Multnomah County
FY 2026 Budget Work Session Follow Up

Department of County Human Services

May 22, 2025

Commissioner Singleton (District 2) - Please provide the demographics for your CBAC members.

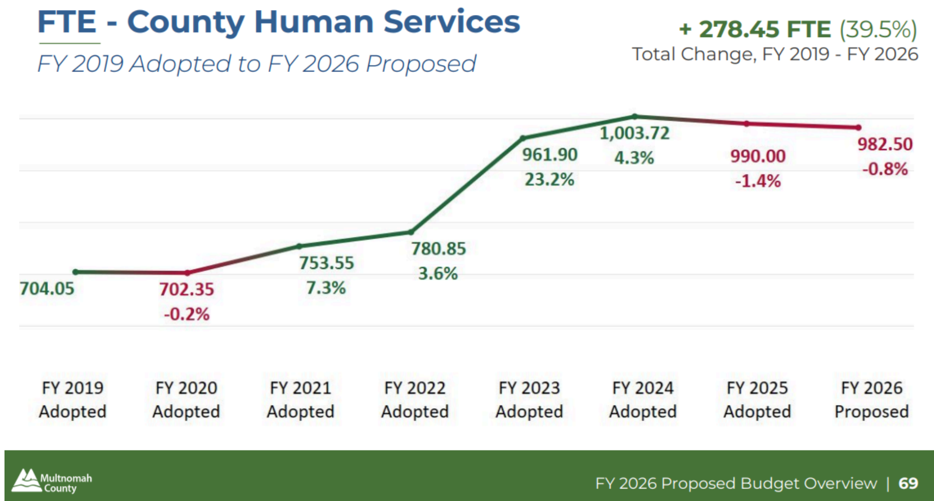
Response:

Four of the five DCHS CBAC members responded to our demographic information request. Below are the results of our survey:

- Two CBAC members live in District 1, one lives in District 2, and one lives in District 4.
- Three CBAC members are aged 65-74 and one is 35-44.
- Three CBAC members identify as white, and one identifies as Hispanic or Latino.

- All four surveyed CBAC members speak English.
- None of the four CBAC members surveyed identify as a person with a disability.
- Three CBAC members identify as female, and one identifies as male.
- Three CBAC members identify as heterosexual, and one identifies as bisexual.
- Two CBAC members have a total household income of $90,000 to $199,999, and two CBAC members have a household income of over $200,000.
- Three CBAC members have a household size of two, and one has a household size of three.
- All four CBAC members own the place where they live.

Commissioner Brim-Edwards (District 3) - Provide the highlights of why DCHS's FTE increased over time.



Response:

The vast majority of the FTE increase for DCHS over the last several years actually happened mid-year FY 2022. There was a supplemental budget action as part of a state funding rebalance process that added 112.00 FTE that year. This was due primarily to a change in the State's caseload modeling toward the middle of the 2021-2023 biennium, adding additional Medicaid revenue to both the IDDSD and ADVSD division. That higher level funding continued into the 2023-2025 biennium, which is why the department's FTE has been largely stable for the last few years.

Additionally, the FY 2022 budget was the first time the Preschool & Early Learning Division had FTE. It has grown from 21.00 FTE in that year up to 54.00 FTE in the proposed FY 2026 budget.

Supportive Housing funded positions first appeared in the department's FY 2023 budget at 10.50 FTE. There are now 12.50 FTE in the proposed FY 2026 budget. This is down from 20.50 FTE in the prior year.

Positions in the County General Fund have also decreased from a high of 178.82 in FY 2024, down to 166.20 in FY 2026. Much of this change is due to an 8.00 FTE reduction in the Administration Division as part of the FY 2025 budget.

Commissioner Moyer (District 1) - How will the State of the Children report be different from the Oregon KIDS Count data?
Response:

The State of the County's Children report will focus on how the county specifically supports children by engaging a variety of partners to compile and review data to better understand the needs of kids and their families in Multnomah County and how our programs are delivering in this area.

The findings in this report will assist the county in refining its approach and identifying priority areas to ensure county investments are targeted and making substantial impacts in the priority areas identified in the report. We will build on the Oregon Kids Count report to do a deeper dive to better understand the root causes and priority populations and how our programs can increase their impact.

Commissioner Brim-Edwards (District 3) - Why is the Newly Arrived Families program budgeted in the Administration Division?

Administration: How the Budget Delivers

Newly Arrived Families: Emergency housing for **110 families** and housing navigation for at least **30 households**.

ESF-6: Emergency Support Function #6, Mass Care Shelter, will respond to declared emergencies and provide **life-sustaining resources and shelter** without turning anyone away.

State of the Children Report: **Research and provide** a comprehensive report on children in Multnomah County that will inform investments in future programming. This will ensure all children have the support and services needed to thrive.

Employer of Choice: Continue responding to employee feedback and implementing workforce equity to build on the positive results in the most recent surveys and audits.

FY 2026 Approved Budget | 19

Response:

DCHS was asked to step in to provide support for this community last year. This was a pilot program that required high level coordination with the governor's office, the Port of Portland, and community based providers. We often run pilot programs out of the Director's Office to monitor implementation, outputs, and outcomes in close proximity. This program will remain in the Director's Office this year due to the complex nature and intersection with federal policies that require the Department Director to be close to the decision making for the program and services provided. If programs become ongoing, they will be embedded in the Division.

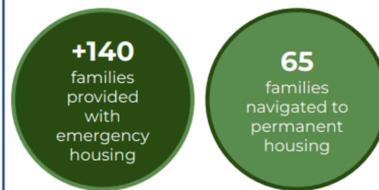
Commissioner Brim-Edwards (District 3) - How many newly arrived families will the total program serve? And how many will be served with Severe Weather. In previous years, were you able to serve everyone who needed services?

Administration: Outcome Statements

Ensuring high-quality program delivery

Severe Weather Shelters (ESF-6)

Newly Arrived Families



FY 2025

FY 2026 Approved Budget | 21

Response:

A. How many newly arrived families were there, versus how many did we serve?

This is a complicated question. Families arrive through many different access points. We created a process with the Port of Portland for families arriving at the airport. Families call the Portland Immigrant Rights Coalition (PIRC) call line and they are connected to the Asylum Seekers Solidarity Collective (ASSC) who managed the waitlist and placement process for The Newly Arrived Families emergency shelter. During the fall of 2025, we did have a waitlist for the emergency shelter, but we were able to create capacity through transitioning families to the family shelter system or into permanent housing and we now do not have a waitlist.

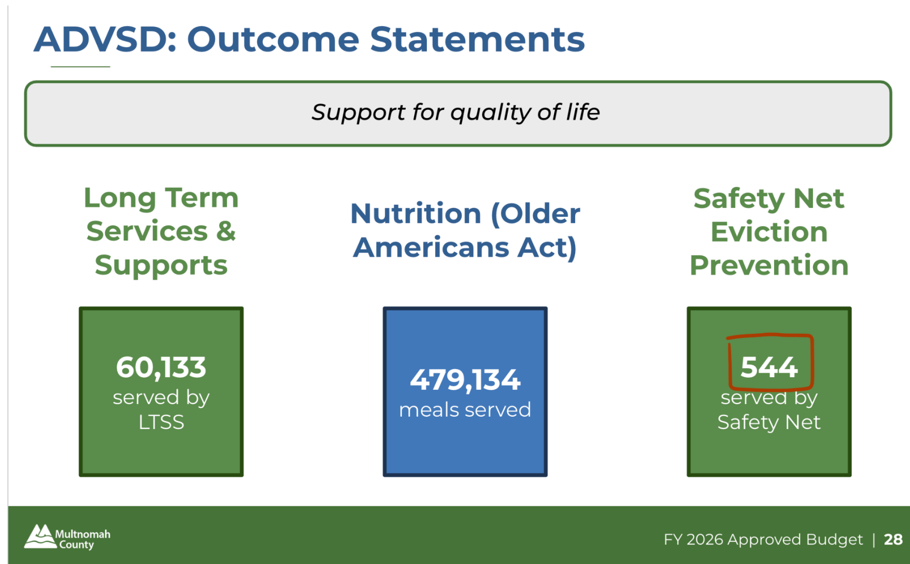
This program is primarily serving Venezuelan families as those are the families who have contacted the PIRC line. Families from other countries of origin are often reaching out directly to some of the other organizations (Afghan Support Network, Catholic Charities, Pacific NW Refugee Support Group…etc).

It is difficult to assess the number of families who are in Multnomah County due to the complex nature of their immigration status, different points and methods of arrival, and the different processes families are navigating to seek Asylum.

B. And how many will be served with Severe Weather. In previous years, were you able to serve everyone who needed services? *(Slide 21)*

The number of people served changes from year to year and depends on the severity of each weather event, how long it lasts, whether we stay open 24 hours per day and the number of days activated in a season. The severe weather shelters have not turned anyone away. DCHS has a 24-hour support service (ESF-6 Lead) call line. This line is for Person In Charge positions to reach out if we are nearing capacity. If this occurs, the ESF-6 Lead on shift will contact the Deputy Director of DCHS who then notifies the Unified Command and they assess the situation and create plans to create additional space if necessary. We monitor daily use during an activation and expand throughout an activation to respond to the need. DCHS ESF-6 team leads a planning assumption process in partnership with MCEM and HSD and the Health Department to look at trends, locations, forecasts and other factors to determine a capacity plan for each season and adjust that based on specific activations.

Commissioner Singleton (District 2) - Are the eviction prevention numbers for households or people? What are the retention rates?



Response:

- We misstated in the budget presentation it is actually 544 households served and that includes 598 applicants and co-applicants. This number does not include children, so we don't have the full number of people in the households because we don't currently track that.
- We do not currently track retention rates. There are currently two employees that serve clients in this program and their time is 100% dedicated to intakes. We will look at capacity and ways to track this information in FY 2026
- Housing Plans: The Safety Net program case managers work with consumers to make sure that the consumer has a plan to continue to remain in their present housing after the one time financial assistance is provided. ADRC staff also ask the question -"If you get help this month, would you be able to continue paying rent/utilities after?" If the consumer does not have a plan, the SN CMs provide complex case management

assistance with connecting this consumer with other resources. This approach, the intensive case management, allows the SN program to use resources to support consumers who will remain housed with only one time funding assistance. And also allows to support consumers who might be losing housing as they are not able to continue paying for rent/utilities.

Commissioner Singleton (District 2) - What services are the Community Based Organizations providing?

Response:

The full list of CBOs and services that are offered can be found in the appendix.

Terms/Definitions:	Color Code: Culturally Specific/Enhancing Equity (EE) Providers	EE= Enhancing Equity	DC= District Center									
Contractor	**Type of contract**	**Case Management for Family Caregiver**	**Case Management - Older American Act**	**Case Management-Oregon Project Independence program**	**Focal Point: recreation, volunteer recruitment and services**	**Evidence Based Health Promotion**	**Home Delivered Meals**	**Congregate Meals**	**Information, Referral & Assistance**	**Options Counseling**	**Transportation: Scheduling and Coordination**	**Transportation Services**
ASIAN HEALTH & SERVICE CENTER	EE and Nutrition	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	
Cascade AIDS Project	EE				Yes							
ECUMENICAL MINISTRIES OF OREGON	Nutrition						Yes					
EL PROGRAMA HISPANO CATOLICO	EE and Nutrition	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes	
Filipino Bayanihan Center	EE				Yes				Yes			
Friendly House (includes Elder Pride)	DC and EE	Yes	Yes	Yes	Yes				Yes	Yes	Yes	
HOLLYWOOD SENIOR CENTER - Center for Positive Aging	DC	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	
IMMIGRANT & REFUGEE COMMUNITY ORG IRCO	DC, EE, and Nutrition	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	
IMPACT NW	DC	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	
Legal Aid of Oregon	Legal Services											
MEALS ON WHEELS PEOPLE INC	Nutrition						Yes	Yes				
NATIVE AMERICAN REHABILITATION ASSOCIATION OF THE NORTHWEST INC	EE		Yes		Yes							
NATIVE AMERICAN YOUTH & FAMILY CENTER	EE		Yes		Yes	Yes		Yes		Yes		
RADIO CAB	Transportation											Yes
RIDE CONNECTION	Transportation											Yes
Somali-American Council of Oregon (SACOO)	EBHP					Yes						
Stone Soup PDX	Nutrition							Yes				
TRIMET	Transportation											Yes
URBAN LEAGUE OF PORTLAND	EE	Yes	Yes	Yes	Yes				Yes	Yes		
YWCA	DC	Yes	Yes	Yes	Yes				Yes	Yes	Yes	

In addition, there is an appendix that provides a comprehensive description of services to be provided under Community Services for Older Adults contracts January 2024-December 2028.

Homeless Mobile Intake team - how do we reimagine this? How do we make sure that our services are provided for housed and unhoused? What is the total FTE for eligibility and intake?

Response:

What makes this program successful?

HMIT is a unique resource that combines expertise in homeless outreach and the ability to determine eligibility for Long Term Services and Supports to eliminate barriers that frequently prevent people living on the streets from accessing the services they need.

This cross-functional team is able to serve homeless individuals where they are, without the need of additional referrals and steps to follow. HMIT staff includes bicultural and bilingual case managers, and staff with lived experience of homelessness. People who are found eligible for Long Term Services and Supports (LTSS) can be housed using Medicaid resources and obtain long term case management services through LTSS.

