	784
Disabled Adults: American Indian / Alaskan Native	311	405	283	199	161
Under FPL: American Indian / Alaskan Native	722	572	633	248	133
Under FPL: 55+ American Indian / Alaskan Native	36	120	109	15	33
60+ Population	26,064	27,852	28,118	20,008	26,922
60+ Minority	3,547	6,304	7,129	3,111	2,646
55+ American Indian / Alaskan Native	302	326	280	132	263

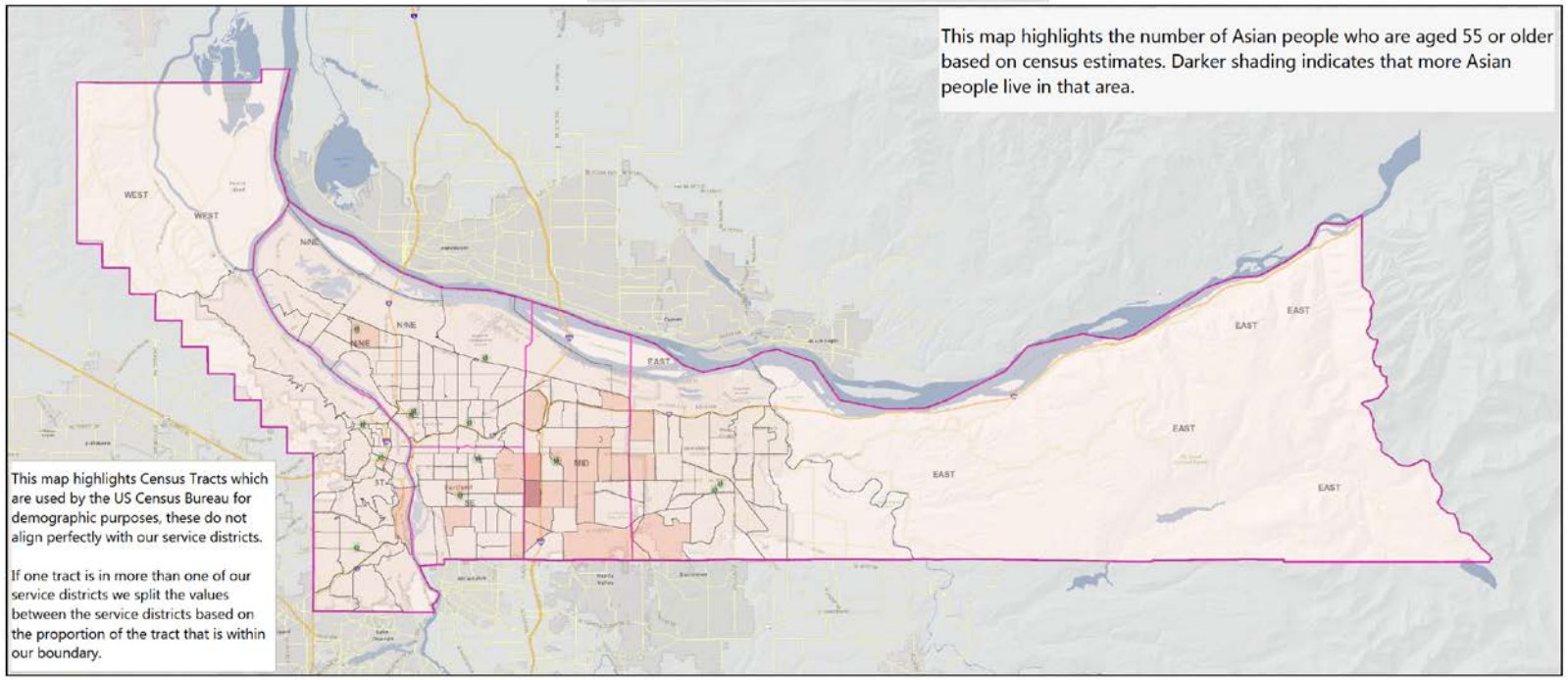
Selected measures that result in map shading:

	EAST	MID	N/NE	SE	WEST
AGE RACE (55-64 American Indian / Alaskan Native)	133	128	186	75	129
AGE RACE (65-74 American Indian / Alaskan Native)	89	135	94	46	107
AGE RACE (75-84 American-Indian / Alaskan Native)	64	30	0	9	0
AGE RACE (85+ American-Indian / Alaskan Native)	16	34	0	2	27

Asian County Aging Profile

Multnomah County
Aging, Disability and Veterans Services Division

Figures based on 2014 American Community Survey 5-yr estimates by 2010 Census Tracts. Figures are estimates, boundaries are approximate.



Measures selected that result in map shading:

	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
AGE RACE (55-64 Asian)	733	2,041	998	1,157	499	5,428	0.72%
AGE RACE (65-74 Asian)	399	1,352	420	616	297	3,084	0.41%
AGE RACE (75-84 Asian)	706	1,479	293	602	336	3,417	0.45%
AGE RACE (85+ Asian)	137	453	198	194	121	1,103	0.15%

More information about Multnomah County:

	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
60+ Population	26,064	27,852	28,118	20,008	26,922	128,964	17.03%
Population	153,863	159,114	184,868	126,962	132,564	757,371	100.00%
Median Age	30	28	30	26	32	29	100.00%
Disabled Adults	16,038	16,421	15,468	11,150	9,208	68,285	9.02%
Poverty (Below 185% FPL)	57,545	70,332	59,585	37,569	30,777	255,808	33.78%
HH with Person 60+ Receiving SNAP	769	952	1,573	1,043	1,019	5,356	0.71%
55+ Population	35,807	37,394	38,984	28,396	36,965	177,546	23.44%
55+ Poverty (Below 185% FPL)	9,008	12,298	11,760	7,636	7,425	48,127	6.35%
55+ Hispanic	1,455	1,270	1,993	914	970	6,602	0.87%
55+ African-American / Black	1,180	1,453	4,974	261	431	8,299	1.10%
55+ American Indian / Alaskan Native	302	326	280	132	263	1,304	0.17%
55+ Asian	2,697	7,481	2,798	3,904	1,789	18,669	2.46%
55+ Native Hawaiian / Pacific Islander	189	103	383	19	37	731	0.10%
55+ Other Race	436	595	722	415	521	2,689	0.36%
55+ Two or More Races	352	362	608	99	259	1,680	0.22%

Map 3

Black or African-American County Aging Profile

Multnomah County
Aging, Disability and Veterans Services Division

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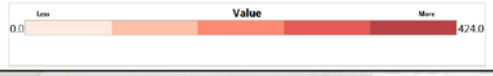

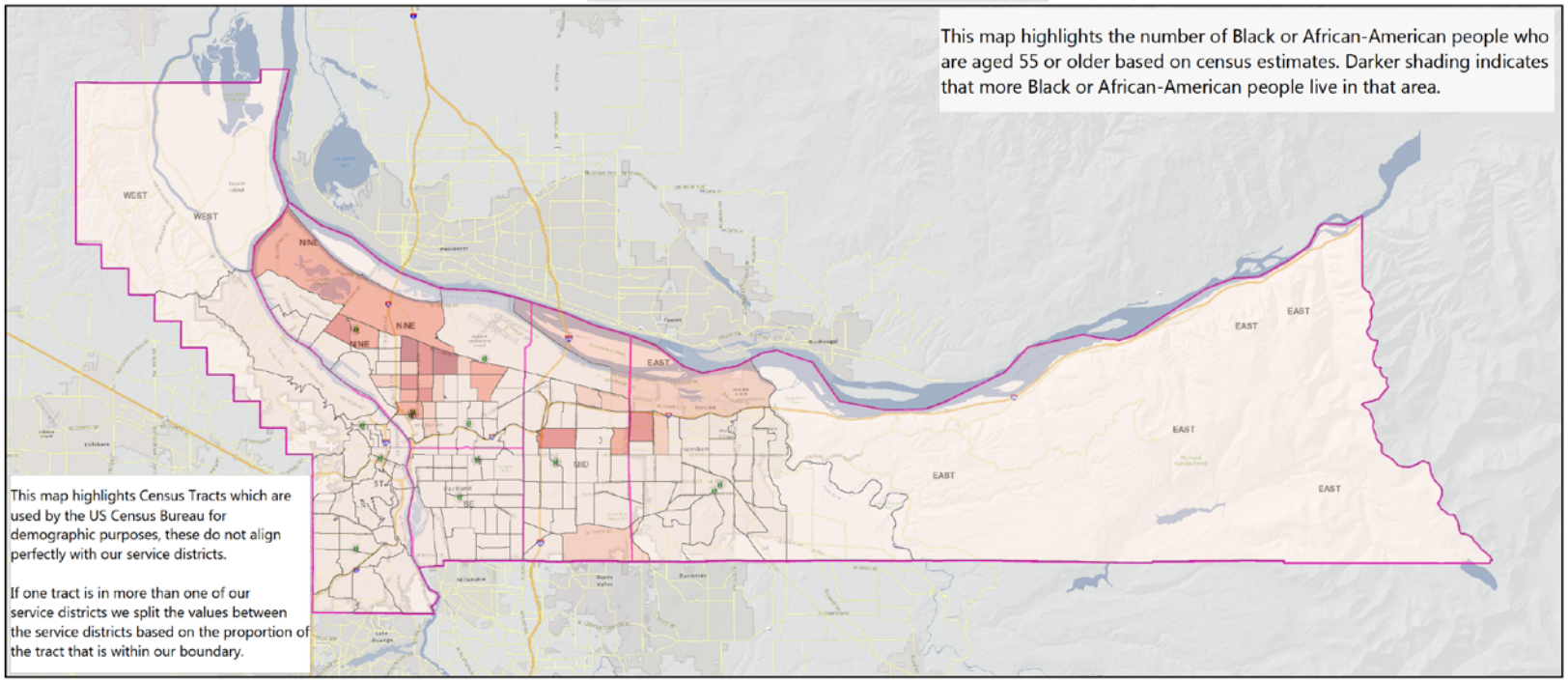

Measures selected that result in map shading:

	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
AGE RACE (55-64 Black / African American)	726	835	2,579	166	249	4,556	0.60%
AGE RACE (65-74 Black / African American)	210	432	1,423	52	154	2,271	0.30%
AGE RACE (75-84 Black / African American)	150	108	653	16	21	949	0.13%
AGE RACE (85+ Black / African American)	93	78	318	27	6	523	0.07%

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Hispanic County Aging Profile

Multnomah County
Aging, Disability and Veterans Services Division

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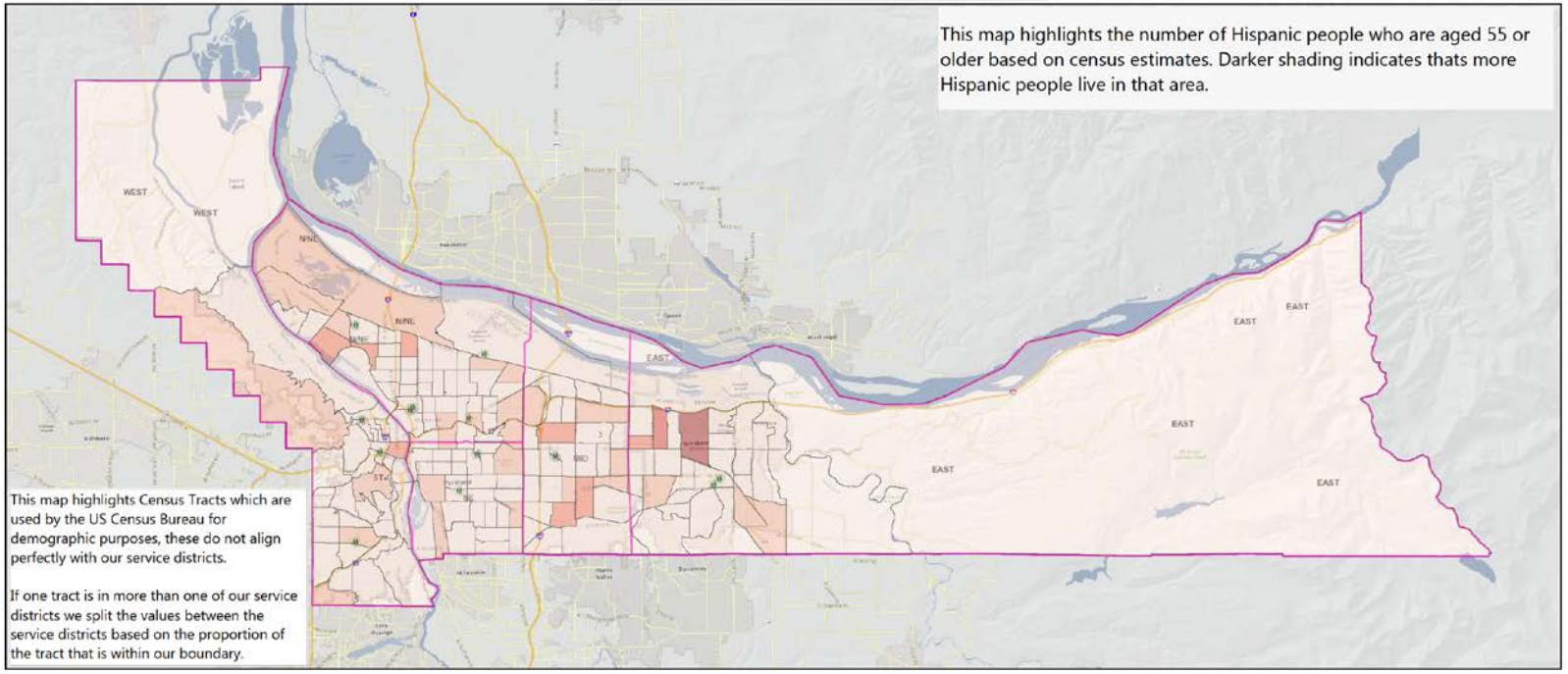

