CENTRAL OREGON COUNCIL ON AGING
2017-2020 AREA PLAN

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SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A–1 Introduction:

The Council on Aging of Central Oregon is the federally designated Area Agency on Aging (AAA) for the planning and service area (PSA) of Crook, Deschutes and Jefferson Counties, and is part of the Aging and Disability Resource Connection (ADRC) for 10 counties in Central Oregon.

Incorporated as a 501(c)3 in June 1975, the Council on Aging has served seniors, caregivers, and adults with disabilities for more than four decades. To provide support services across a large geographic area that includes rural and urban communities, the Council on Aging coordinates planning and service provision with key agencies and organizations in its PSA. These include, most notably, DHS, APD, APS, the CCO led by PacificSource's Health Council, mental and behavioral health departments in all three counties, and the Central Oregon Intergovernmental Council (COIC) that provides public transportation. Planning is coordinated through multi-disciplinary teams, ADRC collaborations, agreements (such as with COIC), community "huddles," and long-standing working relationships between the Council on Aging and other organization staff that have formalized into accepted practices.

In this increasingly significant part of the state, it is imperative that the Council on Aging not only keep pace with – but stay ahead of – changing demographics and increased demand for service. To do so, the Council on Aging must understand the nature and extent of need among seniors, particularly high priority seniors as determined by economic and social considerations. This Area Plan – both the process and product – is key to the Council on Aging's ability to understand, plan for, and respond to need in Central Oregon. The Council on Aging welcomes input from those reading this plan, who may contact the Council on Aging's Executive Director at 541-678-5483 or through admin@councilonaging.org with comment.

Key factors that drive the Council on Aging's strategic planning include:

- Extremely rapid growth in Deschutes County; as per U.S. Census Bureau data, the county's population aged 65+ grew by 40.0% from 2010 to 2015 due to aging of the existing population and an influx of new seniors
- Large geographic area that requires a distributed meal site model, including contracts with senior centers and vendors for nutrition services
- Rural and remote communities that offer few resources, require commitments of staff time and agency dollars to visit, have limited public transportation options, and add to the social isolation of seniors
- Increased cost of living, driven by rising costs of food, housing, and health care, that greatly impact seniors living on fixed and limited incomes
- Under-representation of seniors of color in the Council on Aging's client base and need for improved equity, diversity and inclusion

- Area Plan survey results that show high need among at-risk respondents for hunger prevention as well as III-B services including information and assistance, transportation, and in-home care

The Council on Aging's 2017-2020 Area Plan relies on *strategic partnerships, targeted resources, efficient operations,* and *capacity building*g in order to meet increased need driven by accelerated growth in Central Oregon.

A–2 Mission, Vision, Values: The Council on Aging has revisited the organization's mission, vision, and values; which have been updated at this time.

The Council on Aging envisions a world that grows older better, together.

Accordingly, the Council on Aging's mission is to advocate for, empower and guide older adults and their loved ones to live with independence and well-being in age-friendly communities.

Everything the Council on Aging of Central Oregon does is guided by compassion, collaboration, reliability, integrity and respect.

To operationalize its vision and values, the Council on Aging seeks input from stakeholders, works collaboratively with partners, and enters into agreements with service providers. Stakeholders include seniors, family members, caregivers, and specific communities (rural, urban, low-income, high-risk, Latino, Spanish-speaking, and Native American); partners include DHS, APD, APS, county offices, the Latino Community Association, the Let's Talk Diversity Coalition, the GeroLeadership Alliance, and all agencies represented in the ADRC; service providers include senior centers, COIC, and in-home health care and respite providers

A–3 Planning and Review Process:

The Council on Aging used the following to assess need among seniors aged 60+, those aged 50-59, unpaid family caregivers, and priority seniors:

- Area Plan survey
- Meyer Memorial Trust-funded community needs assessment with Latino, Spanish-speaking, and Native American seniors
- Consultation with third-party consultant for both Area Plan survey and community needs assessment with Latino, Spanish-speaking, and Native American seniors
- Three "town hall" meetings, one in each of the Council on Aging's three counties, to receive community input on survey results

Hallmarks of the Council on Aging's planning and review process included:

- Agency-wide involvement, with leadership team members gathering input from staff
- High level of investment, with leadership team members, under the direction of the Executive Director , preparing draft plans based on staff input for review by the Advisory Council and Board of Directors

Tools and resources included:

- SWOT conducted at all-staff retreat
- Surveys and assessments as noted above
- Review of accomplishments and continuing challenges across functional areas
- Reports and studies noting trends, such as the "Alice" report and the *2015 White House Conference on Aging* paper.
- Demographic data, both that supplied by the SUA and more recent U.S. Census Bureau (2015) data
- Consideration of funding and capacity issues, particularly with regard to appropriate and meaningful use of discretionary funds to serve those with high economic and social need

The Council on Aging's Advisory Council and Board of Directors play an ongoing role in the Council on Aging's planning process. The Council on Aging's Executive Director works collaboratively with the Council and Board on service planning and priorities for the agency. The Advisory Council includes a representative from the Warm Springs tribes. The Council meets every other month to hear guest comments, review agency reports, move on action items, and "roundtable" partner updates. The Board meets monthly, and sub-committees meet as needed, to advise on budget matters, support fundraising, and provide governance. Most recently, the Board is working with the Executive Director and her leadership team to develop a strategic plan.
The Advisory Council reviewed and approved the draft plan on July 15, 2016. The Council on Aging's Board of Directors reviewed and approved the draft plan on September 22, 2016.

Scope of Need – Area Plan Survey

The Council on Aging's Area Plan survey methodology was developed to reach those with greatest economic and social need.

With regard to social need, even though the survey was translated into Spanish and placed in public spaces used by the Latino community, no Spanish-language surveys were returned. This affirmed what the Council on Aging learned from its Meyer Memorial Trust-funded project, namely, that surveys with seniors of color are best conducted verbally, one-on-one, using an interview protocol. The Council on Aging surveyed 62 Latino and Native American seniors this way. The Area Plan responds directly to these findings through inclusion of initiatives to improve service for Central Oregon's seniors of color.

The Council on Aging broadly distributed the survey in both hard copy and online form (see Appendix C), with emphasis on reaching:

- Current Council on Aging clients and current volunteers
- Those not served by the Council on Aging
- Low-income individuals and/or those at risk for institutional placement
- Unpaid family caregivers

- Future seniors (those 50-59 years old)

The Council on Aging used social media to point individuals to the online survey, including:

- The Council on Aging website
- Bookmarks with Survey Monkey link
- Email
- Facebook, Nextdoor and Twitter

Response rate was high, with a slight preference for hard copy over online surveys. Of ~1,000 hard copy surveys distributed, 507 were returned. An additional 298 surveys were completed online via Survey Monkey. The result was 805 surveys completed, 507 (63%) in hard copy and 298 (37%) online.

All three counties in the Council on Aging's PSA were well represented, which in turn ensured good representation of the Council on Aging's mix of urban and rural communities.

county	*# surveys*	*% by county among survey respondents*	*% by county in the Council on Aging's PSA*
Deschutes	597	74.2%	77.1%
Jefferson	111	13.8%	10.4%
Crook	97	12.0%	12.4%
Total PSA	805	100.0%	100.0%

Returns by age group were as follows:

age group	*#*	*%*
50-59	73	9.1%
60-64	108	13.4%
65-79	365	45.3%
80-94	219	27.2%
95 and older	7	0.9%
Under age 50, but unpaid caregiver	5	0.6%
(blank)	28	3.5%
Total	805	100.0%

Returns by income level were as follows:

income level	*# respondents*	*% respondents providing income (n = 650)*	*% all respondents*
less than $1,000	105	16.2%	13.0%
$1,000 - $1,999	244	37.5%	30.3%

$2,000 - $2,999	120	18.5%	14.9%
$3,000 or above	181	27.8%	22.5%
Unknown or Prefer not to answer	119		14.8%
Blank	36		4.5%
Total	805	100.0%	100.0%

Area Plan Survey Findings

- Analysis focused on unmet need, food insecurity, behavioral health, and physical ailments.
- Analysis compared these areas by income level, gender, age and county, in an attempt to identify clusters of need.
- For unmet need ("Are your critical needs being adequately met?") – 90% of respondents answered, with 20% (1 in 5) of these answering no or not sure. 48% of respondents went on to specify needs that are, or might in future, be unmet:
  - 24% of these indicated unmet need for information, referral, and advising services
  - 24% - transportation
  - 23% - home repair and safety improvements
  - 14% - affordable in-home care
  - 10% - food

- The lower the income, the higher the rate of reported unmet need. Among those responding with incomes under $1,000/month, 36% (more than 1 in 3) answered no or not sure to their critical needs being met. This compares to 8% (less than 1 in 10) among respondents with incomes of $3,000/month and higher.
- Level of unmet need varies by county, with Jefferson County reporting the highest rate per capita of unmet need (28% of respondents said no or not sure to "Are your critical needs being adequately met?").
- Few differences in unmet need emerged when disaggregating the data by gender. Females had slightly higher need for transportation than males, and males had slightly higher need for food than females.
- Differences emerged by age. The youngest (50 – 59) had the highest rate of critical unmet need (29% of those responding said no or not sure to need being met). Rate of unmet need was stable at about 19% across respondents aged 60 – 94. Rate dropped to 14% among respondents age 95+, though it should be noted that in this group, n = 7. The fact that those eligible for Council on Aging services (those aged 60+) reported lower unmet need than those aged 50-59, suggests that AAA services – or other age-dependent services such as social security -- are in fact meeting need.
- Across almost all income levels, age groups, and counties, the three highest unmet needs were: 1) information, referral, and advising, 2) home repair and safety improvements; and 3) transportation. An exception was Jefferson County, which had high need for food.

- For food insecurity ("Do you have enough to eat?") - 92% of respondents answered, with 10% (1 in 10) of these saying they never or only sometimes had enough to eat.
- The lower the income, the higher the rate of food insecurity. Among those responding with incomes under $1,000/month, 20% (1 in 5) answered never or only sometimes to having enough to eat.
- Food insecurity also varied by county, with Jefferson County having highest rates. This corresponds to food being one of the top three critical unmet needs among Jefferson County respondents.
- As was the case for unmet need, differences were noted by age, with the youngest (50-59) reporting the highest rate of food insecurity (19% of those responding saying no or only sometimes having enough to eat).
- For behavioral health ("Which of the following have you experienced? a. social isolation/boredom, b. depression/anxiety, c. anger/frustration, d. other) – 46% of respondents answered, meaning that 54% (more than half) of respondents did NOT report behavioral health concerns.
- Because those who responded could select more than one response ("check all that apply"), 566 responses were logged by 374 respondents. Of the 566 responses:
  - 46% indicated experiencing depression/anxiety
  - 36% - social isolation/boredom
  - 15% - anger/frustration
  - Other behavioral health issues cited were grief, PTSD, and stress

- Behavioral health responses differed by gender, with 20% of responses from males indicating experience of anger/frustration vs. 12% of females, and 48% of responses from females indicating experience of depression/anxiety vs. 40% of males.
- For physical ailments ("Which of the following conditions do you or have you had?" followed by an extensive list, with an "other" option) – 83% of respondents answered.

- Because those who responded could select more than one response, 1,583 responses were logged by 665 respondents. Of the 665 responses:
  - Arthritis/osteoporosis was indicated by 30% of females and 21% by males
  - Hypertension – 20% of females and 22% of males
  - Vision problems – 13% of females and 17% of males

- These top three physical ailments were consistent across income levels.

<u>Meyer Memorial Trust – Community Needs Assessment Findings</u>

Major findings from the Council on Aging's community assessment of Latino, Spanish-speaking, and Native American seniors included:

- Native American seniors reported a high rate of knowledge (93%) of senior services, most likely due to the presence and visibility of the Title VI-funded Warm Springs Senior Center.
- Native American seniors reported need for better understanding of health care coverage and service options. This suggests need for "single-point-of-contact"

advising service (perhaps like ADRC or Options Counseling) to help seniors develop individual “action plans” for affording and accessing service.

- Latino seniors reported lower rates of knowledge (44%) of senior services.
- Latino seniors reported high need for food assistance (71%)**.** Latino seniors who access food assistance primarily use SNAP. Latino seniors had little knowledge of Council on Aging meal services and reported minimal service utilization.
- Word-of-mouth and “culturally located” media (KWSO radio in Warm Springs and *La Bronca* Spanish-language radio) were noted by Native American and Latino seniors respectively as primary information sources.
- Highest reported needs were for transportation and medicine (affordable prescription medications), followed by advising and information on health care coverage and service options.
- Latino seniors noted that they would welcome outreach from and engagement with the Council on Aging. However, Latinos expressed high desire for service deliverers who represent the Latino culture and speak the language. They also would prefer family member(s) present when meeting with a Council on Aging representative – which might necessitate evening home visits. They also preferred female over male service deliverers.
- Latino seniors tend to live in intergenerational households, with family being a key value in the Latino culture.
- Both Native American and Latino seniors expressed desire for culturally familiar foods including, for Native Americans, game meats.
- Both Native American and Latino seniors expressed desire for more fresh fruits and vegetables that are expensive (particularly so on the reservation and/or when using food stamps), not readily available through food banks which rely on shelf-stable foods, and often not carried in neighborhood markets.
- Native Americans expressed high need for food assistance that helps them manage diabetes.

A–4 Prioritization of Discretionary Funding:

- Waitlists for home-delivered meal service occur periodically when requests from eligible clients exceed spaces available (with spaces determined by funding allocated to – and kitchen and volunteer capacity of -- specific meal sites). Some sites, such as the Redmond Senior Center, are more heavily impacted than others and so have to institute wait lists. Because all clients waitlisted are eligible, they are served according to their position on the waitlist.
- Changes in service based on changes in funding – Reduction of Gatekeeper services due to loss of funding; increase in health promotion due to biennial funding; plan for ADRC sustainability due to end of planning grant funding. Also, new services have resulted from increases in private funding (from grant writing, fundraising and development efforts). These new programs and services include Healthy Choices nutrition education program, fresh fruit and fresh salad program, bilingual outreach, expanded Volunteer Program, Teen Elder Computer Help or

TECH program, and respite care and transportation grants for those suffering from Alzheimer's and related dementias.

Based on the Council on Aging's extensive needs assessment described above, priorities for use of discretionary funds are as follows. (Discretionary funds include those: 1) that remain after minimal Title III-B expenditure requirements are met, and 2) are raised by the Council on Aging from additional government grants and private and local sources.)

- Priority = Addressing food insecurity and improving nutrition
  a. Eliminate wait lists, raise contracted meal reimbursement rates, and increase caps on meal service at impacted sites
  b. Include fresh fruit and fresh salads with frozen meals
  c. Explore feasibility of new meal sites, particularly in rural areas

- Priority = Assisting clients through Information, Assistance and Referral and ADRC
  a. Ensure robust response via Options Counseling training and AIRS certification
  b. Strengthen ADRC partnerships, seek new funding to ensure sustainability
  c. Match mental health resources to behavioral health needs through collaboration with Central Oregon Health Council's Older Adult Behavioral Health Initiative to identify and develop Central Oregon behavioral health providers and community education Mental Health First Aid

- Priority = Providing transportation options
  a. Redirect financial resources as appropriate and necessary to improve low-cost/no-cost, on demand, door-to-door service, particularly in rural areas
  b. Develop partnerships to improve transportation options

- Priority = Improving service for seniors of color
  a. Increase diversity and cultural competence of staff, council and board
  b. Develop culturally responsive, language-appropriate services and delivery methods
  c. Partner with community-based organizations that serve communities of color

With regard to prioritizing economic need, the Council on Aging's practice is to direct funds (for example, family caregiver respite grants) to those who are low income and who do not qualify for other forms of assistance.

In the event of funding reductions the Council on Aging would, as it did in response to sequestration and past funding cuts, reduce level of service instead of reducing number of clients served. In the happy event of increased funding, the Council on Aging would first increase number of clients served, with emphasis on those in greatest economic and social need, and then would increase level of service.

