**WASHINGTON COUNTY DISABILITY, AGING AND VETERAN SERVICES**

**2017-2020 AREA PLAN**

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**Section A-Area Agency Planning and Priorities**

**A-1 Introduction:**

Washington County is located on the western edge of Portland. Washington County occupies an area of 727 square miles with a population of 574,326 in 2015. This is an 8.4% increase in population since 2010) demonstrating recent substantial growth (https://www.census.gov/quickfacts/table/PST045215/41067). Washington County is a mix of urban, suburban and rural areas with each area having specific needs related to population density. The eastern half is composed of service industries, light manufacturing, and residential and commercial activities. The western half is primarily farms and rural settings together with several smaller incorporated and unincorporated areas.

The county seat is located in the City of Hillsboro and governed by a five person elected Board of Commissioners. The board appoints a county administrator as the chief executive officer. Washington County Disability, Aging and Veteran Services (WCDAVS), is a division of the Washington County Health and Human Services Department (WCHHS) and acts as the designated Area Agency on Aging. WCDAVS is charged with providing leadership in planning and developing services to meet the needs of the county's older adults, adults with disabilities and veterans.

The Board of Commissioners provides oversight and appoints the thirteen member citizen Area Agency Advisory Council. The council also advises the director of the Area Agency on Aging (WCDAVS) in the planning process and provision of services. Positions on the Area Agency Advisory Council are designed to best represent the various population groups within Washington County. WCDAVS also coordinates and provides services with partner agencies and organizations through memorandums of understanding, intergovernmental agreements and contracts with community providers.

Questions: Contact Washington County Disability, Aging & Veteran Services at (503) 846-3060 or by e-mail at davsinfo@co.washington.or.us Website: http://www.co.washington.or.us/HHS/DAVS/

**A-2 Mission, Vision, Values:**

WCHHS has recently been through a strategic planning process utilizing community, management and staff input of which all WCDAVS employees were participants. WCHHS's vision is a healthy, equitable and supportive community. Its mission is to promote health and well-being by influencing policies, systems and environments, providing education, programs and services and responding to the needs of vulnerable populations. Values of WCHHS include equity, accountability, transparency, respectfulness, cultural responsiveness and collaboration.

The mission, vision and values for WCDAVS specifically were developed as part of a strategic planning process in 2014. The mission is to strive to create options that maintain the quality of life for older adults and people with physical disabilities. With quality and compassion, WCDAVS provides the people they serve, as well as their families and caregivers, with the information and resources that enable them to live safely and independently for as long as possible. The vision is to be a cornerstone in helping create a thriving community for older persons, people with physical challenges and veterans that reflects Washington County's values, diversity and pioneering spirit. Values of the agency include honoring client independence, promoting

informed choice, person centered and directed services, personal dignity, personal responsibility and engagement, equity and inclusivity, partnership and collaboration and a commitment to quality.

These values are operationalized from the beginning of staff employment. They are introduced at Washington County's New Employee Orientation and WCDAVS' division specific onboarding. Ongoing education and conferences continue to build and reinforce these principles. WCDAVS recognizes successful partnerships in the community and with clients are based in positive, respectful relationships which are crucial to delivering programs and services.

**A-3 Planning and Review Process**

To inform the area plan on aging, staff conducted a rapid needs assessment of older adults in Washington County. Tools used to collect community input included written surveys, online surveys and focus groups conducted across the county.

**Scope and Populations Consulted**

WCDAVS strives to create and foster a community where all older adults can thrive. In alignment with this goal, staff targeted various populations to capture the needs of older adults in the community. These populations included both older adults and those who care for them, either professionally or personally. To reflect the diversity of our community, staff solicited information from both English-speaking and Spanish-speaking communities, as well as those from the Chinese, Vietnamese, and Korean communities. Other specifically targeted groups included veterans and those who identify as LGBT. Since Washington County is a unique mix of urban and rural geographies, staff made efforts to reach as many portions of the county as possible. Overall, staff received feedback from at least 24 of the county's 34 zip codes.

**Washington County Community Survey**

During August 2016, WCDAVS conducted an online and written survey to inform the community needs assessment. The written survey and online surveys were distributed throughout the community and were available in both English and Spanish. The surveys included questions regarding the individual's knowledge of available services, perceived demand for specified services, perceived concerns regarding various issues (e.g. housing costs, accessing appropriate health care, handling feelings of depression), activity-related interests, financial security, caregiving, living situation, and various demographics. Online surveys were distributed through e-mail distribution lists, social media, and fliers. Written surveys were distributed at focus groups (discussed below) and community centers, and were supplied to homebound seniors receiving Meals on Wheels. Full details of the distribution scope and sample materials are available in Appendix C.

The community survey gathered information from 439 individuals. Respondent characteristics are outlined in table 1. The majority of respondents were female. Veterans were well represented within the sample, accounting for 20% of respondents, and 26% of respondents were spouses of veterans. Roughly 8% reported Hispanic ethnicity. Approximately 91% of respondents self-identified as heterosexual, while 4% identified as LGBTQ, and the remaining 5% of respondents did not wish to specify. Roughly 92% identified their race as White or Caucasian, followed by 3.6% each of those identifying as Asian/Pacific Islander or two or more races. Of those reporting two or more races, 79% reported being both American Indian and White or Caucasian. Although racial characteristics of survey respondents were somewhat less diverse than the general

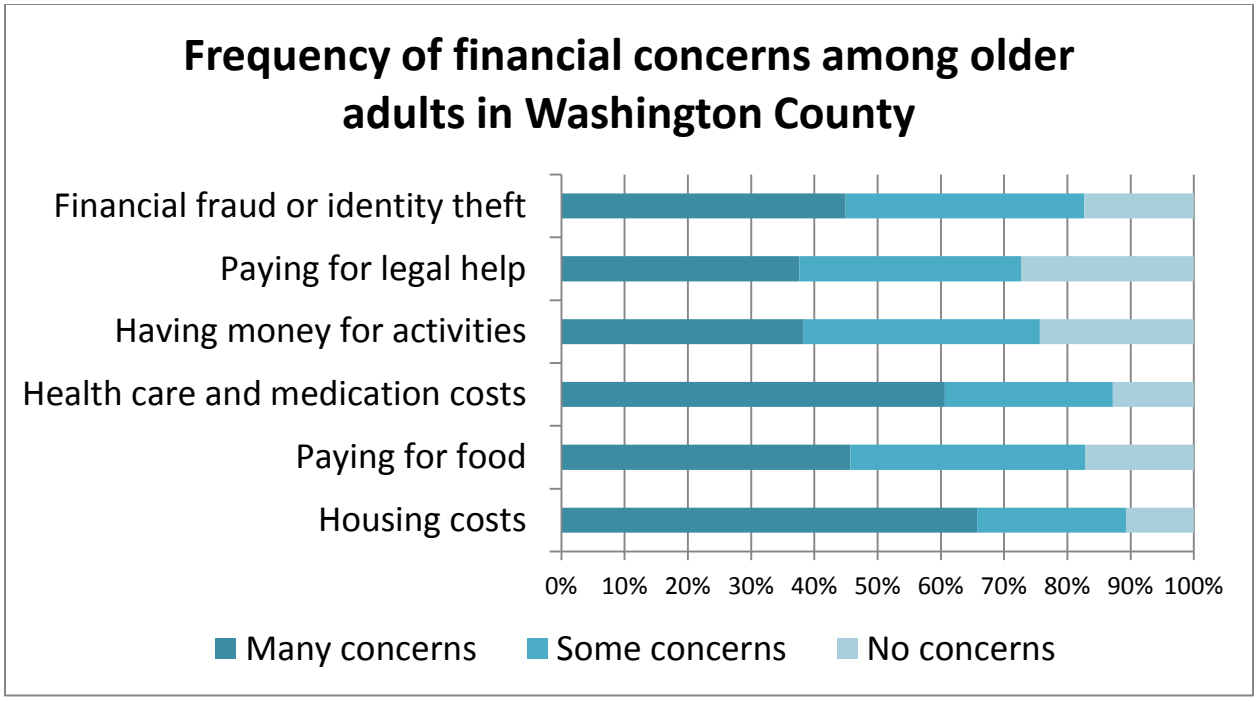
Washington County population, the respondents generally appeared to reflect the population of Washington County residents who are over age 60. The primary exception to this was response among those identifying as Asian or Pacific Islander; the survey sample was comprised of 3.6% Asian or Pacific Islander, compared to the 6.3% estimated to be living in the county.

**Table 1**: Survey respondent demographics

| | Survey sample | Washington County (adults over 60) | Washington County (all ages) |
|---|---|---|---|
| **Gender** | | | |
| **Female** | 67.7% | 55.6% | 50.7% |
| **Male** | 30.4% | 44.4% | 49.3% |
| **Not identified as male or female** | <1% | Not available | Not available |
| **Do not wish to say** | 1.4% | Not available | Not available |
| **Race** | | | |
| **American Indian/Alaska Native** | <1% | <1% | <1% |
| **African American/Black** | 1.0% | <1% | 1.7% |
| **Asian/Pacific Islander** | 3.6% | 6.3% | 9.1% |
| **Caucasian/White** | 92.3% | 89.5% | 77.4% |
| **Two or more races** | 3.6% | 1.3% | 4.3% |
| **Other** | 2.8% | 1.5% | 6.3% |
| **Ethnicity** | | | |
| **Hispanic** | 8.0% | 3.9% | 16.0% |
| **Non-Hispanic** | 92.0% | 96.1% | 84.0% |
| **Veteran status** | 20.0% | 20.9% | 7.9% |

**Concerns in the Community**

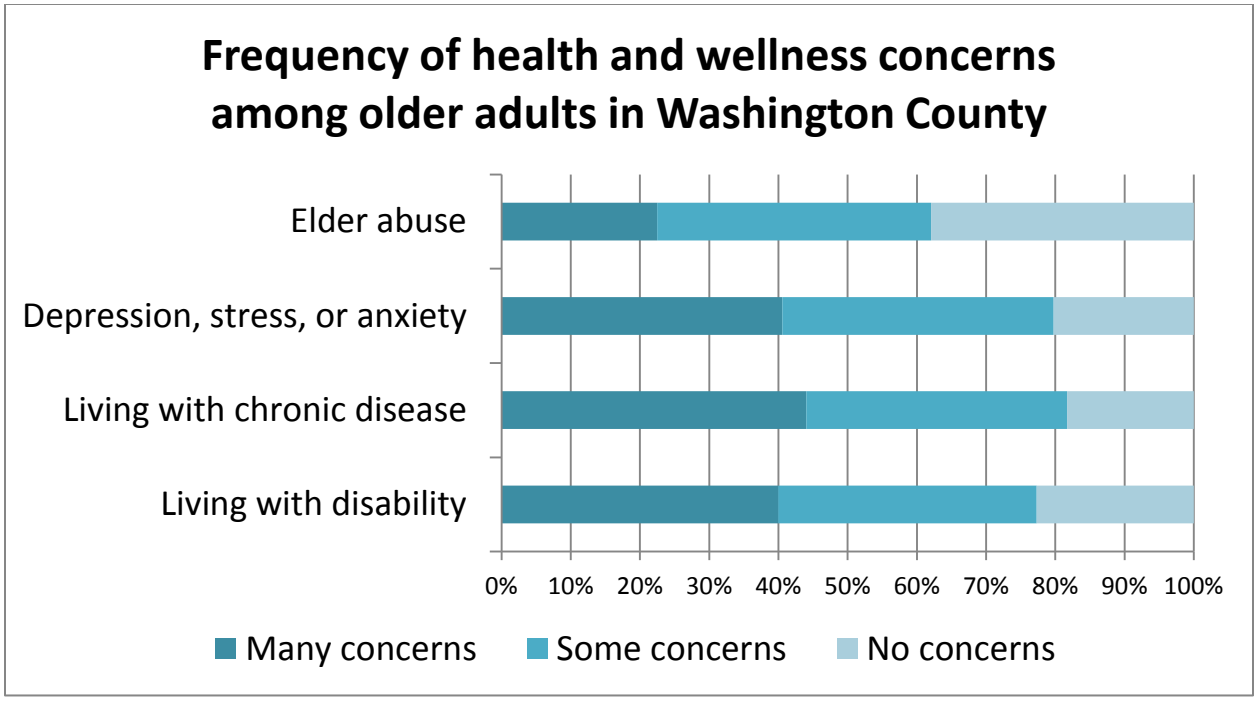
Beyond demographic measures, the survey also gathered information regarding concerns in the community. Respondents were given a list of various potential concerns, and were asked whether they had heard "many concerns, some concerns, or no concerns at all" among older adults. Results are displayed in Figure 1. The most commonly reported concern was related to housing costs, with two-thirds of respondents reported being aware of many concerns and another quarter being aware of some concerns. Roughly 4 in 5 of those between ages 50 and 64 reported that they have heard many concerns regarding paying for housing.