Measures selected that result in map shading:

	Branch						% of Population
	EAST	MID	N/NE	SE	WEST	Grand Total	
AGE RACE (55-64 Hispanic)	798	671	1,287	429	542	3,727	0.49%
AGE RACE (65-74 Hispanic)	327	394	244	237	255	1,457	0.19%
AGE RACE (75-84 Hispanic)	298	192	388	230	89	1,197	0.16%
AGE RACE (85+ Hispanic)	32	13	73	18	85	221	0.03%

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HH with Person 60+ Receiving SNAP	769	952	1,573	1,043	1,019	5,356	0.71%
55+ Population	35,807	37,394	38,984	28,396	36,965	177,546	23.44%
55+ Poverty (Below 185% FPL)	9,008	12,298	11,760	7,636	7,425	48,127	6.35%
55+ Hispanic	1,455	1,270	1,993	914	970	6,602	0.87%
55+ African-American / Black	1,180	1,453	4,974	261	431	8,299	1.10%
55+ American Indian / Alaskan Native	302	326	280	132	263	1,304	0.17%
55+ Asian	2,697	7,481	2,798	3,904	1,789	18,669	2.46%
55+ Native Hawaiian / Pacific Islander	189	103	383	19	37	731	0.10%
55+ Other Race	436	595	722	415	521	2,689	0.36%
55+ Two or More Races	352	362	608	99	259	1,680	0.22%

B-2: Target Populations

During the past four years, ADVSD has devoted considerable attention to improving services for older adults with the greatest economic and social needs as well focusing on equity issues impacting communities of color and communities from diverse ethnic and cultural backgrounds. During the 2013-2016 Area Plan, we began contracting with nine (9) providers to offer a range of services to racial, ethnic, and sexual minority elders. These five-year contracts, titled Enhancing Equity for Racial, Ethnic, and Sexual Minority Elders, have funded services such as options counseling, evidence-based health promotion, recreation, volunteer services, caregiver access assistance, and congregate meals, and target six underserved populations—Asian; African American; Hispanic; Native American; Immigrant and Refugee; and Lesbian, Gay, Bisexual, and Transgender elders. We are continuing with this service delivery model and plan to further diversify how our funding is allocated to community partner agencies to be more reflective of the community and the needs of racial, cultural, ethnic and sexual minority elders. We are redesigning our service model and funding formula which will result in a dramatic shift in how funds are allocated to culturally responsive and culturally specific providers.

Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse client populations and communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional, and individual.

Organizations providing culturally specific services demonstrate commitment to safety and belonging through advocacy; design of services from the norms and worldviews of the community; reflect core cultural constructs of the culturally specific community; understand and incorporate

shared history; create rich support networks; engage all aspects of community; and address power relationships.

Last, ADVSD will conduct outreach to underserved populations and employ measures to promote equity in its operations. Making inroads with isolated and disenfranchised people, such as deaf-blind people, residents without citizenship status who are isolated by fear of retribution, people who are isolated by language, and people who have been disenfranchised by institutions such as Native American veterans, LGBT veterans, and people aging with HIV. Individualized counseling for Medicare and Medicaid beneficiaries to prevent healthcare fraud, for example, will target Hispanic and urban Native American elders. ADVSD will continue to utilize the Equity and Empowerment Lens—a tool that is used to make equity the foundation of planning, decision-making, and service delivery.

B-3: AAA Services and Administration

Information in this section serves, in part, as narrative accompaniment to Attachment C - described further in Section D- Services Provided to OAA and/or OPI clients.

Advocacy: Focuses on monitoring, evaluating, and, where appropriate, commenting on all policies, programs, hearings, levies, and community actions that affect older adults. Activities include representing the interests of older persons; consulting with and supporting 04ad, the statewide AAA advocacy organization; and coordinating efforts to promote new or expanded benefits and opportunities for older adults.

Adult Day Care/Adult Day Health: Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health.

Caregiver Access Assistance: A service that assists caregivers in obtaining access to available services and resources in their communities. To the maximum extent possible, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures.

Caregiver Cash and Counseling: Services provided or paid for through allowance, vouchers, or cash that is provided to clients so that they can obtain the supportive services they want.

Case Management:
Case Management for Elders is a comprehensive service provided to individuals age 60 and over who are experiencing complex or multiple problems that affect the individual's ability to remain independent. Additionally, **Case Management for Family Caregivers** is a comprehensive service provided to family caregivers who are caring for persons age 60 and over, or for individuals who are grandparents 55 years of age or older who is a relative caregiver of a child. The definition of Family Caregiver has been broadened to include friends, neighbors and domestic partners who care for someone age 60 or older. Its goal is to provide access to an array of service options to assure appropriate levels of service and to maximize coordination in the service delivery system. Case management must include four general components: access, assessment, service implementation, and monitoring.

Cash and Counseling: Services provided or paid for through allowance, vouchers, or cash that is provided to clients so that they can obtain the supportive services they need.

Chore: A service for eligible OPI clients that provides assistance such as heavy housework, yard work, sidewalk maintenance, and bed bug treatment preparation . (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov) Note: Chore services are provided on an intermittent basis.

Chronic Disease Management, Prevention, and Education: Programs such as the evidence-based Living Well with Chronic Conditions (Stanford's Chronic Disease Self-Management) program, weight management, and tobacco cessation programs that prevent and help manage the effects of chronic disease, including osteoporosis, hypertension, obesity, diabetes, chronic pain, HIV, and cardiovascular disease.

- Living Well with Chronic Conditions and Diabetes Prevention Program (DPP) will be provided to Chinese, Korean, and Vietnamese elders using translated materials, and to African American elders through two agencies with a specific focus on the African American population under ADVSD's Enhancing Equity contracts.
- Tomando Control de Salud will be provided to Hispanic elders under ADVSD's Enhancing Equity contracts.
- Positive Self-Management Program for HIV (PSMP) is offered in partnership with Multnomah County Health Department and will be an option for Enhancing Equity contractors in the future.
- Chronic Pain Self-Management Program will be added to the suite of programs in the 2017-2020 planning cycle.

Congregate Meal: A meal provided to a qualified individual in a congregate or group setting that meets all of the requirements of the Older Americans Act and state/local laws.

- Five meal sites provide culturally-specific cuisine to Asian, Hispanic, Slavic, and Native American elders, four of which are funded under ADVSD's Enhancing Equity contracts.

Elder Abuse Awareness: Public education and outreach for individuals, including caregivers, professionals, and paraprofessionals on the identification, prevention, and treatment of elder abuse, neglect and exploitation of older individuals, with particular focus on prevention and enhancement of self determination and autonomy.

Financial Assistance: Limited financial assistance for clients with low-income, aiding them in maintaining their health and/or housing. Services

may include prescription, medical, dental, vision care or other health care needs not covered under other programs; and, the cost of utilities such as heat, electricity, water/sewer service or basic telephone service.

Guardianship/Conservatorship: Performing legal and financial transactions on behalf of a client based upon a legal transfer of responsibility (e.g., as part of protective services when appointed by court order) including establishing the guardianship/conservatorship.

Homemaker: Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

Home-Delivered Meals: A meal provided to a qualified individual in his/her residence that meets all of the requirements of the Older Americans Act and state and local laws. (Note: The spouse of the older person, regardless of age or condition, may receive a home-delivered meal if, according to criteria determined by the area agency, receipt of the meal is in the best interest of the homebound older person.)

Information & Assistance: Provides individuals with a) information about services available in the community; b) links individuals to services and opportunities that are available in the community; and (c) to the maximum extent practicable, establishes adequate follow-up procedures.

Information for Caregivers: A service for caregivers that provides the public and individuals with information about resources and services available to individuals in their communities. These activities are directed to large audiences of current or potential caregivers and include disseminating publications, conducting media campaigns, etc.

Interpreting/Translation: Provides assistance to clients with limited English speaking ability to access needed services. Provide assistance to accommodate the communication needs of people with disabilities.

Legal Assistance: Legal advice or representation provided by an attorney to older individuals with economic or social needs, including counseling or other appropriate assistance by a paralegal or law student acting under the direct supervision of an attorney, or counseling or representation by a non-lawyer where permitted by law. Priority legal assistance issues include income, health care, long term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. Legal services may also include assistance to older individuals who provide unpaid care to an adult child with disabilities and counsel to assist with permanency planning for the child. Assistance with will preparation is not a priority service except when a will is part of a strategy to address an OAA-prioritized legal issue.

Nutrition Education: A program to promote better health by providing accurate and culturally responsive and culturally specific nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.

Options Counseling: Counseling that supports informed long term care decision making through assistance provided to individuals and families to help them understand their strengths, needs, preferences and unique situations and translates this knowledge into possible support strategies, plans and tactics based on the choices available in the community.

- Asian; African American; Native American; Lesbian, Gay, Bisexual, Transgender (LGBT), Immigrant and Refugee' and Hispanic elders will receive Options Counseling under ADVSD's Enhancing Equity contracts.

Personal Care: In-home services provided to maintain, strengthen, or restore an individual's functioning in their own home when an individual is dependent in one or more Activities of Daily Living (ADL), or when an individual requires assistance for ADL needs. Assistance can be provided either by a contracted agency or by a

Homecare Worker paid in accordance with the collectively bargained rate.

Physical Activity and Falls Prevention: Programs for older adults that provide physical fitness, group exercise, and dance-movement therapy, including programs for multi-generational participation that are provided through local educational institutions or community-based organizations. Programs that include a focus on strength, balance, and flexibility exercise to promote physical activity and/or prevent falls; that are based on best practices; and that have been shown to be safe and effective with older populations are highly recommended.

- Racial, cultural, and ethnic minority elders will participate in Tai Chi: Moving for Better Balance; Walk with Ease, or Arthritis Foundation Exercise Program under ADVSD's Enhancing Equity contracts

Public Outreach/Education: Services or activities targeted to provide information to groups of current or potential clients and/or to aging network partners and other community partners regarding available services for the elderly. Examples of this type of service would be participation in a community senior fair, publications, conferences, other mass media campaigns, presentations at local senior centers where information on OAA services is shared, etc.

Recreation: Activities that promote socialization, such as sports, performing arts, games, and crafts, either as a spectator or as a participant.

- Asian, Native American, LGBT, Immigrant and Refugee, and Hispanic elders will be provided culturally-specific and other recreation activities under ADVSD's Enhancing Equity contracts.

Senior Center Assistance: Financial support for use in the general operation costs (i.e., administrative expense) of a senior center.

Transportation: Assist older adult consumers and others acting on behalf of older adults with transportation scheduling and coordination. This includes bus passes and tickets, cab rides, and door-to-door rides through contracts with local transportation providers for ADVSD clients to access

services that help them maintain their independence in the community for as long as possible. This service includes activities such as

- screening for eligibility for transportation services,
- assessing transportation needs,
- verification of eligibility for transportation,
- assisting in the completion of forms and applications for transportation,
- advocacy on behalf of older adults requesting transportation services,
- scheduling and coordinating rides with transportation providers, and
- the distribution of bus passes and tickets.

Clients needing transportation will be prioritized according to the following ADVSD criteria:

1. Medical trips (doctors, therapists, hospital, test, or health-related treatment) for non-Medicaid clients;
2. Congregate nutrition; and
3. Multiple supportive services (i.e. Multicultural Centers, Senior Centers, etc.).

Volunteer Recruitment: Identifying, training, and assigning an individual to a volunteer position.

Volunteer Services: Uncompensated supportive services to AAAs, nutrition sites, and other ADVSD contracted partners. Examples of volunteer activities may be, but are not limited to meal site management, Board and Advisory Council positions, home-delivered meal deliveries, office work, support group facilitation, etc.

B-4: Non-AAA Services, Service Gaps and Partnerships to Ensure Availability of Services Not Provided by the AAA

The services listed below complement those provided by ADVSD, and information about them is available at the ADRC website, **www.adrcoforegon.org**, or by calling ADVSD's **Helpline** at **503-988-3646**. Providers noted can also be contacted directly.

