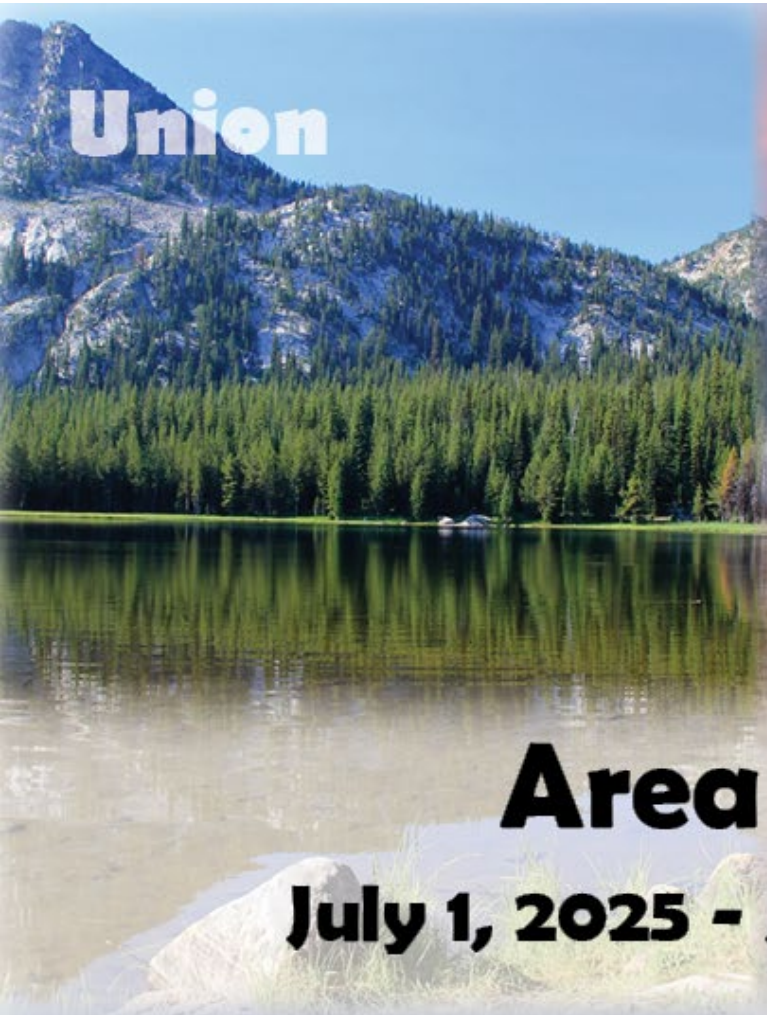
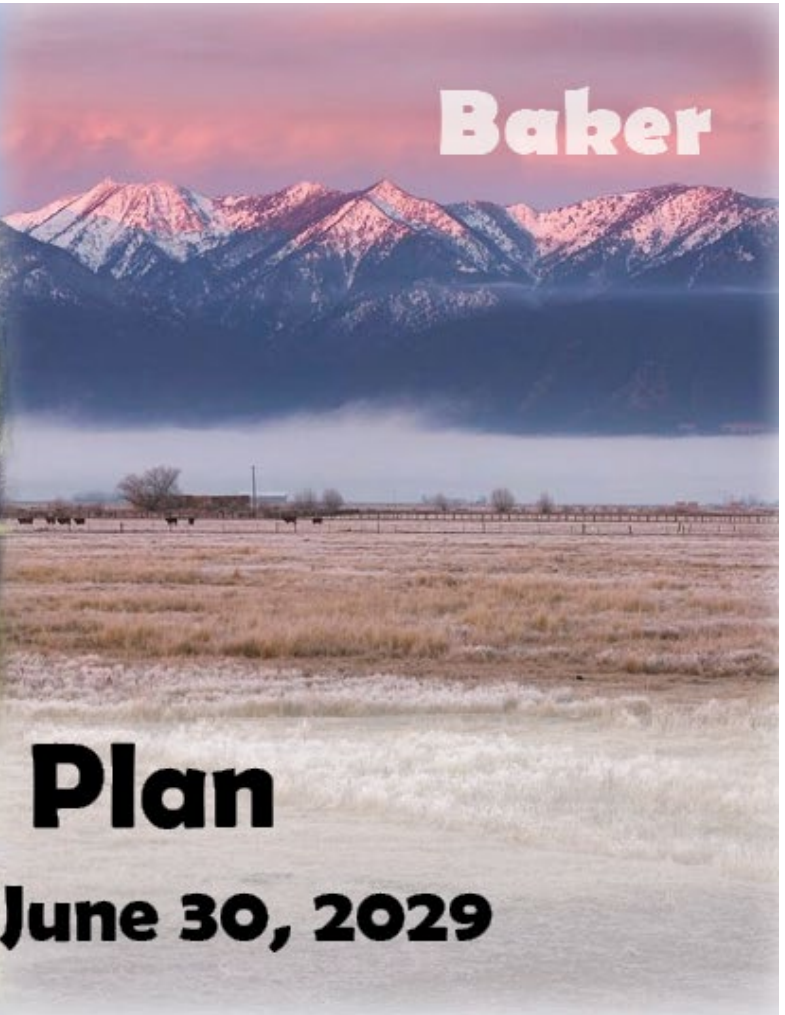




Union

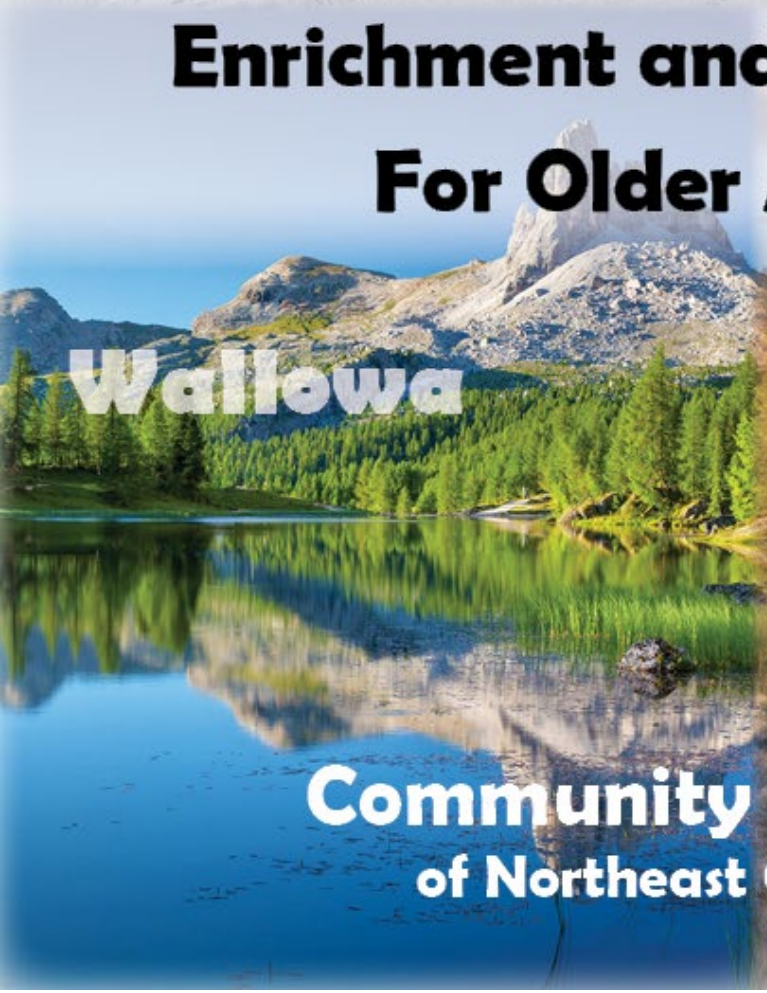


Baker

Area Plan

July 1, 2025 - June 30, 2029

**Enrichment and Enhancements
For Older Americans**



Wallowa



Grant

**Community Connection
of Northeast Oregon, Inc.**

COMMUNITY CONNECTION OF NORTHEAST OREGON, INC.
2025 – 2029 AREA PLAN

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SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A – 1 Introduction:

Community Connection of Northeast Oregon, Inc. (CCNO) is a private non-profit, 501 (c)(3) organization that has served Baker, Union, and Wallowa counties since 1969. In 1987, Grant County was added to our planning and service area. CCNO is governed by a 9–15 member Board of Directors consisting of 1/3 low-income sector, 1/3 private sector, and 1/3 public sector representatives. We are a dynamic, adaptable organization driven by the needs of the communities and populations that we serve.

Since inception, CCNO has been a Community Action Agency (CAA). A CAA's purpose is to reduce poverty and to that end, we assist homeless and low-income community members with emergency housing, utility assistance, weatherization and home rehabilitation, food banks, self-sufficiency programs and other such programs.

We also operate an extensive public and special needs transportation system in Baker, Union and Wallowa counties. We are a HUD-Certified Housing Counseling Agency and a Regional Food Bank agency for all four counties.

CCNO accepted appointment as the Area Agency on Aging (AAA) in 1979 pursuant to the consumers of the Older Americans Act (OAA) which had been enacted by Congress in 1965. According to Title III of the OAA, an Area Agency's purpose is "to develop a comprehensive coordinated service system to provide supportive and nutrition services for older individuals/families."

CCNO has a decentralized structure with services customized to the local level as much as possible (service design will vary by county). Managers and program delivery staff in each county implement the programs we provide to our communities. Our Site Managers work side-by-side with administrative staff and centralized program managers to identify the needs of and to serve our rural aging and low-income community members. The administrative staff and centralized program managers provide program guidance and technical support to our county staff daily. Administrative staff collect data from our Site Managers and compile the information into reports required of CCNO for all programs. Budgets, which are established collaboratively between site managers, the Fiscal Manager, and the Executive Director, are approved by the local Advisory Councils before going to the Board of Directors for final approval.

The purpose of this comprehensive Area Plan is to outline the services and supports that CCNO will provide to our aging community members. Our ultimate goal is to help seniors and people with disabilities live as independently as possible with dignity and choice in a safe environment and to prevent unnecessary or premature placement in a care facility.

To enable our aging community members to remain as independent as possible, CCNO provides the following:

- Congregate and Home-Delivered Meals
- Legal Assistance Referrals
- In-Home Care Assistance
- Information & Referral/Assistance
- Options Counseling
- Client Outreach
- Case Management
- Family Caregiver Support
- Caregiver Training
- Elder Abuse Awareness and Prevention Activities
- Chronic Disease Management and Educational Workshops
- Reassurance Calls
- Volunteer Opportunities
- Public Outreach and Education
- Public Transportation
- Recreational and Educational Activities
- Advocacy
- Other needed services

To inquire about this plan or for more information about CCNO, please contact the office below or visit our website: www.ccno.org

Community Connection of Northeast Oregon, Inc.
Administrative Office
2802 Adams Avenue
La Grande, Oregon 97850
(541) 963-3186

A – 2 Mission, Vision, Values:

The mission of Community Connection of Northeast Oregon, Inc. is to advocate for and assist senior citizens, children, low-income persons, and persons with disabilities in attaining basic human needs and in becoming more self-sufficient. This will be accomplished by providing direct client services; stimulating a more efficient use of existing resources; broadening the available resource base; and providing decent, safe, sanitary, and affordable housing for low and moderate-income persons.

Our “can-do” attitude and our broad range of services have earned us the label of the “go-to” organization in our region, a distinction we gladly accept. This attitude pervades our organization from our dedicated Board of Directors to our talented, committed employees, partners, Advisory Councils, local businesses, and our hard-working volunteers. This

coordinated team approach has created the successful “go to” agency CCNO is today. Our vision is to be good stewards of the funds entrusted to us, provide excellent customer service, and uphold integrity and accountability is paramount.

A – 3 Planning and Review process:

Planning for the Area plan involved input from our management staff, the community, our fiscal department, and our Senior Services Manager. The plan was then evaluated by our Executive Director, Assistant Director, Senior Service Manager and our Executive Assistant. We used our Community Needs Assessment to establish goals and objectives. During this process, we received input from the Pacific Islander community which is the biggest culturally specific group in our area. We also worked with staff from Oregon Department of Human Services for input into the plan. After being evaluated, the plan was taken to each of our 4-county Advisory Councils for input, changes, and approval. The plan was presented in its entirety to our Board of Directors on June 24, 2025 for final approval. Data in the Area Plan was taken from the U.S. Census.

If no funding is available for a program and we have a waitlist, we could use discretionary funding. The waitlist would start with the most vulnerable population and those with social and economic need. Discretionary funding would assist these populations first. See attached Appendix C Public Process.

A – 4 Prioritization of Discretionary Funding:

After meeting the minimum Title IIIB expenditure requirements, CCNO has discretion in how to use the remaining OAA funds. Setting priorities is an evolutionary process, continual in its nature. As staff, seniors or partners become aware of needs, opportunities, and best practices, this information is discussed in depth at all levels of the organization: staff, advisory councils, the board, and with appropriate partners and the public.

The Executive Director and the board make the final determination of priorities.

New needs and opportunities are weighed against existing needs and programs, and choices must be made to continue business as usual or to make changes. Decisions are based upon:

- The greatest social and economic need of our area’s seniors and people with disabilities- this was determined from the results of our Needs Assessment and our Customer Satisfaction Surveys.
- A determination of where and how we can make the most significant impact-again, this was also from our Needs Assessment and our Customer Satisfaction Surveys.
- Political pressures, and
- Available funding

The IIB priority list if discretionary funding is available is as follows:

1. Advocacy
2. Program Coordination & Development
3. Information & Referral/Assistance
4. Volunteer Services
5. Recreation
6. Health, Medical, and Technical Assistance Equipment including activities to address social isolation
7. Chore Service
8. Telephone Reassurance
9. Outreach to Individuals/Families
10. Public Outreach and Education
11. Newsletters

The services that we provided to each of our 4-county area did not change from the previous year.

Discretionary funding contributed by local governments and other organizations as well as money earned from local fundraising efforts support congregate meals and home-delivered meals. These meals are priorities of our Advisory Councils and our Board of Directors.

As far as waiting lists, we currently have only one waiting list in Baker County.

A – 5 Service Equity (Recommended, Optional):

Our Mission for Service Equity is to engage communities and create dialogue for improved and customized services in each of our four counties for BIPOC and LGBTQIA2S+ communities.

We will work with COFA Alliance National Network (CANN) and Marshallese American Network for Interacting Together (MANIT). We will also reach out to the Latino communities and other groups to ensure we are covering the hard-to-reach populations.

Goals: CCNO will provide DEI education training for all staff; increase services to the BIPOC and LGBTQIA2S+ communities; continue to work with partners and groups in identifying needs, gaps, and barriers surrounding these populations.

SECTION B – PLANNING AND SERVICE AREA PROFILE

B – 1 Population Profile:

This section lists the demographics for each county. There are 18,210 individuals ages 60 and over: 2,682 live in poverty and all live in rural areas.

Demographics population profiles for Baker, Grant, Union, and Wallowa counties					
Characteristics	Baker County	Grant County	Union County	Wallowa County	Regional Totals
Total Population	16,938	7,218	26,177	7,659	57,992
Total Ages 60-85+	5,600	2,815	7,115	2,680	18,210
Ages 60-74	3,831	1,895	4,965	1,840	12,531
Ages 75-84	1,116	665	1,620	685	4,086
Ages 85+	653	255	530	155	1,593
+60 Living in Poverty	1,055	360	1,005	262	2,682
+60 Living alone	685	425	770	370	2,250
+60 with a disability	1,210	680	1,160	390	3,440
+60 Grandparents raising grandchildren	45	10	80	25	160
White	15,887	6,756	24,161	7,270	54,074
African American	136	22	209	38	405
Native American	271	144	366	84	865
Asian	119	51	314	46	530
Pacific Islander/Native Hawaiian	34	7	393	15	449
Multiple race	491	238	734	206	1,669
Hispanic	915	310	1,466	322	3,013

These estimates retrieved from: <https://www.census.gov>; <https://agid.acl.gov>; and <https://www.pdx.edu/prc>

Although the overall population growth in our area has been relatively static for decades, as the baby boomers age our percent of older adult community members is projected to increase significantly over the next 5 years in Baker, Grant, Union, and Wallowa counties. Currently, 31% of our population are over the age of 60, compared to 16.8% statewide.

As the result of an increase of our older population, we will begin to see an increase in chronic conditions such as arthritis, coronary heart disease, diabetes, high blood pressure, high cholesterol, and stroke. As our older population begins to age and their health begins to decline, we will see a greater demand on our limited services under the Older Americans Act (OAA). We will offer Options Counseling as funding allows. Options Counselors will

work with clients to help them explore and develop a safe plan to help them age with independence, dignity, and choice.

One challenge we will face with our younger aging population is that many individuals in their 60's don't view themselves as "aging" or "seniors". Many of these individuals are still active and do not seek services that could help them in the future. The younger baby boomers are less likely to attend lunch at our meal sites, which could lead to declined numbers in attendance. CCNO will be working toward attracting younger baby boomers to senior meal sites and other services as well as assisting them in planning for the future. The population profile above will assist CCNO in serving clients with the greatest social and economic needs by giving us an idea of the population of each group. For example, we know that 2,250 seniors live alone, so we will market and outreach to this specific population. Knowing that 3,440 seniors in our area have a disability gives us places to market and outreach to this population, etc.

B – 2 Target Populations:

CCNO works with many local organizations and partners to identify community members with the greatest economic and social needs. Throughout Baker, Grant, Union, and Wallowa counties, our targeted population includes:

- Older individuals 60 years of age or older. 18,210 (31% of the total population)
- Older individuals 60 years of age or older living alone. 2,250 (4% of the total population)
- Older individuals 60 years of age or older living in poverty. 2,682 (5% of the total population)
- Older individuals 60 years of age or older with a disability. 3,440 (6% of the total population)
- Grandparents raising grandchildren. 160 (1% of the total population)
- Rural and Frontier communities, LGBTQIA2S+ persons, immigrant communities, and religious minorities.

Assisting older individuals who are disabled, living in poverty, or grandparents raising grandchildren will be our focus in all four counties.

We have great working relationships with Aging and People with Disabilities (APD), the Center for Human Development (CHD), health care organizations, and hospitals. These groups refer clients to our Care Coordinators who can connect them with necessary services. Part of our role in these working relationships is to educate our partners about the programs that we have available and their eligibility requirements. In turn, our partners educate our staff about their programs and eligibility so we can make appropriate referrals when we encounter barriers or challenges in serving a client.

Our agency, being a Community Action Agency, can also offer older individuals/families energy assistance, rental assistance, weatherization, housing rehabilitation,

transportation, housing counseling, and referrals to food pantries. Having these programs in our offices makes it easier to assist older individuals/families, keeping them safe and in their homes as long as possible.

For the last targeted population listed above, we will provide brochures and flyers about all our programs to our 21 food pantries to put into food boxes, hand deliver to home delivered meals recipients, post them in local stores, post office and libraries. This will give people in our smaller communities information on what services we offer, where to go to get the services, and what documents to bring with them.

B – 3 AAA Services and Administration:

Administration:

The administrative office of CCNO is located in La Grande. From this site, the Executive Director, Assistant Director, and Fiscal Manager ensure that the responsibilities of administering the Older Americans Act are fulfilled. The agency's Site Managers, located in Baker City, La Grande and Enterprise, are instrumental in working with their Advisory Councils and partners to maximize our services to meet OAA regulations.

Advocacy is a continual process. The Executive Director is the lead advocate for the area's senior citizens, and it is her responsibility to represent our area's interests at the local, state, and national levels. The Assistant Director along with our Site Managers work alongside the Executive Director with senior citizens' best interests. The Board of Directors and Advisory Councils are kept abreast of issues and trends that affect senior citizens and are asked to assist in advocacy efforts. Other administrative staff assist with newsletters, public outreach, education, and advocacy from time-to-time.

Program coordination and development activities occur at multiple levels within CCNO depending on the agency with which we are working at any given time. The Executive Director leads most efforts with neighboring AAA's, state offices, and other service organizations that serve multiple counties. The director and the Site Managers work closely with other service providers within each county to ensure that the needs of our region's seniors are being met and to develop local support.