Concerns about medical costs were the second-most commonly reported across all age groups. Other prominent issues included concerns about living with disabilities; living with chronic disease; being victim to financial fraud; and handling feelings of stress, anxiety, or depression.

**Table 2**: Proportion of respondents having heard many concerns within the older adult community regarding specific issues, by age group

| | 49 years or under | 50-64 years | 65-79 years | 80 years or over | All ages |
|---|---|---|---|---|---|
| **Housing costs** | 75.0% | 79.1% | 63.4% | 53.6% | 66.6% |
| **Food costs** | 48.2% | 49.5% | 47.8% | 40.6% | 46.8% |
| **Health care costs** | 73.2% | 71.4% | 56.3% | 52.9% | 61.7% |
| **Activity costs** | 32.1% | 48.4% | 41.0% | 32.3% | 39.6% |
| **Legal costs** | 35.7% | 45.6% | 37.5% | 33.9% | 38.3% |
| **Financial fraud** | 37.5% | 51.1% | 48.1% | 42.6% | 46.1% |
| **Living with disabilities** | 53.6% | 47.3% | 41.2% | 41.8% | 43.9% |
| **Living with chronic disease** | 53.6% | 55.0% | 38.7% | 36.4% | 44.0% |
| **Handling feelings of depression** | 44.6% | 50.6% | 33.6% | 38.8% | 40.5% |
| **Elder abuse** | 26.8% | 25.3% | 20.8% | 20.3% | 22.5% |




**Accessing services**

Additionally, the survey asked questions regarding access to services, and whether individuals would know where to find certain types of help if they wanted it. Table 3 outlines the proportion of older adults who know how to access various services, and Table 4 outlines those who don't know how to access various services *but want to know*. The most common services that people want to know how to access include finding affordable legal services (42.3% of respondents), finding a place to live (31.6%), and getting transportation (30.0%).

**Table 3**: Proportion of older adults who know how to find help for specific services, by age group

| | 50-64 years | 65-79 years | 80 years or over | All |
|---|---|---|---|---|
| **Finding volunteer opportunities** | 47.3% | 52.2% | 31.8% | 46.3% |
| **Help with personal care (e.g., bathing)** | 37.8% | 37.1% | 40.0% | 38.0% |
| **Finding a care facility** | 35.2% | 32.9% | 38.4% | 34.8% |
| **Finding legal services** | 25.3% | 26.5% | 40.8% | 29.5% |
| **Getting transportation** | 43.5% | 50.6% | 49.4% | 48.4% |
| **Finding a place to live** | 33.0% | 36.9% | 37.5% | 35.9% |
| **Money management help** | 30.7% | 37.8% | 29.4% | 34.0% |
| **Finding a Medicare provider** | 30.8% | 47.5% | 39.7% | 41.1% |
| **Finding mental health care** | 40.0% | 41.0% | 28.8% | 38.1% |
| **Finding healthy food** | 48.4% | 59.8% | 53.6% | 55.1% |
| **Finding recreational activities** | 42.2% | 53.1% | 34.3% | 45.8% |

**Table 4:** Proportion of older adults who do not know how to find help for specific services but want to learn, by age group

| | 50-64 years | 65-79 years | 80 years or over | All |
|---|---|---|---|---|
| **Finding volunteer opportunities** | 25.3% | 16.2% | 20.8% | 19.8% |
| **Help with personal care (e.g., bathing)** | 28.9% | 25.8% | 33.3% | 28.4% |
| **Finding a care facility** | 31.9% | 26.8% | 19.2% | 26.5% |
| **Finding legal services** | 50.6% | 42.0% | 32.9% | 42.3% |
| **Getting transportation** | 37.0% | 27.1% | 27.3% | 30.0% |
| **Finding a place to live** | 40.7% | 31.9% | 19.4% | 31.6% |
| **Money management help** | 31.8% | 15.4% | 10.3% | 18.9% |
| **Finding a Medicare provider** | 41.8% | 24.7% | 19.2% | 28.2% |
| **Finding mental health care** | 32.2% | 18.0% | 22.7% | 23.1% |
| **Finding healthy food** | 29.0% | 18.9% | 21.7% | 22.4% |
| **Finding recreational activities** | 38.9% | 19.4% | 21.9% | 25.4% |

**Aging in Washington County Focus Groups**

WCDAVS conducted 14 focus groups with more than 250 total participants. Participants included older adults, family members, care takers, and professionals who serve older adults. Focus groups were structured around five basic questions covering the following topics: general wants and needs to make the community a better place to age; mental health and handling feelings of loneliness or depression; nutrition needs; aging in place; and subgroup questions targeted to the specific audience. When possible, focus groups were scheduled alongside community events that were already scheduled, such as congregate meals at senior centers, to encourage greater participation in the needs assessment. Focus group locations included the Hillsboro Community Senior Center; MOWP meal sites in Beaverton, Forest Grove, Hillsboro, and Sherwood; Centro Cultural de Washington County, a culturally Hispanic organization aimed at serving Latino residents, particularly new immigrants; Asian Health & Services Center, where four focus groups were conducted among the Fu-Yo (Blissful Friends) Club conducted in Mandarin Chinese, the Beaverton Friday Group conducted in Cantonese Chinese, the Beaverton Korean Healthy Friends Club conducted in Korean, and the Beaverton Vietnamese Club conducted in Vietnamese; the Q Center, an organization serving the LGBTQ community across the Portland metropolitan area; and the Forest Grove Elks Lodge during their weekly veterans' luncheon.

**Focus Group Findings**

Several common themes emerged during focus group discussions.

<u>Housing</u>

Concerns regarding housing were prominently discussed at all focus groups, though not specifically called out as a focus group question. Individuals raised concerns primarily regarding the affordability of housing,

referencing recent rent increases and being priced out of their current living situations. Participants expressed that having to move frequently due to rent increases was causing them stress.

Transportation

Knowledge regarding transportation services was mixed across groups. While some participants were aware of local transportation services available (e.g., TriMet, Ride Connection), others vocalized that getting to places they need to go remains a challenge. Participants reported that public transit is not convenient, either in terms of proximity to where they live or in terms of service frequency. Community members also discussed the cost of transit, and referenced programs elsewhere that provide free bus passes to low-income older adults. Walking as a mode of transit also emerged as a theme. In some areas, participants reported that they would like to be able to walk to their destinations, but have difficulty because of various barriers, including the lack of sidewalks; the lack of lighting on the street to make them feel safe after dark (especially during winter when the days are shorter); the lack of benches or places to rest along the way; and short amounts of time allotted by traffic signals for crossing at intersections.

Vitality and Opportunities for Socialization

Another common theme was the need to stay engaged. Some expressed that although they were retired, they still wanted to contribute to society and be a part of things. There was strong interest in staying a part of the community and not being segregated out from younger generations, whether in terms of classes, community events, or for other socialization opportunities. Some individuals lamented that they feel some members of the community are disengaged. In response to this, others suggested that help organizing social functions would be valuable, especially if they were low cost to participants. Several groups emphasized that maintaining a connection to the community, young or old, was essential to maintaining their mental health.

Mental Health

Community members at every focus group expressed a lack of knowledge about where to go for mental health care. In particular, minorities were often unaware of mental health services and brought up the additional barrier of finding help in their own language. As discussed above, individuals often pointed to socialization opportunities as their way to bolster their mental health and stave off feelings of loneliness or depression. Some suggested various opportunities to support mental health, such as sending out “check-in postcards” to older adults who may be housebound or live in rural settings, to let the people know that they’re being thought of and to see how they are doing. Another idea was to have drop-in mental health support groups for older adults.

Home Assistance

Participants were asked how the county might help support older adults to stay in their homes longer, or “age in place.” People requested both financial and hands-on assistance with having their homes fixed or modified to help them as they age. Help with housecleaning, home maintenance (e.g., changing lightbulbs, cleaning gutters), and paying for utilities were consistently reported as valuable services. Some individuals also expressed interest in help with home modifications, such as installation of safety bars in bathrooms or some way to help getting walkers upstairs.

Personal Care

Services to assist older adults with personal care activities were repeatedly discussed. Help with bathing and foot care services were noted as being valuable, particularly for homebound older adults who cannot go out.

Access to Healthy Food

A common theme across focus groups was the need for *affordable* healthy food. Focus group participants valued the low- or no-cost meals available to them at congregate meal sites, but also expressed concerns about obtaining food outside of that setting. Individuals stated that they would like for grocery stores to be more accessible, but that housing for older adults is often a distance from grocery stores. Although farmers markets appealed to most participants, they reported that food there was typically too expensive for them to afford. Another issue that arose was related to transportation of groceries, which can be difficult to carry, particularly when trips to the grocery store are less frequent.

Culturally Specific Resources

Across all of the themes discussed previously, participants from minority populations consistently reported needs for culturally specific resources. For accessing healthy food, people noted that the food provided to homebound seniors and at congregate meal sites is only American cuisine. For those who have spent their lives eating the cuisine of their cultures, these services are not adequate. Minority participants frequently reported a desire for more materials in their native language. Requested materials included not only information on specific services, but enriching materials such as books, magazines, and DVDs at libraries and senior centers. Participants with very limited English proficiency requested a hotline that would connect them to an interpreter to use to communicate with Washington County staff.

LGBT Older Adults

WCDAVS conducted a focus group at the Q Center to gather more information regarding the needs of the aging LGBT population. This focus group discussed many of the concerns mentioned above, but also lent insight into some of the particular challenges of LGBT older adults. For example, there is some hesitation from within the LGBT community to access services for older adults because of fears that they may not be LGBT friendly and concerns that they will have to explain their personal details in an uncomfortable setting. Additionally, there are concerns about vulnerabilities and physical safety among LGBT older adults as they age, as this population is at higher risk for harassment and hate crimes. Self-defense classes were suggested as a possible support. However, these concerns are particularly striking for the more fragile LGBT individuals who are in need of an assisted living facility or nursing home but fear entering because of institutional homophobia.

Veterans

The Forest Grove Elks Lodge is one location for veterans' luncheons in Washington County. A focus group was conducted there to gather input specifically related to the county's older adults who served in the military. In addition to the broader services already discussed, participants in the veterans focus group expressed the helpfulness of having a WCDAVS staff member visit them weekly onsite. This setup allows the individuals to obtain information regarding services and help navigating the Veterans Affairs system.

Staff/Advisory Council/Plan Alignment

Staff and providers also had opportunities to contribute in both survey and focus group formats. Common themes during the staff focus group included concerns about housing, transportation, access to healthcare, aging in place services, recreational opportunities, improving partnerships, concerns regarding caregivers and a lack of resources to adequately serve client needs. WCDAVS also sought guidance from the Advisory Council via newsletter, email and during an Advisory Council meeting. The Advisory Council members were also sent the link for the survey.

This Area Plan aligns with the Community Health Improvement Plan (CHIP) for Washington County. WCDAVS participates in the CHIP implementation work on three strategic direction committees (access to care, chronic disease prevention and suicide prevention). Work to improve the overall health and well-being of the community through work on the CHIP complements WCDAVS' efforts to best prioritize programs and resources to serve the needs of older adults, people with disabilities and veterans.

**A-4 Prioritization of Discretionary Funding**

Opportunities in funding for Benefits Enrollment Center (BEC) have assisted WCDAVS in expansion of outreach and services. BEC dollars have allowed further outreach to eligible low income older adults and people with disabilities who would otherwise not access benefits. WCDAVS anticipates these opportunities will continue for 2017-2020.