Service	Contact
Alzheimer's Resources	ADVSD collaborates with the Oregon Chapter of the Alzheimer's Association and several other partners on the STAR-C project, a grant-funded evidence-based intervention aimed at reducing caregiver stress among those caring for older adults with Alzheimer's disease or related dementias. Family Caregiver Support Program staff collaborates with the Alzheimer's Association on targeted community outreach events. The Multnomah County and Portland Age-Friendly Advisory Council are also integrating Dementia Friendly Community best practices into planning efforts.
Transportation Resources & Services	**Paratransit Service**: Helpline staff, contracted District Senior Center staff, and Enhancing Equity contractors provide referrals to Tri-Met Lift, which assesses consumers' functional eligibility for services. District Senior Center staff may assist consumers with Lift applications. **Non-Emergent Medical Transportation (NEMT)** and its more limited companion service--Non-Medical **Community Transportation** services for waivered long term care recipients are key benefits for members of the Oregon Health Plan (OHP). NEMT assists older adults as well as adults with disabilities to go to and from routine or scheduled OHP-covered medical services. Community Transportation assists frail older adults and adults with disabilities who qualify for long term services and supports (LTSS) to go grocery shopping, to conduct personal business, and to participate in community activities that are part of their person-centered long term care service plan authorized by their case manager. **Ride Connection** provides older adults and people with disabilities with information and access to all transportation options in the region, travel training, door-to-door transportation for any reason, and other mobility enhancing services.
Disability Services Programs	ADVSD partners with Independent Living Resources (ILR) on grant-funded projects, and Helpline, District Senior Center, and Enhancing Equity contractor staff refer people with disabilities to ILR, and other disability services providers as their needs dictate. ADVSD has recently joined the Deaf-Blind Services Task Force to bring more attention and services to people who are aging with combined vision and hearing loss.
Employment Services	ADVSD is a host site for the Title V Senior Community Service Employment Program, providing limited part-time employment to

	eligible individuals, and Helpline staff refers consumers to community Work Source providers other employment services in the county.
Energy Assistance	Low-income energy assistance is provided by the county's community action agencies, which include several ADVSD contracted partners—El Programa Hispano, Impact Northwest, Immigrant & Refugee Community Organization (IRCO), Native American Rehabilitation Association (NARA), NAYA Family Center, and Neighborhood House. Helpline Supervisor meets annually with community action agency staff to distribute energy assistance information to the aging and disability network.
Food Access, Pantries, and Gleaners	Helpline staff, contracted District Senior Center staff, and Enhancing Equity contractor staff provide referrals to food pantries and gleaners, which are numerous and located throughout the county to provide emergency food boxes to those in need. Several District Senior Centers host senior food box programs. Store to Door delivers and unloads groceries and prescriptions to homebound older adults and people with physical disabilities to parts of Multnomah and Washington Counties. Farmer's Markets are exploring mobile options and offer neighborhood-based access to fresh produce. SNAP benefits can be used in many, but not all, Farmer's Markets.
Housing	Helpline staff refers consumers to housing services based on their identified need (e.g. low-income residences, independent senior living, assisted living, etc.). Referrals are made to Home Forward, NW Pilot Project, Northwest Housing Alternatives, and a number of other housing providers.
Information & Referral	Through an agreement with 211Info, ADVSD ensures that seniors and adults with disabilities are referred to the Helpline for assistance.
Mental Health Services	Helpline staff refers consumers to mental health services based on their presenting issue (e.g., depression, anxiety, bereavement, etc.) and available treatment options include outpatient and inpatient counseling, group therapy, home-based mental health, support groups, and peer counseling. Helpline and the County Mental Health Crisis Call Center cross-train and share cross-referral processes. The Older Adult Behavioral Health Initiative offers resources for complex case coordination across mental health, aging, and addictions program areas.

Section C: Focus Areas, Goals and Objectives

C- 1: Information & Assistance Services and Aging & Disability Resource Connection (ADRC)

Profile of the issue

The Aging & Disability Resource Connection (ADRC) is the Front Door for older adults, people with disabilities, veterans, their families and community organizations. This community resource emphasizes coordination among AAAs and aging network organizations to strengthen community resources so that wherever consumers turn for help they receive seamless assistance and a “no wrong door” approach.

The Information and Assistance and ADRC programs are monitored for quality and access and improvements are made continuously. Multnomah County ADRC exceeded state standards for quality assurance in 2015, as reflected in our consumer satisfaction survey results for both quality of service and ease of access. As part of our ongoing regional ADRC Quality Improvement process, survey results are routinely shared with the I&R staff across the Metro ADRC and information gathered is used to develop customized training and support for staff. We also use accountability measures to track assistance to the linguistically and culturally diverse community. Although all programs across our system have access to interpreter and translation services and many of our brochures are translated into a number of languages, equitable access remains an area for improvement.

Coordination is a hallmark of the “no wrong door” approach. We have better integrated our Veterans Services Program into the 24/7 ADRC, including direct referrals and tracked client outcomes, better data collection for Veteran status and a system for additional follow-up with Veterans. We piloted a Long Term Care (LTC) Service Screener project with our Branch Offices as a way to reduce wait times. This innovative pilot allows us to screen complex cases using Helpline staff to provide initial assessment and immediate connection to resources to consumers who have needs but do not appear to be eligible for Medicaid. In addition, we continue to work to develop closer ties with 211info and the Multnomah County Mental Health call center to better support the needs of shared clients. In all these examples, more clearly defined roles and responsibilities have helped our team to focus on providing person-centered, streamlined access to information and services.

Problem/need statement

Participants in the Multnomah County listening sessions identified "ease of access" and "connecting to important services" as most important to them within the focus area of Outreach, Information and Referral. Culturally specific communities identified this focus area as more important than English speaking communities. Culturally specific clients also indicated in higher numbers the need for more of this focus area and were less likely than English-speaking clients to say our services are working well.

Our five regional District Senior Centers and nine Enhancing Equity culturally-specific community partners require additional support to better address the needs of older adults who face linguistic and cultural barriers and may not know or trust our ADRC and I&A services as they are currently delivered. One clear gap is the lack of funding currently allocated for I&A services to our Enhancing Equity partners who are an invaluable resource for reaching our increasingly diverse population. In 2016, we will modify our Quality Assurance process to measure consumer satisfaction specific to District Senior Centers and agencies that serve racial, ethnic, and sexual minority elders.

Multnomah County ADRC works strategically with the Metro ADRC advisory council, the AAA Network and the State Unit on Aging to address the larger issue of sustainable funding for these critical services. We are exploring the provision of services to CCOs and hospitals, fee for service private case management, offering our services through Employee Assistance Programs and developing a proposal for Medicaid match for non-Medicaid functions of the ADRC. By working together, we also hope to increase access to the ADRC for all consumers by making technology improvements especially around multiple languages and for consumers experiencing visual loss and other disabilities. We continue to monitor trends for most requested needs unmet needs and share these reports with stakeholders to inform our work plans and strategies.

Goal: Decrease isolation and barriers to access experienced by physically, emotionally, culturally or linguistically isolated older adults.

Objectives:

1. Build capacity to provide inclusive and culturally specific services.

2. Utilize a targeted outreach approach that builds on existing relationships, trusted cultural centers, and leverages strength of community.

Goal: ADRC is recognized by the community as a valuable resource for older adults and people with disabilities.

Objectives:

3. Utilize a multimodal approach to promote ADRC as front door/coordinated entry to all ADVSD/ Enhancing Equity services
4. 75% of consumers at District Senior Centers, agencies that specifically service racial, ethnic, and sexual minority elders, will express satisfaction (excellent or good) with services and activities provided at these community access points.

Focus Area - Information and Assistance Services and Aging & Disability Resource Connection (ADRC)						
Goal: Decrease isolation and barriers to access experienced by physically, emotionally, culturally or linguistically isolated older adults.						
Measureable Objectives Build capacity to provide inclusive and culturally specific services.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Train HelpLine staff to decrease use of jargon and increase ability of clients to navigate the ADRC	Program Manager	November 2016	March 2017	
	b	In-person contact in field sites to help District Center consumers access the ADRC database	Program Manager and Community Services Team	July 2018	June 2019	
	c	Understand barriers to accessing services in specific communities	ADRC Outreach focal point, Community Advisory Council, EE / DC contract liaisons	January 2017	December 2017	

Focus Area - Information and Assistance Services and Aging & Disability Resource Connection (ADRC)						
Goal: Decrease isolation and barriers to access experienced by physically, emotionally, culturally or linguistically isolated older adults						
Measureable Objectives Utilize a targeted outreach approach that builds on existing relationships, trusted cultural centers, and leverages strength of community.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Outreach in culturally responsive manner	ADRC Outreach Coordinator	January 2017	December 2017	
	b	Maintain current programs with culturally specific partners (called Enhancing Equity contracts) since they already have relationships w/ community members	Program Manager	on-going		
	c	Establish baseline using existing data to analyze currently serviced people by race, ethnicity, age, disability and income.	Program Manager, Resource Specialist, Outreach Coordinator, Data Analyst, community partners	March 2017	June 2017	

Focus Area - Information and Assistance Services and Aging & Disability Resource Connection (ADRC)						
Goal: ADRC is recognized by the community as a valuable resource for older adults and people with disabilities						
Measureable Objectives Utilize a multimodal approach to promote ADRC as front door/coordinated entry to all ADVSD/ Enhancing Equity services.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Create marketing plan, increasing outreach	ADVSD Outreach & Marketing Committee	October 2016	March 2017	
	b	Improve ADRC access and increase available languages by working together with the Metro ADRC.	Resource Specialist Program Manager	January 2018	December 2019	
	c	Empower Community Based and culturally specific partners to do outreach and produce materials.	ADRC Outreach Coordinator	July 2017	June 2018	

Focus Area - Information and Assistance Services and Aging & Disability Resource Connection (ADRC)						
Goal: ADRC is recognized by the community as a valuable resource for older adults and people with disabilities						
Measureable Objectives 75% of consumers at District Senior Centers will express satisfaction (excellent or good) with services and activities provided at these community access points.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Strengthen existing Quality Improvement (QI) measures to include focus on non-English speakers, and communities of color.	Program Manager and Resource Specialist; Metro ADRC QA Committee	January 2017	December 2017	
	b	Explore increasing center-based I&A for contracted partners especially Enhancing Equity organizations.	Program Manager, ADVSD Management	February 2017	June 2017	
	c	I&A more integrated between DCs and Branch Offices; explore co-location of services	Resource Specialist Program Manager	January 2019	December 2019	

C-2: Nutrition Services

Profile of the issue:

The purpose of the OAA Nutrition Program is to reduce hunger and food insecurity, promote socialization, and help ensure older adults' good health and well-being by providing access to nutritious meals and nutrition education that empowers older adults with the information to make better nutritional choices for their health. A healthy daily diet is an important key in helping adults 60 years and older to positively impact their physical and mental health and prevent or delay the onset of disease. The benefits of proper nutrition include increased mental acuity, resistance to illness and disease, higher energy levels, a more robust immune system, and faster recuperation from illness and medical treatments.

Currently, ADVSD contracts with several community agencies to provide congregate meals. The largest provider is Meals on Wheels People. They have eleven (11) congregate meal sites and four (4) satellite sites in the county. These meal sites offer two (2) daily lunch options in the interest of appealing to diverse tastes, and at a few locations, ethnic cuisine is served to attract diners from diverse cultural backgrounds. These meals are considered to be culturally responsive.

ADVSD also contracts with four culturally specific agencies to provide culturally specific meals. This change was made in 2012 to better meet the needs of culturally specific populations and help ADVSD provide person-directed services. Asian Health and Service Center provides culturally specific meals for Asian elders. NAYA Family Center provides culturally specific meals to Native American elders. El Programa Hispano Católico provides culturally specific meals to Hispanic elders. The Immigrant and Refugee Community Organization (IRCO) provides culturally-specific meals to the populations they serve that include Slavic, Asian, and African elders.

The culturally specific meals are currently being delivered in four ways: 1) Co-delivering with MOWP. The culturally specific partner has a satellite congregate meal site on their premises. 2) Meals are prepared at a MOWP congregate site and transported to culturally specific partner to serve at their site. 3) The use of culturally specific restaurant delivered meals that are served at the culturally specific agency. 4) Providing a prepared culturally specific meal in the culturally specific agency's commercial kitchen.

ADVSD also contracts with Meals on Wheels People to provide home delivered meals to older adults who cannot attend a meal site because they

are frail, have a chronic condition that limits their mobility, or are recuperating from surgery or a hospital stay. Because many homebound older adults have special dietary needs, low sodium, soft food, vegetarian and diabetic meals are available as part of this service. This program also provides a social contact, information dissemination and nutrition education.

Problem/need statement:

Over 9,000 adults 65 years and older in Multnomah County live below the Federal Poverty Level (FPL) and more than 25 percent of that number are racial and ethnic minority elders. Congregate meal sites and home-delivered meals are vital resources for these older adults, in particular, and for the broader population of people 60 years and older, as well. The poverty rate of racial and ethnic minorities is X time that of their white counterparts.