SECTION B – PLANNING AND SERVICE AREA PROFILE

B–1 Population Profile:

Data provided by the CSSU indicate the following:

characteristic	*Crook Co*	*Deschutes Co*	*Jefferson Co*	*PSA*
Aged 60+	6,193	36,634	4,965	47,792
Low income	669	3,047	363	4,079
Seniors of color	287	1,257	697	2,241
Low income seniors of color	76	170	67	313
Limited English proficient*	358	4,024	1,324	5,706
Seniors with disability (per 2016 US Census)	4,683	32,018	3,802	40,503
Rural	2,590	12,716	3,299	18,605
Native American seniors	64	163	465	692
Native American tribes			Warm Springs, Wasco, Paiute	

*Based on those aged 5+

B–2 Target Populations:

Using the above, as well as more recent U.S. Census Bureau (2015) data, enabled the Council on Aging *to identify demographic trends and target populations that impact our plan for – and prioritization of – services*. Trends and targets include:

- High rate of growth – As noted previously, U.S. Census Bureau data show Deschutes County to have the *fastest growing senior population in the state*. See Table 1 next page.

- Economic need – Almost 48,000 seniors aged 60+ live in Central Oregon; over 4,000 of them (8.5%) live in poverty. The Council on Aging's Area Plan survey found *more than 1 in 10 respondents living on less than $1,000/month* having to, as one senior described, choose between buying food or medicine. 20% of these low-income seniors reported "never" or "only sometimes" having enough to eat. See Table 2.

- Social need –
  a. Geographic isolation, *i.e.,* rural: Two of three counties, namely Crook and Jefferson, exceed state averages on all indicators of poverty. And 42% of Crook Co seniors, as well as 66% of Jefferson Co seniors, live in rural areas. See Table 3.
  b. Disability: *25,254 adults with disability live in the Council on Aging's tri-counties*. The majority live in Deschutes County. However, *the rural counties of Crook and Jefferson have a higher proportion of adults with disability than does Deschutes County* (19.3% of Crook County population, 11.2% of Deschutes County population, and 20.0% of Jefferson County population).

c. Race, ethnicity and culture: Seniors of color have been underrepresented in the Council on Aging's client base. Such seniors represent almost 5% of those aged 60+ in the Council on Aging's PSA. The poverty rate among these seniors of color (14.0%) is much higher than the poverty rate for all seniors in the Council on Aging's PSA (8.5%). The Council on Aging has prioritized service to these seniors based on their past under-representation combined with their high economic and social need. *Inclusion and equity are hallmarks of the Council on Aging's Area Plan 2017-2020*. See Tables 4 and 5.

d. Language: The majority of census tracts in the Council on Aging's PSA show relatively low-rates of individuals who speak English less than "very well." Exceptions are rural census tract 10.02 in Deschutes County, with 9.4% speaking English less than very well, and Census Tracts 9602.01and 9603.02 in Jefferson County, with rates of 20.1% and 7.5% respectively.

Table 1: Increase in Senior Population (65+) in the Council on Aging's PSA based on U.S. Census Bureau Data 2016 vs. 2010

Measure	*Crook County*	*Deschutes County*	*Jefferson County*	*Total*
#65+ in 2016	5,575	34,992	4,316	44,883
# 65+ in 2015	5,343	33,125	4,103	42,571
# 65+ in 2010	4,196	23,502	3,323	31,021
Increase in # (2016 – 2010)	+ 1,379	+ 11,490	+ 993	+ 13,862
% Increase	32.9%	49%	30%	44.7%

Table 2: Senior Poverty Rates by County within the Council on Aging's PSA based on U.S. Census Bureau - American Community Survey (ACS) 2014-2016 Data

County	*Total population*	*Senior population*		*Seniors living in poverty*	
Crook	22,570	5,575	24.7%	792	14.2%
Deschutes	181,307	34,992	19.3%	3,709	10.6%
Jefferson	23,080	4,316	18.7%	747	17.3%
PSA	226,957	44,883	19.8%	5,247	11.7%

Table 3: 2014 Indicators of Poverty by County within the Council on Aging's PSA based on January 2014 Data from Oregon Department of Human Services

County	*Population*	*Poverty rate*	*Unemployment rate*	*Food stamps*	*Welfare*	*Medicaid*
Oregon	3,919,020	16.6	6.7	20.2	2.2	25.1
Crook	20,690	18.8	9.3	24.0	2.6	30.0
Deschutes	162,525	15.7	7.5	19.6	2.0	27.0
Jefferson	22,040	19.9	8.4	32.8	5.7	35.3

Table 4: Population Size and Poverty Rates by Race/Ethnicity for the Council on Aging's PSA from SUA Data

race/ethnicity	*total population*	*# and % 60+*		*# and % 60+ living in poverty*	
All	202,920	47,792	23.6%	4,079	8.5%
African American	659	105	15.9%	0	NA

Asian	2,066	205	9.9%	63	30.7%
Hispanic	17,597	772	4.4%	108	14.0%
Native American	5,025	692	13.8%	69	10.0%
Native Hawaiian/PI	420	27	6.4%	0	NA
2+ races/ethnicities	4,741	440	9.3%	73	16.6%

Hispanic and Native American seniors account for the largest number and percent of the Council on Aging's seniors of color. These seniors have high need for service as evidenced by the following:

- Hispanic seniors have 33.1% lower household incomes than white seniors ($35,981 versus $53,821 in 2013 as per U.S. Department of Health and Human Services)
- 47% of white seniors report their health as very good to excellent, compared to 30% of Hispanic and 28% of Native American seniors
- Significant health disparities exist between white seniors and seniors of color, *e.g.*, Latinos are twice as likely to develop type 2 diabetes – and are more likely to die from diabetes – than are white seniors (*Latino Age Wave* report)
- Despite high need, seniors of color – even when eligible – under-enroll in food programs; as per the AARP Foundation's *No Mas Hambre* report, Hispanics experience food insecurity at double or more the rate of whites
- Hispanics under-enroll in SNAP; research shows that Hispanics "…often turn to their families or make ends meet with the little that they have…" as opposed to accessing hunger prevention programs (Hiram Lopez-Landin, AARP Foundation analyst)
- Nationally, AAAs such as the Council on Aging, are not meeting need among seniors of color. The Hispanics in Philanthropy *Latino Age Wave* report notes:
  - A majority of AAAs (87%) cannot serve Spanish-speaking clients; only 1 in 5 have websites in Spanish
  - A majority referred callers to online "search for service" databases — particularly inappropriate for older adults with limited technology skills and low English proficiency
  - The report concluded "…that the nation's federally-funded aging infrastructure is ill-prepared to handle the Latino aging boom…language barriers serve as a form of discrimination that effectively excludes Spanish-speaking older adults from receiving critical services."

By combining race/ethnicity data with county data, the Council on Aging can identify areas of greatest economic and social need: These include:

- Crook County which, although it has a relatively small population, has high need among all seniors and particularly Hispanic seniors
- Deschutes County which, despite being urban as opposed to rural, has the second highest poverty rate within the Council on Aging's PSA
- Jefferson County, which has the largest Native American population within the Council on Aging's PSA

Identifying, engaging, and serving target populations:

- Low-income older adults, including low-income minority adults – Identified and engaged through referral from a) other agencies (DHS, APD, APS, county health), b)

Latino Community Association and Let's Talk Diversity Coalition, c) OHP providers including Mosaic Medical and Best Care Treatment Services, d) I&R specialist. Served by nutrition programs, OPI, caregiver support, case management, legal aid, SHIBA services and elder advocacy.

- . .
- Older adults living in rural areas –Identified, engaged and assisted by rural serving La Pine Senior Activity Center, Jefferson County Senior Center and Prineville Soroptimist Senior Center. Also served by Case Manager dedicated to La Pine and Southern Deschutes County and by Case Manager dedicated to Crook and Jefferson County
- Older adults at risk for institutional placement – Identified by family, friends, neighbors, and community members (through Gatekeeper training). Public education on elder neglect and abuse promotes referral from friends and neighbors. Referred by St. Charles Health Systems and other facilities with intent to prevent recidivism and return to institutional placement. Services include coordination of in-home and personal care, minor repair to improve home access (ramps) and safety, companionship and connection to transportation, and all nutrition program and case management services.
- Native American seniors – Identified and engaged by Outreach Coordinator, Case Managers, and through growing relationship with Warm Springs Senior Center. Served through that center's Title VI nutrition programs. Also eligible for OPI (if funds are available) and services such as SHIBA.
- 5. LGBTQI+ individuals – This is one of the most difficult target populations to identify and engage. The Council on Aging has been in conversation with the Human Dignity Coalition regarding service, and also has had staff presence at the Central Oregon Pride festival. Outreach to the LGBTQI+ community will be a priority in the Council on Aging's marketing plan.
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B–3 AAA Services and Administration:

Information in this section serves, in part, as narrative accompaniment to Attachment C as described further in Section D.

Service	Crook County	Deschutes County	Jefferson County
Number of Congregate Meal sites	**1**	**4**	**1**
Number of Home Delivered Meal sites	**1**	**4**	**1**
I & A/I & R sites	**1**	**3**	**1**
Alzheimer Resource Center	**0**	**1**	**0**

Core Functions of the Council on Aging as the AAA for Central Oregon are:

- Identify the needs of seniors, adults with disabilities, and their caregivers and target programs to populations based on greatest social need.
- Develop and implement accessible systems of care which prioritize services to best address need

- Coordinate existing services while working closely with community partners and develop new services as needed
- Advocate on behalf of seniors, adults with disabilities and their caregivers
- Coordinate program offerings and integrate with other public supports and refer clients to appropriate resources
- Help people to access the services they need through Information and Assistance and Information and Referral
- Provide Information and Referral in support of the Central Region ADRC while coordinating other ADRC functions with ADRC partners

The Council on Aging oversees services in its PSA, offering direct services and contracting with service providers and other partners. The Council on Aging contracts with senior centers throughout the PSA to provide congregate and home-delivered meals and to serve as accessible locations for nutrition education, health promotion classes and SHIBA counseling.

The Council on Aging also contracts with local home care and personal care agencies to provide direct in-home services to clients under the OAA IIIB and OPI programs.

The Council on Aging programs have served Central Oregon seniors and disabled populations since 1975. Programs include:

- Information and Assistance/Information and Referral: A service for older and disabled individuals that provides current information on opportunities and services available within their communities; assesses the problems and capacities of the individuals; links individuals to the opportunities and services; to the extent possible, and by establishing adequate follow-up, ensures that the individual is made aware of opportunities and receives needed services.
- Senior Nutrition Program: Designed to promote better health and well-being among seniors through nutrition and socialization. Offers nutritious meals in both a group setting (congregate) and to those who are home bound (home-delivered meals or Meals on Wheels). Home-bound persons are those unable to shop for – or to prepare meals for – themselves.
- Transportation: Central Oregon Intergovernmental Council (COIC) is the umbrella organization for public transportation in Central Oregon. Public transportation includes Cascades East Transit, local city bus service and Dial-a-Ride. The latter provides transportation for seniors and those with disability (of any age) to local senior centers, medical appointments, shopping and personal errands. The Council on Aging has input on services offered and directs funding to COIC as part of OAA IIIB transportation program.
- Case Management: Council on Aging case management assesses client need and develops and implements a person-centered plan of care. The care plan identifies appropriate program offerings for the client and coordinates all needed services, both those offered by the Council on Aging and those offered by other agencies. Case management provides ongoing care coordination in response to the client's changing needs.

- In-Home Services: Through Oregon Project Independence and OAA programs for at-risk seniors, the Council on Aging connects clients to contracted home health agency partners and home care workers. This enables clients to access both home care and personal care.
- Family Caregiver Support Program: The Council on Aging supports family and informal caregivers with the following services: Information about available services; assistance in accessing services; individual counseling, support groups and caregiver training to help the caregiver make decisions and solve problems related to their caregiver roles; and respite and supplemental services on a limited basis to complement the care provided by the caregiver. Program extends to grandparents and older relatives who are caring for children.
- Options Counseling: Offered through both the Council on Aging and ADRC, options counseling helps individuals and their families make informed, long-term care decisions. By helping individuals to better understand their strengths, needs, preferences and unique situations on the one hand, and available community resources on the other, certified options counselors help individuals integrate the two into a cohesive plan that includes support strategies and tactics.
- Senior Centers: Support congregate and home-delivered meals, I&R, health promotion classes, nutrition education and SHIBA counseling.
- Elder Rights Protection: Includes elder abuse awareness/prevention presentations at senior centers; safe house sponsorship (emergency short-term shelter) for at-risk seniors; support of volunteer Ombudsman; and public education and awareness. The Council on Aging also works with the DOJ on fraud prevention, serves on MDT and high risk teams for community connections regarding elder abuse, and helps APS by providing emergency shelter for seniors removed from their living arrangement because of abuse/suspected abuse.
- Volunteer opportunities for seniors: Meals on Wheels, SHIBA, and general support for Council on Aging-sponsored functions.

Services, noted above, affected by budget increases or reduction include:

- Senior Nutrition Program – Enhanced nutrition education made possible with private funding for a staff dietitian (see Healthy Choices, below.) Improvements to nutritional value of meals (fresh fruit and fresh salad program) as noted below.
- Transportation – Loss of both volunteer transportation and companionship services offered by Volunteers in Action, given that VIA could not sustain itself with private funding.
- Senior Centers – Loss of congregate dining site in Bend, due to financial constraints experienced by Bend's Community Center. In response, the Council on Aging is partnering with St. Charles Health System in Bend to pilot "Café 60," A senior, voucher-based meal program. Update: the St. Charles program was not continued after the pilot due to the partner being unable to continue. Bend Senior Center continues to provide two congregate meals per week to seniors; the Council on Aging manages and funds one of the meals. The Council on Aging also is using private funding to increase meal reimbursement and meal site caps for senior centers partnering with the Council on Aging to offer nutrition programs.

- Volunteer opportunities – The Council on Aging is expanding and strengthening its Volunteer Program with Walmart Foundation that are providing for increased staffing, a van wrap for recruitment purposes, a case management vehicle, and volunteer incentives and recognition. The Council on Aging also increased the hours of the La Pine Site Coordinator to add the duties of Volunteer Coordinator.

Resources available to provide similar services include:

- Alzheimer Foundation of America respite care and transportation grants.
- Latino Community Association-based OHP counselors who are being trained and certified as SHIBA counselors
- Support from OSU dietitians for nutrition education

Best practices include:

- Healthy Choices Nutrition Education Program – Includes a Tool Kit for Case Managers, so that they can administer nutritional risk analyses with home-bound clients that drive individualized, one-on-one nutrition education.
- Registered and Licensed Dietitian – Was brought on staff with Walmart Foundation funding to increase the Council on Aging's capacity in the area of nutrition education. The dietitian offers quarterly nutrition education presentations at congregate sites, analyzes meals and menus for nutritional value, provides nutrition education training and materials for case managers, and helps meal site staff access ServSafe training.
- . We no longer have any bi-lingual staff. We have not had demand from the Spanish speaking community to justify the replacement of a bi-lingual case manager. When we have Spanish speaking needs; we partner with the Latino Community Association to translate and support needs. Our bi-lingual Outreach Manager left the organization. We interviewed both Spanish speaking as well as Native American affiliated candidates. We hired a Native American background candidate and this has helped us in re-establishing a relationship with the Warm Springs tribes.
- Meal improvement – Achieved by using funding from the Cow Creek Umpqua Indian Foundation and the Hunger Prevention Coalition to add a whole piece of fresh fruit and a fresh green, pasta, or fruit salad to Bateman frozen meals. Update: after conducting a taste test and survey of our Bateman frozen meals with staff and clients; the Council on Aging changed its frozen food provider from Bateman to Golden Gourmet effective January, 2018. The change appears to be very well received by clients.

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

The Council on Aging partners with the following agencies and community-based organizations to bridge gaps and address the needs of Central Oregon seniors and adults with disabilities.