For the budget section later in this plan, services have remained the same with no impact from the previous year. We do not foresee any impact to our budget in the near future.

Services:

Information & Referral Assistance – This program is essential for our senior population and their families. When a consumer needs information about assistance, they call one of our senior centers or our administrative office. Working with many social service agencies, community based organizations, faith-based groups and the state gives us a broad array of contracts to match to our consumers. Information given to our consumers can range from a limited response to detailed information about community service systems and

assistance accessing these services and their guidelines, requirements, and application process.

Options Counseling – At each of our senior center offices, we have staff that provide Options Counseling to seniors and their families. Consumers often present multiple needs and are unsure of where to turn for help. CCNO staff help the senior and/or family members sort out their needs and identify options for fulfilling those needs. As the consumer or family member decides on their course of action, our staff provides support, often being consulted multiple times during the process. A person-centered approach is the key for the best outcomes for the consumer.

Outreach – The purpose of this program is to identify potential consumers and to encourage them to access our services. Visiting the most rural outlying areas and discussing our programs is one way we reach the consumers with the greatest need. Our Care Coordinators may also visit consumers in their homes to identify their needs and refer them to the services that can best assist them. We provide information regarding our services to partners, and to the public. This is achieved by speaking at senior centers, at meetings with civic groups, faith-based organizations and at public events. Each of our county offices distributes monthly newsletters along with menus to seniors. These newsletters inform them of available services and other activities of interest at our senior center sites. We utilize social media to share information and receive contact from community members through our website and the ADRC website.

Home Delivered Meals CCNO delivers nutritious midday meals to the homes of frail, elderly individuals who are unable to leave their homes. We deliver hot, refrigerator-ready and/or frozen meals during the week. Often, the volunteer or staff member delivering the meal is the only outside contact the senior may have all day.

Congregate Meals – CCNO serves all adults 60 years of age and older a hot, nutritious meal at each of our senior centers. Lunches are served on the following schedule: M-F in Baker City and La Grande; M-W-F in Enterprise and Wallowa; Monday and Thursday in John Day; and one day a week in Prairie City and Monument. These meals not only ensure at least one nutritious meal, but also serve the individuals' social needs by providing a gathering place to meet friends, play cards, bingo, dance, and attend educational classes and workshops, etc. All meal sites are open to the public.

Telephone Reassurance – Staff make regular friendly telephone calls to seniors to check on their safety, ensure they are taking their medication, offer assistance if needed, and simply visit with them.

Nutrition Education – We promote better health by providing nutrition, physical fitness, and health information to consumers in group or individual settings that are overseen by experts or by providing educational material when seniors are visiting the meal sites for a meal.

Homemaker – Home Care Workers (HCW) assist frail seniors 60 years of age and older with activities of daily living (ADL) such as bathing, dressing, and transferring along with independent activities of daily living (IADL) such as light housekeeping, cooking, and shopping. Approval of services may include meals-on-wheels, durable medical equipment, and chore services when funding is available.

Chore Service – Assistance for seniors with heavy housework, yard work or minor home maintenance. Chore service is provided on an intermittent basis through volunteers or businesses. This service is heavily dependent on funding availability.

Case Management for OPI and OPI-M Oregon Project Independence (OPI) and Oregon Project Independence Medicaid (OPI-M) - Care Coordinators work with consumers and their families to develop an individual in-home care plan to ensure the consumer receives the best services available with a focus on Health and Safety. These coordinators offer other community services to create an overall person-centered in-home plan for each consumer. We partner with the Veterans Administration to provide in-home care for area veterans.

Information for Caregivers including Older Relatives Raising Children – The Senior Services Manager and Care Coordinators provide caregivers with a variety of information on resources and services available. When making a presentation to a group, they will distribute information about the program. This information is available at each of our senior center sites for caregivers.

Caregiver Access Services – The Senior Services Manager and Care Coordinators provide caregivers the information needed to access services that are available in their communities. This is accomplished face-to-face or on the phone, with brochures, or presented in group activities or virtual trainings.

Caregiver Respite Care/Older Relatives Raising Children – The staff mentioned above provide services to support the growing number of caregivers in our counties. When caring for an elderly family member or an elderly friend, or if the caregiver is 60+ or 55+ and caring for a relative child, CCNO can provide re-imbursement for a short-term substitute for the caregiver.

Caregiver Supplemental Services – These are services provided on a limited basis that complement the care with legal assistance referrals, home modifications, transportation, assistive technologies, home delivered meals, and incontinence supplies.

Caregiver Training – CCNO provides training opportunities for caregivers to enhance their role in caregiving. Staff are trained to deliver the evidence-based Powerful Tools for Caregivers classes that are held periodically throughout our service area. These trainings give the caregivers the tools to support and enhance their caregiving experience. Staff visit

with caregivers about making decisions related to their caregiving roles and about support groups and trainings that could benefit their situations.

Preventative Screenings – CCNO hosts a variety of Health Clinics which may include blood pressure clinics, cholesterol clinics, foot clinics, eye screenings, and hearing aid screenings. Professionals in each field typically perform these services inside our senior centers on a monthly basis. Seniors are assisted on a first-come, first-served basis. These services benefit our consumers by having qualified people trained in each field performing these vital services.

We have staff members and volunteers who are qualified to lead the following programs or trainings when funding is available:

- Chronic Disease Promotion – management and education
- Living Well series: Chronic Disease Self-Management
- Pain Self-Management (under license from Stanford University) – these workshops are six-week courses, two hours per class, which teach clients how to live a normal life with chronic conditions.

We provide the opportunity for older adults to participate in physical fitness, group exercise and dance-movement therapy. We include programs that focus on strength, balance, and flexibility.

Health, Medical and Technical Assistive Equipment – We lend assistive devices that help individuals maintain their independence in performing activities of daily living. For example, walkers, canes, and other equipment are loaned to persons in need as well as training on technology to help seniors avoid social isolation.

Elder Abuse Awareness and Prevention – We provide education and promote the importance of preventing, identifying, and reporting elder abuse in our newsletters, at meetings and as other opportunities arise. Our Senior Services Manager and Care Coordinators are all mandatory reporters. Staff in each county serve on Multi-Disciplinary Teams.

Legal Assistance – For seniors 60 years of age and older, referrals are made to legal services. We contract with Oregon Law Center for Baker and Grant counties, and Oregon Legal Aid for Union and Wallowa counties. They provide legal counseling on many topics at no cost to clients.

Recreation – We plan, and support assorted recreational activities: billiards, swing or line dancing, chair exercises, card playing, bingo, lending library, etc. This assortment of activities promote socialization for seniors. These activities take place at each of our senior centers.

Volunteer Services – Volunteers work at our nutrition sites to deliver Meals-On-Wheels, perform office work, help with fundraising, and serve on board and advisory councils. Volunteers are an essential resource to providing services to our seniors.

Budget Impact – When our services experience shortfalls, in some instances, a waiting list will be created. We will contact consumers from the waiting lists for assistance when and if funding permits. In other cases, we turn to fundraising efforts such as bake sales, banquets, and garage sales. Community Connection provides nutrition services and Family Care Giver services because there is no other service provider in our rural and frontier counties that can provide these services. We will reach out in the next year to local providers to see if anyone can provide these services to our clients.

Service Matrix and Delivery Method – Attachment C:

Please see Attachment C

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

Service	Baker, Grant, Union, and Wallowa counties
Community Healthy Aging & Care Transitions	Our Senior Services Manager and Care Coordinators participate in the local Long-Term Care Transitions and Multiple Disciplinary Team (MDT) meetings on a monthly basis. During these meetings, community partners and professionals meet to inform each other of new and existing services. These groups work together to brainstorm about the best services available to assist consumers.
Oregon Department of Human Services (ODHS)	Our Senior Services Manager and Care Coordinators work closely with each County's ODHS office, making referrals to Medicaid, long-term care, SNAP, and other financial services for community members with low incomes who may be struggling to make ends meet.
Elder Abuse Awareness/Prevention	Our Senior Services Manager and Care Coordinators work with Aging and People with Disabilities (APD). When CCNO staff hear about possible elder abuse and neglect, they immediately report it to APD.
Employment Services	WorkSource Oregon provides job listings and training for all jobseekers in Baker, Grant, Union, and Wallowa counties.
Health Departments	For Baker County, we work with the Health Department who provides immunizations, childhood vaccines, vital records, case management, and diabetes information. In Union County, CCNO staff work with the Center for Human Development (CHD) who provides services such as family planning, maternal and child health, communicable disease prevention and treatment, Women, Infants and Children (WIC) nutritional program, mental health services and Tobacco Prevention & Education Program. Community Counseling in Grant County focuses on treatment services for mental health and substance abuse related issues. The Wallowa Valley Center for Wellness, Inc. provides outpatient services, psychological and behavioral problems, and assists persons with alcohol and drug problems as well as case management services for persons with developmental disabilities.
Hospitals	Staff have a working relationship with the discharge planners at the local and surrounding hospitals. When appropriate, the discharge planners will make a referral to CCNO for community members. In turn, CCNO will

	contact the community member and provide the member with Options Counseling and other services which they may be eligible for.
Housing Authority	CCNO works with Northeast Oregon Housing Authority (NEOHA) to identify community members who need housing assistance.
Intellectual/Developmental Disabilities	In Baker County, New directions Northwest Inc. (NDN); in Grant County, Community Counseling Solutions (CCS); in Union County, Center for Human Development (CHD); in Wallowa County, Wallowa Valley Center for Wellness (WVCW). These organizations provide services to individuals living with intellectual/developmental disabilities and their families. All organizations respond to allegations of abuse and neglect; provide crisis response; and provide family support services to plan and develop supports for children with developmental disabilities.
Mental Health	The same organizations as listed in the Intellectual/Developmental Disabilities above provide mental health services to individuals with low incomes.
Support Groups	Several of our county partners will provide support groups for Alzheimer's/Dementia, Cancer, Parkinson's Disease, and caregivers. Home Health and Hospice will offer Grief and Loss Support Groups and Caregiver Support Groups throughout the year. CCNO refers clients to Greater Oregon Behavioral Health, Inc. (GOHBI).
Transportation	CCNO offers public transportation to our senior and disabled community in each of our counties except for Grant County where these services are provided by People Movers.
Veterans Service Officers	When CCNO staff meet with a community member who is a Veteran, they connect or refer them with the appropriate Veterans Service Officer (VSO) to ensure the Veteran is aware of all services available to them.

The only service in our area that we contract with is legal services. We work with Oregon Law Center that covers Baker and Grant counties, and Legal Aid Services of Oregon that covers Union and Wallowa counties.

Gaps in services-last year we discovered a gap in services for minorities when attending an event. The group informed us that they had no way of getting culturally specific food items. Our Regional Food Bank Manager has since started ordering culturally specific food items from Oregon Food Bank. We have received feed back thanking us for having these food items available for them.

SECTION C – FOCUS AREAS, GOALS AND OBJECTIVES

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

1. Information and Referral Services and aging and Disability Resource Connection (ADRC)

Throughout all Focus Areas, the principles and methodologies of Person- Centered Services and Supports along with Service Equity will be the Goals and Objectives to promote health, safety, and independence for everyone in our four-county area to eliminate discrimination and disparities. We will continue with our community partnerships for cross-referral/collaboration of all sectors of the population. Additionally, we will provide older adults and family caregiver services in a manner that is person-centered, trauma-informed, and culturally sensitive.

The ADRC is a free service available that helps people of all ages, incomes, disabilities, and caregivers learn about long-term options and other community resources in their communities. The ADRC is a central source of information, referrals and access to unique local community resources for older people, people with disabilities, their families, natural support, hospital discharge planners, home health, or other community partners. Option Counseling or Information & Referrals is available at each county office and administration office, over the telephone, in-home visits, or at the local office for person centered assistance. We provide one central source of reliable and objective information about a broad range of community resources of interest to seniors, their families, and people with disabilities to support independent living and to prolong the need for long -term care. We provide referrals and education to a variety of Federal or State programs. Our marketing and outreach will support and educate community members about ADRC services to promote and increase service usage with an emphasis on priority populations, including older adults in our rural communities, those who speak languages other than English, LGBTQIA2S+ older adults, Tribal Elders and older adults living with HIV/AIDS by providing a link on our website to ADRC of Oregon, monthly social media posts about ADRC services and how to access those services.

Several of CCNO's staff are Options Counselors who are ADRC Get Care I&R trained. The Senior Services Manager is Alliance of Information & Referral Systems (AIRS) certified, who partners with CSSU liaison to maintain and support the ADRC resource database with local information. The Senior Services Manager in partnership with each County Manager will quarterly review ADRC activities in Get Care for adherence to ADRC program standards. We continue to train new employees as needed. We continue entering I&R/and Options Counseling activities into the ADRC Get Care database. We make referrals to APD for Medicaid and SNAP services, LTC and QMB.

Some of our key partners in providing services are as follows:

- Affordable Housing Properties
- Centers for Independent Living
- Civic Organizations
- Domestic Violence Providers
- Employment Department
- Hospitals
- Assisted Living Facilities
- Cities and Counties
- ODHS (APD, CW, & SS)
- Eastern Oregon University (EOU)
- 18 Food Pantries
- Local business

- Mental Health Providers
- Northeast Oregon Housing Authority
- Oregon Law Center/Oregon Legal Aid
- Police Departments
- Public Transit Division of ODOT
- Transportation Brokerage
- Workforce Agency
- Motels (for emergency housing)
- Oregon Housing & Community Services
- Other non-profit churches
- Public Health
- Senior Citizen Organizations
- Veterans Services Offices

We use our Get Care data, results from our customer satisfaction surveys to tell a story to each community showing the need for the ADRC program. We try to maximize collaboration with partners and other streams to supplement the ADRC program.

Community Connection will look at other funding streams to support and sustain the program. These could include: revisiting OMAC, reach out to partners, and may use our own general fund dollars.

Focus Area - Information and Referral Services and ADRC

Goal: Generate more awareness of the ADRC program within the community and our partners

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Increase the number of I&R calls by 2%	a	More outreach/marketing to our partners, church groups, businesses about our ARDC program on a quarterly basis.	Senior Services Manager, Site Managers and front-line staff.	7/1/2025	6/30/2027
	Accomplishment or Update				
	b	Perform bi-annual presentations to partner agencies and all our senior centers for the ADRC program.	Senior Services Manager, Care Coordinators and Site Managers.	7/1/2025	6/30/2027
	Accomplishment or Update				

Goal: Increase agency capacity to provide ADRC I&R services

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Have one more staff member trained and certified through Inform USA	a	Sign appropriate staff member to take the training necessary.	Site Managers, Senior Services Manager	7/1/2025	6/30/2027
	Accomplishment or Update				
	b	Continue to train the staff member, quarterly for the first year, annually after.	Senior Services Manager	7/1/2025	6/30/2028
	Accomplishment or Update				

Goal: Provide high-quality Person-Centered Options Counseling

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Provide Person-Centered Options Counseling to at least two (2) seniors and/or their families yearly.	a	Perform outreach quarterly to each county, especially outlying areas.	Senior Services Manager, and Care Coordinators.	7/1/2025	6/30/2029
	Accomplishment or Update				
	b	Review Options Counseling data for quality assurance	Senior Services Manager.	7/1/25	6/30/29
	Accomplishment or Update				

Goal: Marketing and outreach to promote ADRC and increase services

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Advertise ADRC through our website, Facebook, and other media platforms.	a	Update and monitor our website and Facebook posts.	IT & Program Engagement Specialist.	7/1/2025	6/30/2026
	Accomplishment or Update				
	b	Provide ADRC materials to spread awareness to culturally specific persons, groups, and people of color in our rural areas	Senior Services Manager and county staff.	7/1/2025	6/30/2026
	Accomplishment or Update				
Outreach to culturally specific groups.					
	c	Provide ADRC materials to the Confederated Tribe Council for Native Americans. Perform outreach at local events, meetings, to those with greatest social and economic need.	Senior Services Manager and county staff.	7/1/2025	6/30/2029
Outreach to those with greatest social and economic need.	Accomplishment or Update				

2. Nutrition Services (OAA Title IIIC)

Our senior centers in each county provide home delivered and congregate meals to reduce hunger and food insecurity, promote socialization, improve health and well-being, and help prevent the onset of adverse health conditions resulting from poor nutrition or sedentary behavior. CCNO strives to consider everyone's person-centered preferences, needs, values, cultures, and diverse backgrounds, culturally sensitive and are diligent in our efforts to ensure all services are free from discrimination and disparity.

The following is a list of our meal sites, addresses, days and times of service, and average participation at each site:

Baker County Senior Center

2810 Cedar Street

Baker City, Oregon 97814

Congregate Meals: Monday through Friday, 11:30 a.m. to 12:30 p.m.

Home Delivered Meals : Monday through Friday, 11:00 a.m. to 12:00 p.m.

New Bridge Grange

43108 Main Street

Richland, Oregon 97870

Home Delivered Meals – Frozen meals: One day a week.

Enterprise Senior Center

702 NW 1st Street

Enterprise, Oregon 97828

Congregate Meals: Monday, Wednesday, and Friday, 11:30 a.m. to 1:00 p.m.

Home Delivered Meals : Monday, Wednesday, and Friday, 11:00 a.m. to 12:00 p.m.

Wallowa Senior Center

204 E 2nd Street

Wallowa, Oregon 97885

Congregate Meals: Monday, Wednesday, and Friday, 12:00 to 1:00 p.m.

Home Delivered Meals : Monday, Wednesday, and Friday, 11:00 a.m. to 12:00 p.m.

John Day Senior Center

142 NE Dayton

John Day, Oregon 97845

Congregate Meals: Monday and Thursday, 12:00 to 1:00 p.m.

Home Delivered Meals : Monday and Thursday, 12:00 to 1:00 p.m.

Monument Senior Center

269 Main Street

Monument, Oregon 97864

Congregate Meals: Tuesdays from 12:00 to 1:00 p.m.
Meals-On-Wheels: Tuesdays from 12:00 to 1:00 p.m. (Meals are delivered from the John Day Senior Center)

Prairie City Senior Center
204 N. McHaley Street
Prairie City, Oregon 97869

Congregate Meals: Wednesdays from 12:00 to 1:00 p.m.
Home Delivered Meals : Wednesdays from 12:00 to 1:00 p.m. (Meals are delivered from the John Day Senior Center)

Union County Senior Center
1504 Albany Street
La Grande, Oregon 97850

Congregate Meals: Monday through Friday, 11:30 a.m. to 12:30 p.m.
Home Delivered Meals : Monday through Friday, 11:30 a.m. to 12:30 p.m.

Average participation by county:

Baker County: 69 per day
Grant County: 20 per day
Union County: 36 per day
Wallowa County: 41 per day

We will use Title IIIC funds to implement Congregate Meals and Home Delivered Meals. Volunteers are at each site to assist when needed with the meals and volunteers and staff deliver Home Delivered Meals to clients' homes. Annually, CCNO staff and volunteers take trauma-informed training to support our HDM recipients. We are exploring a more inviting "café" environment to the public to encourage younger senior attendance, but we currently don't have any plans to change the meal production or delivery system at any of our sites. CCNO takes great pride in providing quality meals. We have a Registered Dietitian that approves each of our site's menus. Our dietitian offers one-on-one nutritional education by appointment at least annually to HDM recipients upon request. CCNO offers quarterly Living Well Health promotion evidence-based classes via ZOOM to all consumers 60+.

We will continue our partnership with APD to expand the number of Title XIX meals, and OPI-M delivered in each of our counties.

For fundraising, we reach out to all our local partners, business owners, and the community at large to participate in our Entrée Sponsorship program. Other fundraising activities include catering, banquets, and silent auctions. We have established endowment funds at Oregon Community Foundation to support senior programs.

