COLUMBIA COUNTY AREA AGENCY ON AGING
2017-2020 AREA PLAN

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SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A – 1: Introduction:

Columbia County has a community-based senior service delivery system. The majority of OAA services are administered through the Community Action Team's main office. CAT receives the OAA contract and provides staff support to the AAA in the county. Specifically, Oregon Project Independence (OPI), person centered option counseling, respite services, family caregiver support, and care coordination for home delivered meals are scheduled and coordinated through the CAT office. Additionally, meals, both congregate and in-home are contracted and provided by four (4) Senior Centers located throughout the county. Preventative health programs/classes are offered throughout the county by trained CAT staff and volunteer leaders at the local senior centers, public health clinics, churches and other community venues.

The geographic focal points of service are the CAT office in St. Helens, OR, and four (4) Senior Centers located throughout the county in the following communities: Clatskanie, Rainier, St. Helens, Scappoose and Vernonia. These Centers work in concert to make services available throughout the county. Each Senior Center is a separate, private, not-for-profit organization. Currently Vernonia is waiting to break ground on a new senior center building, so they have been borrowing space from other agencies. CAT uses an office in the building used by the senior center thrift store where consumers in the Vernonia area can meet with the County Veteran's Service Office and CAT's senior staff care coordinators at specific times throughout the month.

Senior Centers offer opportunities for foot care, wellness checks, blood pressure monitoring, recreation, socialization and education on issues affecting seniors. Each center manages its own programming. CAT contracts with individual centers to provide meals, both in-home and congregate. A congregate meal service and a home delivered meal services is available once a day, five (5) days a week through the senior centers.

This delivery system provides county-wide access to services for all seniors including those in rural areas. Seniors in our most rural locations have limited access to services through Columbia County Rider's Dial-a-Ride transportation system though funding cuts in recent years have led to service decisions that have reduced the system's flexibility. Care coordinators visit with rural consumers in their homes to connect them to services such as energy, HDM, weatherization, etc.

Low-income seniors are targeted through our low-income Energy Assistance Program. This program provides energy bill payment assistance to low-income seniors throughout Columbia County. Each fall an outreach campaign is conducted to identify and mail service information to low-income seniors.

Senior OAA staff are centrally located at the Community Action Team office in St. Helens. Staff specializations exist for Information & Assistance (AIRS CIRS-A/D Certified), Person centered option counseling (ADRC), Care Transitions (ADRC), Oregon Project Independence (OPI), Family Caregiver Counseling (RCI REACH, PEARLS, and SAAVY CAREGIVER), and Chronic Disease Management (Stanford Self-Management Programs and CDC Diabetes Prevention Program). All CAT care coordinators are responsible for: intakes, referral, care coordination, advocacy, outreach, and information & assistance. All staff are cross-trained to provide back-up during vacations and sick time.

When a senior staff member receives a referral, the senior is contacted immediately to set up an assessment. Needed services are made available to the consumer based on the problem areas identified by the assessment. Subsequently, the Senior Care coordinators provide ongoing monitoring to insure that appropriate services are being accessed or stopped as the case requires.

A – 2: Mission, Vision, Values:

Community Action Team's vision is "Vibrant communities with hope and opportunity where basic needs are met." Our mission is "CAT connects people with resources needed to become self-sufficient." As a Community Action Program (CAP) CAT works to end poverty in Clatsop, Columbia & Tillamook Counties through addressing basic needs, building self-reliance, improving access to affordable housing and community facilities. CAT provides a range of human, child and family and community investment programs allowing for specialized delivery of services to individuals and families. The senior programs fall within the Human Investment Area though the Community Investment programs also serve senior consumers through affordable housing properties and housing rehabilitation efforts.

The senior programs at CAT and in the Senior Centers strive to find the appropriate balance between senior independence and safety in their service delivery system.

A – 3: Planning and Review Process:

Scope of Need: According to the Portland State University Population Research Institute's estimates, Columbia County has 12408 residents age 60 or older Of those, 2,961 (26%) are under 185% Federal Poverty Level (FPL) and 776 (7%) are under 100% FPL. (See Table 1)

Table 1. Age of residents - Columbia county

		% of total population	% of senior population
TOTAL population	50390	100	
59 and younger	37982	75.38	
60-64	3809	7.56	30.70
65-69	3075	6.10	24.78
70-74	2188	4.34	17.63
75-79	1546	3.07	12.46
80-84	902	1.79	7.27
85+	888	1.76	7.16
	12408	24.62	100

Population Research Center, PSU, April 2016, Population Estimates by Age and Sex for Oregon and Its Counties: July 1, 2015.

During the next 25 years, the fastest growing segment of the senior population will be the 65-75 age group. Services for this age group should experience the highest increase in demand. Overall, the over-60 population is projected to grow to 15,645 in 2025, a 139% increase.

The majority of the seniors in Columbia County reside in rural communities with populations under 10,000. The only city with greater than 10,000 is St. Helens with a population in 2014 of 12,990 according to the US Census. Columbia County's senior population is predominately white (96%). The largest senior minority group is Hispanic Latino at 1.4% (DHS/OHA, State of Oregon).

Persons and groups consulted: On March 3, 2016, our Area Agency on Aging convened its first committee meeting to work on the 2017-2020 Area Plan. The committee is comprised of senior center directors or designees and other community volunteers. By the end of March a community needs survey was released online through Survey Monkey and promoted on CAT's website and Facebook pages. A paper version was distributed throughout various communities in Columbia County. Senior consumers were the primary target audience, but adults of all ages were encouraged to participate. The survey was closed June 1st and all efforts resulted in 338 respondents. Survey responses were obtained from each community in the county (St. Helens, Scappoose, Clatskanie, Rainier, Vernonia, Columbia City, Prescott, and unincorporated areas).

Concurrently, town hall meetings were held in five communities to engage residents and solicit their input regarding senior and Veteran's services. The meetings were promoted online and with eye-catching posters where surveys were available and other locations such as local store fronts. Attendance was encouraging with a minimum of ten residents at each meeting, up to 19 at others.

After a review of the survey data and considering their individual knowledge about the community-specific needs, over the course of four meetings the committee and staff identified key approaches to services in the five target areas required by OAA. First the group made decisions about family caregiver services and I&A/ADRC; then nutrition, preventative health, and finally elder rights and legal assistance.

The final report was presented to the AAA Advisory Board on September 15th and to the CAT Board on September 26th.

The AAA Advisory board includes consumers, service providers, health care professionals, advocacy groups and partner organizations.

Tools employed: A paper version of the survey was distributed through senior centers, libraries, food banks, mental health office, public health offices, thrift stores, municipal offices, and other key partner organizations. It was also available online via Survey Monkey.

Resources Used: In addition to custom survey data, Census data, GIS mapping data, DHS service data, and records from senior centers were used.

A – 4: Prioritization of Discretionary Funding:

OAA, IIIB funds are used for the following required programs: legal aid, nutrition, preventative health, supportive services, caregiver support and caregiver access services. In addition, we also intend to use these funds to support: volunteer recruitment and training, identification of seniors needing emotional support/validation and suicide prevention, and overall administrative and oversight of program delivery.

Other IIIB fund use include respite such as giving a family caregiver a needed time off for rest and by providing homemaker services for seniors in subsidized housing who are not likely to pass and inspection of their home and are, therefore, at risk of eviction.

We have very limited private donations and a minimal amount of United Way funds that we use as discretionary funds. For use of those funds, we use OPI standards to determine eligibility. We used the same risk factors, specifically Client Assessment and Planning System (CAPS) assessments to determine eligibility.

We partner with Columbia Community Mental Health (CCMH) to provide community mental health services. For transportation, we work with Columbia County Rider, volunteers, and churches, to provide transportation services for seniors. For housing and energy assistance, weatherization, mortgage foreclosure and veteran's services, we work with in the array of services provided to us in house as a Community Action Program.

Waiting Lists for Services: Usually CAT does not keep a waiting list, but there are times it is necessary. In those instances, care coordinators conduct a risk assessment over the phone in order to prioritize access to services. If program funds were reduced, the same process would be employed to ensure the most vulnerable are served. Efforts to secure funding from other sources is employed, but limited. CAT does partner with the local Department of Human Services in identifying the seniors who have the greatest needs.

SECTION B – PLANNING AND SERVICE AREA PROFILE

B – 1: Population Profile:

The majority of seniors in Columbia County reside in rural areas. The overall county population estimated by the US Census in 2011 is 49,351. The largest city is St. Helens with a population of 12,990 based on the same data set.

According to the 2016 DHS/OHA, State of Oregon data, 11,264 individuals in Columbia County are aged 60 or over. 776 (7%) of those over age 60 are living at or below 100% poverty level. In addition, 6,353 adults in Columbia County report living with a disability. Age distribution data was not available in the same categories as were used in other parts of this report. However, 3007 (27%) of those reporting a disability were aged 65 or older.

The total minority population of Columbia County is 6.6% or 634 individuals. As stated in planning section A-2, the largest minority group in the over 60 population is Hispanic Latino at 1.4% (DHS/OHA, State of Oregon Data). Columbia County has no Native American Tribes represented, although .8% of Columbia County's population identified as American Indian/Alaskan Native. No other senior minority group exceeds 1% of the population. According to the US Census data, the frequency of individuals reporting limited English proficiency was negligible.

B – 2: Target Populations:

Columbia County's AAA sits within a Community Action Agency whose mission it is to provide resources and support to low and moderate income individuals. Low income seniors eligible for services will be identified through all CAT's service delivery programs including homelessness, energy assistance, weatherization, housing rehabilitation, veterans and by collaborative agreements with the county's senior centers. Other local agencies, and faith-based organizations refer people to CAT for senior services. The medical community is referring to CAT more as preventative health services are expanding.

Columbia County has a community-based senior service delivery system. The geographic focal points of service are the CAT administrative office and five (5) Senior Centers located throughout the county in the following communities: Clatskanie, Rainier, St. Helens, Scappoose and Vernonia. These centers work in concert to make services available throughout the county. Each Senior Center is a separate, private, not-for-profit organization. Senior Centers also offer opportunities for foot-care, wellness checks, blood pressure monitoring, recreation, socialization and education on issues affecting seniors. In addition, the senior centers are subcontractors and provide both home-delivered and congregate meals.

Low income seniors are targeted through our Low-Income Energy Assistance Program (LIHEAP). This program provides energy bill payment assistance to low-income seniors throughout Columbia County. Each fall an outreach campaign is conducted to identify and mail service information to low-income seniors.

Senior service care coordinators are located in St. Helens at the Community Action Team Office. Four care coordinators have responsibility for outreach, intake, referral, assessment, care coordination, person-centered option counseling, advocacy, risk management, and information and assistance. All care coordinators are currently participating in the training on "Person Centered Assessment and Care Coordination" through the Department of Human Services.

Consumers in rural areas have access to senior care coordinators by phone through a local or 800 number or by visiting during regular office hours in designated rural locations. A case manager has regular hours in both the Clatskanie and Rainier Senior Centers. The Vernonia senior center is currently waiting to break ground on their new center so the case manager regularly meets in office space provided by the senior center's thrift store. Consumers are encouraged to come in at designated office times to visit with staff in these rural areas. In

addition to senior staff, the county Veteran's Service Office also uses the same office to meet with consumers needing assistance with veteran's services. Case manager's also help consumers with energy assistance, housing issues, weatherization/home repair needs and referrals to other CAT programs.

Outreach is done by senior service care coordinators attending meetings, events and activities within the service area. CAT employs a Hispanic bilingual case manager to assist in outreach to the Hispanic/Latino community. CAT uses Tele Language for individuals who call needing assistance in a language other than Spanish. TTY, VCO and STS are used for calls from consumers with a hearing or speech impairments. CAT is recognized countywide as the resource and referral nexus for Columbia County and those individuals and households facing poverty. CAT has recently started inputting calls from consumers with a disability or senior consumers into the RTZ database of the Aging and Disability Resource Connection (ADRC) in order to better track calls.

Marketing and outreach efforts are also conducted through the Metro ADRC. Ads are included in local papers, at movie theatres, local publications, and via the web. Exhibits with information are presented at county fairs, farmer's markets, children's fairs (targeting grandparents raising grandchildren), at local expos such as the "Gay and Grey Expo" and the "Portland Pride Festival," and other community events.

B – 3: AAA Services and Administration:

All intake and care coordination staff within the Human Investment program areas at CAT have been cross trained to provide intakes for all program areas, seniors included. Human Investment Care coordination staff meet weekly to discuss cases which have come in and collectively make service decisions. In this way, the senior-specific expertise which exists can be shared more broadly with other staff new to the field. In addition to weekly staff meetings, senior staff participate in a county-wide inter-disciplinary team (IDT) with the local Adults and People with Disabilities (APD) staff, Columbia Community Mental Health (CCMH) staff, The Public Health Foundation of Columbia County (TPHFCC) staff, local law enforcement, and District Attorney's office staff.

Specific direct service positions associated with senior service delivery include 4 care coordinators who will provide assessments for Meals on Wheels, care coordination, Person centered option counseling, OPI, respite, family caregiving, risk management, and other OAA services. These 4 individuals will have primary responsibility for providing all senior services within Columbia County. Two of the care coordinators are also certified I&R Specialists (CIRS-A/D) and provide information and assistance/referrals for all aging and disability programs in Columbia County. A certified I&R Specialist (CIRS) is responsible for resource entry and renewal in the ADRC RTZ computer system.

Administrative, fiscal and program management of the Human Investment area, which includes Senior Services will be completed by CAT's Executive Director, Chief Fiscal Officer and the Senior Programs Manager/Budget Analyst. Please note that costs for their time will be divided among all the programs within Human Investment.

Because of budgetary reductions, Columbia County's AAA will focus only on essential services, until such a time as more resources exist. Please see the Service Matrix and Delivery Method in Attachment C for details.

Specific Services:

- Personal Care (#1a): Providing assistance in the home for ADLs and IADLs. This service will be provided by home care workers. (OPI only)

- Homemaker (#2,#2a): Providing assistance in the home with basic home making services. This service will be provided by home care workers. (OPI and OAA)

- Chore (#3a): Providing assistance with shopping and errands. This service will be provided by home care workers. (OPI only)

- Home Delivered Meals (#4): Contracted meals provided to seniors in their homes which comply with Dietary Guidelines for Older Americans. This service will be contracted with meal sites through an RFP process. Assessments will be conducted by the senior programs care coordination staff and covers the primary communities in the county. Historically the meal sites have been the senior centers in each community.

- Person Centered Case Management (#6): Providing on-going support to seniors based on a mutually-agreed upon plan. This service will be provided by all Human Investment Care coordination staff with specific case assignments made to one of three care coordinators with expertise in serving seniors.

- Congregate Meals (#7): Contracted meals provided to seniors at senior meal sites which comply with Dietary Guidelines for Older Americans. This service will be contracted with meal sites through an RFP process. Historically the meal sites have been the community senior centers in Clatskanie, Scappoose, St Helens, Rainier and Vernonia. Currently Vernonia is waiting for a new building. During this time of transition, dietary-approved meals are being provided by three restaurants in Vernonia.

- Assisted Transportation (#9): Providing assistance and transportation escort for consumers needing help getting to medical appointments or other necessary appointments.

- Transportation (#10): Providing bus passes for consumers to get to appointments. This service does not include assistance from another person. Columbia County Rider will be used for this service.

- Legal Assistance (#11): Providing legal advice, counseling and representation by an attorney. Contracted provider will be determined through an RFP process at the completion of the Area Planning process. Areas of service include guardianship, power of attorney, landlord tenant disputes, consumer protection, elder abuse, and age discrimination.

- Nutrition Education (#12): Providing basic education about nutrition and dietary guidelines for older Americans. Some of this is provided through written materials such as placemats with talking points and newsletters. More one-on-one services will be provided by care coordination staff.

- Information and Assistance (I&A) (#13): Providing current information on opportunities and services available to seniors in Columbia County by AIRS certified staff. Assessing the problems and capabilities of seniors, linking them to opportunities and services and following up to ascertain if opportunities and services were utilized. CAT is part of the METRO ADRC.

- Outreach Services (#14): Contacts initiated by care coordinators for the purpose of identifying potential clients and encouraging their use of existing services. Contacts include senior services, service clubs, local police and fire departments and programs at Community Action Team, especially Low-Income Energy Assistance programs.

- Information for Caregivers (#15/15a): Group-based education and outreach at senior centers and other community partner agencies.

- Caregiver Access Assistance (#16/16a): Family caregiver support through one-on-one care coordination. This is provided by senior care coordinators who have also been trained in person-centered options counseling for family caregivers.

- Caregiver Respite (#30-5/30-5a): Contracted services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Assessments for caregiver respite services are conducted by senior care coordinators using the state's established respite assessment form.

- Caregiver Support Groups (#30-6/30-6a): Support groups are offered at Avamere Assisted Living Facility for Alzheimer and Parkinson's disease. A care coordinator attends each meeting to promote family caregiver/care recipient services.

- Caregiver Supplemental Services (#30-7/30-7a): Incidental services and supplies such as transportation, assistive technologies, emergency response systems, home modification, and incontinent supplies which complement the care provided by family caregivers.

- Physical Activity and Falls Prevention (#40-2): Evidence-based programs administered by trained leaders. Columbia County is currently looking at the feasibility of participating in the O4AD/ADRC development of preventative health programs to include OTAGO and Tai Chi: Moving for Better Balance programs.

- Preventive Screening, Counseling and Referral (#40-3): Providing education about benefits and a Medicare screening that is provided primarily by senior care coordination staff. Nutrition Screening and Education is completed upon initial assessment and at least annually for all Home Delivered Meal participants.

- Mental Health Screening and Referral (#40-4): The PHQ-9 and depression assessment is completed for Program to Encourage Active and Rewarding LiveS (PEARLS) program participants. Also, the Rosalynn Carter Institute's Resources for Enhancing Alzheimer's Caregiver's Health (RCI REACH) uses a family caregiver assessment and PHQ-9 completed for family caregivers to assess eligibility of RCI REACH program. Consumers with high PHQ-9 scores are referred to the local mental health/suicide prevention programs at their request.

- Elder Abuse Awareness and Prevention (#50-3): Gatekeeper services have been provided through Metro ADRC as funds permit. However, CAT still serves as a gatekeeper for the utilities, post office, landlords, and other emergency service agencies due to their relationships with these agencies through all of CAT's programs. CAT staff ensure timely referrals of all suspected abuse to the local Adult Protective Service (APS) office. If APS requests, a risk assessment is made by CAT's care coordination staff. CAT's care coordination staff participate in the county wide IDT/MDT for elder cases.

- Reassurance (#60-3): Providing regular telephone calls to selected seniors to determine they are safe and well, determine if they need assistance, and provide reassurance. This program is currently inactive; volunteers will be recruited and trained to perform this service.

- Volunteer Recruitment (#60-4): Recruiting volunteers into positions to be of service to the agency and consumers.

- Newsletter (#70-5): Quarterly newsletter providing support to family caregivers on self-care and nutrition provided by Human Investment Program Analyst.

- Public Outreach/Education (#70-10): Providing public education about senior issues, to potential clients, services for the elderly through information booths at public events, senior centers, etc.

- Chronic Disease Prevention, Management/Education (#71): Providing group-delivered, evidence-based programs to help seniors manage their health and prevent illness and falls. We are partnering with the Columbia County Health Promotion Collaborative to begin providing evidence-based programs in Columbia such as the Stanford Suite of

Program. This is a collaborative between CAT, Public Health, Acumentra, Legacy Clinic, OHSU Clinic, CCMH, APD, and other care partners.

- Cash and Counseling (#72): Consumers are provided a stipend to obtain the supportive services needed. This is usually short-term assistance. Historically this has been used by consumers needing help in their home when moving, for a one-time cleaning to pass an NOHA inspection, or to help with minor home modifications in order to maintain independence. The consumer meets with a care coordinator to discuss their need and works with the care coordinator to establish the service needed.