Fourteen percent of comments received during the 2016 community listening sessions were about nutrition resources and education. As many comments indicated that nutrition services were working well as those that indicated more resources were needed. People indicated that receiving a variety of culturally appropriate, healthy, and medical or other diet appropriate food was important. In addition to lunch programs available through congregate meal sites, people wanted education about resources or eligibility criteria for other types of nutrition support, such as SNAP, Farmer's Markets, and transportation or assistance to purchase and manage groceries, and to prepare nutritious meals. Affordability of food and earning a living wage were also mentioned as barriers to nutrition for older adults.

Eating in community, whether it was at a congregate meal site, in an apartment community center, or with family or friends in their home, was cited as important for reducing loneliness and feeling good. Community members asked for more creative support to access healthy foods, such as group travel to Sauvie Island, farmer's markets, and cooking classes. Some thirty-six people indicated that they get pushed aside at food banks and wanted to have Elder-first policies to ensure they had the same access as faster, more able-bodied people.

The responses from racial, ethnic, and cultural minorities indicate that access to food, culturally specific home delivered meals, and nutritious culturally specific food to be a gap.

Goal: Older adults will have ready access to healthy food that is affordable and supports a healthy diet.

Objective:

1. Provide access to low or no-cost healthy food in a variety of settings to meet the diverse needs of older adults.

Goal: Be a leader in equity around food security.

Objective:

2. Programming is targeted to the highest need populations.

Focus Area - **Nutrition Services**						
Goal: Older adults will have ready access to healthy food that is affordable and supports a healthy diet.						
Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Provide access to low or no-cost healthy food in a variety of settings to meet the diverse needs of older adults.	a	Deliver 128,160 meals containing 1/3 of the US RDA to homebound older adults.	ADVSD Nutrition Services Contract Liaison, Meals on Wheel People (MOWP)	January 2017	December 2020	
	b	Congregate nutrition sites will serve fresh fruits and vegetables for a minimum of four (4) months each year.	ADVSD Nutrition Services Contract Liaison, MOWP	January 2017	December 2020	
	c	Congregate nutrition sites will provide 70,702 meals containing 1/3 of the US RDA to older adults who attend the sites regardless of their ability to make a monetary donation	ADVSD Nutrition Services Contract Liaison, MOWP	January 2017	December 2020	

	d	Culturally-specific congregate meal providers—Asian Health and Service Center, NAYA Family Center, El Programa Hispano, and the Immigrant and Refugee Community Organization-- will serve approximately 14,800, 2,100, 1,600, and 8,100 meals containing 1/3 of the US RDA, respectively, to older adults who attend the sites regardless of their ability to make a monetary donation.	ADVSD Nutrition Services Contract Liaison, Culturally-specific congregate meal providers	January 2017	December 2020	
	e	Eleven (11) Meals on Wheels People's congregate nutrition sites will provide nutrition education a minimum of four (4) times yearly.	ADVSD Nutrition Services Contract Liaison, MOWP	January 2017	Dec. 2020	
	f	Increase number of individual nutritional assessments completed annually	ADVSD Nutrition Services Contract Liaison	January 2017	Dec. 2020	

Focus Area - **Nutrition Services**						
Goal: Be a leader in equity around food security.						
Measureable Objectives Programming is targeted to the highest need populations.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Serve culturally specific communities through culturally specific agencies providing culturally specific congregate meals.	ADVSD Nutrition Services Contract Liaison, EE Contractors	January 2017	Dec. 2020	
	b	Ensure programming and allocation is reflective and proportional to the population need/served.	ADVSD Community Services Manager	May 2018	December 2020	
	c	Support culturally specific providers to meet the dietary standard and dietician requirement with innovative ideas like using nutrition students or government dietician resources to help build menus in collaboration with culturally specific restaurants and providers.	ADVSD Nutrition Services Contract Liaison	January 2017	Dec. 2020	
	d	Work with the State on component meals as a way that culturally specific providers can meet the nutrition criteria with culturally specific restaurants.	ADVSD Nutrition Services Contract Liaison	January 2017	Dec. 2020	

C-3: Health Promotion (OAA Title IIID)

Profile of the issue:

According to the Centers for Disease Control and Prevention, it is estimated that chronic diseases are responsible for 7 out of 10 deaths nationally each year. Treatment costs for persons with chronic diseases account for 86% of national healthcare costs. Statistics from the Oregon Health Authority in 2014 show that more than half of Oregon residents have one or more chronic condition. These numbers are mirrored in Multnomah County, with roughly 50% of the population having one or more chronic condition. Additionally, it should be noted that African Americans, Native Americans and Latinos have the highest rates of Chronic Disease in Multnomah County.

Problem/need statement:

ADVS contracts with nine community partners to provide Evidenced-Based Health Promotion programs in our area. Our District Center partners and our Enhancing Equity partners provide workshops across the county in easy to access community centers. There is a need for additional courses, along with marketing and outreach to educate the public about these valuable workshops and exercise opportunities. Despite the startling statistics that over 50% of Multnomah County residents have one or more chronic conditions, there is encouraging news about the effectiveness of evidenced-based health promotion programs. These programs have the ability to help improve quality of life and reduce healthcare expenditures.

Findings from studies on patient outcomes for Chronic Disease Self Management Courses include; greater self-efficacy, better psychological well-being, greater energy, lower health distress, self-rated health status improvement and decreased depression. Tai Chi for Arthritis has shown benefits that include reduced pain and less falls. The Walk with Ease program helps participants improve arthritis symptoms, and perceived control, balance, strength, and walking pace. These Programs can help older adults and people with disabilities have more control and empower them to learn new ways to improve their quality of life.

The availability of these programs has increased over the last several years, but there is still a need to enhance program offerings. Programs specializing in pain management, HIV focused Self-management programs, Diabetes Prevention and additional courses offered in Spanish, have been identified as areas where growth is needed. ADVS continues to

work with neighboring AAAs to address both the variety of programs offered, in addition to the accessibility and registration issues. There is also a regional goal to build working relationships with local Healthcare agencies, which will increase offerings and also potentially provide additional funding streams.

Goal: Improve county-wide access to and utilization of services by racial, ethnic, cultural minority and other underserved groups of elders that address the social determinants of health and/or forge links between health systems and community services

Objectives:

1. Increase access and utilization of culturally and linguistically diverse evidenced-based workshops and activity offerings throughout the region.
2. Older adults and people with disabilities and chronic conditions will learn disease specific information through regional efforts to improve coordination, leverage resources and build capacity of evidence-based health promotion and self-management education programs.
3. Participate with and explore opportunities through the Portland and Multnomah County Age-Friendly Health Services, Equity, and Prevention Committee.

Goal: Involvement in health promotion programs will reduce social isolation by providing older adults and people with disabilities support through social networks and direct linkages to community resources offered by our contracted partners.

Objective:

4. Participants in evidence-based health promotion programs will have access to ADRC, options counseling, nutrition programs, etc.

SECTION C – 3 Health Promotion

Goal: Improve county-wide access to and utilization of services by racial, ethnic, cultural minority and other underserved groups of elders that addresses the social determinants of health and/or forge links between health systems and community services

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Increase access and utilization of culturally and linguistically diverse evidenced-based workshops and activity offerings throughout the region.	a	Increased availability of exercise at EE & DC's and programs in multiple languages (promotional materials, speakers, cultural inclusivity factors specific to population)	Evidenced-Based Health Promotion Program Coordinator	August 2016	December 2018	
	b	Increase availability of CDSMP at EE & DC's and programs in multiple languages (promotional materials, speakers, cultural inclusivity factors specific to population)	Evidenced-Based Health Promotion Program Coordinator	August 2016	December 2018	

Goal: Improve county-wide access to and utilization of services by racial, ethnic, cultural minority and other underserved groups of elders that addresses the social determinants of health and/or forge links between health systems and community services						
Measureable Objectives Older adults and people with disabilities and chronic conditions will learn disease specific information through regional efforts to improve coordination, leverage resources and build capacity of evidence-based health promotion and self-management education programs.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Increase participation through education & linkage with community partners, health plans, hospitals, and primary care clinics	Tri County Joint Aging, Disability and Health Systems Steering Committee, Evidenced-Based Health Promotion Program Coordinator	August 2016	December 2019	
	b	Improve coordination, build referral systems and develop sustainable payment structures.	Tri County Joint Aging, Disability and Health Systems Steering Committee Evidenced-Based Health Promotion Program Coordinator	August 2016	December 2020	

Goal: Improve county-wide access to and utilization of services by racial, ethnic, cultural minority and other underserved groups of elders that addresses the social determinants of health and/or forge links between health systems and community services						
Measureable Objectives Participate with and explore opportunities through the Portland and Multnomah County Age-Friendly Health Services, Equity, and Prevention Committee.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Develop relevant and desired age-specific training to Community Health Workers	ADVSD Planning & Development Specialist, Age-Friendly Health Services	August 2016	December 2017	
	b	Strengthen relationships with other community resources, such as public pools, gyms, dance classes, etc.	Evidenced-Based Health Promotion Program Coordinator & Age-Friendly Health Services, Prevention, and Equity Committee	September 2016	December 2018	
	c	Conduct transportation program analysis	ADVSD Transportation Workgroup	September 2016	December 2016	

Goal: Involvement in health promotion programs will reduce social isolation by providing older adults and people with disabilities support through social networks and direct linkages to community resources offered by our contracted partners.					
Measureable Objectives Participants in evidence-based health promotion programs will have access to ADRC, options counseling, nutrition programs, etc.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)	Accomplishment or Update
				Start Date	End Date
	a	Develop a plan for monitoring the quality and fidelity of EBHP programs	Evidenced-Based Health Promotion Program Coordinator	August 2016	December 2017

C-4: Family Caregivers

Profile of the Issue:
The majority of older adults with long-term care needs rely on family caregivers and other informal caregivers who are often new to the caregiving role. Because of this new role, family caregivers need access to a wide variety of information to help them move forward in their caregiving role from a person-centered/family centered perspective to meet their specific needs.

According to the Family Caregiver Alliance, minority and low-income caregivers may face additional challenges both in meeting their basic needs and being able to afford support services and supplemental paid care that higher income people may rely on. As a result, lower-income caregivers are half as likely to have paid respite type services. Because of lack of support, caregiver stress and burden levels can increase jeopardizing the caregivers ability to continue to provide care. In addition, according to the Family Caregiver Alliance, Facts and Figures, one–third of family caregivers who participate in the Administration for Community Living respite program report that they spend 40 hours per week caring for an older relative; this time commitment certainly can also add to caregiver burden. The Alzheimer's Association reports that 61% of family caregivers, many of whom are between the ages of 45-64, report high emotional stress, 43% report high physical stress, and their average annual health care costs increased by $550. There are approximately 175,000 estimated unpaid caregivers in Oregon.
54% of residents in licensed care settings have dementia diagnosis (DHS) and the World Health Organization has ranked severe dementia as the disability that creates the greatest impact to daily living. These statistics point to the profound importance of caregivers and the need to support them.

Problem/need statement:
Participants in the Multnomah County listening session identified culturally specific outreach and training as important to family caregivers. Additionally, they indicated that caregiver respite and education is working well, but that they still need more of caregiver respite and educational training.

- Family Caregivers need access to information and resources that are delivered in person centered and culturally relevant formats.
- Family caregivers who have low-incomes are unable to afford support services, including respite care, resulting in higher caregiver stress and burden levels. Slightly more than half of Asian-American caregivers (53%) and four in
  ten white caregivers (42%) report household incomes of $50,000 or more. Only one-third of African-American caregivers (33%) and 37% of Hispanic caregivers report the same according to Caregiving in the U.S., National Alliance for Caregiving and AARP, 2004.
- Family caregivers, caring for a person with Alzheimer's or another dementia, experience higher levels of caregiver stress and depression than other family caregivers. Family caregivers caring for a person with Alzheimer's or another dementia, benefit from Alzheimer's/dementia specific training to support them in their caregiving role and to decrease caregiver stress and burden.
- Currently, the evidence based caregiver training centered on caregivers caring for people with Alzheimer's or another dementia have training materials only offered in English.

Goal: Support quality services for family caregivers.

Objective:

1. Provide culturally relevant caregiver training

Goal: Promote access to family caregiver services and resources, including respite services, to meet the needs and preferences of family and informal caregivers from diverse cultural backgrounds.

Objective:

2. Increase participation by family and informal caregivers that identify in racial, ethnic, and cultural minority groups.

