Community Services for Older Adults

2018-2022 Program Model

Aging, Disability, and Veterans Services Division

November 2017

This document describes the programs and services procured by Multnomah County Aging, Disability, and Veterans Services Division from January 1, 2018 – December 31, 2022. These programs include Community Services for Older Adults, Evidence-Based Health Promotion, and Nutrition Services. This Program Model is subject to change, due to changes in funding, administrative requirements, processes, or community needs. www.multco.us/ads

PROGRAM PURPOSE AND OVERVIEW

Multnomah County Aging, Disability, and Veterans Services Division (ADVSD) is the designated Area Agency on Aging (AAA) for Multnomah County. AAAs are funded by the State under the Federal Older Americans Act (OAA) and are responsible for planning, leadership, advocacy, coordination, and delivery of OAA services for all older Americans living in the service area. As an Area Agency on Aging, ADVSD is required by the OAA to designate community Focal Points to be the community contact points through which older persons gain access to information and services. District Senior Centers served as Focal Points in the 2011-2017 contract periods. However, in the 2018-2022 contracts, this function will also be available to organizations that provide culturally specific services.

A major philosophy of the OAA is that preventive and supportive services that help older people to maintain their independence should be available to all older persons and their families. The ADVSD philosophy is that policies, programs, and services are established in response to the needs and expectations of participants; and to ensure an outcome of quality service for older individuals and their families.

The ADVSD service delivery system is the result of community planning spanning more than twenty years. The services provided through the District Centers are determined by ADVSD system priorities defined in the Area Plan, an annual plan submitted to the State Department of Human Services, Seniors and People with Disabilities Division. The current service delivery system includes District Centers that serve as the community focal point for senior services in a specific geographic area and provide a required mix of services, and Enhancing Equity contractors that focus on the needs of a particular cultural, racial and/or ethnic group in the entire County and provide services chosen from a menu of possibilities, based on community need and organizational capacity.

GUIDING PRINCIPLES

- Maintain a regional and culturally specific approach to service delivery.
- Maintain the major service areas.
- Maintain commitment to funding culturally specific services.
- Services are to be participant-centered and participant-driven.
- Build on recent service system changes.

POPULATION SERVED

The target population to be served is ADVSD's eligible participants residing within the borders of Multnomah County. ADVSD's priority target populations of seniors for District Center services include:

1. Adults age 60+ with physical or mental impairments which severely limit their ability to live independently;

2. Adults age 60+ who are very frail, due to advanced old age and who are likely to be placed in a nursing home unless they receive support services;
3. Adults age 60+ who have been abused, neglected or exploited and need protection;
4. Adults age 60+ who are low income or near low income;
5. Minority older adults, racial and ethnic older adults, older adults with limited English-speaking proficiency, and gay, lesbian, bi-sexual and transgender older adults;
6. Adults age 60+ who live in rural communities, such as the rural areas of north, northwest, outer southeast, and east Multnomah County;
7. Adults age 60+ who live alone and are isolated from family and friends;
8. Adults age 60+ who lack a natural support system;
9. Adults age 60+ caring for children, and
10. Family caregivers of older relatives.

FUNDING SOURCES

The funding for the services described in this Program Model comes mainly from the federal Older American's Act http://www.aoa.gov/AoA_programs/OAA/Index.aspx through the Administration on Aging http://www.aoa.acl.gov/. In addition, the State provides funding for Oregon Project Independence and for Evidence Based Health Promotion. This federal and state funding is administered by the Oregon State Unit on Aging http://www.oregon.gov/dhs/seniors-disabilities/SUA/pages/index.aspx. The County also supplements these funding sources, including major funding for in-home services.

ALLOCATION FORMULA

The allocation formula for this RFPQ allocates **38%** of the funding for each service area (see RFPQ Structure below) to organizations providing Culturally Specific services and **62%** to Culturally Responsive organizations. (Note that all organizations applying under this RFPQ must be Culturally Responsive.) For District Senior Centers, funding is allocated to each region based on the same demographic factors used in the last RFPQ for District Center, updated with current population statistics. These factors are: people aged 60 and over: people aged 60 and over who are below 185% of the Federal Poverty Level; minorities aged 60 and over; minorities aged 65 and over who are below the Federal Poverty Level; people aged 85 and over; and people aged 60 and over who are parenting children under age 18. Please see Attachment C for more information about the processes used to determine this allocation formula.

STRUCTURE OF CONTRACTED SERVICES

The RFPQ for these services will encompass three service areas:

1. Community Services for Older Adults
2. Evidence-Based Health Promotion
3. Nutrition Services

Applicants may apply to provide services in one, two, or all three of these service areas. Qualified applicants will enter into a single contract with ADVSD for the selected services.

RFPQ SERVICE CATEGORIES AND BUDGET

Community Services for Older Adults	**$ 2,293,708**
Evidence-Based Health Promotion	**$ 88,459**
Nutrition Services	**$ 1,907,601**
Annual Total	**$ 4,289,768**

BUDGET DETAIL

Service Categories	**FY 18 Budget**
Community Focal Point for Older Adults*	$ 458,742
Information & Referral**	$ 344,979
Case Management & Related Services	
Options Counseling	$ 423,358
OAA Case Management	$ 512,624
OPI Case Management	$ 428,296
Family Caregiver Services	$ 125,709
Community Services for Older Adults Total	**$ 2,293,708**
Evidence-Based Health Promotion	**$ 62,000**
Congregate Meals	$ 1,001,491
Home Delivered Meals	$ 906,110
Nutrition Services Total	**$ 1,907,601**

**Beginning in FY 18, Focal Point funding will be equivalent to 20% of total Community Services for Older Adults budget*

***Includes Transportation Scheduling & Coordination*

SUMMARY OF SERVICES

COMMUNITY SERVICES FOR OLDER ADULTS

COMMUNITY FOCAL POINT FOR OLDER ADULTS

These services include leadership and advocacy on aging issues, community outreach, and coordination of services for older adults, senior center educational and recreational activities, and leveraging of resources such as partnerships, volunteers, and donations. This service category includes:

RECREATION

Activities such as fitness classes, performing arts, games, cooking, and crafts that appeal to the leisure time interests of participants and promote socialization.

VOLUNTEER RECRUITMENT AND SERVICES

Volunteers are recruited and trained to support a contractor's services to its participants or other identified groups in the community.

REASSURANCE

Regular friendly telephone calls and / or visits to physically, geographically, or socially isolated individuals to determine if they are safe and well, if they require assistance, and to provide reassurance. This service may be provided by a paid staff member or trained volunteer.

FAMILY CAREGIVER SUPPORT GROUPS

Peer support groups for family caregivers, such as Grandparents Raising Grandchildren.

INFORMATION AND REFERRAL

Information and Referral (I & R) provides participants with information about services available in the community and benefits for which they may be eligible. The I & R process consists of active listening and effective questioning to determine the needs of the participant, clarifying those needs, providing requested information and/or identifying appropriate resources from the GetCare database, and making referrals to organizations capable of meeting those needs. I & R staff provide appropriate information about each organization - for example, describing how intake works and required documentation - to help participants make an informed choice and to help them connect successfully to services and benefits.

TRANSPORTATION SCHEDULING & COORDINATION

ADVSD purchases a limited number of rides via bus tickets and passes, and through contracts with local transportation providers for older adults who are not eligible for transportation services through Medicaid. Only agencies contracted to provide Information and Referral will have access to these rides and transportation services. Each organization selected to provide Transportation Scheduling and Coordination will be given access to a specific allocation for transportation services. Trained staff provide Transportation Scheduling & Coordination services for the ADVSD Transportation program, including distribution of bus tickets and passes, coordination of cab rides, determining level of service based on assessment outcome, and authorization of rides according to priorities determined by ADVSD to help older adults maintain their independence for as long as possible. Using input from ADVSD's Fare Assistance Workgroup, we recommend that agencies focus transportation funding on addressing the major transportation needs of fewer people, rather than providing a larger number of people with a small number of rides. The allocation for coordination is based on that recommendation. A contractor that chooses a different approach will need to find other funding for the increased costs of coordination.

In the event that funding does not meet demand, Transportation Coordinators are responsible for managing a wait list – this includes conducting an annual review to prioritize consumers based on need.

CASE MANAGEMENT AND RELATED PROGRAMS

Case Management is a comprehensive service provided to individuals age 60 and over who may be experiencing complex or multiple problems that affect the individual's ability to remain independent. Depending on the program and participant needs, Case Managers may assess the need for services; determine eligibility; develop and implement a service plan; authorize and/or coordinate services; counsel and problem-solve; evaluate and monitor the success of the service plan; regularly reassess the needs of participants; advocate on behalf of participants; and provide follow-up.
Case Management is provided under several programs:

OAA CASE MANAGEMENT

OAA Case Management is the basic service for individuals age 60 and over who need ongoing support to remain independent. The service provides assistance in problem solving and connects the participant to resources and community supports that will enhance independence. OAA Case Management does not include in-home services.

OPI CASE MANAGEMENT

Oregon Project Independence (OPI) serves individuals age 60 and over who need in-home services but are not eligible for, or decline, Medicaid services. In addition to in-home services, participants receive case management, including assistance with problem solving and connection to resources

and community services. OPI Case Management is provided by Case Managers who can authorize in-home services using either consumer employed Home Care Workers registered with the State or in-home care agencies under contract with ADVSD. It is likely that the OPI program will be completely full and maintaining a waiting list by January 2018, so any contractors new to providing this service will serve an existing caseload.

CASE MANAGEMENT FOR FAMILY CAREGIVERS

Case management is provided to family caregivers who are caring for persons age 60 and over and to grandparents 55 years of age or older who are caregivers of a related child. The definition of Family Caregiver includes friends, neighbors, and domestic partners who care for someone age 60 or older. Case Managers for Family Caregivers can access ADVSD's Family Caregiver Support Program, which provides small grants to family caregivers. Note: Support groups for family caregivers are an aspect of Focal Point.

OPTIONS COUNSELING

Options Counseling is not traditional Case Management as described above, but is a related service. Options Counseling is short-term facilitation that supports informed long-term care decision-making by the participant. The Options Counselor works with individuals and/or families, regardless of income, to help them understand their strengths, needs, preferences and unique situations. The Options Counselor translates this knowledge into possible support strategies, action plans, and tactics based on the choices available in the community. Options Counseling can be a stand-alone service for a participant, or can lead to longer-term case management.

EVIDENCE-BASED HEALTH PROMOTION

The purpose of providing Evidence-Based Health Promotion and Disease Prevention programs is to empower older persons to adopt healthy behaviors, improve health status, and better manage chronic conditions. Programs designated as "evidence-based" are proven by scientific research to improve health outcomes and reduce healthcare costs (e.g., fewer visits to physicians, reductions in the number of medical procedures performed, etc.).

NUTRITION SERVICES

The OAA provides funding for nutritious meals for older adults. Meals must meet specific dietary guidelines. **Congregate Meals** are provided to eligible participants at a nutrition site, senior center or other group setting. **Culturally Specific Congregate Meals** are provided by an organization that provides Culturally Specific services and are designed to appeal to the preferences of a particular culture (or group of cultures.) **Home Delivered Meals** are delivered to homebound older adults; frozen meals may be provided to cover weekends and holidays. Meal

contractors also provide **Nutrition Education** to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health information and instruction to participants.

ADMINISTRATIVE REQUIREMENTS

ADVSD contracts for these services on a fee-for-service basis. Reporting is based on requirements such as the National Aging Programs Information System (NAPIS) and State Unit on Aging (SUA) rules. Several different databases are used, depending on the service. See Attachment D: Administrative Requirements Summary Table for each service, the unit of service for billing, the monthly reporting requirements, and the database used, as well as a summary of training/certification and required meetings.

For all services in this RFPQ, ADVSD limits administrative costs to 12% of the direct costs of providing the service(s). This limit applies regardless of whether the contractor has a current federally negotiated indirect cost rate.

ADVSD expects that the contracts executed under this RFPQ will be subawards using federal funds. Contractors will be subject to the requirements for subrecipients under the Uniform Guidance codified at 2 CFR Part 200. Federal funds awarded under this RFPQ may make the contractor subject to the federal audit requirements of this circular.

In order to maintain Older Americans Act funded services throughout the year, Contractors funded under this RFPQ will be responsible to project monthly service levels and expenses to maintain service provision at mutually agreed upon levels throughout the year, unless ADVSD agrees otherwise.

Failure to perform at least 80% of the planned services may cause ADVSD to take corrective action, including service level adjustment, revision of funding or allocation levels, or termination of the contract.

MATCH

All contractors providing services under this Request for Programmatic Qualifications will be required to provide 11.12% match. The match is the Contractor's contribution and is in addition to the total allocated amount for services. The funding match will be built into the budgets for the contracted services. Federal funds may not be used as a match.
The entire match must be for services awarded through this procurement, and can be generated from the following:

- Donated supplies;
- Work performed by volunteers valued at the current rate as of 2016 for Oregon as recognized by the Independent Sector in the amount of $24.15 per hour;
- Donated professional services or programming; and

- Cash match from fundraising or grant sources that directly support the contracted services.

The Proposer's match will not increase their allocation for any of the services.

SUBSIDY

Contractors may provide more services than can be reimbursed from their County allocation. We request that contractors show additional service units provided without reimbursement as "subsidy" on their invoices. There are two reasons for this. First, it allows us to accurately report the services provided to older adults in our community. Second, ADVSD may have the ability to pay for some of these services (such as OPI or Culturally Specific Meals) at the end of the fiscal year, for example, if another contractor was unable to use their entire allocation. Note that this depends also on the source of funds that the contractor used to pay for the services.

Reimbursement for subsidy depends of the availability of funds that can be used for the specific services and ADVSD's determination of the best use of these funds to benefit the community. Subsidy that cannot be reimbursed includes:

- Subsidy used to meet the match requirement;
- Subsidy where the Contractor used federal funds to provide the service;
- Subsidy in any situation where reimbursement would result in Contractor being paid twice for the same service;
- Subsidy of the unit rate by the Contractor.

In general, ADVSD will not reimburse subsidy for services that are paid by monthly allotment, such as Focal Point, Transportation Scheduling & Coordination.

VOLUNTARY CONTRIBUTIONS

For services funded with Older Americans Act Title III funding, the Contractor will provide participants with the opportunity to contribute to the cost of the service. Federal rules require that the Contractor:

1. Protect the privacy of each participant with respect to their contributions;
2. Establish appropriate procedures to safeguard and account for all contributions;
3. Use contributions for supportive services and nutrition services to expand supportive services and nutrition services respectively; and
4. Not deny any older person a service because the older person will not or cannot contribute to the cost of the service.

These voluntary contributions shall be considered program income and will be used to expand services available to the community, not to subsidize the cost of service. When preparing invoices to request reimbursement for services, the Contractor will show the amount of program income collected on the invoice in the column labeled "Program Income", and subtract the program income during the month to arrive at the amount due for the month.