Agency / CBO	*service/Funding Sources*
Department of Human Services / Aging and People with Disabilities	The Council on Aging coordinates with DHS/APD offices in each county to help bridge gaps in service. DHS/APD provides Elder Abuse awareness education, advocacy, and coordination of care for those who transition to Title XIX, Medicaid, SNAP and in-home services. The Council on Aging provides OAA- and OPI-specific programs and services to help bridge gaps. The Council on Aging also assists with the tri-county disaster preparedness list.
Elder Abuse MDT	Council on Aging staff sits on MDT and provides support and information as needed. MDT is fully staffed with community partners, including APS, law enforcement, DA's office, and other community partners. No external funding.
Mental Health / Behavioral Health:	The Council on Aging works with DHS, Deschutes County Behavioral Health, local law enforcement, MCAT team, Best Care in Jefferson County and Lutheran Community Services in Crook County to provide education and counseling for clients, caregivers, and staff. High Risk Team meetings are also held in Jefferson and Crook counties through the Central Oregon Health Council.
Transportation: Central Oregon Inter-governmental Council (COIC)	Transportation for seniors to and from meal sites via Cascades East Transit/Dial-A-Ride. Also provides Volunteer Ride Match to those who qualify through an application process. The Council on Aging is working to further develop the Ride Match Program. The Council on Aging provides Title III-B to COIC to pay for units of service.
Housing:	
Faith Communities	Supply medical equipment, food/energy/utilities assistance and additional support services to bridge the gaps experienced by service populations.
Habitat for Humanity	Partners with the Council on Aging to make home repairs using Title III-B funds. Currently, communication and resources are unclear and service populations are unable to navigate eligibility criteria without assistance.
Housing Works	HUD provides elderly low-income individuals in the tri-counties with access to affordable housing. The Council on Aging makes referrals and directs clients through the

	application process (the lottery system used tends to confuse those in the service population).
KOR	KOR's mission is to provide affordable housing for seniors and diverse populations. Council on Aging staff participates as a voting board member.
Legal Aid	Provides space, scheduling and coordination to facilitate seniors' access to attorneys for legal consultation. Funding through Title III-B.
NeighborImpact	Collaborates with the Council on Aging on referrals to organizations that provide heat and energy assistance, home rehabilitation and weatherization, and housing information, education and subsidies for low-income residents.
Employment: Work Source	Provides Title V programs throughout the tri-counties to help those aged 55+ access on-the-job training to re-enter the work force.
Disability:	
Abilitree	Provides information and advocacy regarding ADA. Special emphasis on accessibility and physical access. Connecting individuals and coordinating referrals for social security, employment, training, and independent living.
Alzheimer's Association	The Council on Aging works directly with the regional office to connect family caregivers and those with ADRD to resources and services such as support groups and educational opportunities. No external funding.
Commission for the Blind	Offers information, assistance, and equipment for seniors with loss of vision, including life class training. The Council on Aging makes referrals. No external funding.
Senior Centers:	The Council on Aging contracts with area senior centers for congregate and home delivered meals. I&A numbers and volunteer hours are requested from the sites. The Council on Aging provides III-C1, III-C2, and local and private funding.
Care Transitions:	
Assisted Living Facilities / Adult Foster Care	Offer limited FCSP respite and emergency respite care in coordination with APS throughout the tri-counties. The Council on Aging provides clients throughout the Central Oregon ADRC with information on current availability.
Care Transitions / St. Charles Medical System	Provides care and education for those transitioning from hospital or institutional care to home. The Council on Aging interacts frequently with social work department regarding discharge planning and support services needed to ensure client safety. Gap exists between discharge planners and other community partners regarding resource available. Funding comes from hospital system(s).

Home Health / Transitions / Hospice	The Council on Aging collaborates frequently with providers, referring clients, coordinating services, developing ongoing care plan, and facilitating communication.
Health Promotion:	
Central Oregon Community College (COCC)	Partners with the Council on Aging to provide health promotion classes, such as *Better Bones and Balance.* The Council on Aging provides Title III-D funds.
Deschutes County Health Services	Partners with the Council on Aging to offer educational programs for seniors, including *Living Well with Chronic Conditions* and the *National Diabetes Prevention Program.* The Council on Aging provides Title III-D funds. Health Department also provides direction on Emergency Preparedness.
Target Populations:	
Latino Community Association / Let's Talk Diversity Coalition	Both organizations participated in the Council on Aging's community needs assessment of seniors of color. They provide representation on the search committee for bilingual staff positions and assist with outreach to underserved populations.
The Confederated Tribes of Warm Springs	Provide health and human services to tribal members located on the reservation. The Council on Aging is strengthening its relationship with the tribes to bridge gaps in services provided on the reservation. This includes participating in the Tribal Navigator program.
Veteran's Services	Referrals made with regard to services provided by federal, county, and non-profit organizations to address veteran needs including in-home care, medical assistance, mental health, spousal support, housing and benefits.

Continuing concerns within the Council on Aging's PSA are on-demand door-to-door transportation, affordable housing, and affordable health insurance and health care, particularly to cover prescription medications. A major challenge includes the loss of Volunteers in Action (ViA), which was a non-profit providing transportation, companionship and home repair to the service population.

Section C–1 Information and Assistance Services and Aging & Disability Resource Connections (ADRCs)

The Council on Aging's exceptional information, assistance, and referral services exceeds 22,000 units annually, while it's public education and outreach impacts almost 12,000 community members a year.

The Council on Aging views the Aging and Disability Resource Connection (ADRC) concept as an important component of service to seniors and adults with disabilities. The Council on Aging's accomplishments on behalf of Central Oregon's 10-county ADRC* include:

- .Fully vetting and updating the ADRC database
- Dedicating one full-time I&R Specialist to maintaining the database, educating the public, and providing resources to individual clients. The Council on Aging will also be adding an I&R Specialist to other locations throughout Central Oregon Senior Centers on a monthly basis. These sites include the Jefferson Co. Senior Center, LaPine Senior Center and the Redmond Senior Center. There is currently an I&R Specialist serving the Prineville Soroptomist Center monthly.
- Training almost all Council on Aging staff in the Oregon options counseling curriculum, with key staff members also becoming AIRS certified, to ensure person-centered services

Although accomplishments are many, challenges persist, as evidenced in the most common information and assistance inquiries. These include callers:

- Confusing the Council on Aging with the Department of Human Services (DHS)
- Routed to the Council on Aging from another county and looking for resources in that county
- Seeking affordable housing and/or in need of transportation
- Requesting Senior Health Insurance Benefits Assistance (SHIBA)/Medicare assistance and/or needing options counseling
- Requiring legal help re: wills, property, guardianship/POA, rental rights, and eviction notices
- Seeking financial assistance for various reasons

Of these, the most challenging are housing and transportation inquiries because, at this time, there are no real solutions to offer. A joint transportation committee, of which the Council on Aging's Executive Director is a part, is actively seeking solutions. Housing is more difficult, given Central Oregon's extreme housing shortage which has driven housing costs to levels well out of reach for many residents. Housing is a crisis for many seniors.

Such needs of seniors and their caregivers are increasing. The following chart, showing increase in need for SHIBA service, well illustrates the issue.

type of SHIBA contact	*2012*	*2015*	*% increase*
Total client contacts	1,327	2,041	54%
First contact for the client's issue	916	1,420	55%
Continuing contacts for the client's issue	411	621	51%
Total time spent with or on behalf of the client	864.92	1,341.82	55%

Much of Central Oregon's rural community is challenged by limited access to services (including access to public and private Long-Term Services and Supports), lack of caregivers, and inability to meet basic needs. The many components of information, assistance, and ADRC -- options counseling, I&R, health promotion, nutritional counseling, care transitioning and coordinated health care – converge to directly respond to these challenges.

Through ongoing work to ensure inclusion, equity and diversity, the Council on Aging will improve Information and Referral/Resources (I&R) service for priority and rural populations. And by embracing the ADRC's main service components, as well as its "no wrong door" approach to successful aging, the Council on Aging will continue to meet community need.

In 2017-2020, the Council on Aging will work with current community partners, such as Aging & People with Disabilities (APD), the Center for Independent Living (Abilitree), and the Veteran's Administration, while aggressively looking for additional funding.

In addition to direct ADRC collaboration, key staff members are involved in other similar community groups, including the Gero Leadership Alliance, the Older Adult Behavioral Health Initiative, and the Community Resource Huddle.

Focus Area – Information and Assistance Services and ADRC

Goal 1: Better assist Latino, Spanish-speaking and Native American populations					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update

• Increase by 5% annually the number of Latino, Spanish-speaking and Native American clients served	a. Provide for Spanish-language/bilingual services b. Develop practices and procedures for staff to serve older adults of color and other priority populations c. Train staff in cultural competence	Outreach Manager	7/1/16	12/31/20	In process
Goal 2: Connect clients to a range of resources by providing accurate, up-to-date, and easily accessed information, assistance and referral services					
• Accurate and current database maintained with >90% of resources updated annually	a. Call / email the listing administrator to update database listings as they become due, at least annually	I&R Specialist	7/1/16	12/31/20	Ongoing
Goal 3: Increase the Council on Aging's capacity to assist clients by ensuring AIRS certification for all information and referral (I&R) and Options Counseling staff					
• Increased capacity for I&R and options counseling achieved	a. All identified staff apply, prepare for, and achieve AIRS certification within 18 months of hire b. All identified staff attend Oregon Options Counseling training	I&R Specialist, Options Counselor(s)	7/1/16	12/31/20	Complete, unless new staff is added
	a.				

	a.				

C–2 Nutrition Services (OAA Title IIIC)

The Council on Aging uses a distributed meal site model to provide home-delivered and congregate meals across its large geographic area. Funds flow through the Council on Aging on a contract basis to community and senior centers as well as to vendors.

Council on Aging Meal Services

Site	*Meals provided by:*	*Home-delivered*	*Congregate*
Bend Senior Center	Golden Gourmet frozen meals (home delivered) In-house kitchen (congregate)	M-F, up to 5 meals	Thursday
Back Door Cafe	In-house kitchen		Wednesday
La Pine Senior Center	Golden Gourmet (home-delivered) In-house kitchen (congregate)	T, W, Th, up to 5 meals	T, W, Th
Redmond Senior Center	In-house kitchen	M-F, up to 5meals	M-F
Sisters Community Church	Golden Gourmet frozen meals	T, up to 5 meals	Tuesday
Jefferson Co Senior Center	Deer Ridge Correctional Facility	T, W, F, up to 7 meals	T, W, F Waiver on file
Prineville Soroptimist Sr Center	In-house kitchen	M-F, up to 5 meals	M-F

In fiscal year 2016, the Council on Aging – in concert with partners, volunteer drivers, and local and private funders -- provided 45,368 congregate meals to 2,695 unduplicated clients and 82,559 home-delivered Meals on Wheels to 700 unduplicated clients. In fiscal year 2017, the Council on Aging provided 36,915 congregate meals to 2,695 unduplicated clients and 82,051 home-delivered Meals on Wheels to 742 unduplicated clients. The Council on Aging's robust development efforts are realizing on average a quarter million dollars in additional support a year, the majority of which is directed to nutrition services.

The Council on Aging routinely surveys clients in order to improve nutrition services. All home-delivered meal clients are surveyed by Case Managers during annual assessment. Congregate clients complete surveys annually at the meal site. The Council on Aging also surveys homebound seniors who end meal service. A spring 2016 survey found the top reason for ending service to be improved health. This was followed by the client passing away while still receiving meal service. This can be read as a positive outcome, in as much as these seniors passed away while still in their own homes.

Nutrition service challenges included:

- Rapid growth rate in PSA leading to increased demand for service
- Rising costs of living that increase food insecurity among seniors living on fixed and limited incomes

- Increased costs of doing business (i.e., rising costs for food/meals)
- Volunteer recruitment and retention

As a result:
- New clients are, at times, wait-listed for home-delivered meals.
- Sites sometimes exceeded contracted caps for reimbursement of congregate meals, resulting in sites spending their reserve funds
- Bend's Community Center could not sustain congregate dining services due to internal financial and administrative considerations. A meal voucher program, Café 60, was initiated in partnership with St. Charles in its stead. The program was unable to sustain itself beyond January 2017 and was discontinued.

In response, the Council on Aging is:
- Increasing its contracted per-meal reimbursement rate by 16.7% in order to build capacity of meal sites (from $3.00 to $3.5 per meal)
- Raising contracted caps for reimbursement of both home-delivered and congregate meals at impacted sites in order to meet existing need
- Providing for additional expansion via $30,000 in increased support for home-delivered meals and $20,000 for congregate meals
- Setting aside $80,000 to further increase capacity, meet existing need, and expand meal service

To promote health and well-being of seniors, the Council on Aging enhanced nutrition education services and improved the nutritional value of meals by:
- Securing Walmart Foundation funds to hire a licensed and registered dietitian who has since been retained permanently by the Council on Aging and is employed full time
- Developing a nutrition education "Tool Kit" that Case Managers use to conduct nutritional risk analyses with home-bound clients; the risk analysis allows for nutrition education in response to individual client need
- Using Food Processor software to analyze meals and menus as part of monthly meal site reviews
- Partnering with OSU Extension on quarterly nutrition education presentations at congregate sites that feature taste tests of take-home, low-salt/low-fat recipes. The partnership was discontinued when the program goals for OSU Extension were changed and staff were allocated elsewhere.
- Securing *Cow Creek Umpqua Indian Foundation, Reser Family Foundation,* and *Hunger Prevention Coalition* funds to add fresh fruit and salads to Golden Gourmet frozen meals
- Covering costs for ServSafe training for kitchen staff at contracted sites; providing food safety certification for food handlers and training for volunteer drivers
- Delivering printed information with Meals on Wheels on topics including nutrition, exercise, medication, lifestyle, fraud, and abuse prevention

Nutrition education is provided through quarterly presentations by the Council on Aging Dietitian at all congregate dining sites and by Case Managers during initial, in-home

assessment with all home-delivered meal clients. Case Managers also provide nutrition education during annual re-assessment visits. Case Managers use the nutritional risk analysis and Council on Aging Dietitian developed nutrition “Tool Kit’ noted above to deliver individual nutrition education to clients.

The Council on Aging also helps clients to prevent or better manage chronic conditions by:

- Announcing health promotion, fitness, and wellness classes at congregate sites
- Offering classes such as the *Eat Smart, Live Strong* USDA-approved and evidence-based course (supported with St. Charles Health System grant funds)

Nutrition services connect to the Family Caregiver Support Program (FCSP) through Case Manager’s initial and annual assessments of home-bound clients. Assessments determine client need, which in turn drives the Case Manager’s connection of the client to appropriate resources such as FCSP for which s/he is eligible.

An additional, primary goal for 2017-2020 is to ensure that nutrition programs are culturally and linguistically relevant for priority populations. The Council on Aging will:

- Provide services in Spanish in both oral and written form
- Explore new ways of delivering service for seniors who are part of intergenerational families to include: a) potential subsidy of existing family dining services provided by churches and other CBOs, b) delivery of food staples or “commodities” that could be incorporated into family meals, c) inclusion of culturally familiar foods in meals, and d) vouchers for use at community restaurants and markets.