WCDAVS consistently designates a portion of the Older Americans Act Title III-B allocation for program development and coordination. These funds are used to carry out responsibilities as an Area Agency on Aging and for development of new programs and coordination of existing programs and services for persons age 60 and older within the service area. Examples of program development and coordination activities include gathering and analyzing data to determine older adult needs for programs and services within the WCDAVS service area and using needs assessment information to establish goals for program modification, enhancement and development. WCDAVS also works with communities and groups within the service area to encourage local responses and resources to meet the needs of older adults. WCDAVS serves on committees, advisory councils and boards of organizations providing services which have an impact on the lives of older adults (services such as transportation, health care, education, volunteer programs and others).

WCDAVS also facilitates long-term care services and supports development with coordinated care organizations (CCOs) and Aging and People with Disabilities Offices (APD). The agency has also conducted new outreach for the Senior Health Insurance Benefits Assistance Program (SHIBA) including classes at Portland Community College and other locations in the county. Ongoing emergency disaster planning is also a focus. WCDAVS will also be using discretionary funding for a new Money Management Program which will engage volunteers to assist older adults and people with disabilities manage their finances. The volunteers will be trained in modules from an Easter Seals program. These modules include topics like use of the ADRC, dementia information, social security information, HIPPA training, mandatory reporting and boundaries. The program also includes ongoing training and monthly or quarterly support for volunteers. Discretionary funds are also used to support the Steps for Success program which provides information and training to older adults regarding how to hire in-home caregivers. WCDAVS has also been working on a project with area healthcare providers (Providence, Legacy, OHSU and the CCOs) to implement the Community Care Transitions

program. Community Care Transitions is an evidence-based coaching and mentoring model designed to reduce readmissions to hospitals for older adults.

WCDAVS currently maintains a waitlist for Oregon Project Independence (OPI) serving consumers 60 and older. To prioritize consumers awaiting OPI, a standardized tool called the Risk Assessment Tool (RAT) is used. This tool includes information regarding the consumer's income, resources, natural supports and unique care needs. Other waitlists are maintained on an as-needed basis for services that spend out annually such as Family Caregiver Respite and supportive services.

WCDAVS is committed to serving older adults in their own homes whenever possible. WCDAVS continues to build community partnerships and seek additional funding opportunities to support service priorities in the event of reductions or increases. If funds were reduced or increased, WCDAVS will serve older adults in accordance with the primary goals of the OAA to include serving the health, safety and independence needs of the most frail and vulnerable older adults, preventing self-neglect and elder abuse, serving older adults who are isolated or have limited English proficiency, assisting those who lack or have limited access to other long-term care services and those at risk for nursing facility placement. If services are reduced or eliminated, WCDAVS will preserve services for these most at-risk clients as appropriate.

**SECTION B-PLANNING AND SERVICE AREA PROFILE**

**B-1 Population Profile**

The population of Washington County has grown to an estimated 547,451, of which 88,770 individuals are age 60 and over (ACS 2010-2014 5-year estimates). Overall, this reflects a growth in the older adult populations over recent years, increasing from 13.3% in 2009 to 16.2% in 2014. Current estimates suggest that roughly 1.6% of the county's total population is accounted for by individuals age 85 and older. Older adults affected by poverty has also increased, with 7.5% of individuals over 60 currently estimated to be living in poverty versus 6.3% five years prior. The preponderance of older adults in Washington County is female, comprising 56.2% of the older adult population, compared to 50.8% of the total population. Washington County is classified as an urban area, with only 6% of the population living in rural areas (ACS). The county's rural population accounts for about 4% of the state's total rural population.

**Minority Populations**

About 12.7% of Washington County's older adult population is made up of minorities (non-White, or Hispanic), compared to 31.3% of the general population. The population of adults over 60 is estimated to be 3.8% Hispanic, 6.3% Asian, 0.7% African American, 1.3% two or more races, and less than 1% each of Hawaiian/Pacific Islander and Native American. Overall, minority groups comprise a larger proportion of the Washington County older adult community (11.1% in 2009 vs. 12.7% in 2014). This has largely been driven by an increase in the Asian older adult population, from 5.3% five years ago to 6.4% in current estimates. This trend will likely continue, as the proportion of Asian individuals in the general population has also increased from to 8.1% to 9.0%. Other minority populations have increased, including the Hispanic population, which has seen a slight (0.4%) increase in the general population, though remaining relatively steady among the older adult population. English is the only language spoken at home for 76.6% of Washington County residents, compared to 86.9% of residents aged 60 or greater. However, this gap narrows when estimating those who can speak English less than "very well," with 9.3% of the general population and 7.8% of the population aged 60 or greater.

**Economic Characteristics**

For owner-occupied housing units in Washington County, almost one-third of owners aged 60 or greater are spending 30% or more of their household income for housing. However, this number drastically increases for renter-occupied housing units, where 61.0% of those aged 60 or greater are spending more than 30% of household income on housing. The ratio of owning versus renting has remained at about 3:1 for the past several years, with approximately 25% of older adults renting. Mean retirement income among those over age 60 is estimated to be approximately $25,298 annually, having risen approximately $2,000 over the past five years, roughly keeping pace with inflation during that time.

**Disabilities and Health Conditions**

The prevalence of any disability among older adults has remained steady over the past five years, accounting for about 27.3% of the population over 60 in Washington County. The prevalence of chronic health conditions increases with age, as reflected in Washington County (Table 5).

**Table 5**: Prevalence of chronic health conditions in adults over 60 in Washington County

| | 60-74 years | 75+ years |
|---|---|---|
| **Arthritis** | 50% | 59% |
| **Coronary Heart Disease** | 9% | 10% |
| **Diabetes** | 14% | 14% |
| **High Blood Pressure** | 46% | 60% |
| **High Cholesterol** | 48% | 48% |
| **Major Depression** | <1% | 3% |
| **Stroke** | 4% | 9% |

**B-2 Target Populations**

**Overview:**

WCDAVS' target population includes not only those adults over age 60, but also low-income, minority older adults, those with limited English proficiency, older adults living in rural areas, those at risk of social isolation or institutional placement and Native American and LGBT older adults. WCDAVS also serves people with physical disabilities and veterans. WCDAVS utilizes a variety of methods to identify, engage and serve these populations. Community outreach, training and educational opportunities, local health fairs, community forums and public service announcements in print and digital media are some examples of outreach activities. Staff participates in a variety of local networking groups that include senior centers, assisted living facilities, partnerships with emergency responders, multi-disciplinary teams, nutrition services providers, veterans groups, transportation providers and public health agencies. WCDAVS is an established and well-known agency among these partners and service providers. WCDAVS staff are frequently consulted and invited to speak or participate in the planning and development of other community programs serving the needs of similar populations.

**Low income or residents in rural areas or those at risk for institutional placement:**

Low income, residents in rural areas and those at risk for placement in higher levels of care are identified, engaged and served by many of the activities described above. Specifically, WCDAVS works with hospitals to identify those most vulnerable for higher levels of care. WCDAVS also works closely with APD to identify, engage and serve consumers who might not be eligible for APD services. Referrals are made to WCDAVS to meet this population's needs.

**Older Individuals with limited English Proficiency:**

WCDAVS engages in outreach to minority and limited English proficiency populations in collaboration with other community providers, such as health services providers and community service agencies such as Virginia Garcia Community Health, El Centro Cultural de Washington County and Asian Health & Services Center. WCDAVS partnered with El Centro Cultural de Washington County to help engage older adults from the Latino community who are eligible for OPI. WCDAVS also has a long-standing collaboration with Asian Health & Services Center to provide information, assistance, training and counseling to older adults from the Asian community.

**Older individuals who are Native Americans:**

Recent efforts to identify, engage, and serve older adult Native Americans included outreach to local agencies serving this population in the tri-county area including Native American Rehabilitation Association (NARA), Native American Youth Association (NAYA) and local representatives at the Indian Health Board. WCDAVS will initiate engagement of older adult Native Americans through partnerships with these and other organizations during the next four years as part of the implementation of this Area Plan.

**Older individuals who are LGBT:**
WCDAVS has focused specifically on issues identified by LGBT seniors through a metro-wide alliance convened regularly to strategize outreach and engagement of this community. More recent efforts also include outreach to Washington County residents who participate in LGBT older adult programming at Sage, Friendly House and the Q Center. WCDAVS staff also attended local PFLAG (Parents Families and Friends of Lesbians and Gays) meetings in Washington County to present information about WCDAVS services.

Regarding service provision, WCDAVS has earned a bronze star with SAGE Care, indicating that 25% of staff completed one hour of an array of "LGBT and Aging" trainings in person or online. The trainings provide an overview of the needs, concerns and unique history of older LGBT adults, as well as meaningful steps that staff can take to immediately improve the quality of support and services they provide. Over the next four years, WCDAVS will maximize the number of trained staff to earn the higher designation. WCDAVS can communicate to the public through signage and other media that WCDAVS is LGBT friendly. WCDAVS can cultivate relationships in LGBT communities by having a presence at events such as the Gay and Grey Expo held each year, attending Friendly House, Q Center and SAGE events and ongoing participation in the Portland PRIDE Week activities. WCDAVS has hosted social events for LGBT older adults at the Elsie Stuhr Center to address the needs of this population. WCDAVS will continue to seek opportunities for outreach in this area. These activities will establish trust and connections with individuals who can be important allies in promoting and educating this community about WCDAVS programs and services.

LGBT older adults have some unique needs including in many cases a lack of family support due to family abandonment or not having children. Therefore reliance on friends and peers and potential services becomes more important. WCDAVS would like to help support the cultivation of supports locally in Washington County for LGBT older adults to meet and network. WCDAVS will strengthen the relationship with PFLAG in an effort to create more supports for this population in Washington County. Accordingly, WCDAVS can educate and assist senior centers, meal sites, and other places where older adults gather to work on efforts to better include this population in programming.

**Veterans:**
WCDAVS provides assistance to veterans and their dependents in obtaining federal, state and local benefits. This is accomplished through active outreach within local communities, at long term care- facilities and through in-home visitations. A pilot project has also involved staff going to the Forest Grove Elks Lodge Veteran's Lunch once per week to offer services and assistance. This outreach effort involving the co-location of staff has been very successful. Other service elements include staff assisting veterans in filing claims for benefits with the federal and state Veterans' Affairs Departments and acting as a representative for veterans in appeals concerning claims with the U.S. Department of Veterans' Affairs. Staff link potentially eligible veterans with OAA, OPI, Medicaid and food assistance programs. They also take referrals of Medicaid clients to estabilish VA eligibility and file claims as required by Medicaid. WCDAVS has partnered with the VA Medical Center to provide case management services for the VA's Veteran's Directed Home and Community Based Services Program. WCDAVS partners with Ride Connection to provide Veteran to Veteran transportation through the Ride Together program which recruits veterans to drive veterans to medical appointments, pick up medications or for trips to the grocery store. Ongoing services are needed to educate and assist veterans, their dependents and other veteran representatives, groups and organizations.

**B-3 AAA Services and Administration (narrative accompaniment to Attachment C, described further in Section D)**

Numbers identifying each service correspond to the listing found in Attachment C.

**Personal Care #1** (contracted) **#1a** (HCW) (1 unit = 1 hour)
In-home services provided to maintain, strengthen, or restore an individual's functioning in their own home when an individual is dependent in one or more ADLs, or when an individual requires assistance for ADL needs. Assistance can be provided either by a contracted agency or by a homecare worker paid in accordance with the collectively bargained rate. (OAR 411-0032)

**Homemaker #2** (contracted) **#2a** (HCW) (1 unit = 1 hour)
Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov).

**Chore #3** (contracted) **#3a** (HCW) (1 unit = 1 hour)
Assistance such as heavy housework, yard work or sidewalk maintenance. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Home Delivered Meals #4** (1 unit = 1 meal)
A meal provided to a qualified individual in his/her place of residence that meets all of the requirements of the Older Americans Act and state and local laws. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

***OPI Home Delivered Meals #4** (1 unit = 1 meal)
A service that includes a meal provided to an eligible individual in the individual's place of residence. Home Delivered Meals are prepared and delivered in compliance with applicable state and local laws, meet a minimum of 33 1/3 percent of Dietary Reference Intakes and Dietary Guidelines, include meal menus approved by a registered dietitian, require an in-person initial assessment and a minimum annual assessment and provide nutrition education to the individual one time per year.