Note: This does not apply to Oregon Project Independence, which has its own requirements for participant contributions based on income.

CUSTOMER SATISFACTION

Multnomah County ADVSD has developed a division-wide process, the Participant Experience Project (PEP), to collect consistent feedback on our services from the people we serve. ADVSD brought together a participant satisfaction advisory group consisting of stakeholders, service providers, advisory group members and participants who drafted recommendations for ADVSD. The advisory group created recommendations on the definition of a customer, survey collection methodology, survey utilization, and content. ADVSD launched the PEP in ten sites, in nine languages, and will expand to all culturally specific and culturally responsive contractors in 2018. Contractors will be required to participate in the project and the goal is to solicit at least 2% response of the total registered service participants for ADVSD services.

GRIEVANCE PROCEDURES

All contractors providing services under this RFPQ must establish a written Clients Rights document, which includes their grievance procedures through which participants and their family members may present grievances about the operation of the Contractor's services. The grievance procedure must include progressive steps that allow the consumer to escalate their complaint to Multnomah County ADVSD if they are not satisfied with the response from the contractor. Contractors shall make these procedures readily accessible and available to clients. This may include posting in a conspicuous place and distribution of the procedures and applicable grievance forms in areas frequented by clients. Contractors shall provide advice to participants and their family members upon request.

Contractors shall provide these written procedures to the County upon request. In addition, each Contractor shall notify their ADVSD contract liaison of all grievances that the Contractor is not able to resolve, and shall process these grievances as directed by ADVSD, in accordance with any applicable ADVSD, DCHS, and County grievance procedures.

CULTURAL COMPETENCY PLAN

All contractors providing services under this RFPQ are required to have a Cultural Competency Plan: https://multco.us/purchasing/responsible-business-practices-vendors. This plan will outline policies and activities that promote culturally competent services and must address, at a minimum:

a. Non-discrimination in Service Delivery
b. Accessibility to Services
c. Training
d. Culturally Specific Programs and Services
e. Community Outreach
f. Plan Evaluation

CONFLICT OF INTEREST

The policy of ADVSD is to avoid real or potential conflict of interest in promotion and development of a community-based network of services. ADVSD will work with successful applicants to develop procedures that ensure the avoidance of conflict of interest.
In the interest of improving quality of service to older adults, ADVSD understands that under certain circumstances, contractors may develop their own fee-for-service programs and desire to make internal referrals. Contractors may utilize internal resources, i.e. staff, fundraising, etc., to develop fee-for-service programs that improve the quality of a service to participants. For example, one current District Center contractor hired a case management assistant to provide home care support for participants. The cost of providing such a service can be built into organization's District Center budget. In such cases, ADVSD will ensure, and must approve that appropriate procedures are in place, which may include establishment of a review committee with members not associated with the contractor, to review and approve any referrals made by the contractor's case manager.

CRIMINAL BACKGROUND CHECK REQUIREMENTS

Contractors who provide services under this RFPQ are required to have Criminal Background Checks done through the Oregon State Background Check Unit for all staff and volunteers who provide any of these services. For more information, see the Oregon State Background Check Unit's website:
http://www.oregon.gov/DHS/BUSINESS-SERVICES/CHC/Documents/crim-records-abuse-rules-dhs-employees-volunteers-contractors-407.pdf

PROGRAM MONITORING

The State Unit on Aging (SUA) requires ADVSD to participate in monitoring of various programs. At this time, these include Oregon Project Independence, Nutrition, Evidence Based Health Promotion, and Family Caregiver Support Program. The timing of the monitoring is determined by the SUA, is subject to change with little notice, and contractors for these services are required to participate. ADVSD will notify contractors of changes determined by the SUA. The SUA monitoring schedule as of fall 2017 is included below.

Program	**2018 site visits**	**2019**	**2020**	**2021**
Evidence Based Health Promotion	February - April	March - May	*Focus on*	
Nutrition	February - April	March - May		

Oregon Project Independence	July - September		*2021-2025* *Area Plan*	May - July
Family Caregiver Support Program	July - September			May - July

PRIVACY AND HIPAA COMPLIANCE

Contractors who provide services under this RFPQ will be Business Associates of the County under the Health Insurance Portability and Accountability Act (HIPAA) and are subject to all the applicable requirements, including safeguarding Protected Health Information (PHI.) Agencies applying under this RFPQ may be required to describe their HIPAA compliance program. Information about free training on HIPAA compliance responsibilities can be found at www.multco.us/ads. Contractors are bound by state and federal laws for keeping Personally Identifiable Information (PII) confidential to safeguard the privacy of individuals.

TECHNOLOGY REQUIREMENTS

Any contractor who provides services to ADVSD Community Services must have an effective and secure computer system and must be able to use basic Microsoft Office Suite programs such as Word and Excel, compatible with PCs. Contractors who provide I & R services must provide each I & R staff person with access to computer (ideally with two monitors), consistent internet connection, telephone with reliable call quality, and ability to transfer and conference calls, as well as a headset allowing for hands free call taking.

SECURE EMAIL

ADVSD will give contractors providing services under this RFPQ access to the County's secure email system to communicate with ADVSD when transmitting information about individuals (PHI.) It cannot be used to communicate with organizations other than the County. Transmittal of Protected Health Information outside of the County system may be done by any secure method. Contractors are responsible for protecting PHI as required by HIPAA. Information containing PHI may be transmitted by encrypted email, fax, phone, mail, or personal delivery.

DATA SYSTEMS

Several different databases are used to record participant and/or service information for ADVSD CS programs.

State of Oregon Databases

The State of Oregon maintains two databases that are used for ADVSD Community Services programs: Oregon Access and the State Mainframe. Both databases are accessed through a (web-based) portal called Citrix. More information, including specific hardware and software requirements can be found at: https://multco.us/file/31723/download
Contractors performing services for ADVSD Community Services programs must:

1. Sign a data-use agreement with the State of Oregon
2. Identify staff who need access to the systems and request access through ADVSD
3. Notify ADVSD immediately (within one business day) when an individual no longer needs this access

Oregon Access is used for recording participant information for these services:

- Oregon Project Independence
- Older Americans Act Case Management
- Evidence Based Health Promotion
- Family Caregiver Support Program

State Mainframe is used for authorizing payments to individual Home Care Workers.

ADRC RTZ GetCare Database is a web-based system that is used to locate referrals, as well as entering participant and service information for these programs:

- Information, Referral and Assistance
- Options Counseling

Universal Client Registry (UCR)

This is the ADVSD Community Services web based application that tracks client services, contractor budgets, invoice processing, and provides reports on services, funding, authorizations, and more. ADVSD CS contractors enter client and service data directly into the UCR - specifically clients not entered in Oregon Access and Transportation services. Contractors also submit their monthly contract deliverable, i.e. client service list, generally in Excel format, which is uploaded by ADVSD staff into the UCR.

EQUITABLE SERVICE DELIVERY

At Multnomah County, we are committed to examining the ways our policies, procedures, practices, and organizational culture contribute to injustice and institutional racism, as well as opportunities for fairness, inclusion, belonging, and community well-being for all. Our goal is to use strategies to target resources that are culturally responsive and appropriate to the communities most negatively impacted by systemic racism, health inequity, and barriers to opportunity, and to advance positive outcomes for all residents.

To support this goal, the Department of County Human Services has been examining our allocation of funds to better align with the needs of those negatively impacted communities. In developing our program model and funding formula, ADVSD has chosen to increase the amount and percentage of funds available to organizations providing culturally specific services.

CULTURALLY RESPONSIVE SERVICES

At a minimum, all contracting organizations must provide culturally responsive services. Culturally responsive services are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse participant / participant 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 priorities of and challenges facing diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional, and individual.

A culturally responsive organization reflects the following characteristics: The organization prioritizes responsiveness to the interests of communities experiencing inequities and racism, and provides

> *"culturally-grounded interventions [that] have been designed and developed starting from the values, behaviors, norms, and worldviews of the populations they are intended to serve, and therefore most closely connected to the lived experiences and core cultural constructs of the targeted populations and communities."*

Culturally responsive organizations affirmatively adopt and integrate the cultural and social norms and practices of the communities they serve.

A culturally responsive organization seeks to address power relationships comprehensively throughout its own organization, through both the types of services provided and its human resources practices. A key way of doing this is engaging in critical analysis of the organization's cultural norms, relationships, and structures, promoting those that support

democratic engagement, healing relationships, and environments. Culturally responsive organizations value and prioritize relationships with people and communities experiencing inequities universally, paying particular attention to communities experiencing racism and discrimination. Culturally responsive organizations commit to continuous quality improvement by tracking and regularly reporting progress, and being deeply responsive to community needs. A culturally responsive organization strives to eliminate barriers and enhance what is working.

CULTURALLY SPECIFIC SERVICES

Organizations providing Culturally Specific Services demonstrate alignment of founding mission with the community proposed to be served (creation of mission was historically based in serving communities experiencing racism) and alignment with the outcomes desired by the program. Organizations providing Culturally Specific Services demonstrate intimate knowledge of lived experience of the community, including but not limited to the impact of structural and individual racism or discrimination on the community; knowledge of specific disparities documented in the community and how that influences the structure of their program or service; ability to describe the community's cultural practices, health and safety beliefs/practices, positive cultural identity/pride/resilience, immigration dynamics, religious beliefs, etc. and how their services have been adapted to those cultural norms.

Organizations providing Culturally Specific Services demonstrate multiple formal and informal channels for meaningful community engagement, participation and feedback exists at all levels of the organization (from service complaints to community participation at the leadership and board level). Those channels are constructed within the cultural norms, practices, and beliefs of the community, and affirm the positive cultural identity, pride, and resilience of the community. Community participation can and does result in desired change.

Organizations providing Culturally Specific Services demonstrate commitment to a highly skilled and experienced workforce by employing robust recruitment, hiring and leadership development practices including but not limited to valuing and screening for community and/or lived experience; requirements for professional and personal references from within the community; training standards; professional development opportunities and performance monitoring.

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.

COMMUNITY SERVICES FOR OLDER ADULTS

DISTRICT SENIOR CENTERS

This area will fund five District Senior Centers and additional Culturally Specific services addressing the needs of underserved and at-risk populations. The geographic regions will remain unchanged from the previous contract period.
The funding for District Centers will be distributed by geographic area as shown in the table below:

District Center	60+	60+ Below	60+ Minority	65+ Minority	85+ Populati	Grandparents	Total Points	Percent
East County	26,064	2,150	3,547	544	2,266	1,745	36,315	**19.29%**
Mid-County	27,852	3,770	6,304	1,265	4,061	937	44,189	**23.47%**
North\Northeast	28,118	3,445	7,129	1,494	2,261	918	43,365	**23.04%**
Southeast	20,008	2,245	3,111	1,423	2,053	363	29,203	**15.51%**
West	26,922	2,390	2,646	585	2,439	199	35,180	**18.69%**
Totals	128,964	14,000	22,736	5,310	13,080	4,162	188,252	100%

Data Source: Tableau Workbook for Printed Map: ADVSDSumm_Final_AreaDistributions_Printing.pdf

Each **District Senior Center** must provide these core services*:

- Community Focal Point for Older Adults;
- Information and Referral, including Transportation Scheduling & Coordination;
- Case Management & related services including
    - Options Counseling
    - Family Caregiver Case Management
    - Older Americans Act Case Management
    - OPI Case Management

Applicants for District Senior Centers must be Culturally Responsive and may be organizations providing Culturally Specific services.
*District Senior Centers may subcontract for any of these services.

ENHANCING EQUITY PARTNERS

Organizations providing Culturally Specific services may also apply for any services on the menu below. The target populations to be served are adults 60 years and older throughout Multnomah County, including, but not limited to the following:

- African American;
- American Indian / Alaska Native;
- Asian / Pacific Islander;
- Immigrants & Refugees;
- Hispanic / Latino;
- Lesbian, Gay, Bisexual, Transgender (LGBT);
- People Aging with HIV/AIDS Long-Term Survivors.

Menu of services:

- Community Focal Point for Older Adults *(note this includes Recreation, Volunteer Services and Reassurance)*;
- Information and Referral, which may also include:
    - Transportation Scheduling & Coordination
- Options Counseling
- Family Caregiver Case Management
- Older Americans Act Case Management
- Oregon Project Independence(OPI) Case Management

COMMUNITY FOCAL POINT FOR OLDER ADULTS

ADVSD is allocating up to 20% of the funding for Community Services for older adults to Community Focal Point for Older Adults.

Focal Point services include leadership at the local level in aging issues, community outreach, advocacy, the development of community partnerships and collaborations, and the coordination of services for older adults, with the goal of increasing awareness of and access to services for all older persons. Focal Point also includes senior center development, defined as senior center activities that include educational, recreational, and intergenerational programs for older adults, and the leveraging of resources such as volunteers, in-kind and cash donations.
A Community Focal Point provider will meet the following criteria:

1. Have access to adequate meeting space for social activities such as, community gatherings, meals, etc. The space may be multi-purpose and located at different sites that are accessible and convenient to the community.
2. Provide consistent, reliable, and sufficient hours of operation to serve the needs of the community.

3. Be able to justify that the hours of operation are based on needs of the community.
4. Propose hours of operation will be reviewed by ADVSD and agreed upon mutually.
5. Clearly post agreed upon hours of operation.
6. Communicate changes in the hours of daily operations, excepting posted closures for holidays or other special events, to the ADVSD contract liaison (with rationale) for ADVSD review and approval.
7. Provide notice of changes at least 30 days in advance to limit the disruption to participants. This notice should be posted in a conspicuous place at the affected location and via other regularly used communication channels, such as online newsletters, printed newsletters, announcements at meal times, letters to members, etc.
8. Provide phone and program coverage throughout the business hours, and, to the extent possible, use reception coverage to connect callers and walk-ins to a live person.
9. Have sufficient staff to provide coverage for programs, activities, and volunteer supervision.
10. Implement nutrition guidelines or a wellness policy that promotes healthy eating and physical activity for participants.
11. Attend all required trainings and meetings at the request of the County.

Program Requirements

1. Provide single entry "no wrong door" access to services.
2. Establish a network of access points with all providers of services to older adults within the district;
3. Provide planning and coordination of services;
4. Engage in active outreach to vulnerable older people in the community;
5. Engage in active culturally appropriate outreach to cultural, ethnic and racial minority communities, including the LGBTQ community;
6. Provide advocacy and community leadership on aging issues;
7. Promote the District Center's or Culturally Specific Organization's visibility in the community;
8. Be committed to performance-based evaluation of the services that are provided under the ADVSD contract;
9. Work cooperatively with other ADVSD providers, including the other District Centers/Culturally Specific providers; and
10. Build relationships among community organizations and aging network professionals.
11. Senior Center Membership Policy: For those agencies who are operating as a "District Senior Center" and providing community focal point for older adults, Contractor shall have a written policy regarding any voluntary contributions, membership dues and participant fees requested for Older American Act (OAA) funded activities and non-OAA funded activities that are offered in the senior center, to be referred to as the Senior Center Membership Policy. Contractor's policy will follow the guidelines described in the ADVSD Senior Center Membership Policy. The implementation of

voluntary contributions, membership dues, and participant fees shall be based on the Contractor's policy.