SECTION C - 4 Family Caregivers						
Goal: Support quality services for family caregivers						
Measureable Objectives Provide culturally relevant caregiver training	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Assess training needs for culturally specific family caregivers by working with Enhancing Equity partners, Multnomah County Health Department outreach staff and other community partners.	FCSP Coordinator, ADVSD Research & Evaluation Specialist	August 2016	July 2017	
	b	Research evidence based and best practices training programs that address the culturally specific training needs identified in year one. Find evidence based family caregiver training in other languages that address the needs identified for culturally specific family caregivers. If evidence based programs are not available, or cost prohibitive, find training considered “best practice”.	FCSP Coordinator	August 2016	Dec 2018	

	c	Find and train 1-2 culturally diverse trainer(s) to teach an evidence-based or best practice family caregiver training. Recruit trainers from either an Enhancing Equity Partner, a Multnomah County Health Dept employee, or other community partner, to teach one cultural specific training for family caregivers.	FCSP Coordinator	July 2017	July 2018	
	d	Find and train a 2nd and 3rd culturally diverse trainer(s) to teach an evidence-based or best practice family caregiver training. Recruit trainers from either an Enhancing Equity Partner, a Multnomah County Health Dept employee, or other community partner, to teach one cultural specific training for family caregivers.	FCSP Coordinator	August 2018	June 2019	

Goal: Promote access to family caregiver services and resources, including respite services, to meet the needs and preferences of family and informal caregivers from diverse cultural backgrounds.					
Measureable Objectives Increase participation by	Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
			Start Date	End Date	

family and informal caregivers that identify in racial, ethnic, and cultural minority groups.	a	Develop culturally specific outreach materials and other methods to serve culturally diverse family caregivers. (loriann)	FCSP Coordinator	July 2016	June 2020	
	b	Distribute culturally specific outreach materials and conduct other methods of reaching out to culturally specific family caregivers.	FCSP Coordinator	July 2017	June 2020	
	c	Hold bilingual outreach event(s) targeting Spanish-speaking family caregivers, Elders, and professionals who serve them, in places identified by the Spanish-speaking community as appropriate.	FCSP Coordinator	July 2017	Sept 2017	
	d	Collaborate with PreSERVE Coalition to promote access to African-American family caregivers.	FCSP Coordinator	July 2016	June 2020	
	e	Develop capacity for meeting the needs of LGBT elders and family	ADVSD Planner	July 2016	June 2020	

		and informal caregivers.				
	f	Identify age-specific training topics that are desired by community health workers to help them better serve older adults and family caregivers () (ADVSD Planner)(July 2016-June 2020)	Age-Friendly Health Services, Equity, and Prevention Committee - CHW Task group, ADVSD Planner	July 2016	September 2016	
	g	Support the development of age-specific training topics that are desired by community health workers to help them better serve older adults and family caregivers.	Age-Friendly Health Services, Equity, and Prevention Committee - CHW Task group, ADVSD Planner	September 2016	June 2017	

C-5: Elder Rights and Legal Assistance (OAA Titles VII & IIIB)

Profile of the issue

Protecting older adults from abuse, neglect, and exploitation is a critical element to helping them remain healthy and engaged in community life, and as the baby boom cohort enters retirement, it is essential that steps be taken to reduce the incidence of elder abuse and to prevent it from increasing apace with the rapidly growing population of older adults. Although the exact scope of the problem is not known because many instances of abuse are not reported, an elder abuse study published in 2013 in *The American Journal of Public Health* noted that 11 percent of respondents reported being victims of abuse, neglect, or exploitation, and importantly, those surveyed did not include older adults with dementia or those living in institutional settings—groups that are often at the greatest risk of being abused.

In recent years, financial abuse has become increasingly common, accounting for over 40 percent of Oregon's substantiated cases in 2010, and as several studies have shown women are more likely than men to be victims of this form of abuse. Perpetrators of these crimes include once trusted relatives, friends and acquaintances that gain the confidence of victims, and unscrupulous financial advisers. The consequences can be devastating financially and emotionally for those who have been abused and exploited in this fashion. ADVSD's Adult Protective Services (APS) is charged with investigating such cases in collaboration with local law enforcement, and benefits from receiving referrals from the agency's ADRC and Gatekeeper Program, as well as Elders in Action's Peer Advocates. APS has an established Financial Abuse Specialist Team (FAST) to conduct investigations and prosecute financial abuse cases.

To assist older adults faced with civil (non-criminal) legal issues, ADVSD contracts with the Legal Aid Services of Oregon (LASO), to provide counsel and representation on tenant rights, eligibility for public benefits, and other matters. In addition, LASO maintains a corps of attorneys who volunteer their time to provide 30-minute consultations to county residents who are 60 years and older or spouses of someone 60 years and older, and these clients may be eligible for continuing pro bono legal services if they meet eligibility guidelines.

Problem / Need Statement

Combating abuse will require early detection of potential dangers, as well as education in the form of training for the aging network staff, private and public sector employees who are in contact with older adults (bank and credit union staff, letter carriers, utility company customer service representatives, etc.), and community members is a vital element of reducing elder abuse. Another critical element is to ensure that instances of abuse receive appropriate follow-up and disposition, effective communication and coordination among the many parties that may be involved in a case is essential. Finally, because the cost of legal services is often prohibitive for low-income older adults, ensuring that subsidized consultation and representation is available for those dealing with civil legal issues, is critical in this focus area. Based on feedback received at community listening sessions, it is essential that the area agency is able to respond in a culturally specific way, to concerns of abuse and neglect. Examples of this need for culturally specific response, as garnered from community listening sessions include:

- LGBT Community - lack of safety in community, senior centers, housing, ALF, etc. Asset transfer information for non-married partners. End of life decision making. Medical decision making/advance directives.
- Elder abuse within, specific cultural communities, particularly some Asian and African Elder communities, based on feedback from community listening sessions.

Goal 1:

Ensure that older adults and people with disabilities have access to protection against abuse, financial exploitation, and neglect, with particular attention focused on resources, access, and financial stability.

Objectives:

1. Adult Protective Services (APS) will demonstrate effective response to complaints.
2. 1,500 Multnomah County Medicare/Medicaid beneficiaries will receive personalized counseling by skilled volunteers, with special attention devoted to increasing the number of Hispanic/Latino and urban American Indian/Alaskan Native beneficiaries.
3. Enter into a regional partnership to develop a Benefits Enrollment Center (BEC) model that may serve up to 1000 older adults who need additional

assistance with applications for various benefit programs, including Medicare Savings programs.

Goal 2: Ensure adequate and equitable access to legal support, peer support, and advocacy for older adults.

Objective:

1. An average of 850 older adults will receive civil legal assistance yearly, with an emphasis on developing capacity to serve racial, ethnic, and cultural minority group elders.

Focus Area - **Elder Rights and Legal Assistance**						
Goal: Ensure that older adults and people with disabilities have access to protection against abuse, financial exploitation, and neglect, with particular attention focused on resources, access, and financial stability.						
Measureable Objectives Adult Protective Services (APS) will demonstrate effective response to complaints.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Apply learnings and recommendations from MDT evaluation to ensure consistent and equitable access to services and supports provided thru MDT referrals.	ADVSD Adult Protective Services and ADVSD Research & Evaluation			
	b	Outstation with Ortiz Center to serve Hispanic and African immigrant community	ADVSD Adult Protective Services			

Focus Area - **Elder Rights and Legal Assistance**					
Goal: Ensure that older adults and people with disabilities have access to protection against abuse, financial exploitation, and neglect, with particular attention focused on resources, access, and financial stability.					
Measureable Objectives 1,500 Multnomah County Medicare/Medicaid beneficiaries will receive personalized counseling by skilled volunteers, with special attention devoted to increasing the number of Hispanic/Latino, urban American Indian/Alaskan Native and LGBT-identified beneficiaries	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)	Accomplishment or Update
				Start Date / End Date	
	a	Conduct community outreach to diverse communities to identify volunteers to work with SHIBA and BEC, to increase participation by consumers representative of these communities.			
	b	Engage people that identify as racial and ethnic minorities to become new SHIBA and BEC volunteers.			
	c	Provide program-specific training to identified volunteers, including training to assist with application completion.			

	d	Continue to provide training to volunteers regarding Medicare benefits and access to benefits for transgender beneficiaries.				

Focus Area - **Elder Rights and Legal Assistance**						
Goal: Ensure that older adults and people with disabilities have access to protection against abuse, financial exploitation, and neglect, with particular attention focused on resources, access, and financial stability.						
Measureable Objectives Enter into a regional partnership to develop a Benefits Enrollment Center (BEC) model that may serve up to 1000 older adults who need additional assistance with applications for various benefit programs, including Medicare Savings programs.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Create a BEC workgroup to draft scope of BEC	Metro ADRC Executive Council			

	b	Respond to an RFP in collaboration with Metro ADRC to create a Benefit Enrollment Center	Metrol ADRC Executive Council			
	c					
	d					

Focus Area - **Elder Rights and Legal Assistance**					
Goal: Ensure adequate and equitable access to legal support, peer support, and advocacy for older adults.					
Measureable Objectives An average of 850 older adults will receive civil legal assistance yearly, with an emphasis on developing capacity to serve racial,	Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
			Start	End	

ethnic, and cultural minority group elders.				Date	Date	
	a	Reach people aging with HIV and AIDS Long-Term Survivors to provide legal information and services related to health care decision making, protection of assets for the care of unmarried partners, and navigating Federal VA, Ryan White, and other entitlements.	ADVSD Planning & Development Specialist, Regional LGBT Alliance			
	b	Provide program-specific training to identified volunteers, including training to assist with application completion.				
	c	Develop culturally specific abuse awareness, education, and prevention resources.	APS Program Manager			

C-6: Older Native Americans (OAA Titles VI & IIIB)

Profile of the Issue:

Multnomah County is home to more than 884 Native Americans 60 years and older according to the 2014 U.S. Census American Community Survey 5-yr Estimates—a figure that is likely an undercount, as Native Americans have historically been underrepresented in U.S. Census reports. The area's urban Native American elders are diverse. One local organization serves Native American people representing more than 380 tribal backgrounds and those in federally recognized and recorded tribes represent less than 1% of Multnomah County's 60+ population and 4% of its minority 60+ residents. The older Native American community is fairly young, with nearly 50% of Native Americans 55 and older in the younger cohort of ages 55-64.

The lifetime effects of discrimination and biased policies have created disparate impacts to the health of the community. As data from the National Resource Center on Native American Aging and the Coalition of Communities of Color 2011 report, *The Native American Community in Multnomah County: An Unsettling Profile*, show: Native American elders are more likely than their white counterparts to suffer from chronic diseases, with the prevalence of diabetes being particularly high; live in poverty; and have a shorter life expectancy.

Native American elders are buoyed, despite systemic and cultural bias, by a culture that embraces and honors aging. The relational and communal nature of tribes is a protective factor for many older adults and presents a model for the larger community to embrace and learn from.

ADVSD coordinates with the Native American Rehabilitation Association (NARA) and NAYA Family Center (NAYA) to serve the county's urban Native American elders, and both agencies will have Enhancing Equity contracts in place over the course of this area plan to provide options counseling, recreation, evidence-based falls prevention, caregiver support, and congregate meals to their clients. NAYA staff participate on the Multicultural Action Committee, an ADVSD advisory body of stakeholders representing racial, ethnic, and cultural minority elder issues to regularly inform policy and programs.

Problem / Need Statement:

Elders attending a community listening in Spring 2016 indicated that the health promoting classes and culturally-specific nutrition programs they

are receiving through our contracted partners are working well. The community they experience through these programs helps them feel connected and respected. They talked about the challenges they face with transportation, affordable housing, and finding culturally appropriate information and services for grief, depression, and abuse.

Native American elders come from all over the county to receive services from these trusted organizations, but the capacity to serve this diverse group is limited. On an annual basis, ADVSD serves less than 100 Native American elders, through the culturally-specific services offered by NAYA and NARA.

ADVSD has developed relationships with our two contracted partners that serve Native American elders, but not yet with the Confederated Tribes of Grand Ronde or Siletz, or the multitude of other organizations serving our urban native elder community.

Goal: Increase accessibility to culturally specific services and support the needs identified by Native American Elders.

Objective:

1. Work with current culturally-specific providers, stakeholders, and community members to better identify and provide the services and supports needed and desired by Native American Elders.

Goal: Enhance services for urban Native American elders by promoting capacity-building in agencies that serve them.

Objective:

2. Provide technical assistance to culturally specific providers.

Focus Area - **Older Native Americans**						
Goal: Increase accessibility to culturally specific services and support the needs identified by Native American Elders						
Measureable Objectives Work with current culturally-specific providers, stakeholders, and community members to better identify and provide the services and supports needed and desired by Native American Elders.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Develop a culturally responsive engagement plan specific to Native American-identified organizations and leaders that serve or interact with Native American Elders in Multnomah County.	ADVSD Planner, Program Specialist	July 2016	June 2017	
	b	Contract with culturally-specific providers to deliver recreation, options counseling, short term case management, evidence-based health promotion and chronic disease prevention.	Enhancing Equity Contract Liaison	July 2016	June 2020	
	c	ADVSD will contract with NARA to provide 40 recreation activities yearly.	Enhancing Equity Contract Liaison	July 2016	June 2020	

	d	ADVSD will contract with NAYA to provide 644 hours of Older Americans Act Case Management, 130 classes of Tai Chi: Moving for Better Balance, four (4) Recreation activities and 2000 congregate meals yearly.	Enhancing Equity Contract Liaison	July 2016	June 2020	

Goal: Enhance services for urban Native American elders by promoting capacity-building in agencies that serve them						
Measureable Objectives: Provide technical assistance to culturally specific providers.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Conduct quarterly Enhancing Equity contractor meetings.	ADVSD Enhancing Equity Contract Liaison	July 2016	June 2020	
	b	Work with providers to better understand their contract, how to fulfill the contract, and determine if the contracted services fulfill the community need.	ADVSD Enhancing Equity Contract Liaison	July 2016	June 2020	

	c	Work with local tribal entities,and other stakeholder groups to explore enhancing services through alternative funding such as grants	ADVSD Planning and Development Specialist	January 2017	June 2018	
	d	Enter into an MOU with Confederated Tribes of Siletz and Confederated Tribes of Grand Ronde that enables ADVSD and our partners to better meet the needs identified by Native Americans.	ADVSD Community Services Manager	July 2018	June 2020	

C- 7: Health System Transformation

Profile of the Issue:

Oregon has undertaken a fundamental structural transformation in the way Health care services are delivered and paid for in order to respond to federal health care reform and to achieve better health, better health care, and lower healthcare costs.