How do we ensure our services are provided for housed and unhoused?

We ensure that we are serving housed and unhoused people by reaching out to shelters and places in the community where we can locate people who need housing, as well as assist people in staying

housed by providing resources, including client assistance funding when necessary.

In terms of envisioning the future of the HMIT, we would like to continue to serve this population that has historically been very difficult to reach.
Serving this unique population requires us to find creative ways to house and keep people housed. Some of the ways that we have done this include:

- Soundproofing an apartment so the neighbors were not bothered by noise at night.
- Purchasing clean linens and clothes when people move into care facilities to replace old or soiled clothes.
- Purchasing 'smoke eater' air purifiers so clients can smoke outside their new home under covered porches and out of the rain.

We also envision continuing partnerships with Painted Horse Recovery, JAMI center/Urban League, and we will have a presence at the new East County Day Center once built.

What is the total FTE for eligibility and intake?

Typically, LTSS intake and eligibility happens on two separate but concurrent tracks: Financial eligibility is determined by an eligibility case manager and service eligibility is determined by a service case manager.

HMIT case managers navigate both of these processes at the same time, and have access to both systems. This, combined with the HMIT's specialization in serving unhoused people, simplifies and

expedites the eligibility process for HMIT referrals and reduces the risk that clients could not be located during the process

HMIT is also not held to the same timelines required by the State. Serving these clients with Medicaid puts ADVSD at risk because the complexity of the cases makes it very difficult to meet intake and timeline requirements.

HMIT's total FTE for eligibility and intake are 4.00 FTE (Case Manager Senior positions) and 1.00 FTE (Case Manager Assistant)

The total LTSS Case Manager intake and eligibility FY 2026 position count is as follows:

Position	Hospital Grants	Metro Supportive Housing Services	Providence Med Ctr	TITLE XIX	Grand Total
Case Manager 1				84	84
Case Manager 2		1		112	113
Case Manager Senior	4	4	1	29	38
Grand Total	4	5	1	225	235

- Case Manager 1 positions are responsible for determining financial eligibility (initial and ongoing) for State and Federal benefit programs, including Medicaid long-term care, SNAP, and more.
- Case Manager 2 positions are responsible for determining ongoing service eligibility for Medicaid long-term care and developing person-centered case management and service planning.
- Case Manager Senior positions are responsible for determining initial functional eligibility (intake) for Medicaid long-term care and service planning.

LTSS is in the process of completing an Alignment Project - adapting its roles to better align with state systems and to manage workloads,

case loads, and wait times for consumers. All CM2 and CM Senior positions will work on long-term care intakes and ongoing case management, rather than separate teams working on each task.

Commissioner Jones-Dixon (District 4) - Who does the HMIT team work with in East County?

Response:

The HMIT program is building relationships with the homeless services outreach program at the city of Gresham and has a meeting set next month with their homeless services outreach manager.

ADVSD works with all East County homeless providers. Approximately 22% of referrals come from East County.

The team takes referrals from the WyEast shelter, Gresham Women's shelter as well as the Blackburn medical center. We are building

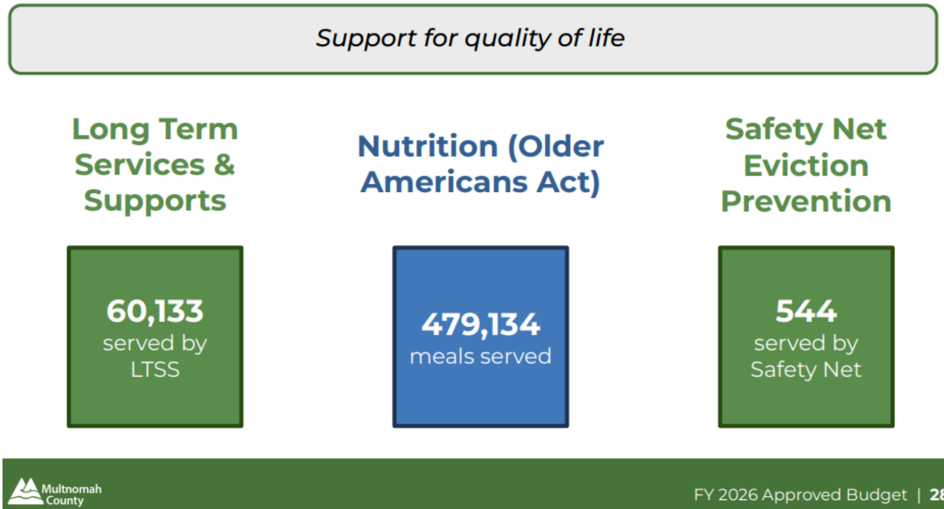
relationships with the East County Homelessness Resource Center and will take referrals as they are operational.

The Homeless Mobile Intake Team (HMIT) is different from other homeless outreach services because we have the ability to do Medicaid assessments for long term care, assist with long term places, SNAP benefits and other Medicaid services.

The HMIT works with the Homeless Services Department by coordinating with case staffing, referring to Coordinated access and by taking referrals from their contracted providers.

If the HMIT team is operational in the future we will continue to grow and build relationships with East County providers with a focus on culturally specific organizations. HMIT has a diverse team who are bilingual and bicultural and have lived experience and are well suited to serve the diverse homeless population in Multnomah County.

Commissioner Brim-Edwards (District 3) - Why is there a reduction in the program for nutrition (meal) services for older adults?



Response:

For FY 2025 and FY 2026, our target is lower than FY 2024 due to three factors:

1) Over the past few years, food prices and delivery costs have increased.
2) We increased the reimbursement rate for meals mid-way through FY 2024 and also brought on a new provider to serve the homeless community.
3) Due to the Older Americans Act (OAA) ARP funding going away and a decrease in state OAA funding, there was a decrease in Nutrition program funding from FY 2025 to FY 2026.

Question 1: Could we please receive the target number of meals served for Fiscal Years 2024, 2025 and 2026 and the Actuals for Fiscal Years 2024 and 2025.

Answer:

- FY 2024 Program Offer Target: 450,000 meals
- FY 2024 Actual: 479,134 meals
- FY 2025 Program Offer Target: 360,000 meals
- FY 2025 Actuals (through Q3): 339,921 meals (we expect to serve 452,270 in FY 2025)
- FY 2026 Program Offer Target: 360,000 meals

Question 2) How much additionally to the proposed budget would it cost to budget for 460,000 meals?

Answer:

The additional cost for bringing the meal distribution count up to 460,000 meals in FY 2026 would be $269,012

- In FY 2025 and FY 2026, for the program offer targets, we were conservative in our estimate based on meal costs going up. When we did a deeper dive, we realized that our providers have been able to serve more meals than we expected.
- For FY 2025, our program offer target is 360,000 and we are expecting to serve 452,270 meals.
- For FY 2026, our program offer target is 360,000 and we think that we can serve approximately 444,483 meals
- The reason that we are able to serve more meals than we expected is because the meal costs have not been as high as expected.
- In order to stay at the FY 2025 number of meals served in FY 2026 (452,270), we would need $135,012 (this is the amount of reduction in nutrition pass through funding to contractors in FY 2026)
    - 59% to culturally responsive providers: $79,657

    - 41% to culturally specific providers: $55,355
- In order to increase by 7,730 meals in FY 2026 (to bring meals up to 460,000), we would need an additional $134,000
    - 59% to culturally responsive providers: 5,717 meals at $13.83 / meal (home delivered) - $79,060
    - 41% to culturally specific providers: 2,013 meals at $27.30 / meal (congregate) - $54,940

Additional information: changes in CBO funding over the years

- Funding to CBOs has dropped significantly over the years due to OAA ARP funding going away, and this has impacted all providers over the past five years.
- Also to note: In the second half of FY 2024, we increased the meal reimbursement rate for providers but did not increase their allocations enough to support the increase in need

Commissioner Brim-Edwards (District 3) - What happens to the ~6,000+ intakes that don't result in an abuse investigation?

ADVSD: How the Budget Delivers

Eligibility and Intake: Long Term Services and Supports (LTSS) will serve more than **60,000** people in FY 2026, and the Aging and Disability Resource Connection will answer more than **60,000** contacts and make more than **44,000** referrals to county and community resources.

Case Management: Community Services contractors will serve **2,400** people in case management or in-home services, and **800** people will be served by culturally specific providers. LTSS will provide case management to **12,000** individuals in long term care in FY 2026.

Abuse Investigation: Adult Protective Services will have **9,800** intakes and complete **3,000** investigations.

Veterans Services: Veterans Service Officers will bring in **$3.7M** for Veterans in FY 2026 in retroactive benefits.

FY 2026 Approved Budget | **23**

Response:

The number of intakes is related to all calls/reports made to APS. Intakes that meet the definition of abuse, neglect or self neglect, as defined by OAR 411-020-0002 become investigations. These intakes are assigned to an abuse investigator within Adult Protective Services.

Cases may not be assigned for investigation for a variety of reasons. Calls may be:

- For an APS program in another state
- For another APS program/county in the State of Oregon
- For another APS program in Multnomah County (I/DD or Behavioral Health)
- A licensing complaint/concern, rather than a report of abuse
- A report that does not meet the definition of abuse, neglect or self neglect.

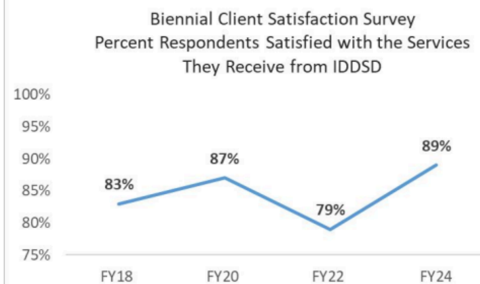
APS screeners often provide information and referral or consultation to the caller in an effort to connect them with the program or organization that can best address their concern if it is outside of the scope of our program.

Multnomah County's Adult Protective Services program has a no wrong door approach to callers. We accept, track and document all calls to our program. We clearly identify what resources were provided to the caller in the Centralized Abuse Management database.

Commissioner Singleton (District 2) - What is our response rate for surveys in comparison to total numbers served?

IDDSD: Outcome Statements

Support for quality of life – clients and families are satisfied with the services they receive from Multnomah County IDDSD



FY 2026 Approved Budget | 32

Response:

The response rate can only be calculated using the number of clients who actually received the survey at the time we sent the survey, not the total number served at the end of that same fiscal year.

Every time we send out the survey, there are many surveys that are returned due to insufficient address. The denominator is the total number of clients at the time the survey was sent out, minus the number of surveys returned due to insufficient address: that is our total who received the survey. The response rate is calculated by taking the number of responses and dividing it by the number who received the survey.

In 2024, we sent the survey to a representative sample of clients, not the entire client population. The numbers are a bit smaller, but we still see the response rate go down in 2024.

2018 = 704 / (4,133 - 348) = 19%

2020 = 803 / (4,514 - 490) = 20%

2022 = 603 / (5,004 - 332) = 13%

2024 = 338 / (3,524 - 173) = 10%

Commissioner Brim-Edwards (District 3) - Can you provide a breakdown of the outcomes for the IDD abuse investigations?

IDDSD: How the Budget Delivers

Eligibility & Intake: Ensures clients are enrolled in services and meet diagnosis requirements. Processes over **1,340 eligibility referrals** annually.

Plan of Care: Conducts background checks and processes **21,000 timesheets** annually for Personal Support Workers (PSWs). Builds service plans for clients.

Case Management (Adult, Young Adult, Children, Coverage): Provides lifelong case management and facilitates access to attendant care, transportation, community inclusion, housing, and employment services for **6,011 clients**.

Abuse Investigation: Screens **2,000 reports of abuse** annually, ensures protected services, conducts abuse investigations, and completes death reviews.

Multnomah County   FY 2026 Approved Budget | **30**

Response:

- **Abuse Investigation:** Screens **2,000 reports of abuse** annually, ensures protected services, conducts abuse investigations, and completes death reviews.
  - Less than 20% of screenings are opened for investigation.
  - Death reviews are required for all clients 18 and older who pass away. There are no concerns for abuse & neglect for the vast majority. Many are older individuals or individuals with acute medical conditions.
    - FY 2024/25 opened 435 investigations and 82 death reviews
    - FY 2023/24 opened 367 investigations and 82 death reviews
    - FY 2022/23 opened 345 investigations and 62 death reviews

Commissioner Brim-Edwards (District 3) - Can you break out the 2,779 (people/households) supported with housing/economic stability by the type of support?

YFS: Outcome Statements

Improving quality of life for consumers at every stage of life by providing intentional services and advocacy

Domestic & Sexual Violence Coordination Office

4,649 survivors received deeper navigation & support

2,354 restraining orders supported

575 served in response to law enforcement pages

2,779 supported with housing/ economic stability

237 received mental health & addiction counseling

Bienestar de la Familia

Data is from FY24

FY 2026 Approved Budget | 39

Response:

Bienestar de la Familia is a County-staffed program that promotes the wellbeing of families through services that help increase housing retention and economic stability. The program also promotes self-efficacy, prosperity, and success. Bienestar is the Direct Service Provider within Youth and Family Services that provides rent assistance and other client services.