Faith-based groups and civic and local organizations provide volunteer assistance at our dining centers. Our staff accept donations of food from local orchards and farms. We also receive bulk and boxed produce from the Oregon Food Bank that we give out to seniors and people with disabilities through our Harvest Share program. Fresh Alliance is another successful program we offer. We receive produce, meat, bread, etc. from local grocery stores that are distributed to our sites for the general public.

CCNO staff have developed partnerships with local hospitals, home health agencies, the OSU extension office, and physical fitness and therapy-related agencies to provide nutrition and physical fitness related education. Our Care Coordinators partner with our nutrition staff to provide informational flyers on nutrition, physical fitness and other health information to all home delivered meal participants and at our congregate sites.

Monthly newsletters are distributed at all dining centers, and to home delivered meal participants. These newsletters provide information on special and regular activities at our sites, information on educational presentations, our menu for the month, and other community information.

At the time of HDM eligibility assessment staff will share other resources available within the agency and community partners. CCNO staff will ask HDM recipients of other services they may need, to include whether there is a family or natural support caregiver. CCNO staff will offer educational information about the meal's standards, expectations on receipt of delivery and storing or consuming the meal. At least quarterly, HDM delivery drivers will bring educational information about nutrition to review with the HDM recipient. This may include how food may interact with medications or how to stay hydrated during heatwaves.

Focus Area – Nutrition Services

Goal: Promote the health and wellbeing of older individuals

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Serve nutritious meals in a more attractive manner that also includes culturally specific options.	a	Set up meeting with the Pacific Islander group to discuss types of meals that would attract them to the mealsites.	Cooks, Site Managers, Senior Services Manager and/or Assistant Director	7/1/2025	6/30/2028
	Accomplishment or Update				
	b	Survey attendees on what meals will attract more attendance.	Senior Services Manager and Senior Center Manager.	7/1/2025	6/30/2027
	Accomplishment or Update				
	c	Change menu based on survey results.	Cooks, Site Managers.	7/1/2025	6/30/2028
	Accomplishment or Update				

Goal: Maintain or increase number of people and meals served at meal sites

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Maintain or increase the number of meals being served at our meal sites by 10%	a	Perform outreach and marketing quarterly.	IT & Program Engagement Specialist, Site Managers and staff.	7/1/2025	6/30/2027
	Accomplishment or Update				
	b	Give free meal tickets to new attendees. Record number of tickets given out, as well as tracking when tickets are used.	Site Managers, kitchen staff.	7/1/2025	6/30/2027
	Accomplishment or Update				

3. Health Promotion (OAA Title IIID)

CCNO partners with Oregon Wellness Network (OWN) under their license for the National Diabetes Prevention Program and Chronic Disease Self-Management. Under this license, we have trained staff and volunteers who offer these programs. CCNO staff will ensure services are provided to consumers 60+ and family caregivers in a manner that is person-centered, trauma-informed, and culturally sensitive to all who participate in any Health Promotional workshops. All workshops or sessions are available in all four of our counties and are free to participants. After classes, consumers are asked to fill out a questionnaire. We will use these questionnaires to evaluate and improve classes. This will help improve the quality of the program and classes. Classes are offered to everyone and we ensure that all classes are available to meet everyone's needs.

Our Senior Services Manager has contact with staff from OWN for updates, suggestions, and questions.

CCNO's outreach efforts for these workshops and programs include public service announcements, paid newspaper and radio advertisements, announcements at our senior centers, newsletters, our website and Facebook postings.

Through CCNO's outreach efforts and requests for referrals, we work with APD, EOCCO, public health, mental health, hospitals, clinics, and local agencies serving at-risk or older individuals to provide information regarding upcoming classes and workshops. Evidence-based Health Promotion classes are offered quarterly by trained CCNO staff in each county as funding allows. Baker County is recognized as a Dementia Friendly Community and hosts monthly support group meetings where access to preventative services or healthcare options are regularly offered. Our other three counties are working to include Dementia Friendly Community sponsorships.

All senior centers provide or network with other community partners to connect seniors to options for equipment lending.

Focus Area – Health Promotion

Goal: Promote Evidence Based programs and evaluate demand for services

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Annually conduct a survey to evaluate what Evidence Based Health programs consumers will participate in	a	Create and distribute survey, to include medical clinics	Senior Services Manager and Assistant Director	7/1/2025	6/30/2028
	Accomplishment or Update				
	b	Evaluate survey results after each class.	Senior Services manager and Assistant Director	7/1/2025	6/30/2027
	Accomplishment or Update				

Goal: Provide programs based upon demand and budget

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Select at least one Evidence Based program to provide to consumers once per quarter.	a	Key on selecting program from responses from the surveys.	Senior Services Manager, and Care Coordinators.	7/1/2025	6/30/2026
	Accomplishment or Update				
	b	Prepare program as a virtual setting for hard to reach consumers	Care Coordinators and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				

4. Family Caregivers (OAA Title IIIE)

The Family Caregiver Support Program (FCSP) is designed to assist caregivers who are caring for a family member 60 years of age and older, or Older Relatives Raising Relative Children who are age 55 years and older and are caring for qualifying Relative Children. FCSP provides individuals with assistance in gaining services, individual counseling, and training to help family caregivers make decisions and solve problems they may be facing in caring for their loved ones. Case Management is provided for all consumers enrolled in FCSP. The main goal of FCSP is to provide respite care, temporarily relieving family caregivers from their caregiving responsibilities. We regularly refer Older Relatives Raising Relative Children to Oregon Kinship Navigator for services and support that Family Caregiving program doesn't provide.

Outreach is done through newspaper articles, radio advertisements, our website, Facebook posts, and partnerships with local community partners who serve a diverse population. With is partnership in our four rural counties, we work together to identify limited English speaking or ethnic groups, including Native American/Pacific Islanders, older caregivers in greatest social and economic need, those who are socially isolated, caregivers(as are identified in CCNO FCSP Manual), LGBTQIA2S+ older adults, Tribal Elders and older adults living with HIV/AIDS. We distribute brochures at local events, civic groups, hospitals, and to other service providers.

Based on annual funding, we use the following to prioritize assistance once a quarter and annually to each caregiver: 1st – adult family member of another individual who is a provider of in-home care to any age adult who has Alzheimer or has a related disorder such as dementia. 2nd – adult family member of another individual caring for an older individual age 60 years or older. 3rd – Older Relatives Raising Relative Children, step grandparent who is 55 years of age or older, providing care for a child with disabilities or an adult child with a disability. They must live with the child and are the primary caregiver of the child. 4th – Older Relatives Raising Relative Children who is 55 years of age or older providing care for a child who is 18 years of age or younger. They must live with the child and are the primary caregiver of the child. CCNO has an FCSP Protocol, Procedures, and Documents Manual which covers Primary Goals, Eligibility Requirements, Prioritizing, Enrollment/Disenrollment, Steps to Qualify FCSP for all services, Reimbursement process. This is available in Appendix J.

Core Elements: Information Services - a public and media activity that conveys information to caregivers about available services, including in-person interactive presentations, booth/exhibits, or radio, TV, or Web site events. This service is not tailored to the needs of the individual. Family Caregiver Information and Assistance – a service that provides the individuals with current information on opportunities and services available to the individual within their communities; assesses the problems and capacities of the individual; links the individual to services; ensures that the individual receives services they are in need of; and services the entire community of older adults. Based on annual funding, once a year, Caregiver Counseling is available to all family caregivers enrolled in the program and they

receive well-informed counseling when needed. Training is offered as well. The Powerful Tools for Caregivers is offered twice annually to any caregiver providing care to a person 60+. PTC classes meet once a week for six weeks. Participating family caregivers learn new tools which help them better care for themselves as well as their loved ones.

Based on annual funding, CCNO offers to all enrolled qualified FCSP caregivers the following services:

1. Caregiver Information and Assistance
2. Counseling and education to access services
3. Caregiver Counseling
4. Powerful Tools for Caregivers classes/referral to Oregon Care Partners
5. Reimbursement once a quarter for respite care of FCPS care receiver
6. Reimbursement once a quarter for qualifying supplemental services
7. Referral to local Caregiver Support Groups, on-line and/or telephone support groups

Due to limited funding available, CCNO utilizes these funds to go directly to the FCSP caregiver to support person-centered care choices. This prohibits partnership to contract with any agency who could support the FCSP caregiver.

Focus Area – Family Caregivers (OAA Title IIIE)

Goal: Provide Powerful Tools for Caregivers

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Increase participation in current courses by 2%	a	Perform outreach, distribute promotions, and schedule classes.	Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				
	b	Enroll participants in program.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2028
	Accomplishment or Update				
	c	Co-teach classes with Care Coordinators.	Senior Services Manager.	7/1/2025	6/30/2028
	Accomplishment or Update				
	d	Track prior attendance to use as a baseline for increased participation.	Senior Services Manager and Care Coordinators.	7/1/2025	6/30/2026
	Accomplishment or Update				
	e	Current courses could be done virtually to increase participation	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				

Goal: Outreach to Grandparents raising grandchildren

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Begin outreach in schools and Head Start to reach Older Relatives Raising Relative Children annually.	a	Develop working relationship with school counselors and administration.	Care Coordinators and Senior Services Manager.	7/1/2025	6/30/2029
	Accomplishment or Update				
	b	Once relationships are established, set up future meetings.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				
	c	Track the number of referrals to partners to show success.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				

5. Legal Assistance and Elder Rights Protection Activities (OAA Titles III-B and VII)

CCNO contracts each year with Legal Aid Services of Oregon for consumers in Union and Wallowa counties and with Oregon Law Center for Baker and Grant County consumers. These providers ensure legal aid is delivered according to Oregon's Legal assistance program standards. We work with our legal service providers quarterly to ensure that legal services are delivered efficiently and effectively, providing a full spectrum of high-quality legal services to clients. We also ensure that LASO and OLC are aware of how important their services are to our clients.

We contract with Legal Aid Services of Oregon and Oregon Law Center because they are the only providers in our area. Other law firms charge beyond our funding limits to do the work that needs done for our clients.

We educate and inform senior citizens of any current scams or fraud issues. We have abuse prevention brochures located in each of our senior centers with emphasis on preventing financial exploitation. Care Coordinators bring brochures to all home visits to include HDM Assessments.

Through our ADRC teams, we work closely with ODHS/APS referring consumers that have a legal or an abuse issue. We have no gaps in services because of our close working relationship with ODHS and the Multi-Disciplinary Teams (MDTs) in each county. The MDT meetings occur quarterly to discuss at-risk seniors and provide resources for consumers, partners, and elder abuse prevention. If there is a concern of potential abuse, our staff will discuss the matter with their Site Manager and call APS to make the referral.

Referrals are not only made from our staff to LASO and OCL, but also to ODHS/APD, law enforcement agencies, and LTCO's.

All Community Connection staff are mandatory reporters and receive thorough training in regard to their responsibilities. This training will assist them in identifying potential fraud or abuse in their daily work. All staff understand how to make appropriate reports to the local APD office and the Ombudsman.

Focus Area – Legal Assistance and Elder Rights Protection Activities

Goal: Educate the community about elder abuse

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Have presentations at senior centers and other partners on ways Elder Abuse may occur twice a year	a	Announce at meal time about upcoming presentation on ways Elder Abuse can occur.	Site Managers, Care Coordinators	7/1/2025	6/30/2028
	Accomplishment or Update				
	b	Track reports from ODHS on number reporting. Document if increase or decrease of reporting.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				
	c	Do presentations at ODHS staff meetings and other partners educating them about Elder Abuse and ways it may occur.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				

Goal: Advocate for Elder Rights

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Attend quarterly Multi-Disciplinary Team meetings throughout Baker, Grant, Union, and	a	Attend and be engaged at the MDT meetings. Advocate for our clients and ways to prevent abuse.	Care Coordinators and/or Site Managers.	7/1/2025	6/30/2027
	Accomplishment or Update				

Wallowa counties annually.	b	Provide feedback to appropriate staff on discussion and decisions made on clients situations and how we can protect our clients.	Care Coordinators and/or Site Managers.	7/1/2025	6/30/2027
	Accomplishment or Updates				
	c	Track consumer success from input at the MDT meetings.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishment or Update				

Goal: Increase visibility of Legal Aid Services

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Oregon Legal Aid and Oregon Law Center to give a presentation at the senior centers in each county annually. Target those with the greatest social and economic need.	a	Contact legal assistance providers to do presentations.	Site Managers, Senior Services Manager, and/or Assistant Director	7/1/2025	6/30/2029
	Accomplishments or Updates				
	b	Distribute yearly, brochures/flyers about all our programs to our partners, post office, local stores, food pantries, and when delivering Home Delivered Meals.	County Managers, Senior Services Manager, and Assistant Director	7/1/2025	6/30/2029
	Accomplishments or Updates				

	c	Document where consumers received information about presentations.	Assistant Director	7/1/2025	6/30/2026
	Accomplishments or Updates				
	d	Increase participation by 2% for the year.	Care Coordinators, and Senior Services Manager.	7/1/2025	6/30/2026
	Accomplishments or Updates				

6. Older Native Americans (OAA Titles VI and III)

Older Native Americans account for less than 1% of the 60+ population in CCNO's service area. We serve this population in the same inclusive manner that we serve the rest of the senior population. When consumers are identified or proclaim they are Native American, we offer them a referral to Yellow Hawk Tribal Services with the Umatilla Confederate Tribes. Tribal Councils offer a full array of services like what our agency can offer of our OAA programs. Through partnership and collaboration with Tribal Councils and CCNO, services are offered to consumers which best fit their needs.

We will collaborate our efforts with Tribal Emergency Management to form a strong partnership. We currently do not have a partnership with the Title VI program at Yellowhawk. We will reach out to the Tribe to start a solid relationship. These relationships will include getting to know their consumers, their needs while also letting them know what services we provide and eligibility.

To build this partnership with Tribal Emergency Management and the Title VI program at Yellowhawk, Community Connection will set up meetings with the Tribe to discuss coordination between our programs and theirs. We will find out the best way to make referrals (vice-versa), and the best way to communicate, via phone, email, virtual or in person. We place a high priority on providing culturally appropriate and trauma-informed services. We will work with the Title VI program to ensure we are doing so and learn additional ways we can accomplish this.

Focus Area – Older Native Americans

Goal: Reach as many older Native Americans as possible

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Assist older Native Americans with services in partnership with Yellow Hawk Tribal Services/ Umatilla Confederate Tribes.	a	Quarterly outreach to partners to reach older Native Americans.	Site Managers, Care Coordinators, and/or administrative staff.	7/1/2025	6/30/2027
	Accomplishment or Update				
	b	Meet twice a year with Title VI Director, Tribal Emergency Management to collaborate with their members so they are aware and have access to the services that CCNO provides.	Site Managers, Care Coordinators, and/or administrative staff.	7/1/2025	6/30/2028
	Accomplishment or Update				
	c	Refer clients to culturally appropriate & Trauma-Informed services.	Site Managers, Care Coordinators, and/or administrative staff.	7/1/2025	6/30/2028
	Accomplishment or Update				
	d	Use GetCare data to track the number of Native Americans being served.	Site Managers, Care Coordinators, and/or administrative staff.	7/1/2025	6/30/2028
	Accomplishment or Update				

Goal: Increase coordination with planning and development

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Have opportunities for Tribal members to serve on our Advisory Councils and our Board	a	Reach out to Tribal leaders and Tribal Emergency Management when an opening comes up on either board.	Site Managers, Care Coordinators, and/or administrative staff.	7/1/2025	6/30/2029
	Accomplishment or Update				

Goal: Increase coordination with planning and development

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Attend Tribal sponsored events once a year	a	CCNO staff to gather dates of Tribal sponsored events	Coordinators, and/or administrative staff.	7/1/2025	6/30/2029
	Accomplishment or Update				
	b	Key staff to reach out to Tribes for permission to attend events.	Coordinators, and/or administrative staff.	7/1/2025	6/30/2029
	Accomplishment or Update				
	c	Staff document each event attended with write up conversation to their supervisor.	Coordinators, and/or administrative staff.	7/1/2025	6/30/2029
	Accomplishment or Update				

SECTION D – OPI AND OPI-M SERVICES AND METHOD OF SERVICE DELIVERY

Administration of Oregon Project Independence (OPI) and Oregon Project Independence – Medicaid (OPI-M)

Administration of Oregon Project Independence (OPI):

a. What are the types and maximum amounts of authorized services offered?

Oregon Project Independence and the new OPI-M waiver program are designed to provide in-home care services to older adults who are 60 years of age and older, or those under 60 years of age who have a physical disability that are at risk of being placed in a licensed care facility prematurely and are not eligible for Medicaid. Services offered are assisted technology, Home Care, and Home Delivered Meals. Individuals interested in OPI or OPI-M must be residing in or returning to their home. CCNO will provide services for Service Priority Level (SPL) 1-18 through the CA/PS assessment process in Oregon Access. OPI consumers will receive 8 to 24 authorized ADL/IADL's hours a month based on their SPL score. OPI-M consumers will receive up to 20 hours per week or 40 hours per pay period based on their OPI-M Person Led Assessment and Notice (PLAN). Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL's) hours will be assigned with the person-centered and natural supports care plan to assist with health and safety while allowing the senior to remain in their home. CCNO will provide Home & Personal care and Services Coordination for OPI. Based on OPI funding Home Delivered Meals, assistive technology devices, or chore service may be provided on the OPI program. OPI/VA will provide the same services as OPI with additional respite care as authorized by the VA. OPI-M waiver services are determined by Oregon Administrative Rules (OAR) 411-014-0000.

b. State the cost of authorized services per unit.

The OPI Income/Fee Determination Record form 287K will be utilized to determine whether the consumer will have a co-payment or a one-time fee. The OPI Fee Schedule (which is updated annually by the State of Oregon) will be used to determine what percentage of co-pay the consumer will have. The full hourly rate of the Homecare Worker (HCW) is set by the collective bargaining agreement with Local 503 SEIU. The current rate is \$20.00 per hour and up depending on the HCW CBA. The OPI Service Agreement form 287L is a signed agreement for maximum monthly co-pay or the one-time \$25.00 fee based on income determination.

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

CCNO has Care Coordinators (CC) in each of our four-county offices. The CC's will contact consumers inquiring about OPI services on the same day, if possible, or within one business day. The CC's will provide I&A to discuss the consumer's needs. This information

will be entered into ADRC Get Care/RTZ. The CC will explain the OPI eligibility process as well as other programs for which the consumer may be eligible. If funding is available, an OPI CA/PS Assessment will be scheduled and completed in the consumer's home within one week of the initial phone conversation. After completion of the CA/PS assessment, a consumer will receive a notice of eligibility or non-eligibility by phone, a letter will be mailed the same day as the phone call. If funding is not available, the consumer will be placed on the OPI Wait List and offered Options Counseling for other services.

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

Senior consumers or their family members who are inquiring about services are entered into ADRC Get Care/RTZ through the I&R informational system by the Care Coordinator. Here, demographics are entered and service referrals are provided. If the consumer is eligible for or would like to learn more about Medicaid services, he/she is referred to the local Aging and People with Disabilities office. Community Connection Care Coordinators contact their consumers at least every three months to see if there have been any changes in the consumers' needs. If a consumer requests services, such as Medicaid, or has a new need for which CCNO is not able to provide, a referral will be made to one of our several community partners. Our Care Coordinators will enter Get Care data and select a three month follow up call.

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

CCNO follows the Oregon Administrative Rule (OAR) 411-032-0020 for determining eligibility. Our Care Coordinators complete an OPI CA/PS assessment, within consumers' homes for initial screening and yearly reviews. These CA/PS assessments determine a consumer's Service Priority Level and eligibility for OPI. Consumers with a SPL ranging from 1 to 18 are determined eligible by the Care Coordinators. We provide the OPI program to our senior Veterans who have been identified by the Veterans Administration for the in-home care program. All senior Veterans must meet OPI criteria guidelines to qualify. No consumer with a SPL of 99 will qualify for OPI services. They will be placed on the OPI Wait List (OPI waitlist protocols are subject to change due to State revisions pending) to be reviewed by our Care Coordinators on a quarterly basis as funding allows.