Home-delivered meal eligibility assessment is reported as Matrix #40-3 Preventive Screening, Counseling and Referral.

***Adult Day Care #5** (1 unit = 1 hour)
Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov).

**Case Management #6** (1 unit = 1 hour)
A service designed to individualize and integrate social and health care options for or with a person being served. Its goal is to provide access to an array of service options to assure appropriate levels of service and to maximize coordination in the service delivery system. Case management must include four general components: access, assessment, service implementation, and monitoring. (OAR 411-032)

**Congregate Meals #7** (1 unit = 1 meal)
A meal provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and state/local laws. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.

**Nutrition Counseling #8** (1 unit + 1 session per participant)
Individualized guidance to individuals who are at nutritional risk due to their health or nutrition history, dietary intake, chronic illnesses, medications use or to caregivers. Counseling is provided one-on-one by a registered dietician, and addresses the options and methods for improving nutrition status. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

***Assisted Transportation #9** (1 unit = 1 one way trip)
Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Transportation #10**
When funds are available we provide this service.

**Legal Assistance #11** (1 unit = 1 hour)
Legal advice or representation provided by an attorney to older individuals with economic or social needs, including counseling or other appropriate assistance by a paralegal or law student acting under the direct supervision of an attorney, or counseling or representation by a non-lawyer where permitted by law. 1OAA 102(a)(33); 2OAA 307(a)(11)(E), 3321(a)(6)

**Nutrition Education #12** (1 unit = 1 session per participant)
A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Information and Assistance #13** (1 unit = 1 contact)
A service that (a) provides individuals with information on services available within the communities (b) links individuals to the services and opportunities that are available within the communities (c) to the maximum extent practicable, establishes adequate follow-up procedures. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Outreach #14** (1 unit = 1 contact)
Intervention with individuals initiated by an agency or organization for the purpose of identifying potential client(s) or their caregivers and encouraging their use of existing services and benefits. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Information to Caregivers #15** (serving elderly) and **15a** (serving children) (1 activity)
A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Caregiver Access Assistance #16** (serving elderly) **16a** (serving children) (1 unit = 1 contact)
A service that assists caregivers in obtaining access to the available services and resources within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Area Plan Administration #20-1**
Area Agency administrative functions required to implement the planned services, maintain required records, fulfill the requirements of federal regulation, state rules, and state unit policies and procedures and support the advisory committee. Includes such responsibilities as bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring and quality assurance. (OAA 301-308)

**AAA Advocacy #20-2**
Monitor, evaluate, and, where appropriate, comment on all policies, programs, hearings, levies, and community actions which affect older persons. Represent the interests of older persons; consult with and support the State's long-term care ombudsman program; and coordination of plans and activities to promote new or expanded benefits and opportunities for older persons. (45 CFR 1321.61(b)(1-5)

**Program Coordination and Development #20-3**
Activities include AAA liaison with other agencies and organizations serving older adults, services development and mobilization of non-OAA funds to enhance delivery of services to older adults (Condensed from AoA PI-83-4)

**Home Repair/Modification #30-1**
Minor home repair for safety such as grab bars, repair of railings, faucets.

**Respite Care #30-4**
Not provided at this time.

**Respite Care #30-5** (serving elderly) **30-5a** (serving children) (1 unit = 1 hour see notes)
Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care includes: (1) In-home respite (personal care, homemaker, and other in-home respite) (2) respite at a senior center or other nonresidential program (3) respite provided by placing the care recipient in an institutional setting such as a nursing home for a period of time (4) and for grandparents/relatives caring for children – day or overnight summer camps. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov & SPR Q&A #28, 2008)

Note: OAA 373 (a)(2)(A & B) states priority shall be given to caregivers providing services to individuals whom meet the definition of 'frail'. (See General Terms and Definitions.)

**Caregiver Support Groups #30-6/30-6a**
Services to support family caregivers.

**Caregiver Supplemental Services #30-7** (serving elderly) **30-7a** (serving children) (1 unit = 1 payment)
Services provided on a limited basis that complement the care provided by family and other informal caregivers. Examples of supplemental services include, but are not limited to, legal assistance, home modifications, transportation, assistive technologies, emergency response systems and incontinence supplies. (AoA Title III/VII Reporting Requirements Appendix –www.aoa.gov)

Note: Supplemental service priority should always be given to caregivers providing services to individuals meeting the definition of 'frail'. (See General Terms and Definitions) Home-delivered meals and transportation to caregivers serving older adults or caregivers serving children are to be reported under this matrix.

**Physical Activity and Falls Prevention #40-2** (1 unit = 1 session per participant)

Programs for older adults that provide physical fitness, group exercise, and dance-movement therapy, including programs for multi-generational participation that are provided through local educational institutions or community-based organizations. Programs that include a focus on strength, balance, and flexibility exercise to promote physical activity and/or prevent falls, that are based on best practices, and that have been shown to be safe and effective with older populations are highly recommended. (OAA 102(a)(14) D, E, F)

**Preventive Screening, Counseling, and Referral #40-3** (1 unit = 1 session per participant)
Education about the availability, benefits and appropriate use of Medicare preventive health services or other preventive health programs. Health risk assessments and screenings, and preventive health education provided by a qualified individual, to address issues including hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, bone density and nutrition screening. Health information on on-going and age-related conditions including osteoporosis, cardiovascular diseases, diabetes, and Alzheimer's disease and related disorders. (OAA 102(a)(14) (A-B),(H)& (J)

Note: Home-delivered meal assessments and congregate nutritional risk assessments may be reported under this service category.

**Mental Health Screening and Referral #40-4**
Services not provided at this time.

**Assistive Technology Device #40-5** (1 unit = 1 payment) Matrix#40-5
Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an individual.

***Health and Medical Equipment #40-5** (1 unit = 1 loan or payment)
Assistive devices such as durable medical equipment, mechanical apparatuses, electrical appliances, or instruments of technology used to assist and enhance an individual's performance in any activity of daily living. (OAR 411-027-0005)

**Registered Nurse Services (OPI) #40-8** (1 unit= 1 hour)
Services provided by a registered nurse on a short-term or intermittent basis that include but are not limited to interviewing the individual and, when appropriate, other relevant parties, assessing the individual's ability to perform tasks, preparing a service plan that includes treatment needed by the individual, monitoring medication and training and educating providers around the provisions of the service plan.

**Medication Management #40-9** (1 unit = 1 session per participant)
Screening and education to prevent incorrect medication and adverse drug reactions, including individual medication reviews or group-based programs that contain information on medication management (including Stanford's Chronic Disease Self-Management program (Living Well)). (OAA 102(a)(14) I) & (H.R. 2764; P.L. 110-161)
Note: Assistance in completing no-cost and/or low-cost prescription medication applications does not qualify as a unit of Medication Management unless education to prevent adverse drug reactions is provided.

**Guardianship/Conservatorship #50-1**
No services provided at this time.

**Elder Abuse Awareness and Prevention #50-3** (1 unit = 1 activity)

Public education and outreach for individuals, including caregivers, professionals, and para-professionals on the identification, prevention and treatment of elder abuse, neglect and exploitation of older individuals. Training for individuals in relevant fields on the identification, prevention, and treatment of elder abuse, neglect, and exploitation, with particular focus on prevention and enhancement of self-determination and autonomy. (Definition based on OAA 721(b)(1, 2, & 6)) Note: Multi-Disciplinary Teams (MDT), Gatekeeper education programs, short-term emergency shelter or transportation funding are allowable activities under this service.

**Volunteer Recruitment #60-4** (1 unit = 1 placement)
One placement means one volunteer identified, trained and assigned to a volunteer position. (Definition developed by AAA/SUA workgroup)

**Interpreting/Translating Services #60-5** (1 unit = 1 hour)
Providing assistance to clients with limited English speaking ability to access needed services. (Definition developed by AAA/SUA workgroup)

**Options Counseling #70-2** (1 unit = 1 hour)
Counseling that supports informed long-term care decision making through assistance provided to individuals and families to help them understand their strengths, needs, preferences and unique situations and translates this knowledge into possible support strategies, plans and tactics based on the choices available in the community. (Based upon NASUA's definition.)

**Caregiver Counseling #70-2a** (serving elderly) **70-2b** (serving children) (1 unit = 1 session per participant)
Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups and caregiver training (of individual caregivers and families). (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

**Newsletter #70-5** (1 unit = 1 hour)
Preparation and regular distribution of publications that inform seniors and the community of available services and activities. (Definition developed by AAA/SUA workgroup and SPR Q&A #61, 2008)

**Fee-based Case Management #70-8** (1 unit = 1 hour)
A service designed to individualize and integrate social and health care options. Its goal is to provide access to an array of service options to assure appropriate levels of service and to maximize coordination in the service delivery system. Case management must include four general components: access, assessment, service implementation, and monitoring. (OAR 411-032)

**Caregiver Training #70-9** (serving elderly) **70-9a** (serving children) (1 unit = 1 session per participant)
Training provided to caregivers and their families that supports and enhances the care giving role. For example: Powerful Tools training; Communicating Effectively with Health Care Professionals; conferences, etc. (A session for conferences would be equal to one day's attendance at the conference). (DHS/SPD/SUA definition)
Note: This does not include training to paid providers.

**Public Outreach/Education #70-10**
Services or activities targeted to provide information to groups of current or potential clients and/or to aging network partners and other community partners regarding available services for older adults. Examples of these types of services would be participation in a community older adult fair, publications, publicity

campaigns, other mass media campaigns, presentations at local senior centers where information on OAA services is shared, etc. (Definition developed by AAA/SUA workgroup)

**Chronic Disease Prevention, Management, and Education #71 –** (1 unit = 1 session per participant)
Programs such as the evidence-based Living Well (Stanford's Chronic Disease Self-management) program, weight management, and tobacco cessation programs that prevent and help manage the effects of chronic disease, including osteoporosis, hypertension, obesity, diabetes and cardiovascular disease. (OAA 102(a)(14)(D))

**Money Management #80-5** (1 unit = 1 hour)
Assistance with financial tasks for seniors who are unable to handle their personal finances. (Definition developed by AAA/SUA workgroup.)

**Volunteer Services #90-1** (1 unit = 1 hour)
Uncompensated supportive services to AAAs, nutrition sites, etc. Examples of volunteer activities may be, but not limited to, meal site management, board and advisory council positions, home-delivered meal deliveries, office work, etc.

***These services have been affected by the budget for OPI**

**B-4 non-AAA Services, Service Gaps and Partnerships to Ensure Availability of Services Not provided by the AAA:**

The needs of the populations served by WCDAVS cannot be fully met through the resources of any single organization. WCDAVS has developed collaborative relationships with other service providers in the local communities that are not readily apparent in routine program reports. WCDAVS provides information to those seeking assistance for issues that are not typically provided by the agency or through a contracted provider. WCDAVS maintains the Assistance Services and Aging & Disability Resource Connection (ADRC) data base to assist in directing clients to providers who can appropriately address their needs. Some of those service needs and providers are listed in Attachment B.

**Attachment B**

| Service | Provider | AAA Role |
|---|---|---|
| Mental Health | County Mental Health contracted providers<br>Urgent Care Center Co-located 2017<br>Pacific University Clinic<br>Older Adult Behavioral Health Program | Participate in Advisory Meetings, refer veterans to Pacific University's program, Older Adult Behavioral Health Program Coordinator Co-located at WCDAVS |
| Transportation | Tri-Met, Ride Connection | Participate in Advisory Meetings, advocacy |
| Housing | County Housing Department | Participate in Advisory Meetings, advocacy |
| Elder Abuse Awareness/Prevention | Sheriff's Office | Contract to provide Elder Safe |
| Employment Services | Employment Department | Member of SAC, Veterans Committee |
| Energy Assistance Programs | Community Action | Grant partnership, referral source, advocacy |
| Disability Services and Programs | Independent Living Resources, State Independent Living Council | Partner on various grants, consultation around advocacy |
| Community Healthy Aging | County Public Health | Partner on various grants |
| Senior Centers | 7 Throughout PSA | Partner through grants, advocacy |
| Information & Referral/Assistance | 211 | Participate in regional networking |
| Services Targeted to Minorities | Centro Cultural de Washington County, Asian Health & Services Center, Virginia Garcia Memorial Health Center | Contractual and partnership agreements to target agencies that serve minority populations |
| Alzheimer's/Dementia | Alzheimer's Association, Portland State University | Partner with organizations |

In addition to the partnerships identified in Attachment B, WCDAVS participates in a regional effort to engage and communicate with the local CCO's (Health Share and FamilyCare). Through memoranda of understanding (MOU), collectively the organizations have committed to better service, lower costs and improved outcomes for all older adults in the region.