Community Focal Point for Older Adult activities/projects will include, but will not be limited to the following:

1. Outreach, including transportation outreach to unserved and underserved populations, including minority populations;
2. Public-private collaborations and partnerships;
3. Community and political advocacy and work with elected officials;
4. Intergenerational programs;
5. Leveraging of resources and volunteers through community partnerships;
6. Development of innovative approaches to service delivery that improve the quality and/or level of service to older people most in need of services;
7. Projects that involve community livability, civic engagement and volunteerism;
8. Participation of staff in cooperative programs and services that are related to the ADVSD contract that either exist at the time of the contract or are developed during the course of the contract period, including participation in ADVSD evaluation of participant experience;
9. Coordination of services, such as legal services, insurance counseling, and others; and
10. Soliciting and utilizing input from older people on behalf of older people (especially those who are frail, have a disability, are low income, lack family or other social support systems, and/or are racial or cultural minorities), for the purpose of program planning, evaluation, making improvements to District Center/ Culturally Specific services and political advocacy.
11. Service Coordination with Meals Program Provider: ADVSD reserves the right to require the meal site operator to co-locate a meal site with the ADVSD Area Office or Community Focal Point Provider in accordance with a plan to increase service coordination. When it is not possible to co-locate, the Community Focal Point Provider will provide coordination between their organization, meal site, and ADVSD Area Office, to ensure that appropriate services are available to participants.

ADDITIONAL SERVICES INCLUDED IN COMMUNITY FOCAL POINT

RECREATION

Activities such as sports, performing arts, games, cooking, and crafts that appeals to the leisure time interests of participants and promote socialization. These activities may take place on a regularly scheduled basis or be special events at the contractor's organization or in the community, and participants may be involved as participants or spectators.

Recreation Service Requirements:

- A record of regularly scheduled activities and special events must be maintained;
- Participant attendance at regularly scheduled activities and special events must be recorded;
- Admission fees for special events attended by the organization's participants must be documented; and
- A qualified individual who has passed a Criminal Background Check must lead any activities that involve instruction (e.g., art, crafts, cooking).

VOLUNTEER RECRUITMENT AND SERVICES

Volunteers are recruited and trained to support a contractor's services to its participants or other identified groups in the community.

Volunteer Recruitment Service Requirements:

- Contractor shall facilitate volunteer support for participants.
- Volunteer services must have a stated purpose and scope. Services may include meal site management, Board and Advisory Council positions, home-delivered meals, office work, etc.
- Contractor shall integrate volunteers into Contractor's operations by ensuring that:
    - Volunteer services are clearly defined;
    - Volunteers are trained according to an established training plan;
    - Volunteer time is recorded; and
    - Volunteers pass a Criminal Background Check.

REASSURANCE

Regular friendly telephone calls and / or visits to physically, geographically, or socially isolated individuals to determine if they are safe and well, if they require assistance, and to provide reassurance. This service may be provided by a paid staff member or trained volunteer.

Staff or Trained Volunteer Qualifications:

- Ability to interact with participants and/or their families with tact and understanding, both in person and on the phone;
- Ability to judge if a participant is in need of help beyond what the staff member or trained volunteer can provide when offering reassurance;
- Understanding of warning signs that an individual may be suffering from neglect or abuse, and knowledge of when and where to refer in instances of suspected neglect or abuse; and
- Must pass a Criminal Background Check.

Staff or Trained Volunteer Responsibilities:

- Contact identified participants on a regular basis;
- Document contacts and record case notes, as needed, if a participant's situation changes and / or a referral is required; and
- Make appropriate referrals when needed.

Supervision:

- Staff or trained volunteers will receive at least one (1) hour of supervision per month to review service provided to participants

Documentation:

- Contractor shall maintain a record of telephone calls and home visits to participants, noting participant names and addresses, dates and length of interactions, and the status of participants.

INFORMATION AND REFERRAL

Applicants that receive funding for Information and Referral services must provide I & R staff with access to a computer (ideally with two monitors), consistent internet connection, telephone with reliable call quality and ability to transfer and conference calls, as well as a headset allowing for handling calls hands- free. ADVSD has identified these items as the minimum needed to meet AIRS technology standards.

Information and Referral is the designated access point for new referrals from other agencies and the public. The goal of Information and Referral (I & R) is to assist participants in accessing appropriate services via the GetCare database. I & R is provided to adults age 60 and older, for people living with a disability, and their family members; as well as people of any age inquiring on behalf of older adults and people living with disabilities. I & R provides single entry ("No Wrong Door") access to services; any person requesting information or referral will receive the appropriate information or connection through their first contact with a District Center or Enhancing Equity I & R Specialist.

District Centers and Enhancing Equity partners serve as "one-stop centers" as part of the larger Aging and Disability Resource Connection (ADRC) system for I & R that includes federal, state, and local public and private sector services and benefits for older adults and people with disabilities. The I & R Specialist must be able to provide information about and connection to a broad range of services, including topics as diverse as long term care, housing, transportation, employment and leisure time activities. The I & R staff screen and schedule appointments at their location for Senior Health Insurance Benefits Assistance (SHIBA) volunteers, who are trained and supervised by ADVSD, to help people who are not on Medicaid sort out their Medicare options.

I & R is a distinct function and should be performed separately from other direct service provision and organization functions at all times. I & R is distinguished from reception and routine inquiries by the level of training and expertise needed to provide a response to an inquiry or request, or to resolve an issue. The organization providing I & R should provide instructions and supervision to assure that there is a clear distinction between I & R and other functions of the organization. When I & R staff are providing coverage at reception, they are not providing I & R, and should forward the call appropriately. I & R is different from other direct service programs

and implementation of those programs (such as transportation ticket distribution or other assistance provided by the organization) and does not count toward I & R service units for payment. Current I & R providers with one dedicated FTE I & R Specialist handle 100-200 billable contacts per month; the range reflects varying complexity of interactions and contact volume.

The following Aging and Disability Resource Connection (ADRC) contact types further define I & R:

1) Information
Contractor shall provide information in response to specific inquiries about human services. Participants are self-directed, and do not express underlying needs. The information may range from a limited response, such as a phone number or address, to detailed descriptions of programs and services and the conditions under which they are available. NOTE: Excludes reception related activities (i.e. calls for your organization's staff or about internal programs).

2) Referral
Contractor shall provide referrals as well as information needed to access services. Referrals involve assessing the needs of a participant as openly and unobtrusively as possible, identifying appropriate resources that meet those needs, and allowing the participant to choose from a variety of service options. Participants may be aware of their problems in a general way but may need the assistance of an I & R Specialist to define their specific needs and understand potential solutions.

3) Assistance / Advocacy
Contractor shall provide assistance, which includes activities such as counseling, assessment, problem solving, care coordination, and follow up. When unsure of the available resources of a referral, Contractor advocates on participant's behalf. This helps eliminate making inappropriate referrals. Advocacy is offered on behalf of a participant when, once eligibility is confirmed, services are not being adequately provided or when the individual is unable to obtain a service on their own.

4) Follow-up
Contractor shall conduct follow-up to make sure that vulnerable individuals in difficult circumstances get the help they need. Follow up involves contacting participants, with permission, to check on their situation a few days after the referral to ensure that the participant received the help they needed, or, if the participant did not receive the help they needed, to explore other ways to meet their needs.

5) Crisis Intervention
When circumstances warrant, Contractor shall also perform crisis intervention to ensure the safety of the participant or others. People in crisis include individuals threatening suicide, homicide, or

assault; victims of domestic abuse or other forms of violence, child abuse/neglect, or elder abuse/neglect; sexual assault survivors; runaway youth; people experiencing a psychiatric emergency; chemically dependent people in crisis; survivors of a traumatic experience; and others in distress. In many of these circumstances, I & R staff will be expected to warm transfer the caller to the Multnomah County Mental Health Crisis line (24/7) or in a life-threatening situation to call 911. ADVSD will provide training to successful applicants about how to respond to these types of calls.

Administrative Standards and Program Requirements

I & R service will be available Monday through Friday during normal business hours, i.e. 8:00 am to 5:00 pm, or, proposed hours that will be reviewed by ADVSD and mutually agreed upon with a plan to meet community need and provide appropriate staffing. Any changes in proposed hours of daily operations, excepting posted closures for holidays or other special events, will be communicated to the ADVSD contract liaison (with rationale) for ADVSD review and approval.

1. I & R must be performed by I & R staff or skilled staff such as Case Managers and supervisors.
2. Contractors must have policies in place that delineate duties and responsibilities of I & R services which maintain reception related activities separate from I & R function.
3. Utilize the Oregon Aging and Disability Resource Connection (ADRC) electronic resource directory when assisting callers and walk-ins.
4. Assist ADVSD in maintaining up-to-date resources, both local and standard resources, in the ADRC electronic resource directory.
5. Ensure that staff is trained in handling calls/walk-ins for individuals with limited English language proficiency and use the ADRC to identify approved interpreters and translators, or use available internal resources.
6. One staff member will be designated as the I & R Lead Specialist and will work collaboratively with other skilled staff to ensure consistency of service across the entire team.
7. Designated I & R staff will be assigned and available as back up to the I & R Lead.
8. Contractor will arrange for telephone answering service, provide a voicemail option, and/or provide a recording that refers callers to the Multnomah County ADRC Helpline, 503 988-3646, for coverage during non-service hours or in case of an emergency during normal business hours.
9. Maintain confidential participant information and send participant information by secure electronic format only.
10. A quality assurance plan for monitoring the I & R service will be developed by the contractor together with ADVSD staff, and will include individual performance measures tracked monthly.

Staff Qualifications

I & R Specialist will be Alliance of Information and Referral Systems (AIRS) certified with the Aging/Disabilities focus (CIRS-A/D) within their first year of employment. I & R Specialist (or Case Manager or Supervisor filling in as back up) will have the following knowledge and abilities:

1. Knowledge of the aging process;
2. Knowledge of the purpose of the information and assistance/case management program and the services it provides;
3. Knowledge of the responsibilities of the case management and information and assistance staff;
4. Familiarity with public and private services available for older persons in Multnomah County, including program eligibility requirements;
5. Ability to effectively communicate with participants in a clear and respectful manner; work with participants experiencing trauma and crisis in a calm and helpful manner;
6. Ability to ask additional questions, by phone or in person, to determine if there are underlying or additional issues beyond those initially presented by the caller;
7. Ability to assess for needed services based on the information available; resolve the issue or make appropriate service referrals; and
8. Ability to navigate and use the ADRC electronic resource directory and accurately document the I & R transaction.

Staff Responsibilities

Staff responsibilities include the following:

1. Responding to requests for information, referral, or assistance;
2. Screen and schedule appointments at their location for Senior Health Insurance Benefits Assistance (SHIBA) volunteers;
3. Reporting changes to information in the community resource ADRC electronic resource directory to the Multnomah County ADRC Resource Specialist
4. Maintaining expertise in the use of the ADRC electronic resource directory;
5. Maintaining password access to the State Mainframe, Oregon Access database, and ADRC electronic resource directory;
6. Sharing community resources not in ADRC resource directory with the Multnomah County ADRC Resource Specialist;
7. Documenting contacts as they occur (no later than 3 days after contact);
8. Preparing and submitting monthly reports on ADVSD approved forms and reporting in formats required by ADVSD; and
9. Active participation in meetings, training, and program evaluation as required by ADVSD.

Supervision

1. All District Center and EE staff providing an I & R function must receive at least one (1) hour a month of supervision in which calls, required documentation, and their disposition are reviewed.
2. Supervision will include support in the following areas:

a. Handling difficult calls effectively;
b. Understanding the difference between reception related activities, information, assistance and referral, and how to assess participant need;
c. Reviewing accuracy and completeness of required documentation; and
d. Training and support to improve service delivery.

Training

I & R staff will receive a minimum of three (3) hours of in-service training twice a year and seven (7) hours of formal training for each FTE (full time equivalent) to meet AIRS re-certification requirement. ADVSD holds mandatory I & R quarterly meetings and provides monthly training opportunities for I & R and other skilled staff, and provides information about other relevant community-based trainings.

Training for I & R staff must include the following elements:

1. **Orientation** which covers the following subjects before new staff begin providing services to older persons:
    a. Introduction to the services and programs for older adults, people with disabilities and veterans in Multnomah County;
    b. Introduction to the ADVSD Mission, Vision and Values;
    c. Service principle of "no wrong door" access ;
    d. Organization policies and procedures;
    e. Protocol for working with other agencies, including how to make referrals;
2. **Training** to include the following elements:
    a. How to use the required state data system, the ADRC electronic resource directory and RTZ Call Module, and the State Mainframe and Oregon Access databases;
    b. How to complete ADVSD-required reports and document calls
    c. How to assist ADVSD in the maintenance of the ADRC electronic resource directory;
    d. Interviewing skills;
    e. Knowledge of the case management intake process;
    f. Assessment procedures; and
    g. Services authorized under the OAA, OPI, and other programs serving older people;
    h. AIRS certification within the first year of employment.
3. Additional **"best practices"** training may include the following:
    a. Cross-training with Case Managers;
    b. Customer service techniques;
    c. How to discern a potentially complex situation from an apparently simple request for information;
4. Individualized training will be provided to fill gaps in knowledge or skills and shall include seven (7) hours of formal training each year for each full-time position. Formal training may be

through college courses, workshops, seminars, or conferences, or other organization staff or professionals in the community may provide structured training.

5. Seasoned I & R staff are encouraged to share knowledge and expertise with new I & R staff from other contractors.

Procedures

District Centers and EE Partners will use the following procedures when providing I & R services:

1. Information
    a. Assess the nature of the request by phone or in person.
    b. Provide information by phone or in person about services and programs found in the ADRC electronic resource database.
    c. Record appropriate information regarding the contact.
2. Referral
    a. Assess the needs of the participant in an open and unobtrusive way.
    b. Identify appropriate resource(s) that meet identified needs as found in the ADRC electronic resource database.
    c. Allow participant to choose from a variety of options without overwhelming them with choices. Three referrals are considered an adequate amount for one contact.
    d. Make a referral by contacting the resource organization on behalf of the participant by phone or share resource information with participant in-person, over the phone, via email, or by postal mail.
3. Assistance
    a. Assist the participant in the completion of intake forms.
    b. Arrange for and schedule legal service and other services as appropriate, including SHIBA appointments.
    c. Record appropriate information regarding the contact.
    d. Follow-Up with service recipients within a month after the referral to ensure that appropriate assistance was received.
    e. If appropriate assistance was not received, advocate on the recipient's behalf and problem solve for other available resources as needed.