Focus Area – Nutrition Services

Goal 1: Expand/enhance meal service for Central Oregon's growing senior population					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update
• Wait lists reduced • Increased capacity for nutrition services achieved • Additional meal site(s) proposed • Evaluation of meal service provider	a. Increase meal reimbursement rates for all sites and budget caps at impacted sites; review annually b. Conduct feasibility study for additional meal site(s) c. Assess vendor options for frozen meal provision	Executive Director, Board of Directors, Nutrition Manager/Dietitian Nutrition Manager/Dietitian	07/01/2016 01/01/2017 07/01/2019	12/31/2020 01/01/2018 12/31/2020 01/08/2018	02/01/2018 Waitlists discontinued 03/31/2018 Closing on new meal site property scheduled. Fall 2020 Meal site operational Meals from 5 different vendors were assessed. Conversion to new vendor meals completed.
Goal 2: Move the Council on Aging toward greater equity and inclusion with regard to nutrition services for priority populations, including Central Oregon's Latino and Spanish-speaking community					
• New meal model(s) for priority seniors explored	a. Inventory existing family meal programs b. Partner with organizations serving priority populations c. Determine feasibility of	Outreach Manager Outreach Manager Nutrition Manager	01/01/2017 07/01/2017 07/01/2018	06/30/2017 07/01/2018 06/30/2020	The need for Latino specific meals was not actualized. However, partnerships

• New meal model(s) recommended to Board of Directors	culturally responsive and family friendly meal options				were developed with Back Door Café and Family Kitchen to provide meals to high risk homeless seniors.
Goal 3: Ensure person-centered service through nutrition programming and case management.					
• Development of person-centered plans that reflect client choices and build on natural supports • Connection of clients to additional resources • Advocacy for clients	a. Develop and measure progress against person-centered plans b. Enlist support of family, friends and professionals in client plan c. Determine client eligibility for add 'l programs and services d. Assist client in accessing programs, services and resources, and in gaining positive response e. Ensure that plans are reviewed/revised at least annually	Case Managers Program Managers Case Managers and I&R Specialist Client Services Manager	01/01/2017 01/01/2017 01/01/.2017 01/01/2018	06/30/2020	
Goal 4: Increase financial support for nutrition services					
• Increased local and private support realized	a. Identify, solicit and secure new funding sources b. Build donor base, conduct appeals, steward donors toward major gifts, and submit grant proposals	Development Manager Development Manager	07/01/2016 07/01/2016	06/31/2017 06/31/2017	New funding sources identified. Working with Marketing consultant to

					increase quality of Direct Mail campaigns.

C–3 Health Promotion

The Council on Aging's Health Promotion and Education programs include effective top-tier, evidence-based programs that enable older Central Oregon adults to live safely and independently with greater quality of life. The Council on Aging promotes and supports chronic disease self-management programs, as well as physical activity and fall prevention programs. The Council on Aging will continue to support and grow these programs, particularly for low-income seniors in rural areas, in Crook, Deschutes, and Jefferson Counties, including classes in Spanish.

The Council on Aging's Program Coordinator oversees all programs. She is trained to lead *Living Well with Chronic Conditions*, *Diabetes Self-Management Program* and *Walk with Ease,* and the *National Diabetes Prevention Program*. However, she is only facilitating the National Diabetes Prevention Program. The Council on Aging partners with Deschutes County Health Services for Stanford self-management programs, Central Oregon Community College for *Better Bones & Balance*, and with other organizations for physical activity/fall prevention programs such as *Tai Chi* and *Matter of Balance*.

Challenges:

- The Council on Aging can count participants only when staff leads a class or when we support the hosting location. Currently, only one Council on Aging staff member is certified to lead Living Well classes. Because programs in Bend are held at Deschutes County Health Department, there is no need for Council on Aging support.
- In La Pine we support a growing Tai Chi program at the senior center. Stanford Chronic Disease Self-Management programs are hosted and staff by the La Pine Health Center.
- Stanford Programs in Central Oregon are again under the coordination of Deschutes County Health Services. Walk with Ease currently is offered by Mosaic Medical in Madras and Redmond.
- Lack of Bilingual leader(s) for physical activity/fall prevention programs throughout the Central Oregon area.

Solutions:

- Assist with promotion of classes that we can support, especially in La Pine. We added support for a Tai Chi class in La Pine in 2017 and have added Matter of Balance in Madras in 2018.
- Partner with new Stanford program coordinating agency (Deschutes County Health Services) to support as many classes as possible.
- Offered rent support to Deschutes County Health Services for Stanford Programs held outside their facilities and support new volunteer training expenses in exchange for Bend attendance. Work with La Pine and Madras activity coordinators to identify certified leaders or volunteers who can be certified to lead programs.
- Support new Tai Chi classes and instructors in In La Pine and Bend. This was accomplished in 2017.

- Work with Council on Aging Outreach Coordinator to acquire a Bilingual (English/Spanish) volunteer willing to be trained in the Evidence Based Health Promotion and Education classes and teach to Priority Populations, especially in the Madras (Jefferson County) area. In 2018 we lost our bilingual Outreach Coordinator.

The area plan survey identified fitness and wellness programs of interest that can help guide our efforts:

CLASS SURVEY INTEREST VS ACTUAL FY16														
Location	**Tai Chi**		**Matter of Balance**		**Walk with Ease**		**Better Bones and Balance**		**Powerful Tools for Caregivers**		**Living Well with Diabetes**		**Living Well with Chronic Conditions**	
	Int	Act	Int	Act	Int	Act	Int	Act	Int	Act	Int	Act	Int	Act
Bend	90		114		115		110	27	30		35		85	
La Pine	13		16		24		11		5		2		9	12
Madras / Culver	18		23		24		17		5		8		22	
Prineville	23	26	28		35		27		8		13		27	
Redmond / Terrebonne	44	90	62		61	9	56		19		11		32	22
Sisters	15		19	7	13		14		4		3		11	
Total	**203**	**116**	**262**	**7**	**272**	**9**	**235**	**27**	**71**	**0**	**72**	**0**	**186**	**34**

Int = Interest reflected on Needs Assessment Survey
Act = Actual participants to date

Subject to state funding, we will support and grow the following evidence-based programs throughout our PSA:

- Stanford Self-Management Programs including *Living Well with Chronic Conditions*, *Living Well with Chronic Pain*, and *Diabetes Self-Management* in English and Spanish
- National Diabetes Prevention Program one-year program for pre-diabetics or those at high risk for diabetes
- Tai Chi 12-movement Sun-style program developed by Paul Lam
- Matter of Balance eight-week program designed to reduce the fear of falling
- Better Bones and Balance designed by Oregon State University to decrease the risk of osteoporosis fractures
- Walk with Ease designed by the Arthritis Foundation to develop a walking program over six weeks

Focus Area – Health Promotion

Goal 1: Support *National Diabetes Prevention Program* in Central Oregon					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update
• Certify at least one staff member to lead classes • Partner with Deschutes County Health Department for program delivery	a. Schedule Health Education Coordinator for training b. Coordinate with Health Dept. to schedule and support one class per year lead by Council on Aging trained staff	Executive Director Program Coordinator	7/01/2016 7/01/2016	6/30/2017 6/30/2020	Certified 7/23/16 First cohort completed 2/20/18; Second cohort completed 2/19/19
Goal 2: Expand Physical Activity/Fall Prevention Program in Jefferson County, Specifically Priority Populations					
• Determine location for physical activity/fall prevention class • Identify certified leader for at least one evidence-based program • Schedule 1-2 classes per year in Madras, with at least one conducted in Spanish	a. Secure easily accessible location for classes b. Contact state organizers for Walk with Ease/Matter of Balance for locally certified leaders c. Coordinate with leader(s) and site to schedule classes d. Work with Outreach Coordinator to acquire a Bilingual instructor	Program Coordinator	7/1/2016	6/30/2019	Matter of Balance begun in Madras 10/2018 Tai Chi instructors are being trained to start in Madras, 2019
Goal 3: Increase Participation of Health Promotion and Education Classes in La Pine					
• Increase participation and attendance in HP classes in La Pine	a. Aid in promoting existing classes, such as Tai Chi b. Work with activity coordinators to identify possible leaders	Program Coordinator	7/1/2016	6/30/2017	9/1/16 added Tai Chi ongoing program in La Pine

C–4 Family Caregivers (OAA Title IIIE)

Harnessing more than 18,000 volunteer hours – and assisting in 240 cases of caregiver support, access, and respite – the Council on Aging cares for those who care about seniors. The Council on Aging provides respite grants ranging from $500 to $1,000 to unpaid family caregivers in need of respite care. The Council on Aging promotes FCSP throughout its PSA via presentations and outreach to community partners and the general public. This is accomplished by Case Managers, Outreach Manager, and through the ADRC.

The Council on Aging provides culturally relevant services to a variety of caregiver populations:

- The Council on Aging's partnership with the Latino Community Association has allowed for individuals within the Latino, Spanish speaking communities to better access FCSP services and resources. Increased partnership with the Warm Springs tribe has also allowed for communication lines to be opened regarding services through the Council on Aging. FCSP can be tailored to meet the needs of these groups in order to provide culturally appropriate and person centered services. The Council on Aging has created a satisfaction survey, used to better understand what is effective, helpful to the client; as well as what is not working for those who have received the grant. This is allowing the Council on Aging to better understand how to improve the program and ensure that service delivery is done in a person directed manner.
- Although as per FSCP standards there are no low-income qualifying requirements, the Council on Aging attempts to serve those with greatest economic need. We assess caregivers' current ability to pay for the program out of pocket, as well as any financial resources that might be available to caregivers through other organizations. Caregivers with greatest social need are assessed for both current need and barriers to service. Case Managers reach out to community partners to address need and barriers, if possible. This includes using additional services provided by outside organizations that best fit the caregiver's needs.
- The Council on Aging works closely with the local Alzheimer's Association and with communities that specialize in Alzheimer's disease and related dementias. The Council on Aging received a grant from the Alzheimer's Foundation of America to provide respite grants to caregivers of those with Alzheimer's disease and related dementias, which was utilized in its entirety.
- The Council on Aging's FCSP focuses on support for family members caring for those at risk of institutionalization. Support includes respite grants and Options Counseling. The latter helps clients create long-term plans which may involve reaching out to other community partners such as the VA or DHS.
- Non-traditional family caregivers are encouraged to utilize FCSP. The Council on Aging strives to remain unbiased in terms of familial structure or make-up. Special accommodations are made whenever possible to address the needs of all family caregivers. The Council on Aging is building a partnership with the Human Dignity Coalition, which serves Central Oregon's LGBTQI+ community.

- Clients aged 55+ are entitled to assistance and may have access to respite care, supplemental support, information and assistance, counseling, and assistance accessing programs that will assist them in their caregiver role. The Council on Aging will continue to reach out to this underserved population.
- Older individuals caring for children with severe disabilities, including developmental disabilities, are eligible for assistance for respite care, as well as Options Counseling to ensure that they have access and support to apply for all possible services which would assist and enhance caregiving. This includes referrals made by Council on Aging staff to community partners such as Abilitree.

FCSP Core Elements:

- Information Services, Group Activities: By working with the I&R Specialist and the ADRC, the Council on Aging offers information services to those in need. The Council on Aging also works with community partners to co-sponsor presentations across the PSA. The Council on Aging's *Directions* resource guide is distributed to seniors across the PSA as well.
- Specialized family caregiver information (one-to-one): The Council on Aging offers Options Counseling and has AIRS certified staff on hand. Staff is able to compile resources to meet the senior's needs and to assist with long-term planning and referrals.
- Counseling: Case Managers and/or professional counseling are provided; support groups are encouraged.
- Training: Funding is provided for fees and respite care, so that caregivers can attend conferences or trainings, including Powerful Tools for Caregivers which is offered by the Council on Aging. The Council on Aging notifies family caregivers of available trainings as they are known (note: this class is no longer being offered).
- Support Groups: The Council on Aging offers two Caregiver Support Groups every Monday afternoon. Co-facilitated by a Council on Aging staff member and a volunteer leader, it is open to all family caregivers. The Council on Aging uses respite funds as needed so that participants may attend meetings. The Council on Aging also refers family caregivers to other disease- and diagnoses-specific support groups offered throughout the PSA.
- Respite Care Services: Referrals from outside organizations, as well as direct calls to the Council on Aging regarding FCSP, are directed to the appropriate Case Manager. Case Managers contact the interested parties within 3 business days. If it appears that the party might meet FCSP eligibility standards, the Case Manager schedules an in-home assessment. During the home visit, needs are assessed based on the caregiver's (as well as, when possible, the care receiver's) self-report. A list of potential resources/supports is compiled to help meet expressed and observed needs. Resources/supports include those offered by the Council on Aging, by outside organizations and community partners, and by local county and state offices. Options for respite care include in-home providers as well as assisted living facilities or adult foster care that can accommodate the care receiver on a limited basis (overnight or weekend stays). Some caregivers have a trusted respite

caregiver, but need help to pay for respite. A voucher to help pay for such respite is available.

- Supplemental Services: These services – which include building ramps, providing bathroom and medical equipment, or purchasing incontinence supplies -- enhance the caregiver's ability to provide in-home care. The Council on Aging contacts local contractors to bid on repairs. The Council on Aging also partners with equipment providers such as NORCO and Bi-Mart to provide equipment.

Focus Area – Family Caregiver

Goal 1: Expand the FCSP program to better serve the Latino, Spanish-Speaking, and Native American populations					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update
• Increase the number of Latino, Spanish-Speaking and Native American family caregivers receiving FCSP respite support	a. Identify family caregivers within these populations who would benefit from respite b. Match them with private and/or agency-based respite providers appropriate to meet their cultural needs	Case Managers and Outreach Manager Case Managers	7/1/2016 7/1/2016	6/30/2017 12/31/2020	Partnership with LCA has allowed for additional support for caregivers. Efforts continue
Goal 2: Assess caregiver satisfaction with the program following their completion					
• Quantify satisfaction ratings of family caregivers following their FCSP participation • Adjust program delivery model based on family caregiver responses	a. Create an assessment tool to be administered to FCSP caregivers b. Process data to provide a satisfaction rating c. Utilize assessment tool data results to better understand the satisfaction rate experienced by family caregivers	Client Services Manager supported by all Case Managers Operations Manager Client Services Manager	12/1/2016 7/1/2017 7/1/2017	6/30/2017 12/31/2020 12/31/2020	Complete, surveys have been created and are administered to all caregivers who have completed a grant. 33 have been returned and the results have been entered into Survey Monkey

C–5 Elder Rights and Legal Assistance

The Council on Aging elder rights and legal assistance efforts help protect seniors from elder abuse and financial exploitation. The Council on Aging raises public awareness, provides information and education, and connects seniors to appropriate resources that reduce risk for – and ensure strong response to – elder abuse, fraud, and other financial exploitation.

For legal services, the Council on Aging partners with Legal Aid, referring clients directly to them when the need is indicated by the client. The Council on Aging schedules clients into individual appointments for quarterly on-site, no-cost legal advising and assistance offered by a local attorney facilitated by Legal Aid . These half-hour consultations focus on priority legal assistance as defined by OAA 307(a)(11)(E) and include matters related to income, health care, long-term care, housing, and age discrimination and includes approximately six clients per quarter per community.

Council on Aging Case Managers and staff members work with Adult Protective Services (APS) to resolve issues in the best interest of clients. When a client or third party contacts the Council on Aging's Information & Resource specialist, every attempt is made to have the client or third party contact APS directly. This is per APS's request, as they would need to talk directly to the complainant even if the Council on Aging made the call on his/her behalf. Case Managers refer cases to APS when it is their professional determination that the client's safety is at high risk and that the situation is urgent.

Additional safeguards include:

- Policies in place for all Council on Aging staff, volunteers and, other providers regarding elder abuse detection and reporting. Training for volunteers is held annually.
- Council on Aging staff attendance at bi-monthly multi-disciplinary team meetings in Deschutes County, as well as monthly high risk team meetings in Jefferson and Crook counties.
- Ongoing commitment to, despite loss of funding for, the ADRC Gatekeeper program. The Council on Aging remains committed to educating the public on the signs of elder abuse, and uses both staff and volunteers to educate local organizations and businesses on elder abuse using the Gatekeeper model.
- Distribution of relevant information regarding financial fraud and exploitation distributed to Council on Aging clients (approximately 360 clients).

The bi-monthly, multi-disciplinary team (MDT) meetings include the Deputy District Attorney, Department of Human Services Supervisor, representatives from county mental health and law enforcement, a Council on Aging Case Manager, and additional attorneys. Discussion centers on elder rights and violations against seniors including fraud, embezzlement, and compliance (e.g., foster homes out of compliance). Individual cases are discussed as well, with attention on how resources can best be brought to

bear to assist and manage difficult cases. Examples of individual cases that were triaged include an Oregon Project Independence (OPI) client whose behavior had so deteriorated that personal, in-home care was unmanageable, and a client whose constant calls to 911 were a risk to public safety.