Another key partner is APD. As a primary relationship with the ADRC, APD provides Medicaid, food benefits, and long term care services and supports to the most vulnerable low income consumers in our county. APD has strategically located three offices in Washington County with their Hillsboro office joined to WCDAVS further enhancing communication and coordination of benefits between the agencies. Through an MOU and BEC, WCDAVS and APD coordinate access to all long-term care services and supports available to older adults and people with disabilities in the area.

**SECTION C-FOCUS AREAS, GOALS AND OBJECTIVES**

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

1. **Information and Assistance Services and Aging & Disability Resource Connections (ADRCs)**

**Brief Profile**

WCDAVS was officially recognized as an Aging and Disability Resource Connection (ADRC) by the State of Oregon in May 2013. ADRCs provide a visible, trusted source of unbiased information and support to older adults and people with disabilities, as well as their families and caregivers. Supported by a statewide searchable database, website and 1-800 phone line, professionally trained, Alliance of Information and Referral Services (AIRS) certified staff not only provide information, but also help consumers access a wide variety of public and private services. Additionally, Washington County's ADRC provides Person Centered Options Counseling, which helps clients make informed decisions about long-term care options, in-home support services and benefits counseling.

**Specific Information**

To ensure ADRC services are available to all members of the community, WCDAVS employs English/Spanish bilingual staff in the call center and utilizes two phone or in-person translation services. WCDAVS collaborates with Asian Health & Services Center, Centro Cultural de Washington County and Virginia Garcia Memorial Health Center to promote services to the Asian and Latino populations in the county. WCDAVS and the Regional ADRC partners also participate in various LGBT outreach events in order to extend the ADRC's reach into that community.

WCDAVS is part of a consortium which established a Regional ADRC in the Portland Metro Area (see attached MOU) which also includes the Multnomah, Clackamas and Columbia County Area Agencies on Aging. This Regional ADRC also includes APD offices located in Columbia, Clackamas and Washington Counties and the Independent Living Resource Center covering the Portland metro area. Members of the Regional ADRC have all agreed to work together to pool resources and information so clients experience an advanced level of care coordination across the region. All resources are shared, without bias, so that consumers can make informed, objective decisions. Regional ADRC partners can take advantage of each other's assets. For example, while one county may be closed due to a compressed work week, another county will take the calls and make referrals. In another instance, one county operates a 24 hour call center that can be accessed by consumers in counties where staff is available only during regular business hours. This collaboration provides added flexibility and allows the Regional ADRC to make a greater impact across the area. The Regional ADRC also has a contract with Oregon Health and Science University, Tuality Hospital and Providence Hospitals to provide Care Transitions coaching to help reduce patient readmissions. WCDAVS has an MOU with the Regional ADRC including CCO's and APD offices. This agreement reflects the above and allows agencies to combine resources and provide complex case consultations as needed.

Since state ADRC funding ended in 2015, WCDAVS has chiefly utilized Options Counseling funding and Older Americans Act IIIB funding to sustain its information and assistance call center functions. The largest potential source of ongoing ADRC funding rests on a viable Medicaid claiming system. To this end, WCDAVS and other AAA partners have worked closely with APD over the last three years on a Medicaid claiming pilot project. The pilot project involves tracking tasks that are eligible for Medicaid match such as outreach and assistance including application completion. This pilot is entering its last phase and participants are hopeful that it will result in a long term source of revenue for the ADRCs.

**Problem/Need**

In order for the ADRC to be successful as a central location for resources for older adults more effective marketing could be utilized. It is a challenge to have staff and funding capacity dedicated to the needs of the ADRC both locally and statewide. Partners in the ADRC project could also be more actively invested in the project in the future.

**Goals and Objectives**

Goal: Pursuing sustainable sources of funding for marketing and system updates.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Evaluate and expand sustainable sources of funding | A | Participate in evaluation of Medicaid Pilot | Supervisor, WCDAVS | 1/2017 | 6/2017 | |
| | B | Increase number of staff participating by 2 | Supervisor, WCDAVS | 1/2017 | 1/2018 | |
| | C | Identify 3 or more grant opportunities | Senior Program Coordinator, WCDAVS | 1/2017 | 1/2018 | |

Goal: Improve ability to meet housing needs requests by increasing staffing.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Hire a housing coordinator | a | Complete hiring process | Supervisor, WCDAVS | 1/2017 | 1/2017 | |
| | b | Develop referral process for housing coordinator | Supervisor, Housing Coordinator WCDAVS | 1/2017 | 3/2017 | |
| | c | Develop tracking metrics for successful outcomes | Supervisor, Housing Coordinator, WCDAVS | 3/2017 | 12/2017 | |

Goal: Increase knowledge of and access to transportation resources in the community.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Improve and maximize outreach and access opportunities | a | Connect with transportation partners regarding distribution of outreach material | Supervisor, WCDAVS | 1/2017 | 6/2017 | |
| | b | Initiate revitalization of Regional Transportation Coordinating Committee | Supervisor, WCDAVS | 1/2017 | 6/2017 | |
| | c | Explore grant partnerships to increase transportation opportunities | Program Supervisor, Senior Program Coordinator, WCDAVS | 6/2017 | 12/2017 | |

### 2. Nutrition Services (OAA Title IIIC)

**Brief Profile**

Senior nutrition services are among the largest funded and most vital of services provided from Older American Act funds. These dollars allow for clients to receive a nutritious meal in a community based environment five days per week, while also offering socialization, education and opportunities for inclusion and volunteerism. Older adults often experience a decline in receiving nutritious meals as they age due to a variety of challenges including lack of interest in preparing food for just one or two, hardship with transportation, shopping, carrying and lifting, access to fresh or seasonal foods, challenges with taste or chewing and changes in income. Clients who are homebound also receive hot, nutritious meals delivered to their homes, additionally serving as a daily check-in and social support for those who otherwise may not have frequent or any visitors. Senior nutrition services provide a robust set of benefits, far beyond a nutritious meal, contributing to the wellbeing of the older adult and their ability to maintain their independence and dignity for as long as they are able.

**Specific Information**

**Identify how Title IIIC funds will be used to implement nutrition services, including a list of locations, days/times of service, and partner involvement in making nutrition services available**.

WCDAVS is in the second year of a five year contract with a nutrition services provider, Meals on Wheels People, Inc. (MOWP). MOWP was awarded the contract in response to an RFP. Nutrition services make up the largest allocation of OAA funds, which average about 40% of the actual cost of providing congregate and

home-delivered meals in our county. MOWP was selected based on their approach and ability in providing county-wide service equity for congregate and home delivered meals. Plans and policies are in place to provide meals for weekends, for emergencies or during disasters and inclement weather. Policies also cover the nutritional content and palatability of the food, the attention to special dietary needs and high standards for food handling safety. This contract meets the high and growing need for quality older adult nutrition, which is an important component toward maintaining independence and health as people age.

Funds are provided monthly upon receipt of a detailed invoice. Congregate and home delivered meals are provided five days per week from seven senior/community centers in the county. When additional weekend meals are authorized, they are delivered as frozen entrées on Fridays. MOWP held an additional contract at Edwards Center, a service center for people with disabilities. WCDAVS partnered with this center and MOWP to open their site to older adults in the community one day per week, creating an additional option for meals in Washington County. The Hillsboro Senior and Community Center is not included in contracted services, receiving no OAA funding, but serves as an additional community partner offering a daily congregate meal and no home delivered meal service. This partnership is collaborative and referrals are made among the centers to best match the appropriate service needs for older adults.

**Locations**

The meal site locations are as follows with operating hours around a lunch time meal service. Centers open earlier in the morning based on schedules of transportation partners. Centers offer coffee, tea, muffins and rolls for consumers who arrive early. Socialization and interaction is an important part of this pre-lunch waiting period. Center managers provide activities including puzzles, TV and videos, arts and crafts, magazines and occasional guest speakers.

North Plains Senior Center
31450 NW Commercial, North Plains, OR 97133

Forest Grove Senior & Community Center
2037 Douglas St., Forest Grove, OR 97116

Tigard Senior Center
8815 SW O'Mara Street, Tigard, OR 97223

Hillsboro Meals on Wheels People
541 Baseline St., Hillsboro, OR 97123

Hillsboro Senior & Community Center
750 SE Eighth Avenue, Hillsboro, OR 97123

Sherwood Senior Center
21907 SW Sherwood Blvd. Sherwood, OR 97140

Elsie Stuhr Center
5550 SW Hall Blvd. Beaverton, OR 97005

Juanita Pohl Center
8513 SW Tualatin Rd., Tualatin, OR 97062

Edwards Center
4375 SW Edwards Place, Aloha, OR 97007

**Identify any plans to change the meal production and delivery system(s).**

There are no plans to change meal production or delivery systems in the near future. As WCDAVS monitors the locations and works with MOWP, discussion has occurred about the cost-effectiveness of operating this

number of centers. However, there is great value placed on services being available across the county in multiple locations. The number of clients served has fluctuated over the years, as the oldest older adults have moved away from the area or passed away. The younger older adults may not identify with attending a senior center meal program, may still be working and may have other choices of socialization they pursue as they age or simply may not be aware of these centers as service providers. Despite this, there is still significant need for the service.

**Identify how you will develop partnerships and with whom, and how you will engage in fundraising opportunities and other activities to support the costs of providing nutrition services.**
At this time, WCDAVS provides the contracted amount of OAA funds to MOWP with the agreement that they have the responsibility for fund-raising the remaining funds needed to provide nutrition services. MOWP holds two large annual fundraising luncheons each year and each meal site is required to raise a set amount of funds throughout the year. These funds, along with client donations provided for their meals, are documented as funds provided to operate each specific location.

**Indicate how nutrition education, nutrition counseling and other nutrition services will be provided for both congregate and home-delivered meal recipients.**
Nutrition education is provided as outlined in the State Standards for Congregate and Home Delivered Meals of at least two occurrences per quarter. The criterion for delivering nutrition education includes active and passive dissemination of educational information. For example, brochures and flyers with information may be available for view but also highlighted or actively explained by staff at the site.

Nutrition counseling and nutrition assessments are offered for every new client who is registered for home delivered meals, with follow up at six months or one year based on specific need. This service is provided by MOWP client service coordinators. Congregate clients are assessed by the National Aging Program Information System (NAPIS) form filled out when registering at a meal site location. At any time, a congregate client may request nutrition counseling, which is then scheduled and provided by the client service coordinator assigned to the area.

**Explain how nutrition services are linked to and coordinated with health promotion, family caregiver, and other applicable AAA services.**
NAPIS forms are provided to WCDAVS, and entered into the Oregon Access database which may prompt identification of need for additional services. The point of entry for a client could be via the NAPIS form filled out at a meal site, or could be part of an expansive set of referrals identified from the ADRC, which includes nutrition. MOWP is trained to refer clients to WCDAVS, and trains staff and volunteers to recognize additional client needs which may warrant referral. The ADRC phone number is widely conveyed within MOWP's network.

**Problem/Need**
While nutrition services are a large component of Older American Act funding, the funding has not increased at the same pace as the aging demographic numbers nationally. As the newest generation of older adults, has aged into their sixties the current population of older adults are living longer with many aging into their late

eighties and nineties. Continued senior nutrition programming is dependent on OAA funding, in addition to NSIP and state funded OPI dollars. MOWP as the provider depends on WCDAVS funding in addition to funds they receive from Medicaid, SNAP, corporate sponsorship, fundraising and client contributions and donations.