2,779 households were served with Housing Stability and Eviction Prevention services at Bienestar in FY 2024. This includes:

- Imminent eviction prevention (emergency rent assistance and case management focused on crisis support, application completion, landlord negotiation and resource brokering).
- Housing stability programs (short-term rent assistance with case management) to prevent homelessness – including the Economic Recovery program which is case management for up to 12 months with client assistance resources.
- The focus of these ongoing Bienestar programs is to keep families stable in their housing. In some circumstances, a family needs help moving to a new place.

In FY 2025, Bienestar has also played a large role in supporting the Newcomer Support Service Pilot by working with the program to secure housing. This includes housing search, placement, and rent assistance.

Bienestar also provides food security resources, mental health & addiction services, youth services, and community education.

Commissioner Singleton (District 2) - Can you provide a breakout and explanation of the services provided in the SUN Continuum and the budget that supports them?

Response:

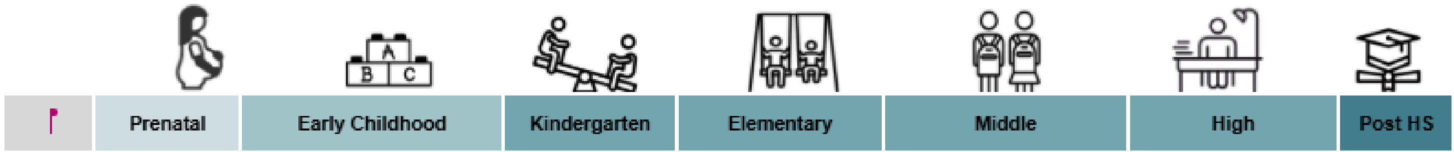
The SUN Service System is an aligned system of care that provides support for children, youth and families along a continuum of ages and needs.

SUN Service System programs, including SUN Community Schools, SUN Youth Advocacy, and Successful Families, are aligned and support families from infancy through high school graduation. Parent Child Development Services prepares preschool-aged children for school, after which they can join SUN Community Schools. As children progress to middle and high school, they can access after-school activities and individual support from SUN Youth Advocates or Successful Families to facilitate graduation.

The visuals below (which link to a full document for better visibility), show how the programs work together within the SUN Service System and meet needs for children, youth and families to support educational success and family stability.

SUN Service System Visual: Service Continuum with Details

The SUN Service System - an aligned system of supports for children and families across their life span



Prenatal	Early Childhood	Kindergarten	Elementary	Middle	High	Post HS

SUN Community Schools - 25145
Provide and integrate supports to meet basic needs, offer after school and summer programs, and engage families. Services below are linked to SUN Community Schools - either offered at SUN CS sites or through system connections.

Prenatal - 3rd Grade- 25152
Diverse parent centered family engagement to welcome families into their neighborhood schools and support kindergarten transition. They do not do one on one supports

SUN Youth Advocacy - 25149
Fosters youth social, emotional and professional development and academic achievement by providing a variety of year-round, school-linked age-appropriate support to children and youth who are at risk of facing academic challenges and disconnection from school.

Parent Child Development Services - 25151
Provides culturally specific child development services and one on one support with families. Support with appointments to developmental screenings, vaccinations & health check ups for kids. Also supports connecting families to Preschool for All.

Early Kindergarten Transition - 25152
2-3 week kindergarten transition program for children & their families in SUN Community Schools

Sexual Gender Minority Youth & Technical Assistance - 25155
Provides services to connect youth to resources that help them meet their goals and provide training and education to the community so that they may provide competent and relevant services to LGBTQIA2S+ youths.

Multnomah Stability & Initiative - 25139
Engages households living on low incomes in ways that can foster hope, leadership and community so they avoid crises, achieve stability and access opportunities to reach prosperity. Case management and client assistance support families.

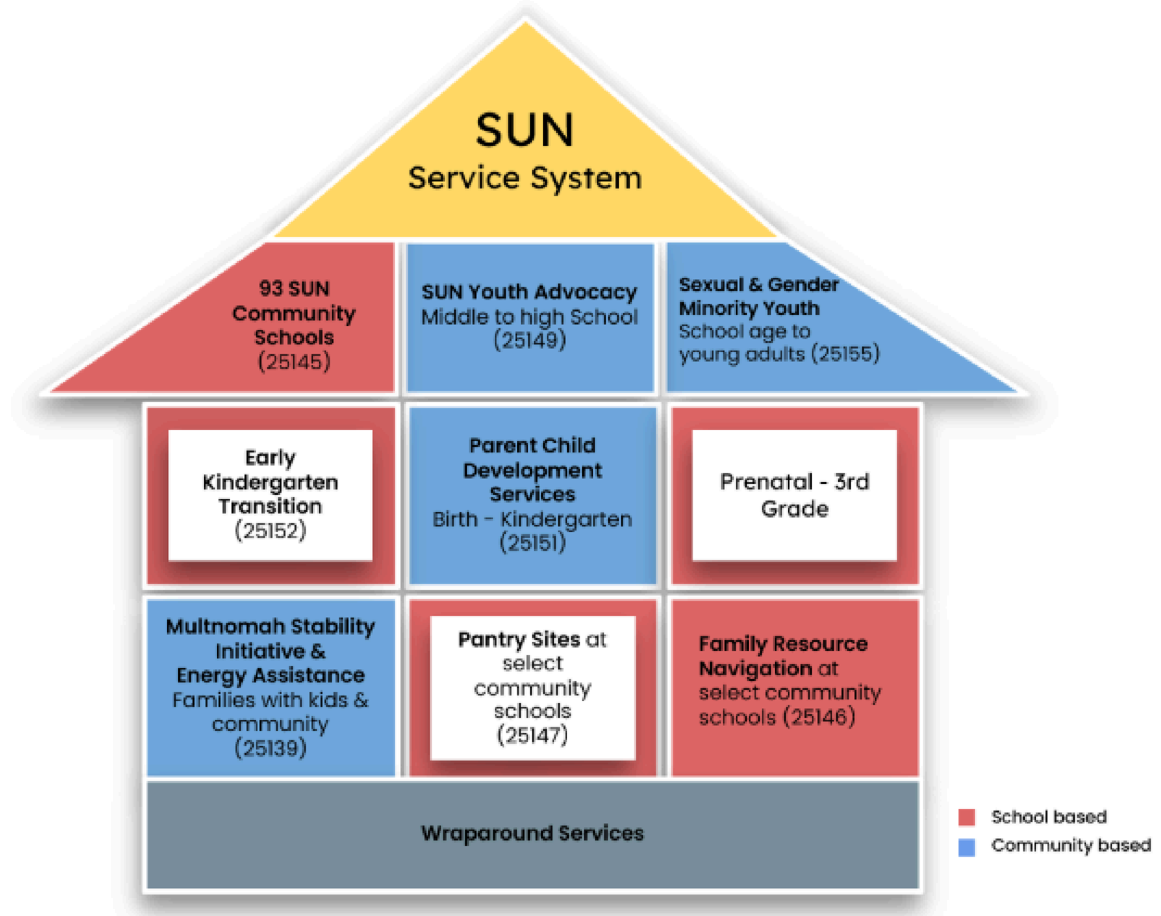
Hunger Relief - 25147
Weekly grocery distribution at pantry sites, access to fresh fruits and vegetables at Free Market Sites and free meals for out of school time activities.

Family Resource Navigation - 25146
Helps families navigate systems of care to reduce barriers & stressors at home so students can learn and families can thrive.

- Early Learning Support
- Family Stability Support
- Youth & Family Advocacy

SUN Service System Visual:
How Services & Programs Fit Together Into a Wraparound System (pg 2 of link)

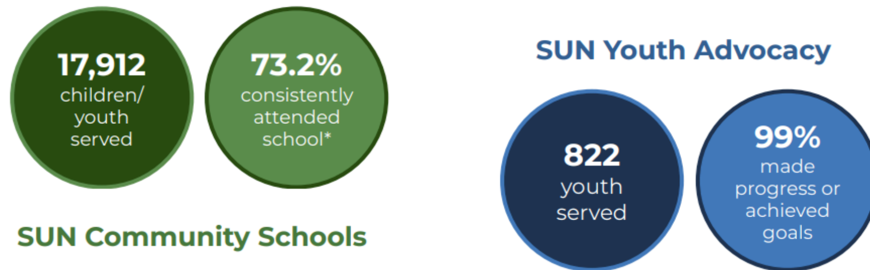
This visual demonstrates how the different programs and services fit together to create the SUN Service System that supports families and students.

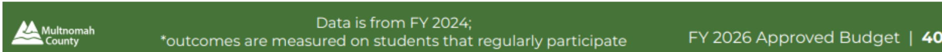


Commissioner Brim-Edwards (District 3) Provide the details behind the wage study for the SUN wage increase? Provide two or three years of data for the “Consistently attended school.”

YFS: Outcome Statements

Improving educational access and support through education programs and resources delivered through the SUN Service System, providing connection, resources, and community for youth and families





Response:

DCM conducted a study in 2023 to look at nonprofit wages and benefits in order to understand wage parity between nonprofit and county positions. The compensation study asked SUN Service System contracted organizations to submit information to Multnomah County.

The main takeaways were:

- The wage study demonstrated a wage gap of about 23-35% for salaries at SUN contractor agencies compared with county staff in comparable positions.
- There were no large pay differences between the six organizations who submitted information.
- YFS committed to utilizing this study to inform potential wage expectation requirements for the upcoming SUN Service System procurement.

Commissioner Singleton (District 2) - Can you provide FY 2025 to FY 2026 comparison of Eviction Prevention program (budget by funding source)? What are the retention vs. rehoused rates for the Emergency Rent Assistance program?

YFS: Outcome Statements

Increasing economic stability for participants through rent, energy, and food assistance, along with advocacy and case management support

Emergency Rent Assistance

12 months after assistance

Energy Bill Pay Assistance

Multnomah County | Data is from FY 2024 | FY 2026 Approved Budget | 41

Response:

Slide 77 in the appendices (below) shows the comparison of Eviction Prevention Services & Emergency Rent Assistance funding from year to year, including FY 2025 and FY 2026. This chart reflects the total County/City resources aligned to support imminent eviction prevention services each year. In FY 2025 and FY 2026, resources are only county, as the city no longer has an investment in emergency rent assistance.

The specific amounts by funding source for FY 2025 and FY 2026 are:

Source	FY 2025	FY 2026
Federal ARP	$2.6 million	$0
State OREDAP	$9.6 million	$7.8 million
Supportive Housing Services (SHS)	$4.5 million	$0
County General Fund (CGF)	$7.0 million	$6.2 million

Retention vs. rehoused rates

On this slide, you see the stable housing outcomes at 12 months after assistance for emergency rent assistance in FY 2024. Emergency rent assistance is one-time support for households at imminent risk of eviction. Case managers provide crisis support, resource triage, screening, application completion assistance, and landlord negotiation.

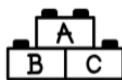
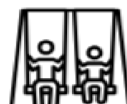
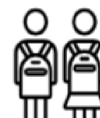
YFS programs are not rehousing households with these resources. The resources are focused on prevention of homelessness either by keeping families in their existing housing or offering them support to be able to seek other housing successfully on their own. Placement into housing from homelessness is within HSD.

At 12 months after assistance, we saw:

- Over 92% stayed in the housing they were in when they received emergency rent assistance or, if they left that housing, they moved to stable housing. This breaks down as:
    - 71.3% stayed in the same housing as when they received the rent assistance
    - For those who were not in the same housing as when they

received assistance, 72.4% of them moved to another stable housing situation

The SUN Service System - an aligned system of supports for children and families across their life span

Prenatal	 Early Childhood	Kindergarten	 Elementary	 Middle	High	Post HS

SUN Community Schools - 25145
Provide and integrate supports to meet basic needs, offer after school and summer programs, and engage families. Services below are linked to SUN Community Schools - either offered at SUN CS sites or through system connections.

Prenatal - 3rd Grade- 25152
Diverse parent centered family engagement to welcome families into their neighborhood schools and support kindergarten transition. They do not do one-on -one support.

SUN Youth Advocacy - 25149
Fosters youth social, emotional and professional development and academic achievement by providing a variety of year-round, school-linked age-appropriate support to children and youth who are at risk of facing academic challenges and disconnection from school.

Parent Child Development Services - 25151
Provides culturally specific child development services and one on one support with families. Support with appointments to developmental screenings, vaccinations & health check ups for kids. Also supports connecting families to Preschool for All.

Early Kindergarten Transition - 25152
2-3 week kindergarten transition program for children & their families in SUN Community Schools.

Sexual & Gender Minority Youth & Technical Assistance - 25155
Provides services to connect youth to resources that help them meet their goals and provide training and education to the community so that they may provide competent and relevant services to LGBTQIA2S+ youths.