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

State Certified Home Care Workers with active State Provider Numbers can only provide services for the OPI program and OPI/VA program in the home of the consumer. If OPI or OPI/VA consumers already have a state certified approved HCW, that HCW can be added to the service plan. The Care Coordinator will refer the consumer to The ARC of Oregon who contracts with Employer Resource Connection through the Oregon Home Care Commission to hire a HCW through the Carina Program. Once hired, an HCW will work directly for the consumer and only work the number of hours assigned to the consumer

approved by the Care Coordinator for OPI or OPI/VA Program. The OPI or OPI/VA consumer and HCW sign a Task List (598) which identifies hours and duties as the contractual agreement. The HCW must utilize the OR PTC DCI system to record hours worked to be Electronic Verification Visit (EVV) compliant as determined in the Local 503 SEIU contractual agreement. These hours are determined or approved by OPI or VA authorization based on the consumer's service priority level and VA authorized hours. Any hours worked in addition to the service plan, CCNO will not pay. The consumer will pay the additional hours as private pay hours. This information is communicated to the consumer at the planning meeting of the Service Benefit Plan prior to services beginning. A letter is sent to both the consumer and the HCW explaining how if additional hours are needed, private pay can be utilized. Narration in OA and copies of letters are stored in the consumers case file.

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

When prioritizing consumers on the OPI Wait List, CCNO's Care Coordinators will utilize OAR 411-032-0020 prioritization rules as well as:

1. Select consumer from the OPI Waiting List based on highest risk level.
2. If two or more consumers have the same Risk Level, the person with the most need will be selected first based on:
 - a. The consumer is a person with Alzheimer's or a related disorder, such as Dementia.
 - b. The consumer has a Chronic Medical Condition.
 - c. Consumer is low-income; and/or availability or lack of a support network.
3. If two or more consumers have the same Risk Level, but do not have any distinguishing needs listed on the OPI Waiting List Tool, the consumer who was placed on the Waiting List first will be selected.

Once a consumer is selected from the OPI Waiting List Tool, an in-home CA/PS assessment will be completed within one week. Care Coordinators will place a consumer on OPI if his/her service priority level is 1-18 as long as funding is available.

Existing OPI consumers will have priority for services over consumers on the OPI Waiting List. When determining how many hours a consumer is eligible for, Care Coordinators will use the following example:

Example: If a consumer has a SPL of 11, he/she would be eligible for 9-15 hours per month. Keeping in mind the HCW is on a two-week voucher system and odd numbers are not applicable to the system and must be entered in whole hours. If funding allows, Care Coordinators will provide the consumer with the maximum number of hours for which he/she is eligible.

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

OPI services are denied for a consumer when his/her CA/PS assessment determines he/she does not have a service priority level of 1-18, is no longer residing in the county, has moved to a licensed care facility, or is under the age of 60. If services are denied, service hours are reduced, or services are terminated, our Care Coordinators will mail a letter explaining the reason along with information on the grievance process. We call prior to the letter so they know it is coming. When appropriate, Care Coordinators will refer the consumer to Seniors and Persons with Disabilities for Medicaid services. When a consumer has been denied services or has a reduction or termination of services, Care Coordinators will offer the consumer Options Counseling and help in gaining alternative services. CCNO also has a grievance policy in place.

When faced with OPI budgetary shortfalls per county or overall agency, a reduction or termination of services may be put into place. If this occurs, Care Coordinators will notify consumers by phone and in writing explaining the reasoning for the reduction. CCNO will strive to keep as many consumers as possible on the OPI services by first reducing each consumer to the lowest eligible hours based on their service priority level. If termination of OPI services must occur, consumer with the highest SPL 10-18 will have their services terminated first. When any reduction or termination of hours occurs due to budget constraints, Care Coordinators will work with each consumer and refer them to other organizations and services which may be able to assist them until funding is restored. We can also offer Options Counseling to the client.

i. Specify the agency's policy for informing consumers of their right to grieve adverse eligibility, service determination decisions and consumer complaints.

When a grievance is requested via verbal or written, the Senior Service Manager will review the consumer's case file and set up a Grievance Review Meeting within three business days of the request. The Senior Services Manager will notify the consumer via written letter and telephone conversation that grievance has been received with date, time, and location of the meeting. After the meeting, the Senior Services Manager has ten (10) days to prepare a written statement about the decision. The consumer is then able to file a grievance with the Executive Director. The Executive Director has ten (10) days to prepare a written statement about the decision. If the grievance is filed due to a reduction of hours or termination of services (unless due to budgetary shortfalls) the consumer's services will be extended for 30 days during the grievance review period.

Grievance Policy: (For denial of new, continued services, reduced service hours). Upon denial of new or continued services, you are entitled to request a grievance. The Senior Services Manager must receive a request for a Grievance within 30 days of the date of this letter. The Executive Director will review in the event of no resolution. If all parties cannot reach a sound conclusion you have a right to an Administrative Review through Oregon Department of Human

Services (ODHS) per OAR 411-032-0020(4) (c). You have the right to a representative present. If you would like more information on the Grievance process, please contact the Senior Services Manager at 541-963-3186 or if you have questions or concerns.

j. Explain how fees for services will be developed, billed, collected and utilized.

Consumers with a monthly fee for service on OPI will be charged a percent of the hourly State Homecare Worker's (HCW) fees. Consumer fees are based on the household's Adjusted Gross Income (AGI) and number of people living in the household. The consumer's AGI is determined by utilizing the "Oregon Project Independence (OPI) Income/Fee Determination Record 287K" by subtracting all eligible medical deductions from the household's total gross income. The AGI is then compared to the annual "OPI Fee Schedule" (annually adjusted) to determine the consumer's monthly fee for service. Each consumer's AGI and fee for service is reviewed annually.

Example: A HCW's hourly wage is \$20.67 per hour and works for the OPI client for 15 hours per month; a total of \$310.05 a month. The OPI consumer's monthly fee for service is five (5%) percent of the total HCW's monthly payment. In this case, the OPI consumer will be charged \$15.50 per month.

At the end of each month, once all Oregon Provider Time Capture Direct Care Innovations – Electronic Verification Visit (OR-PTC DCI-EVV) entries from HCW's are received for the calendar month, CCNO's Care Coordinators will mail an invoice stating the consumer's fee for service for the month and the due date. Fees for service are due two weeks from the date the letter was mailed. Billable amounts cannot exceed their signed OPI Service Agreement form 287L.

Once a consumer's fee for service is recorded, copies of the payment form, date, amount paid, and narration of bill are placed in the consumer's file and in OA Narration. The payment is then recorded into the office incoming monies folder for deposit. Other staff within each county office will deposit the payment on the same day. All collected fees for service are then credited to the OPI program.

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

Community Connection's policy for non-payment of fees for services is included in the consumer's income assessment along with his/her hourly co-pay amount. It states that consumers with charges past due by two (2) months are in danger of having their services terminated. If the consumer is struggling to pay his/her monthly fee for service, due to increased medical expenses, he/she may request an early income assessment. If it is determined the consumer is unable to pay all or part of their past due fees for service,

Community Connection may waive the fee. If it is determined that the consumer is able to pay the past due fees, but refuses to make payments, services will be terminated within two weeks of determination. This is supported by the Oregon Project Independence Service Agreement (287L). Termination of services or payment plans to bring current are reviewed with the Senior Service Manager on a case-by-case basis. Senior Services Manager will counsel with the consumer to see if sponsorship is available by their natural support to bring OPI fees current or sponsor monthly. Oregon Administration Rule (OAR) 411-032-0044 identifies how fee is determined. (OAR) 461-160-0610 and (OAR) 461-160-0620 states why monthly payments are required. Each consumer will receive a copy of his/her income assessment at the start of services showing the determination of fees for service. Narration in OA is required.

l. Delineate how service providers are monitored and evaluated.

Community Connection utilizes State Home Care Workers (HCW) through the Home Care Commission (HCC) under the Client-Employed Provider Program. Before OPI or OPI-M services begin, all OPI or OPI-M consumers or an authorized representative (this cannot be the HCW) must complete a “Client-Employed Provider Program Participation Agreement” (form SDS 0737). This form states the consumer understands that receiving services through the Client-Employed Provider Program requires him/her to be able to take on the responsibilities as the employer of the HCW, which includes monitoring and evaluating the HCW’s performance. If a consumer is unable to perform tasks required of the Client-Employed Provider Program and does not have an authorized representative, Community Connection cannot provide OPI or OPI-M services to the consumer.

Although Community Connection does not act as the direct employer of HCW’s, if a Care Coordinator has concerns about a HCW and their ability to perform tasks or is concerned the HCW is taking advantage of an OPI or OPI-M consumer, a report will be made with Adult Protective Services (APS) HCC and the Senior Service Managers. The Care Coordinator will also speak with the OPI or OPI-M consumer to see if he/she has concerns of his/her own that need to be addressed with APS, HCC and/or the Senior Services Manager. For OPI consumers at least quarterly the OPI case manager will conduct an in-home visit or phone conversation with the OPI consumer to get a status update on how services are going. This can also be on a more regular basis if requested by the consumer or due to complexity of care. This will be narrated in OA consumer case. For OPI-M frequency of status update is determined at time on PLAN along with narrated in OA consumer case and on OPI-M Service Tracker and risk mitigation.

m. Delineate the conflict of interest policy for any direct provision of services for which a fee is set.

See attached Appendix G Conflict of Interest Policy.

n. Explain if the AAA will make any changes to the above policies with the implementation of Oregon Project Independence-Medicaid (OPI-M)

Community Connection is not a service provider for the OPI pilot for 18-59 years of age. Once OPI-M is open and available to the public in the spring of 2025, all individuals age 60 or older requesting in-home care services will be screened for OPI, OPI-M and Options Counseling.

Individuals ages 18-59 will be referred to APD for Choice Counseling and Program Consultation for OPI-M and LTSS.

o. Describe if the AAA prioritizes the following populations when a waitlist is not in effect: older adults in rural areas, those who speak languages other than English, LGBTQIA2S+ older adults, Tribal elders and older adults living with HIV/AIDS.

Yes, we ensure that seniors or family meet OPI eligibility and if funding is available. We do not turn anyone away. Eligibility criteria is the driving force of who receives the services.

SECTION E – AREA PLAN BUDGET

See attached Area Plan Budget – Attachment A

APPENDICES

See attached Appendix A, B, C, D, F, G, H, and J

ATTACHMENT A

SECTION E: AREA PLAN BUDGET

(3)	(4)	(5)					(6)	(7)	(8)	OAA											(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
Matrix	SERVICE NAME	Contract or Direct Provide	Estimated Units	Unit Definition	Estimated Clients	T III B	T III C-1	T III C-2	T III D	T III E	T VII	OAA Total	NSIP	COVID Relief (ARP, VACS and SLFRF)	OPI (Classic and/or Pilot)	Other State-provided Funds	Other Cash Funds	Total Funds	Estimated Cost Per Unit	Comments								
FAMILY CAREGIVER SUPPORT																												
	15/15a Caregivers Information Services / Information and	D	76.00	1activity	320																							
	16/16a Caregiver Case Management	D	150.00	1contact	50																							
	30-5/5a Caregiver Respite	D	1814.00	1hour	35																							
	30-6/6a Caregiver Support Groups			1session																								
	30-7/7a Caregiver Supplemental Services	D	2.00	1payment	2																							
	70-2a/2b Caregiver Counseling	D	35.00	1client served	126																							
	70-9/9a Caregiver Training	D	36.00	1session	6																							
	73/73a Caregiver Self-Directed Care			1client served																								
SOCIAL & HEALTH SERVICES																												
40-2	Health Promotion: Evidence-Based	D	155.00	1session	85																							
50-1	Elder Abuse Prevention (50-1	D	44.00	1activity	8																							
50-1	Guardianship/Conservatorship, 50-3 Elder Abuse	D		1activity																								
50-3	Elder Abuse Awareness and Prevention	D	25.00	1activity	12																							
50-4	Crime Prevention/Home Safety			1activity																								
60-4	Volunteer Services			1hour or activity																								
60-1	Other Services (60-1 Recreation; 70-8 Fee Based	D	6070.00	1hour or activity	542	\$15,000						\$15,000																
71	CM; 80-5 Money Management; 80-6 Center	D	36.00	1session	6																							
72	Chronic Disease Prevention, Management & Ed	D		1client served																								
	Self-Directed Care			1client served																								
80-1	Senior Center Assistance			1hour or activity																								
80-4	Consumable Services			1hour or activity																								
80-5	Money Management			1hour or activity																								
80-6	Center Renovation/Acquisition			1center acquisition																								
900	Computer Technology Expense			1payment/activity																								
901	Other (specify)																											
901	Other (specify)																											
901	Other (specify)																											
GRAND TOTAL						\$134,689	\$127,940	\$83,715	\$7,400	\$61,910	\$1,550	\$417,204	\$66,000	\$0	\$278,300	\$0	\$645,750	\$1,407,254										

Cash Match/In-kind Match

(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
SOURCE OF OAA CASH & INKIND MATCH FUNDS Be descriptive (e.g. Donated dining space @ SC)								
Inkind - Home-Delivered Meals	Admin. Cash Match	Inkind Match	III B & C Cash Match	III B & C Inkind Match	OAA III E Cash Match	III E Inkind Match	TOTAL Cash Match	TOTAL Inkind Match
Inkind - Congregate Meals				\$58,000			\$0	\$58,000
Inkind - Administration		\$25,000		\$120,000			\$0	\$120,000
Inkind - Physical Activity & Fall Prevention				\$1,500			\$0	\$25,000
Inkind - Prevention Screening, Counseling & Referral				\$12,000			\$0	\$1,500
OPI - Caregiving					\$20,000		\$20,000	\$12,000
Fundraising			\$11,600				\$11,600	\$0
Donations			\$22,000				\$22,000	\$0
Under 60 Meals			\$12,000				\$12,000	\$0
Rebate Income			\$850				\$850	\$0
Entrée Donations			\$52,000				\$52,000	\$0
Senior's Inc.			\$3,800				\$3,800	\$0
Other Income			\$2,000				\$2,000	\$0
Column Totals:		\$0	\$25,000	\$191,500	\$20,000	\$0	\$124,250	\$216,500

(12)	(13)
SOURCE OF MEDICAID LOCAL MATCH FUNDS	TOTAL
Column Totals:	\$0

Notes/Comments

Medicaid/OAA/OPI/OPI-M Staffing Plan

ADMINISTRATIVE POSITIONS				Breakout of funding sources										
(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
Position Title	FTE	Annual Salary (excludes OPE)	Annual OPE	Total Salary + OPE	OAA Funds	OPI Funds	OPI-M Funds	Other Funds	Medicaid Funds Regular Allocation	Medicaid Funds Local Match	Medicaid Matched by Local Funds	Total		
	Worked													
Executive Director	1.00	119,674.00	40,689.00	160,363.00	12,829.00	3,207.00	1,100.00	144,327.00				\$161,463		
Assistant Director	1.00	113,804.00	38,693.00	152,497.00	12,200.00	3,050.00		137,247.00				\$152,497		
Fiscal Director	1.00	79,462.00	27,017.00	106,479.00	8,518.00	2,130.00	3,800.00	95,831.00				\$110,279		
HR Manager	1.00	89,381.00	30,390.00	119,771.00	9,582.00	2,395.00	596.00	107,794.00				\$120,367		
HR Specialist	1.00	49,275.00	16,754.00	66,029.00	5,282.00	1,321.00	500.00	59,426.00				\$66,529		
Executive Assistant	1.00	46,704.00	15,879.00	62,583.00	5,007.00	1,252.00		56,324.00				\$62,583		
Fiscal Assistant - AP	1.00	64,401.00	21,896.00	86,297.00	6,904.00	1,726.00	4,500.00	77,667.00				\$90,797		
Fiscal Assistant - AR & PR	1.00	57,866.00	19,674.00	77,540.00	6,203.00	1,551.00	6,500.00	69,786.00				\$84,040		
Fund Accountant	1.00	61,937.00	21,059.00	82,996.00	6,640.00	1,660.00	3,300.00	74,696.00				\$86,296		
				\$0								\$0		
				\$0								\$0		
				\$0								\$0		
				\$0								\$0		
				\$0								\$0		
				\$0								\$0		
ADMINISTRATIVE TOTAL	9.00	\$682,504	\$232,051	\$914,555	\$73,165	\$18,292	\$20,296	\$823,098	\$0	\$0	\$0	\$934,851		

DIRECT SERVICES POSITIONS												
Position Title	FTE Worked	Annual Salary (excludes OPE)	Annual OPE	Total Salary + OPE	OAA Funds	OPI Funds	OPI-M Funds	Other Funds	Medicaid Funds Regular Allocation	Medicaid Funds Local Match	Medicaid Matched by Local Funds	Total
Senior Services Manager	1.00	73,528.00	20,604.00	94,132.00	46,124.00	20,643.00	27,365.00					\$94,132
Baker County Manager	1.00	84,346.00	28,678.00	113,024.00	4,521.00	-	-	108,503.00				\$113,024
Baker Self Sufficiency Coordinator	1.00	51,975.00	17,672.00	69,647.00	696.00	-	-	68,951.00				\$69,647
Baker Office Specialist	1.00	51,760.00	17,598.00	69,358.00	13,872.00	-	-	55,486.00				\$69,358
Baker Care Coordinator	1.00	32,929.00	11,196.00	44,125.00	17,650.00	1,562.00	16,088.00	24,913.00				\$60,213
Baker Head Cook	1.00	48,354.00	16,440.00	64,794.00	58,315.00	-	-	6,479.00				\$64,794
Baker Assistant Cook	0.88	35,482.00	12,064.00	47,546.00	42,791.00	-	-	4,755.00				\$47,546
Baker Kitchen Assistant	0.60	18,870.00	6,416.00	25,286.00	22,757.00	-	-	2,529.00				\$25,286
Union County Manager	1.00	75,284.00	25,597.00	100,881.00	4,035.00	-	-	96,846.00				\$100,881
Union Care Coordinator	1.00	55,724.00	18,946.00	74,670.00	747.00	18,668.00	27,844.00	27,411.00				\$74,670
Union Office Specialist	0.60	31,056.00	10,559.00	41,615.00	8,323.00	-	-	33,292.00				\$41,615
Union Head Cook	1.00	48,354.00	16,440.00	64,794.00	58,315.00	-	-	6,479.00				\$64,794
Union Assistant Cook	1.00	40,320.00	13,709.00	54,029.00	48,626.00	-	-	5,403.00				\$54,029
Union Kitchen Assistant	0.38	11,951.00	4,063.00	16,014.00	14,413.00	-	-	1,601.00				\$16,014
Union Kitchen Assistant	0.25	9,635.00	3,276.00	12,911.00	11,620.00	-	-	1,291.00				\$12,911
Union Self Sufficiency Coordinator	1.00	57,866.00	19,674.00	77,540.00	775.00	-	-	76,765.00				\$77,540
Wallowa County Manager	1.00	72,092.00	24,511.00	96,603.00	3,864.00	-	-	92,739.00				\$96,603
Wallowa Office Specialist	1.00	51,760.00	17,598.00	69,358.00	13,872.00	-	-	55,486.00				\$69,358
Wallowa Care Coordinator	1.00	52,832.00	17,963.00	70,795.00	708.00	17,699.00	9,900.00	42,488.00				\$70,795
Wallowa Head Cook	0.60	28,357.00	9,641.00	37,998.00	34,198.00	-	-	3,800.00				\$37,998
Enterprise Head Cook	0.60	27,110.00	9,217.00	36,327.00	32,694.00	-	-	3,633.00				\$36,327
Wallowa Assistant Cook	0.48	20,711.00	7,042.00	27,753.00	24,978.00	-	-	2,775.00				\$27,753

ATTACHMENT C

SERVICE MATRIX & DELIVERY METHOD

SERVICE MATRIX and DELIVERY METHOD

Instructions: Indicate all services provided, method of service delivery and funding source. (The list below is sorted alphabetically by service.)