**Goals and Objectives**

Goal: Explore development of opportunities for improved access to alternative food sources.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Begin conversation regarding potential opportunities | a | Initiate conversation with alternative food sources to discuss opportunities for improved access | Program Coordinator, WCDAVS | 1/1/17 | 1/2018 | |

Goal: Explore feasibility of meeting nutrition needs of diverse populations.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Conduct needs assessment and development plan to better meet needs | a | Assess population specific nutrition preferences by area | Program Coordinator, WCDAVS | 1/2017 | 6/2018 | |
| | b | Identify potential funding sources | Program Supervisor, Senior Program Coordinator, WCDAVS | 6/2018 | 6/2019 | |
| | c | Develop an implementation plan | Program Supervisor, Senior Program Coordinator, WCDAVS | 6/2019 | 7/2020 | |

### 3. Health Promotion (OAA Title IIID)

**Brief Profile**

WCDAVS believes proper nutrition, healthy lifestyle choices and access to health promotion activities can enhance individual health and quality of life. As a result, WCDAVS participates in a variety of activities designed to promote good health among older adults and people with disabilities.

**Specific Issues**

WCDAVS is committed to supporting existing evidence-based and best practice programs. WCDAVS encourages and facilitates community partners in an effort to bring other evidence-based health promotion

and disease prevention programs to the region. For example, WCDAVS collaborates with Pacific University to provide counseling services for veterans. Regarding chronic disease prevention, WCDAVS is actively involved with chronic disease self-management programs (CDSMP) and has an agreement with Tuality Healthcare to enhance referrals to the Living Well CDSMP. WCDAVS also formed a steering committee in Washington County, bringing together all licensees, WCDAVS and Washington County Public Health to better coordinate Living Well in Washington County. The steering committee also worked to improve workshop planning and sharing of referrals for both Living Well and Tomando Control. Collaboration between the Long Term Care Innovator Agent and Acumentra Health brought together Tomando Control leaders from Washington County to increase coordination of workshops as well. Through this team, WCDAVS is providing access to cross training of leaders for diabetes self-management to further support these trainers in the community. Additionally, WCDAVS has a partnership with AARP Oregon, Portland State University and others to advocate for issues that impact the health of older adults and people with disabilities.

WCDAVS is also an active participant in the Community Health Improvement Plan (CHIP) in Washington County which includes representatives from public health, hospitals, DHS, education, CCOs and other health partners. As a participant on the Chronic Disease Prevention CHIP Committee, WCDAVS works with these partners on specific goals and objectives designed to improve overall health and livability in Washington County.

**Problem/Need**

Evidence shows preventative measures such as regular physical activity decreases the risk of developing chronic conditions such as high blood pressure and diabetes, helps to prevents falls, and enhances the quality of life for older adults and people with disabilities. In addition, the benefits of a nutritious, balanced diet and remaining engaged in the community have been shown to have emotional and physical benefits as people age. Evidence-based education to older adults about managing chronic conditions helps maintain good health. Healthy communities encourage and promote physical activity, offer readily accessible, nutritious food and provide opportunities for socialization with peers.

**Goals and Objectives**

Goal: Enhance access to chronic disease self-management programs.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Increase availability of CDSMP in Washington County | A | Increase number of CDSMP workshops | Senior Program Coordinator, WCDAVS | 1/2017 | 1/2019 | |
| | B | Increase number of leaders trained in Stanford CDSMP | Senior Program Coordinator, WCDAVS | 1/2017 | 1/2019 | |
| | C | Enhance number of leaders trained in Tomando and DSMP | Senior Program Coordinator, WCDAVS | 1/2017 | 1/2019 | |

### 4. Family Caregivers (OAA Title IIIE)

**Brief Profile**

The National Family Caregiver Support Program (FCSP), as articulated in the Older Americans Act (OAA), was developed to provide critical services to unpaid caregivers caring for adults with functional disabilities or relatives who are raising children. The program recognizes both the tremendous value to family care recipients and the added responsibility and sacrifice provided by caregivers. The program is designed to help provide caregivers with the skills, understanding and support necessary to meet the inherent demands of caregiving, balanced with the need for self-care.

**Specific Information**

**Information Services/Group Activities**

WCDAVS and ADRC participate in numerous outreach events and fairs throughout the year to share information about the FCSP. The county website section on FCSP continues to be updated and improved to include links to upcoming events for family caregivers and self-help tools and relevant websites. WCDAVS' Facebook page includes posts about family caregiver events and information. WCDAVS continues to produce a large print publication available by mail previously, now online, which includes "*The Caregiver Advisory*," a section dedicated to family caregiver information, classes, trainings and issues relevant to caregivers. *The Advisory* is published six times per year. The FCSP was also featured recently in a 20-minute segment of the Community Matters cable TV program. It aired for a month on TVCTV with a potential reach of 400K households. It was also viewed 57 times on YouTube. The program is archived and available on the WCDAVS website for ongoing viewing.

**Specialized FCG information (one-to-one)**

Intake occurs by telephone to share service information and set up an initial home visit with a case manager or options counselor. A home visit is offered whenever a family caregiver is indicating a need for an in-person visit to discuss their challenges and support services as well as for those requesting paid respite.

**Counseling**

Counseling is offered through a contract with Courageous Mourning Counseling Services**.** The program will pay for up to three one-on-one counseling sessions during the fiscal year, with a qualified mental health professional. If more sessions are needed, the family caregiver may continue with services at the private pay or sliding scale fee established by the contractor. The counseling is focused on the client's identified concerns with the overall goal of supporting caregivers managing their responsibilities. Counseling of this kind also often includes work specific to grief.

**Training**

Training opportunities through community partners such as the Alzheimer's Association, Oregon Care Partners, Powerful Tools for Caregivers (PTC), Home Instead and Tuality Health Education are promoted in *The Advisory,* in program information packets and through the ADRC. Classes are available in person and online. PTC, a six week evidence-based self-care curriculum, is offered three times per year WCDAVS in partnership with Tuality Health Education at various locations throughout the county. An annual one day Washington County Family Caregiver Conference has occurred for the past thirteen years. This is a well-attended event reaching an average of 150 family caregivers and community members each year. Additionally, WCDAVS offers an annual worksite three-part "brown bag" series for working family caregivers who are Washington County

employees. The series has been so well received that Washington County Employee Wellness has built it into their annual program offerings.

**Support Groups**
Monthly family caregiver support groups are offered through the contract with Courageous Mourning. These are offered in three locations (Beaverton, Tigard and Hillsboro) to make it easier for family caregivers across the county to attend.

**Respite Care Services**
Paid respite is provided through two contracts with Home Instead Senior Care (Hillsboro and Beaverton franchises) for in-home respite. The respite benefit functions as an introduction to paid in-home services, allowing family caregivers to experience 18 hours of respite (about a $400.00 value), to be used within a 60 day period.

**Supplemental Services**
WCDAVS has two contracts with medical suppliers (Active for Life and McCann's Medical Supply) and an account with Amazon.com to provide durable medical equipment, adaptive aids and incontinency supplies for up to $200 during the fiscal year per family caregiver.

***Describe goals, objectives and activities which reflect the experience of gathering information and feedback on needs of caregivers, as well as identifying existing gaps in service:***
Because family caregiving is a widespread and universal experience for families of aging loved ones, WCDAVS has utilized its robust partnerships to help gauge caregiver need. The Family Caregiver Alliance compiles data on caregiving profiles and needs on a national level. More locally, the AARP Oregon Chapter has made family caregivers one of its program priorities. The AARP Oregon Chapter has coordinated numerous events across the state, two specifically in Washington County, dedicated to caregiver concerns. These events have focused on respite--one of the most frequently cited needs expressed by caregivers.

WCDAVS mails an annual Family Caregiver Client Satisfaction Survey to 10% of its clients served (approximately 40 - 45 family caregivers chosen through random selection). The return rate for the survey is over 50%. The survey asks a variety of questions about how caregivers experience the services they are receiving and solicits suggestions for ongoing needs. Consistently the highest identified area of need for family caregivers is for respite alternatives.

Each year WCDAVS staff co-leads several Powerful Tools for Caregivers (PTC) classes throughout the county. Class members complete evaluations and provide feedback about the course and their challenge areas. Often participation in the PTC series leads to connection with other training, support groups and individual counseling services.

Additionally, attendees to the annual Washington County Family Caregivers Conference held every November complete an evaluation which includes suggestions for future presentations and resource representation. This is the largest county gathering of family caregivers during the year. The content of the conferences is based primarily on requests from attendees.

***Describe how AAA and service partners will conduct outreach and public awareness as well as culturally-relevant services to the following caregiver populations, with particular attention to the target groups identified through the 2006 reauthorization of the Older Americans Act and at the state level:***

- **Limited English-speaking and ethnic caregivers, including Native American caregivers:**

WCDAVS recognizes the need to increase outreach and public awareness as well as culturally relevant services to limited English-speaking and ethnic caregivers including Native American caregivers. WCDAVS provides the Oregon Family Caregiver Handbook in Spanish to caregivers and community partners as needed. WCDAVS recognizes improvements can be made in this area through new and enhanced partnerships with organizations who serve these populations.

In the area of staff development, WCDAVS has worked with human resources to increase the opportunities for bilingual (Spanish) candidates to apply for positions serving older adults and their caregivers. These efforts have resulted in the addition of a bilingual administrative assistant and a bilingual program specialist in the ADRC. WCDAVS recognizes an opportunity in the next four years to increase opportunities for culturally relevant training for staff. WCDAVS Also acknowledges the need for culturally relevant materials and will continue efforts to translate and revise materials over time to better serve the multicultural populations in Washington County.

WCDAVS has an ongoing partnership with Asian Health & Service Center. This is a community agency which provides culturally-specific services to Asian family caregivers who speak primarily Chinese, Japanese, Korean and Vietnamese. This is a multi-generational center which provides a variety of services including classes on health, wellness and exercise, socialization opportunities and family caregiver support including counseling, information and access to services.

WCDAVS recognizes the need for additional efforts to partner with the Latino caregiver community. One goal over the next four years would be to provide scholarships for bilingual community members to receive training to bring Powerful Tools for Caregivers to Spanish speaking caregivers. WCDAVS will also pursue efforts to develop partnerships with organizations who serve older adult Native Americans. Through these new relationships, WCDAVS will pursue a needs assessment to gather information about older adult Native Americans living in Washington County to inform efforts to best serve them in the future.

- **Caregivers who are in the greatest economic and social need:**

For paid respite, WCDAVS prioritizes those caregivers managing a higher acuity of caregiving responsibility, who have fewer to no natural supports and those with the greatest economic need. Respite funds are very limited and each request is carefully considered during a weekly staffing of cases after the initial home visit. Caregivers managing the needs of a family member with Alzheimer's disease or related dementias are at greater risk for depression and this is also a consideration. The age and health of the family caregiver are also important determining factors in prioritizing who receives respite services.

- **Non-traditional family caregivers:**

WCDAVS is an active member of the Metro LGBT Alliance and participates in the annual Portland Gay Pride event. Older LGBT adults often travel to Portland for socialization at established programs provided by community agencies such as Friendly House and the Q Center. An outreach event for aging LGBT individuals has been held the last two years at the Elsie Stuhr Adult Center in Beaverton. This year there were no attendees; and, staff is considering other options to reach out to the aging LGBT community in the county. One opportunity may be to cultivate informal relationships and support natural socialization and gatherings in Washington County such as at the local PFLAG meetings to begin to better connect with this community.

- **Grandparents raising grandchildren:**

Grandparents raising grandchildren may access individual counseling services through the counseling contract. A stipend program which was previously available to grandparents to subsidize a relief break from caregiving was eliminated due to budget constraints. There is discussion to revive this option. This was a successful

program and has been replicated in other counties. One opportunity to revive the program may be to utilize respite funding along with other funding alternatives.

- **Older individuals caring for people, including children with disabilities:**

WCDAVS continues to have a partnership with Washington County Developmental Disabilities after the Lifespan Respite Program ended. Clients who meet the OAA criteria continue to be served through the FCSP. WCDAVS has made multiple efforts through a conference, presentation series, group opportunities and events to reach this caregiver population and support them. Despite these efforts, this population of caregivers continues to be a challenge to reach and serve due to the high demands of the caregiving they are providing.