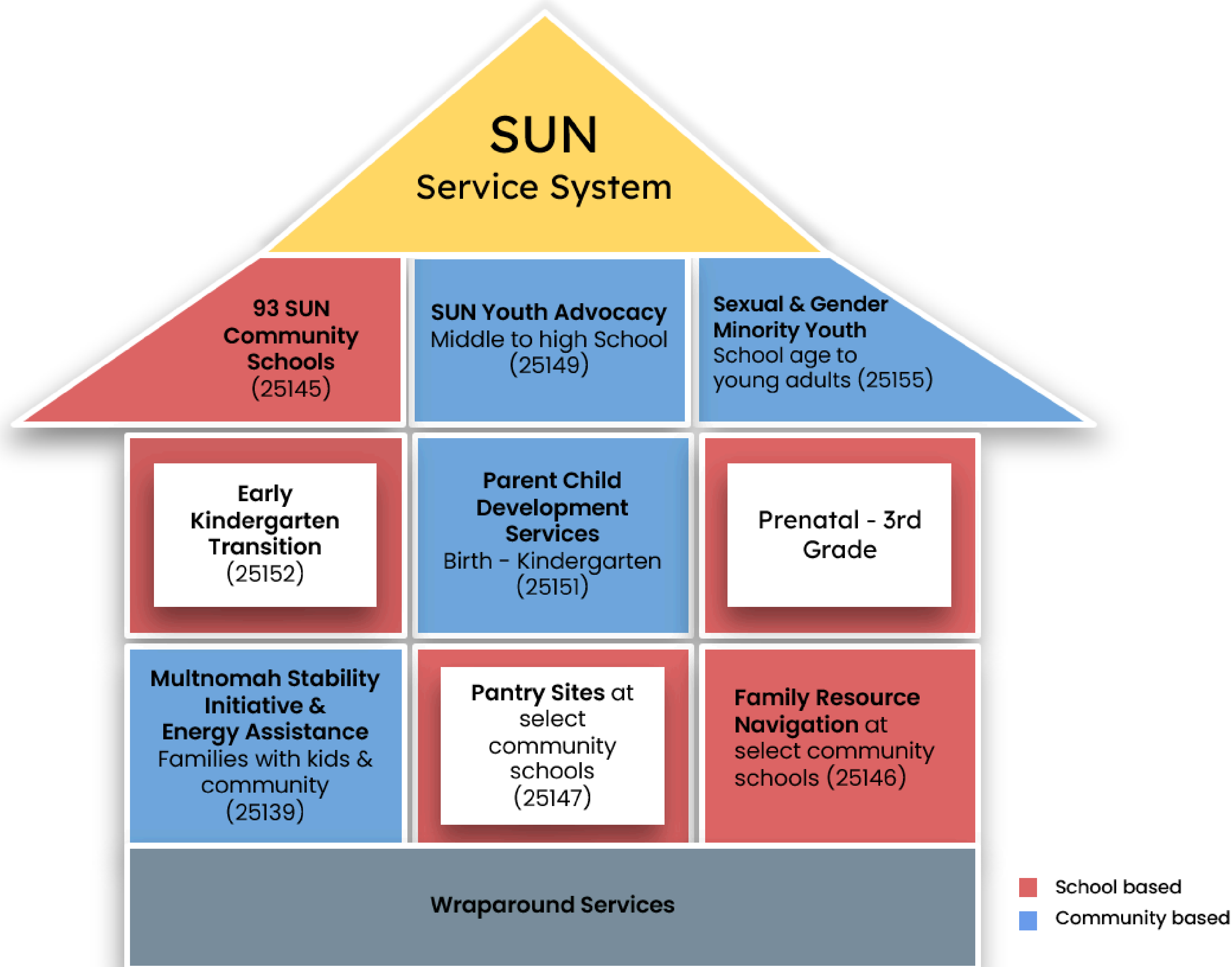
Multnomah Stability & Initiative - 25139
Engages households living on low incomes in ways that can foster hope, leadership and community so they avoid crises, achieve stability and access opportunities to reach prosperity. Case management and client assistance support families.

Hunger Relief - 25147
Weekly grocery distribution at pantry sites, access to fresh fruits and vegetables at Free Market Sites and free meals for out of school time activities.

Family Resource Navigation - 25146
Helps families navigate systems of care to reduce barriers & stressors at home so students can learn and families can thrive.

Early Learning Support
Family Stability Support
Youth & Family Advocacy

This visual demonstrates how the different programs and services fit together to create the SUN Service System that supports families and students.



Aging, Disability & Veterans Services

Community Services for Older Adults

PROGRAM MODEL

(July 2024 Updates)
FINAL

January 2024 - December 2028

Note: All Titles are hyperlinks, select the topic in the Table of Contents or Document Outline to advance to each section.**

TABLE OF CONTENTS

TABLE OF CONTENTS......2
LAND AND LABOR ACKNOWLEDGEMENTS......4
PROGRAM PURPOSE AND OVERVIEW......4
- DISTRICT CENTERS......5
- ENHANCING EQUITY......5
- NUTRITION SERVICES......6
- HEALTH PROMOTION......6
- GUIDING PRINCIPLES......6
- POPULATION SERVED......6
- COMMONLY USED ACRONYMS......8

FUNDING SOURCES......9
- FUNDING ALLOCATION......9
- CONTRACTS AND PROCUREMENT......10

STRUCTURE OF CONTRACTED SERVICES......11
- COMMUNITY SERVICES FOR OLDER ADULTS*......11
- EVIDENCE BASED HEALTH PROMOTION......11
- NUTRITION SERVICES......11

SUMMARY OF SERVICES......12
- COMMUNITY SERVICES FOR OLDER ADULTS......12
- FOCAL POINT SERVICES......12
- INFORMATION AND ASSISTANCE......13
- CASE MANAGEMENT AND RELATED PROGRAMS......14
- EVIDENCE-BASED HEALTH PROMOTION......17
- NUTRITION SERVICES......18

ADMINISTRATIVE REQUIREMENTS......19
- Data Reporting......19
- Seamless Service Delivery Network......19
- Contract Service Levels......20
- Language Access......22
- Customer Satisfaction......23
- Conflict Of Interest......24
- Criminal Background Check Requirements......25
- PROGRAM MONITORING......26

Note: All Titles are hyperlinks, select the topic in the Table of Contents or Document Outline to advance to each section.

PRIVACY AND HIPAA COMPLIANCE 27
TECHNOLOGY REQUIREMENTS 27
SERVICE EQUITY 30
LEADING WITH RACE 30
EQUITY AND EMPOWERMENT LENS 31
CULTURALLY RESPONSIVE SERVICES 32
REALD - DEMOGRAPHIC INFORMATION REQUIREMENTS 35
DESCRIPTION OF PROGRAMS AND REQUIREMENTS 36
DISTRICT SENIOR CENTERS 36
ENHANCING EQUITY PARTNERS 37
COMMUNITY FOCAL POINT FOR OLDER ADULTS 38
INFORMATION AND REFERRAL 43
CASE MANAGEMENT AND RELATED SERVICES 59
EVIDENCE-BASED HEALTH PROMOTION 75
NUTRITION SERVICES 82

LAND AND LABOR ACKNOWLEDGEMENTS

From its earliest days Oregon, as a state, has deeply rooted its identity in the exclusion and genocide of Black and Indigenous people. While exclusion laws were never officially enforced, the legacy of White supremacy has shaped Oregon's communities, the impacts of which are still felt today.

The Kathlamet, Wasco, Clackamas, Bands of Chinook, Tualatin, Kalapuya, Molalla, Multnomah, and other Tribes lived along the Columbia and Willamette Rivers for thousands of years where the boundaries of Multnomah County are drawn today. We honor these tribes as the original stewards of this land. We acknowledge the intentional and ongoing attempts to destroy Native people and erase Native culture. We recognize and honor the lives of the African people who were stolen and enslaved by White occupiers to perform unpaid labor to further the colonization of these stolen lands. The Aging, Disability and Veterans Services Division recognizes that the history of these lands has been intentionally unspoken and White dominated, the impacts of which remain largely unaddressed and palpably reverberate in this place that is recognized today as Multnomah County, Oregon.

PROGRAM PURPOSE AND OVERVIEW

Multnomah County, herein called "the 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 of Oregon by and through the Federal Older Americans Act (OAA).

AAA's are responsible for planning, leadership, advocacy, coordination, and delivery of OAA services for all older Americans and family caregivers living in the service area. With other funding sources, programs serve not only older adults, family caregivers but also adults with disabilities. Area Agencies on Aging (AAA) provide a range of services to help older adults live safe, healthy and independent lives. Across Oregon, there are 16 AAAs that administer and support community-based care services. As an Area Agency on Aging, ADVSD is required by the Older Americans Act to designate community contact points through which older persons

gain access to information and services. Our contracted partners, District Senior Centers and Enhancing Equity partners, served as those contact points.

A major philosophy of the Older Americans Act is that preventive and supportive services that support 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, people with disabilities and their families.

ADVSD's service delivery system is the result of community planning spanning more than twenty six years. The services provided through the District Centers and Enhancing Equity Partners are determined by ADVSD's priorities defined in the Area Plan, an annual plan submitted to the State Department of Human Services - Office of Aging and People with Disabilities Division.

The most recent Area Plan can be found here:
https://www.multco.us/ads/2021-2025-advsd-area-plan

The 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. Each of the five districts of Multnomah County has **one** contracted District Center. The five districts are: N/NE, Westside, SE, Mid County and East County. Those contracted District Centers serve consumers who live in the zip codes associated with the district and

ENHANCING EQUITY

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.

NUTRITION SERVICES

congregate and home delivered meals provided by both Culturally Responsive and Culturally Specific providers who serve all of Multnomah County

HEALTH PROMOTION

approved Evidence Based Health Promotion classes and workshops offered by both Culturally Responsive and Culturally Specific providers. Evidence-based programs are proven programs that work. In order to be considered "evidence-based," programs must be evaluated using a control or comparison group, with documented and published outcomes.

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 and Enhancing Equity 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 live on a low income or near low income
5. Older adults with historically and systemically marginalized identities, including people who are Black, African-American, Asian, Pacific Islander, Latino or Hispanic, Native American, First Nations, Native Hawaiian or Alaska Native, African, Middle Eastern & North African, Salvic, immigrants and/or refugees, linguistically isolated or speak languages other than English, and gay, lesbian, bi-sexual and/or transgender or gender expansive 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
10. Family caregivers of older adult relatives and those with dementia or chosen family members who are older adults

Other funding sources such as Oregon Project Independence state funding targets adults age 18+ who meet the care needs and financial determination criteria for this program. The objectives are to support older adults and people with disabilities to live their lives safely, with independence, choice and dignity; to delay or prevent a portion of consumers becoming eligible for full Medicaid, and offer an alternative to those who may otherwise be Medicaid-eligible but who choose not to receive all Medicaid services. Adults serving as family caregivers are also served as part of this RFPQ process.

COMMONLY USED ACRONYMS

AAA: Area Agency on Aging

ADVSD: Aging, Disability & Veterans Services Division, a division under Multnomah County Department of County Human Services

DCHS: Department of County Human Services, a department within Multnomah County

ACL: Administration on Community Living

NWD: No Wrong Door refers to systems that empower individuals to make informed decisions, to exercise control over their long term care needs

OAA: Older Americans Act

CGF: County General Fund

OC: Options Counseling

ADRC: Aging, Disability Resource Connection/Center

AIRS: Alliance of Information and Referral Systems

I&A: Information and Assistance

I&R: Information and Referral

OAA: Older Americans Act

HDM: home delivered meal

CS: Culturally Specific

CR: Culturally Responsive

EE: Enhancing Equity

DC: District Center

FCSP: Family Caregiver Support Program

RAAP: relative acting as parent

OPI: Oregon Project Independence

OPIM: Oregon Project Independence Medicaid

ECM: Eligibility Case Manager for the OPI-M program. This team member is an employee of ADVSD Community Services

SCM: Services Case Manager for the OPI- M program. This team member is an employee of a District Center or Enhancing Equity agency and serving OPI-M consumers.

EBHP: Evidence Based Health Promotion

MMP: Multco Marketplace.

REALD: a type of demographic information, like age, marital status, employment and more. REALD stands for the types of information it includes: Race Ethnicity, and Language Disability.

HCW: Home Care Worker

FUNDING SOURCES

The funding for the services described in this Program Model comes mainly from the federal Older Americans Act http://www.aoa.gov/AoA_programs/OAA/Index.aspx through the Administration on Aging https://acl.gov/about-acl/administration-aging
In addition, the State provides funding for Oregon Project Independence.
Oregon Project Independence Medicaid (OPI M) is funded with Medicaid federal dollars. This federal and state funding is administered by the Oregon Community Services and Supports Unit (formerly the State Unit on Aging)
https://www.oregon.gov/odhs/providers-partners/community-services-supports/Pages/default.aspx
The County also provides funding (county general fund) per the county budget process, in addition to federal and state funding.
Each service that your agency provides may be funded by a variety or a mix of different sources that may have different restrictions and requirements. All of your funding can be viewed and tracked in the Mult Co ADVSD database UCR. More about that is a later section. Your contract liaison is available to support you to understand your funding along with the team that receives your invoice each month. That also is covered in more detail in other sections in this document.

FUNDING ALLOCATION

For **District Senior Centers**, funding is allocated to one contractor in each of

the five regions, based on demographic factors updated with current population statistics. These factors are: people aged 60 and over: people aged 60 and over with incomes at or below 185% of the Federal Poverty Level; people with marginalized identities aged 60 and over; people with marginalized identities aged 65 and over, with incomes below the Federal Poverty Level; people aged 85 and over, and people aged 60 and over who are raising children under age 18.