- Caregiver counseling (#70-2a/70-2b): Care coordinators meet with family caregivers to assist them in understanding the options and services available to them and their care recipient. Care coordinators help with person-centered decision making, problem solving, support, and training so the care provider can better care for their person.

- Person-Centered Options Counseling (#70-2): The service helps seniors and people with disabilities develop a long term care plan and provides important services and resources. This service is conducted by staff trained in person-centered option counseling. Currently, all four senior care coordinators are going through the person-centered options counseling training provided through the ADRC. Service is provided by CAT's trained options counselors. This service is part of the METRO ADRC and service information is entered into the RTZ database system.

- Caregiver Cash and Counseling (#73/73a): Family caregivers are given a stipend to obtain the supportive services which are needed to relieve the stresses of caregiving. Historically this program has been used to provide funds for the family caregiver to attend support group meetings or conferences such as the McGinty Conference.

- Volunteer Services (#90-1): Use of volunteers to provide transportation, board members, meal site management, home delivery of meals, home repairs, friendly visiting, reassurance and other activities/services.

Because CAT is a full-service Community Action Program, many additional services exist within our walls that are helpful to seniors. These include:

  - Housing: CAT provides affordable housing and assistance with housing issues. CAT's Housing Solutions program helps seniors, persons with disabilities, veterans and their families obtain and maintain affordable housing, help with move-in or relocation costs, assistance with deposits, and assistance in filling out housing applications or applications for social security. CAT's weatherization department helps consumers with energy education, window treatments and other energy saving appliances, furnace repairs and other services to keep people in their homes. CAT's senior department partners with the other CAT departments to ensure senior consumers receive a wide variety of programs and services to maintain independence and safety.

- Utility Assistance: CAT uses a number of different sources, (i.e., LIHEAP, Oregon Energy Assistance, United Way, Emergency Food & Shelter Program) to provide financial assistance to help low-income seniors meet the cost of heat, electricity, natural gas, and water/sewer.

- Mortgage Foreclosure: For those seniors facing home foreclosure issues, the Housing Center at CAT is available to provide information and resources to prevent foreclosures.

- Veterans: CAT employs the Columbia County's Veterans Service Officer and provides assistance to veterans and their family members seeking benefits. CAT is also a recipient of the Supportive Services to Veteran's and their Families grant to help veterans with housing and employment.

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

Columbia County is a Type A AAA and has a Memorandum of Understanding (MOU) in place with the local Aging and People with Disabilities office. The MOU articulates joint efforts such as warm transfers between our agencies when clients call for Medicaid screening, risk assessment, and other joint services. The APD Program Manager sits on the AAA Advisory board to advance collaborative efforts between the agencies. Both offices have experienced extensive budget cuts and find that by working together we are able to continue some services.

The services listed below are representative of some services that are lacking and are needed by seniors. For each, a description of what is available or what is lacking in Columbia County is provided.

- Mental Health – Columbia County has one public mental health provider – Columbia Community Mental Health (CCMH). They provide a broad array of services to substance addicted, developmentally disabled and chronically mentally ill patients. Medicine Wheel is a new addiction service provider that CAT works closely with when consumer needs dictate.

- Transportation – Columbia County Rider offers limited fee-based transportation services throughout the county and outside the county. This services has been hard hit with budget cuts limiting the mobility of some senior consumers. A one way ticket is $5.00, schedules are limited, and routes are drastically reduced.

- Housing – CAT provides a variety of affordable housing services throughout Columbia County. The housing and homeless service department is part of the service delivery system in our organizational model.

- Elder Abuse Awareness and Prevention – Gatekeeper training and education is provided by CAT through ADRC Gatekeeper program. In addition, APD provides training to

community partners as requested. Even though the gatekeeper funding through the ADRC was cut calls still come in from community partners with concerns.

- Employment Services – Oregon Employment Department provides basic employment and unemployment services as well as vocational rehabilitation. Pacific NW Works provides supported work experiences, volunteer work experiences and other services. There is a veteran's employment officer in the Oregon Employment Department specific for veterans.

- Energy/Utility Assistance Programs – CAT provides energy and utility financial assistance through a variety of programs to residents with low income.

- Disability Services and Programs (e.g., Developmental Disabilities, Independent Living Centers) – The APD office provides the only physical disability Services in Columbia County. CCMH provides the only intellectual disability program in the county. There is no Center for Independent Living in Columbia County.

- Community Healthy Aging and Care Transitions Partners (e.g., local public health, healthcare systems, health promotion programs) – Local public health has agreed to partner with us on health promotion programs. Columbia County has no hospital, one clinic in St. Helens/Scappoose, one clinic in Vernonia, and two school based health clinics that are considering expanding to include seniors. The CCO process will be developed and administered by Greater Oregon Behavioral Health, Inc. (GOBHI) and Care Oregon in combination.

- Senior Centers – Columbia County has four senior centers located in Clatskanie, Rainier, St Helens and Scappoose. The senior center in Vernonia is getting ready to break ground on their new building in 2017 (Currently they occupy a rented space at the thrift store. They are not able to provide any activities at this time). Each is a private, independently operating not-for-profit center responsible for their own programming, fiscal management and personnel management.

- Information and Referral/Assistance Programs (non-AAA funded, e.g., United Way, 211, Independent Living Centers) – the Columbia County AAA is part of the METRO ADRC and participating fully in its processes. CAT partners with 211 on a limited basis. The AAA receives United Way funding for respite care, homelessness assistance, and utility assistance.

- Education and Counseling Programs (non-AAA funded, e.g., SHIBA, Benefits and Benefits Counseling Projects, Easter Seals Money Management Program). SHIBA is administered in Columbia County through Washington County. Washington County is also administering the Money Management program, however they plan on dropping Columbia County from their grant agreement in spring 2017.

- Case Management (fee-based or privately funded) – There are no fee-based case management services.

- Services that target minority, limited English proficiency (LEP) or other persons with unique needs (e.g., Title VI services, or an ethnic health clinic which serves elders). There are no programs specific to limited English proficiency in Columbia County.

- Any service which specifically serves persons with Alzheimer's disease or other dementia, or their caregivers (Family Resource Center, Support Groups) – Avamere Assisted Living has a monthly Alzheimer's Support Group meeting. CAT also has implemented RCI REACH. The RCI REACH coordinator attends the support group meetings at Avamere and is working to provide more caregiver training and education opportunities in Columbia County.

Columbia County lacks significant resources locally to provide services to seniors. Below is the current status of the items listed for consideration on the plan's instructions.

- Hospital – There is no hospital within Columbia County. The closest hospitals are in Portland, 35 miles away. There is one located in Longview WA that is close for Rainier, but not other parts of the county.

- Transportation – Primarily limited to Columbia County Rider which is expensive, somewhat inflexible, unreliable, and has had repeated budget and service cut-backs. APD offers transportation through Ride Care to senior consumers who are eligible through their Medicaid insurance coverage.

- Affordable Senior Housing – Complexes exist in Rainier, St. Helens, and Scappoose, but not in other communities in Columbia County. Columbia County is currently experiencing a housing crisis for all types of housing. For example: at the Rainier complex of 27 units, there is a waiting list of 125 people. In Scappoose there are 30 waiting for 21 units.

- Elder Abuse Awareness and Prevention – CAT staff participate in the county-wide multi-disciplinary team. In addition, CAT collaborates with APD to promote education and outreach services that help identify and prevent abuse and neglect of older adults and people with physical disabilities.

- Employment Services – They exist in St. Helens and are adequate.

- Energy Assistance Programs – Programs are operated by CAT and provide mail-out services to seniors and people with disabilities. Those needing assistance to complete the forms are referred to senior care coordinators for in-home assistance.

- Developmental Disability Services and Programs – There is one program available through Columbia County Mental Health for developmental disabilities. There is not an independent living center within Columbia County.

- Senior Centers – there are four within Columbia County (until Vernonia opens its new facility in late 2017).

- Information and Referral/Assistance Programs – CAT provides ADRC I&R service for the county. We publish the county wide resource directory in English and Spanish on a semi-annual basis. 211 is newly operational within the county.

- Education and Counseling Programs – The program below provides significant benefit to the seniors in the county.
    - Senior Health Insurance Benefits Assistance (SHIBA) – currently provided by Washington County. We did not have the capacity to run this program when approved in 2011-12, nor do we have it now.

- Case Management – APD offers senior-specific case management services.

- Services that Target Minority Populations – Limited English Proficiency or other persons with unique needs: CAT has a bilingual-bicultural staff person to provide care coordination for OPI, Respite and Meals on Wheels and other services as identified for persons of Hispanic/Latino origin.

- Medical clinics sufficient to serve the county – There are three clinics in Columbia County, but they have more of an urgent-care focus. For chronic conditions or long-term needs of seniors, the vast majority of people have to leave the county to find appropriate care. There have been discussions about expanding the school-based health clinics to serve family members of students but that will not help our senior population; there remains a great demand and need for local medical care. Also, there is not a women's health clinic.

- Housing Authority – CAT is part of the Northwest Oregon Housing Authority (NOHA) that serves Columbia, Clatsop and Tillamook Counties. NOHA is located in Clatsop County.

For senior specific needs, we lack all the following. Each of these was mentioned at one point or more often during the assessment and planning process.

- There are limited caregiver supports
- Limited Alzheimer's resources
- No dementia or adult day-care
- No Title VI Nutritional Services

SECTION C – FOCUS AREAS, GOALS AND OBJECTIVES

Person-Centered Approach Overview

CAT implements a person-centered and directed approach throughout all programs, including AAA Senior Programs. In order to avoid repeating information in each of the Section C topics, we are providing a summary of that approach as it applies to all the programs.

In the past two decades, the number of options for receiving Long-Term Services and Supports (LTSS) has grown immensely. While these options are welcome and provide more flexibility for people seeking LTSS, they also can make the process of finding and accessing the right LTSS very complex. People do not know where to get reliable information to meet their unique needs. Many professional roles are limited to specific tasks. The result is a fragmented and unwieldy process for people seeking help with no single point of contact to understand a more holistic and person-centered approach to arranging services and supports.

The vision of the No Wrong Door (NWD) system is a single, state-wide system for supporting access to LTSS options from any source, including those paid for through Medicaid, other government programs, insurance, and private pay. It is meant for any person, of any age or need, who is seeking or planning for LTSS. In Oregon, the Department of Human Services and the Aging and Disability Resource Connection are striving to provide education opportunities for those who seek to help consumers navigate the LTSS. A NWD approach system that leverages the state's strengths in supporting people to reach their goals has been proposed. The proposed NWD system seeks to streamline the process of accessing LTSS. It seeks to help people of all ages, abilities, and income levels understand their options for services and support and arrange them in a timely and preferred way. It seeks to help communities put structures in place that will support the NWD system.

NWD in I&A

The METRO ADRC is active in developing partnerships, both formal and informal, to bring the NWD system to Columbia, Multnomah, Clackamas and Washington Counties. These partnerships include not only the ADRC information and referral system but nursing homes, hospitals, public health programs, senior centers, preventative health programs, veterans affairs medical centers and more. These partnerships make it easier for professionals to collaborate. In addition, it should better support people's access to the resources that best meet their needs.

NWD in Outreach

People often don't know much about LTSS until they are in crisis. Once a person is in crisis, the most expensive and least preferred options are often all that are available. The NWD system strives to serve all people and all payers and to do so before people have gotten to

the point, physically or financially, where they are eligible for public programs. Therefore, it is very important to engage in outreach so that all community members know about the support offered through the NWD system. The purpose of outreach is to increase awareness about the role of the NWD system and its available resources. It's also to develop necessary partnerships between crucial parts of the system. The NWD system is meant to become a trusted and comprehensive source for unbiased support in accessing LTSS in a person-centered way. It should be well-known within all parts of a community.

NWD in Person Centered Options Counseling and Care Coordination

Person-centered counseling (PCC) is an approach that uses person-centered thinking, planning, and practice skills to discover and organize each person's goals, strengths, interests, and preferences. Typical entry into the LTSS system is not completed in a comprehensive and person-centered way. PCC helps ensure the overall hopes of each individual are not lost in the professional's attempt to meet their immediate needs. The NWD system trains professionals to connect people with resources and help them put these into action in ways that are meaningful to individuals and take into account their unique aspirations and resources.

Providing consistent, person-centered support to people as they navigate LTSS is important. People who understand their options can make better, more informed choices. Connecting with the right resources can enhance a person's quality of life and do so with judicious use of resources. As care coordinators with CAT receive training in the Person-Centered counseling/case manager approach, they will be able to help people find the best match in support. They will be connected to the community and understand the importance of community living.

NWD in Data Collection/Information Sharing

People seeking LTSS are often met with a maze of options and paperwork that they must access through a variety of organizations or departments, often without clarity of purpose. They might be vulnerable, sick, or in crisis. They may become overwhelmed by all the details. As a result, they can end up with very expensive services that drain their own or community resources or with services that don't meet their needs. Streamlining access reduces the burden on those entering the system. Streamlining access requires a coordinated effort across organizations, such as the partnership between CAT and the DHS-APD, and processes to ensure people do not have to repeat information or connect with multiple professionals and entities that could communicate with each other. To ensure this happens, states need to change processes for eligibility and assessment and make good use of MIS and other data sources to collect and analyze information to carry out NWD functions.

NWD in Person Centered Options Counseling

CAT will use a variety of person-centered options counseling approaches to support people with a variety of different needs. A focus on the person's strengths, goals, and preferences is important. An emphasis on their ability to experience choice, direction, and control as they choose supports is also important. Duties may include:

- Use person-centered discovery to understand a person's goals and preferences while building a foundation for all work with the person.
- Address urgent and basic concerns (such as homelessness) as immediately as possible. However, look at longer-term solutions as well.
- Collaborate with other professionals, such as Medicaid staff, to speed-up processes and access to services.
- Consider natural support and typical solutions to issues (such as asking a neighbor for help) as a part of organizing options.
- Provide accurate information about eligibility criteria and application processes for federal, state, and local programs.
- Support the person in researching alternative LTSS resources as appropriate (i.e. if they do not qualify for a specific program or prefer not to use some available options).
- Offer to follow up and adjust plans and goals as desired by the person.
- Keep good records to avoid duplicative efforts or confusion later.

CAT will work with other partnerships to streamline access to LTSS for persons seeking assistance. This means connecting people to meaningful resources in ways that reduce confusion and burden along the way.

C – 1: Local Focus Areas, Older Americans Act and Statewide Issue Areas:

1. Information and Assistance Services and Aging & Disability Resource Connection (ADRC)

Profile of the Issue: Columbia County is a member of the METRO ADRC. The METRO ADRC includes Multnomah, Washington, Clackamas and Columbia Counties. The ADRC is considered the entry-point for older adults, people with disabilities, veterans, their families, and community organization. ADRC and AAA work in coordination to strengthen community resources so consumers know where to turn for help. This has been called the “No Wrong Door” approach to services.

The METRO ADRC helps people learn about and navigate through various options for long-terms care services. It is a highly visible and trusted place where people of all income and ages can turn for unbiased, reliable information on the full range of long-term support options. It integrates aging and disability service systems so people will have access to the information and assistance they need.

METRO ADRC Core Services –

Information, Referral and Awareness – The METRO ACRC serves as the first stop for consumers, family members, and friends as they seek to find resources for those who are aging or have a disability. The METRO ADRC is designed to streamline access to information about long-term care. Referrals are made to programs and organizations that may meet the

individual's specific needs. Assistance is provided in accessing services when needed or requested.

Online Resources – An online database of resources is provided through www.ADRCofOregon.org. The database is maintained by a resource specialist who is part of the METRO ADRC resource group that meets monthly. The database is updated at least annually and as new resources are identified or existing resources change.

Person Centered Options Counseling and Assistance – Trained professionals assess the situation presented and offer options for services. Home visit assessments are available if needed and requested. Help is also provided for navigating the system of programs and services available. Person-centered options counseling training is offered through the State Unit on Aging for staff providing the service.

Care Transition Assistance – The Metro Care Transitions Program (MCTP) is a four-county collaborative that aims to reduce hospital readmissions by building patient and caregiver confidence, improving self-management skills, and coaching patients to take a more active rule during transitions from one care setting to the next. The MCTP uses the Coleman Care Transitions Model. This is a short-term 30-day intervention model that focuses on patient activation. The in-home visit by a health coach empowers the client to learn about following four pillars: dynamic patient-centered records, red flags specific to the client's health condition, follow-up on medical appointments, enhancement of physician communication, and medication self-management. In addition to providing the Care Transitions intervention, Care Transitions Coaches frequently assist participants in connecting to vital community resources such as in-home care services, behavioral health support services, home-delivered meals, Supplemental Nutrition Assistance Program benefits (SNAP/food stamps), family caregiver support services, transportation services, Medicaid medical benefits, and many more.

Problem/Need Statement: CAT is already known as the primary point of contact for most local human services in Columbia County. While CAT works in tandem with the METRO ADRC, it is difficult for CAT to meet all of the requirements of a fully operational ADRC. The larger counties (Multnomah, Clackamas, Washington) have been supportive of Columbia County as part of the METRO ADRC. They provide coverage for weekend and holiday calls, take the lead for grant writing (e.g., care transitions and preventative health programs), and oversight of the money management and SHIBA programs.

The impetus for the development of the ADRC was a state directive, not a client-driven request. Counties were expected to comply. CAT is already the primary point of contact for most local human services. Columbia County is frequently overlooked and underrepresented compared to the other three large counties. In addition, as a Community Action Program, CAT provides a multitude of human and community services to the entire county, not just seniors. The requirement to enter all CAT clients into RTZ – even though the majority of them are not seniors – is an enormous burden on our small staff. All the information entered into RTZ is already being entered into a database for another program such as OPUS for energy

assistance or Service Point for housing. Therefore, most of the data in RTZ is a duplication and could be provided from another source. This pulls our staff away from serving more clients. However, in our best effort to comply with the RTZ requirements, we had our receptionist enter CAT's energy/utility clients into RTZ. It is worth noting it took her over 40 hours at a cost of more than $800. To extract the information needed from OPUS, the energy database, it would have taken the program manager ten minutes. In addition, the four employees in senior programs spend an average of 8 – 10 hours each month re-entering data into RTZ that they have already entered into program-specific data bases.

The MCTP was initially funded by Centers for Medicare and Medicaid Services (CMS) as part of the Affordable Care Act and served Medicare Fee-For-Service clients in Multnomah, Clackamas, Washington or Columbia counties who were diagnosed with one of the following conditions: COPD, diabetes, pneumonia, cerebral vascular accident, coronary atherosclerosis, aortic valve disease, cardio myopathy, congestive heart failure, orthopedic surgery, renal failure, deep vein thrombosis, coronary artery disease, ischemic heart disease, atrial fibrillation, unstable angina, acute myocardial infarction. The grant ended in early 2016.

By providing fairly limited, yet wrap-around support services, the program has shown significant positive impacts for program participants. The MCTP program has served over 4200 patients between April 2014 and May 2016, and was successful in decreasing readmissions to those served by 50%, far exceeding the initial goal of a 20% reduction. CMS recognized the program's excellence in delivering the Coleman Intervention as having the lowest re-admission rates amongst participants in the nation. Currently, in Oregon, approximately 16% of hospitalized patients with chronic conditions readmit within 30 days. Assuming that the MCTP serves a monthly panel of 200 patients and reduces the readmission rate by a little over half, the MCTP will save approximately $310,016 per month at a cost of $57,500 per month. The approximate Return on Investment (RIO) is 5.4:1.