Future need in this area will be met only through continued partnerships with the Department of Justice and Legal Aid, and by accessing pro-bono legal services of local attorneys. The Council on Aging also is investigating educational opportunities and money management options to help seniors remain fiscally sound and safe. However, the Council on Aging has decided at this time that we do not have the capacity, either human or physical, to oversee the money management program at this time.

Focus Area – Elder Rights and Legal Assistance

Goal 1: Become more knowledgeable on elder rights & legal assistance					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update
• Acquire better knowledge and understanding of elder rights and legal assistance	a. Pursue and attend educational opportunities regarding elder rights and legal assistance b. At least one staff member to attend a minimum of one educational opportunity per year	I&R Specialist, Case Managers	7/1/16	12/31/20	Regional Director of Legal Aid for our PSA presentation to all COA staff on Legal Aid services and establishment of a priority handoff process between Case Management and Legal Aid.
Goal 2: Ability to meet the legal assistance needs of our clients					
	a.	Executive Director, I&R Specialist	7/1/16	1/1/2019	Legal Aid Regional Director educated COA staff to refer all legal needs clients who meet the federal poverty guidelines to their office. No need to wait for Law Days.
Goal 3: Increased awareness of financial fraud and exploitation					

• Increase awareness of financial fraud and exploitation amongst clients and caregivers	a. Acquire printed information regarding financial fraud and exploitation in both English and Spanish b. Distribute information to Council on Aging clients and their caregivers on a regular basis, at least bi-monthly (approximately 360 people each time) in Crook, Deschutes, and Jefferson counties c. Promote awareness at any events where the Council on Aging has a table or booth, at least once per year d. Share relevant information on social and printed media e. Share relevant information via the Council on Aging's Outreach Manager, especially the Spanish speaking population as the opportunity arises	I&R Specialist	7/1/16	12/31/20	

C – 6 Older Native Americans (OAA Titles VI and IIIB)

The Confederated Tribes of Warm Springs (the Warm Springs, Wasco and Paiute Tribes) comprise the Title VI-funded tribal entity in the Council on Aging's PSA. The majority of Native American elders in the Council on Aging's PSA live in Jefferson County, where the Warm Springs Reservation is located. However, data show 227 Native American elders to live in Crook and Deschutes County. These seniors, and most likely many others, are out-of-reach of services offered by the Warm Springs Senior Center.

Although the Confederated Tribes are represented on the Council on Aging's Advisory Council (through Destry Begay, Warm Springs Senior Center staff), there is minimal coordination of service between the Council on Aging and the tribes, particularly when compared to the possibilities presented in the Area Plan webinar.

To move forward in this critical area, the Council on Aging undertook the Meyer Memorial Trust-funded community assessment (described in Section A – 3 Planning and Review Process). Findings related to Native American seniors included:

- Native American seniors reported a high rate of knowledge (93%) of senior-specific services, most likely due to the presence and visibility of the Title VI-funded Warm Springs Senior Center.
- Native American seniors reported need for better understanding of health care options related both to coverage and actual service. This suggests need for "single-point-of-contact" advising service (perhaps like ADRC's) that would help seniors understand various options, eligibility for each, and how best to develop coordinated and individualized "action plans" for affording and accessing service.
- Word-of-mouth and "culturally located" media (KWSO radio in Warm Springs and *La Bronca* Spanish-language radio out of Redmond) were noted by Native American and Latino seniors respectively as primary information sources.
- Native Americans expressed high need for food assistance that takes into consideration management of diabetes.
- Both Native American and Latino seniors expressed desire for culturally familiar foods including, for Native Americans, game meats.
- Both Native American and Latino seniors expressed desire for more fresh fruits and vegetables that are expensive (particularly so on the reservation and/or when using food stamps), not readily available through food banks which rely on shelf-stable foods, and often not carried in neighborhood markets.

In line with these findings, the Council on Aging identified the following goals and objectives for its Older Native Americans focus area:

- Replaced our bilingual Outreach Coordinator in 2018 with an Outreach Manager who is 50% Native American. Her participation in recent meetings and social events with the members of the Warm Springs tribe has greatly improved the receptivity of the community to the Council on Aging.Schedule ongoing meetings with Warm

Springs Senior Center staff to: 1) strengthen the Council on Aging/Warm Springs relationship, 2) explore feasibility of ADRC or “options counseling” service for seniors, and 3) to pursue greater pooling and leveraging of resources
- Access word-of-mouth networks in order to build critical mass of priority seniors and families using Council on Aging services
- Offer a diabetes health class at the Warm Springs Senior Center
- Participate in the Tribal Navigator program through DHS

The intent is for these initial efforts to lay the foundation for a long-term, mutually beneficial and coordinated response on behalf of the Council on Aging and the Confederated Tribes of Warm Springs to ensure the dignity, well-being, and independence of Native American elders.

Focus Area – Older Native Americans

Goal 1: Build the Council on Aging's capacity to serve Native American seniors					
Measurable objectives	Key tasks	Lead position and entity	2017-2020 Timeframe Start date	End date	Accomplishment or Update
• Support and sustain the Council on Aging's new Outreach Coordinator • Provide Council on Aging staff and board with cultural competence training • Explore feasibility of joint training opportunities for Council on Aging and Warm Springs Senior Center staff	a. Train and adequately resource an Outreach Manager b. Use culturally appropriate outreach (Warm Springs newspaper, KWSO radio, existing on-reservation events) to engage and better serve seniors c. Develop advising services to help elders navigate their health care options and eligibility status d. Leverage resources to provide joint training for Council on Aging and Warm Springs staff	Executive Director Outreach Manager Outreach Manager Client Services Manager	07/01/2016 01/01/2017 06/01/2017 01/01/2018	12/31/2016 ongoing 01/01/2018 01/01/2019	
Goal 2: Establish relationship with Confederated Tribes of Warm Springs Title VI entity in order to address unmet need among Native American seniors					
• Establish regular, ongoing meetings between the Council on Aging and the Warm Springs Senior Center • Offer health	a. Identify a Council on Aging liaison at Warm Springs reservation b. Train Outreach Coordinator to provide evidence-based diabetes management class at Warm Springs	Executive Director Outreach Manager	01/01/2017 01/01/2018	06/30/2017 12/31/2018	

promotion classes targeted to elders	c. Offer class in conjunction with Warm Springs Senior Center				

D–1 Administration of Oregon Project Independence (OPI)

a. Describe how the agency will ensure timely response to inquiries for service.
Every effort will be made to telephone inquiring parties within 24 hours. All inquiries will be addressed by a Case Manager within three (3) business days. If the Case Manager believes the client might be OPI-eligible based on care needs discussed during a brief screening, the manager will set a time to meet with the client. Case Managers will ask clients about their current medical benefits to ensure they are not receiving state services that would make them OPI-ineligible. Every effort will be made to set the visit within three (3) business days following telephone contact.

b. Explain how clients will receive initial and ongoing periodic screening for other community services, including Medicaid.
Council on Aging Case Managers administer and are aware of many programs and community resources that provide a variety of assistance to seniors. All applicants are informed of Council on Aging and community services at intake, at reviews, and when need for other services becomes apparent. Case Managers screen all potential OPI clients to see if Medicaid referrals are warranted. If continuing clients might be Medicaid-eligible, they are referred during the periodic review to the local Medicaid office to start the application process. The client and his/her spouse are assessed for veteran status to determine eligibility for veteran benefits in lieu of AAA or state services.

c. Describe how eligibility will be determined.
Eligibility is determined through an in-home assessment. This assessment is based on observation and information gathered from the client, physician and/or family members. Completing the Client Assessment and Planning System (CA/PS) provides information on medical, mental, ADLs, IADLS, and the individual's support systems. The CA/PS is used to determine the client's service level eligibility. Service Priority Level (SPL), used in support of eligibility determination, is determined after the CA/PS assessment is entered into OACCESS.

d. Describe how the services will be provided.
Case management helps seniors to make cost-effective and appropriate decisions regarding their care needs. Case management includes assessment of individual/family needs, problems and resources; care planning and arrangement for provision of informal and formal services; ongoing monitoring to assure appropriate service delivery; and reassessment to adjust care plans to changing needs.

When a Case Manager receives a referral from a client, family, friend or another agency, they have three (3) business days to telephone the client to set a home visit to conduct a needs assessment. When needs are determined, the Case Manager identifies providers for needed services.

The Case Manager looks to both informal and formal support systems, helping to develop plans for enhancing natural systems on behalf of the client by engaging

neighbors, friends, family members, fellow church goers, or friendly visitors. The Case Manager's role is to support the natural system, not to replace it. This includes finding equipment, such as a bath bench, to make client care easier.

The Case Manager then looks to formal support systems for services not met by the informal system. Formal systems include home health, transportation, congregate meals, home-delivered meals, etc. The Case Manager gathers information about the client's financial status to make appropriate referrals to formal support systems. Formal systems can be challenging due to lack of resources, service gaps, and complexity in accessing services. This requires creative problem-solving on the part of Case Managers, as they search for alternative resources to meet need.

Once plans are in place, Case Managers monitor and adjust them as needs change. All clients are reassessed annually. Formal reassessments also are triggered by specific events such as hospitalization, when an application for alternative care is made, or when a provider or others call with concerns. The goal of Case Management is to help delay or prevent inappropriate institutionalization, and to serve as the senior's advocate in order to maximize independence. Case Management is much less costly than institutional care (average monthly community-based care is 300% less than nursing home care) and, more important, it provides choice, dignity, independence, and quality of life to the elderly.

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

Priority is based on Activities of Daily Living (ADLs). Persons needing assistance with the following ADLs have higher priority:

- Mobility
- Eating
- Bowel/Bladder
- Bathing/Personal Hygiene
- Dressing/Grooming
- Cognition

Priority also is given to at-risk referrals, seniors discharged from hospitals, and those without insurance or family or other natural supports. Hours are assigned based on client need, assessment of natural supports, and available OPI hours. Clients are allotted a maximum of 25 hours a month, unless otherwise approved by the Client Services Manager and the Executive Officer. Services provided by the Council on Aging are as follows:

- Assistive technology device: As approved by Case Manager and based on current budget availability.
- Registered nurse services: Based on required hours put forth by the contracted in-home agency. Not to exceed one (1) hour per month.
- Home delivered meals: Up to five to seven meals dependent upon location of consumer.

- Case management (Service Coordination): As frequently as needed based on consumer's need.
- Home care (provided by Home Care Worker or contracted in-home care agency): Not to exceed 30 hours a month unless otherwise approved by the Client Services Manager
- Personal care (provided by Home Care Worker or contracted in-home care agency): Not to exceed 30 hours a month unless otherwise approved by the Client Services Manager.

The wait list is prioritized based on the client's Risk Assessment score. Those with higher scores are given priority based on their needs, available natural supports, and eligibility for/receipt of other services.

f. Describe the agency policy for denial, reduction or termination of services.
Cases are denied when clients are receiving duplicate Medicaid services, certain state medical benefits, or when they do not meet the established priority level. Service reductions are based on need and available funding. Cases are terminated when funds are no longer available or when clients no longer need OPI, move to an alternative care setting, or pass away. Cases also may be terminated due to unresolvable conflicts between providers and clients. Using established procedures and notice letters, The Council on Aging notifies clients in writing of adverse actions and their rights to a hearing. Clients are provided with community resource information, including information on services for which they might be eligible.

g. Describe the agency policy for informing clients of their right to grieve adverse eligibility, service determination decisions or consumer complaints.
During initial intake, clients are advised of their rights to grieve an agency decision regarding their care requests or to file a complaint regarding the services they receive. The Case Manager advocates for the client, addressing complaints about services provided by an in-home care agency on behalf of the client. If clients are receiving OPI services through a Homecare Worker, they or their representative will need to address those concerns. If the decision is made to reduce or terminate services, clients are provided in writing the reasoning behind the decision. Clients also are provided with the AAA grievance procedures per OAR 411-032-0020(4), which instruct them to contact their Case Manager within 10 working days of notification if they wish to proceed with the grievance procedure.

h. Cost of authorized services per unit:
The Case Manager authorizes the number of hours per month the client will receive and notifies the contracted provider accordingly. All authorized units are listed within the Council on Aging's agency contracts; contracted costs-per-unit range from:
- Homecare: $25/hour
- Personal Care: $25/hour
- RN Services: $65/hour

If the client has a fee for service, it is billed monthly. A state-mandated sliding scale based on monthly income, with consideration of medical deductions, determines the fee for service. Fees collected constitute program income.

i. **Describe the agency policy for addressing consumer non-payment of fees:**
New OPI clients are charged a one-time fee of $25 if they do NOT have a monthly pay-in to the program. The Case Manager may on a case-by-case basis waive the one-time fee if needed. The OPI Service Agreement reflecting this fee is submitted to the Fiscal Office. The Fiscal Office invoices the client for the one-time fee. If payment is not received within ninety (90) days, the Fiscal Manager notifies the Case Manager who follows-up with the client. If the issue cannot be resolved, it may result in the delay or termination of services.

For clients with monthly pay-ins, Case Managers complete OPI Service Agreements with the client, calculating the hourly rate to be paid as well as the maximum monthly cost for which the client is responsible. The Case Manager submits this form to the Fiscal Office. The Fiscal Office Assistant invoices the client monthly, not to exceed the monthly maximum. Clients are expected to make their pay-in within sixty (60) days of the invoice date. The Fiscal Office Assistant logs and monitors payments. If payment is not received with the sixty (60) days, the Fiscal Manager notifies the Case Manager who follows-up with the client. If the issue cannot be resolved, it may result in the delay or termination of services.

j. **Delineate how service providers are monitored and evaluated:**
When using an in-home care agency: All contracted in-home care providers are licensed. Case Managers have frequent contact with clients to review any issues and to determine client satisfaction. Case Managers also have open communication with the providers and discuss client concerns and issues on a regular basis. All contractors must have a grievance policy in place, per the contract, to address any issues and client satisfaction. The Case Manager becomes involved if the client and contractor cannot resolve the issue or at any time the client requests the Case Manager's assistance.