**Problem/Need**

Nearly 80% of the care provided to older adults is delivered in the home by unpaid family caregivers. Baby boomers are the largest aging cohort in the history of the United States (AoA, 2008; National Alliance for Caregiving and AARP, 2015, Caregiving in the U.S.). People are living longer, often with chronic diseases, at the same time the cost of placement options continue to increase. The resulting demands and stresses on unpaid family caregivers will only grow over time. Funding for family caregiver programs has not kept pace with the demand for services. Despite this, WCDAVS will continue to work creatively and innovatively to maximize funds to help family caregivers provide care to others and care well for themselves.

**Goals and Objectives**

Goal: Strengthen the core elements of WCDAVS Family Support Caregivers Program to address the needs of caregiving families in Washington County.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Improve and expand access to caregiver training and respite and improve outreach to the LGBT caregiver community | a | Expand sponsorships and partnerships for the annual Washington County Family Caregiver Conference to fund other services | Program Coordinator, WCDAVS; community partners | 1/2017 | Ongoing | |
| | b | Expand commitment to fund culturally-specific caregiver training | Program Coordinator, WCDAVS; Tuality Health Education, Asian Heath & Service Center, Latino community | 1/2017 | 7/2018 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | partners and others | | | |
| | c | Explore and implement new outreach approaches to the LGBT community | Program Coordinator, WCDAVS; Metro LGBT Alliance, SAGE | 1/2018 | 1/2019 | |
| | d | Explore and introduce additional evidence-based training(s) to support FCG's | Program Coordinator, Director, WCDAVS | 1/2017 | 1/2018 | |

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

**Brief Profile**

Older adults deserve a safe and secure retirement. Unfortunately, some older adults fall victim to abuse, fraud or other crimes. Older adult abuse includes several types of older adult maltreatment. Physical abuse can be the use of force that may result in bodily injury, physical pain or impairment and inappropriate restraint. Sexual abuse includes non-consensual sexual contact of any kind with an older adult. Emotional or psychological abuse constitutes the infliction of anguish, pain or distress. Financial abuse is defined as the illegal or improper use of an older adult's funds, property or assets. This can include forgery, fraud, unexplained transfers of an older adult's assets and the unexplained disappearance of funds or valuable possessions. Neglect of an older adult is the refusal or failure of a caregiver to fulfill his or her caregiving responsibilities.

Older adult crime victims are among the most underserved of any victim group in the United States, according to Susan Herman, executive director of the National Center for Victims of Crime. Serving this group presents an enormous challenge for the criminal justice system and older adult agencies as the proportion of older adults continues to increase faster than any other age group.

**Specific Information**

**Elder abuse prevention efforts:**

WCDAVS supports elder abuse prevention in a variety of ways including community awareness efforts, trainings, community partnerships, support of the Elder Safe program and collaboration with APD. WCDAVS funds and coordinates the annual Elder Abuse Forum which combines many of these effots. For the past four years, the Elder Abuse Forum has focused on raising community awareness and training for the public and law enforcement on how to identify and report suspected abuse. Law enforcement and the banking industry were also trained on how to work together more effectively to combat older adult financial fraud. District Attorneys have been provided with strategies for working with older victims and prosecuting elder abuse cases.

In collaboration with the Washington County Sheriff's Office (WCSO), WCDAVS funds the Elder Safe program using OAA Title VII funds. WCDAVS has an MOU with WCSO to support this collaboration which is currently in the renewal process. Elder Safe serves about 1,000 senior crime victims aged 65 and over each year. These victims are identified through the REGIN law enforcement database, WCSO and reports generated by the police departments of Beaverton, Forest Grove, Hillsboro, King City, Sherwood, Tigard and Tualatin. Other crime victims are identified through the Washington County District Attorney's Office and APD's Adult Protective Services (APS). Victims are contacted and informed of the availability of court advocates, restraining orders, domestic violence counseling, WCDAVS services and other community services to meet their needs.

Elder Safe also provides home visits and phone contacts to provide personalized assistance to crime victims negotiating the criminal justice system. They expedite cross referral of elder abuse and crime reports between APS and law enforcement. They assist with the coordination of the Washington County Elder Abuse Multi-disciplinary Team and identify and organize educational opportunities for law enforcement, prosecutors, APS, community partners and the community-at-large on elder abuse issues and other crimes. Elder Safe also manages the Project Lifesaver radio transmitter bracelet program and the Help Me Home database for older adults and people with disabilities at risk for wandering. Lastly, they provide twelve Gatekeeper trainings each year to employees who in their jobs may have contact with older adults or those with disabilities in need of assistance.

**Identify gaps in the current system:**
One significant gap is the general lack of a strong coordinated system for communicating and staffing elder abuse cases despite the community partnerships and best efforts of all agencies who have a piece of prevention as part of their mandates. Another gap is community awareness regarding identifying and reporting abuse. Sustainable funding for the Gatekeeper trainings which help train community members in these areas would also improve awareness.

**Support the work of their legal services provider:**
WCDAVS has a contract with Oregon Law Center to provide legal services targeted to the most vulnerable older adults to protect their health, welfare, independence, security and dignity. They also conduct community legal education in a variety of forums to various audiences to equip families and providers with information to prevent costly legal problems from developing. Oregon Law Center operates an advocacy program in coordination with the Long Term Care Ombudsman and SHIBA. Oregon Law Center also assists in the coordination of the Senior Law Project in Washington County Senior Centers. The Senior Law Project is a program where attorneys volunteer their services to older adults in Washington County.

Specific services to individual clients are intended for those at greatest need who are unable to access other resources. Those who are most vulnerable may include residents of all types of long-term care facilities, those with chronic health problems, mental health concerns or developmental and intellectual disabilities. Older adults that struggle to access healthcare, may be homeless or victims of crime are also be served by the Oregon Law Center. Oregon Law Center prioritizes cases in the following areas: housing, defense of guardianship, prevention and rectification of abuse, neglect and exploitation, health care issues, long-term care, social security, age discrimination in employment, utilities challenges and grandparents raising grandchildren.

**Develop and implement a written referral protocol to the APD services office:**
WCDAVS has a long-standing partnership with APD in Washington County. Staff routinely make referrals to APS when elder abuse is suspected. This partnership is spelled out in an MOU which includes procedures for

making and receiving referrals to our various programs. This MOU does not include a written procedure for making APS referrals, an oversight that will be addressed in an updated MOU as soon as possible.

**Integrate elder rights in delivery system:**
WCDAVS works with APS, Washington County Sherriff's Office, Washington County Courts, Elder Safe and citizens of Washington County to identify and intervene on behalf of older adults at risk of abuse, neglect or financial exploitation. WCDAVS collaborates with partner agencies to move guardianship and conservatorship cases through the legal system by assisting in investigations and providing testimony. WCDAVS will also be using discretionary funding for a new Money Management Program which will engage volunteers to assist vulnerable older adults who are at risk of or are experiencing financial abuse or exploitation. At risk clients are identified by APS and WCDAVS from those enrolled in services such as OPI, OAA Case Management, Project REACH and Options Counseling.

**Support the adult abuse multi-disciplinary team:**
WCDAVS is a member of the Washington County Elder Abuse Multidisciplinary Team (WCEA MDT), which is comprised of the District Attorney's Office, APD, every law enforcement agency in the county, mental health, and other community partners. The WCEA MDT reviews difficult elder abuse cases, develops investigative guidelines, identifies needed training, and helps coordinate procedures and other activities between agencies.

**Problem/Need**
One significant challenge is the general lack of understanding in the community about older adult abuse and its impact on individuals, families and the community as a whole. Additionally, there are service gaps between the partnering organizations which can present challenges to education and awareness, intervention and service provision.

**Goals and Objectives**
Goal: Increase public awareness of elder abuse and prevention.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Increase awareness through improved attendance at and an increased number of trainings | a | Increase attendance at Elder Abuse Forum by 10% | Staff, WCDAVS | 1/2017 | 1/2018 | |
| | b | Support and explore options for alternate funding for Gatekeeper training | Staff, WCDAVS; Advisory Council | 1/2017 | 6/2018 | |
| | c | Increase number of Gatekeeper trainings being offered by 50% | Staff, WCDAVS; partnering agencies | 1/2017 | 1/2019 | |

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

**Brief Profile**

The vast majority of older adult Native Americans in the US do not live on reservations (www.socialsec.gov, 2012). Indian Health Service reports from 2015 also indicate a number of health disparities amongst older adult Native Americans in comparison to the total population, particularly in the areas of injury, diabetes, liver concerns and flu and pneumonia. Some of this may be attributable to the years of Native American youth being forced to live away from families in boarding schools and a lack of federal services to Native Americans between 1953-1975 due to the Termination Act in 1953 (Understanding the Approach, Recognizing the Need Partnerships in Indian Country, SUA Webinar, 2016). The long and difficult history of Native Americans' mistreatment by the government in the United States complicates efforts to create relationship and provide services. Many older adult Native Americans distrust government and governmental services. WCDAVS recognizes both the need to serve this population and the potential geographic, cultural, historical and logistical challenges of doing so.

**How will the AAA coordinate with any tribes in the area or provide services for older Native Americans:**

While there are no tribes in the area, there are older adult Native Americans living in Washington County. WCDAVS will make efforts over the next four years to establish partnerships with existing organizations which serve this population. Through this effort it is hoped WCDAVS will be better able to do outreach to and customize services for this population.

**How will services be culturally and linguistically responsive:**

WCDAVS strives to provide culturally and linguistically appropriate services to all older adults in the service area. For this particular population, WCDAVS will first build relationships with agencies in the area currently serving older adult Native Americans and then through these partnerships assess needs and opportunities. Based on information gathered, services and outreach can be tailored to be culturally and linguistically appropriate.

**List of tribes in the county:**

Information provided by the SUA indicates members of the Grand Ronde and Siletz tribes live in Washington County. There are no tribes located within the county.

**Problem/Need**

WCDAVS recognizes the need to provide outreach and services to this underserved and at-risk population of older adults. WCDAVS currently lacks partnerships with key agencies that currently serve older adult Native Americans. Such partnerships would greatly enhance WCDAVS ability to reach this population.

**Goals and Objectives**

Goal: Have sustainable partnerships with key organizations serving older adult Native Americans.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Create, cultivate and sustain relationships | a | Initiate in-person meetings with leadership from NAYA, NARA, Indian Health Board and any other relevant organizations | Program Supervisor, WCDAVS | 1/2017 | 6/2017 | |
| | b | Assess needs and opportunities for partnerships with these agencies | Program Supervisor, WCDAVS; NAYA, NARA, Indian Health Board | 3/2017 | 9/2017 | |
| | c | Develop and implement plan for ongoing partnership | Program Supervisor, WCDAVS; NAYA, NARA, Indian Health Board | 9/2017 | 9/2020 | |

### 7. Veterans

**Brief Profile**

There are over 35,000 veterans in Washington County and only a small percentage of these veterans are receiving the veteran's benefits that they are eligible to receive because of their service (https://catalog.data.gov/dataset/compensation-and-pension-by-county-2015; http://www.va.gov/vetdata/Veteran_Population.asp). Many veterans are unaware of their eligibility for medical and in some cases monthly cash benefits. The Veterans Administration (VA) has made changes to make their programs more accessible. Despite this, the process can still feel convoluted and challenging to navigate for veterans.

WCDAVS works with a variety of community partners to share information about programs to eligible veterans. Regular attendance at group meetings that have high veteran attendance, such as at Elks Lodges, and the Veterans of Foreign Wars, allows WCDAVS to provide both presentations and leave pertinent informational pamphlets. In addition, staff attends community events, like farmers markets, to provide information to the community.

WCDAVS assist veterans with completing all VA forms and gathering necessary information to file a successful VA claim. WCDAVS educates veterans regarding steps in the process to help them more successfully file their claim. This information also helps the veteran send the necessary and appropriate information which decreases the processing time for their claim. In addition, if a claim is denied staff are able to represent the veteran in the hearings process.