The Metro Care Transition management and staff are very pleased with the effectiveness of this intervention. We'd like to expand our program to help all older adults and persons with disabilities who are discharging from the hospital, regardless of payer and who may be at risk for readmission. Unfortunately the CMS grant ended in May of 2016, so partners are working to find ways to sustain this important program and bring this valuable service to additional participants. One way we are already accomplishing that through a contract directly with the Oregon Health Sciences University hospital. Currently, the MCTP is serving approximately 30 patients per month discharging from OHSU. Additionally, the program is in process of developing contracts with Providence Health Systems and Prestige Care. Ultimately the program will have the capacity to serve as many as 400 individuals per month, as well as to extend services outside of our current service area.

Focus Area - **Information and Assistance Services and Aging & Disability Resource Connection (ADRC)**:

Goal: Empower Columbia County's older residents, their families, and other consumers to make informed decisions about and to easily access existing health and long-term care options though the ADRC Services.

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Review the ADRC readiness assessment tool as provided by the SUA on an annual basis	a	Review the tool and determine how the ADRC program can be successfully implemented at CAT	AAA/CAT directors and staff	1/2017	12/2017	
	b	Require all staff who provide Information & Referral (I & R) to become Alliance of Information Referral Systems (AIRS) certified within one year of hire	AAA/CAT I & R staff	1/2017	12/2020	Two staff have completed AIRS certification. The third will be taking the exam summer 2019
	c	Improve ADRC access by working with the METRO ADRC	AAA/CAT directors and staff	1/2017	12/2020	ADRC Operations Council for Metro ADRC re-organized and started meeting at least quarterly in December.

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Update RTZ resource database annually and ensure consumers are satisfied with the services and activities provided (with excellent or good ratings).	a	Review the current database and identify resources to be added, updated or deleted	AAA/CAT ADRC Resource Database staff	1/2017	12/2020	Annually
	b	Develop and follow a timeline to update the database on an annual schedule	AAA/CAT ADRC Resource Database staff	1/2017	Ongoing	
	c	Improve ADRC resources in RTZ to make searching more accurate	Resource Specialist/Program Manger	1/2017	12/2019	Monthly meetings
	d	Strengthen existing Quality Improvement measures to include focus on non-English speakers, communities of color and LGBTQ (This is a Metro ADRC Key Task)	Metro ADRC QA committee/CAT Executive Director/Resource Specialist/Program Manager	1/2017	12/2017	Ongoing

Goal: To maintain and sustain the ADRC in Columbia County through collaboration with the METRO ADRC

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
Ensure ADRC sustainability in Columbia County	a	Identify stable, recurring funding sources to support the ADRC program	AAA/CAT Executive Director Program Manager	1/2017	12/2020	Ongoing

	b	Strengthen outreach efforts and contacts in Columbia County	Outreach Manager/Program Manager	1/2017	12/2020	Ongoing

Goal: To establish and maintain a viable Care Transition Program in Columbia County as part of the Metro Area Care Transition Program through the METRO ADRC

Measureable Objectives		**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2017-2020 (by Month & Year)**		**Accomplishment or Update**
				Start Date	**End Date**	
Work with community partners (CCO, Public Health Clinics) and Portland Area hospitals to fund and expand the MCTP to 400 individuals per month and become self-sustaining.	a	20 of 400 individuals served will be in Columbia County	MCTP Staff/Partners/CAT Care Transition Staff	1/2017	12/2018	Ongoing Yearly
	b	Strengthen outreach and awareness efforts and contacts in Columbia County to include the CCO, Public Health Clinics, Doctor's offices about the MCTP	Outreach Manager/Program Manager/Care Transition Staff	10/2017	12/2020	

2. Nutrition Services (OAA Title IIIC)

Profile of the Issue: The purpose of the OAA Nutrition Program is to reduce hunger and food insecurity, promote socialization, promote health and well-being, and delay adverse health conditions for older individuals. Good nutrition is a key component in maintaining the health of vulnerable, older adults. Maintaining a healthy diet is an important key in helping older adults positively impact their physical health, mental health, and delay or prevent the onset of diseases.

Historically, both congregate and home-delivered meals have been contracted to the five senior centers in Columbia County. Each center is autonomous and is responsible for staffing the meal program, preparing and delivering the meals, recruiting volunteers to manage and deliver meals, and is held responsible for nutrition and program compliance. The senior centers are located in five of the seven incorporated towns in Columbia County: Clatskanie, Rainier, Scappoose, St. Helens, and Vernonia.

In March of 2016, the senior center building in Vernonia was demolished due to FEMA regulations from the flood of 2007. Vernonia Seniors have obtained block grants, city grants, and independent funding to build a new structure scheduled to break ground in the spring of 2017. Currently, home-delivered meals are being prepared by three restaurants in Vernonia. Each meal has been approved by a dietitian. Participants in the congregate services receive ten vouchers for meals each month. They are able to use the vouchers at any one of the three participating restaurants of their choice. Home delivered meals are being served five days per week from the restaurants by volunteers from the Vernonia Senior Center. The center maintains an office in a local building that also serves as the senior thrift store.

Problem/Need Statement: The Columbia County senior population is spread over a large geographical area. Two current senior centers are in unique circumstances. Because Vernonia is without a dedicated building, congregate meals have been provided through local restaurants. Seniors were provided with vouchers to purchase meals from predetermined menus that meet dietary standards. Clatskanie has been experiencing significant reductions in meals served due to accessibility of the center (it is located in the basement of a historical building), change of cooks (three in the last year), lack of volunteers, decline in donations, and general decline of the seniors participating in meals.

As a result, the AAA Advisory Board considered several options for meal delivery in Columbia County. Seven different possibilities were created: maintaining five meals sites, four meal sites, three meal sites, three meal

sites and one centralized site, as well as options for restaurant meals in the remote areas and/or delivery from another meal site to a remote area for distribution. At the Advisory Board's direction a recommendation was made to reduce the number from five meal sites to three. CAT will send out a request for proposal (RFP) seeking to have subcontractors provide congregate meals in three of the five specific cities in Columbia County to include Clatskanie, Rainier, Scappoose, St. Helens, and Vernonia with the potential to provide home delivered meals to cover the other two sites. Home delivery may be one, two, three or five times per week but must deliver five meals per week per client. UPDATE: The AAA Advisory Board decided to keep 5 meals sites for 2017-18. Beginning 2/20/2018 Scappoose will no longer be participating in the senior meal programs. Columbia county now has 4 meal sites with St Helens covering the Scappoose HDM area.

The current congregate meal sites include:

- St. Helens: Senior Center Monday through Friday at 11:45 am
- Rainier: Senior Center Monday through Friday at 12:00 pm
- Clatskanie: Senior Center Monday, Wednesday and Friday at 12:00 pm
- Vernonia: Senior Center Monday through Friday at any time at one of three local restaurants

Home Delivered Meals are provided for five days a week, but may be deliver several at a time due to the rural nature of the service areas. HDM for Scappoose will be delivered from the St Helens Senior center.

Because each meal site is an autonomous organization contracted by the AAA, they are responsible for their own fundraising efforts. Most have events, items for sale in a thrift shop, and other strategies.

Nutrition counseling is not provided. However, the RD at the Public Health Foundation has been conducting nutrition classes for people living with diabetes and chronic diseases. Interested persons are connected to these classes.

Health promotional educational materials are distributed through congregate and home delivered meals at least quarterly. Nutrition education is conducted at the senior centers and even those who do not participate in meals are invited to attend.

Nutrition Education Policy:

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. (AoA Title III/VII Reporting Requirements Appendix www. aoa.gov)."

According to the State Unit on Aging, to be effective a program must incorporate methods to encourage behavior change. Community Action Team provides nutrition education for both congregate and home delivered meal participants.

Congregate Meals

Community Action Team (CAT) as the Area Agency on Aging will provide each congregate meal nutrition site with State approved nutrition education materials accompanied by brief talking points which review the main concepts of the nutrition education materials to be presented. The information will be provided quarterly at the AAA Advisory Board meeting and/or the Senior Board meeting to each meal site manager. The meal site manager will review talking points and present the education materials at their respective congregate meal site on a quarterly basis. Education materials may be, but are not limited to: newsletters, tent cards, place mats, brochures, posters, etc.

Home Delivered Meals

CAT Home Delivered Meal care coordinators will use State approved nutrition education materials to review information as it relates to the annual nutritional risk assessment. Care coordinators may also provide additional information as requested or needed by homebound clients. All materials used will be State approved.

Materials

Nutrition Education shall be planned and directed by a licensed dietitian who is covered by liability insurance. Under the direction of the dietitian, individuals with comparable expertise or special training (ie. 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. Nutrition Education materials reviewed by the State Unit on Aging dietitian fulfill the part of the definition related to being overseen by a dietitian.

CAT will use the approved nutrition education materials provided through the State Unit on Aging's registered dietitian.

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

Care Coordinators participate in the available online Person Directed Services and Supports and Service Equity training and await additional face-to-face training opportunities from the state.

Focus Area - Nutrition Services

Goal: Provide nutritious meals that meat 1/3 US RDA Nutritional Requirements to older adults in a congregate setting

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Provide access to healthy food and socialization in a variety of settings to meet the diverse needs of older adults in Columbia County through congregate meal services.	a	Implement new contracts with the four meal sites	AAA/CAT senior program manager	6/2017	7/2017	
	b	Oversee meal site's compliance with OAA nutritional regulations and data reporting requirements	AAA/CAT senior program manager	1/2017	12/2020	Started mandatory training day for meal sites. 05/22/18 will be next training day. Now have cook meetings 2nd Thursday every other month.
	c	Provide 25,573 meals in a congregate setting to older adults regardless of their ability to make a monetary donation.	CAT senior program manager/Meal site staff and volunteers	7/2017	6/2018	Updated annually 2017-2018 – 25,710 meals served

Goal: Provide nutritious meals to homebound older adults that meet 1/3 US RDA Nutritional Requirements – Home Delivered Meals (HDM)

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Provide access to healthy food to homebound older adults throughout	a	Implement new contracts with four meal sites to provide HDM to communities in Columbia County	AAA/CAT senior program manager	6/2017	12/2020	Yearly

Columbia County (five meals per week)	b	Oversee meal site's compliance with OAA nutritional regulations and data reporting requirement	CAT senior program manager	1/2017	12/2020	Twice annual evaluations
	c	Deliver 32,816 meals containing 1/3 of the US RDA to homebound older adults regardless of their ability to make a monetary donation.	Meal site staff and volunteers	7/2017	6/2018	Updated annually 2017-2018 – 34,234 meals served.
	d	Process background checks for delivery volunteers	CAT senior program staff	1/2017	12/2020	Ongoing
	e	Assess new HDM applicants and reassess existing consumers	CAT senior program staff	1/2017	12/2020	Ongoing

Goal: Educate older adults in Columbia County about the importance of good nutrition

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Provide reliable, dietician-approved nutrition education materials at least quarterly to 350 meal participants.	a	Distribute nutrition education accompanied by brochures, newsletters, posters, through the three meal sites.	CAT senior program staff/meal site staff	1/2017	12/2020	Quarterly
	b	Distribute nutrition education accompanied by brochures, newsletters, posters, through the HDM program county-wide.	CAT senior program staff	1/2017	12/2020	Quarterly
	c	Care coordinators will be certified in Person Directed Services and Supports and Service Equity as the training is made available by the state.	CAT senior program staff	1/2017	12/2020	Ongoing

3. Health Promotion (OAA Title IIID)

Profile of the Issue: According to the Center for Disease Control and Prevention (CDC), chronic diseases are among the most common, costly, and preventable of all health problems in the United States. 2014 data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS) shows that 54.8% of Oregon adults have at least one chronic condition, and 89% of Oregon adults have at least one risk factor for developing a chronic disease. In Columbia County, a significant and disproportionate number of adults suffer from chronic conditions. Between 2010 and 2013, the BRFSS reported that 57.9% of adults had one or more chronic conditions. Columbia County data from the BRFSS cites the most prevalent chronic conditions as: arthritis, asthma, diabetes, cardiovascular disease and chronic obstructive pulmonary disease. Chronic Pain is also prevalent in the County. In a 2014 Community Health Assessment conducted by the Columbia Pacific Coordinated Care Organization (CPCCO), insurance claims data gathered from CPCCO members showed that seven out of 10 diagnoses were for pain-related conditions and that the most commonly prescribed medications were opiates for pain management

As part of a statewide effort to advance policies, environments, and systems that promote health and prevent and manage chronic diseases, Columbia County began focusing on establishing an evidence-based chronic-disease self-management program in 2014. In early 2015, peer leaders were trained to facilitate self-management classes that were created by the Stanford Patient Education Research Center for chronic diseases, diabetes, and chronic pain. The six-week workshop teaches participants how to deal with issues such as fatigue, frustration, pain, and isolation. Participants learn exercises that help maintain strength and flexibility. Participants gain information on properly using medications, communicating with health care providers, and evaluating new treatments. The classes aim to empower people living with chronic conditions and the caregivers of those living with chronic conditions to live healthier lives.

In May of 2015, Columbia County received a license from Stanford's School of Medicine to begin offering self-management classes for residents of Columbia County living with chronic conditions. Within the past six months, through partnerships with Acumentra Health, Columbia County's Community Action Team (CAT), and Northwest Senior and Disability Services (NWSDS), The Public Health Foundation of Columbia County (TPHFCC) trained four workshop leaders, two of whom are members of the county's Medical Reserve Corps (MRC) and two are staff of Community Action Team. The trained leaders conducted five, six-week long chronic disease, diabetes, and chronic pain self-management classes.

Problem/Need Statement: Growth and sustainability of the program rely upon the organization's capacity to offer classes on a regular and reliable basis and to expand classes to other parts of the county. To date, classes have only been provided in Scappoose and St. Helens. A larger pool of volunteers is needed to increase the number of classes offered, to offer classes in the North and West County, and to effectively improve access for residents. Increasing the number of trained peer leaders will improve class availability to at least 12 per year and expand offerings to Rainier, Clatskanie, and Vernonia. Living Well classes are

highly participatory and are most effective with between 10 and 16 participants. A secondary goal will be to improve marketing, outreach, and referral efforts to ensure that all classes have optimal participation in each of the communities. CAT will also work with TPHFCC to train a leader for Tomando Control de su Salud to bring a class to the Hispanic Latino community in Columbia County.

The effectiveness of Stanford's self-management program is supported by decades of research. Studies from the Stanford Patient Education Research Center have shown that participants consistently have "greater energy, reduced fatigue, more exercise, fewer social role limitations, better psychological well-being, enhanced partnerships with physicians, improved health status and greater self-efficacy;" and these benefits persist over time. Research also demonstrates reductions in healthcare expenditures such as fewer emergency department visits, hospitalizations, days in the hospital, reduced outpatient visits, and more appropriate utilization of healthcare services. This is especially important in an area with a shortage of providers and socioeconomic barriers to care. The program is effective across socioeconomic and education levels.

Relationships with fellow participants last beyond the workshops, creating a support system across the community. Entire families often benefit as participants bring home new ideas and integrate healthy behaviors into their routines. Ongoing and reliable schedules of classes will reach more people and improve the health of individuals and the County's population. As a result, the community is happier and more resilient.

Additionally, a number of challenges will be addressed in order to increase access and sustain proposed programs. Access issues will be addressed through: increasing the number of classes offered each year, and expanding the geographic reach of culturally specific programs; addressing behavior modification by raising awareness, both among the general population and among healthcare providers, of the importance of managing chronic conditions; creating a regional, centrally-managed program registration system; addressing the transportation challenges of rural populations; an easy-to-use referral system to increase the number of healthcare provider referral. CAT will also be working with the O4AD and other AAA programs to establish sustainability through the creation of a billing system that will connect Medicare and Medicaid, and other payers to providers of Chronic Disease Self-Management Education and Self-Management Education.

Focus Area – Health Promotion:

Goal: Add *additional* preventative health program offerings in all areas of Columbia County

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Add two *new* Self-Management programs and a Diabetes Prevention Program in Columbia County in partnership with The Public Health Foundation of Columbia County (TPHFCC) with at least eight students in each section	a	Recruit leaders for Tomando Control de su Salud	AAA/CAT and TPHFCC	3/2017	12/2018	
	b	Community outreach to Hispanic Latino community.	AAA/CAT and TPHFCC	1/2018	12/2018	
	c	Offer *Living Well with Cancer* program	AAA/CAT and TPHFCC	10/2017	12/2020	Annually
	d	Offer *Tomando Control de su Salud* program	AAA/CAT and TPHFCC	01/2018	12/2020	Annually
	e	Schedule Diabetes Prevention Program (One Year Program)	CAT and TPHFCC	03/2017	03/2018	Scheduled to begin 05/2018.

Goal: Expand frequency of *existing* preventative health program offerings

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Offer *existing* Self-Management courses in all Columbia County communities to include North and West County three times each year.	a	Recruit additional instructor/peer leaders	AAA/CAT and TPHFCC	10/2016	12/2020	Ongoing
	b	Community outreach to participants and medical providers	AAA/CAT and TPHFCC	1/2017	12/2020	Ongoing

	c	Schedule *three* Living Well classes each year in Columbia County	AAA/CAT senior programs staff	1/2017	12/2020	Annually. We have already held 3 classes. 2-DSMP and 1-CPSMP with a 4th CPSMP to begin in April.

Goal: Educate older adults in Columbia County about preventative health

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Provide health education and educational materials through a variety of channels. Measures differ per program tasks. See Tasks for measures.	a	Case managers provide one-on-one education and screenings at least yearly or as requested per consumer.	AAA/CAT senior staff	1/2017	12/2020	Yearly and as needed
	b	Educational materials distributed through congregate and home delivered meals at least quarterly	CAT senior staff, senior center staff and volunteers	1/2017	12/2020	Quarterly
	c	Advocate for the senior population with the Coordinated Care Organization (CCO)	AAA/CAT senior programs staff	1/2017	12/2020	Ongoing
	d	Provide bus passes for rural seniors to get to preventative health classes as needed to promote attendance.	AAA/CAT senior programs staff	1/2017	12/2020	As needed

4. Family Caregivers (OAA Title IIIE)

Profile of the Issue: Families are the mainstay underpinning long-term care for older persons in the United States. According to the Oregon Caregvier Respite Work Group, each year in Oregon Family caregivers make it possible for older adults and people with disabilities of all ages to remain living in their homes.

In a response to the growing needs of caregivers, The National Family Caregiver Support Program was established through the Older Americans Act amendments of 2000. The program is designed to increase available supportive services to family caregivers. The program requires states to give priority consideration to persons in greatest social and economic need, with particular attention to low-income, minority individuals as well as older individuals age 60 or older providing care and support to persons with mental or developmental disabilities and grandparents raising grandchildren.

The Columbia County AAA and local community-service providers offer the following core services for family care givers, including:

1. Information to caregivers about available services.
2. Assistance to caregivers in gaining access to supportive services.
3. Individual counseling, organization of support groups, and caregiver training to assist them in making decisions and solving problems relating to their care giving roles.
4. Respite care to enable caregivers to be temporarily relieved from their care giving responsibilities.
5. Supplemental services, on a limited basis, to compliment the care provided by caregivers.

Family caregivers often face stress and challenges when caring for an elderly or disabled family member. The care required can be unending, unpaid and unappreciated. Yet, these care services provide help and support that may delay a senior's entry into the Medicaid system and institutionalization. Research has demonstrated that support, training and self-care can be useful in reducing caregiver stress.

In Columbia County there are no adult day centers, only one of the assisted living facilities in Columbia County offer a memory care unit, and support groups are limited. CAT has done outreach to various populations in Columbia County, including offering respite for family caregivers, but have had very few applications for services. Most caregivers have difficulty leaving their homes to attend caregiver meetings. With no adult-day services, it becomes difficult for caregivers to get the supports they need.