Documentation

1. Logging, narrating, tracking, and reporting I & R contacts will be completed in the ADRC RTZ Call Module (participant database), at the time of contact.
2. A complete record of contacts received, including who called, the service request, and the disposition of call will be documented, as well as basic demographic information. In addition, records of services that were requested or needed, but not available, will be maintained.
3. Count as I & R service units, activities such as assisting with the completion of forms, research to locate needed services or resources, advocacy with other

agencies or service providers, and coordination of services to respond to requests for single services or to resolve a single issue.

4. I & R counts do not include:
   - Administration of direct services offered to existing clients (distributing bus tickets, food boxes, newsletters, or durable medical equipment);
   - Referrals made to additional services offered by the I & R Specialists organization unrelated to the expressed need;
   - Responses to requests which are normally a reception function, e.g. calls to Case Managers or routine inquiries which can be handled by the receptionist such as inquiries about center hours of operation, calls for information about clinics or classes, signing clients up for clinics or classes.

Payment

I & R will be paid on a fee-for-service basis, based on the number of contacts (units) entered in the ADRC electronic resource directory and RTZ Call Module. A unit of service will be one (1) contact meeting the definition of information, referral, or assistance, which may or may not require additional contacts with the person or other sources, that is handled by the I & R Specialist, and is fully recorded in the ADRC database within three days of the initial contact. The basic rate is for Referral and Assistance contacts; Information contacts are paid at one-half the basic rate. Payment will be based on complete and accurate documentation submitted each month to ADVSD. Payment may be delayed or not authorize if these criteria are not met.

Quality assurance for Information and Referral/Assistance

Monthly reporting requirements	Compliance Measures	Target	Source
GetCare Summary Report Call outcomes: Information calls Assistance calls Referral calls (per AIRS definitions) Quality Assurance Audit	Required fields 100%	TBD	GetCare Reports
	Narration standards	TBD	Quality Assurance Audit
	Contacts recorded within 3 days	TBD	GetCare Reports
	Attendance at I & R/A quarterly meetings	4/year	Sign-up sheets

TRANSPORTATION SCHEDULING AND COORDINATION

Contractors who choose to receive funding for Information and Referral will be eligible for access to an allocation for direct transportation services. Each selected organization will receive funds to coordinate the program. These funds will be provided by a monthly allocation and will be commensurate with the amount of consumers expected to receive fare assistance and rides through the program.

The Fare Assistance program is in line with all other services and support offered by Aging, Disability and Services (ADVSD) in that it is approached and administered with a focus on being person centered and consumer driven allowing for consumer self-direction and meaningful input throughout the process.

- All transportation clients are pre-screened and reassessed annually by I & R staff, using the Transportation Assessment form. The outcome of the screening will determine eligibility for fare assistance and level of assistance received.
- The level of fare assistance the client qualifies for should provide adequate and effective support for the client's personal transportation plan. ***Keep in mind, current funding amount is limited and does not meet the full need of the community.***
- The Transportation Assessment form will also help to identify all transportation resources (including natural resources i.e. family, friends and neighbors who can provide transportation, eligibility for honored citizen downtown Portland pass, etc.) available to the client.

- This tool may be used to create an individualized transportation plan for the client that may or may not include fare assistance from the DC.

Agency rides, which include bus passes and tickets, are transportation services that ADVSD purchases from local transportation providers that help participants maintain their independence in the community. Contractors selected to receive access to an allocation for transportation services will assist older adult participants and others acting on behalf of older adults with Transportation Scheduling and Coordination for organization rides.

This service includes activities such as:

1. Authorizing ADVSD funded organization rides;
2. Scheduling and coordinating organization rides with ADVSD funded transportation providers; and
3. Distribution of bus passes and tickets purchased by ADVSD through contracts with local transportation providers - currently TriMet.

Note that assessment of need, eligibility screening, verification, and assistance with forms/applications, for all transportation services would be eligible for I & R payment, as long as the activity meets the required standards.

Administrative Standards and Program Requirements

1. Transportation Scheduling and Coordination will be available during the same hours as I & R services.
2. Transportation Scheduling and Coordination must be performed by Transportation Specialist staff or skilled staff such as Case Managers and supervisors.
3. Contractors must have clear policies in place that delineate duties and responsibilities of reception services separately from Transportation Scheduling and Coordination services.
4. One staff member will be designated as the Transportation Specialist and will work collaboratively with other skilled staff to ensure consistency.
5. Contractors must ensure that Transportation Specialists are trained in handling calls/walk-ins for individuals with limited English speaking proficiency and have the current list of interpreters and translators, or internal resources.
6. Designated, trained staff will be assigned and available as back up to the Transportation Specialist.
7. The Contractor will maintain confidential participant information, enter participant and service information in the ADVS Universal Client Registry (UCR) database, and transmit participant information (when necessary) by secure electronic format.
8. Designated staff will refer participants for guaranteed door-to-door rides using WiseGuide database.
9. A quality assurance plan for monitoring the Transportation Scheduling and Coordination service will be developed by the Contractor.

10. In addition to the Transportation Scheduling and Coordination described in the body of this program model, Contractors are expected to adhere to ADVSD service standards and policies.

Staff Qualifications

The Transportation Specialist (or Case Manager or Supervisor filling in as back up) will have the following skills and qualifications:

1. Effective listening, interviewing, and communication skills;
2. Knowledge of the different types of transportation services available in the community including Ride Connection rides, Ride Wise Program, Shuttles, TriMet Lift etc.;
3. Ability to keep up-to-date on the transportation services available in the community;
4. Knowledge of program eligibility requirements and the ability to screen for eligibility, verify and assess the most appropriate transportation needs for the participant;
5. Ability to accurately document and bill for the Transportation Scheduling and Coordinating transaction;
6. Ability to use the ADRC electronic resource directory;
7. Active participation in training and evaluation as required by ADVSD as needed;
8. Knowledge of the aging process;
9. Knowledge of the aging network and service delivery system;
10. Knowledge of the District Center's information and assistance and case management programs and the services they provide; and
11. The ability to work as part of a team with co-workers on behalf of participant.

Staff Responsibilities

Staff responsibilities include the following:

1. Responding to requests for transportation scheduling and coordination;
2. Record transportation and coordination services in Ride Connection WiseGuide web-based participant database and in the Multnomah County Universal Client Registry (UCR) database;
3. Billing accurately, and staying within budget;
4. Preparing and submitting monthly reports on ADVSD approved forms and reporting formats required by ADVSD;
5. Attending meetings and trainings as needed or required by ADVSD; and
6. Maintaining password access to the State Mainframe and Oregon Access database.

Supervision

All District Center staff providing Transportation Scheduling and Coordination must receive at least one hour a month of supervision for reviewing calls and their disposition. Supervision will include the following:

1. Ensuring complete and accurate billing, documentation and reporting of transportation transactions;
2. Work with ADVSD and other transportation providers to analyze and improve Transportation Scheduling and Coordination services.

Training

Staff that has the training and skills necessary will perform Transportation Scheduling and Coordination. Depending on the Contractor's staffing plan, Transportation Scheduling and Coordination may be performed by an I & R Specialist, Case Manager, or Transportation Specialist.

ADVSD offers monthly meeting and training opportunities for Transportation Specialists and other skilled staff, as well as updates for community-based training. Contractor staff assigned to provide Transportation Scheduling and Coordination will participate in ADVSD sponsored meetings and training, and other training(s) as required or needed.

Training for Transportation Scheduling and Coordination staff must include the following elements:

1. **Orientation:** New staff will receive an orientation which covers the following subjects before they begin providing services to older persons:
    a. Introduction to the Aging Network;
    b. Introduction to the ADVSD Mission and Values;
    c. Philosophy of the single entry access system through information and assistance and case management services;
    d. Organization policies and procedures;
    e. Introduction to other community resources that serve older persons;
    f. Content of working agreements with other agencies;
    g. Protocol for working with other agencies, including how to make referrals;
    h. How to use the State mainframe, Oregon Access Database to determine eligibility, and ADVSD UCR to enter participant and service data;
    i. How to work as part of a team;
    j. How to complete required forms;
    k. How to use the telephone to provide the services for which they are responsible; and
    l. The documentation of calls.
    m. How to accurately bill for transportation services.
2. I**nitial Training to** include the following:
    a. Interviewing skills;
    b. Knowledge of the case management intake process;
    c. Assessment procedures;
    d. Services authorized under the OAA, OPI, and other programs serving older adults and people with disabilities.
3. **Additional training** may include the following best practices:
    a. Cross-training with Case Managers;
    b. Customer service techniques;
    c. How to discern a potentially complex situation from an apparent simple request for services; and

    d. Using software to submit Transportation Scheduling and Coordination data.
4. Seasoned Transportation Specialists are encouraged to share knowledge and expertise with new Transportation Specialists from other centers.
5. Neighboring Contractors are encouraged to collaborate in transportation outreach venues to reach underserved communities.

Procedures

Contractors will use the following procedures when scheduling and coordinating transportation:

1. Utilize standardized procedures, screening tools, narrative tools, forms and formats approved by ADVSD;
2. Utilize standardized coordination procedures with ride providers;
3. Agency rides can only be authorized and scheduled by ADVSD staff or ADVSD contractors;
4. Assess participant needs and develop a personal transportation plan using a standardized format approved by ADVSD;
5. Register participant using a standardized format approved by ADVSD;
6. Coordinate transportation resources and service that are most appropriate for the participant, and most cost-effective;
7. Facilitate ride schedule for participants as needed;
8. Ensure that staff are trained in handling calls/walk-ins for participants with limited English-speaking proficiency and have an up-to-date list of ADVSD interpreters and translators, or internal resources available; and
9. Provide technical, cultural, and other supports to participant, as well as transportation providers, to ensure prompt and efficient service delivery.

Participants needing organization rides will be prioritized according to the following ADVSD criteria:

1. Medical trips (doctors, therapists, hospital, test, or health-related treatment) for non-Medicaid participants;
2. Congregate nutrition sites; and
3. Sites where the participant is receiving multiple services (such as Senior Centers, etc.)

ADVSD‘s priority target populations for organization rides include:

1. Frail, elderly participants based on activities of daily living (ADL) who have limited endurance, stamina, and are advanced old age;
2. People with disabilities who need to travel with equipment such as walkers, oxygen, etc.;
3. Non-English speaking older adults who have difficulty accessing fixed route transportation due to language barriers; and
4. Volunteers who work in Aging, Disability, and Veterans Services programs and activities.

Whenever feasible, Transportation Scheduling and Coordination will promote the use of fixed route public transportation through the distribution of bus passes and tickets, and through the

utilization of community transportation resources to support participant independence and choice.

Documentation

1. Logging, tracking, and reporting Transportation Scheduling and Coordination services will be completed in the ADVSD UCR or by other methods approved by ADVSD.
2. A transportation assessment to determine eligibility for fare assistance must be completed annually for each transportation participant; copy must be maintained by the Contractor.
3. The Contractor will document a complete record of transportation scheduling and coordination calls received, including at minimum who called, the service request, and the disposition of the call. In addition, the Contractor will maintain records of services that were requested or needed, but not available.

Payment

Each organization's allocation for Transportation Scheduling and Coordination will equal to 25% of the organization's allocation for direct transportation services, and will be paid on a monthly allocation basis and will be based on complete and accurate documentation entered each month in the ADVSD UCR. Payment may be delayed or not authorized if these criteria are not met.

Quality Assurance for Transportation Scheduling & Coordination

Monthly reporting requirements	Compliance Measures	Target	Source
# Assessments By participant: - Rides authorized - Tickets or pass provided	Fare Assistance Assessments completed at enrollment and updated annually	100%	UCR
	Attendance at TSC monthly meetings	80%	ADVSD
	Customer satisfaction	TBD	TBD
	Monthly Ticket/Pass order reconciles with Public Transportation Log and Surplus Ticket Tracker	100%	UCR Surplus Ticket Tracker Vendor (currently TriMet) Invoice

CASE MANAGEMENT AND RELATED SERVICES

Case Management for older adults is a comprehensive service provided to individuals age 60 and over who may be experiencing complex or multiple problems that affect the individual's ability to remain independent. 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.

Trained Case Managers assess the need for services; determine eligibility; develop and implement the service plan; authorize services; coordinate services; counsel and problem-solve; evaluate and monitor the success of the care plan; reassess the needs of participants when indicated and on a regular basis; advocate on behalf of participants; and provide follow-up.

Case Managers authorize services funded through the aging services system or they may serve as advocates to obtain help for their participants by negotiating with other service agencies. Case management is based on a holistic assessment of the participant's situation and participant choice. Case Managers must consider and coordinate an array of services for the total needs of the participant and not restrict the assessment to an evaluation of problems for which an organization has services.

The goals of Case Management for older adults are to assist participants in remaining as independent as possible, delay or prevent out-of-home placement, and support the participant's right of choice.

The goals of Case Management for Family Caregivers is to assist these participants in obtaining information and services that would enhance the caregiver's ability to provide care for the care receiver.

Case management services are mainly provided to participants residing in an independent residential setting. Only Options Counseling may be provided in any residential or care setting.

OLDER AMERICANS ACT CASE MANAGEMENT

Older Americans Act (OAA) Case Management is a comprehensive service provided to older adults who are experiencing complex or multiple problems that affect the individual's ability to remain independent. Contractor shall provide Older Americans Act case management services including: assessing needs, developing action plans with goals, registering participants and documenting in Oregon Access, coordinating services, counseling and problem-solving, advocacy and follow-up.

OAA Case Management is appropriate for participants who are not eligible for OPI in-home services and for whom Options Counseling is not appropriate, either because the period of time is required for the participant to achieve their goals is too lengthy, or because the participant is not self-directed enough to follow through on the Action Plan as required by Options Counseling.