Funding to organizations providing **Culturally Specific** services will be based on agencies that qualify in the RFPQ process. From that qualified pool, contractors will be selected and awards/funds allocated are based on services that qualifying agencies select on their proposal. ADVSD is committed to enhancing equity by contracting and partnering with culturally specific agencies to provide services to older adults in our community and expanding services and funding when possible by:

- increasing the percentage of our funding allocated to culturally specific agencies
- allocating percentages of new funding to culturally specific services
- supporting new culturally specific agencies
- supporting existing culturally specific agencies to expand services provided
- encouraging partnerships and consortiums with District Centers to strengthen the network

CONTRACTS AND PROCUREMENT

Mult Co ADVSD Community Services will procure these services in this Program Model every five years. The procurement process will be held within Mult Co Marketplace (MMP). Multco Marketplace offers a place for staff to interact with suppliers (and for the purposes of this program, “supplier” refer to our contracted partners or agencies who may be applying for a contract in this RFPQ) for market research and small dollar purchases, a place for suppliers (ie: potential contracted partner agencies) to view and respond RFP’s and RFPQ’s, and a place to update business information including changes/expansion of services and, contact information.

STRUCTURE OF CONTRACTED SERVICES

The RFPQ for these services will encompass three service areas and are largely defined by services as defined by the Older Americans Act:

COMMUNITY SERVICES FOR OLDER ADULTS*

1. District Senior Centers (culturally responsive) 1 provider per district
   a. SE
   b. Mid County
   c. East County
   d. N/NE
   e. Westside
2. Enhancing Equity Service Centers (culturally specific)

EVIDENCE BASED HEALTH PROMOTION

Health promotion includes offering evidenced based health promotion classes and workshops for older adults as defined in the Older Americans Act.

1. Culturally Responsive organizations
2. Culturally Specific organizations

NUTRITION SERVICES

Nutrition services include congregate meals and home delivered meals as defined in the Older Americans Act.

1. Culturally Responsive organizations
2. Culturally Specific organizations

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

**Some consumers may be under the age of 60 for some programs that have a broader scope.*

SUMMARY OF SERVICES

For more detailed information about each service, see the section further below in this document.

COMMUNITY SERVICES FOR OLDER ADULTS

These services include case management services (for programs such as Oregon Project Independence, Options Counseling, Older Americans Act Case Management), Information & Assistance and Information & Referral, Family Caregiver Support Program Services, and Transportation Coordination.

FOCAL POINT SERVICES

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. District Centers and Enhancing Equity partners involve the community they serve to identify needs and in the planning of activities and services.

Focal Point Services include:

RECREATION

Activities such as fitness classes, performing arts, games, cooking, and crafts that appeal to the leisure time interests of participants and promote socialization. This could also include health classes that are not "evidence based" but are general information about promoting wellness.

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 ASSISTANCE

Note: State rules of how this program is delivered and documented in the state-wide database

Information and Assistance (I &A) provides participants with information about services available in the community and benefits for which they may be eligible. The I & A 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&A 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. This service category requires collecting REALD demographics (Race, Ethnicity, Language, and Disability) and using the State-wide database used by all AAA's (area agency on aging).

TRANSPORTATION SCHEDULING & COORDINATION

This service is a subset of Information and Assistance. ADVSD purchases a limited number of rides via TriMet bus HOP Card tickets and passes, and through contracts with other local transportation providers for older adults who are not eligible for transportation services through Medicaid.

Only agencies contracted to provide Information and Assistance 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 HOP Card bus tickets and

passes, coordination of cab rides and other transportation options, 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 past input from ADVSD's Fare Assistance Workgroup, which was convened to address the issue of fare assistance available vs community need) 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 and adults age 18-60, 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

Note: Federal and state rules for this program and Mult Co network procedures and processes to deliver the program within the rules

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 support that will enhance independence. OAA Case Management does not include in-home services. This service is aligned with Older Americans Act rules. The service is recorded in the UCR Mult Co database.

OPI CASE MANAGEMENT

Note: State program rules with Mult Co network procedures and processes to deliver the program within the state rules

Oregon Project Independence (OPI) serves individuals age 60 and over and adults under the age of 60 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. This service is in Oregon Access statewide database

CASE MANAGEMENT FOR OPI- MEDICAID PROGRAM

Note: The 1115 state waiver is approved. Phase 1 began June 3rd, 2024.- State Medicaid waiver program with Mult Co network procedures and processes to deliver the program within the state rules

Oregon Project Independence-Medicaid serves adults age 18+ who meet the assessment and financial determination criteria for this program. The objectives of OPI M are to support older adults and people with disabilities to live their lives safely, with independence, choice and dignity; to expand capacity of OPI; to eliminate local waitlists, expand capacity to serve younger adults with physical disabilities statewide and meet increasing demand; to delay or prevent a portion of consumers becoming eligible for full Medicaid services, and offer an alternative to those who may otherwise be

Medicaid-eligible but who choose not to receive all Medicaid services.

This service is in the Oregon Access statewide database. Information can be found here:
https://www.oregon.gov/oha/HPA/HP-MAC/MACmeetings/3.1%20OPI-M%20fact%20sheet%20-%202022.pdf
Eligibility for OPI-M is determined by a Community Services Case Manager. When a consumer is approved for OPI-M, the eligibility Case Manager, (ECM) collaborates with the community partner Service Case Manager (SCM). The Eligibility Case Manager (ECM) completes a warm hand off to the Community Partner Service Case Manager (SCM). The SCM provides on-going case management to the consumer.

CASE MANAGEMENT FOR FAMILY CAREGIVERS

Note: Mult Co ADVSD local decisions on how funding is used within Federal and state AAA rules.

Case management is provided to family caregivers who are caring for persons age 60 and over or someone of any age with Alzheimer's or dementia and to elders 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 a qualifying care recipient. 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

Note: State rules of how this program is delivered and documented in the state-wide database.

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 trained Options Counselor provides individualized person-centered decision support to consumers, family members and/or significant others, regardless of

income, in the home, office, or over the phone depending on consumer preference. Options Counselors work with individuals and/or families, to help them understand their strengths, needs, preferences and unique situations. The Options Counselor creates an action plan for the consumer to navigate possible support strategies, 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. This service is in the GetCare statewide database. Mult Co or State training is required for becoming an Options Counselor.

EVIDENCE-BASED HEALTH PROMOTION

Note: Mult Co ADVSD local decisions on how funding is used within Federal and state AAA rules. Statewide database used for calendaring, documenting and reporting.

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.). There are specific programs and classes that this funding can support, per Multnomah County’s contract with the State. This funding is part of the Older Americans Act. This service is tracked in the statewide database, Compass and is in development to be tracked in the Multnomah county database, UCR.

Standards and program fidelity for each class or workshop are defined by the developers of the evidence based intervention and Multnomah County is committed to ensuring program fidelity. Contractors must commit to delivering the program/class in the way in which they were trained or must partner with trained leaders who are trained in the intervention and who are committed to delivering the program in the way in which they were trained. Contractors must commit to implementing internal quality assurance measures to ensure that the program is delivered in the way in which the model intended. See details for each type of class/workshop and program standards in the section further down in this document.

Each contractor will select programs/classes that they wish to offer each year based on capacity, feedback from their consumers, availability of trained leaders etc. The network will collaborate to share resources and to support availability of classes and ease of registration for consumers throughout the county.

NUTRITION SERVICES

Note: Mult Co ADVSD local decisions on how funding is used within Federal and state AAA rules.

The OAA provides funding for nutritious meals for older adults. Meals must meet specific dietary guidelines, per the Older Americans Act nutrition rules. **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.

Title III-C nutrition services are intended to:

- Reduce hunger, malnutrition and food insecurity
- Promote socialization
- Promote the health and well-being of older people. Services are not intended to reach every individual in the community.

Programs target adults age 60 and older who are in greatest social and economic need, with particular attention to older adults in the following groups:

- Low-income
- Minority groups

- Rural communities
- Limited English proficiency
- Those at risk of institutional car

ADMINISTRATIVE REQUIREMENTS

Data Reporting

ADVSD contracts for these services on a fee-for-service basis. *This means that the contracted agency will provide the service at an agreed upon rate per unit of service such as a unit of case management. The contracted agency will then invoice per unit of service provided and ADVSD will then pay the contracted partner for each verified unit of service provided.* Fee for service contracts means that the contractor provides the service, bills for units of service provided and the funder pays for units of services that are verified as having been provided.
Reporting is based on requirements such as the The Older Americans Act Performance System (OAAPS) (formerly National Aging Programs Information System or NAPIS) and State's Community Services and Supports Unit (CSSU) rules Older Americans Act rules. Several different databases are required, 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.

Seamless Service Delivery Network

As the Area Agency on Aging for Multnomah County, contracted partners for services in this RFQP must function as part of our seamless service delivery network. 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.

Contract Service Levels

Per ADVSD CS guidance , 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 reflect some level of match in their budget. 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 2021 for Oregon as recognized by the Independent Sector in the amount of $29.95 per hour; Donated professional services or programming

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

Note: 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.

1. It allows us to accurately report the services provided to older adults in our community
2. ADVSD may have the ability to pay for some of these services (such as OPI Case Management or Culturally Specific Meals) at the end of the fiscal year, for example, if another contractor was unable to use their entire allocation.

Note: this depends also on the source of funds that the contractor used to pay for the services.

- Reimbursement for subsidy depends on 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.

Note: ADVSD will not reimburse subsidies 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:

- Protect the privacy of each participant with respect to their contributions;
- Establish appropriate procedures to safeguard and account for all contributions;
  - Use contributions for supportive services and nutrition services to expand supportive services and nutrition services respectively
  - 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 (state General Fund program), which has its own requirements for participant contributions based on income.

Administrative Costs

For all services in this RFPQ, ADVSD limits administrative costs up to 15% 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. What this means is that when contracted partners are determining their rate, there cannot be more than 15% of administrative costs factored into the rate.

Subawards using Federal Funds

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.

Language Access

Multnomah County ADVSD maintains interpreter and translation contracts with a variety of agencies. For the purposes of contracts related to this Program Model, contracted agencies have access to utilize these services.
https://www.multco.us/ads/cs-interpretation-and-translation-services

Interpreter services via the ADVSD contracts may be accessed to support phone calls and or home visits for referrals and for case management tasks. If you are unable to access services for your client, try another provider, then email your Contract Liaison and cc advsd.language.services@multco.us

Instructions for Written Translation Projects:

Written translation using ADVSD contracts may be requested by partner agencies for non-state, non-federal forms, brochures or handouts that may be used/relevant countywide for all partners to access in support of the work described in this Program Model. These translated documents would then be posted on the ADVSD Provider Page for all partners to access.
Please email advsd.language.services@multco.us with the details of your translation project and cc your Contract Liaison for review and approval, as funding allows.

Please contact advsd.language.services@multco.us with any questions
Your feedback is essential! Please complete this ADVSD Language Services Feedback Form found here:
https://www.multco.us/ads/cs-interpretation-and-translation-services

Partner agencies should also have their own policies and procedures regarding language access consistent with Title VI for interpretation and translation services.

Customer Satisfaction

Multnomah County ADVSD is dedicated to providing services that meet the needs of participants. All contractors will be required to complete their own consumer satisfaction survey at least annually. Mult Co ADVSD will provide one question to partners regarding cultural responsiveness of the services provided and will also provide a reporting tool and partners will be required to use the tool to report data on the one survey question back to ADVSD as part of contract compliance.

GRIEVANCE PROCEDURES

All contractors providing services under this RFPQ must establish a written Participant 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 participants. This may include posting in a conspicuous place and distribution of the procedures and applicable grievance forms in areas frequented by participants. 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:

- Non-discrimination in Service Delivery
- Accessibility to Services
- Training
- Culturally Specific Programs and Services
- Community Outreach
- 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 the 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.
Contracted partners providing case management services must maintain "conflict free case management" procedures and practices. Conflict free case management means that assessment and coordination of services are separate from the delivery of services, with the goal to limit any conscious or unconscious bias a case manager or agency may have, and ultimately promote the individual's choice and independence.

Criminal Background Check Requirements

Per state and AAA requirements, contractors who provide services under this RFPQ are required to have Criminal Background Checks done through the Oregon State Background Check Unit using The Oregon Criminal History and Abuse Records Data System (ORCHARDS) for all staff and volunteers who provide any of these services. For more information, see the Oregon State Background Check Unit's website:

https://www.oregon.gov/dhs/business-services/chc/Pages/index.aspx

https://www.oregon.gov/dhs/POLICIES/Pages/ss-admin-rules.aspx

What is ORCHARDS?

ORCHARDS is the Oregon Criminal History and Abuse Records Data System. It provides a portal for submitting background checks and receiving fitness determination results. Oregon started using ORCHARDS in July of 2020. ORCHARDS was developed on behalf of the Centers for Medicare and Medicaid Services for the National Background Check Program (NBCP).

Only qualified entities can submit background checks in ORCHARDS. This includes:

- Oregon Department Human Services (ODHS) and Oregon Health Authority (OHA).
- Businesses regulated by ODHS or OHA.
- Businesses not regulated by the state that meet criteria to use the

BCU Clearinghouse. These are businesses that serve youth, older adults or people with disabilities.

★ The contract that your agency has with ADVSD Community Services for senior/older adult services makes you a “qualified entity”

For new agencies contracting with ADVSD CS you must get set up with ORCHARDS and run background checks on your Subject Individuals before you start to deliver services defined in your contract.