CAT has responded to a need for education and awareness for caregivers of persons with memory issues. CAT was award a grant in March of 2015 to begin a Rosalynn Carter Institute Resources for Enhancing Alzheimer's Caregiver's Awareness (RCI REACH) program in Columbia County. The RCI REACH program is an evidence-based program proven to improve the caregiver's experience by teaching strategies to cope with troubling behaviors, reducing feelings of caregiver burden and helplessness, teaching effective stress management techniques, increasing caregiver self-care and reducing depression. This program is delivered to individual caregivers in their homes. CAT found this to be the best way to deliver supportive services in a rural county.

In addition, CAT has been working with the Alzheimer's Association Oregon Chapter to bring education opportunities to the congregate meal sites. The short educational opportunities have been well received.

Problem/Need Statement: Currently there are few resources in Columbia County for family caregivers. Past attempts to provide caregiver support groups by CAT at local senior centers have been unsuccessful. Few members attend or participate and quickly interest falls without participation. Avamere Assisted Living offers an Alzheimer's and Parkinson's Caregiver Support Group each month. The support groups are attended by 4 to 6 participants each month. CAT's senior program family support specialist also attends the meetings to provide information and outreach. However, attendance at the support groups tends to be the same people each week. Respite care is provided by CAT on a limited basis and relies on United Way or donations from individuals for funding. CAT has done outreach to various populations in the county including offering respite but have had very few applicants for those services.

Yet in the AAA Community Surveys, 27% of participants responded there was a need for support groups, 40% of participants responded there was a need for Adult Day Services and 10% responded there is a need for respite care in Columbia County. Many participants responded they were unaware of any family caregiver programs in Columbia County. This data shows us there is a need for outreach, awareness and education, and building community partnerships to increase programs for family caregivers in Columbia County.

As a Community Action Program for the county, CAT already has programs/services that put the agency in contact with those in the greatest economic need. All Human Investment Case Managers are trained to assess for family caregivers and family caregiving responsibilities with the clients that come into CAT's office for other services like housing, energy/utility assistance, and veterans services. The vast majority of those seeking services are of low-income and represent this AAA's target senior population. The goal is to create screening and assessment/plans as a part of CAT's integrated service delivery system. After completing a uniform assessment, case

staffing identifies those families with the greatest need for providing services and support in the area of family caregiving. As appropriate, family members will be referred to support groups, training, counseling, and respite services as well as information through the ADRC resource system. While this AAA is open to providing support to relatives raising children, $19,000 per year barely allows us to serve those with the greatest needs.

CAT has created an Outreach Committee to further assess and address identified needs for members of disadvantaged groups.

Because of limited funds, we don't provide much in supplemental services. We track some legal assistance, telephone reassurance and some consumable supplies and as needed, an adaptive equipment closet. Decisions to provide supplemental services is determined by case manager's assessment of need. We have limited resources overall so are often unable to meet service needs. Being rural is also a problem for any group formats. There are limited individuals in each location and transportation becomes a complication as well.

Focus Area - **Family Caregivers**:

Goal: Family Caregivers will be informed about and have access to resources to assist them in caring for older adults, relatives under 18 years of age or adult children with special needs – Family Caregiver Support Program (FCSP)

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Promote the Family Caregiver Support Program. Outreach and education will be conducted at least six times per year.	a	Family Caregiver Coordinator will develop an informational newsletter for family caregivers on a quarterly basis.	CAT's FCSP Coordinator or designee	1/2017	12/2020	Quarterly
	b	Attend and support monthly caregiver support meetings at partner agencies to promote family caregiver services	CAT's FCSP Coordinator or designee	1/2017	12/2020	Monthly
	c	Meet with community service organizations such as Alzheimer's Association, Kiwanians, VFWs, ecumenical associations, and Elks to discuss and promote services for family caregivers	CAT's FCSP Coordinator or designee	1/2017	12/2020	
	d	Ensure existing information about services for family caregivers is accurate & updated and identify new programs currently not listed in the ADRC resource system	CAT's FCSP Coordinator or designee/ADRC resource database specialist.	1/2017	12/2020	Yearly/Ongoing

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Provide a minimum of 200 hours of respite services to family caregivers	a	Recruit new consumers for respite services to double consumers served from five to ten	CAT senior programs staff	1/2017	12/2020	Ongoing 2017-18 – 7 caregivers served with 105.75 hours.
	b	Provide respite services to family caregivers wanting to attend caregiver support groups or caregiver trainings.	CAT senior programs staff	1/2017	12/2020	Ongoing
	c	Hold public outreach meetings in all areas around Columbia County to promote education and awareness of caregiving breaks offered through the FCSP.	CAT senior programs staff	1/2017	12/2020	Ongoing at least Quarterly

GOAL: Provide a series of supportive activities to help caregivers manage their caregiving responsibilities

Measureable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Promote the Family Caregiver Support Program. Outreach and education will be conducted at least six times per year.	a	Family Caregiver Coordinator will develop an informational newsletter for family caregivers on a quarterly basis.	CAT's FCSP Coordinator or designee	1/2017	12/2020	Quarterly

	b	Attend and support monthly caregiver support meetings at partner agencies to promote family caregiver services	CAT's FCSP Coordinator or designee	1/2017	12/2020	Monthly
	c	Meet with community service organizations such as Kiwanians, VFWs, ecumenical associations, and Elks to discuss and promote services for family caregivers	CAT's FCSP Coordinator or designee	1/2017	12/2020	Ongoing
	d	Connect consumers to the ADRC resource database and make them aware of the services offered	CAT's FCSP Coordinator or designee	1/2017	12/2020	
	e	Participate in county health fairs, county events (fairs, parades, etc), Veteran's Stand Down, Brown Bag meetings, etc. in order to provide awareness and education about services to caregivers.	CAT's FCSP Coordinator or designee/CAT Senior Staff	3/2017	12/2020	As provided. 2017-18: The Veteran's Stand Down was attended in November 2018. We attended the senior day at the county fair in 2018. The Senior Health Fair was attended in October 2018.
	f	Distribute and provide information at the county-wide area lunches at least 6 times per year.	CAT's FCSP Coordinator or designee/CAT Senior Staff	2/2017	12/2020	The AAA board decided to curtail the 5-area lunches. However, the staff have been attending the center's member lunches and/or board meeting days.

Goal: Increase awareness and participation in the RCI REACH Program

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Increase RCI REACH participants from four per year to eight per year.	a	Identify and recruit new clients for RCI REACH.	CAT's FCSP Coordinator or designee	1/2017	12/2020	Ongong. Have presented information at the senior center lunches.
	b	Continue to attend caregiver support meeting as an outreach to new program participants	CAT FCSP Coordinator/CAT senior programs staff	1/2017	12/2020	
	c	Hold public outreach meetings in rural areas around Columbia County to promote education and awareness of the RCI Reach Program.	CAT FCSP Coordinator/CAT senior programs staff	1/2017	12/2020	

5. Elder Rights and Legal Assistance (OAA Titles VII & IIIB)

Profile of the Issue: Seniors are often victims of abuse, neglect, financial abuse, fraud and scams. Many live on fixed incomes without resources to seek recourse if they are wronged. Additionally, there are some seniors without mental capacity to look out for their own best interests. These seniors need protection from people who would seek to cause them harm physically, emotionally, financially, and in other ways.

The gatekeeper program was part of the METRO ADRC. Gatekeeper programs train employees of community businesses and organizations to recognize and refer at-risk older adults and people with disabilities to the ADRC. CAT provided training to postal workers, Columbia County Emergency Management Team, area landlords, utility providers, financial institutions, and ecumenical societies in 2015-2016. Unfortunately the program's funding was eliminated from the budget in 2016. However, CAT feels the program is essential to providing services and protection for older adults and people with disabilities, especially with the remote nature of our rural communities. CAT seeks to continue this program with OAA Elder Abuse Funds and partnership with DHS-APD.

The Multi-Disciplinary Team (MDT) for Columbia County started in October of 2016 and is still trying to get protocols and meetings in place. The mission of the Columbia County Vulnerable Adult MDT is to develop a professional team committed to protecting the elderly and adults with disabilities (Collectively referred to as "vulnerable adults"). It uses a team approach to the assessment, investigation and prosecution of abuse cases involving vulnerable adults. MDT members work in collaboration to address the abuse of vulnerable adults served in Columbia County, and to facilitate a process in which professionals from diverse disciplines are able to work together more effectively and efficiently.

Columbia County MDT is comprised of representatives from:

- community mental health program
- community developmental disabilities program
- Department of Human Services or designee of the department
- Oregon Health Authority or a designee of the authority
- local area agency on aging
- district attorney's office
- law enforcement
- an agency that advocates on behalf of individuals with disabilities
- others specially trained in the protection of adults

The MDT has a written protocol (shown below) signed by representatives of all team agencies. The purpose of this protocol is to clarify each agency's duties and responsibilities and to improve agency coordination.

MULTI-DISCIPLINARY TEAM (MDT) MEMBER AGENCIES

This protocol represents the partnership and agreement to support these policies among the following agencies:

- Law Enforcement *As Required By HB 2205
    - St Helens Police Department
    - Scappoose Police Department
    - Columbia County Sheriff's Department
    - Rainier Police Department
    - Vernonia Police Department
    - Columbia City Police Department
    - Oregon State Police St. Helens Office
- Department of Human Services *As Required by HB 2205
- Seniors And People With Disabilities
- Adult Protective Services
- Columbia County District Attorney's Office *As Required By HB 2205
- Oregon Health Authority (Or) Designee *As Required By HB 2205
- Columbia County Area Agency on Aging *As Required By HB 2205
- Columbia Community Mental Health *As Required By HB 2205
- Columbia County District Attorney Victims' Assistance Program
- SAFE of Columbia County
- Community Action Team – Senior and Respite Services
- Columbia County Legal Aid
- Columbia County Public Health
- Columbia County Senior Citizens Council
- National Alliance for the Mentally Ill
- Columbia County Community Corrections

Protocol Mission Statement

The mission of the Columbia County Vulnerable Adult Multi-Disciplinary Team (MDT) is to develop a professional team committed to protecting the elderly and adults with disabilities, herein collectively referred to as "vulnerable adults."

Purpose Statement

Multidisciplinary Teams are a team approach to the assessment, investigation and prosecution of abuse cases involving vulnerable adults. MDT members work in collaboration to address the abuse of vulnerable adults served in Columbia County, and to facilitate a process in which professionals from diverse disciplines are able to work together more effectively and efficiently.

The MDT has a written protocol signed by representatives of all Team agencies. The purpose of this protocol is to clarify each agency's duties and responsibilities and to improve agency coordination.

Goals

The goals are to provide services that are in the best interest of the vulnerable adult;

- to conduct abuse investigations in an expedited and effective manner;
- to prevent the abuse of other potential victims;
- to increase the effectiveness of the prosecution of criminal cases,
- to provide increased safety through victim advocacy, and
- to provide information to all involved agencies in a coordinated and efficient manner.

Each agency's participation shall be consistent with its commitment to the interests of vulnerable adults within the context of the agency's statutory, administrative and policy obligations.

Composition of the Multidisciplinary Team

The MDT includes, but is not limited to;

- personnel from the community mental health program,
- the community developmental disabilities program,
- the Department of Human Services or designee of the department,
- the Oregon Health Authority or a designee of the authority,
- the local area agency on aging,
- the district attorney's office,
- law enforcement
- an agency that advocates on behalf of individuals with disabilities
- others specially trained in the abuse of adults.

Responsibilities

- Provide a forum for education and discussion, assessment and review of cases.
- Provide a forum for identifying, discussing and resolving interagency issues.
- Overseeing the implementation of the interagency vulnerable adult abuse protocol. This includes review and update of the protocol as needed.
- Minimize trauma to victims.
- Review the progress of the working team.
- Assist in the development of education/training for MDT agency members with an emphasis on consistency and quality.
- Review and address system issues and evaluate system response.
- Build and maintain effective working relations.
- Strengthen county wide communication.
- Understand each other's roles and barriers.
- Staff difficult and/or high risk cases.
- Ensure compliance with these protocol guidelines and with statutory mandates.
- Identify and pursue resources.
- Identify needed legislation.
- Maintain clear focus on mission/purpose.
- Address other relevant matters relating to vulnerable adult abuse cases.

The District Attorney shall designate a member of his or her staff to chair the MDT.

- The Columbia County MDT Chair is Deputy District Attorney Kim Silverman (503) 397-0300 kim.silverman@co.columbia.or.us .

- The MDT Chair shall have the responsibility and authority for setting up subcommittees to review and make recommendations to the MDT.

Each agency's participation shall be consistent with its commitment to the interests of vulnerable adults within the context of the agency's statutory, administrative and policy obligations.

Problem/Need Statement: In Columbia County, there are many seniors without the ability to afford legal counsel when needed. They may be victims of abuse, neglect, financial scams, and forms of discrimination. Although CAT uses a minimum of 3% of their OAA funds for Legal Aid, there are not enough funds to provide all of the legal needs of older adults and people with disabilities in Columbia County. In addition, the legal aid contractor is limited in nature and does not always provide the services requested by consumers.

Since the elimination of Gatekeeper funding in June of 2016, CAT has been using funds from OAA to continue providing education and training of community gatekeepers. In the survey conducted by the AAA in Spring 2016, 46% of respondents indicated Elder Abuse Awareness and Education is needed while only 7% responded in the negative. CAT wants to work with DHS-APS to provide training and education throughout all of Columbia County.

Since the MDT is a new entity in Columbia County it is difficult to determine the effectiveness of this program. The goal will be to continue participation in the program and provide services, information, training, and assistance when necessary.

GATEKEEPER REFERRALS

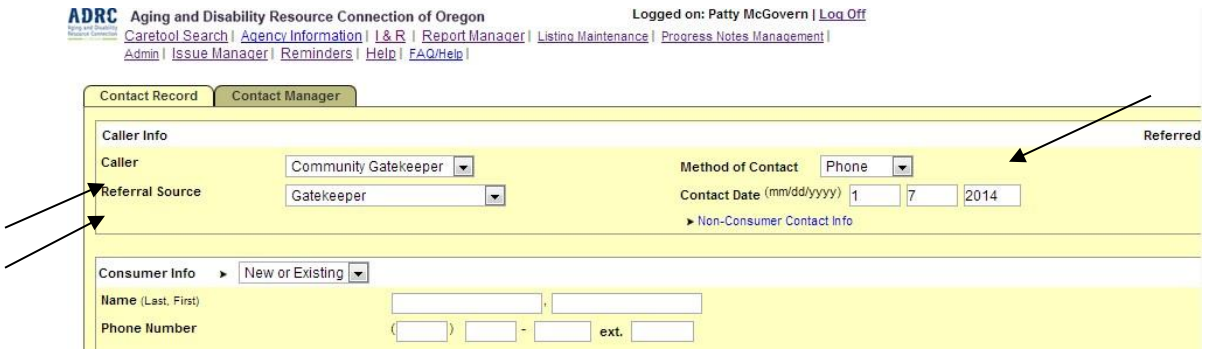
Gatekeeper services are part of the Metro ADRC Network. The following instructions on how to record calls and make referrals should be followed:

Instructions for Recording Gatekeeper Calls in ADRC of Oregon

Definition of Community Gatekeeper: Individuals employed by organizations such as utility companies, departments of sanitation, local post offices, banks, etc. who have been trained to look for and report concerns of abuse and/or neglect. Gatekeepers work in residential neighborhoods on a regular basis (reading gas, electric and water meters, collecting refuse or delivering mail) and are likely to notice if an individual's normal routines have suddenly changed (for example: if the person's mail has not been picked up on a regular basis or they suddenly begin over-drafting their account). Gatekeepers also include police departments and other organizations that conduct regular welfare checks in situations where people have requested the service.

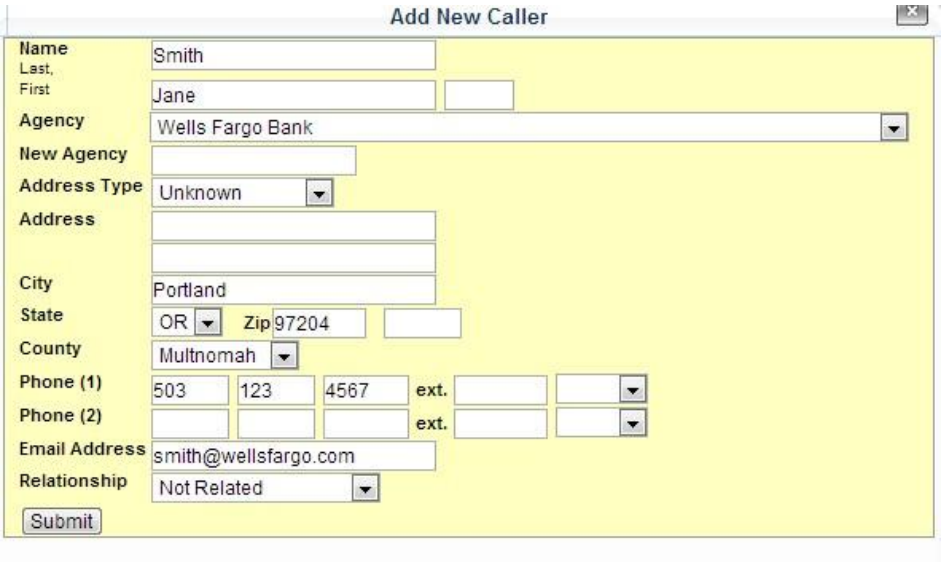
Data Input for Community Gatekeeper Calls:

1. From a fresh Contact Record in ADRC
2. Caller = Community Gatekeeper
3. Referral Source = Gatekeeper
4. Method of Contact = Phone (most often)



5. Non-Consumer Contact Info
   - Search for Caller/Gatekeeper using a limited character search (first 2 letters of last name and first 2 letters of first name)

   - Select Existing or Add New
   - Record Agency
   - Record Telephone Number
   - Relationship = Not Related



6. Consumer Info
   - Search for consumer using a limited character search (first 2 letters of last name and first 2 letters of first name)
   - Select Existing or Add New
   - Record Consumer's Telephone #
   - Record Consumer's Address
   - DOB (if available)

Consumer Info ▸ New or Existing

Name Test, Test T
DOB 01-01-1953
GetCare ID 481996
SSN XXX-XX-0000
Address 1234 SE Test Avenue Portland OR 97214 Type
Homeless?
Directions to Home
Phone(s) (503) 123-1234
Email [redacted]
Comments

Edit Record | Search Again

▾ Hide Call History | Caretool | Show Family Members

Call History | Follow-Ups | Referrals | Notes | Enrollments

7. Demographics
   - Record Consumer's Age (if DOB was not entered)
   - Record Consumer's Gender
   - Record Consumer's Race
   - Record Consumer's Ethnicity
   - Record Consumer's County (if address was not entered)
   - Record Consumer's Zip (if address was not entered)
   - Record Urban/Rural
   - Record Veteran Status (if able to record)

Call Outcomes | Branch | Units | Non-Traditional ADRC Call

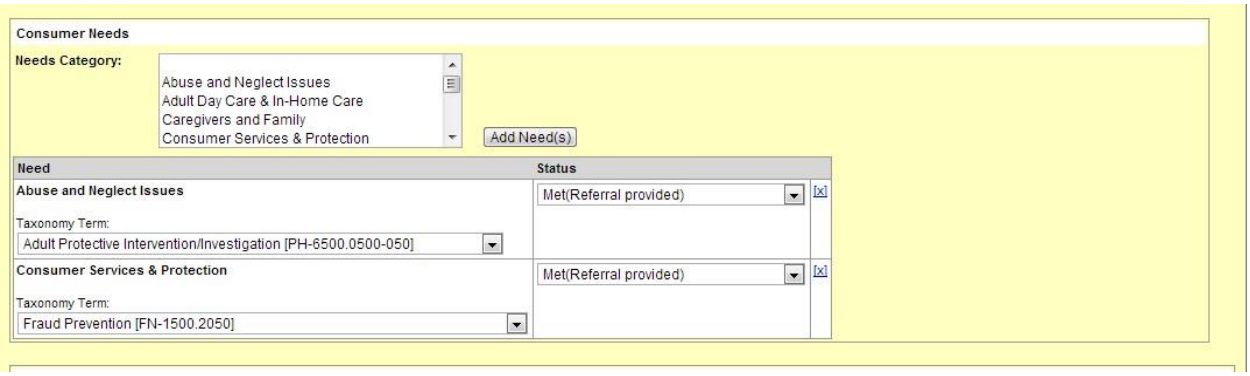
Complete Call | Incomplete Call | Save | Add Another Consumer

Age	61	Lives With	
Gender	Male	Relationship Status	
Transgender		Urban/Rural	Urban
Income Information		Veteran Status	No
Race	White	English Fluency	Fluent
Ethnicity		Primary Language	English
County	Multnomah	Functionally Impaired	None Physical Disability MR-Developmental Disability Mental Illness
Zip Code	97214		

Check to perform search with demographic info

8. Needs

   For needs category it's going to depend. The most common need category for a Gatekeeper call will be Abuse and Neglect Issues. The taxonomy choice would most likely be Adult Protective Services, Senior Centers, or an existing service worker (whichever ADS office the service worker is located). The concerns listed by Gatekeepers can of course vary in their nature and some will require APS response; while some will be better suited for a visit from a senior center case manager to assess what programs may be able to help.
   RECORD ANY OTHER ADDITIONAL NEEDS



9. Referrals
   - Record all programs referred

10. Add Notes (following the Oregon Access Standards)
11. Schedule Follow-Up (as needed)

<u>You get a caller who states they want to make a Gatekeeper referral.</u>

1.) Thank them. Remember these people are outside the ADRC world and aren't very familiar with our language and procedures. They are calling because they are concerned about a senior or person with a disability and are hoping we can help.