☐ **#5 Adult Day Care**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#20-2 Advocacy**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#9 Assisted Transportation**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#16/16a Caregiver Case Management**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#70-2a/70-2b Caregiver Counseling**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#15/15a Caregiver Information Services/Information and Referral**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#30-5/30-5a Caregiver Respite**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#73/73a Caregiver Self-Directed Care**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#30-7/30-7a Caregiver Supplemental Services**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#30-6/30-6a Caregiver Support Groups**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#70-9/70-9a Caregiver Training**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#6 Case Management**

Funding Source: ☐ OAA ☒ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#3 Chore (by agency)**

Funding Source: ☒ OAA ☒ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#3a Chore (by HCW)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☒ **#7 Congregate Meals**

Funding Source: ☒ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#80-4 Consumable Services**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#50-1 Elderly Abuse Prevention (50-1 Guardianship/Conservatorship; 50-3 Elder Abuse Awareness & Prevention; 50-4 Crime Prevention/Home Safety; 50-5 LTCO)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#40-4 Health Promotion: Evidence-Based (Access)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#40-2 Health Promotion: Evidence-Based (40-2 Physical Activity and Falls Prevention; 40-4 Mental Health Screening and Referral; 71 Chronic Disease Prevention, Management/Education)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☒ **#40-3 Health Promotion: Non-Evidence-Based (Access) (40-3 & 40-4)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#40-5 Health Promotion: Non-Evidence-Based (In-Home) (40-5 & 40-8)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#4 Home Delivered Meals**

Funding Source: ☒ OAA ☒ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#30-1 Home Repair/Modification**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#2 Homemaker (by agency)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#2a Homemaker (by HCW)** Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ **#13 Information & Assistance**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#60-5 Interpreting/Translation**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#11 Legal Assistance (50-1 Guardianship/Conservatorship; 50-3 Elder Abuse Awareness & Prevention; 50-4 Crime Prevention/Home Safety; 50-5 LTCO)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Legal Aid Services of Oregon, P.O. Box 1327 Pendleton, OR. 97801; Oregon Law Center, 2449 SW 4th Ave. Suite 208 Ontario, Oregon 97914

☒ **#8 Nutrition Counseling**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#12 Nutrition Education**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#70-2 Options Counseling**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#900 Other – Computer Technology Expense**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#60-1 Other Services (60-1 Recreation; 70-8 Fee Based CM; 80-5 Money Management; 80-6 Center Renovation/Acquisition)**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#70-8 Other Services - Fee-based Case Management - Access**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#901 Other (specify)** Health, Medical and Technical Assistive Equipment

Funding Source: ☒ OAA ☒ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#14 Outreach (14 Outreach; 70-5 Newsletter; 70-10 Public**

Outreach/Education)

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#1 Personal Care (by agency)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds ☐ Other (describe):

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#1a Personal Care (by HCW)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds ☐ Other (describe):

☒ **#20-3 Program Coordination & Development**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☒ **#60-3 Reassurance**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

☐ **#30-4 Respite Care - Other (IIB/OPI)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#72 Self-Directed Care**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#80-1 Senior Center Assistance**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#10 Transportation**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#60-4 Volunteer Services**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is “for-profit” agency):

☐ **#90-1 Volunteer Services (In-Home)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

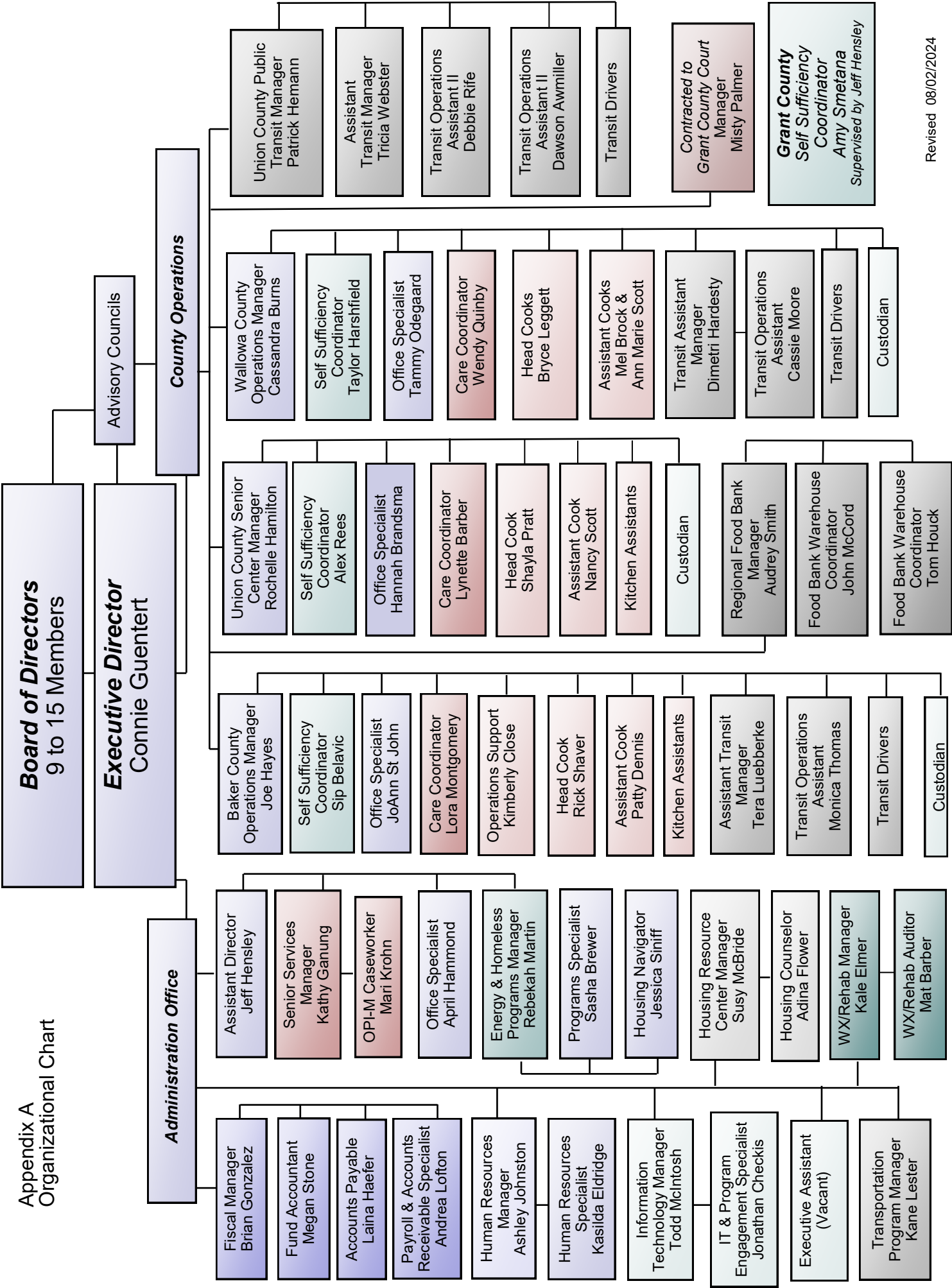
Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency):

APPENDIX A

ORGANIZATIONAL CHART

COMMUNITY CONNECTION OF NORTHEAST OREGON, INC.

Appendix A
Organizational Chart



APPENDIX B

ADVISORY COUNCILS & GOVERNING BODY

Appendix B Advisory Council(s) and Governing Body

Community Connection of Northeast Oregon, Inc. Board of Directors - FY' 2025

Name	Phone Number	Represents	Term Expires
Steve McClure - Board Chair	Home: (541) 605-0013 Cell: (541) 786-2462	Union County Low-Income Sector	1/31/2025
Scott Myers - Board Vice-Chair	Work: (541) 575-0059 Cell: (541) 620-4022	Grant County Public Sector	Indefinite
Bruce Nichols - Treasurer	Cell: (541) 403-2525	Baker County Public Sector	Indefinite
Doug Gaslin	Cell: (541) 319-1382	Baker County Private Sector	4/30/2025
John Hillock	Work: (541) 426-4543 Cell: (541) 398-0141	Wallowa County Public Sector	Indefinite
Barbara McCormack	Home: (541) 605-8233	Wallowa County Low-Income Sector	6/30/2026
Julie Kay Dudley	Cell: (541) 786-5087	Union County Low-Income Sector	4/30/2025
Roswitha Parks - Secretary	Cell: (541) 910-0521	Wallowa County Private Sector	4/30/2025
Elsie Pellissier	Home: (541) 523-7095	Baker County Low-Income Sector	6/30/2025
Matt Scarfo	Work: (541) 963-1001 Cell: (541) 786-4887	Union County Public Sector	Indefinite
Jim Hicks	Home: (541) 263-0059	Wallowa County Private Sector	7/31/2025
Dan Seaman	Home: (541) 568-4702 Cell: (541) 786-0114	Union County Private Sector	5/31/2026

Community Connection of Northeast Oregon, Inc. Baker County Advisory Council - FY' 2025

Name	Phone Number	Represents	Term Expires
Elsie Pellissier - Chair	Home: (541) 910-0521	Baker County	6/30/2026
Phyllis Hammer - Secretary	Cell: (541) 403-2772	Baker County	6/30/2026
Mary Jo Carpenter	Cell: (541) 403-0335	Baker County	6/30/2025
Michael Shoemaker	Cell: (541) 403-0744	Baker County	6/30/2025
Kellie Taylor DHS-SPD Secretary	Work: (541) 523-5846	Baker County	6/30/2026
Terrie Evarts	Home: (541) 519-3495	Baker County	6/30/2026
Jim Kauth	Cell: (541) 519-0181	Baker County	6/30/2027
Rodney Hillman	Cell: (408) 221-9980	Baker County	6/30/2026
Betty Hillman	Cell: (408) 687-8423	Baker County	6/30/2026
Steve Perlain	Cell: (503) 309-3269	Baker County	6/30/2027
Michelle Asaspa	Cell: (503) 396-8146	Baker County	6/30/2027

Community Connection of Northeast Oregon, Inc.
Union County Advisory Council - FY' 2025

Name	Phone Number	Represents	Term Expires
Daniel Seaman - Chair	Home: (541) 568-4702 Cell: (541) 786-0114	Union County	5/31/2027
Carol Gunnels	Home: (541) 963-8381	Union County	5/31/2027
Dyann Seaman	Home: (541) 568-4702	Union County	5/31/2027
Judy Sherman	Home: (541) 963-6474	Union County	1/31/2027
Jean Spence	Cell: (541) 656-6630	Union County	1/31/2027
Kay Durham	Home: (541) 962-1002	Union County	3/31/2027

Community Connection of Northeast Oregon, Inc.
Wallowa County Advisory Council - FY' 2025

Name	Phone Number	Represents	Term Expires
Jim Hicks, Jr. - Chair	Cell: (541) 263-0059	Wallowa County	7/1/2025
Jane Dunn - Vice Chair	Home: (541) 263-0078	Wallowa County	7/1/2025
Paul Pelley	Cell: (407) 461-1322	Wallowa County	1/31/2025
Gail Pelley - Treasurer	Cell: (407) 461-1322	Wallowa County	7/1/2025

Community Connection of Northeast Oregon, Inc.
Grant County Advisory Council - FY' 2025

Name	Phone Number	Represents	Term Expires
Gwynne Wulfert	Cell: (416) 212-2978	Grant County	6/30/2027
Bonnie Booth - Secretary	Cell: (503) 507-7060	Grant County	6/30/2026
Janet Binger - Chair	Cell: (541) 620-3870	Grant County	6/30/2025
Mark Webb	Cell: (541) 620-2546	Grant County	6/30/2026

Total number age 60 or over = 33

Total number of minorities = 0

Total number rural = 37

Total number self-indicating having a disability = 0

APPENDIX C

PUBLIC PROCESS

Appendix C – Public Process

Communities were given 30-day notice for public input on the Area Plan. Meetings were held in each of our four counties to gather feedback on the Area Plan. The public meetings were announced in the East Oregonian, and our Facebook pages, and held at the following sites with number of attendees and their comments.

Baker County meeting on October 30th at 12:30 p.m.
Baker County Senior Center, 2810 Cedar Street, Baker City, Oregon 97814

Attendees: 13 Community Connection Staff: 4

Comments: More food bank access, more options for no cost out of town transportation, affordable housing for seniors, not just low-income, but medium-income, More weatherization assistance, dental assistance, classes for seniors on how to use cell phones, zoom, technology and safety, continue the meal program, it is excellent and helpful, continue the transportation program, add a respite program for full time caregiver, and high need for homecare workers.

Grant County meeting on October 24th at 12:30 p.m.
John Day Senior Center, 142 NE Dayton St., John Day, Oregon 97845

Attendees: 15 Community Connection Staff: 4

Comments: More options for no cost out of town transportation and meal site bus, more in-home caregivers, affordable housing for seniors, more affordable housing for the workforce to keep the business, lack of medical providers, no mental health available, more legal aid/affordable attorneys, need volunteers at the senior centers, and more funding to support three senior centers with more food, activities, and community involvement.

Union County meeting on October 29th at 12:30 p.m.
Union County Senior Center, 1504 Albany Street, La Grande, Oregon 97850

Attendees: 12 Community Connection Staff: 4

Comments: Need for weatherizing older homes and mobile homes in parks, more in-home caregivers, affordable housing for seniors, no affordable housing for people if the work, people can't see doctors for months for medical issues, and need for energy assistance.

Wallowa County meeting on October 21st. at 12:30 p.m.
Enterprise Senior Center, 702 NW First Street, Enterprise, Oregon 97828

Attendees: 5 Community Connection Staff: 4

Comments: More weatherization assistance, more options for out-of-town transportation, more in-home care, need for dental assistance, classes for seniors on phones, zoom and other technical stuff, need ambassadors for newcomers at the senior center, more networking with community partners, organizations, schools, etc. for seniors to get back into the community which will help with loneliness and socialization.

The Area Plan was presented in its entirety during each county's Advisory Council meeting for review, feedback and approval on:

- Baker County – November 19, 2024
- Grant County – December 3, 2024
- Union County – November 22, 2024
- Wallowa County – November 11, 2024

All feedback from public meetings and Advisory Councils was presented to our Board of Directors on January 26, 2025 for review and discussion. On this day, the board unanimously approved the 2025-2029 Area Plan.

Please see attached:

- Sign in sheets
- Public meeting flyers
- Facebook advertising meeting dates, location, times.

BAKER PUBLIC HEARING

Wednesday, October 30th

@12:30 pm



Baker County

Senior Center

2810 Cedar St, Baker City

**Community Connection
of Northeast Oregon, Inc.**

COMMUNITY NEEDS ASSESSMENT RESULTS

The Area Plan is an overview of senior services that CCNO provides and the service delivery systems for the next four years.

Community members are encouraged to attend and provide feedback to help improve senior programs in Baker County.

**If you have questions, please contact
Jeff Hensley, Assistant Director at 541-963-3186**



The Community Needs Assessment Survey has ended and we are holding a public hearing to re...



Post · Published on: Wed Oct 23, 12:30pm

Boost

Top performer

Continue getting results when you boost this post and spend \$7 each day

Estimated daily

results

560 - 1.6K

more reach

Boost

Feed preview



Community Connection of Baker County

Published by Jonathan Checkis

October 23 at 12:30 PM ·

Overview

Reach

870

Higher than typical

Impressions

949

Higher than typical

Interactions

7

Higher than typical

Link clicks

--

Community Needs Assessment Survey has ended, we are holding a public hearing to review the results and create our area plan for Baker County. The plan is an overview of senior services that CCN provides and the service delivery system for the next 5 years. Community members are encouraged to attend and provide feedback to help improve senior programs in Baker County.

Hope to see you there!

#cityoregon #communitysupport #seniorservices

Reach

800

600

400

200

0

15m

4h

9h

16h

1d 6h

BAKER PUBLIC HEARING

Wednesday, October 23 @ 12:30pm

Baker County Senior Center



Happening tomorrow! The Community Needs Assessment Survey has ended and we are holdin...



Post · Published on: Tue Oct 29, 5:00pm

Boost

Top performer

Continue getting results when you boost this post and spend \$7 each day

Estimated daily

results 560 - 1.6K more reach

Boost

Feed preview



Community Connection of Baker County

Published by Jonathan Checkis



· 6d ·

opening tomorrow!

Community Needs Assessment Survey has ended. We are holding a public hearing to review the results and create our area plan for Baker County. The plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to attend and provide feedback to help improve senior programs in Baker County.

hope to see you there!... See more

Overview

Reach

507

Higher than typical

Impressions

517

Higher than typical

Interactions

5

Higher than typical

Link clicks

--

Reach

600

400

200

0

15m

4h

9h

16h

1d

6h

3d



COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Baker City, Oregon Baker County DATE: 10/30/2024

PLEASE SIGN IN. THANK YOU.

Mary Jean Mauer

Bobbie Daugherty

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Baker City, Oregon Baker County DATE: 10/30/2024

PLEASE SIGN IN. THANK YOU.

James J. Regan

Walt Washington

Virginia Klein

Cheryl Martin

STAFF:

KATHY GANNING

JEFF HEUSLEY

JOE HAYES

LORA MONTGOMERY

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Baker City, Oregon Baker County **DATE:** 10/30/2024

PLEASE SIGN IN. THANK YOU.

Joanne Fletcher

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Baker City, Oregon Baker County DATE: 10/30/2024

PLEASE SIGN IN. THANK YOU.

Rayne Pleyron

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Baker City, Oregon Baker County DATE: 10/30/2024

PLEASE SIGN IN. THANK YOU.

See [unclear]

ANONYMOUS - REFUSED TO SIGN

//

//

//

//

//

//

GRANT PUBLIC HEARING

Thursday, October 31st

@1:00 pm



**Grant County
Senior Center**

142 NE Dayton St, John Day

**Community Connection
of Northeast Oregon, Inc.**

COMMUNITY NEEDS ASSESSMENT RESULTS

The Area Plan is an overview of senior services that CCNO provides and the service delivery systems for the next four years.

Community members are encouraged to attend and provide feedback to help improve senior programs in Grant County.

**If you have questions, please contact
Jeff Hensley, Assistant Director at 541-963-3186**



The Community Needs Assessment Survey has ended and we are holding a public hearing to re...

Post · Published on: Thu Oct 17, 5:00pm

Boost

Overview

Reach

102

Higher than typical

Impressions

111

Higher than typical

Interactions

2

Higher than typical

Link clicks

--

Feed preview



Community Connection of Grant County

Published by Jonathan Checkis

October 17 at 5:00 PM · 🌐

Community Needs Assessment Survey has ended, we are holding a public hearing to review the results and create our area plan for Grant County. The plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to attend and provide feedback to help improve senior programs in Grant County.

hope to see you there!

ndayoregon #communitysupport #seniorservice

Reach

200

150

100

50

0

15m

4h

9h

16h

1d 6h

3d

Facebook post reach

Typical

Interactions

Reactions

1

Comments

0

Shares

1

Saves

0

ANT PUBLIC HEAR

Thursday, October 3
@1:00 pm

Grant County
Senior Center



The Community Needs Assessment Survey has ended and we are holding a public hearing to re...

Post · Published on: Thu Oct 24, 5:00pm

Boost

Overview

Reach Impressions Interactions Link clicks

32

35

2

--

Typical

Typical

Higher than typical

Reach

40

30

20

10

0

15m

4h

9h

16h

1d

6h

3d

Typical Facebook post reach

Interactions

Reactions

Comments

Shares

Saves

1

0

1

0

Feed preview



Community Connection of Grant County

Published by Jonathan Checkis

October 24 at 5:00 PM

Community Needs Assessment Survey has ended, we are holding a public hearing to review the plan and create our area plan for Grant County. This plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to provide feedback to help improve senior programs in Grant County.

I hope to see you there!

#communitysupport #seniorservice

GRANT PUBLIC HEARING

Thursday, October 31 @ 1:00 pm

Grant County Senior Center



Happening tomorrow! The Community Needs Assessment Survey has ended and we are holdin...