OPI CASE MANAGEMENT

Oregon Project Independence (OPI) is a comprehensive service provided to older adults needing in-home services that are experiencing complex or multiple problems that affect the individual's ability to remain independent. Contractors provide case management services, including: assessing needs, developing service plans, documenting in Oregon Access, authorizing services, coordinating services, counseling and problem-solving, evaluation of services, advocacy, follow-up and reassessment. *Please note: It is likely that the OPI program will be completely full and maintaining a waiting list by January 2018, so successful contractors will serve an existing caseload.*

SUMMER 2017 OPI CASELOAD DEMOGRAPHICS

Row Labels	HISPANIC OR LATINO	NOT HISPANIC OR LATINO	NOT REPORTED/ UNKNOWN/ BLANK	Grand Total	Percentage
AMERICAN INDIAN/ALASKA NATIVE		5		5	**1%**
ASIAN		9		9	**2%**
BLACK/AFRICAN AMERICAN		95	1	96	**16%**
NATIVE HAW/OTHER PAC ISLANDER		3		3	**1%**
UNREPORTED/UNKNOWN/BLANK	6	5	30	41	**7%**
WHITE/CAUCASIAN	5	424	6	435	**74%**
Grand Total	**11**	**541**	**37**	**589**	
Percentage	**2%**	**92%**	**6%**		**100%**

OPI Case Managers will work in Oregon Access and the State Mainframe to set up OPI client service plans. Consumers may choose to be served by an In-Home Care organization contracted with ADVSD, or by a participant-employed Home Care Worker (HCW) registered through the State. For participants using In Home agencies, Case Managers notify the organization of the

authorized hours. For participants using Home Care Workers, Case Managers ask the designated voucher clerk at their organization to generate Home Care Worker (HCW) vouchers in the State Mainframe.

Separation of Duties: No case manager shall set up, issue, or approve HCW vouchers for payment by the State. Any contractor providing OPI services must have staff other than a Case Manager set up, issue, and approve HCW vouchers for payment in the State Mainframe. These vouchers must be approved for payment within a time period specified by the State and cannot be delayed, so back-up staffing for voucher processing is required. Applicants for OPI services must have a plan to ensure that 1) HCW vouchers are approved for payment on time; and 2) no staff person both authorizes services and issues/approves payment of HCW vouchers. Individual contractors providing OPI services may work with each other to ensure the separation of duties required by the State. https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/OPI.aspx

CASE MANAGEMENT FOR FAMILY CAREGIVERS

Family Caregiver Support Program Case Management is a comprehensive service provided to Family Caregivers who are caring for older adults, are caregivers of a relative child or children, or are caring for a loved one with Alzheimer's disease or other dementia. This program also covers non-parental relatives age 55 or older who are caring for any related adult with a disability. Contractor shall provide case management services including: assessing needs, developing care plans, documenting in Oregon Access, authorizing services, coordinating services, counseling and problem-solving, evaluation of services, advocacy, follow-up and reassessment.

CASE MANAGEMENT ASSISTANCE (CMA)

Contractors providing Case Management services may use Case Management Assistants (CMA) to support any of these services. Case Management Assistance includes direct services provided to participants as well as assistance to case managers. Case Management Assistants handle many duties that do not require the training and judgment of a case manager but are vital to the participant's well-being and/or successful service plan, or which would require too much of a case manager's time, or where separation of duties from the case manager is considered a best practice. Some examples of possible Case Management Assistant duties include paying Home Care Worker vouchers; making follow-up and welfare check phone calls or home visits; delivering items to the participant's home; purging and organizing participant hard files; conducting QA monitoring of participant hard files, and administrative tasks such as processing daily mail; creating spreadsheets, forms and flyers; and special projects such as preparing mass mailings to participants.
There are two categories of CMA services:

1. **Case Management Assistance Employee** is a service performed by a skilled employee of the Contractor.
   Hourly rate: $20.00

2. **Case Management Assistance Volunteer** is a service performed by a skilled volunteer.

   Hourly rate: $15.00

Administrative Standards and Program Requirements

The following case management standards apply to case management for older adults and family caregivers:

1. Client records must be maintained using forms and formats provided by ADVSD.
2. Priority shall be given to participants who are at a higher level of risk.
3. Case Managers will apply a person-centered approach in providing the appropriate level of assistance needed to connect each participant with programs and/or services as necessary and be familiar with, and consider all possible services that could be useful to the participant.

   Case Managers shall:

   a) Use ADVSD approved assessment tool(s) to assess the needs of participant.
   b) Develop action plans that include participant's goals and case manager's activities.
   c) Case manager's activities may include, as needed:
      1. Assess participant's eligibility for various programs and/or services;
      2. Contact providers on behalf of participant;
      3. Coordinate services on behalf of participant;
      4. Assist participant in completing applications for programs and/or services; and
      5. Work with family members of participant to facilitate the participant's access to services.
      6. Provide information about services including transportation, in-home care, counseling, adult day services, transportation, respite services, home delivered meals and other relevant services.
4. Case management procedures apply to OAA, Options Counseling, and OPI participants, other case management participants, Gatekeeper referrals, Multi-disciplinary Team (MDT) referrals, Adult Protective Service referrals, and Public Guardian participants. The case management process should be used to manage services for participants who come into the system through these programs.
5. Response to referrals must be made within five (5) calendar days of the referral. Gatekeeper referrals must be followed-up by face-to-face contact within five (5) days unless the caller indicates the situation requires more immediate investigation. Schedule an in-person meeting, usually a home visit, with the participant and/or their support system within two (2) weeks of the initial contact, or sooner if the situation requires it. Multiple meetings will be conducted as needed by the participant.
6. Maintain confidential participant information and transmit participant information by secure electronic format.
7. Case management staff must be provided time to attend ADVSD sponsored training and other training as appropriate.

8. For planning purposes, a recommended caseload at any point in time is between 65 and 85 case management participants (depending on severity and complexity of participant needs) per one (1) FTE case manager.
9. The unit of service will be one (1) hour of case management that relates to a specific case management participant.

Staff Responsibilities

In general, Case Management staff shall

1. Respond in a timely manner to requests for information about available options;
2. Provide the appropriate level of assistance needed to connect participants with services;
3. Document assistance that is provided
4. Maintain expertise in the use of the ADRC electronic resource directory; and
5. Maintain password access to the State Mainframe and Oregon Access database

Staff Responsibilities are described in detail in Appendix

Supervision

1. The purpose of supervision and training is to ensure continuous quality improvement of the case management staff and to ensure the ability of Case Managers to serve participants with increasingly difficult needs.
2. All Case Managers will have an assigned supervisor who is qualified to supervise case management by virtue of having had case management training or experience.
3. There will not be more than one (1) full time supervisor for every five (5) full time Case Managers. If there are fewer than five (5) Case Managers assigned to the ADVSD contract, a proportionate amount of the supervisor's FTE should be assigned to cover case management supervision.
4. Each case manager or trained volunteer will have a one-to-one meeting with the supervisor and receive at least one (1) hour of supervision per month to review service provided to participants. Staff employed for less than six months will have a one-to-one meeting of at least one (1) hour for every 80 hours worked. The purposes of the meetings are to:
    a. Review case records for service plan content as well as compliance with recording regulations and requirements;
    b. Provide coaching on techniques and approaches to providing participant services; and
    c. Provide consultation on job performance.
5. Each case management supervisor will spend at least two (2) three-hour time segments per year (one segment equals one morning or one afternoon) in the field with assigned Case Managers to observe the case manager in the actual setting to assure quality of service and to identify training needs of the case manager.
6. Each case manager supervisor shall maintain a supervision record for each volunteer or case manager they supervise documenting the monthly supervision and joint field visits required in #4 and #5 above. Record shall include date and duration of each meeting or field visit and a brief synopsis of coaching provided and skills or aspects of the work that

were reviewed with the volunteer or case manager. This document will be provided to the county upon request.

7. Co-assessments may be part of the field supervision. The amount of time spent in the field with an individual case manager will depend on the case manager's experience and job performance.
8. Supervisors are also expected to attend training that increases their professional skills in the area of case management supervision. Supervisors are to maintain an annual record of trainings they have attended and make it available to the county upon request.

Training

The following training standards apply in addition to the Standards for Single Entry Case Management.

1. Contractor will have a process for identifying the training needs of staff, both at initial employment and during their employment. Training shall be provided to meet identified needs.
2. All new staff will receive an orientation before they begin providing services to older persons. Orientation will include:
    a. Introduction to the services and programs for older adults, people with disabilities and veterans in Multnomah County;
    b. Introduction to the ADVSD Mission, Vision and Values;
    c. Service principle of "no wrong door" access;
    d. Organization policies and procedures;
    e. Protocol for working with other agencies, including how to make referrals;
    f. How to use the required state data systems, currently the ADRC electronic resource directory and Call Module; and the State Mainframe and Oregon Access databases;
    g. How to complete ADVSD-required forms and call documentation;
    h. Procedures for handling emergency situations;
    i. On-the-job training prior to commencing participant visits which shall include observation and mentorship by a supervisor or experienced case manager for a minimum of two weeks. This specific training shall cover how to perform all case management functions including documentation, making field visits with the supervisor or another case manager, an orientation to the geographic area they will serve; and
    j. Additional training which may include using software to submit case management data electronically to ADVSD.
    k. Staff performing OAA Case Management should receive OAA Case Management training within six (6) months of hire, using available training resources.
3. All staff will receive individualized ongoing training to fill gaps in their knowledge or skills. This training will be based on supervisor evaluation, related to job duties, and identified through supervisory contacts, case record reviews, and formal training.
4. It is recommended that an estimated 24 hours of formal training will be provided to each full-time case manager annually. Formal training for less than full-time case management staff will be pro-rated with 24 hours of training per FTE as standard.

5. Case Managers will be trained in the use of the State Mainframe, Oregon Access, and Oregon Access Client Assessment and Planning System (CA/PS) as the basis for developing and monitoring the participant case plan.
6. Formal training may be provided through college courses, workshops, seminars, conferences, or provided by organization staff or professionals in the community (including the Multi-Disciplinary Team). Training may also include required ADVSD trainings, required ADVSD case manager meetings, webinars, State trainings, and subject matter conference calls. Supervisors are encouraged to support staff in attending trainings that specifically address that employee's goals and skill development needs as well as add to the employee's professional development.
7. Supervisors shall maintain an annual record of trainings each volunteer or case manager has attended and make it available to the county upon request. Record shall include date of attendance, name of training, length of training, and name of organization that provided the training.

Case Management Procedures

ADVSD requires Contractors providing Case Management to follow the case management standards, policies, and procedures specific to the type of case management provided and as defined by National Aging Program Information Systems (NAPIS).

Documentation

In addition to the required documentation of case management services described below, Contractors shall follow case management standards, policies, and procedures specific to the type of case management provided.

1. For Oregon Project Independence (OPI) case management, a Client Assessment and Planning System (CA/PS) in Oregon Access must be completed to determine eligibility and Service Priority Level (SPL) for all OPI cases. All client registration, documentation, and narration for OPI consumers are entered in Oregon Access.
2. For clients being placed on the OPI wait list, the case manager completes an OPI risk assessment on the ADRC Care Tool.
3. For OAA case management, the Case Manager meets with the participant to conduct an initial home visit or face-to-face meeting to assess the participant's needs. The OAA case manager registers the OAA case managed participant in Oregon ACCESS, completing all required tabs. OAA case managers use an ADVSD standardized OAA narration template to assess the participant's needs, record the outcome of home visit and to document contact with the participant.
4. Family Caregiver Case Management client registration, documentation, and narration must be completed in Oregon Access and a Universal Client Registration (UCR) form must be completed for the person in care and for the client. The family caregiver is the client in this program.

5. All narration for all types of case management must follow ADVSD Narration Standards. Use of the ADVSD narration template is considered a best practice for initial assessments and reassessments and is strongly encouraged.

Quality Assurance for Case Management

Monthly reporting requirements	Compliance Measures	Target	Source
For each participant, Case Manager, # hours	OPI: Participants have up-to-date CA/PS assessments and service plans	90%	Oregon Access
	OAA: OAA Service tab information is complete and narration of assessment and follow up steps is complete	90%	Oregon Access
	Demographic data recorded	92%	Oregon Access
	Family Caregiver: Narration & FCGSP fields completed	TBD	Oregon Access
	Customer Satisfaction measured by PEP	TBD	TBD

OPTIONS COUNSELING SERVICES

Options Counseling is a short-term (up to 180 days), comprehensive, person-centered service provided to older adults, and/or to others acting on their behalf, regarding the full range of available immediate and long-range options for long-term support. Options Counseling helps individuals understand available community support options; assesses individual's needs and resources; assists individuals in developing and implementing their choices; and empowers individuals to make informed, cost-effective decisions about long-term support services.

Activities of Options Counseling include: meeting with the program participant at the hospital, their place of residence, or other location convenient to the participant to provide comprehensive, objective, up-to-date, user-friendly information about the full range of available immediate and long range options; helping program participants understand available community support options; assessing needs and resources; assisting in the development and implementation of long-term support choices; and empowering individuals to make informed, cost-effective decisions about long-term support services. Documentation in the ADRC Statewide client database by the Options Counselor includes a person-centered assessment, action plan, and progress notes.

For Multnomah County, contracted agencies are key partners in the implementation of Options Counseling services. Case Managers from the partner organization will provide Options Counseling for individuals referred to their site.

Administrative Standards and Program Requirements

Contractors providing Options Counseling are required to provide a 24-hour, one (1) business day, returned response call to the participant. The initial face-to-face visit must be completed within five (5) days of the initial call; preference is within three (3) business days. If the Options Counselor will be unable to respond within a 24-hour period, the ADVSD Helpline staff should be notified immediately so the referral will be sent to the next closest Contractor providing Options Counseling.
The average service hours per Options Counseling program participant will be 12 - 15 hours, over a one to three-month period, with part of service time occurring face to face with the participant in the setting of their choice. Some participants may need up to 180 days of service to reach their goals. The number of participants that will be served by each Partner organization is unknown. The staff member who will perform Options Counseling and their supervisor are required to attend a three-day Options Counseling training provided by State Unit on Aging. The training must be completed prior to providing Options Counseling.

Staff Qualifications

Individuals with any combination of experience and training that would likely provide the required knowledge and abilities may qualify. A typical way to obtain the knowledge and abilities would be:

- Education and/or Training: Equivalent to a bachelor's degree from an accredited college or university with major coursework in social science, social service, or a related field, and
- Experience: Two (2) years of increasingly responsible case management work experience.

Staff Responsibilities

Options Counseling staff must:

1. Demonstrate commitment to person-centered counseling with attention to participant preferences, strengths, culture, and individual situation when meeting with participants and their representatives.
2. Show effective participant advocacy skills with providers, family members, public and private agencies, and others.
3. Communicate clearly in a concise, respectful manner, both verbally (in person and on the phone) and in writing (including electronic methods). Utilize active listening and effective in-depth interviewing techniques to elicit required information.
4. Perform visual assessment of participant to determine signs of potential abuse or neglect; participant's ability to perform activities of daily living and instrumental activities of daily living; and, when applicable, participant's living situation for safety and hygiene.
5. Be able to understand complex written rules, policies, regulations and laws, demonstrate attention to detail and solid administrative, case and project tracking skills.
6. Have a basic understanding of medical terminology and disease processes in the areas of gerontology, physical, mental and developmental disabilities, and pharmacology. Have knowledge of basic math to calculate benefits.
7. Maintain confidential participant information and transmit participant information by secure electronic format.
8. Be able and willing to travel to participant location, regardless of accessibility or availability of public transportation to perform site visits; travel to meetings and training sessions.