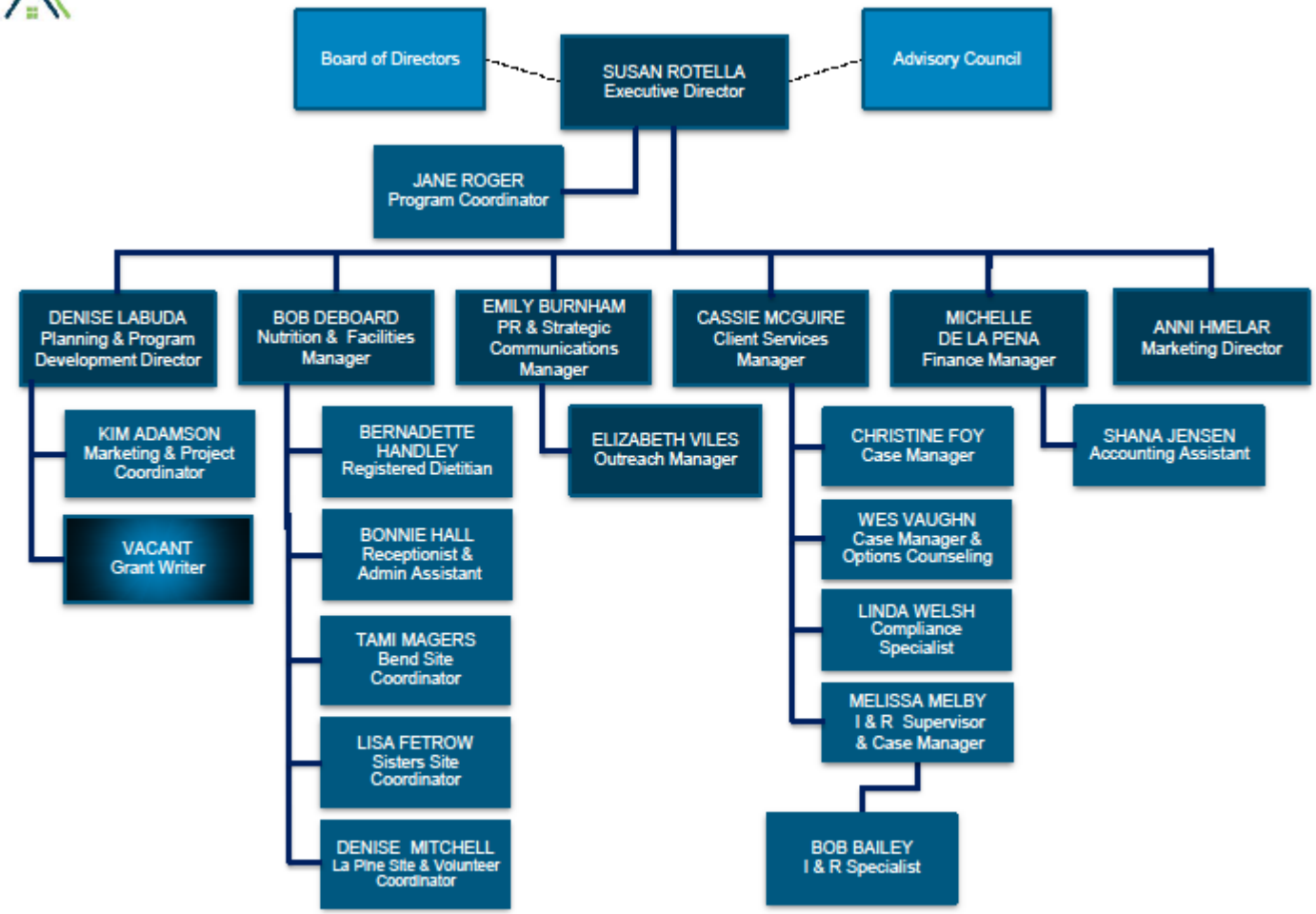
D-2 Services provided to OAA and/or OPI consumers:
See Attachment C

Section E – Area Plan Budget

See Budget Attachment (Excel File)

Appendix A – Organization Chart

Council on Aging Organizational Chart as of 02/23/18



Organizational Chart

Appendix B – Advisory Council(s) and Governing Body ***Board of Directors:***

BOARD OF DIRECTORS
COUNCIL ON AGING OF CENTRAL OREGON
(Updated 1-4-19)

Anabel Pelham, Ph.D. (President)
363 SW Bluff Drive #404
Bend, OR 97702
415-713-2532
apelham@sfsu.edu
1st Term Expires 2020
President, National Assoc. of Professional Gerontologists. Professor Emerti and founding director of the Gerontology Program at San Francisco State University.

Peter Metherall (Vice President)
3527 NW Braid Road
Bend, OR 97703
608-658-3409
pmetherall@gmail.com
1st Term Expires 2019
Retired Vice President for Dean Health Systems, Wisconsin; Past Board Member Howard University Hospital.

Jenna Corbly (Secretary)
2155 NE 6th Street, Apt. 95
Bend, OR 97701
503-347-0140
jcorbly@hotmail.com
Fill-in Term Expires 2019
Executive Director, Pilot Butte Rehab Center, Bend OR; served on Junior League in Portland and Eugene.

Judy Goodrich (Treasurer)
5826 SW Harvest Ave.
Redmond, OR 97756
541-598-6110
Jlgrich2@gmail.com
2nd Term Expires 2021
Retired, financial bookkeeper, property management, caregiver

Wendy Miki Glaus
20302 Mariner Dr.

Bend, OR 97703
808-381-7521
wmglaus@hurley-re.com
Fill-in Term Expires 2020
Attorney specializing in elder law, estate planning. Served as Board member on Hawaii Board of Public Accountancy, Domestic Violence Clearinghouse Hawaii, and University of Hawaii Alumni Assoc.

Total number age 60 or over = 3
Total number minority = 1
Total number rural = 1
Total number self-indicating having a disability = 0

Advisory Council:

COUNCIL ON AGING ADVISORY COUNCIL
(Updated 2-4-2019)

Deschutes County/Bend:
Gerry Smith (Chairman)
1563 NW Davenport Ave.
Bend, OR 97703
541-306-6976
ggsmith@bendbroadband.com
1st Term Expires 2019

Deschutes County/Redmond:
Open Position
Fill-in Term expired 2016

Deschutes County/Sisters:
Dixie Eckford
PO Box 396
Sisters, OR 97759
541-639-5888
Dixie.eckford@me.com
1st Term Expires 2020

Toni Landis
188 N. Wheeler Loop
Sisters, OR 97759
541-480-4803
Tonilandis70@gmail.com
1st Term Expires 2020

Deschutes County/La Pine:
Sandra Nicol
PO Box 3034
La Pine, OR 97739
541-536-5465

s.m.nicol@q.com
1st Term expires 2019

Crook County:
Neva McPherson
696 NW Pinkston Ct.
Prineville, OR 97754
Cell: 541-480-5219; hm: 541-447-4290
2nd Term expires 2021

Jefferson County/Madras, Warm Springs:
Louise Muir
549 NE Begonia
Madras, OR 97741
541-419-1275
Lmmuir35@gmail.com
1st Term expires 2020

Jefferson County/Culver, CRR
Open Position
Term expired 2011

At Large:
Gloria DiSanto
21067 Perrigan Drive
Bend, OR 97702
541-904-5253
Gloria@realestateglo.com
1st Term Expires 2020

Destry Begay
PO Box 854
Warm Springs, OR 97761
541-553-3313
destry.begay@wstribes.org
1st Term Expires 2021

Kim Luis
19699 Mountaineer Wy #F229
Bend, OR 97702
541-408-7621
Luisteam00@gmail.com
1st Term Expires 2020

Pauline Martinez
2403 NW Brickyard Street
Bend, OR 97703
650-279-0139
pmartinez@alz.org
1st Term Expires 2020

Martita Marx
683 NW Silver Buckle
Bend, OR 97703
703-863-6927
Martita.marx@gmail.com
1st Term Expires 2020

Aging & People with Disabilities Liaison:
Deanne Lockridge
deanne.k.lockridge@state.or.us

Total number age 60 or over = 8
Total number minority = 1
Total number rural = 6
Total number self-indicating having a disability = 0

Disabilities Services Advisory Council:

NAME & CONTACT INFORMATION	*REPRESENTING*	*DATE TERM EXPIRES*
Fred Johnson	County A	NA
Elvira Franck	City Council representative	NA
Dewey Choate	County B	NA
Myra Garcia	County C	NA

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

ADRC Governing Council for Central Oregon:

NAME & CONTACT INFORMATION	*REPRESENTING*	*DATE TERM EXPIRES*
Susan Rotella	Council on Aging of Central Oregon	NA
Frank King	Aging & People with Disabilities (APD)	NA
Greg Sublett		

	CIL (Abilitree)	NA

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

Appendix C – Public Process (text of town hall press release)

Contact:

Jean McPherson
Operations Manager
Central Oregon Council on Aging
jmcpherson@councilonaging.org
541-678-5483

CENTRAL OREGON COUNCIL ON AGING
SEEKING PUBLIC COMMENT ON DRAFT AREA PLAN

Bend, OR (June 29, 2016) – The Older Americans Act requires each designated Area Agency on Aging (AAA) to develop an area plan. Currently, active four-year AAA Area Plans and updates expire on 12/31/16. The local AAA is the Central Oregon Council on Aging (COCOA), located in Bend, Oregon. COCOA is seeking public comment on its Draft Area Plan for the next four years. Seniors, family members caring for an older loved one, elected officials, advocates, and other interested parties are invited to a public hearing, which will be conducted at the following:

Prineville Senior Center: Wednesday, July 6, 12:30 pm
Bend Senior Center: Thursday, July 7, 12:30 pm
Jefferson County Senior Center: Friday, July 8, 12:30 pm

The hearing will include a brief overview and highlights of the Draft Area Plan, with the majority of the time allotted for public comment. Written comments may be mailed or delivered to the COCOA office at 373 NE Greenwood Ave., Bend, OR 97701, submitted at the hearing, or emailed to admin@councilonaging.org. COCOA will accept written comments through July 14, 2016.

About Central Oregon Council on Aging

The Older Americans Act created a network of local Area Agencies on Aging (AAA)

across the United States to provide supportive services that enable older adults to live with independence and dignity in a setting of their choice. As the designated AAA for Central Oregon, COCOA works to meet basic, direct and immediate need among Central Oregon's low-income and high risk seniors. Services, which include meal delivery and nutrition programs, case management, caregiver support, and resource referral are vitally important to seniors' health and quality of life. The expertise of COCOA's staff, the commitment of its board, and the dedication of its more than 200 volunteers combine across the diverse communities of Crook, Deschutes and Jefferson Counties to support one of the region's greatest assets – its seniors. For more information on COCOA visit www.councilonaging.org or call 541-678-5483.
Broad distribution of the Council on Aging's Area Plan survey included the following:

Crook County

- Crook County Library
- Prineville Caregiver Support Group
- Prineville Soroptimist Senior Center including home-delivered meal clients, congregate diners, and volunteers

Deschutes County

- Bend Community Center including congregate diners
- Bend Memorial Clinic
- Bend Senior Center including Meals on Wheels clients and volunteers
- Cascade Swim Center
- Central Oregon Veterans Outreach, Veteran's Administration and Veterans of Foreign Wars
- Civic groups including Bend Moose Lodge, La Pine American Legion, La Pine Moose and Sunriver Rotary
- Deschutes Public Library including Downtown Bend, East Bend, La Pine, Redmond, Sisters and Sunriver branches
- Family Caregiver Support Group
- Gero Leadership Alliance
- La Pine Chamber of Commerce
- La Pine Senior Activity Center including Meals on Wheels clients, congregate diners and volunteers
- Newcomers Club of Bend
- Oregon Trail Appaloosa Horse Club
- QuiltWorks
- Redmond Parks & Recreation
- Redmond Senior Center including Meals on Wheels clients, congregate diners and volunteers
- Retirement and assisted living facilities including Discover Park Lodge, Mt. Laurel Lodge, Pilot Butte Retirement Center, Snowberry Retirement Center, Suntree Village Retirement Center and Vintage Retirement Center

- Sisters meal site including Meals on Wheels clients, congregate diners and volunteers
- TECH attendees

Jefferson County

- Crooked River Ranch Senior Center, Culver meal site, Jefferson County Senior Center, and Terrebonne meal site including home-delivered meal clients, congregate diners and volunteers
- Jefferson County Library
- Let's Talk Diversity Coalition

PSA-wide

- Council on Aging Advisory Council, Board of Directors, staff members and volunteers
- Health Promotions class lists
- I&R clients
- Latino Community Association
- PacificSource Health Plans - Resource Huddle
- Seniors formerly involved in Council on Aging's Foster Grandparent Program
- Webco

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

Family Caregivers

- Establish full FCSP
  - ✓ FCSP well-established and operating in full
- Identify possibilities for increased funding for respite care
  - ✓ Possibilities identified and funding secured from Alzheimer's Foundation of America for respite care for families of those suffering from ADRD

I&A and ADRC

- Increase resources available to ADRC by working with adjacent AAAs to become one, cost-efficient regional ADRC
  - ✓ The Region 10 ADRC was officially launched and will soon be fully functioning. Region 10 ADRC includes ten counties divided into three areas by AAA: North (MCCOG), Central (Council on Aging), and South (KLCCOA).

- Seek new funding through "…grants, fund development through our non-profit status, and economizing and regionalizing."
  - ✓ Effort is ongoing as part of the ADRC's sustainability plan.

- Streamline software platform (i.e., end need for double-entry into state database) in order to accurately track and support the I&R function
  - ✓ State-mandated software platforms are in use.

- Make statewide information system and resource directory available online
  - ✓ Information system and resource directory are available online and will be annually updated.

- Partner with local state offices"… until such time as we have a solution to our inability as a Type A to address Medicaid options for clients"
  - ✓ Ongoing effort

Nutrition Services

- A registered dietitian will provide nutrition education on a quarterly basis at all congregate meal sites
  - ✓ The Council on Aging has a registered dietitian on staff
  - ✓ The registered dietitian developed Healthy Choices, a grant-funded nutrition education program that greatly increased the Council on Aging's capacity to deliver nutrition education to congregate and home-delivered meal clients
  - ✓ Nutrition education is offered quarterly at all congregate meal sites, presentations include on-site preparation of recipes, taste testing of dishes, incentives for

participation, distribution of printed information, and completion of surveys by clients

- Host educational programs in Spanish
  - ✓ Due to lack of bilingual staff, programs in Spanish were not provided
  - ✓ The Council on Aging now has a bilingual Case Manager and bilingual Outreach Coordinator, both of whom are offering services in Spanish

- Provide home-delivered meal clients with one-on-one nutrition education based on topics identified during initial and annual assessments
  - ✓ Individual nutritional risk analyses are conducted by case managers during initial and annual assessment; this allows for one-on-one nutrition education to meet each client's particular dietary needs

- Provide low-sodium, low-carbohydrate, and low-fat meal options
  - ✓ A low-sugar desert alternative is offered at some meal sites; additional progress required to provide meal options to help manage conditions such as hypertension, diabetes and heart disease

Health Promotion

- Partner with CCO to develop full health promotion and educational component
  - ✓ The Council on Aging received state funding for Health Promotion for the biennium July 2015-June 2017. Funding required that the Council on Aging support evidence-based programs as defined by the Center for Disease Control and Prevention and the Administration for Community Living. The Council on Aging therefore focused on development of evidence-based programs in the PSA as opposed to partnering with the CCO.

- Work with Alzheimer's Association to bring local chapter back to Central Oregon
  - ✓ This action has been completed with Council on Aging participation.

- Serve as pilot project for University of Washington NIH RAD grant to better assist those with Alzheimer's disease.
  - ✓ The Council on Aging participated in a University of Washington School of Nursing 2013 "RDAD" pilot program. The pilot tested the effective delivery of the program by AAAs as well as by other offices – including APD -- that deliver services such as OPI, respite, and Powerful Tools. The Council on Aging delivered RDAD to ~20 couples in their homes over 9 weeks, for 180 units of Caregiver Training. Outcomes were measured and the project moved out of the pilot phase. The Council on Aging elected not to participate beyond the pilot phase given lack of in-house resources coupled with the opportunity to partner with the new, local Alzheimer's Association chapter.

Elder Rights and Legal Assistance

- Access pro-bono services of local attorneys in order to increase availability of no-cost/low-cost options for clients
- ✓ This action has been completed; with referrals routinely made to such attorneys.

- Investigate educational opportunities and money management options to help seniors stay fiscally safe
  - ✓ Educational materials are distributed to clients on a regular basis. However, the Council on Aging has postponed participation in the Money Management Program due to lack of personnel.

Older Native Americans

- Continue to improve relationship with Confederated Tribes of Warm Springs
  - ✓ The Council on Aging partnered with the confederated tribes through its Meyer Memorial Trust-funded community needs assessment; the assessment has led to significant changes in the Council on Aging's staffing pattern including the addition of a bilingual Case Manager and bilingual Outreach Coordinator
  - ✓ The confederated tribes are represented on the Council on Aging's Advisory Council

Appendix E – Emergency Preparedness Plan

The Council on Aging participates in the Red Cross Disaster Preparedness planning and education. These efforts, given threat of seasonal wild fires and potential for evacuations, make this an important part of the Council on Aging's overall support. The Council on Aging provides the Disaster Preparedness Team with a quarterly Community Alert report on vulnerable clients served.

Potential hazards in Central Oregon include summer wild fires, winter extended cold and snow, and seismic activity.