2.) Record CALLER TYPE as Community Gatekeeper. REFERRAL SOURCE can be Gatekeeper (I take this to mean they are a trained gatekeeper. Otherwise they'll know about it from another source like friend/neighbor and this would be recorded.) But most importantly record caller as Community Gatekeeper. Get the caller's info including agency and a good contact number.

3.) If a caller has not been officially trained as a Gatekeeper but is calling from a community business or agency, which is how they came into contact with the person they're concerned about, record as Community Gatekeeper and send the PDF to the Gatekeeper Coordinator. They can then reach out to them for a Gatekeeper training.

4.) Get as much of the client/consumer info as you can. The Gatekeeper may not be able to answer all of the usual questions (for example DOB) but we need enough info to follow up with the person they're concerned about.

5.) For needs category it's going to depend. The most common need category for a Gatekeeper call will be Abuse and Neglect Issues. The taxonomy choice would most likely be Adult Protective Services, Senior Centers, or an existing service worker (whichever ADS office the service worker is located). The concerns listed by Gatekeepers can of course vary in their nature and some will require APS response; while some will be better suited for a visit from a senior center case manager to assess what programs may be able to help.

6.) The Gatekeeper ask if you can follow up with them. You cannot. But if they indicate they're willing to be contacted by APS or a case manager at a senior center, they could be called for further information. All Gatekeeper calls are confidential, meaning the client would not be told who the referral came from.

7.) If someone calls to make a Gatekeeper referral and the situation requires immediate response warm transfer Gatekeeper to Emergency Services/911 or the non-emergency line. Such as situations that could result in serious injury or death without immediate intervention. If you do warm transfer to 911, please still record as Community Gatekeeper, and be sure to narrate your actions and the caller's statements well.

8.) Lastly, after completing the call, save the PDF version and send to appropriate agency. (APS, Senior Center, Case Manager)

Dementia-Capable Gatekeeper Outreach

Gatekeeper services include the following:

- ADRC staff that follow-up on Gatekeeper referrals, including I&A and OC staff, have completed ADRC dementia training.
- ADRC staff actively refer individuals and families dealing with dementia to the Alzheimer's Association (or Alzheimer's Network) and other community dementia-related resources.
- Staff track when dementia is an issue in a Gatekeeper referral in the statewide RTZ system, and review data at least annually to assess potential gaps and/or successes in reaching at-risk older adults dealing with dementia through the Gatekeeper program.

The Metro ADRC shall:

1. Promote the Gatekeeper program as part of overall ADRC services, using the ADRC logo, toll-free number, and website on Gatekeeper program materials and as part of Gatekeeper program training.
2. Include basic information on dementia (eg 10 warning signs) as part of training for community Gatekeepers.
3. Ensure that all Gatekeeper and ADRC staff following up on Gatekeeper referrals have completed ADRC dementia training.
4. Track and report Gatekeeper referrals using the RTZ software.
5. Prepare and submit to the SUA a report that includes at a minimum:

- RTZ data showing Gatekeeper referrals, the needs of those referred, Gatekeeper services provided, and the numbers of individuals dealing with dementia, as tracked through follow-up I&A and OC contacts, resulting from Gatekeeper referrals.
- A list of active and trained Gatekeeper organizations.

Metro ADRC Gatekeeper Program
Columbia County Work Plan

Goal: To establish linkages within the community in order for seniors and disabled persons to meet their daily survival needs and remain in their homes in a safe and healthy environment for as long as possible.

Purpose: To reduce the negative consequences of isolation, trauma and untreated serious mental illness for older adults by training gatekeepers to identify and refer individuals to the Gatekeeper Program. This program would then work to link people to community services.

Target Audiences: Community service providers, community mental health organizations, community leaders, clergy/religious organizations, utility providers, landlords, public safety officers, and local community governments.

Development:

1. Identify key partnerships within Columbia County interested in Gatekeeper training. (Timeline: Immediate and Ongoing)
    a. Department of Human Services
    b. Columbia Community Mental Health
    c. Sheriff's Department
    d. Police Departments in local communities.
    e. Utility Service Providers – Electric, Natural Gas, Water/Sewer
    f. Postal Service
    g. Community Business Leaders
    h. Kiwanis
    i. Banking Institutions
    j. Clergy Leaders
2. Develop Gatekeeper training program. (Timeline: Completed)
    a. Resources are available through the Metro ADRC Gatekeeper Program.
    b. Brochure specific to Columbia County and the Metro ADRC Developed.
3. Develop a call in process for Gatekeeper Referrals (Timeline: Completed)
    a. Metro ADRC will take calls for Columbia County
    b. Calls coming in directly to Community Action Team will be recorded in RTZ.
    c. After hours/weekend calls refer directly to Juliann's cell phone number.

4. Begin training of identified community partners. (Timeline: Goal of one training per month for the first year of program)
    a. First training held for landlords in August.
    b. Second training planned for Utilities
    c. DHS contacted. Plan to go to APD case manager meetings.
    d. Clatskanie Clergy leaders to have training.
    e. Plan to speak to Sheriff Department and Police in St. Helens
5. Identify other opportunities to support gatekeepers in our communities.

Focus Area - Elder Rights and Legal Assistance

Goal: To ensure and protect the rights of older adults and prevent their abuse, neglect and exploitation.

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Strengthen efforts to prevent elder abuse in Columbia County through six community educational or training events each year	a	Create opportunities to educate target populations on legal, financial and social strategies to help older adults and people with disabilities avoid abuse, victimization and neglect by working with APD-APS to provide training/education at the local senior centers and focal points	AAA/CAT staff and partners	1/2017	12/2020	This is an ongoing task. We have sponsored 4 meetings in our senior centers presented by DHS-APS.
	b	Continue to provide gatekeeper education and services with community partners.	AAA/CAT staff	1/2017	12/2020	Presentations at Kiwanian's breakfast, Faith Based leader breakfast, Armstrong, Clatskanie PUD, and Columbia River PUD.
	c	Work in partnership with APS to identify and evaluate consumers to ensure consistent and equitable access to services and supports.	AAA/CAT staff	1/2017	12/2020	Ongong. Christy Dewey from DHS-APS sits on our AAA Advisory board now.

Focus Area - Elder Rights and Legal Assistance

Goal: To ensure and protect the rights of older adults and prevent their abuse, neglect and exploitation.

Measureable Objectives		**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Strengthen efforts to prevent elder abuse in Columbia County through one community educational or training event each year specifically for the Hispanic senior community at the Sycamore View Apartments in Scappoose.	a	Create opportunities to educate target populations on legal, financial and social strategies to help older adults and people with disabilities avoid abuse, victimization and neglect by working with APD-APS to provide training/education at the local senior centers and focal points	AAA/CAT staff and partners	1/2017	12/2020	Ongoing.
	b	Continue to provide gatekeeper education and services with community partners.	AAA/CAT staff	1/2017	12/2020	
	c	Work in partnership with APS to identify and evaluate consumers to ensure consistent and equitable access to services and supports.	AAA/CAT staff	1/2017	12/2020	

Focus Area - Elder Rights and Legal Assistance

Goal: To ensure and protect the rights of older adults and prevent their abuse, neglect and exploitation.

Measureable Objectives		**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
Strengthen efforts to prevent elder abuse in Columbia County through one community educational or training event each year specifically for the most remote of our rural communities – Birkenfeld – at their fire department.	a	Create opportunities to educate target populations on legal, financial and social strategies to help older adults and people with disabilities avoid abuse, victimization and neglect by working with APD-APS to provide training/education at the local senior centers and focal points	AAA/CAT staff and partners	1/2017	12/2020	
	b	Continue to provide gatekeeper education and services with community partners.	AAA/CAT staff	1/2017	12/2020	
	c	Work in partnership with APS to identify and evaluate consumers to ensure consistent and equitable access to services and supports.	AAA/CAT staff	1/2017	12/2020	

Measureable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2017-2020		Accomplishment or Update
				Start Date	End Date	
Develop effective outreach materials	a	Work with APD-APS to create/provide outreach flyers to distribute at the	AAA/CAT staff and partners	1/2017	12/2020	

		senior centers, through HDM volunteers, and at local senior events				
	b	Reach out to six new community partner organizations to provide gatekeeper education and awareness in recognizing elder abuse and neglect.	AAA/CAT staff and partners	1/2017	12/2020	
	c	Serve on the MDT for community connections regarding elder abuse	AAA/CAT staff and partners	1/2017	12/2020	

Goal: To give older adults access to free or reduced legal services

Measureable Objectives	**Key Tasks**		**Lead Position & Entity**	**Timeframe for 2017-2020**		**Accomplishment or Update**
				Start Date	**End Date**	
20 older adults will receive free or reduced-cost legal services each year.	a	Work with Oregon Law Center (OLC) to provide a wider range of services in Columbia County	AAA/CAT staff and OLC	1/2017	12/2020	2017-18 – 11 served
	b	Provide office space for OLC to serve older individuals at CAT	AAA/CAT staff	1/2017	12/2020	OLC met at CAT for a few months. They no longer meet here at the CAT building.
	c	Ask private legal offices in Columbia County to provide pro bono or reduced-cost legal services to older adults	AAA/CAT staff and partners	1/2017	12/2020	We are working with a group of judges and lawyers to develop a public guardianship service and education in Columbia County. Some of the work may be pro bono.

6. Older Native Americans (OAA Titles VI & IIIB)

Columbia County has no recognized Native American tribes.

7. Other Focus Areas – any other area of the AAA's choosing. (Optional)

Columbia County has chosen to address no other issues areas.

SECTION D – OAA/OPI SERVICES AND METHOD OF SERVICE DELIVERY

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

a Delineate how the agency will ensure timely response to inquiries for service. Include specific time frames for determination of OPI benefits.

As listed in our policy manual, we respond within 72 hours to requests for OPI service. A risk assessment is completed for all individuals requesting OPI services to determine need of services. Those at high risk are assessed first. An in home assessment is complete usually within one month of the request for all consumers. Due to the number of application requests we do not keep a waiting list for services but we do have a waiting list for assessments.

Once a prospective consumer calls, an application will be sent out the same day they call. If it's a family member or friend, we schedule a family meeting with the consumer. We respond within 72 hours for all OPI services. That includes reassessments.

For emergencies, we respond the same day, as immediately as possible.

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

Upon our pre-screening, if it is assessed that the consumer might be eligible for Medicaid or other community services such as mental health, housing, energy assistance, weatherization, foreclosure prevention, veterans, etc., appropriate referrals are made on behalf of the consumer.

After a few days' time, staff will call and check with consumer to make sure that follow up has happened.

c. Specifically explain how eligibility will be determined and by whom.

We base eligibility on OPI rules: OAR 411-032-0020. Specifically, eligible consumers must be:

- Age 60 or older or under 60 with a medically documented diagnosis of Alzheimer's or related disorder.
- Not be receiving financial assistance or Medicaid, except Food Stamps, Qualified Medicare Beneficiary or Supplemental Low Income Medical Beneficiary Programs; and
- Meet the requirements of the Long Term Service Priority Rule OAR chapter 411, division 015.

O4AD has worked to develop uniform eligibility determination rules and forms. Columbia County uses all those forms, and complies with all policies and procedures.

We use the OPI Case Manager Manual published by DHS, SUA 2009.

d. Plainly state and illustrate how the services will be provided.

Authorized Services include:

- Home Care supportive services limited to:
  - Home Care
  - Chore
  - Personal Care
- Service Coordination

We use Consumer-Employee Provider (CEP) program. Consumers are given a list of potential providers from the Homecare worker registry of eligible home care workers by Case Managers. Consumers are also provided the website so they can go on line and select their provider as well. Our experience is that most rely on the

information coming from the Case Manager. Consumers are responsible for selecting their own worker.

The consumer has primary responsibility for locating, interviewing, screening and hiring his/her own employees. All consumers are offered help through the STEPS program. A referral is made to STEPS on the consumer's behalf if requested. STEPS phone and internet information is given to each consumer.

e. Describe the agency policy for prioritizing OPI service delivery for both the waiting list and hours/types of services for the individual.

1) Community Action Team serves clients with SPL 1-18. We use a service matrix to determine the amount of hours based on the SPL level and hours of service. The maximum number of hours is 24. A copy of the service matrix is included in the OPI If a consumer has a SPL 1-9, we make a warm referral to the DHS-APD office to see if they would qualify for more hours through Medicaid.
2) Eligible consumers shall receive authorized services on a priority basis, with highest priorities receiving services first. Risk assessments are completed for all consumers requesting services in order to determine needs. Those with high risk scores are served first.

3) Priority for receipt of authorized services shall be:

   a. Consumers already receiving authorized services as long as their condition denotes services are needed.

   b. Consumers who are to be placed immediately in an institution if needed authorized services are not provided.

   c. Consumers who are probably to be placed in an institution if needed authorized services are not provided.

4) O4AD's OPI subgroup worked to develop uniform priority screening and services. Part of that process included a financial assessment to determine if the consumer would have a fee for services. We comply with these requirements. All OPI consumers are entered into the RTZ system.

f. Describe the agency policy for denial, reduction or termination of services, and, if the AAA is terminating services, illustrate how the goals of OAR 411-032-0001 are being accomplished.

If the consumer fails to meet program requirements, they may be denied, reduced or terminated from services.

Denial - Consumers will be denied if their CAP score is above the service priority level 18, or if they have existing natural supports to help them with service needs.

Reduction – Consumers will have a reduction in OPI services if their CAPS assessment showed an improvement, if there was a reduction in risk of institutional care requirements, if they showed an increase in natural support systems (i.e. daughter moves in with them),

Termination – Consumers will be terminated if their health improved above the service level above 18, if they have natural support, or if, they have a required mandatory fee and fail to pay their fee. If they fail to hire a home-care worker within 30 days they may be terminated from services. If they leave the home for 14 days without a return date and no communication with regards to plans, they could also be terminated.

If a consumer is denied, reduced or terminated from services, they will receive a letter of denial detailing the reasons along with a grievance procedure policy. They have 14 days to submit in writing a request for grievance to request a hearing. The policy describes the process and the appropriate contacts to lodge a formal grievance. The Executive Director of CAT or his designee is the grievance officer for the OPI program at CAT.

g. Specify how the agency informs consumers of their right to grieve adverse eligibility and/or service determination decisions and how the agency handles consumer complaints.

Grievance Procedure:

1. General

Representation: The consumer may be represented at any stage in the grievance process by a representative of the consumer's choosing, including legal counsel.

Written Decision: A decision, rendered at any level, shall be in writing, setting forth the decision and the reason for it. The decision shall be promptly mailed to the consumer and/or representative.

Correspondence: Notices of grievance and other written correspondence regarding grievances and are to be mailed and delivered to Community Action Team at the following address:

Community Action Team, Inc.
OAA Program

125 N. 17th Street
St. Helens, OR 97051

2. Notices to Applicants and Consumers

- **Denial of service**: When Community Action Team (hereby referred to as CAT) determines that an applicant for services will not be provided with services as requested the worker shall provide to the applicant, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the consumer's grievance rights, including the deadline for submitting a grievance.

- **Reduction or Termination of Service**: When CAT determines that service to a consumer is to be reduced or terminated, the worker shall provide to the consumer, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the consumer's grievance rights, including the deadline for submitting a grievance.

- **Voluntary Reduction or Termination**: When a consumer and CAT mutually agree that service for the consumer is to be reduced or terminated, the agreement shall be confirmed in the following manner: The worker shall provide to consumer, by mail, a written notice of this agreement. This notice shall list the reason(s) for the decision and, in the event that the consumer has second thoughts about this action, shall describe the consumer's grievance rights, including the deadline for submitting a grievance and/or request for change.

3. Informal Grievance and Problem Resolution Process:

Ideally, differences of opinion between a consumer and CAT should be resolved at the lowest level possible. If the consumer or his/her representative wishes to avail himself/herself of the first step in the Grievance Process explained below, the consumer, or consumer's representative should contact CAT and the worker involved in the consumer's case within ten (10) days of the date of mailing of the notice. Within five (5) days of this contact, CAT shall schedule a meeting with the claimant and representative (if any) to attempt to reach a mutually acceptable resolution of the matter. The worker and his/her supervisor shall attend the meeting and the worker will promptly inform the claimant or representative, as appropriate, of a decision regarding this matter.

4. Formal Grievance Process:

a. **Filing a Grievance**: A consumer or representative may file a formal grievance with CAT without taking advantage of the informal process described above. If this informal process is omitted, the consumer or his/her representative must file a written notice of grievance with CAT to the address listed above within seven (7) days from the date of the notice.

b. **Scheduling Grievance Administrative Review**: Upon the receipt of a written notice of grievance, CAT shall schedule a grievance review hearing. This hearing shall be scheduled within ten (10) days of the receipt of the grievance and a time and location convenient and agreeable to both parties. The claimant and his/her representative shall be notified by mail of the date, time and location of the meeting.

c. **Grievance Administrative Review**: The grievance review hearing will be held at the date, time and location specified in the grievance hearing notification. This prompt meeting assures the claimant due process. It offers the claimant or the claimant's representative opportunity to present all pertinent evidence surrounding the issue. Issues that may be protested in these hearings include: denial, reduction or termination of HDM services as well as the action, proposed action or lack of action on the part of CAT and the HDM program to meet the consumer's needs. To assure impartiality, the review hearing shall be conducted by a CAT supervisor or manager who does not directly supervise the CAT employee who routinely works with aggrieved claimant.

d. **Conclusion of Grievance Administrative Review**: Within five (5) days of the conclusion of this meeting, the CAT supervisor or Manager who conducted the meeting shall inform the claimant or representative, as appropriate, of a decision regarding this matter. The decision shall be binding unless the aggrieved claimant wishes to pursue this matter with the Oregon Department of Human Services (see section e below).

e. **Right to Request a Formalized Administrative Review**: Rule 411-032-0020 4, c: Applicants who disagree with the results of the AAA grievance review have a right to an administrative review with the Department, pursuant to ORS chapter 183. This information is provided to the applicant in a written notification at the time of the grievance review decision. The address for The State Unit on Aging Manager at Aging and People with Disabilities, 500 Summer St NE, E12, Salem, OR 97301.