This standard includes staff and volunteers that have access to personal information about consumers/clients/participants including but not limited to Social Security numbers, dates of birth, driver license numbers, medical information, personal financial information, or criminal background information; has access to information the disclosure of which is prohibited by state or federal laws, rules, or regulations or information that is defined as confidential under state or federal laws, rules, or regulations;

Your agency’s Human Resources may determine that conducting a **new/additional** criminal records check and fitness determination for an employee during the course of their employment (i.e. if they take a different position on the team such as a promotion) is not required as long as there has been no break in employment. Full rules can be found here: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1626

PROGRAM MONITORING

The State's Community Services and Supports Unit (CSSU) 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 CSSU, 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 CSSU. The CSSU monitoring schedule can be found here:

https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SUA/Pages/Area-Agency-Aging.aspx

Mult Co ADVSD also strongly encourages each contractor to develop their own internal monitoring and quality assurance procedures consistent with contract requirements, case management standards, narration standards, I&A standards, consumer satisfaction standards and the state monitoring tools, HIPAA, privacy, etc.

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.

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, mobile device(s) and must be able to use basic Microsoft Office Suite or Google suite programs such as Word and Excel, or Google Sheets, Google Doc, compatible with PCs and video conferencing capability such as Google meet, Zoom, Teams, etc.

Contractors who provide I & A services must provide each I & A staff person with access to a computer (ideally with two monitors), consistent, secure 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.

Partner agencies that are providing contracted services that require electronic storage of consumer/client files, must have a secure electronic file storage system that meets all HIPAA and privacy standards.

Electronic tools used in the field, such as tablets, laptops, USB drives, smartphones, etc, must be encrypted password protected.

SECURE EMAIL

Contractors are responsible for protecting PII and PHI as required by HIPAA. All contracted partners must use encrypted email for transmitting messages

that contain PII or PHI. Privacy and HIPAA policies and procedures must include standards for transmitting information containing PII and PHI. PII and PHI must be transmitted by encrypted email, fax, phone, mail, or personal delivery.

REQUIRED DATA SYSTEMS

Several different databases are used to record participant and/or service information for ADVSD CS programs.
Office/administrative staff, managers, agency fiscal/budget team members, direct client/case management staff, data entry, call center staff and volunteers who may need database access must all have their own login credentials for any and all databases with the appropriate level of permissions. Sharing of login credentials is strictly prohibited and may result in loss of privileges. Under no circumstances is it allowed to have general or shared login credentials (ie: shared login for all of your interns or shared login for your case managers or the manager shares a log in with a case manager) If someone has forgotten their login credentials they must contact the Multnomah county useraccess support to get assistance.

STATE OF OREGON DATABASES

The State of Oregon maintains three databases that are used for ADVSD Community Services programs: Oregon Access, GetCare and the State Mainframe. Two of these 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:

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

OREGON ACCESS

Used for recording participant information for these services:

- Oregon Project Independence

ADRC RTZ GETCARE DATABASE

A web-based system that is used to locate referrals, as well as entering participant and service information for these programs:
Information, Referral & Assistance, Evidence Based Health Promotion, and Options Counseling

UNIVERSAL CLIENT REGISTRY (UCR)

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

UCR is used for recording participant information for these services:

- Older Americans Act Case Management
- Family Caregiver Support Program
- EBHP

COMPASS

Compass is a unique online portal developed as a registration and data management tool. Compass assists organizations in delivery and tracking of evidence-based health programs, including the Stanford Chronic Disease Self-Management Programs, the Diabetes Prevention Program, Walk With Ease, Tai Chi for Better Balance,and Arthritis Foundation Exercise courses. Access to Oregon Compass is available with no charge for organizations providing Stanford self-management programs.

SERVICE EQUITY

Multnomah County's Aging, Disability and Veterans Services Division (ADVSD) strives to be a leader in the work toward racial justice both in the County and in our lines of business. We recognize that multiple systems of oppression are reinforced in ADVSD policies, practices, and processes. To address this, ADVSD has developed a Service Equity Plan that will, in the course of the contracting period described in this Program Model, be integrated into the structure of the 2021-2025 Area Plan, that strategic plan for OAA services in the Multnomah County Planning and Service Area.

ADVSD continues to align and realign the approach in all aspects of this work to reflect and reinforce the County's commitment to Leading with Race. Our goal is to use strategies to allocate and prioritize target resources that are culturally responsive and appropriate to the community and individuals being served.

LEADING WITH RACE

From Multnomah County's Statement Why We Lead with Race

Leading with race is important because:

Strategies to achieve racial equity differ from those to achieve equity in other areas. "One-size-fits all" strategies are rarely successful.
A racial equity framework that is clear about the differences between individual, institutional and structural racism, as well as the history and current reality of inequities, has applications for all marginalized groups.
Race can be an issue that keeps other marginalized communities from effectively coming together. An approach that recognizes the interconnected ways in which marginalization takes place will help to achieve greater unity across communities.

For ADVSD, Service Equity is currently defined as Equitable access to and delivery of programs and services funded by ADVSD and those provided by

the network of community-based organizations that partner with ADVSD. In practice this will look like allocating resources to services that are Culturally and Community Specific and Culturally and Community Responsive, as well as seeking demonstration of an organization's ability to reach and serve people living with historically and systemically marginalized identities.

EQUITY AND EMPOWERMENT LENS

At Multnomah County, we utilize the Equity and Empowerment Lens a.k.a The Five P's to examine 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 our communities most negatively impacted by systemic racism, health inequity, and barriers to opportunity and to advance positive outcomes for all our residents.

CULTURALLY RESPONSIVE SERVICES

At a minimum, all contracting organizations must provide Culturally and Community Responsive Services. Culturally and Community Responsive services are respectful of, and relevant to, the identities, beliefs, practices, culture and linguistic needs of diverse individuals participants / participant populations and communities whose members identify as having particular cultural norms, or language access or other needs or other identities or affiliation needs linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or primary 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.

CULTURALLY AND COMMUNITY RESPONSIVE ORGANIZATION (CHARACTERISTICS)

- The organization prioritizes responsiveness to the interests of communities experiencing inequities and racism
- 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 and Community Responsive organizations affirmatively adopt and integrate the cultural and social norms and practices of the communities they serve.
- A Culturally and Community 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.

CULTURALLY SPECIFIC ORGANIZATION (CHARACTERISTICS)

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, andaddress power relationships.

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, andaddress power relationships.

REALD - DEMOGRAPHIC INFORMATION REQUIREMENTS

- The State Office of Aging and People with Disabilities requires ADVSD to provide a report on the identities of the presumed service population, the people served by ADVSD programs, and our employees and contractors utilizing the REALD racialized identity categories and expanded Sexual Orientation Gender Identity data. Collecting REALD information helps us understand who is most impacted by health inequities and how we can best support these community members to access the services and resources they need to be healthy and thrive.
- Partners who contract with Mult Co ADVSD per this program model are required to collect REALD Demographics, per Mult Co's AAA contract with the State of Oregon.

DESCRIPTION OF PROGRAMS AND REQUIREMENTS

DISTRICT SENIOR CENTERS

This area will fund five District Senior Centers (one contract per district) 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

TABLE 1: POPULATIONS BY ADVSD SERVICE AREA

Note: All estimates are for the 60+ population unless otherwise noted

	County	East District	Mid District	N/NE District	S/SE District	West District
Below 185% FPL	33,890	6,404	9,590	6,566	5,260	6,069
BIPOC	31,185*	5,436	9,640	7,728	3,948	4,433
People 18-59 with a disability	48,767	11,219	12,180	10,791	7,729	6,848
People 60+ with a disability	47,865	10,263	12,679	9,598	6,620	8,706
Primary languages other than English	6,373	1,074	2,948	626	1,001	724
African	973	154	268	314	1	236
American Indian or Alaska Native	2,419	506	587	428	506	392
Asian	10,615	1,570	4,163	1,719	1,942	1,221
Black or African-American	7,683	776	1,633	4,041	437	796
Native Hawaiian or Pacific Islander	732	210	180	169	132	41
Latino, Latinx or Hispanic	4,978	1,102	1,535	1,034	565	743
Middle Eastern	966	313	202	86	54	311
Slavic	5,011	910	1,685	511	838	1,067
White	132,026	27,500	25,918	26,656	20,128	31,824
Totals	**151,827**	**33,281**	**31,823**	**32,193**	**22,790**	**33,701**

Each of the Five contracted **District Senior Centers** must provide these Core Services:

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

- Black and African American
- American Indian or Alaska Native
- Asian
- Pacific Islander or Native Hawaiian
- Immigrants and/or Refugees
- Hispanic and Latino
- African
- Middle Eastern or North African
- Slavic
- Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+)
- Transgender, Two-Spirit, Gender Queer, Gender Expansive or Nonbinary
- Older Adults who are unhoused and living in shelter
- Veterans
- People living with mental and behavioral health
- People living with a disability
- People speaking primary languages other than English
- Older Adults who are formerly incarcerated

- People aging with HIV and AIDS Long-Term Survivors

Menu of services:

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

PROVIDER CRITERIA - COMMUNITY FOCAL POINT

- 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.
  - Provide consistent, reliable, and sufficient hours of operation to serve the needs of the community
- Be able to justify that the hours of operation are based on needs of the community
- Proposed hours of operation will be reviewed by ADVSD and agreed upon mutually

- Clearly post the agreed upon hours of operation
  - 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
  - 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
  - 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
  - Have sufficient staff to provide coverage for programs, activities, and volunteer supervision
  - Implement nutrition guidelines or a wellness policy that promotes healthy eating and physical activity for participants
- Attend all required training and meetings at the request of the County

PROGRAM REQUIREMENTS - COMMUNITY FOCAL POINT

- Provide single entry “no wrong door” access to services
- Considerations for language access
- Establish a network of access points with all providers of services to older adults within the district
- Provide planning and coordination of services
- Engage in active outreach to vulnerable older people in the community
- Engage in active culturally appropriate outreach to Black, Indigenous and other communities of color, communities, including the LGBTQ community and identities that have been historically and systemically marginalized
- Provide advocacy and community leadership on aging issues
- Promote the District Center’s or Culturally Specific Organization’s visibility in the community

- Be committed to performance-based evaluation of the services that are provided under the ADVSD contract
- Work cooperatively with other ADVSD providers, including the other District Centers/Culturally Specific providers
- Build relationships among community organizations and aging network professionals
- 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

ACTIVITIES/PROJECTS - COMMUNITY FOCAL POINT

- Outreach, including transportation outreach to unserved and underserved populations, including minority populations
- Public-private collaborations and partnerships
- Community and political advocacy and work with elected officials and recommendations to ADVSD’s advisory councils (ASAC and DSAC and SEAW)
- Intergenerational programs
- Leveraging of resources and volunteers through community partnerships
- Development of innovative approaches to service delivery that improve the quality and/or level of service to older people most in need of services
- Projects that involve community livability, civic engagement and volunteerism
- 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

- Coordination of services, such as legal services, insurance counseling
- Soliciting and utilizing input from older people on behalf of older people (especially those who are frail, have a disability, live on a low income, lack family or other social support systems, and/or have racialized identities or other identities or life circumstances that are marginalized or experience exclusion based on racialized identities), for the purpose of program planning, evaluation, making improvements to District Center/ Culturally Specific services and political advocacy.
- 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 IN COMMUNITY FOCAL POINT

RECREATION - SERVICE REQUIREMENTS

Activities such as sports, performing arts, games, cooking, and crafts that appeal 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.

- 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
- 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
    - Volunteers pass a Criminal Background Check (ORCHARDS)

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 - COMMUNITY FOCAL POINT

- 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
- Must pass a Criminal Background Check (ORCHARDS)

RESPONSIBILITIES STAFF OR TRAINED VOLUNTEER

- 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
- 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.

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.

I & R CONTACT TYPES

- **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).

- **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.

- **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.

- **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.

- **Crisis Intervention:** When circumstances warrant, the 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, andothers in distress. In many of these circumstances, I & R staff will be expected to warmly 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.

I & R - 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 needs 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
- I & R must be performed by I & R staff or skilled staff such as Case Managers and supervisors

- 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
- Utilize the Oregon Aging and Disability Resource Connection (ADRC) electronic resource directory when assisting callers and walk-ins
- Assist ADVSD in maintaining up-to-date resources, both local and standard resources, in the ADRC electronic resource directory
- Ensure that staff is trained to serve people who call walk-ins and who may speak languages other than English (consistent with Title VI and use the ADRC to identify approved interpreters and translators, or use available internal resources
- Serving people with marginalized identities and who are unhoused.
- 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
- Designated I & R staff will be assigned and available as back up to the I & R Lead
- 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
- Maintain confidential participant information and send participant information by secure electronic format only
- 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

I & R - STAFF QUALIFICATIONS

I & R Specialists 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:
- Knowledge of the aging process
- Knowledge of the purpose of the information and assistance/case management program and the services it provides
- Knowledge of the responsibilities of the case management and

information and assistance staff
- Familiarity with public and private services available for older persons in Multnomah County, including program eligibility requirements
- 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
- 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
- Ability to assess for needed services based on the information available resolve the issue or make appropriate service referrals
- Ability to navigate and use the ADRC electronic resource directory and accurately document the I & R transaction

I & R - STAFF RESPONSIBILITIES

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

I & R - 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 recertification requirements.