Post · Published on: Wed Oct 30, 5:00pm

Boost

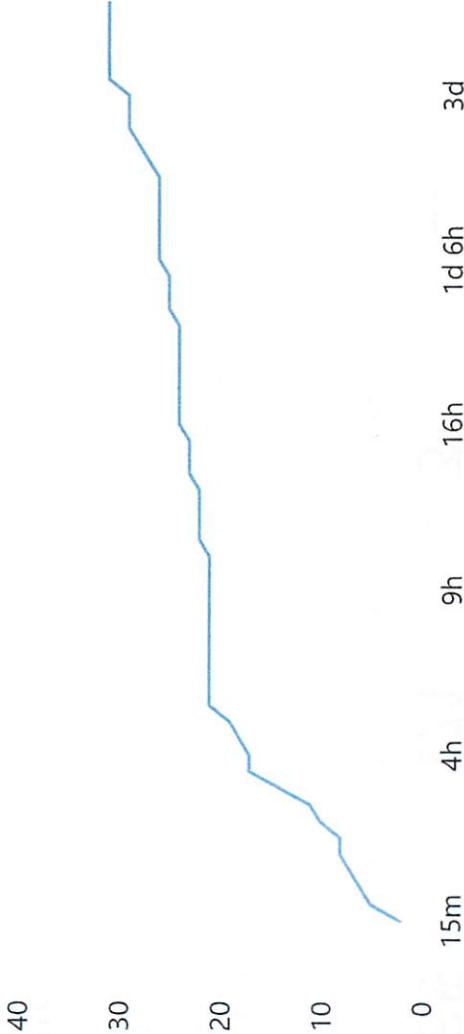
Overview

Reach Impressions Interactions Link clicks

31 32 1 --

Higher than typical Typical Typical

Reach



Interactions

Reactions Comments Shares Saves

1 0 0 0

Feed preview



Community Connection of Grant County

Published by Jonathan Checkis

5d · 🌐

opening tomorrow!

Community Needs Assessment Survey has ended! We are holding a public hearing to review the results and create our area plan for Grant County. The plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to attend and provide feedback to help improve senior programs in Grant County.

hope to see you there!... See more

ANT PUBLIC HEAR

Thursday, October 3 @1:00 pm

Grant County Senior Center

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: John Day, Oregon Grant County DATE: 10/31/2024

PLEASE SIGN IN. THANK YOU.

D. Shay Lewis

Misty Palmer

Jeanette Julsrud

Mark Webb

LauraBeth Walkenstein

Heather Swank

Carolyn Stout

Mya Ennis

LT Kuhl

Kayme Leary

Valeda Grant

Elsie Huskey

Janet Binger

Ginger Kendall

Sherley Dinsmore

Staff

Leff Hensley

Kathy Canung

Misty Palmer GC

D. Shay Lewis GC

UNION PUBLIC HEARING

Tuesday, October 29th

@12:30 pm



**Union County
Senior Center**

1504 N Albany St, La Grande

**Community Connection
of Northeast Oregon, Inc.**

COMMUNITY NEEDS ASSESSMENT RESULTS

The Area Plan is an overview of senior services that CCNO provides and the service delivery systems for the next four years.

Community members are encouraged to attend and provide feedback to help improve senior programs in Union County.

**If you have questions, please contact
Jeff Hensley, Assistant Director at 541-963-3186**



The Community Needs Assessment Survey has ended and we are holding a public h...



Post · Published on: Wed Oct 16, 5:00pm

Boost

Overview

Reach

165

Higher than typical

Impressions

171

Higher than typical

Interactions

3

Typical

Link clicks

--

Feed preview



Community Connection of Union County

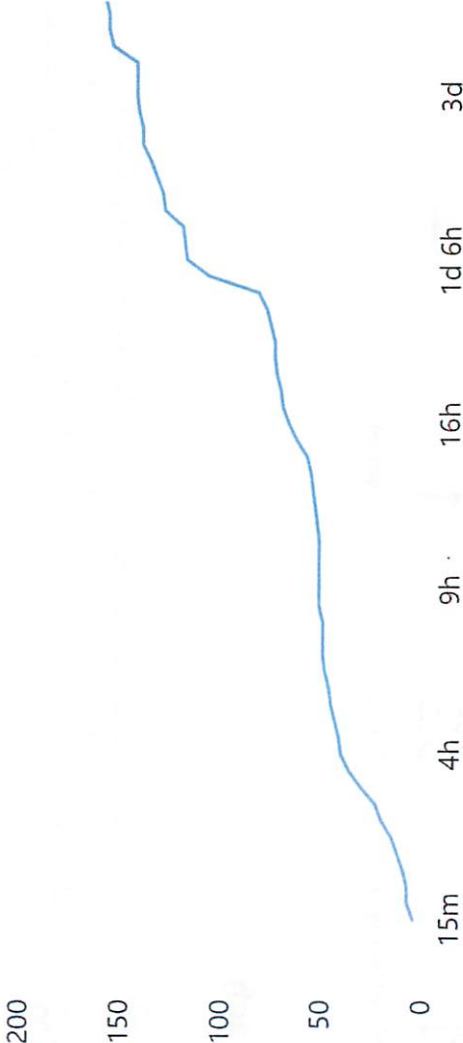
Published by Jonathan Checkis

October 16 at 5:00 PM · 🌐

Community Needs Assessment Survey has ended, we are holding a public hearing to review the plan and create our area plan for Union County. The plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to attend and provide feedback to help improve senior programs in Union County.

I hope to see you there!

[randeoregon](#) #communitysupport #seniorservi...



Facebook post reach

Interactions

Reactions

0

Comments

0

Shares

3

Saves

0





The Community Needs Assessment Survey has ended and we are holding a public h...



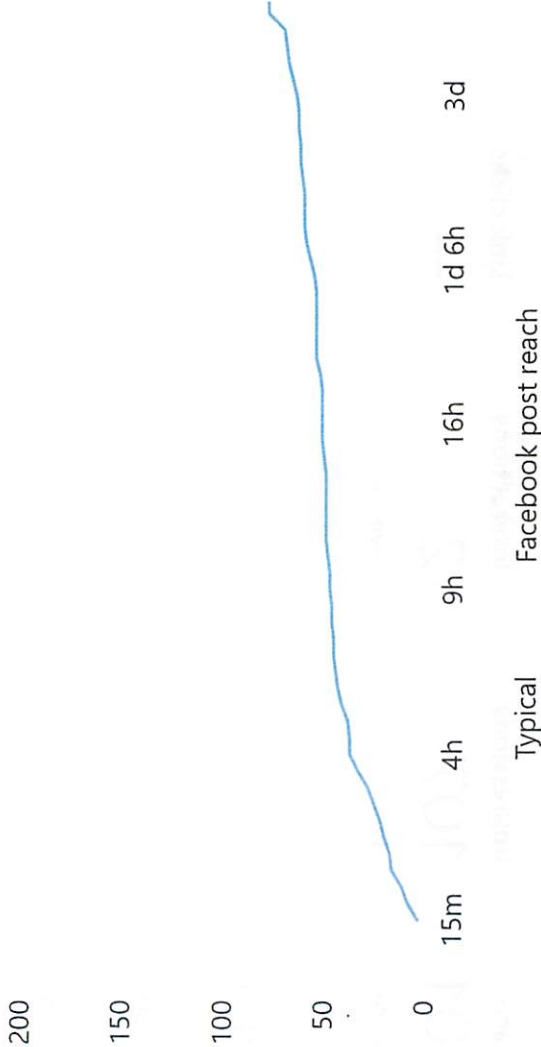
Post · Published on: Tue Oct 22, 12:30pm

Boost

Overview

Reach	Impressions	Interactions	Link clicks
85	87	2	--
Typical	Typical		

Reach



Interactions

Reactions	Comments	Shares	Saves
0	0	2	0

Feed preview



Community Connection of Union County

Published by Jonathan Checkis

October 22 at 12:30 PM · 🌐

Community Needs Assessment Survey has ended. We are holding a public hearing to review the results and create our area plan for Union County. The plan is an overview of senior services that CCN provides and the service delivery system for the next years. Community members are encouraged to attend and provide feedback to help improve senior programs in Union County.

Hope to see you there!

[randeoregon](#) [#communitysupport](#) [#seniorservice](#)





Happening tomorrow! The Community Needs Assessment Survey has ended and w...



Post · Published on: Mon Oct 28, 3:00pm



Boost

Overview

Reach

101

Typical

Impressions

107

Typical

Interactions

2

Typical

Link clicks

--

Feed preview



Community Connection of Union County

Published by Jonathan Checkis



October 28 at 3:00 PM · 🌐

Opening tomorrow!

Community Needs Assessment Survey has ended

We are holding a public hearing to review the plan and create our area plan for Union County. The plan is an overview of senior services that CCN provides and the service delivery system for the next 10 years. Community members are encouraged to attend and provide feedback to help improve senior programs in Union County.

[See more](#)



Reach

200

150

100

50

0

15m

4h

9h

16h

1d

3d

Facebook post reach

Interactions

Reactions

0

Comments

0

Shares

2

Saves

0

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: La Grande Oregon Union County DATE: 10/29/2024

PLEASE SIGN IN. THANK YOU.

12:30pm to 1:15pm

Katherine Burgeson

Katherine McDevitt

George Barlow

Jeanette Wilson

Dody Aseltine

Dan Paulsen

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: La Grande Oregon Union County **DATE:** 10/29/2024

PLEASE SIGN IN. THANK YOU.

Amity I Luther

Linda Lownd
 Betty Sprenger
 Windy L. Benson

denise jacobino
Patty Hindman

WALLOWA PUBLIC HEARING

Wednesday, October 23rd

@12:30 pm



**Wallowa County
Senior Center
702 NW 1st St, Enterprise**

**Community Connection
of Northeast Oregon, Inc.**

COMMUNITY NEEDS ASSESSMENT RESULTS

The Area Plan is an overview of senior services that CCNO provides and the service delivery systems for the next four years.

Community members are encouraged to attend and provide feedback to help improve senior programs in Wallowa County.

**If you have questions, please contact
Jeff Hensley, Assistant Director at 541-963-3186**



The Community Needs Assessment Survey has ended and we are holding a public hearing

Post · Published on: Wed Oct 16, 5:00pm

Boost

Top performer

Continue getting results when you boost this post and spend \$7 each day

Estimated daily results 526 - 1.5K more reach

Boost

Feed preview

Community Connection of Wallowa County

Published by Jonathan Checkis

October 16 at 5:00 PM

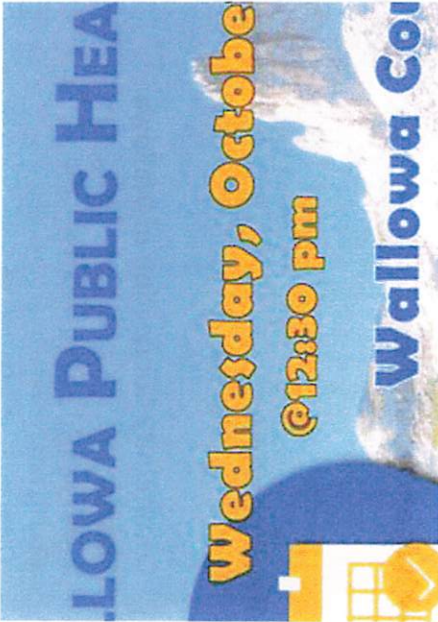
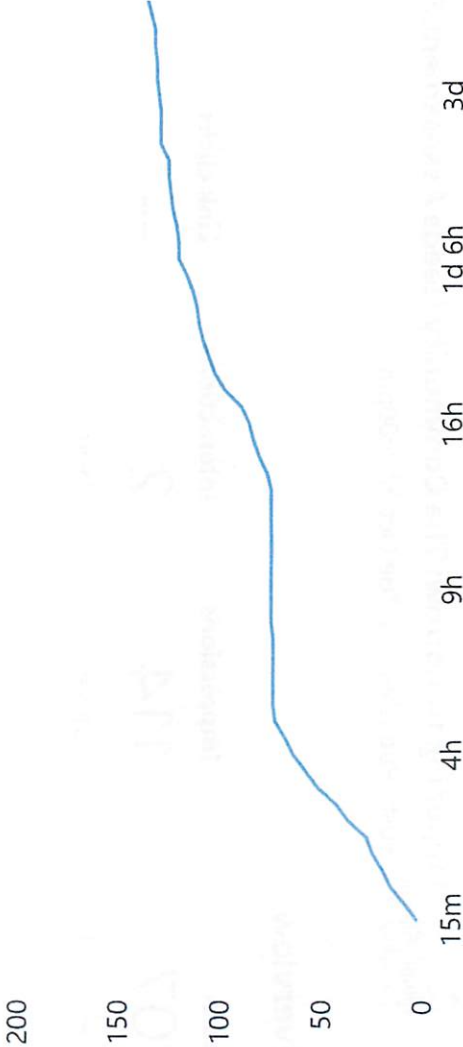
Overview

Reach	Impressions	Interactions	Link clicks
150	156	5	--
Higher than typical	Higher than typical	Typical	

Community Needs Assessment Survey has ended. We are holding a public hearing to review the results and create our area plan for Wallowa County. The area plan is an overview of senior services that our organization provides and the service delivery system for the next four years. Community members are encouraged to attend and provide feedback to help improve services in Wallowa County.

Join the conversation #seniorregion #communitysupport #seniorsenior

Reach





Happening tomorrow! The Community Needs Assessment Survey has ended and w...



Post · Published on: Tue Oct 22, 5:00pm

Boost

Overview

Reach	Impressions	Interactions	Link clicks
107	114	2	--
Higher than typical	Typical	Typical	

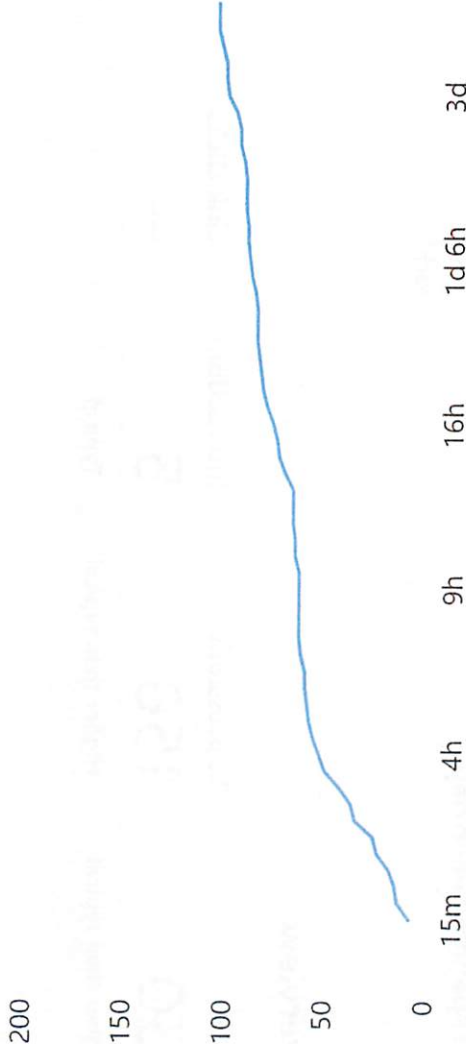
Feed preview

Community Connection of Wallowa County

Published by Jonathan Checkis

October 22 at 5:00 PM ·

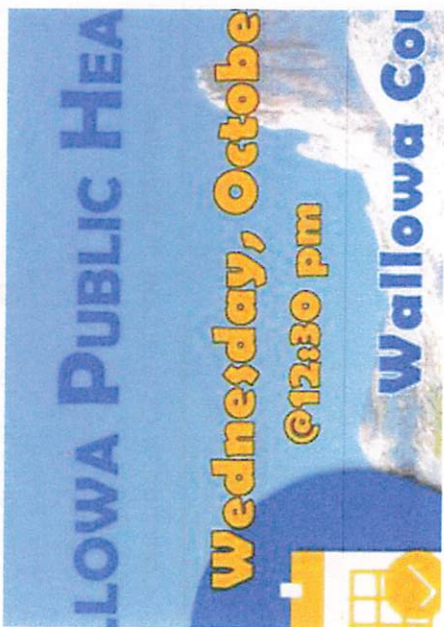
Reach



opening tomorrow!

Community Needs Assessment Survey has ended, we are holding a public hearing to review the plan and create our area plan for Wallowa County. The area plan is an overview of senior services that O provides and the service delivery system for four years. Community members are encouraged to attend and provide feedback to help improve services in Wallowa County.

hope to see you there!... See more



Interactions

Reactions	Comments	Shares	Saves
1	0	1	0

COMMUNITY CONNECTION OF NORTHEAST OREGON

AREA PLAN 2025-2029 PUBLIC MEETING

LOCATION: Enterprise Oregon Wallowa County DATE: 10/23/2024

PLEASE SIGN IN. THANK YOU.

Public

Jeanette Strobel

Stacy Swart

Travis Preciado

Jeanne Vice

Johnnie Paxson

Staff

Jeff Hensley

Cassandra Burns

Kathy Canung

Wendy Quinby

APPENDIX D

FINAL UPDATES FROM 2021-2025 AREA PLAN

Community Connection of Northeast Oregon, Inc.

Appendix D – Final Update on Accomplishments from 2021-2025 Area Plan

Focus Area - Information and Referral Services and Aging and Disability Resource Connection (ADRC):

Goal: Provide timely, accurate, and thorough I&A services

Measurable Objectives	Key Tasks	Objectives Met?	Accomplishments Fiscal Year 2019-2020
Approximately 1,200 individuals will receive 10,000 units of I&A.	Staff are trained in I&A (one AIRS certified) and demonstrate high quality customer service.	Yes	1,384 individuals received 6,094 units of I&A.

Goal: Staff Utilizing Get Care for all OAA services and documentation

100% ADRC Get Care Accuracy.	Train staff on Get Care/RTZ and staff perform data entry.	Yes	Ongoing, ADRC restarted monthly trainings. We are averaging 95% accuracy.
100% NAPIS data entry.	Staff perform data entry.	No	We have a 83% accuracy rate on data entry. There has been a focus on raising funding to support meal programs. This has reduced staff time to complete NAPIS forms with consumers.

Goal: Identify isolated and lonely seniors and connect via technology

Through I&R and other methods identify at least 30 seniors to connect with virtual resources.	Provide tablets, and provide one-on-one training to seniors.	Yes	Thirty-four (34) seniors received referrals for virtual assistance.
Make reassurance calls.	Weekly phone calls to seniors identified with isolation/loneliness.	Yes	Twenty-five (25) seniors received reassurance calls.

Goal: Provide high-quality Person-Centered Options Counseling

Provide Person Centered Options Counseling to at least five (5) seniors and/or their families per month.	Follow up monthly with each Options Counseling consumer and disenroll when appropriate, record and enter I&R . We will review Options Counseling Quality Assurance.	No	This is completed each month, and we partner with the state analyst/trainer to get cleanup reports. Our completion rate is 63% and we are working on improving this percentage.
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Goal: Marketing and outreach to promote ADRC and increase service

Advertisement of ADRC through our website, Facebook, and other media formats at least once a quarter.	Update and monitor website and Facebook posts.	Yes	We update and/or monitor website and Facebook posts 2 or 3 times a week. We have a new IT staff member who has brought our media presence to the forefront.
Provide materials in Marshallese for Pacific Islander and to Confederate Tribe Council for Native American outreach in our counties.	Outreach to the Pacific Islander and Confederate Tribe Council members.	Yes	We are in the process of finding funding to provide these materials

Focus Are - Nutrition Services**Goal: Promote the health and wellbeing of older individuals**

100% of meals served for Home Delivered and Congregate meals will be nutritious and enticing.	Serve hot, nutritious enticing meals in an attractive, welcoming manner.	Yes	We served 36,547 congregate meals in 2023 which was a 47% increase from the previous year. We served 55,135 meals in 2024 which was a 33% increase. For Home Delivered meals in 2023, we delivered 53,068 meals which was a 26% increase from the previous year. In 2024, we delivered 68,653 meals which was a 22% increase from last year.
	Evaluate menus to ensure they meet nutritiounal guidelines.	Yes	We have a Registered Dietitian who reviews our menus on a monthly basis.