5. <u>Claimant Rights at hearing and meetings</u>

All applicants requesting a hearing or informal meeting have the right to:

- A representative at the hearing or meeting
- Present written and oral statements, and other evidence
- Subpoena witnesses and cross examine at formalized hearings, and
- To bring and interpreter to any hearings and meetings

Staff must, in no way limit or interfere with the applicant's freedom to lodge a complaint or request a formal or informal grievance review.

6. Withdrawal of Complaint, Grievance and Request for a Hearing
   A claimant may withdraw their request for a hearing either orally or in writing to the local agency or the State of Oregon, Department of Human Services. Acknowledgement of all withdrawals shall be made in writing to the claimant, the original to be sent by certified mail, one copy to be placed in the consumer's file and one copy sent to the Department of Human Services, Senior and People with Disabilities.

h. State the cost of authorized services per unit and explain how fees for services will be implemented, billed, collected and utilized.

CAT uses the Homecare Workers contracted by DHS through the Oregon Homecare Commission. Currently the average cost is per unit is $17.87 per hour. OPI is based on a sliding fee schedule. Consumers are assessed at the initial service assessment and annually thereafter. Or, if a consumer feels their income has changed significantly, they can request a reassessment.

If the consumer has a pay-in, they will be invoiced after receiving the voucher for the service period from the homecare worker. The pay-in is an agreed-upon amount and is required. The amount is based on the consumer's pat-in percentage multiplied by the cost per hour. Failure to make the monthly pay-in will result in denial of services.

All program income is used first for providing OPI services.

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

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

1. Service provider provides case managers with names of consumers with unpaid balances on a monthly basis at a minimum.

2. Case manager monitors payment of fees and is responsible for the investigation and correction of non-payment situations using these steps:

   a. Confirms consumer payment status with provider prior to speaking with consumer.

b. Informs consumer of arrearage and discusses payment with consumer, reviewing payment expectations of the OPI program.

c. Clarifies consumer income information, medical expenses, adjusts consumer fees where appropriate.

d. Determines whether money management services are indicated due to consumer difficulty in handling bill payment generally.

e. Notifies consumer orally and in writing that non-payment may result in termination of service and establishes deadline for payment not more than 30 days from day of notice.

f. Reminds consumer at least 2 weeks prior to termination that service will end and reason for termination.

g. Documents steps taken to resolve non-payment of consumer fees in narrative section of Oregon Access.

3. Consumer non-compliance with OPI fee-for-service requirements results in termination of service. Consumer will be given written notice of termination along with the grievance policy.

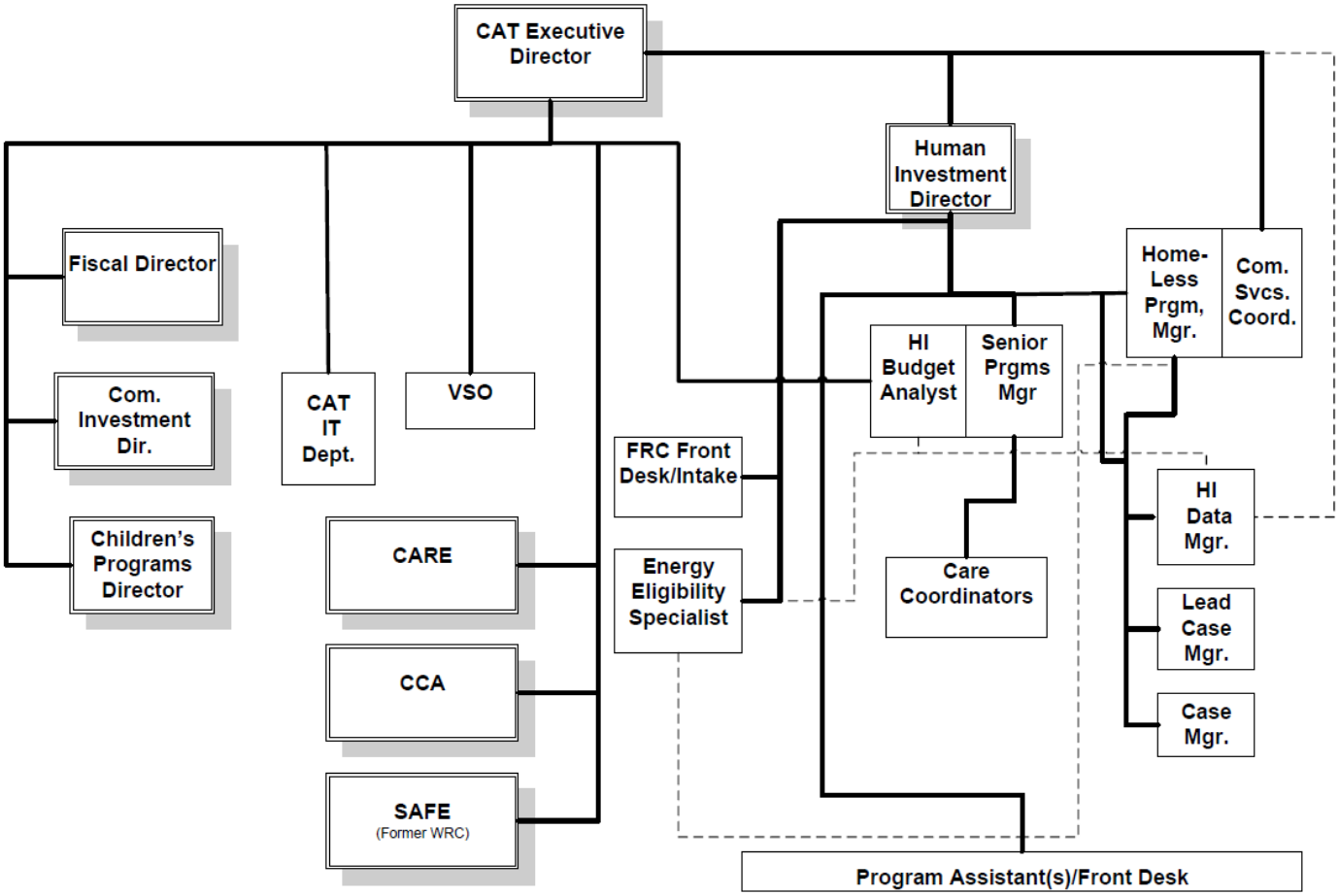
Exceptions to the repayment of fees will only be made in extreme situations, such as when it would become a financial hardship for the consumer. Even, then, every effort will be made to work with the consumer on a plan to repay the balance of the fees.

j. Delineate how service providers are monitored and evaluated.

OPI services are provide through the Oregon Homecare Commission Homecare workers. Contact and assessments with each consumer is completed on at least an annual basis by care coordinators. Additionally, a yearly evaluation/survey is completed for OPI services by a CAT volunteer or the program manager. The survey identifies strengths, areas of improvement, quality of service, adequacy of service, and if outcomes are met.

APPENDICES

Appendix A Organizational Chart



CAT Human Investment Org. Chart

Appendix B Advisory Council(s) and Governing Body

Columbia County AAA Advisory Board

- Cheryl Young – President – St. Helens Senior Center
- Julie Stephens – Scappoose Senior Center
- Jan Rich – Rainier Senior Center
- Jeff Green – Clatskanie Senior Center
- Pat Ray – Vernonia Senior Center
- Carl Hosley – Vernonia Senior Center
- Connie Budge – Rainier Member at Large
- Sherrie Gustafson-Orange – Rainier Member at Large
- Shirley Fowler – Rainier Member at Large
- Erica White – Columbia County APD/DHS
- Christy Dewey – Columbia County APS/DHS
- Julie McCartney – SAFE of Columbia County (domestic violence services)
- Jenny Hicks – Avamere of St. Helens (assisted living facility)

Community Action Team Board of Directors

- John Helm, Chairperson
- Keith Locke, Vice-Chair
- Rita Bernhard, Past-Chair
- Leahnette Rivers, Secretary/Treasurer
- Bill Baertlein
- Henry Heimuller
- Bob Sipe
- Jorge Gutierrez
- Susan McLerie Blackmar
- Yesenia Sanchez
- Lianne Thompson
- Joanna Wagner
- Brian Richards, Sr.
- Tricia Woolworth
- Brittany Cole

Appendix C Public Process

For Immediate Release
March 23, 2016

For more information, contact:
Leanne Murray, Community Action Team
lmurray@cat-team.org or 503-366-6568

WHAT DO COLUMBIA COUNTY SENIOR CITIZENS NEED?

ST. HELENS, OREGON – Columbia County's Area Agency on Aging (AAA) is developing its county-wide four-year Area Plan. Now is the perfect time to share your ideas, concerns, and observations about the needs of our seniors who are 60 years old or better and those who care for them. Your opinion counts.

All community members are invited to complete a comprehensive and anonymous survey. The survey will ask for feedback about the following topics relating to seniors:

- Community supports and services
- Health, mental health, and substance abuse services
- Recreation
- Transportation
- Housing
- Preventative health education

A series of Town Hall meetings will be held throughout the county in April and May. Meetings will open up conversations about the opportunities and challenges Columbia County faces to ensure Senior Citizens have the resources they need. The Columbia County Veterans Services Officer will also be presenting at Town Hall meetings.

You are invited to attend the open meeting that is most convenient for you.

- **Rainier**: Fri., April 15, 1:00 PM at the Senior Center
- **Vernonia:** Tues., April 26, 11:00 AM at the Library
- **Clatskanie:** Thurs., May 5, noon at the American Legion
- **Scappoose:** Mon., May 9, 11:00 AM at the Senior Center
- **St. Helens:** Wed., May 11, 11:00 AM at the Senior Center

Surveys can be picked up at the five area Senior Centers and other locations around Columbia County, or can be filled out online at www.cat-team.org. Look for the link in the yellow box on the left. In order for survey feedback to be considered in the development of the 2017-2020 Area Plan, it must be submitted by June 1, 2016.

Community Action Team, Inc. (CAT) is a locally controlled, private, not-for-profit corporation, serving Columbia, Clatsop and Tillamook Counties. Community Action Team's main focus is to mobilize resources and address the needs of the economically disadvantaged. CAT is the designated organization to serve as Columbia County's Area Agency on Aging which has a separate Board of Directors. As a whole, CAT currently serves over 16,000 persons annually.

# # #

Columbia County Residents!

- *Are you sixty years old or better?*
- *Do you care for someone in Columbia County who is sixty or better?*
- *Have you served in the military?*

Your opinion matters!

Columbia County Area Agency on Aging (AAA) and Veterans Services are gathering input to find out what services matter most to you.

Join us!

Columbia County Town Hall meetings:

- **Rainier:** Fri., April 15, 1:00 PM, Senior Center
- **Vernonia:** Tues., April 26, 11:00 AM, Library
- **Clatskanie:** Thurs., May 5, noon, American Legion Hall
- **Scappoose:** Mon., May 9, 11:00 AM, Senior Center
- **St. Helens:** Wed., May 11, 11:00 AM, Senior Center

Meeting times and Senior Services survey link can be found at www.cat-team.org

Appendix D Final Updates on Accomplishments from 2013-2016 Area Plan

Family Caregivers

Goals: Provide a series of supportive activities to help caregivers manage their caregiving responsibilities.

Accomplishments: There was little to no interest in group caregiver support, so the AAA introduced the RCI REACH program to serve clients one-on-one in their homes. This program has been well-received. In addition, the AAA reached out to the Avamere at St. Helens assisted living facility that hosts caregiver support groups. AAA staff regularly attend those groups in order to identify potential clients to receive caregiver support.

I & A, ADRC

Goals: The main goal of the ADRC and I&R is to get the system up and running.

Accomplishments: The Columbia County AAA is now a part of the Metro ADRC that includes Multnomah, Washington, and Clackamas Counties. We actively participate in collective outreach and quality work. Currently 67% of our staff are AIRS certified and we anticipate being at the required 90% level by the end of 2016.

Elder Rights and Legal Assistance

Goals: Columbia County AAA will be a key player in creating systems that protect the rights and abilities of seniors to protect their interests by providing subsidized legal assistance and a county-wide mechanism for oversight of elder abuse/neglect issues.

Accomplishments: The CC AAA has partnered with Oregon Law Center to provide limited legal services to income eligible seniors. In addition, we partner with the local APD office to provide presentations about elder rights and elder abuse prevention. AAA staff participates in weekly interdisciplinary team meetings with DHS and CCMH, the local mental health agency.

Health Promotion

Goals: Columbia County AAA will utilize a decentralized delivery model to encourage centers to promote preventative health activities within their communities.

Accomplishments: The CC AAA has moved away from providing these services through the senior centers. Instead we have entered into an MOU with The Public Health Foundation of Columbia County and NorthWest Senior and Disability Services to deliver the chronic disease self-management program. We delivered 36 sessions in the 15-16 fiscal year. We provided vouchers for public transportation so that a client in Clatskanie who doesn't drive could attend classes in St. Helens. Between staff and volunteers, we have eight peer leaders trained for chronic disease self-management and diabetes self-management, four for pain self-management, and two for diabetes prevention (to begin early in

2017). We have two PEARLs counselors and served three clients last fiscal year.

Nutrition Services

Goals: Deliver congregate and home-delivered meals through five meal sites and cover the full county and be in compliance with OAA Nutrition standards for older adults. (An addendum was submitted after the initial plan to change the site list from three to five)

Accomplishments: The CC AAA is continually working toward serving as many seniors as possible, including those in very rural and hard to reach areas. Currently there are four senior centers providing congregate and home delivered meals. Vernonia does not have a facility right now (waiting for CDBG funds to come through to build one), so we have gotten creative in identifying ways to serve seniors through restaurants providing meals consisting of menus pre-approved by our dietician (both congregate and home delivered).

Appendix E Emergency Preparedness Plan

The process for notification and communication in case of local disaster is as follows:

1. The Senior Programs Manager is called first no matter where the local disaster is located.
2. If the Senior Programs Manager is not available, the Human Investment Director will be notified.
3. If Senior Programs Manager is not available then the next available Case Manager or Veteran Services Officer is notified.
    4. If phones are out of order then we will use local ham radio operators which are located in Columbia County Fire Stations or at Emergency Management Centers.

Emergency Disaster Plan

Introduction:

The purpose of this specific program disaster plan is NOT to supplant the Columbia County Disaster Plan; instead we will coordinate and work with the established county plan, local city coordinators, and SPD (Senior's and People with Disabilities).

- The Community Action Team/Human Investment Program is the Columbia County Area Agency on Aging as designated by the State of Oregon.

The Human Investment Programs provide services to seniors and veterans in Columbia County. Some of the services are listed below:

- Home delivered meals (Meals on Wheels) to homebound seniors.
- Congregate meals to seniors.
- In-home services (Oregon Project Independence) to seniors in need of services because of a disability or chronic illness.
- In-home respite care services to seniors and people with disabilities.
- Services to veterans and their families living in Columbia County.
- Many other services to seniors in Columbia County through the federal Older American Act programs.

We have trained professional case management staff located in each city in Columbia County.

The following are the Community Action Team case managers and their locations in Columbia County.

- Juliann Davis, Senior Programs Manager/Program Analyst

- Heather Johnson, Senior Care Coordinator South County
- Nikki Harvey, Senior Care Coordinator
- Marge Tuomi, Senior Care Coordinator North County

Our Senior Services staffs are knowledgeable about senior issues and have specific knowledge of local resources and specifically have knowledge of seniors that need specific assistance because of frailty or disability.

Our Veteran Services Officer, Russ Clark, is knowledgeable about veterans and veteran issues in Columbia County.

Potential Hazards: Flood, fire, landslide, snow/ice, widespread power outages, wind storms and down trees.

Agreements with local emergency response agencies: We have a verbal agreement and are part of the team with CERT (Columbia County Emergency Response Team) to participate in their disaster and emergency response process.

Vulnerable populations: The Senior Program Manager carries a password protected thumb drive with client contact information for vulnerable populations, both OPI and Home Delivered Meals. She is the first contact in the event of an emergency.

In case of local or county wide disaster the following will occur -

- The Human Investment Director, Senior Programs Manager, or available Case Manager, will contact all available staff if possible.
    - In case of a major disaster the meeting location will be Columbia County Fire and Rescue Station in St. Helens located at 270 Columbia Blvd.
    - The meeting location will be used to coordinate an action plan directed at assisting Columbia County as a whole, and vulnerable populations in the area affected by the disaster or emergency. We will coordinate and cooperate with the activities of the CERT.
- All Case Management and Veteran Services staff will have prepared <u>accessible</u> emergency kits which will include the following information and supplies:
- Current client list with addresses and phone numbers.
    - Current list or designation of current clients in local area who are homebound and/or receiving Meals on Wheels services.
  - Local contact numbers of emergency service providers.
  - A work or personal cell phone.
  - Local area map.
    - Other needed or essential supplies including gloves, first aid kits, etc.
  - All staff will continue to prepare their offices in case of earthquake, flood or other natural disaster.
- Ensuring that boxes or other containers are not stacked one on top of another.

- Ensuring that current client documents are on the top drawer of filing cabinet.
- Emergency kits are to be located in personal vehicles at all times.
    - Each staff will have their own emergency kit for their homes.
  - The first concern of staff during a disaster or emergency is caring for the staffs' immediate family first before responding to program needs.
  - Work hours for staff during a disaster or emergency will continue to be the same based on current work schedule unless other arrangements have been made to expand hours by Program Director or Program Assistant or designee.
    - Contact information for the Columbia County Emergency Management Director: Steve Pegram, (503)366-3934, steve.pegram@co.columbia.or.us

There will be coordination for all vulnerable population services with:

- The Columbia County Emergency Management Director **OR**
- Columbia County Sheriff **OR**
- Columbia County Fire and Rescue Services.

Food Service: Some of the Senior Centers in Columbia County have been used to provide emergency food. St. Helens, Rainier and Scappoose continue to be willing to be used in that way. Congregate program may be expanded during emergencies to include all ages.

TRAINING:

There are areas which require additional attention and training. These include:

- Seniors who need continued dialysis
- Seniors who are on oxygen
- Seniors who are bed bound
- Seniors with pets who will not leave their homes
- Seniors with mobility issues or in wheelchairs
- In-home disabled veterans

PRACTICE:

- All Program staff will review this disaster plan once a quarter at staff meeting.
- We will participate in local and county disaster drills as directed.
- We will participate in "Table Top" drills from FEMA or READY.gov

Appendix F List of Designated Focal Points (OAA Section 306 (a)(3)(B))

List of the five senior center organizations in Columbia County:

Clatskanie Senior Center
Bes Savage, Center Director
620 Tichenor
PO Box 383
Clatskanie, OR 97016

Rainier Senior Center
Jan Rich, Board President
48 W. 7th St.
Rainier, OR 97048

Scappoose Senior Center
Julie Stephens, Center Director
33342 SW Meadow Dr.
PO Box 797
Scappoose, OR 97056

St. Helens Senior Center
Cheryl Young, Center Director
375 S. 15th
PO Box 692
St. Helens, OR 97051

Vernonia Senior Center
Pat Ray, Board President
No physical location
Vernonia, OR 97064

Appendix G OPI Policies and Procedures

The Oregon Project Independence Program (OPI) was created by the Oregon State Legislature in the early 1980s. The purpose of the program was to provide a "safety net" for those individuals who did not qualify for Medicaid in-home services because of income or resources criteria.

The Oregon Project Independence Program is an in-home care program for those individuals 60 years of age and over. During the Legislative session (2005-06) the Oregon Project Independence Program added people with disabilities (18 yrs. of age and above) with a waiver from the state. The program however currently says that older adults 60 yrs. of age and over **MUST** be served first. Columbia County did not receive a state waiver to serve individuals under 60.