Oregon's network of Coordinated Care Organizations (CCOs) provides a health care system for Medicaid beneficiaries that emphasizes prevention and financially integrates physical, behavioral, and oral health care. However, long term care services and supports have been carved out of the CCO model and remain the responsibility of both state and local agencies serving seniors and adults with physical disabilities. Despite the carve-out, State legislation mandates closer coordination between the CCOs and the aging and disability services network.

In Multnomah County, two (2) regional CCOs, Health Share of Oregon and Family Care, are implementing significant health transformation efforts for individuals receiving Medicaid as well as Medicare funded health services, especially those considered at high risk and with complex needs such as comorbidities.

The Regional Long Term Services and Supports Innovator Agent, housed within ADVSD, is charged with meeting regularly with the CCOs to further the State's goal of closer coordination. These partners have agreed to form the Tri County Joint Aging Disability, and Health Systems Steering Committee. Additionally, the CCOS and the AAAD/APD network have developed a bi-annual Memorandum of Understanding regarding jointly-agreed upon goals, objectives, and tasks.

Participants in the 2016 Multnomah County Area Plan listening sessions identified the following issues as important to Healthy Aging and Behavioral Health:

- Help in maintaining home
- Connection to occupational therapy providers
- Need to educate primary care providers to address quality of life issues
- Help with end of life planning
- Affordable exercise programs
- Programs that are more conveniently located
- Help with medication management
- Access to advice nurse for urgent needs
- Caregiver training and education
- More opportunities to learn about diet and nutrition

- More outreach to isolated elders and cultural minorities
- More peer support programs
- Access to mental health resources without money being such a worry
- More mental health services
- Depression screening and follow up by medical providers
- Culturally aware providers

Many of the above issues will be addressed through expansion of current evidence-based health promotion and self-management education offerings. Additionally, plans are underway to develop more behavioral health-oriented programs and peer services across the region. Current and new culturally-specific community partners will continue to be very engaged in these efforts.

Goal: Improve coordination of care, enhance member engagement in care coordination, improve coordination of transitions across settings, and improve cross-system education related to older adults and adults with disabilities.

Objectives:

1. Work with health plans, hospitals, primary care clinics, and community organizations to map, analyze and improve coordination in transitions across settings for older adults and adults with disabilities.
2. Plan and develop ongoing cross-system learning and networking opportunities for health system, aging and disability, and community partners.
3. Expand member engagement and health system partner participation in interdisciplinary care coordination conferences.

Focus Area - **Health System Transformation**						
Goal: Improve coordination of care, enhance member engagement in care coordination, improve coordination of transitions across settings, and improve cross-system education related to older adults and adults with disabilities						
Measureable Objectives Work with health plans, hospitals, primary care clinics, and community organizations to map, analyze and improve coordination in transitions across settings for older adults and adults with disabilities	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Form Cross-System Regional Transitions work group	LTSS IA, Tri County Joint Aging, Disability and Health Systems Steering Committee	October 4, 2016	October 30, 2016	
	b	Work Group will map and analyze transitions programs and practices in each participating system	LTSS IA and work group members	November 1, 2016	April 30, 2017	
	c	Work Group will Identify areas of overlap, duplication and gaps in the current systems as well as barriers to coordination	LTSS IA and work group members	May 1, 2017	September 30, 2017	
	d	Work Group will develop plan to improve coordination between	LTSS IA and work group members	October 1, 2017	December 30, 2017	

		systems as well as staff knowledge of available resources				
	e	Tri-County Joint Aging, Disability and Health Systems Steering Committee members will seek their respective leader's endorsement of plan	Tri County Joint Aging, Disability and Health Systems Steering Committee	January 1, 2018	February 28, 2018	
	f	Tri County Joint Aging, Disability, and Health Systems Steering Committee will develop and launch implementation plan	Tri County Joint Aging, Disability and Health Systems Steering Committee	March 1, 2018	June 30, 2018	

Goal: Improve coordination of care, enhance member engagement in care coordination, improve coordination of transitions across settings, and improve cross-system education related to older adults and adults with disabilities

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Plan and develop ongoing cross-system learning and networking opportunities for health system, aging and disability, and community partners	a	Form a cross-system learning planning group in each county	LTSS IA, Tri County Joint Aging, Disability and Health	August 1, 2016	October 31, 2016	

			Systems Steering Committee			
	b	Each county planning group will develop an annual plan for calendar year 2017 and present it to the Tri County Joint Aging, Disability, and Health Systems Steering Committee. Each plan will include an evaluation component to measure outcomes in terms of enhanced communication, improved coordination, and increased opportunities for collaboration	LTSS IA and county cross-system education planning groups	November 1, 2016	January 31, 2017	
	c	Develop an ongoing annual process to plan and implement cross-system learning across the region.	LTSS Innovator Agent, Tri-County Joint Aging, Disability, and Health Systems Steering Committee	October 1, 2017	January 31, 2108	

Goal: Improve coordination of care, enhance member engagement in care coordination, improve coordination of transitions across settings, and improve cross-system education related to older adults and adults with disabilities				
Measureable	Key Tasks	Lead Position &	Timeframe for 2017-2020	Accomplishment

Objectives			Entity	(by Month & Year)		or Update
				Start Date	End Date	
Expand member engagement and health system partner participation in interdisciplinary care coordination conferences	a	Ensure that each entity participating in Interdisciplinary Care Coordination Conferences (ICCCs) will review bi-annually the data sources, criteria used to stratify high needs cases, and how data is integrated.	LTSS Innovator Agent, Tri-County Joint Aging, Disability, and Health Systems Steering Committee	August 2017 and April 2018 August 2018 and April 2019 August 2019 and April 2020	June 30, 2018 June 30, 2019 June 30, 2020	
	b	Work with additional health system partners to join in regular ICCCs.	LTSS Innovator Agent, Tri-County Joint Aging, Disability, and Health Systems Steering Committee	August-December 2016	June 30, 2017	
	c	Health Plan and AAAD/APD leads will meet quarterly to review data and outcomes of ICCCs.	LTSS Innovator Agent, Health Share ICCC liaisons, FamilyCare ICCC Liaison	October,January, May, July of each year	November, February, June, and August each year	

	d	Health plan and AAAD/APD leads in ICCCs will document client/member preferences, goals, and participation in ICCCs	LTSS Innovator Agent, Health Share ICCC liaisons, FamilyCare ICCC Liaison	August 1, 2016	On -going	

C-8: Behavioral Health

Profile of the Issue:

Fifteen to 20% of older adults have depression and older adults in general can be a greater risk for clinical depression which can be triggered by chronic illnesses common in later life, such as Alzheimer's disease, Parkinson's disease, heart disease, cancer and arthritis. Between 3% and 14% of older adults meet the criteria for a diagnosable anxiety disorder, and a recent study found that more than 27% of older adults under the care of an aging service provider have symptoms of anxiety that may not amount to diagnosis of a disorder, but significantly impact their functioning.When it comes to suicide, men age 75 and older have the highest suicide rate of any age range or gender. Yet, often these mental health problems often go unrecognized in older adults, as does substance use disorders with up to 15% of older adults being at-risk drinkers and up to 23% misusing prescription drugs. (Mental Health America, 2016, http://www.mentalhealthamerica.net/conditions/depression-older-adults-more-facts, accessed 8/15/2016). However, investment in effective strategies, including effective collaboration, care coordination, and a force of well-trained workers, will help ensure the health, safety and independence of older adults.

Racial, ethnic groups or other minority populations experience higher rates of mental health or addiction issues. For example, rates of depressive disorders are significantly higher among Latinos than non-Latinos. Additionally, the rates for depression, suicidality and substance misuse are higher among LGBT older adults than the overall aging population. (SAMSHA and SAGE)

A recent PSU study of behavioral health services found services are not meeting the growing need for older adults because:

- Systems are fragmented.
- The organizations that could address these needs work in silos with different funding priorities, eligibility requirements, and knowledge base.
- Mental health needs of older adults are not a priority in any agency and services that exist are often not tailored appropriately to the population.
- Knowledge gaps are pervasive about normal aging, available community resources, best practices, and mental health.
- Resources and funding are limited at best.

- Agencies are reluctant to fund services felt to be the responsibility of other agencies (e.g., aging services reluctant to pay for mental health services, mental health services reluctant to pay for those over 65 with a mental illness or with a dual diagnosis of dementia.)

According to community feedback collected from the listening sessions on the topic of behavioral health, community members are most concerned about having behavioral health services. The most common category for comments relating to behavioral health was the need for services. The next most common comments were related to counseling and/or medications. In this category people spoke about wanting shorter waiting times, better quality of services, culturally-appropriate therapy, counseling and medication working well, and needing more home visits. Education and outreach were next most common and most comments in this area fell into the "need more of" category. Comments for education and outreach spoke to the need for help navigating – either the client themselves or caregivers. Current education efforts to reduce stigma and being supported by one's community were seen as working well. Social connectedness was seen as most important, followed by community counseling or group based care. Also a priority was getting connected to community groups and meeting new people. Comments in this category were seen as especially important to those attendees who identified themselves as aging with HIV.

Goal: People who need services know where to go and feel comfortable seeking out services

Objectives:

1. Have extended and far-reaching outreach for current services
2. Strengthen partnerships with culturally-specific agencies to promote the development of resources and to engage community members in existing services
3. Service providers are training to navigate systems to access services for clients with complex needs
4. Work with ADRC staff to increase their skill in recognizing behavioral health needs in community members calling the Helpline

Goal: Develop a system that provides services and supports to people with multiple needs who do not fit into one system.

Objectives:

5. Best practices will be incorporated in to existing care coordination models in order to better serve client with complex needs.
6. Workforce development - service providers will have training readily available to increase their skill working with clients who are facing a myriad of physical, mental and social health issues.
7. Advocate for the development of older adult-specific behavioral health services that are needed such as: home-based services, geriatric-competent therapy, services in languages other than English and peer services.

Focus Area - **Behavioral Health**						
Goal: People who need services know where to go and feel comfortable seeking out services						
Measureable Objectives Have extended and far-reaching outreach for current services	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Create outreach material in multiple languages and have culturally-relevant messaging	Older Adult Behavioral Health Team	Jan 2018	Jan 2019	
	b	Create outreach to share information on current services for caregivers	Older Adult Behavioral Health Team	June 2017	Dec 2017	
	c	Create outreach materials aimed at community members and that will have messaging to reduce stigma	Older Adult Behavioral Health Team	June 2017	Dec 2017	
	d	Host community events to promote awareness about behavioral health needs as they are unique to older adults (approx 3 a year)	Older Adult Behavioral Health Team	Jan 2017	Dec 2018	

	e	Host opportunities for social connectedness among community members	Older Adult Behavioral Health Team	Jan 2018	Dec 2018	

Focus Area - **Behavioral Health**						
Goal: People who need services know where to go and feel comfortable seeking out services						
Measureable Objectives Strengthen partnerships with culturally-specific agencies to promote the development of resources and to engage community members in existing services	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Meet with agencies to learn of existing resources, needed resources and ways to partner	Older Adult Behavioral Health Team	Jan 2017	Dec 2017	
	b	Produce report with findings from the meetings	Older Adult Behavioral Health Regional Coordinator	Dec 2017	March 2019	

	c	Solicit feedback from agencies on outreach materials	Older Adult Behavioral Health Team	Jan 2017	Dec 2017	
	d	Partner with agencies to host 2 events for community members	Older Adult Behavioral Health Team	March 2019	Dec 2019	
	e	Share results from the PEARLS intervention when delivered in culturally-specific agencies	Older Adult Behavioral Health Regional Coordinator	Jan 2017	June 2019	

Focus Area - **Behavioral Health**					
Goal: People who need services know where to go and feel comfortable seeking out services					
Measureable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
			Start Date	End Date	
Service providers are training to navigate systems to access services for clients with complex needs					

	a	Deliver “Navigating Systems” training for a wide-range of service providers (approx. 4 a year)	Older Adult Behavioral Health Team	Jan 2017	Dec 2018	
	b	Work with case managers one-on-one with cases where client has complex needs	Older Adult Behavioral Health Team	Jan 2017	Dec 2020	
	c	Host quarterly networking events that bring together staff from different County divisions and community-based agencies to share the latest information, resources and news to support older adults with behavioral health needs.	Older Adult Behavioral Health Team	Jan 2017	Dec 2018	

Focus area - **Behavioral Health**					
Goal: People who need services know where to go and feel comfortable seeking out services					
Measureable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
			Start Date	End Date	
Work with ADRC staff to increase their skill in recognizing behavioral health needs in community members calling the Helpline					

	a	Update search terms in the ADRC to include commonly used terms older adults may use when searching for behavioral health resources	Older Adult Behavioral Health Regional Coordinator	Jan 2017	Aug 2017	
	b	Conduct asset mapping exercise to align ADRC and Older Adult Behavioral Health Initiative resources	Older Adult Behavioral Health Regional Coordinator	Jan 2017	Aug 2017	
	c					
	d					

Goal: Develop a system that provides services and supports to people with multiple needs who do not fit into one system.						
Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Best practices will be incorporated in to existing care coordination models in order to better serve client with complex needs	a	Conduct Complex Case Consultation	Older Adult Behavioral Health Specialists	Jan 2017	Dec 2020	

	b	Implement pilot project to apply “Wraparound” principles to current models of care coordination within ADVSD	Older Adult Behavioral Health Regional Team, LTSS Innovator Agent and to-be identified Implementation Team	Jan 2017	Dec 2018	
	c	Train staff to apply new principles	Older Adult Behavioral Health Regional Team, LTSS Innovator Agent and to-be identified Implementation Team	Jan 2018	Jan 2019	
	d	Measure impact of changes to care coordination and share results with leadership for program recommendations	Older Adult Behavioral Health Regional Team, LTSS Innovator Agent and to-be identified Implementation Team	Jan 2017	Jan 2019	

Goal: Develop a system that provides services and supports to people with multiple needs who do not fit into one system.