Supervision

1. All Options Counselors will have an assigned supervisor who is qualified to supervise them by virtue of having had Options Counseling training or experience. Options Counselors shall receive at least one (1) hour of supervision per month to review services provided to participants.
2. Supervisors will maintain a supervision record for each Options Counselor. Record shall include date and duration of each meeting and a brief synopsis of coaching provided and skills or aspects of the work that were reviewed with the Options Counselor. Supervisor will provide this document to the county upon request.

Training and License

Specific Required Training:

1. Complete Options Counseling 101 and 102 training sessions prior to serving participants; **OR** Contractor shall ensure that staff performing Options Counseling-receives Options Counseling 101, 102, and 103 training sessions during the first year of the Contract, which will be provided by Metro ADRC staff.
2. Serve under the supervision of a manager who has completed the Options Counseling 101 and 202 training sessions.
3. May require a valid driver's license.

Procedures

The ADVSD Helpline receives referral information from community partners, from older adults seeking services, or from friends or family members concerned about an older adult. ADVSD Helpline reviews referral information, checks for eligibility, and obtains any missing information. The ADVSD Helpline sends verified referrals and accompanying information to the contracted partner site closest to the person's residence.

The Options Counselor contacts potential participant within one (1) business day of the referral within five (5) business days of receiving the referral, or sooner if the situation requires it, discusses any immediate needs on the phone and sets up initial face to face appointment(s). Options Counselor shall:

1. Schedule an in-person meeting, usually a home visit, with the participant and/or their support system within two (2) weeks of the initial contact, or sooner if the situation requires it. Multiple meetings will be conducted as needed by the participant.
2. Register the participant in the Aging and Disability Resource Connection (ADRC) Care Tool and document the assistance that is provided.
3. Provide the appropriate level of assistance needed to connect participants with programs and/or services as necessary, including the following:
    a. Provide information about services including transportation, in-home care, counseling, and other relevant services;
    b. Investigate participant's eligibility for various programs and/or services;
    c. Contact providers on behalf of participants;
    d. Assist participants, if assistance is needed, in completing applications for programs and/or services; and
    e. Work with family members of participants to facilitate the participant's access to services.

Documentation

District Center will document Options Counseling activities, including Person-Centered Assessment and Action Plan in the ADRC Care Tool.

Quality Assurance for Options Counseling

Monthly reporting	Compliance Measures	Target	Source

requirements			
For each participant: # units, Options Counselor, encounter dates	Cases opened & closed in 180 days	>50%	ADRC Care Tool
	Internal ID completed	100%	
	Person-centered Assessment completed	90%	ADRC Care Tool
	Action Plan completed	90%	ADRC Care Tool
	Customer satisfaction measured by PEP	TBD	TBD

Reporting and Payment Terms for Case Management and Options Counseling

Case Management and Options Counseling is paid monthly on a fee-for-service basis, based on an hourly rate (invoiced in fifteen (15) minute increments.) Case Management costs must be identified separately for each program (OAA Case Management, OPI Case Management, Case Management for Family Caregivers, Options Counseling). The hourly rate will be the same for all four of these programs. Case Management Assistance costs do not need to be separated by program, but CMA by Employees and by Volunteers are listed separately. Payment will be based on complete and accurate documentation submitted each month to ADVSD. If these criteria are not met, payment may be delayed or not authorized.

The monthly report must accompany the Contractor's invoice. Report and invoice formats may be found under Contract Reporting and Expectations at https://multco.us/ads/contract-reporting-and-expectations.

FAMILY CAREGIVER SUPPORT PROGRAM

The National Family Caregiver Support Program (FCSP) provides critical services to unpaid caregivers caring for adults with functional disabilities or relatives who are raising children. These services help delay or avoid entry into a long-term care setting and the Medicaid system.
FCSP Core Elements:

- Information Services, Group Activities;
- Specialized family caregiver information (one-to-one);
- Counseling;

- Training;
- Support Groups;
- Respite Care Services (both in-home and out of home); and
- Supplemental Services.

ADVSD's Family Caregiver Support Program has the following elements.

1. **Case Management for Family Caregivers**: a required service of District Centers, and may be provided by any contractor that provides Case Management.
2. **FCGS Stipends** are small grants to family caregivers who are caring for persons age 60 and over, or of any age if the care recipient has Alzheimer's or a related disease; or for individuals who are grandparents 55 years of age or older who are caregivers of a related child or relative adult with a disability (non-parental). This program is accessed by Case Managers of contracted agencies.
3. **Support Groups for Grandparents Raising Grandchildren** and/or for unpaid Family Caregivers of older adults or Adults with Disabilities: provided by contractors. These are included in Focal Point services.
4. **Evidence-based trainings for caregivers**:
    a. Star Caregiver requires a staff person certified in this program. Contractors can invoice for the staff person's time providing this training at their Case Management rate.
    b. Contractors may host a six-week Savvy Caregiver class, run by an ADVSD staff person who is certified in this program.
    c. Contractors may host a six-week Powerful Tools for Caregivers class, to be taught by two certified trainers in this program. An ADVSD staff person is certified in this program and may be available to be one of the certified trainers.

Monthly reporting requirements	Compliance Measures	Target	Source
See Case Management, Focal Point, and/or Evidence Based Health Promotion	Completion of all relevant FCG fields	100%	Oregon Access
	Narration meets required standards	100%	Oregon Access

EVIDENCE-BASED HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve, their own health. Disease prevention includes measures not only to prevent the occurrence of disease, but also to arrest its progress and reduce its consequences once established. Evidenced-based health promotion programs are proven to improve quality of life and reduce healthcare expenditures and they empower older adults and people with disabilities.

ADVSD seeks to provide an array of Evidence Based Health Promotion (EBHP) classes and workshops throughout the county, throughout the year, and with an adequate availability of programming offered by culturally specific providers. Multnomah County ADVSD is committed to providing EBHP to cultural and ethnic older adults and families in ways that are relevant to and meet the needs of community members. 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.

Partners providing EBHP programming address the following considerations:

- Geographic location of programming;
- Willingness and/or ability to provide programming outside of the stated geographic area or outside of the prescribed district center region,
- Partnership or collaboration with others, as needed, to ensure adequate county-wide coverage,
- Strategic plan to meet the needs of older adults from populations experiencing health disparities, with appropriate culturally responsive and/or culturally specific recommendations.

Regional efforts are underway to work with local healthcare agencies to increase referrals, course offerings, and identify new funding resources. Partners providing EBHP with Multnomah County ADVSD will be part of the "EBHP ADVSD Network". Partners will be active in the "EBHP ADVSD Network" and participate in planning of workshops and classes to ensure coverage across the county and throughout the calendar year.

Partners are expected to respond to participant inquiries about EBHP program availability and or registration in line with AIRS I & R standards. (See Information and Referral section for details of these standards.)

Partners are expected to conduct marketing to promote each of their EBHP offering(s) and report their efforts to the Multnomah County EBHP Coordinator. Marketing and promotional efforts may

include organization newsletters and activity calendars, flyers, earned media, paid advertisements, PSA's, phone outreach, mailers, and other creative strategies to spread the word and ensure robust class/workshop enrollment.

Multnomah County ADVSD has established a standardized reimbursement range for each EBHP program. Partners will be expected to propose a rate within the established range with budget justification. Multnomah County ADVSD will also establish a set schedule for payment, based on scheduling and completion of the EBHP program.

Partners are expected to ensure program fidelity for each EBHP program that they are providing according to standards established by the program developer, the State and Multnomah County ADVSD.

Partners are required to comply with program and data reporting protocols. This will include using the State's Compass system to input data for the following programs: Stanford self-management programs (Living Well, Tomando Control, DSMP, Chronic Pain Self-management), Diabetes Prevention Program, Matter of Balance, Walk With Ease, Tai Chi Moving for Better Balance and Arthritis Foundation Tai Chi. The Arthritis Exercise program will need to be reported by submission of Excel sheet data and will be tracked by Multnomah County's data analysis team. Partners will also submit participant information into Oregon Access when appropriate.
Only evidence-based programs meeting the highest-level criteria are eligible (Tier III). The State Unit on Aging has a list of programs that meet the highest-level criteria: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Documents/Evidence-based%20programs.pdf

PROGRAM DESCRIPTIONS

STANFORD CHRONIC DISEASE SELF MANAGEMENT PROGRAMS

Living Well with Chronic Conditions (LWCC) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. The workshop provides support for normal daily activities and dealing with the emotions that chronic conditions may bring about. Additional Stanford programs that will be considered:

- Tomando Control de su Salud, a Spanish-language, culturally adapted version of LWCC;
- Positive Self-Management Program (PSMP) (seven weeks) for HIV;
- Diabetes Self-Management Program;
- Arthritis Self-Management Program;
- Chronic Pain Self- Management Program; and
- Better Choices, Better Health, an on-line version of the workshop.

Four-day leader training for these programs is held regularly in locations around the state. www.healthoregon.org/livingwell or 888-576-7414 or http://patienteducation.stanford.edu/

DIABETES PREVENTION PROGRAM

The Diabetes Prevention Program was created to provide education and tools for lifestyle changes in people with prediabetes, with the goal of reducing their chances of developing type 2 Diabetes. This program last one year and includes several in person sessions that discuss food and lifestyle changes that have been proven to lower disease risk and improve quality of life for those most at risk for developing type 2 diabetes.

TAI JI QUAN: MOVING FOR BETTER BALANCE

Developed by the Oregon Research Institute in Eugene, this simplified, 8-form version of Tai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Classes meet 2-3 times per week for at least three months. Program outcomes include decreased falls, and a decrease in fear of falling. A two-day instructor training is offered in the Eugene area, and occasionally in other areas of the state with support from the DHS Public Health Division. Contact Dr. Fuzhong Li at the Oregon Research Institute, www.ori.org, or 541-484-2123, or for more information on the program in Oregon, visit www.healthoregon.org/fallprevention. Also known as Tai Chi: Moving for Better Balance or YMCA Moving for Better Balance)

ARTHRITIS FOUNDATION TAI CHI PROGRAM

Designed for people with arthritis, this 12-movement Sun-style Tai Chi program was developed by Paul Lam and is supported by the Arthritis Foundation. www.arthritis.org/tai-chi.php

ARTHRITIS FOUNDATION EXERCISE PROGRAMS

Originally developed by the Arthritis Foundation, this program offers low-impact exercises that can be done either sitting or standing to help relieve stiffness and pain and to build strength and stamina. Classes meet 2-3 times per week for at least eight weeks. The programs were developed by physical therapists specifically for people with arthritis or related conditions, although are also appropriate for other frail or deconditioned older adults. Information on training: https://www.aeawave.com/AFProgram.aspx. www.arthritis.org/exercise.php In Oregon, check www.healthoregon.org/takecontrol.

WALK WITH EASE PROGRAM

This community-based physical activity and self-management education program is conducted in groups of 12-15 people led by trained leaders in a structured six-week program. One-hour sessions are held three times a week over the six-week period for a total of 18 sessions. While walking is the central activity, Walk With Ease also includes health education, stretching, and strengthening exercises, and motivational strategies. Group sessions include socialization time, a brief scripted pre-walk informational lecture, warm up and cool down, and a 10-35 minute walking period. Walk

with Ease was specifically developed for adults with arthritis who want to be more physically active, but is also appropriate for people without arthritis, particularly those with diabetes, heart disease and other chronic conditions, who want to get more active. Instructor training is offered on-line. For more information, visit http://extension.oregonstate.edu/fch/walk-with-ease or www.healthoregon.org/takecontrol.

POWERFUL TOOLS FOR CAREGIVERS

This six-week education program developed by Legacy Caregiver Services, focuses on the needs of the caregiver, and is for family and friends who are caring for older adults suffering from stroke, Alzheimer's, Parkinson's disease or similar long-term conditions. The class provides participants with the skills and confidence you need to better care for yourself while caring for others. www.powerfultoolsforcaregivers.org/

SAVVY CAREGIVER

This is 12-hour training program is usually delivered in 2- hour sessions over a 6-week period. Developed at the University of Minnesota, the program focuses on helping caregivers think about their situation objectively and providing them with the knowledge, skills, and attitudes, they need to manage stress and carry out the caregiving role effectively. Research has demonstrated significant positive outcomes regarding caregivers' beliefs about caregiving, their reactions to the behavioral symptoms of their care recipient, and their feelings of stress and burden. www.rosalynncarter.org/caregiver_intervention_database/dimentia/savvy_care giver/

ADMINISTRATIVE STANDARDS AND PROGRAM REQUIREMENTS

- Programs provided must be recognized as Tier III evidence-based and those that meet this standard are listed above in the link to the State Unit on Aging website;
- Staff or volunteers leading classes or facilitating sessions must be trained and qualified to do so, and pass a Criminal Background Check;
- Program participants' attendance must be recorded and tracked;
- Participant progress / outcomes must be tracked and recorded according to program protocols; and
- Partner must have a system to conduct fidelity checks in accordance with program requirements.

Data Collection and Reporting

Reports are made on forms and formats approved by ADVSD. Partners will be required to comply with program and data reporting protocols. This will include using the State's Compass system to input data for the following programs: Stanford self-management programs (Living Well, Tomando Control, DSMP, Chronic Pain Self-management), Diabetes Prevention Program, Matter

of Balance, Walk With Ease, Tai Chi Moving for Better Balance and Arthritis Foundation Tai Chi. The Arthritis Exercise program will need to be reported by submission of Excel sheet data and will be tracked by Multnomah County's data analysis team. Partners will also have to submit participant information into Oregon Access when appropriate.

Monthly progress reports submitted to ADVSD will include the following elements:

- Any data elements/participant demographics and attendance from classes and workshops NOT captured in Compass
- Health Promotion and Disease Prevention activities and completed workshops
- A narrative highlighting special events, new collaborative efforts, outreach, successes and best practices identified to benefit "the network"
- Description of resources leveraged, including volunteer in-kind.

Payment

EBHP is paid on a fee-for-service basis. Multnomah County ADVSD has established a standardized reimbursement range for each individual EBHP program. Multnomah County ADVSD will also establish a set schedule for payment, based on scheduling and completion of the EBHP program. Payment will be based on complete and accurate documentation submitted to ADVSD.

NUTRITION SERVICES

ADVSD will contract with one Culturally Responsive provider in order to provide congregate and/or home delivered meals throughout the County. We will also contract with five Culturally Specific providers who will provide congregate and/or home delivered meals targeting specific populations. All nutrition providers must provide Nutrition Education and assess their participants for nutritional risk annually. We have followed the allocation determination that 38% of funding will be awarded for meals to organizations providing Culturally Specific services. However, ADVSD reserves the right to make allocation changes as determined to be in the best interests of serving participant need and the County.