I. **Background**: The Council on Aging, recognizing the need for a plan to inform, protect, and ensure the safety and security of seniors, developed this disaster preparedness plan in coordination with Crook, Deschutes, and Jefferson County emergency response managers. The respective counties will render appropriate medical or evacuation assistance during a life safety emergency as defined in (ORS 41.025). Assistance will be rendered to seniors and vulnerable persons identified by the Council on Aging in updated, quarterly Community Alert reports provided to emergency action office / 911 Call Centers. The information shall be treated as secure until an emergency is declared.

II. Actions by the Council on Aging: Council on Aging staff members are designated to prepare seniors receiving services to cope with, protect themselves, and seek assistance as necessary in any area-wide emergency or health crisis. The Council on Aging will communicate with community agencies: senior centers, counties, 911 Call Centers, and others involved in management of the crisis.

A. The Facilities Manager is responsible for the overall policy coordination. The Disaster Preparedness Representative as designated by the Facilities Manager will coordinate with tri-county emergency response teams. S/he will keep abreast of all updates and changes to each county's policies and points of contacts. S/he will forward the Community Alert updates to each county quarterly. Finally, s/he will advise staff members of changes in the disaster preparedness plan.

B. Case Managers are responsible for the identification, listing, and forwarding of information on vulnerable clients served, which is based on client assessments made by Case Managers as part of the Council on Aging's in-home services. Case Managers will let clients know if they have been identified as vulnerable, and will obtain client's written authorization to be included in the Community Alert reports. These regularly updated Community Alert reports are placed on the Council on Aging's shared computer drive.

C. Agency Staff will at various times participate in emergency action events/ exercises as conducted by government and/or other agencies such as the Red

Cross, whenever possible. The extent of the Council on Aging's participation will depend on the specifics of any exercise.

III. <u>Follow-up by other Agencies, Government Officials and the Council on Aging:</u> The Council on Aging remains committed to annual review of its internal disaster preparedness plan by county emergency planners. Such review allows for revision of outdated procedures and plans and improves inter-agency communications. The Council on Aging also provides all home-delivered meal clients with a minimum of five shelf-stable meals a year, and is also looking at increasing this number to cover the spring and summer months.

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

Focal Points of Service

Case management services are provided at the Council on Aging and in client residences.

Council on Aging of Central Oregon
373 NE Greenwood Avenue
Bend, OR 97701
541-678-5483; toll-free 877-704-4567

Contracted Service Sites

Congregate meals, Meals on Wheels (home-delivered meals), nutrition classes, and health promotion classes are offered at these sites:

Bend Meal Site
Bend Senior Center
1600 SE Reed Market Road
Bend, OR 97702
541-388-1133

Redmond Meal Site
Redmond Senior Center
325 NW Dogwood
Redmond, OR 97756
541-548-6325

La Pine Meal Site
La Pine Senior Center
16450 Victory Way
La Pine, OR 97739
541-536-3207

Back Door Cafe
680 NW Bond
Bend, OR 97703
425-765-1782

Prineville Meal Site
Soroptimist Senior Center
180 N. Belknap
Prineville, OR 97754
541-447-6844

Madras Meal Site
Jefferson County Senior Center
860 SW Madison
Madras, OR 97741
541-475-1148

Sisters Meal Site
Sisters Community Church
15220 McKenzie Highway
Sisters, OR 97759
541-678-5483

Non-Contracted Service Sites

Crooked River Ranch Meal Site
Crooked River Ranch Senior Center
(Old Ranch House) Ranch House Road
Crooked River Ranch, OR 97760
541-504-8236

Culver Meal Site
Culver City Hall
200 First Avenue
Culver, OR 97734
541-546-6494

Warm Springs Meal Site
Warm Springs Senior Center
2331 High Lookee
Warm Springs, OR 97761
541-553-3313

Family Kitchen
231 NW Idaho
Bend, OR 97703
541-760-5677

Appendix G – OPI Policies and Procedures

History

In 1975, the Oregon Legislature passed House Bill 2163, which directed the Department of Human Services "to develop and place in effect a program of supportive services to persons aged 60 or older" and required a fee for service based on the ability to pay. This general language established OPI in response to two very specific concerns expressed by Oregon's senior advocates, including Older Americans Act-funded AAA Advisory Council advocates.

The first concern was that people who were not Medicaid eligible, but needed in-home services, were falling through the cracks. The second concern was that minimal in-home services could prevent many elderly from going into more costly long term care.

The OPI Program was started in 1976 after initial consultation with the Governor's Committee on Aging. OPI helps achieve the greatest degree of independent function for those who are at high risk of institutional placement. Clients have the option of remaining in their own home or in a community-based living facility. The OPI Program fills the gap between persons who can pay privately for service and those who are eligible for Medicaid programs.

Eligibility Requirements:

To be eligible, the applicant must be: (OAR 411-032-0020)

Age 60 or older; OR under 60 with a medically documented diagnosis of Alzheimer's or related disorder (NOTE: A small amount of money is available to assist clients under the age of 60 who are suffering from any of the following: Alzheimer's Disease, Multi-infarct Dementia (MID), Normal Pressure Hydrocephalus (NPH), Inoperable Brain Tumors, Parkinson's Disease, Creutzfeldt-Jakob Disease, Huntington's Disease, Multiple Sclerosis, Uncommon Dementia (such as Pick's Disease, Wilson's Disease, and Progressive Supranuclear Palsy), who are not receiving services under Waivered Medicaid programs.

NOTE: The applicant must not be receiving financial assistance, Waivered Medicaid programs, full medical benefits, or State Planned Personal care (SPPC) program. They can be eligible for food stamps (SNAP), Qualified Medicare Beneficiary (QMB) and Supplemental Income Beneficiary (SMB) programs and be eligible for OPI if they have applied and been denied in-home service from DHS ; AND

Meet the requirements of the Long Term Service Priority Rule OAR chapter 411, division 015.

Priority for Service

Oregon revised statute clearly states the priority for receiving OPI Services is as follows: (SPL level service by the Council on Aging 1-17)

(a) Clients already receiving authorized services as long as their condition indicates services are needed.
(b) Clients who are to be placed immediately in an institution if needed authorized services are not provided.
(c) Clients who are probably to be placed in an institution if needed authorized services are not provided.

Activities of Daily Living (ADL and IADL) shall be assessed with priority given to those needing **substantial** assistance. OPI services require a fee. A financial assessment of income and medical expenses for the past year will determine the fee the client will pay per hour. The services may be provided by a Home Care Worker (HCW) or a contract agency. All OPI clients shall be reassessed once every 12 months or if the client's needs change (increased or decreased).

Oregon Project Independence

In-Home Service is designed to help homebound seniors achieve the greatest degree of independent function. In-home service will provide minimal or substantial assistance with Activities of Daily Living (ADL's and IADL's) according to client needs:

- Housekeeping
- Shopping
- Laundry
- Meal preparation
- Eating
- Dressing and undressing
- Bathing and personal hygiene
- Bowel and bladder
- Cognition/Mental function
- Meeting mobility and activity needs
- Assisting with self-administered medication

Assessment of a person should include medical, mental and physical needs to determine eligibility for OPI and appropriate referrals. Assisting the person in gaining access to community or social services may require information about financial status.

If the person has a *Long Term Care Insurance Policy* that *does* cover the in-home service needs, connect the person with a local provider. If a waiting period exists before service can be provided, OPI may be started to cover that waiting period if the person is a high risk level.

**If the person may be eligible for *Medicaid programs*, refer the person to the local program office to start the application process. The application can take up to *45 days to process*. *Start OPI if the person is a high risk priority level until eligibility has been*

determined for Medicaid programs such as Medical, SNAP, or In-home service. If the person is *receiving financial assistance or Medicaid programs,* refer them to their DHS/APD Case Manager to request *In-Home Services*. **They may not be eligible for OPI if they are eligible for in-home service through DHS/APD once service begins.** The client may choose to not accept Medicaid programs. The client will be eligible for OPI if they meet the eligibility requirements.

If the person is receiving Food Stamps (FS), Qualified Medicare Beneficiary (QMB) or Supplemental Low Income Medicare Beneficiary Programs (SMB) only and meets the requirements of the Long-term Care Services Priority rule, OAR 411, Division 015, **they may be eligible for OPI if denied in-home service by DHS/APD.**

Authorized services for which OPI Funds may be expended include:
Assistive technology device, Registered Nurse services, Home delivered meals,
. Case Management (Service coordination), Home care, and Personal care.

Intake Procedure
A Case Manager taking a referral for OPI assessment must document the request and the referral source in OACCESS Narrative for the individual within 3 work days. In order to start a new OACCESS record for the individual, the Case Manager will gather at least the following demographic information to start or verify the OACCESS record:

- Name
- Date of birth
- Address

Within 3 work days, the Case Manager will provide a phone or in-person screening to determine if OPI assessment is founded. Information gathered will include:

- Monthly Income
- ADLs

To be eligible for OPI, individual should need assistance with one of the following: mobility/transferring, eating, bathroom assistance, or cognition. Priority will be given to individuals requiring substantial assistance in ADLs. The OPI screening will ensure that only the neediest individuals are served. Disqualifying circumstances include:

- Unused Long Term Care Insurance
- Significant personal assets
- Currently receiving Title XIX Medicaid services
- Full Medical Benefits
- Residing in an Assisted Living or other residence with assistive services

Within 3 business days of a favorable OPI screening, the Case Manager will complete an in-home assessment for OPI Services.

Oregon Project Independence
Financial Assessment

Each potential OPI client will be financially assessed for fee determination. Using the ***OPI Income/Fee Determination*** form, list the following information for the household: State policy is that same sex individuals married in another state where marriage is legal are to be considered as having a married status for the purposes of OPI program.

- Number in household at the time of assessment and the date.
- Annual GROSS Income (any money that comes into the household)
  - Salaries
  - Interest
  - Dividends
  - Pensions
  - Annuities
  - Social security
  - Railroad benefits
  - Rental payments (incoming)
  - Mortgage payment from the sale of a home(incoming)

Note: A one-time gift is not counted
The total **Annual Income** is then written in the box on the *OPI Income/Fee Determination* form**.**

- Allowable Deductions (all medical costs which are the person's responsibilities)
  - Supplemental insurance
  - Doctor bills or co-payments
  - Prescription drugs or co-payments
  - Hospital costs
  - Nursing home costs
  - Life line
  - Air life/fire med
  - Health care equipment (examples: walker, cane, tub/toilet grab bar)
  - Medical supplies (examples: dressing for wound, ace bandage)
  - Incontinence supplies (examples: pads, diapers, briefs)
  - Therapies
  - In-home nursing care
  - Over-the counter medications (if Dr. has ordered)
  - Dental costs
  - Vision exams or glasses
  - Medically necessary home modifications

The total annual **Allowable Deductions** is then written in the box on the *OPI Income/Fee Determination* form.

Annual Income *minus* Allowable Deductions equals ADJUSTED Income.
ADJUSTED Income will be used to determine a rate per unit (one hour) fee the client will be charged. **(See SUA *Fee for Service Chart*.)** Use the chart with the correct number in the family **(one or two)** and the rate for housekeeping **(HC)** and/or personal care **(PC).**

A one-time only **$25 application fee** shall be charged (as of Oct 1, 2013) for those with

income below the sliding scale fee per hour rate. This fee may be waived if approved by the Case Manager.

The ***OPI Service Agreement*** form will be signed at the assessment. It will serve as a record of hourly fee for service and/or $25 application fee. The OPI Service Agreement will be the record of OPI Service Eligibility. Case Manager will then process a copy of OPI Service Agreement form with billing for the Council on Aging. The Council on Aging will bill client one time for payment of application fee.

OPI Payment Policy - OPI One-Time Fee

1. New OPI clients will be charged a one-time fee of $25 if they do not have a monthly pay-in to the program.
2. At the discretion of the Case Manager, the one-time fee can be waived if it causes a financial hardship on the client that cannot be resolved.
3. The Case Manager completes the OPI Service Agreement form with every client and submits the form to the Council on Aging's Finance Manager (Michelle De La Pena) in the Fiscal Office.
4. The Fiscal Office will invoice client with a one-time fee; the client will be expected to pay the one-time fee within 90 days from invoice date.
5. If payment is not received within 90 days, the Fiscal Manager will notify the Case Manager who will follow up with the client.

OPI Pay-In

1. If a client is responsible for a monthly pay-in for OPI services, the Case Manager completes the OPI Service Agreement form with the client, calculating the hourly rate to be paid in as well as the maximum cost the client is responsible for each much. The Case Manager then submits the form to the Fiscal Manager in the Fiscal Office.
2. The Council on Aging's Finance Office Assistant () will invoice the client each month, not to exceed the maximum cost per month.
3. Pay-in is due within 60 days of invoice date. Fiscal Office Assistant logs/monitors payments.
4. If payment is not received within 60 days, the Fiscal Manager will inform the Case Manager who will follow up with the client.

Oregon Project Independence Needs Assessment

First request for OPI service, OPI Risk Assessment Tool should be used to determine the risk level of the client. This tool is also used to determine priority if a waitlist for OPI is in place.

The Case Manager will schedule a home visit to complete a Client Assessment and Planning System (CA/PS) needs assessment within 7 business work days of service request, and narrate these activities.

For persons who ***do not*** **meet the priority criteria** listed below, Case Managers will offer information about local programs/resources and assist in gaining access to programs that will meet the person's needs.

Persons who ***do*** **meet the priority criteria** should have a CA/PS assessment completed**.**

Completing the CA/PS form will provide information on medical, mental, mobility and support systems for the person. *(Use latest CA/PS version 10/1/2017).* CA/PS long form or shorter Assessment Components form can be used. **Enter completed CA/PS form into system. Complete all sections and comment per sections. Narration of contact/activity should be completed in OACCESS.** Narration should be objective, factual, and free from personal bias/opinions for all entries. Chronological records of all contacts and actives include:

- Who initiated contact
- Who was present if a home visit or meeting
- What was the purpose of the contact
- When and where the contact took place
- What, if any, change occurred
- What or why actions were taken
- When actions were effective
- What the plan was
- What follow up was or is needed
- Quotations are only used to reflect direct client statements
- Medical information is present only if relevant to the service request
- Narration will also reflect all forms processed for this client, per the OPI guidelines
- Priority is based on Activities of Daily Living (ADLs)
- Persons who need assistance in the following ADLs will have higher service priority.
    - mobility
    - eating
    - bowel/bladder
    - bathing/personal hygiene
    - dressing/grooming
    - cognition

Priority is also given to *seniors discharged from hospitals*, those who have *no insurance* or *family resources*, or those who are *at risk for falls*. Those persons needing housekeeping only will have less priority.

Staff case with Client Services Manager for available hours. Each location has a total number of hours that can be used. This is a guideline only and not to be used as the *only* number of hours.

- Priority status of person-ADL needs.
- If the person would be eligible for other community resources, such as OAA Family Caregiver Support programs or Medicaid.
- Are there informal family or community supports that could be used to meet some of the person's needs?
- Is the person at risk of being immediately institutionalized if service is not provided?

For Waiting List: Complete a Risk Assessment Tool form. Place client on wait list. Connect with any community programs that will meet needs and continue to monitor. Those with the highest priority will be placed on OPI first when hours are available.

Oregon Project Independence

In order to serve the most individuals possible with OPI funds in Central Oregon, the maximum hours per client is 25 hours per month. With the Client Services Manager's approval, OPI cases may exceed 25 hours per month.

Determining if the hours assigned are Home care or Personal care.

****Home care** (HC) services consist of: (a) assistance, either **minimal** or **substantial**, with Activities of Daily Living (ADLs); (b) assistance with or provision of feeding: and (c) assistance, either minimal or substantial, or provision of self-management activities. Home care services combine homemaker services and housekeeper services.

Examples of home care:

- House keeping
- Laundry
- Shopping
- Verbal reminder to take medication
- Meal preparation

****Personal Care** (PC) services provide in-home services ***under the supervision of an RN.*** Services include: Bowel/bladder care not requiring skilled nursing service; caring for confused and/or mentally ill clients; caring for ***medically unstable*** and/or ***at risk*** client **dependent** in mobility, bathing and/or personal care.