Goal: Maintain or increase number of people and meals served at meal sites

Maintain or increase levels of meals served.	Continue outreach and marketing to attract new diners and retain current diners. Give free meal tickets to new attendees, and develop a "Café" environment attracting new diners.	Yes	We have 1,016 new congregate consumers and a decrease of 195 consumers for HDM. 1,157 free meal tickets were handed out to new attendees. Each center has increased and added new activities instead of a "Café" option which has increased attendance.
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Goal: Develop and maintain adequate funding for nutrition services

Develop catering services in local communities with proceeds dedicated to senior nutrition services.	Through outreach and advertising with local partners to develop catering for meetings and events, and develop enhanced menus, price options, and marketing materials.	Yes	We changed our focus to doing Entrée sponsorships to fundraise supporting meal site programs. Because of current management and staff turnover, developing enhanced menus has been put on hold for now.

Focus Area - Health Promotion**Goal:** Promote Evidence Based Programs & Evaluate demand for classes

Conduct a survey to evaluate what Evidence Based Health programs consumers will participate in virtually.	Create and Distribute surveys.	Yes	Surveys were completed and it was determined that consumers would participate in Living Well classes.
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Goal: Provide programs based upon demand and budget

Select at least one Evidence Based program to provide.	Obtain Evidence Based program training to provide a virtual program.	Yes	We are currently providing Powerful Tools for Caregivers and have four staff trained. We also have four staff trained to provide the Living Well series.
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Goal: Provide Powerful Tools for Caregivers classes

One (1) class each year.	Outreach, promotions, schedule. Enroll participants, teach class and co-teach with Care Coordinators.	Yes	Flyers and brochures were sent out to clients about classes being scheduled. We had ten (10) participants attend a virtual Powerful Tools for Caregivers in October 2021 and ten (10) participants attend the class in September 2022. We held another class in November of 2023 with eight (8) attending. Classes are co-taught with our Care Coordinators.
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Goal: Outreach to Grandparents Raising Grandchildren

Begin outreach in schools and Head Start to reach grandparents raising grandchildren.	Develop working relationships with school counselors and administration so they are able to make referrals to the program.	Yes	We have made contact with each school district in our areas and are building relationships with each for referrals.

Focus Area - Legal Assistance and Elder Rights Protection Activities**Goal: Educate community about elder abuse**

Educate the community and seniors about Elder Abuse with at least one article a year in our newsletters and one press release a year in each of our counties.	Include "Elder Abuse Awareness" articles in newsletters and press releases.	Yes	We had one article in our newsletter and one press release in 2022. National Elder Abuse Awareness Day was the focus in each senior center meal site.
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Goal: Advocate for Elder Rights

Attend at least three (3) Multi-Disciplinary Team meetings throughout our counties.	Attend and be engaged at MDT meetings. Provide feedback to staff.	Yes	Staff have attended six (6) MDT meetings in our area. Staff that attended the MDT meetings provided feedback to our management team.
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Goal: Referring and Reporting of Elder Abuse or concern

Write protocol for referring & reporting Elder concerns to APS or Long-Term Ombudsman.	Write, educate and implement, and follow protocol.	Yes	Protocol has been written and implemented, and staff are following the protocol.
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Goal: Increase visibility of Legal Aid Services

Oregon Legal Aid and Oregon Law Center to give at least two presentations a year in each county.	Contact OLA and OLC to do presentations. Quarterly contact with OLA and OLC about training for staff.	No	In person cost is too costly. Exploring virtual presentations.
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APPENDIX F

EMERGENCY PREPAREDNESS PLAN

Community Connection of Northeast Oregon, Inc.

Appendix F Emergency Preparedness Plan

Purpose:

This Emergency Preparedness Plan (EPP) is to be used by staff of Community Connection of Northeast Oregon, Inc. (CCNO) to help mitigate the effects during and after a county or regional emergency in Baker, Grant, Union and Wallowa counties. Principles of this plan include:

- Create and maintain a list of vulnerable clients for each county who would need outside assistance in an emergency.
- Develop office emergency protocols:
 - What to do if we had to shelter in place at each office.
 - Who needs to report to work in case of a county or regional wide emergency.
- Work with local groceries and water distribution companies to create agreements that during the response and recovery phase of an emergency, CCNO will be given priority when purchasing food and water for local food pantries.
- Coordination and communication with local, state and/or federal emergency authorities is vital to successfully assist our communities in an emergency.
- Responses to emergencies will be different in severity and length of impact and should be approached with flexibility to be able to address the different needs of any given emergency.
- Efforts should be taken to mitigate damage to property. This will ensure our ability to continue providing vital services to the members of our communities during the response and recovery phases of an emergency event.
- Documentation of the nature of the emergency, steps taken, decisions made and funds expended is very important.
- Set up regular briefings at the beginning and end of each day (or shift change) to keep everyone informed of the status of the situation and needed actions to be taken and anticipated.
- Plan ahead. If potential future needs or tasks cannot be done with current resources, contact local partners and the state in the early stages of the emergency.
- Every emergency is stressful for everyone involved, including staff. Some staff may be directly affected by the emergency. It is important to consider and support everyone's emotional, mental and physical health.
- If the response to the emergency is likely to last more than a couple of days, plans should be made to rotate staff (including leadership) to allow for periods of rest.

Emergency Preparedness Plan Members:

Administration

Connie Guentert – Executive Director
Jeff Hensley – Assistant Director
Vacant – Fiscal Manager
Ashley Johnston – Human Resource Manager
Adina Flowers – Executive Assistant

Baker County:

Joe Hayes – Baker County Operations Manager
Josip Belavic – Self-Sufficiency Coordinator
Tera Luebberke – Assistant Transit Manager
Lora Montgomery – Care Coordinator

Grant County:

Amy Smetana – Self-Sufficiency Coordinator
Misty Palmer – Grant County Programs Manager

Union County:

Rochelle Hamilton – Union County Senior Center Manager
McGraig Takeshi - Self-Sufficiency Coordinator
Lynette Barber – Care Coordinator

Wallowa County:

Cassandra Burns – Wallowa County Operations Manager
Taylor Harshfield – Self-Sufficiency Coordinator
Demetri Hardesty – Assistant Transit Manager

These members are responsible to act as the point of contacts between CCNO it's partners, local, state and/or federal agencies.

Vulnerable Clients

- The Baker, Grant, Union, and Wallowa counties teams listed above will keep a list of all known vulnerable clients on site. The list will be updated every six months, and new vulnerable clients will be added as they become aware of new clients. This list will contain the following information about each vulnerable client:

- Name
- At least one emergency contact
- Physical address
- Any know medical conditions
- Any know medications
- Whether or not the client is homebound
- Whether or not the client needs help to evacuate his/her home
- Whether or not the client has pets, and if they would leave his/her pets behind in an emergency.

This Emergency Preparedness Plan can be activated if any of the following circumstances occur:

1. A County Manager from Baker, Grant, Union, and Wallowa County requests the participation of CCNO in response to an emergency event.
2. An event determined by the Executive Director or Board Chair which may cause significant property damage; put at risk the health or safety of vulnerable clients or staff.
3. Any other emergency which warrants activation of this Emergency Plan as deemed by the Executive Director or Board Chair.

Individuals Authorized to Activate this Emergency Preparedness Plan

Connie Guentert, Executive Director
Work Phone (541) 963-3186
Cell Phone (541) 398-2351

Scott Myers, Board Chair
Work Phone (541) 575-0059

Cell Phone (541) 620-4022

Once the plan is activated, all CCNO managers will maintain a telephone list to be utilized to call key staff and volunteers to notify them of the emergency and the needs of CCNO. In a large-scale event, all staff and volunteers may be contacted. Staff from other counties may be contacted to assist.

When contacting staff and volunteers, the Executive Director must consider each staff member's status and ability to come into the office or an alternate site. It is important to remember some, or several staff and/or volunteers, could be directly affected by the emergency and therefore unable to attend. The health and safety of CCNO's staff and volunteers is top priority.

Continuity of the Emergency Preparedness Plan

Oregon Project Independence/ Oregon Project Independence-Medicaid/VA Home Health

Following an emergency event, CCNO will resume these services to the fullest extent possible. Care Coordinators will work with local, state, and/or federal authorities to ensure there is someone able to physically check on all clients at least once a week, or more often, in case their HCW's are unable to continue providing services.

Meals on Wheels

Following an emergency, CCNO will resume Meals-On-Wheels (MOW) services to the fullest extent possible. CCNO will coordinate with volunteer drivers, Red Cross, and the county to establish a volunteer base which will be able to deliver meals to home bound individuals on the MOW's program. For many of our MOW consumers, this will be the only way to ensure their health and safety during an emergency. We will use vehicles from our transportation fleet if necessary.

Food Bank

CCNO will work with local groceries and water distribution companies to create agreements that during the response and recovery phase of an emergency, CCNO would be given priority when purchasing food and water for local Food Pantries. We will continue all normal functions of being the main food distribution site for local food pantries throughout Baker, Grant, Union, and Wallowa counties.

Emergency Transportation

For Baker, Union, and Wallowa counties, normal transportation services will be suspended during the response phase of the emergency. CCNO's transportation vehicles will be utilized for the purpose of evacuation of community members and transportation of goods needed during the emergency. We will take requests from agencies and/or individuals who are in need of vehicles and prioritize each request.

Emergency Meal Sites

Baker County Senior Center, Grant County Senior Center, Union County Senior Center, and Wallowa County Senior Centers (Enterprise and Wallowa) will be the designated Emergency Meal Sites where the community can come to eat a hot meal. We will develop a plan to sustain the Emergency Meal Sites as needed during the recovery phase while resuming normal CCNO services.

Emergency Shelter Sites

As mentioned above, these sites will be designated as Shelter Sites. CCNO will work with Red Cross to utilize each site as an Emergency Shelter Site. We will ensure that goods are received and ordered as needed. The Riveria Activity Center (RAC) gym will also be designated as a Shelter Site.

The Top Five Potential Hazards Per County

Baker County

1. Drought
2. Wildfires
3. Wind Storms
4. Winter Storms
5. Floods

Union County

1. Wildfires
2. Winter Storms
3. Floods
4. Wind Storms
5. Earthquakes

Grant County

1. Wildfires
2. Wind Storms
3. Winter Storms
4. Floods
5. Earthquakes

Wallowa County

1. Wildfires
2. Winter Storms
3. Drought
4. Earthquakes
5. Floods

APPENDIX G

CONFLICT OF INTEREST POLICY

Appendix G – CCNO Conflict of Interest Policy *from personnel policies*

CONFLICTS OF INTEREST

The proper operation of Community Connection requires that employees be independent, impartial, and responsible to the people it serves; that decisions and policy be made in the proper channels of the Community Connection structure; that Community Connection not be used for personal gain; and that the public have confidence in its integrity.

No employee or board member shall engage in any business or transaction or shall have a financial or other personal interest, direct or indirect, which is incompatible with the proper discharge of his/her official duties in Community Connection or would tend to impair his/her independence or judgment or action in the performance of his/her official duties. Personal, as distinguished from financial interest, includes an interest arising from blood or marriage relationships or close business or political association.

Specific conflicts of interest are enumerated below for the guidance of employees:

1. **Interest in Appointments**

Canvassing of members of Community Connection Board of Directors, directly or indirectly, in order to obtain preferential consideration in connection with any appointment to staff service shall disqualify the candidate for appointment.

2. **Preferential Treatment to Individuals Generally**

Granting any special consideration, treatment or advantage to any citizen beyond that which is available to every other citizen, except as required by Affirmative Action policies or where required by law.

3. **Incompatible Treatment**

Engaging in or accepting private employment or rendering services for private interests when such employment or service is incompatible with the proper discharge of his/her duties or would tend to impair his/her independence of judgment or action in the performance of his/her official duties. Outside employment is permitted provided it does not 1) result in loss of on-the-job efficiency, or 2) result in conflict of interest, unfavorable publicity, or poor public relations. All employees shall notify in writing their immediate supervisors of such employment activities.

4. **Disclosure of Confidential Information**

Disclosure of confidential information concerning the employees of, the property or affairs of Community Connection without proper legal authorization; or using such information to advance the financial or other private interest of himself/herself or others.

5. **Representing Private Interests Before a Community Connection Body**

No person whose salary is paid in whole or in part by Community Connection of Northeast Oregon, Inc. shall appear on behalf of private interests before any Community Connection committee or board.

An employee may appear before local communities on behalf of constituents in the course of his/her duties as a representative of Community Connection or in the performance of his/her obligations. However, no person shall accept a retainer or compensation that is contingent upon a specific action by Community Connection

6. **Interest in Contract with Community Connection**

No employee of Community Connection shall have any interest or accrue any from any contract issued by Community Connection

ANNUAL QUESTIONNAIRE

CONFLICTS OF INTEREST AND EXECUTIVE COMPENSATION POLICY DISCLOSURE AND ACKNOWLEDGMENT STATEMENT

[Each Director, Officer and Key Employee
must sign and submit this form annually.]

Disclosure

Please report below any conflicts of interest or potential conflicts of interest between Community Connection of Northeast Oregon, Inc. and you, a family member or a business or corporation with which you are connected within the meaning of the Conflicts of Interest and Executive Compensation Policy.

You have an ongoing obligation to notify the Board promptly of any such conflicts of interest that subsequently arise.

List of Conflicts or Potential Conflicts

Please list and explain any conflicts here:

Acknowledgment

I have received, read, understand and will comply with the Conflicts of Interest and Executive Compensation Policy of Community Connection. I affirm that, other than the interests reported, I am aware of no conflicts of interest that I have or may have within the meaning of the Conflicts of Interest and Executive Compensation Policy.

Signature

Title

Print Name

Date

Please submit this form to the Secretary of the corporation and retain a copy for your records.

APPENDIX H

PARTNER MEMORANDUM OF UNDERSTANDING



Appendix H Partner Memorandum of Understanding

Memorandum of Understanding
Between
Community Connection of Northeast Oregon, Inc.
Area Agency on Aging
And
Oregon Department of Human Services
Aging & People with Disabilities

Purpose

Community Connection of Northeast Oregon, Inc. Area Agency on Aging, hereinafter Community Connection, and Oregon Department of Human Services Division of Aging & People with Disabilities, 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 Community Connection personnel and volunteers regarding services and eligibility criteria established and/or administered by APD on an as needed basis to ensure Community Connection staff have basic programmatic knowledge for information and referral.
- Refer individuals to Community Connection for assessment, case management, and/or service delivery as deemed mutually appropriate by APD and Community Connection personnel.
- Provide a knowledgeable representative who will attend the Community Connection advisory council meetings to provide an update of the current APD operations and policies, as APD staffing levels allow.
- Consult with Community Connection personnel and administration to address system(s) quality and effectiveness.





Community Connection
of Northeast Oregon, Inc.

Helping people. Changing lives.

Memorandum of Understanding
Community Connection and APD
Page Two

- Receive Universal Referral Form and Oregon ACCESS screenings from Community Connection by fax, e-mail and through Oregon ACCESS and register them in the appropriate Medicaid category.
- Coordinate meetings of APD and Community Connection management to support information sharing and programmatic updates in each respective agency.

Community Connection agrees to:

- Participate in training regarding services and eligibility criteria established and/or administered by APD on an on-going basis.
- Provide training to APD personnel regarding services and programs administered by Community Connection on an as-needed basis to ensure APD staff has basic program knowledge for information and assistance.
- Accept referrals of adult individuals made by APD for the purpose of needs assessment and qualification for case management and/or service delivery consistent with Community Connection's capacity to do so.
- 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.
- Consult with APD personnel and administration to address system(s) quality and effectiveness.

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

In witness whereof, the Parties have caused this Memorandum of Understanding to be signed by their duly authorized representatives on the dates indicated below.

For Community Connection

6/27/2025
Date

For APD

06/26/2025
Date



APPENDIX I

STATEMENT OF ASSURANCES & VERIFICATION OF INTENT

Appendix Statement of Assurances and Verification of Intent

For the period of July 1, 2025 through June 30, 2029, Community Connection of Northeast Oregon, Inc. accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) as amended in 2020 (P.L. 116-131) and related state law and policy. Through the Area Plan, Community Connection of Northeast Oregon, Inc. 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.

Community Connection of Northeast Oregon, Inc. 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. OAA Section 306, Area Plans (a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall— (1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 47 attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for

institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need; (2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services— (A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services); (B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and (C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded; (3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 48 (B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated; (4) (A)(i)(I) provide assurances that the area agency on aging will— (aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement; (bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and (II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I); (ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will— (I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider; (II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and (III) meet specific objectives established by the area agency on aging, for providing services to low-income

minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and (iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared — (I) identify the number of low-income minority older individuals in the planning and service area; (II) describe the methods used to satisfy the service needs of such minority older individuals; and (III) provide information on the extent to which the area agency on aging met the objectives described in clause (i). Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 49 (B) provide assurances that the area agency on aging will use outreach efforts that will— (i) identify individuals eligible for assistance under this Act, with special emphasis on— (I) older individuals residing in rural areas; (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas); (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas); (IV) older individuals with severe disabilities; (V) older individuals with limited English proficiency; (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and (VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and (ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and (C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas. (5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities; (6) provide that the area agency on aging will— (A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan; (B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 50 individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals; (C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families; (ii) if possible regarding the provision of services under this

title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that— (I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or (II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and (iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings; (D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan; (E) establish effective and efficient procedures for coordination of— Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 51 (i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and (ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area; (F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations; (G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act; (H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and (I) to the extent

feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals; (7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by— (A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care; (B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better— (i) respond to the needs and preferences of older individuals and family caregivers; Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 52 (ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and (iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings; (C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and (D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to— (i) the need to plan in advance for long-term care; and (ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources; (8) provide that case management services provided under this title through the area agency on aging will— (A) not duplicate case management services provided through other Federal and State programs; (B) be coordinated with services described in subparagraph (A); and (C) be provided by a public agency or a nonprofit private agency that— (i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging; (ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement; (iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or (iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii); (9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 53 Act and expended by the agency in fiscal year 2019 in carrying out such a program under

this title; (B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712; (10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title; (11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including— (A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title; (B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and (C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans; (12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area. (13) provide assurances that the area agency on aging will— (A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships; (B) disclose to the Assistant Secretary and the State agency— (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 54 (ii) the nature of such contract or such relationship; (C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship; (D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and (E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals; (14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title; (15) provide assurances that funds received under this title will be used— (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in

section 212; (16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care; (17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery; (18) provide assurances that the area agency on aging will collect data to determine— (A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and (B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 55 (19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019. Section 306 (e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege. The further assures that it will: With respect to legal assistance — (A) (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis; (B) assure that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services. (C) give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 56 With respect to services for the prevention of abuse of older individuals— (A) when carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective

service activities for— (i) public education to identify and prevent abuse of older individuals; (ii) active participation of older individuals participating in programs under the OAA through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and (iii) referral of complaints to law enforcement or public protective service agencies where appropriate; (B) will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and (C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency. If a substantial number of the older individuals residing in the planning and service area are of limited English-speaking ability, the area agency on aging for each such planning and service area is required— (A) to utilize in the delivery of outreach services under OAA section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and (B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include— (i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under the OAA; and (ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

Attachment A 2025-2029 AREA PLAN INSTRUCTIONS 57

Conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to OAA section 306(a)(7), for older individuals who— (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently; (B) are patients in hospitals and are at risk of prolonged institutionalization; or (C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them. Have policies and procedures regarding conflicts of interest and inform the State agency if any conflicts occur which impact service delivery. These policies and procedures must safeguard against conflicts of interest on the part of the area agency, area agency employees, governing board and advisory council members, and awardees who have responsibilities relating to the area agency's grants and contracts. 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 30- calendar day or greater time period for public review and comment on the Area Plan and a public hearing prior to submission of

the Area Plan to ODHS. The 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.