The Oregon Senior Nutrition Program is part of the continuum of care designed to support independent living of older Oregonians under the Title III (Grants to State and Community Programs on Aging) and Title VI (Grants for Native Americans) of the Older Americans Act (OAA). See complete OAA and OPI Nutrition Program Standards here: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Nutrition-Program.aspx

The objectives of the OAA nutrition programs are to provide an opportunity for older individuals to live their years in dignity by providing healthy, appealing meals; promoting health and preventing disease; reducing malnutrition risk and improving nutritional status; reducing social isolation and increasing social interaction; linking older adults to community-based services; and providing an opportunity for meaningful community involvement, such as through volunteering. Adequate nutrition, on a daily basis, is the key to a person maintaining the adequate health necessary to live at home. Frequent contact with others provides a means to monitor the participant's health, well-being, and safety. The programs across the state strive to accomplish this by providing congregate nutrition programs and home-delivered meals.

Contracted providers will be expected to pursue activities that make services under this Contract accessible and available to people age 60 and older who have the greatest social and economic needs, with special attention to isolated, low-income, minority individuals and people with Limited English Proficiency (LEP).

CONGREGATE NUTRITION SERVICES

The congregate program is designed to help increase the nutrient intake and to prevent health deterioration and social isolation of participants. Congregate meals are offered in a variety of settings, including nutrition sites, senior centers/community centers, churches, schools, adult care facilities, or some other congregate setting under the supervision of a nutrition project.

The congregate setting is designed to provide a welcoming and pleasant atmosphere where people age 60 and older (and their spouses) can gather for a meal. Older adults can enjoy meeting new people, form friendships, and support groups by coming together for meals on a regular basis. The balanced meal and the social contact together provide a positive motivation for self-care for older adults who often eat poorly on their own and can become lonely and depressed in isolation. The nutrition program is more than just a meal—its purpose is to nourish the whole person.

CONGREGATE NUTRITION SERVICES ELIGIBILITY

Congregate meals will be available to persons who are 60 years of age or older, and their spouses (regardless of age), to individuals with disabilities (regardless of age) who reside at home with and accompany older individuals who are eligible under the OAA, to disabled persons under 60 years of age who reside in housing facilities where congregate meals are served and which are primarily occupied by persons age 60 and older and to volunteers (regardless of age) who provide volunteer services during meal hours. And, with approval, to People 50+ Aging with HIV/AIDS Long-Term Survivors

CONGREGATE NUTRITION SERVICES STANDARDS

1. Countywide nutrition provider shall provide at least one hot meal or other appropriate meal in a congregate setting at least once a day, five or more days per week.
2. Congregate nutrition providers will make every effort to obtain the required NAPIS data. There is a NAPIS intake form provided by APD that is located on this page: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Area-Agency-Aging.aspx
3. The OAA Nutrition Risk Assessment should be completed at the time of intake and at annual update. Each AAA office should develop appropriate policies or procedures for review of the nutrition-screening checklist and for making appropriate referrals if participants score at a high nutrition risk. A sample form can be found: stand-alone the risk checklist: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Documents/Nutrition%20Screening%20Checklist.pdf
4. The NAPIS information shall be updated annually. Congregate Nutrition Programs must collect and report the information required by ADVSD and the Older Americans Act and send the information to ADVSD.
5. Participants who decline to provide NAPIS data may not be denied service.
6. Congregate meal participants should be advised to keep an emergency food shelf at home; in case of inclement weather that prevents travel to the congregate site or other such emergencies.
7. Nutrition providers must administer nutrition education to meal site participants at a minimum of quarterly. Nutrition education subjects will be based on the needs of the participants and should be culturally appropriate.
8. Nutrition providers will develop a strategy that allows participants to make confidential donations for congregate meal(s).

9. Site location for the congregate meal program is vital to its success. In order to create a gathering place that offers opportunities for good nutritious meals and social interaction, an ideal facility will:
    a) Be conveniently located to the target population.
    b) Have convenient, accessible, and affordable transportation.
    c) Be in a safe, well lit, well-maintained location.
    d) Be easily visible and open to the public.
    e) Have adequate space to support programming.
    f) Have clear, inviting, and culturally appropriate exterior and interior signage.
10. The physical interior of a meal site should create an atmosphere that is pleasant and inviting, as well as conducive to the needs of the older population. This environment should include:
    a) A welcoming ambience that plays down institutionalization
    b) Adequate lighting
    c) Acoustics that support individual and group conversations
    d) Accessible restroom locations
    e) Kitchens that support high quality and safe meal service
    f) Furnishings that are functional, comfortable, safe and appropriate
11. Site management is important to the success of a comprehensive, safe, and vital meal program. A successful program should include, but is not limited to these components:
    a) Staffing: To be knowledgeable of the aging network system and services, sensitive to aging issues and competent in food service management. Have the training and ability to work respectfully and effectively with participants with challenging circumstances and behaviors, including homeless participants and persons with addiction issues, mental health issues, physical disabilities, and developmental disabilities. Have cross-cultural training to serve participants from different cultural and ethnic backgrounds and to recognize and resolve issues that arise from cultural misunderstandings.
    b) Nutrition and Meal Services: To provide safe and appetizing meals that meet OAA requirements; meals that adapt to the participant satisfaction; and opportunities for nutrition education that is meaningful and culturally responsive and meets OAA guidelines.
    c) Programming: To provide interactions that meet participant interests and needs.
    d) Services Referral: To help participants become familiar with community resources.
    e) Outreach to the Community: To create public awareness of program and services.
    f) Volunteer Opportunities: To provide a volunteer program that cultivates purposeful and responsible involvement. To provide training for volunteers in a variety of areas including cross cultural communication, cultural sensitivity, and conflict management skills.
    g) Administrative: To provide consistent and accurate required reporting, monitoring of budget and fund raising activities, and other duties as needed.

12. Compliance with applicable federal, state, and local code and regulations relating to the public health, safety, and welfare of food preparation is required in all stages of food service operation.
13. Projects must develop, implement, and annually update an operating policy manual containing, at minimum, the following information:
    a) Fiscal Management
    b) Food Service Management
    c) Safety and Sanitation
    d) Staff Responsibilities
    e) Emergency/Disaster Plan
14. Personnel and volunteers who assist with the congregate meal site operations should be instructed in:
    a) Portion control,
    b) FDA Food Code practices for sanitary handling of food,
    c) Organization safety policies and procedures,
    d) Protecting confidentiality and safeguarding collection of voluntary donations,
    e) Cross cultural communication and conflict resolution, and
    f) How to report concerns to appropriate staff for follow-up.
15. Each congregate meal site shall meet ADA requirements for accessibility to public programs. DHS Policy DHS-010-005 See the DHS policy at: www.dhs.state.or.us/policy/admin/exec/010_005.htm#policy
16. Persons handling food/food service will do so in compliance with local public health code regulating food service establishments and the Food Protection Program, which adopted the 2009 FDA Food Code with Oregon Amendments. See https://public.health.oregon.gov/HealthyEnvironments/FoodSafety/Documents/foodsanitationrulesweb.pdf to obtain Oregon's Food Sanitation Rules.
17. Compliance with State of Oregon Public Health Code and local licensing standards for food preparation, storage and delivery, as well as any preparation or distribution standards issued by the Oregon State Unit on Aging. See the Food Safety Training Manual at: https://public.health.oregon.gov/HealthyEnvironments/FoodSafety/Pages/manual.aspx
18. Service coordination with meals program provider**:** ADVSD reserves the right to require the meal site operator to co-locate a meal site with the ADVSD Area Office or District Center/ Culturally Specific Provider in accordance with a plan to increase service coordination.

HOME-DELIVERED MEALS

Meals that are delivered to homebound participants are critical to maintaining independence and allowing participants to remain in their own homes.

Individuals who receive home-delivered meals tend to have more health problems than congregate participants do and may have become homebound because of increasing age or short-term/long-term health problems. Programs can provide nutritional support through the delivery of one or more meals per day and in some cases liquid nutritional supplements.

HOME-DELIVERED MEALS ELIGIBILITY CRITERIA

To be eligible for home-delivered meals, a person must meet the following criteria:

1. Be 60 years of age or older and homebound by reason of injury, illness, or an incapacitating disability or be otherwise isolated, or
2. Be the spouse or disabled dependent child of any age who resides with an older adults who is eligible under this criteria, if it is in the best interest of the participant, or
3. Be a disabled person under 60 years of age who resides in a housing facility where a senior meal site is located, or
4. Be 60 or older and physically or mentally predominantly unable to shop for or safely prepare meals to meet minimal nutrition requirements, or
5. Be 60 or older and have an inadequate support system for food shopping or meal preparation, or
6. Be 60 or older and unable to tolerate a group situation due to physical or mental disability or substance abuse, and
7. Is willing to eat the meal within a reasonable time, such as within 30 minutes of delivery, or refrigerated on arrival and eaten within 48 hours or discarded after 48 hours of refrigeration and
8. Be 50+ and a person Aging with HIV/AIDS Long-Term Survivors
9. Is approved for eligibility by the AAA or the OPI service provider, and
10. Lives within Multnomah County.

HOME-DELIVERED MEAL STANDARDS

1. Meals may be hot, cold, frozen, dried, or canned with a satisfactory storage life.
2. Contractor must take referrals from ADVSD and our contracted partners. Contractor must have the capacity to start providing meals within two business days for requests received by 4pm on a business day.
3. Client Assessment for Home-Delivered Meals: In order for homebound older persons to remain independent and in their own home if possible, it is necessary that each service provider adequately determine their eligibility for home-delivered meals and other appropriate services. Home-Delivered Meal nutrition providers will make every effort to obtain the required NAPIS data, which includes the OAA Nutrition Risk Assessment, from each meal site participant.
4. The OAA Nutrition Risk Assessment, Activities of Daily Living (ADL), and Instrumental Activities of Daily Living (IADL) must be completed at the time of intake and at annual update. Each AAA office should develop appropriate policies or procedures for review of the nutrition risk assessment and for making appropriate referrals if participants score at a high nutrition risk. stand-alone the risk checklist: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Documents/Nutrition%20Screening%20Checklist.pdf and NAPIS form that includes ADL and IADL section http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Area-Agency-Aging.aspx
5. Participants who decline to provide NAPIS data may not be denied service.
6. Initial Assessment

a) The initial assessment shall be conducted in person. The initial assessment should focus both on the individual's strengths and limitations. Other means of realistically obtaining consistent and adequate meals, such as shopping assistance, assistance from friends and family, attending a congregate site and homemaking services should be explored. The presence and usefulness of other means of assistance to the applicant may reduce the need for home-delivered meals and help determine the level of service priority. Coordination of other services within the continuum of care may be appropriate.
b) The initial assessment/screening Title III, Section 339, of OAA, including the required OAA nutrition risk assessment, ADL and IADL needs shall be completed within the period designated by the AAA. stand-alone the risk checklist: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Documents/Nutrition%20Screening%20Checklist.pdf and NAPIS form that includes ADL and IADL section: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Area-Agency-Aging.aspx
c) Program applicants who are determined ineligible to receive home-delivered meals should be directed to the nearest congregate nutrition site or to other appropriate food assistance programs.
d) Conditions or circumstances that place the older person or the household at high risk of abuse, neglect or exploitation must be brought to the attention of appropriate officials (Adult Protective Services or law enforcement) for follow-up.

7. Reassessments
   a) The purpose of reassessments is to determine if a participant's need for home-delivered meals still exists and at what level.
   b) Participants who originally were determined to need meals for a few weeks, such as those recovering from surgery or illness, should be reassessed before the end of that service period to determine if their need for meals still exists. If the participant continues to need home-delivered meals, services should continue and an appropriate reassessment schedule should be determined.
   c) Participants receiving home-delivered meals that are expected to need the service for long periods should be reassessed at least every six months to a year depending on the unique needs of the person receiving the service. Annual reviews must be performed in-person. Six-month reviews may be performed over the telephone if it is not feasible to meet the participant in-person.
   d) If a participant is no longer eligible to receive home-delivered meals, the service provider should direct them to the nearest congregate nutrition site or to other appropriate food assistance services.
8. All nutrition service providers will have a plan to insure participants will receive meals during emergencies, weather-related conditions, and natural disasters. Plan could include shelf-stable

emergency meal packages, four-wheel drive vehicles, volunteer arrangements with other community resources, etc.

9. If the nutrition provider chooses, it is acceptable to provide a combination of two or three meals, including breakfast, lunch, and/or dinner, to participants receiving home-delivered meals. It is also encouraged that nutrition providers offer weekend meals, which could be hot, cold, or frozen meals.
10. Nutrition providers will develop a strategy that allows participants to make confidential donations for home-delivered meal(s).
11. Training: Personnel who assist with the home-delivery meal operations should be trained in safe food handling procedures. Each provider should develop written procedures for all components of meal services. Regular training should be provided to reinforce safe food handling practices.
12. Home-Delivery Projects will develop, implement, and annually update an operating policy manual containing, at minimum, the following information:
    a) Fiscal Management
    b) Food Service Management
    c) Safety and Sanitation
    d) Staff Responsibilities
    e) Gatekeeper and Adult Protective Services referrals (for those delivering meals to the homes and conducting participant assessments).

MENUS AND MENU PLANNING

Oregon State Unit on Aging encourages every attempt to include the key nutrients and recommendations that influence chronic disease and the health of older Oregonians when developing menus for the senior nutrition programs. Oregon SUA also acknowledges that a number of variables affect the ability to fulfill all nutrient requirements.

Each meal served by the Older Americans Act funded nutrition services provider must meet the current USDA/HHS Dietary Guidelines and must contain at least 33⅓ percent of the current Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Academy of Science-National Research Council.

Special needs of the elderly must be considered in menu planning. To help ensure that menus will address the nutritional needs of the elderly, menu planning should be designed to:

1. Include a variety of foods, especially fruits, vegetables and whole grains.
2. Avoid too much total fat, saturated fat, trans fat and cholesterol. Encourage mono and poly unsaturated fats.
3. Include foods with adequate complex carbohydrates and fiber
4. Avoid too much refined carbohydrates and added sugars
5. Avoid too much sodium by using salt free herbs and spices, cooking from scratch and using less processed and manufactured foods

A Registered Dietitian must certify and sign that each meal will meet 1/3 of the Dietary Reference Intakes. Culturally specific meal contractors will work with a Multnomah County dietitian selected by ADVSD to certify culturally specific meals and sign off on menus per the OAA nutrition standards.

1. Each meal certified as having met the nutrient requirements should be served as written
2. Food substitutions should be infrequent or similar nutritional value, not reduce or radically alter the nutritional content and consultation and approval by a Registered Dietitian shall be sought.
3. Any departure from the certified menu must be documented and initialed on the nutrition providers official file copy of the menu and/or nutrient analysis form and kept on file for three years.