The maximum number of hours currently allowed for in-home services under the Oregon Project Independence Program in Columbia County is **24 hours per month.**

Eligibility

In order to qualify for services each eligible individual must:

(A) Be 60 years or older; or be under 60 years of age and be diagnosed as having Alzheimer's Disease or a related disorder;

(B) Not be receiving financial assistance or Medicaid, except Food Stamps, Qualified Medicare Beneficiary or Supplemental Low Income Medical Beneficiary Programs (see page 53 for specific eligibility information ; and

(C) Meet the requirements of the Long-Term Care Services Priority Rule, OAR 411, division 015. Web link: **http://www.dhs.state.or.us/policy/spd/rules/411_015.pdf**

Types of Authorized Services

Authorized services for which OPI funds may be expended include:

(A) Home Care supportive services limited to:

a. Home Care;

b. Chore;

c. Personal Care;

(B) Service Coordination

CAPS-2 (Client Assessment and Planning System)

This assessment is required for all clients requesting services for Oregon Project Independence OR the in-home Medicaid system. The CAPS-2 assessment is done initially at the time of intake and then yearly assessment is done to see if the client needs more assistance OR less assistance than previously determined. A client OR a client's family can request a reassessment of the CAPS at any time if they feel the clients condition has become worse.

The Oregon project Independence Program was NOT designed to provide all of the clients personal and in-home care needs.

Guidelines outlining the OPI program, Person Centered Care coordination, program requirements, policies, and definitions can be found in the OPI Case Manager Manual. The Link to the OPI Case Manager Manual is: **http://www.oregon.gov/DHS/spwpd/sua/docs/opi-man.pdf?ga=t**

The CAPS-2 assessment is a series of questions about the client's daily life based on six **Activities of Daily Living.**

The six Activities of Daily Living are as follows:

(2) "Activities of Daily Living (ADL)" mean those personal care functional activities required by an individual for continued well-being, health, and safety. For the purposes of these rules, ADLs consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior as described in OAR 411-015-0006.

The assessment assigns a numerical value to each Activity of Daily Living.

The assessment then produces a number for each client. The client will have a numerical number based on a 1-18 scale (See Appendix A).

An example of a client with a number 1 is a client who is completely bed bound and needs another person to do everything for them.

An example of a client with a number18 is a client who can do everything for themselves but may need some assistance with housekeeping for example.

The assessment numerical value determines the number of hours a client receives in-home care.

In order for a Home Care Worker (HCW) to work with the Oregon Project Independence Program, the provider MUST HAVE a six digit provider number issued by the State of Oregon / Department of Human Services. Applications for HCW can be picked up at the Department of Human Services Adults and People with Disabilities (APD) office. All care providers will be processed by APD.

What Person Centered Care coordinators should discuss with Home Care Workers:

- Each Home Care Worker (HCW) should have a "Task List" **BEFORE** beginning work. The Task List should be signed by the Case Manager, Care Provider and client before work begins (See Appendix E).

- OPI does **NOT** pay a HCW to do yard care, pet care, or other outside household maintenance.

- The authorized hours may go up and down depending on the client's needs as determined by the assessment.

- OPI services may allow the transport of client/employers however this service must be in the service plan. OPI does pay mileage to HCW for errands such as: picking up prescriptions, buying groceries, or other such tasks for the client/employer.

- The HCW and the client/employer should negotiate tasks needed to be done based on the "Task List."

- The HCW is NOT the servant of the client/employer OR the client/employer's family. The HCW is a partner with the client/employer in order for the client/employer to remain in his or her own home.

- The HCW should keep notes about the client/employer's progress or other care issues that may come up and if necessary share those concerns with the case manager or the Program Manager. **

- The HCW must notify the client/employer of any absences. The OPI Person Centered Care coordinator and client/employer must prior approve any leave or absences.

- Any changes to the task list or hours worked must be pre-approved by the OPI Person Centered Care coordinator and client/employer.

- Confidentiality is required when working with the any client/employer.

- Disputes over pay vouchers should be negotiated with the client/employer first…but if cannot be resolved…should be brought to the attention of the Program Director.

For additional resources regarding the HCW program see; The Homecare Worker Procedures Manual at: **www.dhs.state.or.us/spd/tools/cm/homecare/manual/index.htm**

VOUCHER PAYMENT PROCESS

OPI (OREGON PROJECT INDEPENDENCE) PAYMENT PROCESS-

OPI is a state funded program which is **MANAGED** by the Senior Services Department of Community Action Team (C.A.T.). The state (AKA Department of Human Services, Adults and People with Disabilities) authorizes providers, issues the vouchers, and sends the checks. C.A.T. authorize the number of hours a client receives and inputs the information into the state system (the state then issues the vouchers and mails them to the provider, see Appendix F). Once service for the month is completed, the provider returns the signed voucher to Community Action Team and the information will be entered into the state system (the state then issues the check for payment and mails it to the provider).

Time frame for payment:

On January 1, 2016, Homecare Workers (HCWs) experienced a change in how payments are processed:

- Pay periods will be the 1st through the 15th and the 16th through the last day of the month for all HCWs.

- Providers will have a deadline of three business days after the end of each pay period to submit a correctly completed voucher for payment. Vouchers received after the deadline will not be processed until the next available pay date.

- The processing office will then have eight business days to process each voucher for payment.

- Paychecks will be issued for processed vouchers eleven business days after the end of each pay period.

Tax related information:

- The state requires a new W-4 each year. HCW will be sent a form by the Department of Human Services.
- Any tax withholding is between you and the state – Community Action Team has no say or control over this.
- Any questions concerning OPI Payments should be directed to DHS at 503-945-6979.

HCW Vouchers:

Homecare workers (HCWs) who serve Medicaid or OPI consumers are required to complete vouchers that capture the dates and times of each shift they work. These vouchers list the "Total hours authorized" and the "Service period worked." Article 8, Section 4 of the CBA establishes that in order to be paid, HCWs must turn in a properly completed voucher. Subsection Article 8, Section 1, subsection (b) states that no payment will be paid for hours without prior authorization.

HCW: It is the HCW's responsibility to make sure the number of hours worked and claimed on a voucher do not exceed the Total hours authorized. A HCW who repeatedly works or claims to work hours that were not prior authorized is committing fiscal improprieties under OAR 411-031-0020(25)(a)(I) and is grounds for a HCW's provider number to be terminated.

Consumer: It is the consumer's or their representative's responsibility to manage their HCW's schedule, ensure that the HCW does not exceed authorized hours and ensure the number of hours claimed on a voucher is correct BEFORE signing it. A consumer who signs a voucher with more hours than the Total hours authorized demonstrates an inability to manager their consumer employer responsibilities under OAR 411-030- 0040(8)(a)(C) and (D). Being unable to act as an employer means that to continue receiving in-home services, the consumer must either assign a representative [see OAR 411-030-0020(47)] to act as the employer, or must receive in-home services from an in-home agency.

Exceptions: Occasionally, there may be an emergency that requires a HCW to work more hours than normally scheduled on a particular shift, and doing so may cause the HCW to risk exceeding the Total hours authorized. For instance, the consumer may become severely ill and the HCW needs to wait till the emergency vehicle arrives or another HCW is unable to arrive to provide critical care. In these instances, it is the HCW's responsibility to contact the consumer's case manager **no later than two business days after** the additional hours were worked.

Upon being contacted by a HCW claiming to need additional hours, Case Managers must determine whether the hours remaining in the consumer's service period can safely be adjusted to compensate for the additional hours worked, or whether authorizing more hours for the service period is necessary. Case Managers should authorize hours beyond the Total hours authorized only if the HCW worked those hours in response to the consumer's legitimate emergent need and the consumer's total hours authorized cannot be safely adjusted to meet the consumer's needs for the remainder of the service period. Any authorization of additional hours must be documented in the consumer's ACCESS case narrative.

If a HCW requests hours beyond the Total hours authorized on three or more occasions during a consumer's service authorization period, the Case Manager should conduct a reassessment to ensure that the consumer's service needs are captured correctly in the CA/PS.

Client Fees:

Client fees, also known as client co-pays, for OPI services are a mandatory feature of the OPI program and serve to expand OPI services for other eligible seniors who need the service. Fees for OPI services are charged based on a sliding fee schedule to all eligible individuals whose annual gross income exceeds the minimum, as established by the Department of Human Services.

OPI client fees are assessed by the Person Centered Care coordinator at the time of service authorization. The sliding fee scale is updated and sent out to AAA's at least once per calendar year to reflect changes in Federal poverty levels.

There are 2 parts to the fee assessment process:

1. Assessing the client's adjusted income using the *OPI Fee Determination SDS 0287K Form*
2. Determining the client fee using the *OPI Sliding Fee Schedule for the appropriate year.*

The Person Centered Care coordinator together with the client completes the OPI Fee Assessment Worksheet. The Worksheet documents the fee assessment process and assists the Person Centered Care coordinator in determining the client's adjusted income after factoring in allowable medical deductions.

The client's adjusted monthly income is the client's gross income less all medical out-of-pocket expenses. "Gross Income" means household income from salaries, interest and dividends, pensions, Social Security, railroad retirement benefits, and any other income prior to any deductions. An individual's gross annual income will include:

- Salaries from the household;
- Interest and dividends from the household;
- Pensions, annuities, Social Security and railroad retirement benefits from the household; and
- Any other net income from the household.

"Household" means the individual, spouse and any dependents as defined by the Internal Revenue Service; that is, members of the household who file taxes together or are claimed as dependents on client's tax return.

"Adjusted Income" means the income for all household members after deductions for household medical expenses as described in OAR 411-032-0044. All medical costs that are the responsibility of the household may be deducted from the individual's gross annual income. These include prescription medications, some over-the-counter medications if ordered by a doctor, nutritional supplements, hospital expenses, Medicare or other health insurance premiums, therapies, in-home nursing care, medical supplies and equipment such as adult diapers and hearing aid batteries, and the co-pay expense for medical appointments. Deductions may also include non-medical costs that pose an immediate threat to the health and safety of the client (emergency home repairs, emergency transportation, etc., for which the client has exhausted other resources). In addition all child support paid by a non-custodial parent may be deducted from the individual's gross annual income.

Once the Worksheet is completed the client and Person Centered Care coordinator sign and date the assessment. The signed worksheet is the agreement between the client and OPI program to verify income and determine the client's fair share toward the cost of the services. A copy of the completed and signed worksheet is given to the client and a copy is kept in the client case file.

Individuals will receive written notification of the hourly and maximum monthly fee for service upon initial service determination and whenever there is a change.

A one-time fee of $25.00 will be applied to all individuals receiving OPI services who have adjusted income levels at or below federal poverty level. The fee is due at the time eligibility for OPI service has been determined and is considered a "life time fee". Providers will not be required to make a second attempt to collect Oregon Project Independence fees of $25.00 or less.

Nothing in the Oregon Administrative rules will prevent Oregon Project Independence individuals, or his or her family, from making a donation or contribution. Such donations will also be used to expand services under Oregon Project Independence.

Minimum fees and fee for service determination forms must be a part of each individual's case record. Fee for service determination forms must meet minimum requirements for documentation as established by DHS.

The maximum monthly authorized fee for services will be recorded on each individual's case record upon initial service determination and at least annually thereafter, at time of reassessment.

Individuals will be given a copy of the agency policy pertaining to individual non-payment of fees upon initial eligibility determination.

Non-Payment of OPI Fee:

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

4. Person Centered Care coordinator monitors payment of fees and is responsible for the investigation and correction of non-payment situations using these steps:
    h. Confirms client payment status prior to speaking with client.
    i. Informs client of arrearage and discusses payment with client, reviewing payment expectations of the OPI program.
    j. Clarifies client income information, medical expenses, adjusts client fees where appropriate.
    k. Determines whether money management services are indicated due to client difficulty in handling bill payment generally.
    l. Notifies client orally and in writing that non-payment may result in termination of service and establishes deadline for payment not more than 30 days from day of notice.
    m. Reminds client at least 2 weeks prior to termination that service will end and reason for termination.
    n. Documents steps taken to resolve non-payment of client fees in narrative section of Oregon Access.
5. Client non-compliance with OPI fee-for-service requirements results in termination of service.

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

Priority for Authorized Services

The priority for authorized services is:

1) Maintaining eligible individuals already receiving authorized service as long as their condition indicates the service is needed.

2) Individuals screened utilizing a DHS authorized tool that measures risk for out of home placement based on an individual's financial, physical, medical, and social service needs. Individuals with the highest risk of out of home placement are given priority. (Waitlist)

Waitlist Process

(At this time CAT does not have a waitlist. This policy only applies if circumstances should call for one)

1. Persons who call requesting information regarding in-home services will be informed of the waitlist for OPI. Person Centered Care coordinators will discuss other options with clients or their families. Options counseling may be provided if requested.

2. In-Home Service application will be completed with the consumer's name, birthdate, address, disposition, and social security number (required under ORS 411-032).

3. The DHS Risk Tool (DHS 0287) will be completed upon initial waitlist, annually and at the final determination and/or closing of OPI.

4. The waitlist will be maintained by the Program Specialist.

5. When hours become available, those with the highest risk of out of home placement will be given priority.

In Home Assessment Process

1. An appointment is made for in-home assessment of client.

2. In-home assessment is completed by Person Centered Care coordinator. (The internal Hand Written OPI Assessment Form is currently being utilized)

3. Person Centered Care coordinator enters assessment into Oregon Access. An Assessment Summary Form (SDS002) is printed showing the client's Service Priority Level. Total number of hours for client along with any mileage is written on form.

4. Person Centered Care coordinator will assist client in completing the Statewide OPI Income/Fee Determination Record. Case manage may leave the information for the client to complete.

5. Once the financial information is complete, the Person Centered Care coordinator will send the Statewide OPI Service Agreement and Non-Payment of fee information to the client. **The process cannot continue until the service agreement is signed by the Person Centered Care coordinator and client.**

6. The HCW list can be sent/given to the client upon receipt of the service agreement.

7. The Person Centered Care coordinator will make a copy for the fiscal staff of all client file information.

8. Once choice of HCW is made, the Person Centered Care coordinator will enter HCW into OA and print a Task List (SDS598N). The Person Centered Care coordinator will have task list signed by client, HCW, Person Centered Care coordinator. A copy will be sent to fiscal staff.

9. When the task list is received along with the name of the HCW for the client, the Person Centered Care coordinator staff will send the required information to the HCW which includes:

    a. HCW Authorization From (SE4105)
    b. HCW Brochure for HCW about Agreement (SE0355A)
    c. Copy of the Task list (SDS598)

10. The Person Centered Care coordinator will send the Worker's Compensation form (SE054) to be signed and returned by the client. This form must be in the Person Centered Care coordinator and Administrative File for every OPI client.

11. The Person Centered Care coordinator will continue to monitor client and complete re-assessments on at least an annual basis or as needed/requested throughout the year.

12. Copies of all updated assessments, assessment summary forms or task lists will be sent to fiscal staff.

13. Person Centered Care coordinators will enter all client contacts and actions into their day log.

Important: The collection of required program and fiscal data associated with OPI will be on forms and data systems as approved by DHS. Each agency and service provider will collect data as required by DHS on eligible individuals receiving services. This service data will include clients full Social Security Number and date of birth. For individuals under 60, documentation as having Alzheimer's disease or other related disorder will be placed in the individual's file. (OPI Statute 411-032-0015)

Assessments:

The initial purpose of assessing clients is for the Person Centered Care coordinator to evaluate the functionality of the individual and how well they can survive in their living situation, then determine what service needs are required to allow the person to safely remain in the least restrictive environment. To determine this eligibility requirement, the Person Centered Care coordinator must do a CAPS2 assessment.

Remember –

- Include all comments that support or substantiate your responses in the ADL/IADLs section as you enter them into the CAPS2 wizard in Oregon Access.
- The 'Synopsis' screen in the CAPS2 wizard in Oregon Access allows free entry for personal elements such as drug, alcohol or tobacco use. It is appropriate to narrate this information within the CAPS2 assessment rather than the narrative.
- Once the data entry into CAPS2 wizard in Oregon Access is completed, a service priority level will be generated. Compare this number with the list of SPLs in OAR 411-015-0010 to determine the number of hours allowed, if any.
- If the priority number is not one which our office serves, a denial notice explaining why the person is not eligible, with rules cited and a grievance policy must be sent to the client.

- The 'Client Details' section of the CAPS2 wizard in Oregon Access is designed for entering items such as Medications and Diagnoses. These are items that do not affect the individual's service eligibility or provider payments and hours BUT they are required to complete a holistic assessment. In order for the assessment to be complete, the Client Details should be filled out as completely as possible.
- For the Service Plan, you will need to determine:
  - What areas the client needs help in and discuss what type of help the client thinks they need.
  - Whether the client has any unmet needs or is there someone providing the care already. If they are currently providing care needs, why can they no longer do this?
  - The least costly means of providing their service.
  - Work with the client to develop a service plan that includes only services for those items that are considered unmet needs
- Authorized hours for OPI individuals are subject to the extent of client needs and the availability of funds. The OPI program authorizes paid in-home services only to the extent necessary to ***supplement*** potential or existing resources within the client's personal support system. It is important to assess and utilize available friends and family members as appropriate natural supports, cost-effective assistive devices, durable medical equipment and/or housing accommodations which could reduce the client's reliance of paid in-home service needs.

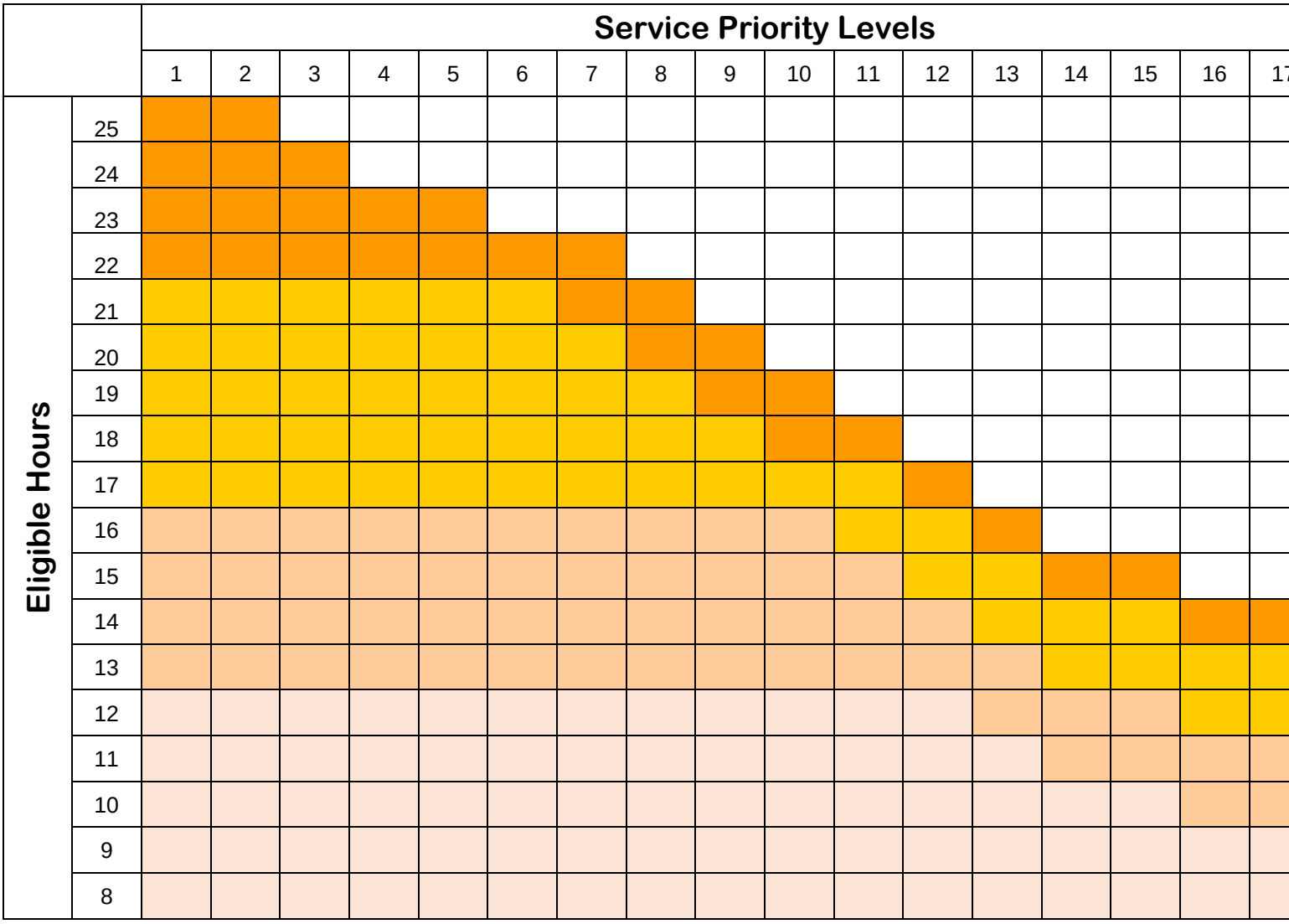
Complete instructions for completing the CAPS2 assessment can be found in the Oregon Project Independence Person Centered Care coordinator manual:

http://www.oregon.gov/DHS/spwpd/sua/docs/opi-man.pdf?ga=t

Resource Page: **http://www.dhs.state.or.us/spd/tools/cm/new_caps/index.htm**

Note: Assisted Transportation is only allowed for OPI on a case-by-case basis. It must be approved by the SUA director prior to being included in the service plan. OAR 411-032-0010 1, b.