Examples of Personal Care:

- Stand-by bath assistance includes:
  - Assistance in and out of tub,
  - Shampooing hair and parts of washing
  - Bed bath/Bath assist for medically unstable client

- Assistance with feeding a client who chokes when swallowing
- Medication monitoring/Med box set-up
- Care provided a client dependent in ADLs
- Mental health issues that require special skills

Setting up the hard file

First Section	**Page 1** **Page 2**	Service Plan/Task list/any communication to agency NAPIS
Second Section	**Page 1** **Page 2**	Misc. Paperwork, *i.e.*: OPI process sheet, home repair, paperwork from other agencies, Service Agreement form, OPI risk assessment tool, Release of information, Case Notes, Narrative past and current
Third Section	**Page 1** **Page 2**	Fee determination (any paperwork pertaining to fee determination) CA/PS assessment (long form or short form), Assessment Summary

Provider paperwork

When CA/PS is completed, and the client has been OPI-approved

To HCW: give copies of the following forms:

In-Home Service Plan
Task List
Change in Service Notice

To Voucher Clerk (Jane Roger): SPD 546 (Clerk will process voucher. Voucher will be mailed from Salem each month to HCW.)

To **Contract Provider:** give copies of the following forms:

The Council on Aging's additional OPI Client Information
In-Home Service Plan
Task list

To stop service: Use Change of Service Notice:
The Council on Aging's Change of Service Notice should be completed for any changes in service or end of service. It should be faxed to the Contract Provider, with a follow-up telephone call to be sure it was received. This Notice will be mailed to HCW's Following notification by the client/representative to the HCW. The Notice will be mailed to the HCW (because the client/representative is the employer, s/he must perform this task).

Reassessment
Annual Reassessment will be completed every 12 months for each OPI client. The annual reassessment will include completion of in-person CA/PS assessment, Risk Assessment Tool, Fee Determination, and Service Agreement. The Case Manager will also have regular communication with individuals to determine if there is a change in service needs.

Notices to reduce/terminate services should be client specific: list statutes, rules and reasons for the action; staff contact information; and the client's right to file a grievance. Notice period: Clients must have at least **10 days** to respond to a notice to reduce/ terminate services.

Appeal/Grievance Process
The following process will be used in resolving differences of opinion between the client and/or client representative and local OPI agency.

1. Client will be provided with written notification of this decision within seven (7) business days of the decision, as well as a full explanation as to why the decision was made.
2. Client will also be informed on how to move forward with the appeal process if needed. Clients will have ten (10) days following the date of the notice to file an appeal with the Case Manager. If client has been denied/terminated from services, they will not continue to receive those services during time of appeal process.
3. If the client and Case Manager fail to resolve the situation, the Case Manager or client may contact the Program Manager/ Client Services Manager.
4. The Program Manager/ Client Services Manager will arrange a meeting within ten (10) working days with the client and the Case Manager and attempt to reach a mutually acceptable agreement.
5. If the client, Case Manager or Program Manager/ Client Services Manager fail to reach a mutually acceptable solution, the Program Manager/ Client Services Manager will immediately notify the Executive Officer. If the Program Manager/Client Services Manager fails to contact the Executive Officer within 5 working days, the client may contact the Executive Officer.
6. The Executive Officer will immediately staff the situation with the Program Manager/ Client Services Manager, Case Manager and the client and attempt to reach a mutually acceptable agreement.
7. If the client, Case Manager, Program Manager/Client Services Manager and Executive Officer fail to reach a mutually acceptable solution, the Executive Officer will contact APD for an Administrative review within 7 working days.

Quality Assurance
Once per quarter, the Program Manager/Client Services Manager will randomly select 4 OPI cases for review. Using the ***OPI Quality Assurance Form***, the Program Manager/Client Services Manager will review OACCESS records and hard files for these cases. Within 14 working days, Case Managers will be responsible for correcting deficits in OACCESS or hard files. At Case Management meetings, general findings will be reported and improvement of processes discussed.

Note: All forms mentioned here are available on the Council on Aging's I drive: case management/OAA Programs/forms

On Monthly Service Performance Report
1 unit = 1 hour Case management

Oregon Project Independence Grievance Policy

The Council on Aging can deny, disallow, or reduce OPI services when they feel a client no longer is eligible, whether that is due to a change in care needs; unresolvable conflict between client and care provider; or any other concern that arises pertaining to eligibility determination.

1. Client will be provided with written notification of this decision within seven (7) business days of the decision, as well as a full explanation as to why the decision was made.
2. Client will also be informed on how to move forward with the appeal process if needed. Clients will have ten (10) days following the date of the notice to file an appeal with the Case Manager. If client has been denied/terminated from services, they will not continue to receive those services during time of appeal process.
3. If the client and Case Manager fail to resolve the situation, the Case Manager or client may contact the Program Manager/Client Services Manager.
4. The Program Manager/Client Services Manager will arrange a meeting within ten (10) working days with the client and the Case Manager and attempt to reach a mutually acceptable agreement.
5. If the client, Case Manager or Program Manager/Client Services Manager fail to reach a mutually acceptable solution, the Program Manager/Client Services Manager will immediately notify the Executive Officer. If the Program Manager/Client Services Manager fails to contact the Executive Officer within 5 working days, the client may contact the Executive Officer.
6. The Executive Officer will immediately staff the situation with the Program Manager/Client Services Manager, Case Manager and the client and attempt to reach a mutually acceptable agreement.
7. If the client, Case Manager, Program Manager/Client Services Manager and Executive Officer fail to reach a mutually acceptable solution, the Executive Officer will contact APD for an Administrative review within 7 working days.

Appeals 411-032-0020(4)

APPEALS. Individuals for whom services are denied, disallowed, or reduced through eligibility determination or service determination are entitled to request review of the decision through the AAA grievance review procedure set forth in policy*.

(a) If services have been disallowed or reduced, individuals must continue to receive authorized services until the disposition of the local AAA grievance review.
(b) The AAA must provide the applicant with written notification of the grievance review determination decision.
(c) Applicants who disagree with the results of the AAA grievance review have a right to an administrative review with the Department of Human Services, pursuant to ORS chapter 183. This information is provided to the applicant in a written notification at the time of the grievance review decision.
(d) Applicants requesting an administrative review from the Department are not eligible for continued OPI authorized services.
(e) All individuals, including those who may have previously been terminated from OPI, have the right to apply for OPI authorized services at any time.

OPI clients do **NOT** have a right to an Administrative Hearing. They **DO** have a right to an Administrative Review per OAR 411-032-0020(4) (c) if they are not satisfied with the results of the Grievance process.

The AAA should make OPI clients aware of their right to an Administrative Review by the Department of Human Services, in the same letter that is sent to them with the grievance procedure. The following is language to include in the decision letter following the AAA grievance review:

If you disagree with the decision from our grievance review you have the right to request an administrative review of the decision. The administrative review is conducted by Department of Human Services, Seniors and People with Disabilities Division. To request an administrative review you must notify (Name), at the above address in writing within thirty (30) days from the date you receive this decision.

Council on Aging OPI Pay-In and One Time Fee Policy

OPI One-Time Fee

1. New OPI clients will be charged a one-time fee of $25 if they do not have a monthly pay-in to the program.
2. At the discretion of the Case Manager, the one-time fee can be waived if it causes a financial hardship for the client that cannot be resolved.
3. The Case Manager completes the OPI Service Agreement form with every client and submits the form to the Council on Aging's Finance Manager (Michelle De La Pena) in the Finance Office.
4. The Finance Office will invoice client with a one-time fee; the client will be expected to pay the one-time fee within 90 days from invoice date.

5. If payment is not received within 90 days, the Finance Manager will notify the Case Manager who will follow up with the client.

OPI Pay-In

1. If a client is responsible for a monthly pay-in for OPI services, the Case Manager completes the OPI Service Agreement form with the client, calculating the hourly rate to be paid in as well as the maximum cost the client is responsible for each month. The Case Manager then submits the form to the Finance Manager in the Fiscal Office.
2. The Council on Aging's Finance Office Assistant will invoice the client each month, not to exceed the maximum cost per month.
3. Pay-in is due within 60 days of invoice date. Finance Office Assistant logs/monitors payments.
4. If payment is not received within 60 days, the Finance Manager (Michelle De La Pena) will inform the Case Manager who will follow up with the client.

Oregon Project Independence
Process for Central Oregon Council on Aging

Initial Inquiry

- OPI inquiries will be directed to the appropriate Case Manager based on territory.
- Every effort will be made to telephone the inquiring party within 24 hours. All inquiries will be addressed by a Case Manager within three (3) business days.
- The Case Manager will set a time to meet with the client if s/he believes the client might be OPI-eligible based on care needs discussed during a brief screening. Every effort will be made to schedule this visit within three (3) business days following telephone contact. Case Managers will ask clients about their medical benefits to ensure they are not receiving state services that would make them OPI-ineligible.
- If there is an OPI wait list, a Risk Assessment Tool will be completed. The Risk Score will be used to prioritize highest need.

In-Home Visit / Initial Assessment

- During the initial home visit, the Case Manager will complete a CA/PS.
- The following forms will be completed after the CA/PS assessment:
  - Risk Assessment Tool
  - Fee Determination Form ($25 one-time fee will be obtained, otherwise the client will have a pay-in based on a state-determined sliding scale fee)
  - Service Agreement
  - Authorization to Use Information
  - Notice of Privacy Practices

In-Home Visit / Following Initial Assessment

- OPI eligibility and hours to be assigned will be determined during home visit, unless SPL level is needed to support eligibility determination. If so, client will be notified within 24 hours.
- Case Manager will discuss the hours to be assigned to the client, including a provider. Provider will be a contracted in-home care agency or a Home Care Worker.
    - If client is to use a Home Care Worker, they must be able to perform the duties of the employer, or have a representative to do so. This will be discussed with the client before having them move forward with hiring a Home Care Worker.

System Input

- Once client has been approved for the program and all signed forms have been obtained, client will be entered into the ACCESS system. Case Managers must follow the appropriate narration process as well.
- If using an agency, Case Manager will begin to reach out to agencies to check on availability to provide the service.
- If using a Home Care Worker, client will notify Case Manager once Home Care Worker has been hired so that Case Manager may assign this individual to their case.

Follow-Up

- Client will be reassessed once every twelve (12) months, unless there is a change in condition or services which warrants for an assessment prior to the 12 months.
- Billing is reviewed by Case Manager every month.

Appendix H – Partner Memorandums of Understanding

Memorandum of Understanding
Between
Central Oregon Council on Aging
And
Oregon Department of Human Services
Aging & People with Disabilities, Central Oregon

Purpose

The Central Oregon Council on Aging, hereinafter COCOA and the Oregon Department of Human Service, Division of Aging and People with Disabilities in Central Oregon, hereinafter APD, agree that adults with chronic illnesses, who may be served by the Oregon Medicaid program should:

- have access to an unbiased assessment of their service needs.
- be informed of available service options to address their needs.
- have their eligibility for services determined as expeditiously as possible.
- have maximum choice with regard to method(s) of service delivery and direction of service provider(s).
- have access to high quality services.
- be served in the most effective manner in the least restrictive setting possible.

Scope of Agreement

APD agrees to:

- Provide training to COCOA personnel regarding services and eligibility criteria established and/or administered by APD on an on-going basis.
- Refer individuals to COCOA for assessment, case management and/or service delivery as deemed mutually appropriate by APD and COCOA personnel, with the consent of the client.
- To refer clients requiring Medicare benefits assistance to COCOA SHIBA program.
- To provide a knowledgeable representative who will attend the COCOA bi-monthly Advisory Council to provide an update of the current APD operations and policies.
- Work with COCOA Case Managers and Aging and Disability Resource Center to process in a timely manner medical and financial eligibility determination for Medicaid waiver services for adults.
- Consult with COCOA personnel and administration to address system(s) quality and effectiveness.

- Provide COCOA with appropriate application forms for Medically Needy, Waiver, Long Term Care and Medicare Supplement programs.

- Receive applications from COCOA by fax and register them in the appropriate Medicaid category. The register number will be entered on the application form and faxed back to COCOA within one workday. The date of application will be the date the faxed application is received in the APD office.

- Conduct eligibility assessment within five (5) to ten (10) working days of receiving all required information necessary to determine eligibility for state services.

COCOA agrees to:

- Provide training to APD personnel regarding services and eligibility criteria established and/or administered by COCOA on an on-going basis..

- Accept referrals of adult individuals made by APD for the purposes of needs assessment and qualification for case management and/or service delivery consistent with the COCOA capacity to do so.

- To work with the APD personnel and administration to expedite medical and financial eligibility determination for Medicaid waiver services for adults by assisting the applicant in providing all necessary information required by APD.

- To consult with APD personnel and administration to address system(s) quality and effectiveness.

- To refer all potential Medicaid clients identified by the SHIBA program, Case Managers or the Senior Helpline to APD for an eligibility assessment.

This memorandum of understanding may be modified at any time upon the written agreement of the principals. This memorandum of understanding shall be considered in force unless terminated by either of the principals giving thirty (30) days written notice and specifying the date thereof.

In witness whereof, the principals hereto have caused this memorandum of understanding to be signed by their duly authorized representatives.

For COCOA

8/29/2012
Date

For APD

8/29/12
Date

Appendix I Statement of Assurances and Verification of Intent
(see attached document for executed version)

For the period of January 1, 2017 through December 31, 2020, Central Oregon Council on Aging (COCOA), the designated Area Agency on Aging (AAA) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, COCOA 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. COCOA 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 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 Native Americans; and d) older individuals with limited English-speaking ability.

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 COCOA 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 AAA 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 AAA will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

B. An assurance that the AAA will, to the maximum extent practicable, coordinate the services the agency provides with services provided under Title VI of the Older Americans Act; and

C. An assurance that the AAA 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.

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. COCOA 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.

9/15/16
Date

Director, [AAA]

9-16-16
Date

Advisory COCOA Chair

9/22/16
Date

Legal Contractor Authority

Board Treasurer
Title

COUNCIL ON AGING
OF CENTRAL OREGON

373 NE Greenwood Avenue
Bend OR 97701

T: (541) 678 5483
F: (541) 647 2689

Memorandum of Understanding for Senior Nutrition Services

Between

Council on Aging of Central Oregon

And

Family Kitchen

This agreement is entered into on July 1, 2018 by and between the Council on Aging of Central Oregon (hereafter called the Council) and the Family Kitchen operated by Trinity Episcopal Church in Bend, OR.

The Council will provide $350 per month to the Family Kitchen to increase meal service for seniors aged 60 years and older. The funds may be used for costs related to food and meals, facilities, and staffing.

Funding is available for services delivered between July 1, 2018 and June 30, 2019 unless extended by agreement of both parties.

Family Kitchen will invoice the council on a monthly basis, and will provide, with each monthly invoice, the names and dates of birth for clients served, along with total number of meals served to those clients *if possible*.

This agreement does not constitute a contract. This agreement may be suspended via written notice from either party should circumstances necessitate such. Each party enters into this agreement in good faith, with the intent to help prevent hunger and malnutrition among seniors in need.

Susan Rotella	7/17/18	Donna Burklo	7/17/18
Signature	Date	Signature	Date
Susan M. Rotella		Donna Burklo	
Name (printed)		Name (printed)	
Council on Aging of Central Oregon		Family Kitchen, Trinity Episcopal Church	

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

Following are non-Council on Aging services, some provided by for-profit or non-governmental agencies, which meet important needs in the lives of seniors in the PSA.

Service	Crook Co	Deschutes Co	Jefferson Co
Hospitals	1	2	1
Clinics	2	18	2
Women's Health	3	3	2
Tribal Clinics	0	0	1
Low-income Clinics	2	7	2
Housing Authority	0	1	1
Tribal Housing	0	0	1
Food Banks	5	16	4
Alzheimer Support Groups	0	5	0
Title VI Nutrition Programs	0	0	1

Attachment C