NUTRITION EDUCATION

Nutrition Education, as defined by the Administration on Aging, is "[a] program to promote better health by providing accurate and culturally sensitive 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 dietitian or individual of comparable expertise."*

To be effective, programs must incorporate methods to encourage behavior change. To do so, nutrition education must be provided on a continuous basis to OAA Nutrition Program participants.

- Each congregate meal nutrition site shall provide nutrition education at a minimum of quarterly.
- Home delivered meals shall provide nutrition education a minimum of one time per year. Nutrition education is required at the first nutrition risk assessment. Local nutrition service providers may determine subsequent yearly nutrition education.

Nutrition Education has to go beyond providing information alone. Distributing newsletters or brochures that contain nutrition information from a trusted source do not constitute nutrition education unless some form of instruction to a group or individual accompanies them. Instruction is defined as imparting knowledge or information.

- In a congregate setting, this may include reviewing main concepts of nutrition education materials prior to the meal.
- In a home setting, this may include reviewing educational materials that relate to the annual nutrition risk assessment or other relevant nutrition education topics with a homebound participant.

Nutrition Education shall be planned and directed by a licensed dietitian who is covered by liability insurance. Under the direction of the dietitian, individuals with comparable expertise or

special training i.e. Cooperative Extension agents or trained Meal Site Coordinators, may provide such activities. An individual with comparable expertise is defined as a person who has a Bachelor's or Master's degree in Home Economics, Family and Consumer Sciences, Public Health Nutrition, Health Education or Human Sciences with an emphasis in Nutrition and Dietetics. The State Unit on Aging Nutrition webpage: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Nutrition-Program.aspx has materials reviewed by the State Unit on Aging dietitian. Their expertise and credentials fulfill the part of the definition related to being overseen by a dietitian.

Nutrition education topics will be based on the needs of the participants and should be culturally appropriate. Teaching methods and instructional materials must accommodate the older adult learners, i.e. large print handouts, demonstrations.

REPORTING REQUIREMENTS FOR NUTRITION SERVICES

CONGREGATE AND HOME-DELIVERED MEALS

Contractor shall record and report the following participant information each month:

1. Name
2. Prime or organization id#
3. Date and score of nutrition assessment
4. # meals this month
5. The program under which the meals were authorized, when required by ADVSD,

Contractor shall:

1. Send this information securely to ADVSD in a mutually agreed upon format; or
2. Provide ADVSD with access to Contractors database to extract this information.

NUTRITION EDUCATION

Contractor shall provide a quarterly report to ADSVD with the following information:

1. Date and location of presentation
2. Name and title of presenter
3. Topic Discussed
4. Client/attendee information (name, prime or organization id#)

PROGRAM OUTCOME INFORMATION

Contractor will provide requested data to ADVSD and will work with ADVSD to measure these outcomes:

1. High nutritional risk HDM participants will have a lowered nutritional risk at annual assessment.

2. Nutrition providers serve as a referral point for other ADVSD services. Consumers receiving nutrition services will have an increased use of other registered ADVSD services.
3. Consumers report being satisfied or very satisfied with nutrition services.

Payment Terms

Service Unit Definition: (one unit = one meal) a meal provided to a qualified individual in a congregate or group setting or provided to a qualified individual in their place of residence. The meal, as served, meets all of the requirements of the Older Americans Act and state and local laws.

- Congregate and Home Delivered Meals will be paid on a fee-for-service basis at meal (unit) rates approved by ADVSD.
    - Unit rates may be different for breakfast, lunch, or dinner.
- A portion of the funding for each meal will come from federal Nutrition Services Incentive Program (NSIP) funds that can only be used to purchase food.
- Contractor shall collect voluntary donations from participants as described in the Service Standards above. Please note: This applies to meals provided under the Older Americans Act, and may not apply to all programs as ADVSD works with other funders who may disallow participant donations.
    - Contractor shall establish appropriate collection, follow-up, and accounting mechanisms for voluntary donations.
    - Contractor shall report these funds as program income and deduct the amount collected from the amount billed ADVSD each month.

Quality Assurance for Nutrition Services

Monthly reporting requirements	Compliance Measures	Target	Source
Consumer names and number of meals for each participant Initial/Annual assessments completed Nutrition education provided for Quarterly for Congregate, annually for HDM	Annual nutrition assessment	TBD	Contract or data
	# of meals		
	Customer satisfaction PEP	TBD	TBD

ATTACHMENT A: ADVSD COMMUNITY SERVICES ANNUAL BUDGET

Community Services for Older Adults	**$ 2,293,708**
Evidence-Based Health Promotion	**$ 88,459**
Nutrition Services	**$ 1,907,601**
Annual Total	**$ 4,289,768**

BUDGET DETAIL

Service Categories	**FY 18 Budget**
Community Focal Point for Older Adults*	$ 458,742
Information & Referral**	$ 344,979
Case Management & Related Services	
Options Counseling	$ 423,358
OAA Case Management	$ 512,624
OPI Case Management	$ 428,296
Family Caregiver Services	$ 125,709
Community Services for Older Adults Total	**$ 2,293,708**
Evidence-Based Health Promotion	**$ 62,000**
Congregate Meals	$ 1,001,491
Home Delivered Meals	$ 906,110
Nutrition Services Total	**$ 1,907,601**

**Beginning in FY 18, Focal Point funding will be equivalent to 20% of total Community Services for Older Adults budget*

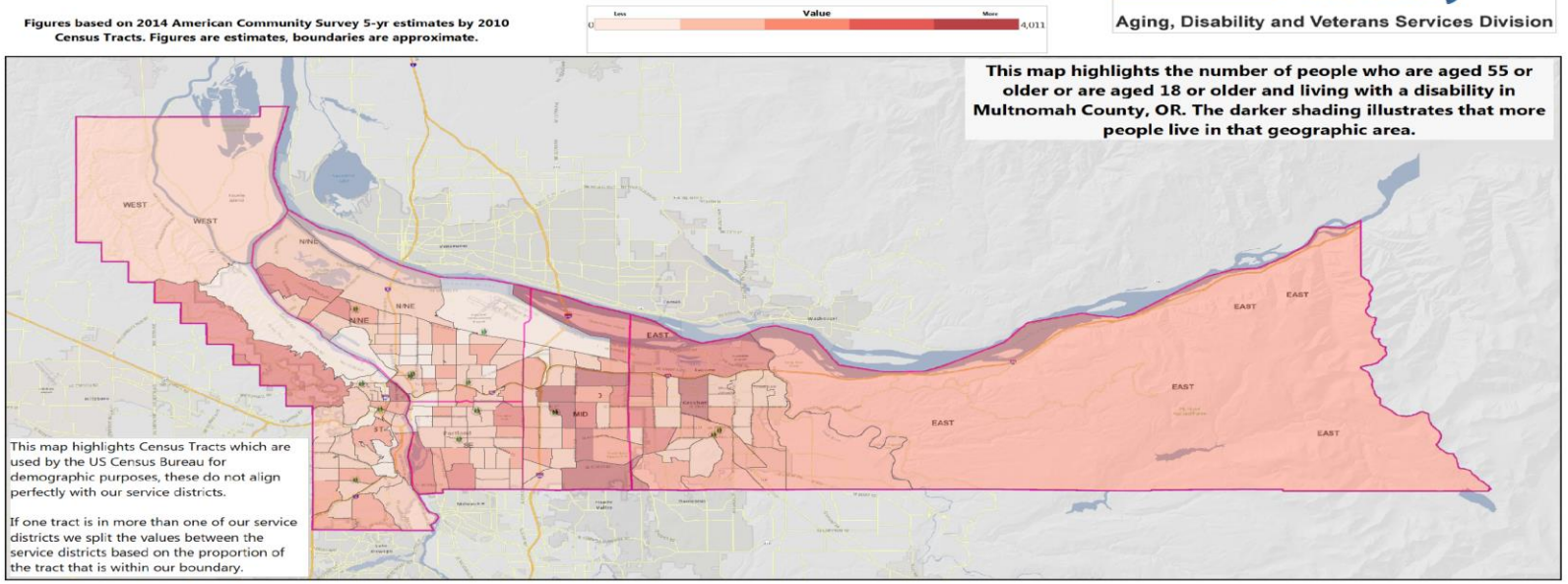
***Includes Transportation Scheduling & Coordination*

ATTACHMENT B: DEMOGRAPHICS OF 55+ POPULATION IN MULTNOMAH COUNTY

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%

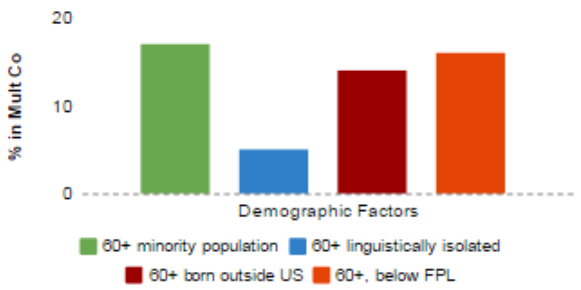
Multnomah County

Aging, Disability & Veterans Services (ADVSD)
Community Services Programming Equity and Funding Allocation

As people age and/or are experiencing chronic health conditions, there is a compounding effect on minority communities that contributes to disparities in health, income, safety, and access and utilization of resources.
ADVSD is focusing on the needs of communities of color and other minority groups by leveraging resources with the goal of creating equitable, culturally specific services.

Since 2010 the population in Mult Co age 60-74 grew 29.41% and our 85+ population grew 5.9%.
ADVSD sought community and client participation to examine the existing allocation as we plan for the May 2017 release of our ADVSD Community Services Request for Proposal (RFP).
Our programs are comprised of Federal, State and local programming, including Older Americans Act (OAA), OPI, Evidence Based Health, Family Caregiver support and an array of community based programs.

Factors that drove us to examine current funding allocation



We hear what you have to say!

PSU Client Satisfaction Survey

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.

Community Listening Sessions

Racial, ethnic and cultural minority elders are less likely to have awareness or access services.

Contractor Feedback Groups

Contractors want program design to be based on aging.

The culturally specific service providers want to provide a broader range of services to their communities.

Equity and Allocations Workgroup

Funding recommendation: 38.5% culturally specific & 61.5% culturally responsive. Recommend to provide technical assistance and training prior to RFP release.

Recommended Funding Allocation

ADVSD recommends 38% of funding be directed to culturally specific providers and 62% to culturally responsive providers. (Our current allocation is 10% and 90%, respectively.) The intent behind the shift is to have better outcomes for older adults from racial, ethnic, and cultural minority groups - consistent with our values of equity, empowerment, and inclusion and responsive to community identified needs.

updated 10/31/16

ATTACHMENT D: ADMINISTRATIVE REQUIREMENTS SUMMARY OF SERVICES

Service	Training/ certification requirements	Required meetings	Unit for payment	Data recording & Monthly reporting requirements	Data Collection Tools & Technology
Community Focal Point for Older Adults (includes Recreation, Volunteer Services, Reassurance, FCGS support groups)		partner meetings	Monthly allocation	Depends on type of service: Generally minimum is list of activities with -Unduplicated client count (estimate) -# units (unit=1 session per participant) OR # & dates of events (for Outreach)	Reported in Excel
Information & Referral (I & R)	Alliance of Information & Referral Systems (AIRS) certification within one year. Preference: Aging/Disabilities designation http://www.airs.org/i4a/pages/index.cfm?pageID=3309	Quarterly ADVSD I & R meetings Monthly ADRC database training meetings hosted by Multnomah County Resource Specialist	Unit = 1 Call* * Call = Referral or Assistance call Rate for Info-only calls is ½ I & R rate	Demographic data & service data per AIRS standards Completed within 3 days* Monthly report of # of Calls: - Information - Assistance - Referral (per AIRS definitions)	ADRC (RTZ) database Call Module Technology Expectation for Contractor: I & R specialist will have access to computer (ideally with two monitors), consistent internet connection, telephone with reliable call quality & ability to transfer and conference calls, as well as a headset allowing for hands free call taking.

Service	Training or certification	Required meetings	Unit for payment	Data recording & Monthly reporting requirements	Data Collection Tools & Technology
Senior Health Insurance Benefits Assistance (SHIBA) Screening & Scheduling	Done by I & R staff (see above) ADVSD SHIBA staff provides training to contractors I & R staff.	See I & R	Unit = Appointment scheduled SHIBA appointment = ½ I & R rate	Included in Information calls	- Oregon Access to screen participants - ADRC (RTZ) database Call module to record calls
Transportation Scheduling & Coordination	ADVSD staff provide training	Monthly ADVSD Transportation meetings	Monthly Allocation	Client info entered in UCR: Rides authorized; Tickets or pass provided; Demographic & assessment data*	Web-based UCR + Oregon Access to determine Medicaid status
Case Management (CM) & Related Services OAA CM FCGS CM	Basic CM skills & knowledge; cultural responsiveness; State Oregon Access training	Quarterly ADVSD Case Manager/Options Counselor meetings	Unit = 1 hour of Case Manager's time, billed in 15-minute increments	Demographic data, assessment/enrollment ,narration for contact/activity, on-going service data entered into Oregon Access within 3 business days Monthly by program type: Case Mgr & # hours for each client	Oregon Access plus State Mainframe for HCW Voucher payment process
Oregon Project Independence CM	Training provided by ADVSD + SUA: 2-day for CMs +1-day for CM Supervisors; HCW Voucher processors training by State DHS and/or ADVSD				

Service	Training/ certification requirements	Required meetings	Unit for payment	Data Recording & Monthly reporting requirements	Data Collection Tools & Technology
Options Counseling	State training series of 3 trainings	Same as CM	Same as CM	Demographic & service data entered within 3 days Monthly for each client: # units, Options Counselor, encounter dates	ADRC (RTZ) database Care Tool
Family Caregiver Support program		Same as CM	Training Unit = 1 hr (billed under CM)	Activities reported under Focal Point	Oregon Access
Star Caregiver	Star CG: Certification by University of Washington				
FCGS support groups	Peer support	n/a	Part of Focal Point	Activities reported under Focal Point	Reported in Excel
Evidence Based Health Promotion (EBHP)	Varies by program – see "Description of Programs and Requirements: Evidence Based Health Promotion"	Quarterly "EBHP network" meetings"	Unit = 1 full program completed	Client demographic data and participation dates; other data depending on the program	Oregon Access and Compass Portal Data Base

Service	Training/ certification requirements	Required meetings	Unit for payment	Monthly reporting requirements	Database
Congregate Meals **Home Delivered Meals**	Menus must meet OAA nutrition standards and be approved by certified dietician	ADVSD contractor meetings	Unit = 1 meal	Demographic data - Consumer names and number of meals for each participant - Initial/Annual nutritional risk assessments completed and scores reported -Nutrition education provided: Quarterly for Congregate meals Annually for Home Delivered meals	TBD - current contractors give ADVSD Data Analyst access to contractor database or provide info in Excel spreadsheet