Service Priority Matrix:



- Base for intensive personal care
- Base for Personal Care* to include: Bathing, Grooming, Dressing (such as helping with TED socks)
- Base for Shopping (local = 1/2 hour/week)
- Base for Housekeeping only. (8 hours for studio/1 bedroom = 2 hours per week)

* Personal Care items:

Bathing Standby = 1/2 hour per week
Bathing Set Up/Clean Up = 1 hour per week
Bathing Full Assist = 2 hours per week

Grooming Minimal = 1/2 hour per week
Grooming Maximum = 1 hour per week

Dressing Minimal = 1/4 hour per week (weekly helping with socks, etc)
Increase by 1/2 hour per week for more intensive up to 1 hour max per week

Administrative Information

OPI is state funded. OPI clients must use Home Care Workers who are registered through the state offices. The rules governing Home Care Workers are set forth in the collective bargaining agreement between the Home Care Commission and the Service Employees International Union, Local 503, OPEU. See: **http://www.oregon.gov/DAS/HR/docs/lr/0911SEIUHCCFin.pdf?ga=t**

Senior Fiscal Responsibility:

1. The Person Centered Care coordinator will send completed assessments and all forms associated with the assessment to the fiscal staff person who will enter service information into Oregon Access.
2. An administrative file will be opened for all OPI clients.
3. The fiscal staff person may assist the Person Centered Care coordinator in income eligibility and pay-in for client.
4. The Person Centered Care coordinator will submit a copy of all forms to the fiscal staff. Once all forms are complete and signed, the fiscal staff will issue a voucher for HCW payment.
5. The fiscal staff person will also send an invoice to the client for the $25.00 annual fee if applicable, OR if a pay-in is required, an invoice will be issued each month to the client for the service fee for hours worked by HCW.
6. The fiscal staff person will track client pay-in and report any non-compliance to the Person Centered Care coordinator. If a client is non-compliant with the pay-in, the staff person along with the Person Centered Care coordinator will work with client in resolving the non-compliance.
7. The fiscal staff person will enter all information into Oregon Access as it pertains to service.
8. Each month the fiscal staff will pay vouchers as they come into CAT. CAT's policy is to enter voucher into the system within 48 hours of receiving them. When the voucher arrives:
    a. Date stamp the voucher the day received.
    b. Check voucher for correct submission. All lines must be completed and dates must be correct. If not, make a copy of the voucher and return the original to the HCW along with the "Homecare Worker Notice of Incorrectly Completed Voucher" from the SUA.
        - Note: not everything you have a question about on a voucher has to be sent back to the homecare worker. The guideline is: clarification = call; correction = send back out. Clarifications could be things such as: AM or PM? Partial missing information which does not affect payment amount.
        - Corrections are things such as: Overlapping time; requires a physical change to something in the system; Missing information affecting payment amount.
    c. If the voucher is properly submitted, the voucher should be paid in the mainframe. A new voucher number will automatically be generated for the subsequent voucher through the ONGO process.
    d. Enter the voucher hours into the OPI spreadsheet.
    e. Enter hours for each client in Oregon Access under the appropriate service category.

f. If the client has a pay-in for service, an invoice needs to be issued. (See below)

9. If there is a problem paying the voucher or issuing a new one, check with the Person Centered Care coordinator to make sure the assessment is entered properly and has not gone over 1 year or past the service agreement dates. The Person Centered Care coordinator is responsible for ensuring the client information is up-to-date and accurate in Oregon Access.
10. The voucher, and invoice if applicable, will be filed in the client's administrative file.

Client Pay-Ins:

OPI is based on a sliding fee schedule. Clients are assessed for service fees at the time of initial service and annually thereafter. If a client feels their income, condition, or resources have changed considerably since the last assessment, they may request another assessment by the Person Centered Care coordinator prior to the yearly anniversary.

If the client meets eligibility requirements and does not have a pay in, they need only be invoiced for the $25.00 one-time fee.

If the client has a pay-in, they will be invoiced after receiving the voucher for the service month. The pay-in is an agreed-upon amount and is required. Failure to make the monthly pay-in will result in denial of service. Rules governing the pay-in can be found in OAR 411-032-0044.

Invoices:

CAT uses their own system for consumer billing invoices, not Oregon Access. The client information is entered into the spreadsheet "OPI Invoices and Payments". The spreadsheet is used to document: invoice numbers, client information, service hours, pay-in billed and pay-in received.

Two copies of the invoice are sent to the client (One for their records and one to return with payment), one copy is placed in the administrative file, and one copy is sent to the fiscal department. The fiscal department will send information on any payments received for the month to the senior fiscal staff person.

The senior fiscal staff person will need to update the Person Centered Care coordinator if the client is not making the pay-in appropriately. The Person Centered Care coordinator is responsible to follow-up with the client as outlined in the ***Non-Payment of Fees Agreement.***

Required Forms:

OPI Person Centered Care coordinator (Required in Case File)
(** = Forms to be completed at least annually)

- Case Notes of all contacts with clients and any changes made to service
- Application - Signed by the Client
- Completed OPI/In-Home Assessment (Initial and Annually thereafter) **
- Assessment Summary from OA (SDS002) **
- Service Plan From for OA (SDS 546N)**
- Task List from OA-signed by client, HCW, Person Centered Care coordinator (SDS598N) **
- OPI Income/Fee Determination Record (Statewide OPI Form (SDS0287K)) **

- OPI Fee Schedule for the current year **
- OPI Service Agreement (Statewide OPI Form (SDS0287L)) **
- Homecare Worker Notice of Authorized Hours of Services (SDS4105) **
- Workers' Compensation Agreement and Consent (SDS0354)
- CEP Participation Agreement (APD 0737)
- NAPIS Form
- Release of Information/Confidentiality Form** (MSC 2099)
- Notice of Privacy Practices and Acknowledgement (MSC 2090) & (MSC 2092)
- Risk Assessment (DHS0287J)

Administrative File (Required)

- Letter to client with original hours/service
- Application and/or CAPS Assessment Form – completed by Person Centered Care coordinator
- Assessment Summary form OA (SDS002)
- Service Plan From for OA (SDS 546N)**
- Task List from OA (SDS598N)
- HCW Authorization Form (SE4105)
- Worker's Compensation form signed by client (SE054)
- CEP Participation Agreement (APD 0737)
- OPI Income/Fee Determination Record (Statewide OPI Form)
- OPI Fee Schedule for current year's assessment
- OPI Service Agreement (Statewide OPI Form)
- HCW Voucher Payment forms (SDS598B)
- Completed NAPIS form for client and other household member (if applicable)
- Release of Information
- HCW Vouchers/Invoices (if applicable)
- Risk Assessment (DHS 0287J)

Intake	Review	OPI OACCESS & Information	Done ✓
X	X	OPI is only for non-XIX (QMB, SMB, CAWEM & SNAP are okay)	
X		CIS register person in ACCESS	
X	X	OPI type of CAPS (cannot use XIX or PAS) SPL 18 or below	
X	X	update Diagnosis in Client Details	
X	X	Update address, phone numbers, contacts as needed	
X	X	OPI Service Benefit/Plan – Local OPI guidelines regarding hours	

X	X	Contract In Home Agency (CIHA)		
X	X	Home Care Worker		
X	X	Home Delivered Meals		
X	X	Adult Day Care		
X	X	Natural Supports (including private paid services)		
X	X	Benefits Tab		
X	X	Add Service Worker and OPI		
X	X	OPI checkbox marked		
X	X	Service Benefit Tab		
X	X	OPI mon fee (see fee determination form)		
X	X	OPI fee %		
X		Service needs tab on the OAA Summary tab		
X		Complete Ethnicity, Race, income & number in household questions		
X	X	NutrRsk/ADL tab Complete information if approving HDM		
X		OAA service needs on the OAA Svc/FCSP tab		
X	X	Complete as directed by local AAA		
X		Add start date (always first day of the month)		
X	X	Narrate all actions, forms and contacts		
		FORMS	**Forms go to**	
X		**2090 DHS Privacy Rights**	Client	
X	X	**2099 Use and Disclosure of Information** (if needed)	File	
X	X	**354 Workers Comp** (if using a HCW)	File	
X	X	**737 CEP Program Participation Agreement** (if needed)	Client, File & Representative	
X	X	**287 J OPI Risk Assessment &/or Risk on RTZ**	File	
X	X	**287 K OPI Fee Determination (client signs)**	Client & File	
X	X	**287 L OPI Service Agreement (client signs)**	Client & File	
X	X	**546 n for HCW or CIHA** **If an in home agency insert wages in the service rates tab**	File, Voucher clerk, Agency	
X	X	**546 ad Adult Day Care authorization (** it is on the forms server**)** **Comments must include " OPI & OPI fee%"**	File Agency	
X	X	**4105 to HCW**	HCW	
X	X	**598 task list for HCW and/or Agency and Client/STEPS** (if needed)	HCW, Agency Client	

Updated 3-2016

Required Elements of OPI Narration in ORACCESS

- Date of Client Home Visit
- Purpose of Visit – Who requested the assessment and why did and OPI assessment occur
- Who was Present at the Home Visit – All present should be noted including Person Centered Care coordinator

- Appearance/Condition of Home – Important to note hazards/risks
- Living Situation – Living alone, with spouse, family, etc. Note any other persons in the home
- Client's Appearance – Note if the client is able to dress, groom, etc.
- Who is helping the Client Now (Natural Supports) – List all both in home and outside of home providing support to the client
- What Happened that the Client Needs Services – List any medical conditions, falls, etc.
- Who Manages Finances – Is client able to manage finances, do they have help, etc.
- Transportation – How does client get to doctor/store
- Yard Care – OPI does not provide yard care but getting into/out of home or hazards should be noted.
- Total Household Income – All household income before deductions.
- Client's Medical Expenses – any monthly expenses for medications, doctor visits, OTC supplies, insurance, etc.
- Client's Net Income – Gross income less medical expenses.
- Pay in Percentage and Amount or One Time Fee – Use correct fee schedule.
- Risk Assessment Tool Score – Enter into RTZ
- SPL – List service priority level. OPI serves 1-18. Referral to Medicaid if under 12.
- Approved Hours – Hours and services approved
- Referrals – List referrals made. Also enter referrals into RTZ
- Follow Up – What follow-up actions need to take place, who is responsible, when will action be completed

REMEMBER: Narration must be entered into ORACCESS within three days of the assessment!

Medicaid & OPI

These codes come from the MMIS screens indicate a 'full' Medicaid plan. These individuals **cannot receive OPI,** *unless* the Medicaid case is reduced or closed.

Benefit Package – *BMD* – *OHP with Limited Drug* will have:

Case Descriptors of either: *SBI, SMB, or SMF*

Benefit Package – ***BMM*** – *QMB + OHP w/Limited Drug* will have:

Case Descriptor of: *QMM*

Benefit Package – *BMH* – *OHP Plus* will have:

Case Descriptors of: *MAA, EXT, OPC, OP6, CHP*, as well as others that are not listed above.

P2 cases are usually okay to receive OPI when looking in the Mainframe, WEBM,find. **Except** those that have any of the following case descriptors:

AMO	**PCR**	**EXT**
CMO	**PWO**	**OPC**
C21	**MAA**	**OP6**

Can have OPI. Individuals who only have Medicare Savings Plans are coded P2 as MED, (which is QMB-only), SMB, and SMF.

Benefit Package – ***MED*** – *Qualified Medicare Beneficiary* will have:

Case Descriptor of: *QMB*

Benefit Package - *SMB* is a non-medical P2 case that pays premiums only

Benefit Package – *SMF* is a non-medical P2 case that pays premiums only

Helpful definitions:

Modified Adjusted Gross Income (MAGI) Medicaid. MAGI Medicaid is a state and federally-funded program which helps low-income Oregonians with medical coverage. One of the goals of the Affordable Care Act (ACA) was to make administration of Medicaid easier while expanding Medicaid coverage to a broader population. In an attempt to make the administration of Medicaid simpler, the ACA calls for the use of information reported on Federal tax filing forms. Adjusted Gross Income is a line item on Federal tax filing forms. This figure is used, with some modifications, in the MAGI determination; hence the program became known as MAGI Medicaid, or MAGI.

MAGI is different from traditional Medicaid programs in that it:

- Uses a new household composition methodology
- Uses a new countable income methodology
- Expanded full OHP Plus coverage to the adult population who were previously only eligible for OHP Standard (OHP-OPU)
- Does not have a participation cap, thus eliminating the "reservation list"
- Allows hospitals to make presumptive eligibility determinations in some cases
- Accepts client attestation as verification for many eligibility factors
- Does not have an asset test or resource limits
- Is exempt from the Post Eligibility Treatment of Income provisions for those in long-term care (i.e. MAGI recipients do not have a service liability)

Individuals who are 65 or older can be MAGI eligible under the Parent or Other Caretaker Relative program. Clients who are Medicare eligible can be MAGI eligible under the Parent or Other Caretaker Relative Program or the Pregnant Woman program (some children with Medicare can also be eligible for MAGI). Clients who receive or are eligible to receive SSI or who are receiving other Medicaid coverage are not eligible for MAGI Medicaid programs. The Oregon Health Authority has exclusive authority to administer MAGI programs.

MAGI Adult. This sub-program serves adults age 19-65 who are not pregnant, not enrolled in Medicare, not receiving SSI, and are not parents or caretaker relatives of a minor child. This program replaced the OHP-OPU program with two significant differences: (1) MAGI Adult eligible clients receive the OHP Plus benefit, and (2) there is no longer a reservation list or an enrollment cap.

Medicaid Management Information System (MMIS). MMIS is a computer system which stores clients' medical benefit data (including Medicare, Medicare buy-in, private insurance, and managed

care/CCO enrollments), Pays Medicaid medical claims, Authorizes some APD long-term-care services, Issues replacement medical ID cards.

Oregon Health Plan (OHP). The Oregon Health Plan Program is a state program that provides health care coverage to low-income Oregonians. OHP is what Oregon calls its Medicaid program. In the past, OHP used alone usually referred to the OHP Standard package of benefits (OHP-OPU), which is now obsolete.

Oregon Health Plan Plus (OHP Plus). OHP Plus refers to the comprehensive package of medical, dental, mental health, and chemical dependency services. While OHP is the general term for Oregon Medicaid, OHP Plus is the specific package of benefits.

Appendix H Partner Memorandums of Understanding

MEMORANDUM OF UNDERSTANDING (MOU)

This Memorandum of Understanding is designed to clarify the roles and responsibilities of Community Action Team, Inc. (CAT) and Columbia County's Aging and People with Disabilities Office (APD/DHS).

Community Action Team, Inc.:

Is a private not-for-profit 501(3)(c) organization, that provides services to families and individuals in need living in Columbia, Clatsop, and Tillamook Counties. Community Action Team's Human Investment Department includes the Senior, Homeless, Energy Assistance, and Veterans Programs.

Under this agreement Community Action Team's Human Investment Department Staff will:

- Provide initial Medicaid screening information and "warm transfer" to APD for any client calling Community Action Team through the ADRC (Aging and Disability Resource Center) toll free number requesting Medicaid Services.
- Narrate basic client information in Oregon ACCESS data base.
- Transfer Oregon ACCESS case to APD case manager/worker of the day upon request.
- Partner with APD/APS (Adult Protective Services) Staff to develop a MDT (Multi-Disciplinary Team) within Columbia County serving seniors and people with disabilities to help protect them from abuse/neglect.

- Provide cross training opportunities or share training information between our two agencies as it become available.
- Through the Benefits Enrollment Center (BEC), CAT will partner with Disability Aging Veterans Services (DAVS) to create our own unique benefits access program or BEC. With this commitment, Columbia County will bring together the local agencies who determine eligibility for SNAP, MSP, Medicaid, LIS and LIHEAP to create a person-centered, seamless process for consumers in our area to apply for all benefits they may be eligible for.

Prohibition of Discrimination:

Community Action Team, Inc. will comply with provisions of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act.

Aging and People with Disabilities (APD/DHS):

Is a State of Oregon agency under the Department of Human Services that provides Medicaid services to seniors, 60 years of age and over, and people with disabilities, regardless of age.

Under this agreement Columbia County's Aging and People with Disabilities Office (APD/DHS) will:

- Work with CAT's Human Investment Program Staff to develop a MDT (Multi-Disciplinary Team) for Columbia County to help protect seniors and people with disabilities from abuse/neglect.
- Provide cross-training opportunities to CAT's Human Investment Program Staff as they become available between our two agencies.
- Participate as a member of the Columbia County Area Agency on Aging (AAA) Advisory Board.
- Provide releases of income to CAT's Human Investment Department.
- Provide release of information regarding additional services and assistance (i.e. food, medical) to CAT's Human Investment Department.
- Provide basic Medicaid screening and training information to CAT's Human Investment Department.

Agreement Expires: with 30 day notice from either party.

Signatures:

Jessica Soltz 11/30/16

Aging and People with Disabilities District Manager/ Jessica Soltesz Date

Dan Brown 11/30/16

Community Action Team, Inc. Executive Director/ Dan Brown Date

Appendix I Statement of Assurances and Verification of Intent

For the period of January 1, 2017 through December 31, 2020, the Columbia County AAA accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 109-365) and related state law and policy. Through the Area Plan, Columbia County AAA shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. The Columbia County AAA assures that it will:

Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals and objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older individuals at risk for institutional placement; d) older Native Americans; and e) older individuals with limited English proficiency.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by the Columbia County AAA for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

Provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with significant disabilities, with agencies that develop or provide services for individuals with disabilities.

Provide information and assurances concerning services to older individuals who are Native Americans, including:

A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DHS. The Columbia County AAA shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

12/16/16
Date

Dan Brown
Dan Brown, CAT Executive Director
Director, Columbia County AAA
Legal Contractor Authority

12-16-2016
Date

Cheryl Young
Cheryl Young, St. Helens Senior Center Director
Advisory Council Chair