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

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

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DHS. Community Connection of Northeast Oregon, Inc. 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.

1-22-2025
Date

Connie Guentert
Executive Director,
Community Connection of Northeast Oregon, Inc.

11-19-24
Date

Elsie Pellissier
Baker County - Advisory Council Chair

Date

SEE ATTACHED SIGNATURE
Grant County - Advisory Council Chair

11-20-24
Date

Daniel Seaman
Union County - Advisory Council Chair

11/18/24
Date

James W. Wicks
Wallowa County - Advisory Council Chair

Date

See Attached Signature
Board Chair,
Community Connection of Northeast Oregon, Inc.

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

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title 11 funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DHS.

Community Connection of Northeast Oregon, Inc. 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.

Date

11-19-24
Date

Date

11-20-24

Date

11/21/24

Date

1/22/2024
Date

Appendix I — Page 2

Executive Director,
Community Connection of Northeast Oregon,
Inc.

Elsie Pellissier

Baker County - Advisory Council Chair

SEE ATTACHED SIGNATURE

Grant County - Advisory Council Chair

Daniel Seaman

Union County - Advisory Council Chair

James W. W. W. W.
Wallowa County - Advisory Council Chair

Scott W. Myers
Board Chair,
Community Connection of Northeast Oregon,
Inc.

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

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

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DHS.

Community Connection of Northeast Oregon, Inc. 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.

Date

Executive Director,
Community Connection of Northeast Oregon, Inc.

Date

Baker County - Advisory Council Chair

12-16-24
Date

Janet Bunzer
Grant County - Advisory Council Chair

Date

Union County - Advisory Council Chair

Date

Wallowa County - Advisory Council Chair

Date

Board Chair,
Community Connection of Northeast Oregon, Inc.

APPENDIX J

FCSP MANUAL

Family Caregiver Support Program Protocol, Procedures, and Documents

*Community Connection
of Northeast Oregon
Inc. July 2024*

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HIPAA AND PHI

- HIPAA and PHI are required annual training.
- We respect the rights that HIPAA grants to individuals regarding their PHI.
- We follow HIPAA regulations and issue a Notice of Privacy Practices that includes specific information.
- You play an important role in protecting individuals' rights by handling requests appropriately.
- **Securing PHI**
- We're surrounded by PHI every day, so much so that it's easy to forget just how important it is to keep it safe from unauthorized disclosure. It's important to remember that all PHI must be kept secure, whether it's printed on paper, stored in an electronic directory, or simply spoken over the phone or to a coworker.

Family Caregiver Support Program (FCSP) Overview

*“Supporting and assisting **unpaid** family caregivers in expanding their roles as a caregiver through providing program components which will ease stress and increase coping.”*

Definition of Respite Program: *Respite care provides relief to the primary **unpaid** caregiver. This relief will allow the caregiver time to attend to personal matters/interests, time needed to participate in doctor’s appointments, shopping trips, caregiver training, the ability to relax and be “off duty” from the care of the care receiver.*

Guidelines and Standards are referenced from the Department of Human Services-Family Caregiver Support Program Standards-Older American Act August 2021.

Primary Goals of FCSP:

- Assist family caregivers to successfully meet the challenges of their caregiver role, while being supported in that role. *We define “family” as someone endeared to the care receiver who the care receiver considers to be family who provides **unpaid** care. This makes allowances for those who are not related by blood or marriage, as not all have the remaining family who can or should provide this role.*
- To deter a care recipient’s need to enter a care facility or memory care facility, when feasible, and promote continued care within the home and in alternative community settings for seniors for as long as possible or desirable by family caregivers.
- Provide the highest service levels possible.
- Assist older relatives (55+) raising children to successfully meet the challenges of their caregiver role, while being supported in that role.

Eligibility Requirements of FCSP:

To be eligible for FCSP the care recipient and the **unpaid** family caregiver must meet one of the following criteria:

1. A family caregiver who is 18 years or older caring for:
 - A person aged 60 years of age or older; or
 - A person with Alzheimer's disease or other dementia of any age.
 2. A parent or older relative caregiver aged 55 or older who lives with, and is the primary caregiver for, an individual with disabilities age 18 or older.
 3. An older relative caregiver (other than a parent) age 55 or older who lives with and is the primary caregiver for a child aged 18 or younger. (OAA372-373)
 4. The family caregiver must be an **unpaid, informal** provider of in-home and community care that is not provided as part of a public or private service program.
 5. The new revised Older Americans Act dated March 2024 clarified three determinations of the *care receiver*:
 - Is **unable** to perform **at least two** activities of daily living without substantial assistance, including verbal reminding, physical cueing, or supervision.
 - At the option of the State agency, care receiver is unable to perform at least three such activities without such assistance; or
 - Due to a cognitive or other mental impairment, requires substantial supervision because the individual poses a serious health or safety hazard to themselves or others.
-
- PLEASE NOTE: Care Coordinators may advocate cases to be reviewed by the Senior Services Manager, Assistant Executive Director, or Executive Director.
 - Senior Services Manager – Kathy Ganung | (541) 963-3186 ex. 1012 | kathyg@ccno.org
 - Assistant Director – Jeff Hensley | (541) 963-3186 ex. 1002 | jeff@ccno.org
 - Executive Director – Connie Guentert | (541) 963-3186 ex. 1001 | connie@ccno.org

Qualifying Family Caregivers for FCSP

Steps to Qualifying Family Caregivers for Respite Services:

NOTE: FCSP is NOT a means assessed program, however, priority is given to family caregivers who are low-income, and/or caring for a person with Alzheimer's/Dementia.

1. An **unpaid** family caregiver applying for respite services must meet the FCSP eligibility requirements listed on page 2.
2. The care coordinator will respond to all referrals on the same day received, if possible, and no later than one (1) week after a referral is received. Creating a Get Care - I & R/Care Tool client file, completing all ADRC/NWD requirements for demographics and referrals, offering Caregiver Counseling and Options Counseling referral services is a requirement.
3. The care coordinator must schedule an in-home visit with the family caregiver and care receiver to complete an FCSP intake application, NAPIS for both caregiver and care receiver and observation. This must be completed and entered in the Get Care program. Narration (Progress note) is required for all interactions with the caregiver.
4. If Caregiver is on FCSP program for additional quarters an in-home visit **at least** every 6 months. At least **one** home visit must be conducted annually before an “over-the-phone assessment” can be considered and **only** with Senior Services Manager approval. Narration (Progress note) in Get Care is required for every action with the FCSP consumer. A word document of additional narration notes can be attached to Get Care file. A hard copy file should be created for each FCSP consumer using the Green folders.
5. An in-home visit allows the care coordinator to see if other resources would be available to better assist the family caregiver, such as:
 - Caregiver Counseling and/or training.
 - Home Modifications to increase his/her ability to care for his/her care recipient.
 - Durable Medical Equipment for the care recipient to which he/she is providing care.
 - Other local services are available to family member/s.
6. After the in-home visit, the care coordinator will send out an eligibility determination letter no later than one (1) business day of the determination. Narration (Progress Notes) in Get Care is required along with a phone call. Narration is always required.
 - Respite providers **cannot** be family members. Definition of “family” - *Family can be someone related by birth, marriage, adoption or residing together in a communal living arrangement. Also see Definition of family on page 1 of this manual.*

- Respite Providers are **NOT** employees of Community Connection of Northeast Oregon, Inc.
 - The family caregiver must give adequate time notifying the respite provider of the need for respite services. The FCSP is not an on-call program.
 - FYQ are:

○ 1 st Quarter – July - September	2 nd Quarter – October - December
○ 3 rd Quarter – January - March	4 th Quarter – April - June
7. Once the family caregiver has selected a respite provider for respite services:
- A monthly time sheet will be issued to the family caregiver. The family caregiver is to have the respite provider fill out the times he/she begins and ends his/her work each day, along with what services were provided to the care receiver. This timesheet needs to be signed by both FCSP caregiver and respite provider and turned into the local office by the 5th of the following month. FCSP Respite is **not** a housekeeping service.
 - The respite provider does NOT need to be a state certified homecare worker. The respite provider must be at least 18 years of age.
 - The maximum reimbursement amount, and the total remaining amount listed on the timesheet must be kept current by the Care Coordinator.
8. Under the FCSP respite:
- Family caregivers will receive reimbursement for respite services rendered; not to exceed **\$360** per fiscal year quarter (FYQ). Care Coordinators may advocate to the Senior Services Manager for additional funds based on a case by case and only if funding is available.
 - If the family caregiver does not use all or any allocated FYQ funds, the FCSP caregiver will forfeit the remaining amount of FCSP funds for that FYQ. Allocations **DO NOT** roll over to the next quarter. Each FCSP caregiver will have up to 30 calendar days after a quarter end to submit for reimbursement.
9. If the family caregiver uses all allocated funds for the FYQ, and requests more funds, a letter from the FCSP caregiver stating why there's a need and an application for additional funds must be completed by the Care Coordinator.
- This application must be reviewed and approved by the Senior Services Manager, Assistant Executive Director, or Executive Director:
 - Senior Services Manager – Kathy Ganung | (541) 963-3186 ex. 1012 | kathyg@ccno.org

- Assistant Director – Jeff Hensley | (541) 963-3186 ex. 1002 | jeff@ccno.org
- Executive Director – Connie Guentert | (541) 963-3186 ex. 1001 | connie@ccno.org

Steps to Qualifying Family Caregivers for Home Modifications

When funding allows:

1. A family caregiver applying for Home Modifications (HM) **MUST**:
 - Be a family caregiver applying for home modification services and who meets the FCSP eligibility requirements.
 - Home Modifications should be **in** the home of the *care receiver*.
2. Any HM's which are approved must assist the family caregiver in taking care of his/her care recipient, by providing him/her with the tools to safely care for his/her care recipient.
3. The family caregiver can receive up to **\$500.00** per fiscal year (FY) in reimbursement to pay for an approved HM.
4. The family caregiver must fill out an application to be approved for **\$500.00** HM assistance through FCSP.
5. Three comparable bids will be required.
6. If a Family Caregiver needs more than **\$500.00** for HM, he/she must complete an application for additional funds. Care Coordinators may advocate to the Senior Services Manager for additional funds based on a case by case and only if funding is available.
 - This application must be reviewed and approved by the Senior Services Manager, Assistant Executive Director, or Executive Director:
 - Senior Services Manager – Kathy Ganung | (541) 963-3186 ex. 1012 | kathyg@ccno.org
 - Assistant Director – Jeff Hensley | (541) 963-3186 ex. 1002 | jeff@ccno.org
 - Executive Director – Connie Guentert | (541) 963-3186 ex. 1001 | connie@ccno.org

Steps to Qualifying Family Caregivers for Durable Medical Equipment or Supplies.

When funding allows:

1. A Family Caregiver applying for Durable Medical Equipment or Supplies (DME) **MUST**:
 - Be a family caregiver applying for Durable Medical Equipment or Supplies and who meets the FCSP eligibility requirements.

- Durable Medical Equipment or Supplies should be **in** the home of the *care receiver* and **benefit** in providing care for the *care receiver*.
- 2. The family caregiver can receive up to **\$500.00** per FY in reimbursement to assist in paying for an approved DME.
- 3. The family caregiver must fill out an application for approval for up to **\$500.00** DME assistance through FCSP.
- 4. If the family caregiver needs more than **\$500.00** for any DME, he/she must complete an application for additional funds. Care Coordinators may advocate to the Senior Services Manager for additional funds based on a case by case and only if funding is available.
 - This application must be reviewed and approved by the Senior Services Manager, Assistant Executive Director, or Executive Director:
 - Senior Services Manager – Kathy Ganung | (541) 963-3186 ex. 1012 | kathyg@ccno.org
 - Assistant Director – Jeff Hensley | (541) 963-3186 ex. 1002 | jeff@ccno.org
 - Executive Director – Connie Guentert | (541) 963-3186 ex. 1001 | connie@ccno.org

Steps to Qualifying Family Caregivers for Older Relatives Raising children.

1. A family caregiver who is applying for assistance under Older Relatives Raising children **MUST**:
 - Live **with** the care recipient/s.
 - A family caregiver applying for respite services must meet the FCSP eligibility requirements.
2. Older Relative/s are eligible for respite care, through reimbursement of day or overnight summer camps.
 - The reimbursement is not to exceed **\$360** per FY for day or overnight summer camps.
3. Older Relative/s are also eligible for reimbursements for Home Modifications and Durable Medical Equipment or Supplies.

Funding for Older Relatives Raising children may also be used to provide “Brown Bag” events for Older Relatives Raising children caregivers in the local community. “Brown Bag” events provide Older Relatives Raising children caregivers with the opportunity to enjoy a nice lunch while connecting with other Older Relatives Raising children caregivers and learn about other resources, they may be eligible for within their communities.

Processing Reimbursement Check Requests for Family Caregiver Support Program

1. When assisting a family caregiver through FCSP, all requests for funds are completed as reimbursements to the family caregiver.
2. The family caregiver must show proof of payment by:
 - Completing the FCSP Respite Timesheet and returning it to the local care coordinator at completion of each quarter prior to the fifth (5) of the following first month of the new quarter. Reimbursement requests received 30 days after a quarter has closed will not be reimbursed.
 - The family caregiver and respite provider must sign the timesheet before the care coordinator will accept it and process it for reimbursement.
 - Provide proof of payment for respite services rendered. This can be a copy of a check or a receipt.
 - Provide receipt of completed Home Modification along with HM application. **Prior approval for all DME is required** by the Senior Services Manager.
 - Provide receipt of purchased Durable Medical Equipment or Supplies along with DME application. **Prior approval for all DME is required** by the Senior Services Manager.
 - Provide receipt of purchase of participation in day or overnight summer camps. **Prior approval for all camps is required** by the Senior Services Manager.
3. When a family caregiver provides the care coordinator with proof of payment, the care coordinator will complete a Check Request and attach proof of payment to the Check Request along with other back up documentation. All documents need to be original documents. Copies of the Check Request need to be placed in the Hard File. Narration (Progress Note) in Get Care is required along with all units entered for services and case management. Data entered on FCSP budget spreadsheet consumer page. All data reporting must be completed **prior** to sending the Check Request to the Administration office. Data entered on **Program Activity Report (PAR)** by the 8th of each month.
 - Date stamp of all documents received from caregiver is required upon receipt.
 - All **original** Check Requests, proof of payments and timesheet must be sent to the Senior Services Manager through internal agency mail **no later than one (1) business day** of receiving the family caregiver's timesheet and proof of payment. Senior Services Manager will forward it to the Fiscal department for payment and make narration (Progress Note) in Get Care along with verification of Get Care documentation.

Prioritizing Services

Although FCSP is not means-assessed, it is important for the care coordinator to use the following prioritization guidelines when selecting a family caregiver off the FCSP Waiting List:

The Older Americans Act prioritizes services to at-risk older adults including those who are frail and at risk for institutional placement; low-income, socially isolated, or minority individuals; Native American elders; older adults with limited English proficiency; those residing in rural areas; and Lesbian, Gay, Bisexual, or Transgender (LGBT) older adults. The Family Caregiver Support Program also specifically calls for states and Area Agencies on Aging to prioritize services to the following populations:

1. Caregivers who are older individuals with the greatest social need, and older individuals with greatest economic need. (OAA 373 (c)(2)(A))
2. Older relative caregivers of children with severe disabilities, or individuals with severe disabilities. (OAA 373 (c)(2)(B))
3. Family caregivers who support their relative that has Alzheimer's disease and related disorders with neurological or organic brain dysfunction. (OAA 372 (b)) Caregivers who are older individuals with greatest social need and/or greatest economic need with particular attention to low-income older individuals and to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
 - ***Greatest Social Need*** – A need caused by non-economic factors, which include physical and mental disabilities; language barriers; and cultural, ethnic status, which restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently.
 - ***Greatest Economic Need*** – A need resulting from an income level at or below the poverty line. See current Federal Poverty Levels for the calendar year.

2. Other Priority Checks:

- Is the family caregiver unable to leave his/her care receiver alone for an hour or more for the safety of the care recipient?
- Does the family caregiver have a support network in place? Does he/she have other adult family members who currently help him/her care of his/her care recipient? If not, the family caregiver has higher priority than those who have an existing support network.
- Does the family caregiver already receive respite through another agency or program? Is the care recipient on any program which provides in-home care – including hospice? If

so, the family caregiver who does not have any other program assistance is given higher priority.

- Does the family caregiver have another adult family member living in the home who regularly cares for the care recipient while the family caregiver is out of the house? If so, the family caregiver would not qualify for the FCSP.
- Did the family caregiver receive respite FCSP services during the previous Fiscal Year Quarter (FYQ)? If so, the family caregiver does not qualify for FCSP for the following FYQ, unless otherwise approved by the Senior Services Manager, Assistant Executive Director, or Executive Director.
 - Senior Services Manager – Kathy Ganung | (541) 963-3186 ex. 1012 | kathyg@ccno.org
 - Assistant Director – Jeff Hensley | (541) 963-3186 ex. 1002 | jeff@ccno.org
 - Executive Director – Connie Guentert | (541) 963-3186 ex. 1001 | connie@ccno.org

At the end of each Fiscal Year Quarter (FYQ) all family caregivers are put on the waiting list. The care coordinator **MUST** review all family caregivers on the waiting list, and select who will receive FCSP services, for the next FYQ, based on the priorities listed above. **At least one in-home visit must occur every 6 months.** All FCSP consumers and care recipients are entered into the Get Care/RTZ system and the case managed within that system.

Enrollment of FCSP Services

To enroll a caregiver in FCSP services, the following assessments and enrollments are required:

•Assessments

Caregiver Assessment/ Reassessment tool

Family Caregiver Intake form- this is about the consumer taking care of the receiver.

Functional Assessment for both Caregiver and Care receiver. (one for each child)

Nutritional Assessment for both Caregiver and Care receiver. (one for each child)

•Service Enrollments

Caregiver Information Service (this would be first contact & any hotlines/trainings you refer to).

Caregiver Information and Assistance

Caregiver Case Management- (this is where you record case management duties).

Caregiver Counseling

Those caring for seniors 60+

Caregiver In-Home Respite/ Caregivers Out-of-Home Respite (Day) / Caregivers Out-of-Home Respite (Overnight)/Caregivers Other Respite/Caregivers Supplemental Services/Caregiver Counseling/ Caregivers Training/ Caregiver Support Groups.

Those caring for children/ consumer must be 55+

Caregiver (Older Relative) In-Home Respite/ Caregivers (Older Relative) Out-of-Home Respite (Day) / Caregivers (Older Relative) Out-of-Home Respite (Overnight)/Caregivers (Older Relative) Other Respite/Caregivers (Older Relative) Supplemental Services/Caregiver (Older Relative) Counseling/ Caregivers (Older Relative) Training

•Optional service enrollments

Home Delivered Meals/Congregate Meals/Reassurance/Chore

Health Promotion- Evidence Based-this can include Powerful Tools for Caregivers.

Health Promotion- Non-Evidence Based (i.e., Equipment lending or supplies, medication management).

Disenrollment of FCSP Services

When a caregiver enrolled in the FCSP no longer needs or qualifies for the FCSP respite reimbursement this is the following process:

1. In Get Care client file a Narration (Progress Note) as to why ending services is required.
2. Enter all units into Get Care.
3. Disenroll caregiver in all OAA programs that apply.
4. If the care receiver has passed- close out client file of care receiver.
5. Enter all PAR units
6. Send out FCSP survey with stamped return addressed envelope to Senior Services Manager. Narration (Progress Note) survey sent in Get Care.
7. Remove all hard file documents to a manila envelope with Consumers First & Last name, date range on program and closed date. Retain in your office for 1 yr. After 1yr. documents may be sent to Admin for storage.
8. Redline consumer on PAR and close out of FCSP spreadsheet.

•There are several tools in One Drive in the FCSP folder to assist in fulfillment of protocols, procedures, documents, tip sheets, check lists, FCSP spreadsheet, etc.