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Workforce development - service providers will have training readily available to increase their skill working with clients who are facing a myriad of physical, mental and social health issues.	a	Develop training plan	Older Adult Behavioral Health Team	Jan 2017	Feb 2017	

	b	Conduct trainings for service providers (approx. 2 a month)	Older Adult Behavioral Health Team	Jan 2017	Dec 2020	
	c	Host 2 large events with national speakers to bring wider attention to the issue of behavioral health issues for older adults	Older Adult Behavioral Health Team	Jan 2017	Dec 2017	
	d	Host community events for older adults bringing awareness to the issues and reducing stigma (approx. 3 a year)	Older Adult Behavioral Health Team	Jan 2017	Dec 2018	
	e	Host quarterly networking events that bring together staff from different County divisions and community-based agencies to share the latest information, resources and news to support older adults with behavioral health needs.	Older Adult Behavioral Health Team	Jan 2017	Dec 2018	

Goal: Develop a system that provides services and supports to people with multiple needs who do not fit into one system.					
Measureable Objectives Advocate for the development of older adult-specific behavioral health services that are needed such as: home-based services, geriatric-competent therapy,	Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
			Start Date	End Date	

services in languages other than English and peer services.	a	Produce final report from stakeholder interviews to summarize community strengths, weaknesses, opportunities and challenges	Older Adult Behavioral Health Regional Coordinator	Jan 2017	Dec 2017	
	b	Produce policy recommendation report on improving access to behavioral health services for older adults	Older Adult Behavioral Health Regional Coordinator	Jan 2017	Dec 2017	
	c	Produce report outlining data gathered during complex case consultations to show the current needs in clients with complex situations	Older Adult Behavioral Health Regional Coordinator	Jan 2017	Dec 2017	
	d	Share all reports with the Statewide OABHI coordinator	Older Adult Behavioral Health Regional Coordinator	Jan 2018	June 2018	
	e	Meet with community and advocacy groups to develop advocacy work plan	Older Adult Behavioral Health Team	Jan 2018	Aug 2018	
	f	Carry out work plan	Older Adult Behavioral Health Team	Oct 2018	Dec 2020	

C- 9: Veterans

Profile of the Issue:

Oregon Department of Veterans Affairs (ODVA) reports that one out of every twelve Oregonians is a veteran and there are approximately 67,000 disabled veterans in our state. Many former members of the military and their surviving spouses who are older adults are less aware of their entitlements to benefits through the Veterans Administration that may allow them to leverage resources to meet their individual care needs. Veterans in our community span four generations across five major wars. In Oregon, more than half the veterans are seniors age 65 and older, eight percent of all veterans are minorities; 2.2% are Native American; and due to the federal Don't Ask Don't Tell law, there are an indeterminable number of LGBT veterans, dating back to World War II. (ODVA, 2015, We Are Oregon Veterans: 2015 Annual Report to the Governor).

Problem/need statement:

Many of our older veterans and older adult women who served in the military on active duty do not identify as a veteran. It is estimated by ODVA that only three out of ten veterans have accessed at least one federal benefit. It is estimated that one in five Multnomah County residents are living below poverty level, with higher proportional rates of poverty within racial, cultural, and ethnic minority groups. People with disabilities were more than twice as likely to live in poverty as people without disabilities and it is estimated that twelve percent of people who are homeless in Multnomah County are veterans. Veterans Services Officers have been shifting outreach efforts to make access easier and approachable. Outreach and education about entitlements to veterans benefits provides a critical link to inform older adults who served during any period of U.S Conflict and peacetime about the availability of benefits through the federal VA that may also allow older adults to leverage those benefits with local resources.

Targeted approaches to outreach, better data to track and refine our performance, and increased capacity to serve our veteran community is needed.

Goal: Older adults leverage entitlements to benefits through the federal Veterans Administration, as well as state and county resources to meet and maintain their individualized care needs.

Objectives:

1. Provide targeted community outreach and engagement to older adults that previously served in the military or are the surviving spouse of someone who served in the military.
2. Collaborate with Veterans Health Administration (VHA) and community-based agencies to engage residents and providers in the long-term service and support system and in their home to reach veterans and/ or their surviving spouse to gain access to less known benefits through the federal VA and so that they may stay in their homes as the age.
3. Identify and narrow the gaps between community-based partners who may serve veterans and their surviving spouses to increase awareness and referrals to the Veterans Service Office.

SECTION C – 8 Veterans

Goal: Older adults leverage entitlements to benefits through the federal Veterans Administration, as well as state and county resources to meet and maintain their individualized care needs.

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Provide targeted community outreach and engagement to older adults that previously served in the military or are the surviving spouse of someone who served in the military.	a	Provide additional walk-in hours to increase access	Veterans Service Office	August 2016	December 2020	
	b	Engage non-traditional community partners, such as faith-based organizations	Veterans Services Supervisors, MyVACascadia Board	August 2016	December 2020	
	c	Build partnership with Native American Veteran-serving organizations to develop culturally responsive outreach and	ADVSD Community Services Manager, ADVSD Veterans Services Supervisor	January 2017	December 2020	

		engagement				
	d	Participate in LGBT outreach events such as PRIDE and the Gay & Grey Expo	ADVSD Veteran Services Office	January 2017	December 2020	
	e	Create opportunities for intergenerational learning between LGBT Veterans	ADVSD Veteran Services Office	January 2017	December 2018	

SECTION C – 8 Veterans

Goal: Older adults leverage entitlements to benefits through the federal Veterans Administration, as well as state and county resources to meet and maintain their individualized care needs.

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Collaborate with Veterans Health Administration (VHA) and community-based agencies to engage residents and providers in the long-term service and support system and in their home to reach veterans and/ or their surviving spouse to gain access to less known benefits through the federal VA and so that they may stay in their homes as the age.	a	Conduct outreach events with LTC and 55 older residential Independent Living Facilities .	Veterans Services Supervisor and CVSO Staff	January 2017	December 2019	

SECTION C – 8 Veterans						
Goal: Older adults leverage entitlements to benefits through the federal Veterans Administration, as well as state and county resources to meet and maintain their individualized care needs.						
Measureable Objectives Identify and narrow the gaps between community-based partners who may serve veterans and their surviving spouses to increase awareness and referrals to Veterans Service Office.	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Develop a network of access points to expand outreach and referrals	VISTA volunteers	August 2016	July 2017	
	b	Provide technical assistance to incorporate Veterans-specific information and familiar language into outreach and screening process of identified network	ADVSD Veterans Service Officers	August 2016	December 2020	
	c	Build and support a culturally responsive volunteer veteran corp	VISTA Volunteers	August 2016	December 2020	

Section D: OAA/OPI Services and Method of Service Delivery

D – 1: Administration of Oregon Project Independence (OPI)

Below are the procedures (supported by policies) that ADVSD and its contractors follow in administering the OPI program.

a.Describe how the agency will ensure timely response to inquiries for service.

OPI case managers are required by the ADVSD contract agreement and ADVSD case management policy and procedures to respond to inquiries for service within five (5) days of the referral. Gatekeeper referrals, which are more urgent requests, must be followed-up by face-to-face contact within five (5) days unless the caller indicates the situation requires more immediate investigation.

b.Explain how clients will receive initial and ongoing periodic screening for other community services, including Medicaid.

OPI case management is based on a holistic assessment of the client's situation and client choice. It considers and finds services for the total needs of the client and does not restrict the assessment to an evaluation of problems for which an agency has services. The case manager plans, coordinates and implements a program of care, taking into consideration the client's natural support system, such as family and non-family unpaid caregivers; client co-pays; and third party payments, etc. and uses these prior resources before OPI. Case managers may serve as advocates to obtain help for their clients by working with other service agencies and to identify and coordinate community resources and natural supports systems for all new referrals and ongoing clients. OPI may be used as a supplement to these primary resources as the client's care necessitates. Clients are reassessed annually or sooner as needed. The case manager documents the gross monthly income of the household, the allowable deductions of the household and determines a co-pay fee, if any, for services. If the client meets the eligibility criteria for Medicaid, the case manager will make the appropriate referral to a Medicaid branch office.

c.Describe how eligibility will be determined.

An applicant is eligible to receive OPI services if they:

- Are 60 years old or older; or under 60 years of age and diagnosed as having Alzheimer's Disease or a related disorder (for OPI) or are between the ages of 18 and 59 (OPI Pilot);
- Are not receiving financial assistance or Medicaid, except Food Stamps, Qualified Medicare Beneficiary or Supplemental Low Income Medicare Beneficiary Programs;
- Are at immediate risk for nursing facility placement. Immediate risk is defined as the probability that the client's condition will deteriorate in

eight to ten months after loss of OPI services to a point that nursing facility placement is necessary;

- Score high on the OPI Risk Assessment Tool. The risk assessment considers activities of daily living, natural supports, the frequency of falls, etc. and is used to determine priority of clients served when OPI wait lists are being maintained;
- Do not have, or, have exhausted sufficient other resources to meet needs, such as personal income, personal assets, third party payment;
- Are already receiving an authorized OPI service and their condition indicates the service is needed; and
- Meet eligibility criteria of the OPI Rules and Oregon Administrative Rules.

d.Describe how the services will be provided.

ADVS contracts with five (5) district senior centers to provide OPI case management services for eligible clients and provides OPI Pilot case management with two county Case Managers. An OPI case manager assesses the client using the Oregon Access Client Assessment and Planning System and develops a comprehensive plan of care with the client. If the client's assessment and care plan warrants the provision of supportive services to maintain independence in activities of daily living in their home, case managers may authorize OPI services, depending on the needs and preferences of the client. Authorized hours are subject to the extent of client need and the availability of funds. Case managers authorize in-home services only to the extent necessary to supplement potential or existing resources within the client's natural support system. Case managers select an appropriate service provider based on the client's needs and preferences, availability of the service and the cost.

Personal care services, housekeeping services and respite care for eligible clients are provided by ADVSD contracts with in-home care agencies and the state Home Care Worker (HCW) program and by local, target service providers for approved and allowable OPI services.. Before considering the HCW program to provide in-home services, the case manager assesses the capacity of the client to supervise and direct the work of the HCW. Services are established (via a service plan) and authorized by the Case Manager and provides detailed information to the client and the agency or HCW . The case manager monitors and evaluates the services being provided by the agency or HCW through visits to the client's home, client feedback and communication with the caregiver/HCW. Case manager reassessments are conducted annually or sooner as needed for OPI clients. HCW rates are established by the Home Care Commission collective bargaining agreement and agency rates are established in the contracting process and written into the contracts.

Other OPI funded providers under contract with ADVS are adult day service centers and personalized grocery shopping service, all of which are contracted with ADVSD and authorized by district senior center case managers.

For all services for which OPI funds are used, the case manager makes the referral and authorizes the number of hours of service per week/month to the provider along with any other instructions needed to support the client's plan of care. The service provider and the case manager communicate regularly with one another and when

there are concerns or changes in the client's condition or when there is a change in the number of authorized service hours.

ADVSD plans to make culturally specific OAA Case Management and culturally specific OPI service option available through an RFPQ to be released in May 2017.

e. Describe the agency policy for prioritizing OPI service delivery.