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 training opportunities.

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

- **Orientation:** which covers the following subjects before new staff begin providing services to older persons:
  - Introduction to the services and programs for older adults, people with disabilities and veterans in Multnomah County
  - Introduction to the ADVSD Mission, Vision and Values
  - Service principle of “no wrong door” access
  - Organization policies and procedures
  - Protocol for working with other agencies, including how to make referrals;
- **Training** to include the following elements:
  - 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
  - How to complete ADVSD-required reports and document calls
  - How to assist ADVSD in the maintenance of the ADRC electronic resource directory
  - Interviewing skills
  - Knowledge of the case management intake process
  - Assessment procedures
  - Services authorized under the OAA, OPI, and other programs serving older people;
  - AIRS certification within the first year of employment.
  - Cross-training with Case Managers
  - Customer service techniques
  - How to discern a potentially complex situation from an apparently simple request for information
- **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.
- Seasoned I & R staff are encouraged to share knowledge and expertise with new I & R staff from other contractors.

I & R PROCEDURES

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

- **Information**
    - Assess the nature of the request by phone or in person.
    - Provide information by phone or in person about services and programs found in the ADRC electronic resource database.
    - Record appropriate information regarding the contact.
- **Referral**
    - Assess the needs of the participant in an open and unobtrusive way.
    - Identify appropriate resource(s) that meet identified needs as found in the ADRC electronic resource database.
    - Allow participants to choose from a variety of options without overwhelming them with choices. Three referrals are considered an adequate amount for one contact.
    - 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.
- **Assistance**
    - Assist the participant in the completion of intake forms.
    - Record appropriate information regarding the contact.
    - Follow-Up with service recipients within a month after the referral to ensure that appropriate assistance was received.
    - If appropriate assistance was not received, advocate on the recipient's behalf and problem solve for other available resources as needed.

I & R DOCUMENTATION

Logging, narrating, tracking, and reporting I & R contacts will be completed in the ADRC RTZ Call Module (participant database), at the time of contact.
A complete record of contacts received, including who called, the service request, and the disposition of the 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.
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.

I & R counts **do not** include:

- Administration of direct services offered to existing consumers (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 consumers up for clinics or classes.

I & R 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 authorized 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

I & R 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 an annual 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 consumers are pre-screened and reassessed annually by a Transportation Coordinator using the Transportation Assessment form. The outcome of the screening will determine eligibility and inform the level of assistance received.
- The level of fare assistance the client qualifies for cannot be met entirely with the allotted transportation funds. The Transportation Assessment form will help to identify all transportation resources: natural supports, family, friends and neighbors who can provide transportation, eligibility for 'honored citizen' downtown Portland pass, or low income fare assistance available to the consumer. This tool may be used to create an individualized transportation plan for the individual that may **not** include fare assistance from the DC transportation budget. The plan may include referrals to other transportation resources, such as, Ride Connection 'free ride' or 'mileage' programs.

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. Scheduling, coordinating and authorizing organization rides with ADVSD funded transportation providers
2. Distribution of bus passes and individual rides 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.

I & R - TRANSPORTATION AND SCHEDULING

TRANSPORTATION AND SCHEDULING - ADMINISTRATIVE STANDARDS AND PROGRAM REQUIREMENTS

Transportation Scheduling and Coordination will be available during the same hours as I & R services.

- Transportation Scheduling and Coordination must be performed by Transportation Specialist staff or skilled staff such as Case Managers and supervisors.
- Contractors must have clear policies in place that delineate duties and responsibilities of reception services separately from Transportation Scheduling and Coordination services.
- One staff member will be designated as the Transportation Specialist and will work collaboratively with other skilled staff to ensure consistency.
- 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.
- Designated, trained staff will be assigned and available as back up to the Transportation Specialist.
- The Contractor will maintain confidential participant information, enter participant and service information in the ADVSD Universal Client Registry (UCR) database, and transmit participant information (when necessary) by secure electronic format
- Designated staff will refer participants for guaranteed door-to-door rides using the Ride Connection WiseGuide database
- A quality assurance plan for monitoring the Transportation Scheduling and Coordination service will be developed by the Contractor.
- 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

TRANSPORTATION AND SCHEDULING STAFF QUALIFICATIONS

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

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

TRANSPORTATION AND SCHEDULING STAFF RESPONSIBILITIES

Staff responsibilities include the following:

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

TRANSPORTATION AND SCHEDULING - 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 quarterly Information & Referral and Transportation meetings. The

Contract Liaison for Transportation will provide training opportunities for Transportation Specialists and other skilled staff upon request. Contractor staff assigned to provide Transportation Scheduling and Coordination will participate in ADVSD sponsored meetings.

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

- **Orientation:** New staff will receive an orientation which covers the following subjects before they begin providing services to older persons:
  - Introduction to the Aging Network
  - Introduction to the ADVSD Mission and Values
  - Philosophy of the single entry access system through information and assistance and case management services
  - Organization policies and procedures
  - Introduction to other community resources that serve older persons
  - Content of working agreements with other agencies
  - Protocol for working with other agencies, including how to make referrals
  - How to use the State mainframe, Oregon Access Database to determine eligibility, and ADVSD UCR to enter participant and service data
  - How to work as part of a team
  - How to complete required forms
  - How to schedule the services for which they are responsible and the documentation of the scheduled rides
  - How to verify and share your transportation invoices for services provided
- **Initial Training to** include the following:
  - Interviewing skills
  - Knowledge of the case management intake process
  - Assessment goals and procedures
  - Services authorized under the OAA, OPI, and other programs serving older adults and people with disabilities
- **Additional training** may include the following best practices:
  - Cross-training with Case Managers
  - Customer service techniques
  - How to discern a potentially complex situation from an apparent simple request for services
  - Using software to submit Transportation Scheduling and Coordination data

Seasoned Transportation Specialists are encouraged to share knowledge and

expertise with new Transportation Specialists from other centers. Neighboring Contractors are encouraged to collaborate in transportation outreach venues to reach underserved communities.

TRANSPORTATION AND SCHEDULING - PROCEDURES

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

- Utilize standardized procedures, screening tools, narrative tools, forms and formats approved by ADVSD
- Utilize standardized coordination procedures with ride providers
- Agency rides can only be authorized and scheduled by ADVSD staff or ADVSD contractors
- Assess participant needs and develop a personal transportation plan using a standardized assessment approved by ADVSD
- Register participant using a standardized format approved by ADVSD
- Coordinate transportation resources and services that are most appropriate for the participant, most cost-effective, and within your transportation budget
- Facilitate ride schedule for participants as needed; authorize rides as required
- Ensure 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
- Provide technical, cultural, and other support to participants, 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:
    - Medical trips (doctors, therapists, hospital, test, or health-related treatment) for non-Medicaid participants
    - Congregate nutrition sites, and site where the participant is receiving multiple services
- ADVSD's priority target populations for organization rides include:
    - Frail, elderly participants based on activities of daily living (ADL) who have limited endurance, stamina, and are advanced old age
    - People with disabilities who need to travel with equipment such as walkers,

oxygen, etc
    - Non-English speaking older adults who have difficulty accessing fixed route transportation due to language barriers
    - 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 other community transportation resources to support participant independence and choice

TRANSPORTATION AND SCHEDULING - DOCUMENTATION

- Logging, tracking, and reporting Transportation Scheduling and Coordination services will be completed in the ADVSD UCR or by other methods approved by ADVSD
- A transportation assessment to determine eligibility for fare assistance must be completed annually for each transportation participant; copy must be maintained by the Contractor, and uploaded in the UCR
- 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

TRANSPORTATION AND SCHEDULING - 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.

TRANSPORTATION SCHEDULING & COORDINATION - QUALITY ASSURANCE

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% initial assessment 90% annual assessment completed within 30 days of due date	UCR
	Attendance at I&R and Transportation quarterly meetings	80%	ADVSD
	Customer satisfaction	85%	annual survey
Submit TriMet invoices for HOP Card and LIFT products to Contracts deliverable at ads.contracts@multco.us; copy the Contract Liaison for Transportation	within 5 business days of receiving the invoice	90%	Contracts Deliverables inbox

CASE MANAGEMENT AND RELATED SERVICES

Case Management for older adults is a comprehensive service provided to individuals age 60 and over (or adults age 18+ who meet the assessment and financial determination criteria for OPI or for OPI M) 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 aged 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.

Conflict-free case management (CFCM) requires that assessment and coordination of services are separate from the delivery of services, with the goal to limit any conscious or unconscious bias a care manager or agency may have, and ultimately promote the individual's choice and independence

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 to develop a service plan, documenting in Oregon Access, authorizing services, coordinating services, counseling and problem-solving, evaluation of services, advocacy, follow- up and reassessment.

Note: OPI is funded with State General Funds and currently has a wait list.

OPI Case Managers will work in Oregon Access and the State Mainframe to set up OPI consumer 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 will work with the Mult Co

Community Services Voucher Clerk team to generate Home Care Worker (HCW) vouchers in the State Mainframe.

Separation of Duties: No OPI case manager shall set up, issue, or approve HCW vouchers for payment by the State. Any contractor providing OPI services will work with the Mult Co Community Services Voucher Clerk team. These vouchers must be approved for payment within a time period specified by the State and cannot be delayed.

OPI Medicaid: SERVICES CASE MANAGEMENT

Eligibility for OPI-M is determined by a Community Services Case Manager. When a consumer is approved for OPI-M, the eligibility Case Manager with ADVSD, (ECM) collaborates with the community partner Service Case Manager (SCM). The Eligibility Case Manager (ECM) completes a warm hand off to the Community Partner Service Case Manager (SCM).. The SCM provides on-going case management to the consumer. The SCM then engages with the consumer to complete THe PLAN which is the service planning tool. The SCM is then the ongoing case manager, working and collaborating with the consumer to coordinate services in this Medicaid program. OPI M Services Case Managers work in Oregon Access and the State mainframe to set up the consumer service plan such as the in-home plan, adult day services, DME, transportation, home delivered meals and other services that are allowed and identified on The PLAN.

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 60 or over, or a loved one with Alzheimer's or dementia, or elders 55 or older caring for a child under age 18 or a disabled adult.
Contractor shall provide case management services including: assessing needs, developing care plans, documenting in UCR, 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:

- **Case Management Assistance Employee** is a service performed by a skilled employee of the Contractor
  - Hourly rate for billing: $32.20
- **Case Management Assistance Volunteer** is a service performed by a skilled volunteer. Hourly rate for billing: $27.20

CASE MANAGEMENT - ADMINISTRATIVE STANDARDS AND PROGRAM REQUIREMENTS

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

- Individual records must be maintained using forms and formats provided by ADVSD.
- Priority shall be given to participants who are at a higher level of risk.
- 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:

- Use ADVSD approved assessment tool(s) to assess the needs of participants.
- Develop action plans that include participant's goals and case manager's activities.

- Case manager's activities may include, as needed:
- Assess participant's eligibility for various programs and/or services
- Contact providers on behalf of participant
- Coordinate services on behalf of participant
- Assist participant in completing applications for programs and/or services
- Work with family members of participants to facilitate the participant's access to services
- Provide information about services including transportation, in-home care, counseling, adult day services, transportation, respite services, home delivered meals and other relevant services
- 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.
- Response to referrals must be made within five (5) calendar days of the referral.
  - Gatekeeper referrals must be prioritized and 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. *Gatekeeper referrals are often issues of self neglect and may be an older adult who is exercising their right to self determination. While this is their right, it is important that an attempt be made to offer support to the consumer and that the consumer have an opportunity to to accept help and support.*
- Maintain confidential participant information and transmit participant information by secure electronic format.
- Case management staff must be provided time to attend ADVSD sponsored training and other training as appropriate
- 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.
- The unit of service will be one (1) hour of case management that relates to a specific case management participant.

CASE MANAGEMENT - STAFF RESPONSIBILITIES

In general, Case Management staff shall:

- Respond in a timely manner to requests for information about available options;
- Provide the appropriate level of assistance needed to connect participants with services

- Document assistance that is provided
- Maintain expertise in the use of the ADRC electronic resource directory
- Maintain password access to the State and County databases

CASE MANAGEMENT - TRAINING

Contractors 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.

All new staff will receive orientation and support at their agency level by identified lead team members or supervisor/manager for the position that they are hired for and the type of case management that they will be providing, including orientation to the databases they will be using.

A request to User Access Support <user.access.support@multco.us> will be made for their own account credentials. *Sharing of login credentials is prohibited.*

Mult Co ADVSD will host regular opportunities for training and orientation to databases including on demand videos and “how to” guides. Mult Co ADVSD also hosts a number of case manager meetings that supports the network of case managers and the work they do for the variety of programs in the Case Management suite. Training may also include required ADVSD training, required ADVSD case manager meetings, webinars, State training, and subject matter conference calls. Supervisors are encouraged to support staff in attending training sessions that specifically address that employee’s goals and skill development needs as well as add to the employee’s professional development.

The state also has training (both live and on demand) to support case management tasks and required functions as well as statewide network meetings, such as the OPI Power Hour, to support peer to peer learning and collaboration.

Other tools, such as onboarding training lists will be available for new case managers for some programs, such as OPI-M.

Multnomah County offers a New Employee Orientation for “New To ADVSD” which contracted partner staff are invited to and welcome to attend. This includes:

- Introduction to the services and programs for older adults, people with disabilities and veterans in Multnomah County

- Introduction to the ADVSD Mission, Vision and Values
- Service principle of “no wrong door” access
- Organization policies and procedures
- Protocol for working with other agencies, including how to make referrals

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).
Supervisors shall maintain an annual record of training each volunteer or case manager has attended and make it available to the county upon request. Records 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).

CASE MANAGEMENT - 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.

For Oregon Project Independence (OPI) and Oregon Project Independence-Medicaid (OPI-M) case management,all consumer registration, documentation, and narration is entered in Oregon Access. For consumers being placed on the OPI wait list, the case manager completes an OPI risk assessment on the ADRC Care Tool. TheOPI-M Person Led Assessment and Notice (PLAN) must be completed to determine the service plan for OPI-M cases .

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 UCR, 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. Documentation, and narration must be completed in UCR

Family Caregiver Case Management consumer registration, documentation, and narration must be completed in UCR for the person in care and for the consumer. The family caregiver is the consumer in this program.

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.

CASE MANAGEMENT - QUALITY ASSURANCE

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 OAA: OAA Service tab information is complete and narration of assessment and follow up steps is complete	90% 90%	Oregon Access Oregon Access
	Demographic data recorded	92%	Oregon Access
	Family Caregiver: Narration & FCGSP fields completed	TBD	UCR
	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, regardless of income, 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 consumer 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.

Individuals delivering services must be trained by Mult Co or by the State as an Options Counselor.

OPTIONS COUNSELING - ADMINISTRATIVE STANDARDS AND PROGRAM REQUIREMENTS

Contractors providing Options Counseling are required to contact the participant within three (3) business days of receiving the referral. , . The initial face-to-face visit must be completed within two weeks of the initial call;unless the participant requests further out. . If the Options Counselor will be unable to respond within three (3) business days 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 members who will perform Options Counseling and their supervisor are required to attend a three-day Options Counseling training provided by the State Unit on Aging. The training must be completed prior to providing Options Counseling.

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
- Experience: Two (2) years of increasingly responsible case management work experience.

OPTIONS COUNSELING - STAFF RESPONSIBILITIES

Options Counseling staff must:

- Demonstrate commitment to person-centered counseling with attention to participant preferences, strengths, culture, and individual situation when meeting with participants and their representatives.
- Show effective participant advocacy skills with providers, family members, public and private agencies, and others.
- 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
- Perform viCSSUl 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.
- Be able to understand complex written rules, policies, regulations and laws, demonstrate attention to detail and solid administrative, case and project tracking skills
- 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
- Maintain confidential participant information and transmit participant information by secure electronic format.
- Be able and willing to travel to participant locations, regardless of accessibility or availability of public transportation to perform site visits; travel to meetings and training sessions

OPTIONS COUNSELING - TRAINING

Specific Required Training:

- 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
- Serve under the supervision of a manager who has completed the Options Counseling 101 and 202 training sessions
- May require a valid driver's license

OPTIONS COUNSELING - 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 participants within three (3) business days of receiving the referral, or sooner if the situation requires it. The Options Counselor will discuss any immediate needs over the phone and schedule the initial face to face appointment(s) within the first two (2) weeks of the referral, unless the participant requests further out

Options Counselor shall:

- Schedule an in-person meeting, in their home, a public setting, hospital or other care setting, 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
- Register the participant in the Aging and Disability Resource Connection (ADRC) Care Tool and document the assistance that is provided

- Provide the appropriate level of assistance needed to connect participants with programs and/or services as necessary, including the following:
  - Provide information about services including transportation, in-home care, counseling, and other relevant services
  - Investigate participant's eligibility for various programs and/or services
  - Contact providers on behalf of participants
  - Assist participants, if assistance is needed, in completing applications for programs and/or services
  - Work with family members of participants to facilitate the participant's access to services

OPTIONS COUNSELING - DOCUMENTATION

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

OPTIONS COUNSELING - QUALITY ASSURANCE

Monthly reporting requirements	Compliance Measures	Target	Source
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 60 and older or someone of any age with Alzhiemers or dementia s or an elderly relative caregiver (55+) raising children or caring for a relative aged 18-59 with a disability.

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)
- Supplemental Services

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

- **Case Management for Family Caregivers**: a required service of District Centers, and may be provided by any contractor that provides Case Management
- **FCSP 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 relatives who are 55 years of age or older who are caregivers of a child under age 18 or relative adult with a disability (non-parental). This program is accessed by Case Managers of contracted agencies.
- **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.

Evidence-based trainings for caregivers:

- 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.
- Contractors may host a six-week Savvy Caregiver class, run by an ADVSD staff person who is certified in this program.
- 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. Evidence-based health promotion programs are proven to improve quality of life and reduce healthcare expenditures and they empower older adults and people with disabilities.

These standards provide an overview of the program purpose, federal funding requirements and expectations for health promotion provided by Oregon's Area Agencies on Aging:

National guidelines about Evidence Based Health Promotion can be found here:
https://acl.gov/programs/health-wellness/disease-prevention
Oregon standards can be found here:
https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SUA/Documents/disease-prevention-standards-2017.pdf

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 per the guidelines from the State of Oregon and our contract as an Area Agency on Aging. 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.

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 provide in-kind support for these programs.. 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.

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-programs.pdf

Performance Standard box:

Measure	Compliance Measure	Target	Source
outreach to people who experience the most disparity in health care services	Develop a strategic plan for outreach include Community collaboration	Provide within 3 months of Contract agreement review annually with Contract Liaison(s)	TBD
% of participants who meet attendance standards as described in each EBHP fidelity	Each EBHP has defined attendance standards	75% of EBHP attendees will meet or exceed the attendance standard for the Health Promotion activity/class/workshop they are enrolled in.	Compass attendance tracking

EVIDENCE BASED HEALTH PROMOTION PROGRAM DESCRIPTIONS

Title III-D of the federal Older Americans Act (OAA) focuses on disease prevention and health promotion services. The funding for these classes was established to support healthy lifestyles and behaviors and class attendance should be prioritized for adults age 60+ with the greatest economic need.

Per the state, the following classes can be paid for using the funding in this RFPQ: https://www.oregon.gov/odhs/providers-partners/community-services-supports/Documents/evidence-based-programs.pdf

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 (DSMP)
- Arthritis Self-Management Program
- Chronic Pain Self- Management Program
- 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 (DPP)

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 lasts one year and includes several in-person sessions in the first 16 weeks 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:
https://www.oregon.gov/OHA/PH/PreventionWellness/SelfManagement/Pages/index.aspx

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. The Walk with Ease course 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 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_caregiver/

EVIDENCE BASED HEALTH PROMOTION - 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
- Partners must have a system to conduct fidelity checks in accordance with program requirements

EVIDENCE BASED HEALTH PROMOTION - 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 Get Care/UCR 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.

EVIDENCE BASED HEALTH PROMOTION - 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 needs 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/CSSU/Pages/Nutrition-Program.aspx
https://acl.gov/sites/default/files/programs/2020-12/SNPGuidetoPrioritizingClients.pdf

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.

The federal eligibility criteria for participation is based on age – a person must be at least 60 years old to participate in either a congregate or home-delivered nutrition programs. Spouses (of any age) of people age 60 or older are also eligible. In addition, Section 339 of the OAA creates the option for programs to offer meals to the following:

- People who provide volunteer services during meal hours
- People with disabilities living in senior housing facilities offering congregate nutrition services (congregate dining sites held in senior housing facilities may serve person with disabilities)
- People with disabilities who reside with eligible older adults

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, or other congregate settings 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 contract 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

- Countywide nutrition providers 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.
- Congregate nutrition providers will make every effort to obtain the required NAPIS data. This information will be completed in UCR and updated annually
- 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.
- Participants who decline to provide NAPIS data may not be denied service.
- 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.
- 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.
- Nutrition providers will develop a strategy that allows participants to make confidential donations for congregate meal(s)
- 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:

- Be conveniently located to the target population.
- Have convenient, accessible, and affordable transportation.
- Be in a safe, well lit, well-maintained location.
- Be easily visible and open to the public.
- Have adequate space to support programming.
- Have clear, inviting, and culturally appropriate exterior and interior signage.

- 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 welcoming ambience that plays down institutionalization
    - Adequate lighting
    - Acoustics that support individual and group conversations
    - Accessible restroom locations
    - Kitchens that support high quality and safe meal service
    - Furnishings that are functional, comfortable, safe and appropriate
    - 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:
    - 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.
    - 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.
    - Programming: To provide interactions that meet participant

interests and needs.
    - Services Referral: To help participants become familiar with community resources.
    - Outreach to the Community: To create public awareness of programs and services.
    - 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.
    - Administrative: To provide consistent and accurate required reporting, monitoring of budget and fund raising activities, and other duties as needed.
- 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.
- Projects must develop, implement, and annually update an operating policy manual containing, at minimum, the following information:
    - Fiscal Management
    - Food Service Management
    - Safety and Sanitation
    - Staff Responsibilities
    - Emergency/Disaster Plan
- Personnel and volunteers who assist with the congregate meal site operations should be instructed in:
    - Portion control,
    - FDA Food Code practices for sanitary handling of food,
    - Organization safety policies and procedures,
    - Protecting confidentiality and safeguarding collection of voluntary donations,
    - Cross cultural communication and conflict resolution, and
    - How to report concerns to appropriate staff for follow-up.

Each congregate meal site shall meet ADA requirements for accessibility to public programs.

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 to obtain Oregon's Food Sanitation Rules. https://www.multco.us/health/food-handlers-test, and https://www3.multco.us/FoodHandlerCard/Document/english.pdf

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://www.oregon.gov/oha/ph/HealthyEnvironments/FoodSafety/Pages/manual.aspx

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:

- Be 60 years of age or older and homebound by reason of injury, illness, or an incapacitating disability or be otherwise isolated, or
- 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
- Be a disabled person under 60 years of age who resides in a

housing facility where a senior meal site is located, or
- Be 60 or older and physically or mentally predominantly unable to shop for or safely prepare meals to meet minimal nutrition requirements, or
- Be 60 or older and have an inadequate support system for food shopping or meal preparation, or
- Be 60 or older and unable to tolerate a group situation due to physical or mental disability or substance abuse, and
- 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
- Be 50+ and a person Aging with HIV/AIDS Long-Term Survivors
- Is approved for eligibility by the AAA or the OPI service provider, and
- Lives within Multnomah County.

HOME-DELIVERED MEAL STANDARDS

Meals may be hot, cold, frozen, dried, or canned with a satisfactory storage life.
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.
Consumer 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.
- 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 when participants score at a high nutrition risk.
- Participants who decline to provide NAPIS data may not be

denied service.

- 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.
- 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/CSSU/Documents/Nutrition%20Screening%20Checklist.pdf and NAPIS form that includes ADL and IADL
        - section: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/CSSU/Pages/Area-
        - Agency-Aging.aspx
    - 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.
    - 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.
- Reassessments
    - The purpose of reassessments is to determine if a participant's need for home-delivered meals still exists and at what level.
    - 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.
    - 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.
    - 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.
- All nutrition service providers will have a plan to ensure participants will receive meals during emergencies, weather-related conditions, and natural disasters. The plan could include shelf-stable emergency meal packages, four-wheel drive vehicles, volunteer arrangements with other community resources, etc.
- 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
- Nutrition providers will develop a strategy that allows participants to make confidential donations for home-delivered meal(s)
- 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
- Home-Delivery Projects will develop, implement, and annually

update an operating policy manual containing, at minimum, the following information:

- Fiscal Management
- Food Service Management
- Safety and Sanitation
- Staff Responsibilities
- 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 CSSU 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:

- Include a variety of foods, especially fruits, vegetables and whole grains.
- Avoid too much total fat, saturated fat, trans fat and cholesterol. Encourage mono and polyunsaturated fats
- Include foods with adequate complex carbohydrates and fiber
- Avoid too much refined carbohydrates and added sugars
- 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
- Each meal certified as having met the nutrient requirements should be served as written
- Food substitutions should be infrequent or of similar nutritional value, not reduce or radically alter the nutritional content and consultation and approval by a Registered Dietitian shall be sought
- Any departure from the certified menu must be documented and initialized on the nutrition provider's 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

- 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's Community Services and Supports Unit Nutrition webpage: https://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.

- Oregon Nutrition Standards can be found here: https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SUA/Documents/oregon-nutrition-standards.pdf

REPORTING REQUIREMENTS FOR NUTRITION SERVICES

CONGREGATE AND HOME-DELIVERED MEALS

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

- Name
- Prime or organization id#
- Date and score of nutrition assessment
- # meals this month
- The program under which the meals were authorized, when required by ADVSD

Contractor shall:

- Send this information securely to ADVSD in a mutually agreed upon format; or

- Provide ADVSD with access to the Contractors database to extract this information.

NUTRITION - EDUCATION

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

- Date and location of presentation
- Name and title of presenter
- Topic Discussed
- consumer/attendee information (name, prime or organization id#)

NUTRITION - PROGRAM OUTCOME INFORMATION

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

- High nutritional risk HDM participants will have a lowered nutritional risk at annual assessment.
- 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.
- Consumers report being satisfied or very satisfied with nutrition services

NUTRITION - 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.
- **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.

------------------**END OF PROGRAM MODEL**-----------------------------