OPI services are prioritized for frail and vulnerable adults who are lacking or have limited access to other long-term care services; those who lack natural supports; and those meet the OPI service priority rule.

When OPI wait lists are being maintained, OPI case managers will prioritize clients who score high on the Risk Assessment Tool and are at the greatest risk for nursing facility placement if OPI services are reduced or eliminated.

f.Describe the agency policy for denial, reduction or termination of services.

Clients are informed in writing 30 days before the effective date of termination, reduction or denial of services. When a client's services are terminated, reduce or denied, the case manager will continue to work with the client to identify and coordinate other supportive services for the client.

Contracted in-home care providers are required to provide services for all clients referred by district centers. Providers will make a special effort to meet the needs of clients with unique living and personal situations, including clients with challenging behavioral issues, and are expected to initiate and continue services under less than ideal conditions while an acceptable plan is being developed in cooperation with the case manager.

In-home care providers may not refuse service to any client referred by district centers unless the in-home worker would be in danger of immediate physical injury, including active use of illegal drugs. In such cases, the provider will immediately contact the case manager with the pertinent details, to be followed by a written confirmation from the provider of the situation to ADVSD within two (2) working days.

A provider may discontinue services to any client who sexually harasses in-home workers or professional staff after having provided a warning to the client to desist in such behavior. The provider will notify the case manager with a written copy of the warning communicated to the client.

In the event the provider is unable to retain a worker for a client due to other client-related causes:

1. The provider supervisor will investigate the problem and report findings to the case manager for mutual resolution. The provider will then place a second caregiver with the client after appropriate instructions are given.
2. If the second caregiver is unable to fulfill the required service, the provider will advise the case manager and client of the problem both via phone and in writing. The case manager will discuss the situation with the client and notify provider when a third caregiver may be assigned to the client.
3. If the third caregiver is unable to provide the services authorized, the provider may be released from serving this client.

g.Describe the agency policy for informing clients of their right to grieve adverse eligibility and/or service determination decisions or consumer complaints.

Clients are informed of their rights and responsibilities, in writing, at the time of determination. They are also informed of both the District Senior Center and ADVSD escalating grievance policies. They are provided this information each time they have a consumer complaint or have had services reduced, denied, or terminated. Each District Senior Center must have their policy approved by ADVSD and they may vary. **See Appendix G.**

h.Explain how fees for services will be implemented, billed, collected and utilized.

A one-time fee of $25.00 is applied to all individuals receiving OPI authorized services who have adjusted income levels at or below federal poverty level. The fee is due at the time eligibility for OPI authorized services has been determined. This fee does not apply to home-delivered meals.

Fees for authorized services are charged based on a sliding fee schedule to all eligible individuals whose annual gross income exceeds the minimum, as established by the State Department of Human Services. The OPI case manager determines the appropriate fee in an initial assessment visit, documenting all monies coming into the client's household, and itemizes the income on the OPI Income/Fee Determination worksheet. The client's gross monthly income is determined based on a sum total of the itemized amounts. Income that is itemized includes social security, VA benefits, pensions, salaries, interest, dividends and annuities, railroad benefits, rental and sale of property and other income. The case manager documents the allowable deductions, which include prescription drugs, over-the-counter medications, supplemental insurance, doctors' co-pays, dental/vision exams, hospital costs, medical equipment/supplies and other medically related deductions. The case manager adjusts the monthly income (monthly income minus allowable deductions) and using the adjusted income and the OPI In-Home Service Fee Schedule determines the fee for service. The client is asked to sign the OPI Income/Fee Determination Worksheet to acknowledge that he/she understands the OPI fee schedule and to agree to pay the fee per month for services.

For contract agency (non-HCW) providers the case manager informs the provider of the client's monthly fee. The provider of the service bills client fees monthly and reports this to the case manager. Clients submit their fee payments to the provider monthly. For the HCW program the case manager bills the client monthly for the client fees. Clients send their fee payment to ADVS, where it is collected and reported to the case manager. Client fees for both contract agency and the HCW program are used to expand in-home services so that the service can be offered to others who need it.

i.Describe the agency policy for addressing client non-payment of fees, including when exceptions will be made for repayment and when fees will be waived.

Client fees are a mandatory feature of OPI service provision and not voluntary. If the client refuses income information or refuses to pay appropriate fees, the case manager cannot authorize OPI services. In circumstances where client payment of fees is in arrears, these collection procedures are followed:

1. Service provider provides OPI case managers with names of clients with unpaid balances.
2. Case manager monitors payment of fees and is responsible for the investigation and correction of non-payment situations using these steps:
    a. Confirms client payment status with provider prior to speaking with client.
    b. Informs client of arrearage and discusses payment with client, reviewing client co-payment expectations of the OPI program.
    c. Clarifies client income information, medical expenses, and adjusts client fees where appropriate.
    d. Determines whether money management services are indicated due to client difficulty in handling bill payment generally.
    e. Notifies client orally and in writing that non-payment may result in termination of service and establishes deadline for payment not more than 30 days from day of notice.
    f. Reminds client at least 2 weeks prior to termination that service will end and reason for termination.

    Client non-payment of OPI fees results in termination of service.

    Exceptions to the repayment of fees will only be made in extreme situations, such as when it would become a financial hardship for the client. Even then, the OPI case manager will make every effort to work with the client on a plan to repay the balance of the fees.

j.Delineate how service providers are monitored and evaluated.

ADVSD conducts regular monthly monitoring of our service providers at the time of invoicing. This monitoring includes:

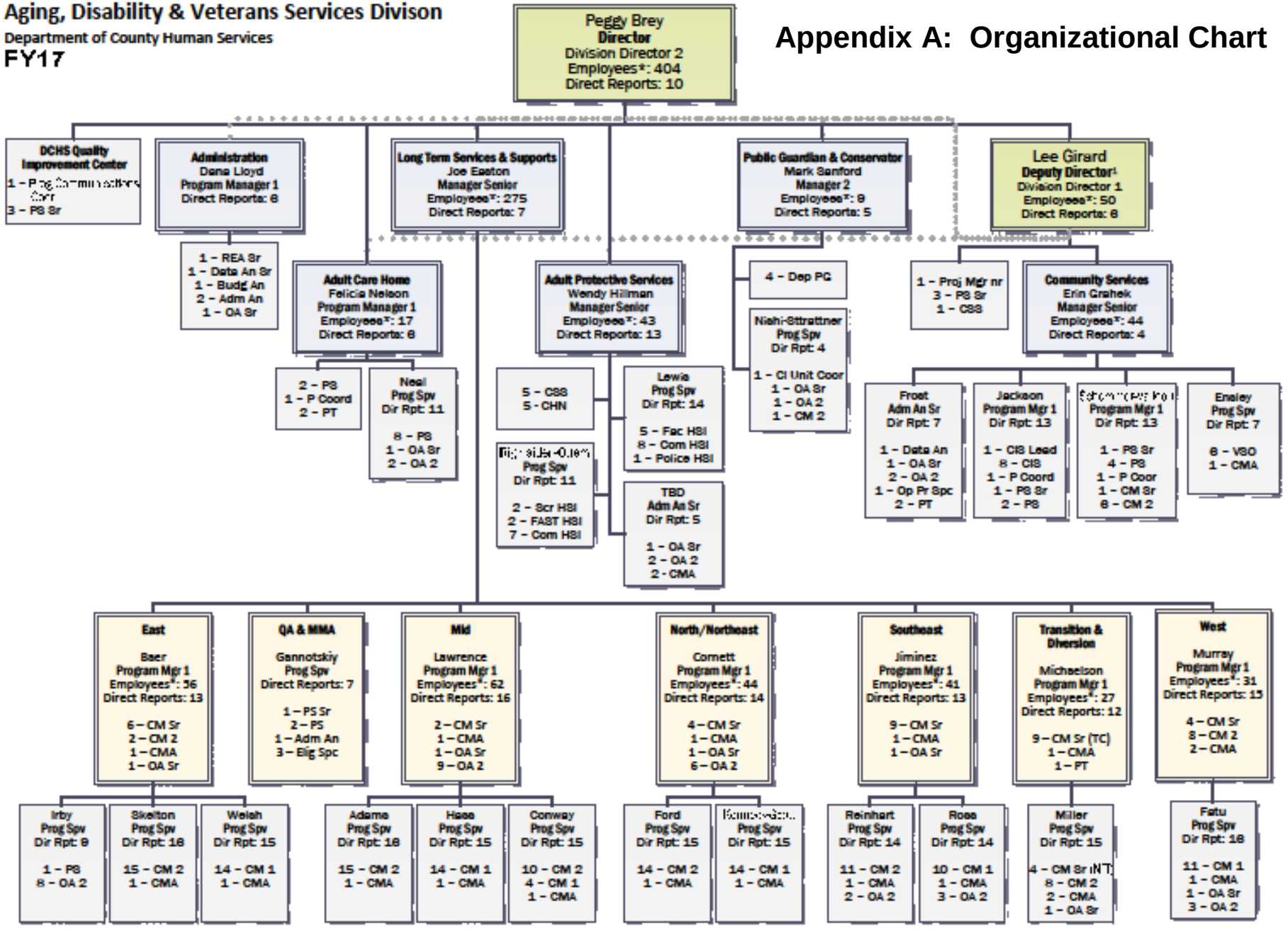
- Timeliness of invoice submission
- Accuracy of invoice, reconciled with client data
- Validating that clients who receive services through an in-home agency have a current assessment and service plan

In addition, ADVSD is instituting a random audits of in-home agency invoices comparing invoiced data with actual time sheets to ensure that services billed were actually provided.

ADVSD also conducts monitoring on various programs and partners via the SUA monitoring schedule, including nutrition monitoring for our nutrition providers, monitoring of our Adult Day Services providers and monitoring our our EBHP providers.

Appendices

Appendix A: Organizational Chart



Appendix B: Advisory Council(s) and Governing Body

Senior Advisory Council, (AKA: Elders in Action Commission)

Barbara Fields 503-853-5366 bfields05@gmail.com
Bill Gentile (503) 274-7620 bill.gentile@gmail.com
Bob Baskett 503-349-3947 SeePDX@comcast.net
Bobbi Yambasu, Chair 503-233-1341 bobbiy4967@gmail.com
Carol (C.J) McKenzie 541-771-2043 rsc@quadinc.org
Catherine (Kate) Cavanaugh Kcavanaugh3446@gmail.com (503) 313-9718
Dolores Hubert (503) 319-3639 dede19319NEclack@netscape.net
Elaine Friesen-Strang (971) 202-3472 strangpdx@comcast.net
LeRoy Patton (503) 284-9805 lpatton@bigplanet.com
Mary Westfall 503-764-8614 westyks@hotmail.com
Steve Weiss 503-232-5043 stevesoc@teleport.com
Suzanne Hansche, Vice Chair (503)287-0324 civicresearch@earthlink.net
Tamara Maher, Budget Officer (503) 285-1294 tamara@tamaramaherlaw.com

Tracy McLafferty
503-460-3342
tracym@pdx.edu

Senior Advisory Council Demographic Data

Total number age 60 or over = 17
Total number minority = 2
Total number rural = 1
Total number self-indicating having a disability = 3

Disability Services Advisory Council

Demographic Data:

Total number age 60 or over = 2
Total number minority = 1
Total number rural = 0
Total number self-indicating having a disability = 5

Name & Contact Information
Joe VanderVeer, Chair 503.349.3568 joevv3@comcast.net
Steve Weiss stevesoc@teleport.com
David Benedetti david.benedetti@multco.us
Sunil Narayan sunil.narayan@multco.us
Grace Reed grace@negotiatingshadows.com

Governing Body – Multnomah Board of County Commissioners

Name & Contact Information	Office	Date Term Expires
Deborah Kafoury (503) 988-3308	Chair, Multnomah County Board of Commissioners	12/31/18
Jules Bailey (503) 988-5220	Commissioner, District 1	12/31/16
Loretta Smith (503) 988-5219	Commissioner, District 2	12/31/18
Judy Shiprack (503) 988-5217	Commissioner, District 3	12/31/16
Diane McKeel (503) 988-5213	Commissioner, District 4	12/31/16

Appendix F: List of Designated Focal Points

ADSD's contracted District Senior Centers are the designated focal points in the county and are listed below.

West Consortium

- Neighborhood House (Lead Agency)
  7688 SW Capitol Highway, Portland, OR 97219

- Friendly House (Partner Agency)
  1737 NW 26th Ave, Portland, OR 97209

North/Northeast Consortium

- Hollywood Senior Center (Lead Agency)
  1820 NE 40th Ave, Portland, OR 97212

- Urban League Multicultural Senior Center (Partner Agency)
  5325 NE Martin Luther King, Jr. Blvd, Portland, OR 97211

Southeast

- Impact Northwest Multicultural Senior Center
  4610 SE Belmont, Portland, OR 97215

Mid-County

- Immigrant & Refugee Community Organization
  10615 SE Cherry Blossom Drive, Portland, OR 97236

East County

- YWCA
  600 NE 8th St, Room 100, Gresham, OR 97030