**Problem/Need**

WCDAVS recognizes the lack of awareness regarding potential benefits and the challenges of navigating the VA benefits system. WCDAVS has seven full time staff dedicated to serving veterans' needs in Washington County. Potential challenges include managing both outreach activities and ongoing claims assistance with individual veterans. WCDAVS manages this challenge in part by allocating one day per week per worker for outreach to accommodate both needs. This is assessed on an ongoing basis.

**Goals and Objectives**

Goal: Improve outreach in the community regarding services available for veterans.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Develop comprehensive outreach plan | a | Create outreach plan for farmers markets | Supervisor, staff, WCDAVS | 1/2017 | 6/2017 | |
| | b | Develop a volunteer position to meet veterans in the community | Supervisor, staff, WCDAVS | 1/2017 | 6/2017 | |
| | c | Create ongoing outreach plan for assisted living facilities and adult foster homes | Supervisor, staff, WCDAVS | 7/2017 | 1/2018 | |

Goal: Facilitate Vet Center providing group counseling sessions and other services in Washington County.

| Measureable Objectives: | Key Tasks | | Lead Position & Entity | Timeframe for 2017-2020 (by Month & Year) | | Accomplishment or Update |
|---|---|---|---|---|---|---|
| | | | | Start Date | End Date | |
| Provide leadership for the development and implementation of co-location plan | a | Convene stakeholders to assess challenges/opportunities | Supervisor, WCDAVS; stakeholders | 1/2017 | 2/2017 | |
| | b | Create/implement plan | Supervisor, WCDAVS; stakeholders | 2/2017 | 2/2018 | |

**SECTION D-OAA/OPI SERVICES AND METHOD OF SERVICE DELIVERY**

**D-1 Administration of Oregon Project Independence (OPI):**

Responses to questions on this page are supported by written policies and procedures attached in Appendix G.

**a. Describe how the agency will ensure timely response to inquiries for service. Upon receipt of the referral:**
WCDAVS will contact the client within five business days. Further preliminary information will be gathered from the applicant over the phone and the sliding scale fee will be discussed. Then the client will be added to the OPI priority list and told that they will be contacted when they are able to begin services. When they are able to begin services, an assessment appointment will be arranged. Once eligibility is determined, Service Plans will be sent to the appropriate provider within five working days after the provider has been determined. After the Service Plan has been sent to a provider, staff will follow-up with the client within two weeks to make sure services are in place.

**b. Explain how clients will receive initial and ongoing periodic screening for other community services, including Medicaid.**
OPI clients are fully assessed on an annual basis. Regular check-ins (via telephone or home visits) occurs at least every six months. WCDAVS staff are trained in strengths-based case management and options counseling and provide these services as part of their role. During these assessments or check-ins information is provided on other resources in the community. If the OPI client requests other services, staff will coordinate the referrals. Retirement Connection directories are also provided to each client.

**c. Describe how eligibility will be determined.**
The determination of OPI services is based on each client's financial, functional, medical and social need for services. This is demonstrated by the service eligibility level determined from the client assessment planning system tool (CA/PS). Service hours are determined according to the current OPI Service Level Matrix.

**d. Describe how the services will be provided.**
WCDAVS conducts client assessments to evaluate the current level of functioning of the individual in their present living situation. The client assessment determines which care needs must be addressed to allow the client to remain safe in the least restrictive environment. Service plans are approved based on the most cost effective holistic plan to manage OPI's limited resources and serve the greatest number of individuals with the highest priority service needs.

Regular OPI Authorized Services include the following: service coordination, Options Counseling, evidence-based health promotion, home care, personal care, respite, registered nursing services, adult day Services, home repair, chore, money management, assistive technology, home delivered meals and assisted transportation. Many of these services are provided based on budget capacity.

**e. Describe the agency policy for prioritizing OPI service delivery.**
Priority for authorized services will maintain consumers already receiving authorized services as long as their condition indicates the service is needed. If OPI budget constraints do not allow for the immediate start of in-home services then consumers will be placed on a priority list. Prioritization of services will be based on the state standardized OPI Risk Tool (SDS 287J) that measures the risk for out of home placement. Consumers with the highest risk of out of home placement are given priority.

**f. Describe the agency policy for denial, reduction or termination of services.**
WCDAVS has a written policy for denial, reduction or termination of services. WCDAVS policy requires a written notice be sent to the client for denial, reduction or termination of services. The notice will include the

reason for such action and the client's right to grieve the decision including the deadline for submitting a grievance. If the consumer signs the OPI Fee Determination and OPI Service Agreement that shows a change or reduction in hours or fee then the consumer is agreeing to these terms and therefore does not have a grievance regarding these issues.

The policy for denial is initiated when the client is unwilling to provide information to open a case, the client exceeds the service priority level, receipt of Medicaid benefits, or there is an inability to create or maintain a safe care plan. The policy for reduction is initiated when the client reassessment indicates service needs have been reduced or there is a notification by the state of a reduction of program funding. The policy for termination occurs when a reassessment determines the client no longer meets service eligibility level, the client refuses to pay fees for services, there is a loss or reduction of program funding, there is inappropriate behavior in regard to treatment of a care provider that cannot be modified with a behavior plan, the client moves out of service area and if the client is approved for Medicaid funding for long-term care services.

**g. Describe the agency policy for informing clients of their right to grieve adverse eligibility and/or service determination decisions or consumer complaints.**
Clients are notified by letter that they have the right to appeal agency eligibility decisions. At that point they are entitled to a reassessment if one has not been done within the past 30 days. If the client is still found ineligible for services then they may contact the WCDAVS Community Services Supervisor or Director for final review and determination. Consumer complaints can be submitted via phone, email or in person. Complaints are generally handled by the Community Services Supervisor or Director.

**h. Explain how fees for services will be implemented, billed, collected and utilized**.
Fees for service will be based on a sliding scale fee to all eligible individuals whose annual income exceeds the federal poverty level. This fee schedule is updated and distributed by DHS to the AAAs annually. OPI fees are assessed at the federal poverty level net monthly income and increase by approximately $25 income increments up to 200% of the federal poverty level. Clients with a net income over 200% of the federal poverty level pay the full hourly rate of the services provided.

A one-time $25 fee is applied to all individuals receiving OPI authorized services who have adjusted income levels at or below federal poverty level. The $25 fee is due at the time eligibility for OPI authorized services has been determined. Consumers who identify a financial hardship may request that the one-time fee of $25 be waived. Consumers who wish to have the fee waived should contact the WCDAVS Community Services Supervisor in writing within ten business days of receipt of the invoice to request a waiver. The invoice will include contact information and instructions on how to request a waiver. Proof of financial hardship may be required by the Community Services Supervisor before approval. Fees due from clients are invoiced and collected by WCDAVS monthly. All fees collected for service are used to expand and maintain services to clients. They are utilized to maintain service hours when funding is reduced.

**i. Describe the agency policy for addressing client non-payment of fees, including when exceptions will be made for repayment and when fees will be waived.**
OPI clients who have been assessed a fee for service will be billed monthly after Home Care Worker vouchers have been processed. If a client is more than 60 days past due, a staff member will send a letter to the client notifying them of their past due amount and informing them that the case will be closed two weeks after the date of the letter if payment arrangements are not made. If the client does not pay by the date listed, staff will discontinue the client's OPI services and send a closure letter to the client. For clients who receive services from a contract care agency, it is the responsibility of the contract care agency to notify WCDAVS of client non-

payments. When this occurs, the same procedure as above applies. Clients may request a payment arrangement for past due payments. Clients must agree to pay the minimum monthly amount plus an additional $10.00 in order to work toward paying off the debt. Fees are generally not waived unless the client is deceased.

**j. Delineate how service providers are monitored and evaluated.**
WCDAVS community contracts are monitored as required annually. In-home service providers who serve OPI are monitored quarterly. All community contracts must meet county, state and federal guidelines and regulations. These requirements and regulations are incorporated into monitoring tools and templates used during on-site monitoring visits each year. These templates help measure compliance with the statement of work, privacy and HIPPA regulations and federal regulations for disbarment and suspension of federal funds.

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

**SECTION E-AREA PLAN BUDGET**

See attached.

**APPENDICES**

**Appendix A Organizational Chart**

See attached.

**Appendix B Advisory Council(s) and Governing Body**

**AGENCY'S GOVERNING BODY**

| Agency's Governing Representative Name & Contact Information | Date Term Expires (if applicable) | Title/Office (if applicable) |
|---|---|---|
| Andy Duyck | December 2018 | Chair, County Commissioner |
| Dick Schouten | December 2016 | County Commissioner |
| Greg Malinowski | December 2018 | County Commissioner |
| Roy Rogers | December 2016 | County Commissioner |
| Bob Terry | December 2018 | County Commissioner |

**AREA AGENCY ADVISORY COUNCIL**

| **Name & Contact Information** | **Date Term Expires** | **Category of Representation** |
|---|---|---|
| Marge Sommers<br>1105 NE Lincoln St.<br>Hillsboro, OR 97124 | 6/30/19 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☐Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public<br>☐ _____ |
| Roger Fields<br>13810 SW Harness Lane<br>Beaverton, OR 97008 | 6/30/17 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |
| John Hartner<br>753 NE Rogahn<br>Hillsboro, OR 97124 | 6/30/17 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |

| Name & Contact Information | Date Term Expires | Category of Representation |
|---|---|---|
| Ian Johnson<br>137 SW 206th Avenue<br>Beaverton, OR 97006 | 6/30/17 | ☐60+ y/o ☐Minority ☐Rural<br>☒Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |
| John Holewa<br>16247 SW O'Neill Ct.<br>Tigard, OR 97223 | 6/30/19 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |
| Marvin Rydberg III<br>7135 SW Brenne Lan<br>Portland, OR 97225 | 6/30/17 | ☐60+ y/o ☐Minority ☐Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public<br>☒ Under 60 Veteran |
| Matthew McKean<br>305 N. First Avenue<br>Hillsboro, OR 97123 | 6/30/17 | ☒60+ y/o ☐Minority ☒Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |
| Michele Limas<br>16200 SW Stahl Dr.<br>Portland, OR 97223 | 6/30/19 | ☐60+ y/o ☒Minority ☐Rural<br>☐Service provider ☐Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |
| Ronald Thompson<br>3231 Lavina Drive<br>Forest Grove, OR 97116 | 6/30/18 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☒Veteran<br>☐Family Caregiver<br>☒Elected official ☒General Public |
| Bob Ludlum<br>13297 SW Maplecrest Ct<br>Tigard, OR 97223 | 6/30/17 | ☒60+ y/o ☐Minority ☐Rural<br>☐Service provider ☐Veteran<br>☐Family Caregiver<br>☐Elected official ☒General Public |

| Name & Contact Information | Date Term Expires | Category of Representation |
|---|---|---|
| Jose Rivera<br><br>202 N. Bridgeton Rd.<br><br>Portland, OR 97217 | 6/30/17 | ☒60+ y/o ☒Minority ☐Rural<br>☐Service provider ☐Veteran<br>☐Family Caregiver<br>☐Elected official ☐General Public |

**Appendix C Public Process**

See attached for sample fliers for Focus Groups in English and Spanish and for a flier with information about accessing the survey online in English and Spanish. A letter regarding Focus Groups and the survey was also sent to 95 consumers on the OPI waitlist (see attached). A media release regarding the survey can be found here: http://www.co.washington.or.us/News/mediareleases.cfm. The Focus Group dates and locations and questions as well as the Survey Distribution list follows.

**Focus Groups Conducted**

| Date | Location |
|---|---|
| 8/4/2016 | Hillsboro Community Senior Center |
| 8/8/2016 | Forest Grove Elks Lodge Veterans' Lunch (Veteran Focused) |
| 8/15/2016 | Q Center (LGBT Focused) |
| 8/17/2016 | WCDAVS Staff |
| 8/22/2016 | Hillsboro MOWP Meal Site (Latino Focused in Spanish/English) |
| 8/23/2016 | Forest Grove MOWP Meal Site (Latino Focused in Spanish/English) |
| 8/24/2016 | Sherwood MOWP Meal Site Writing Group |
| | Sherwood MOWP Meal Site Men's Coffee Group |
| 8/24/2016 | Asian Health & Services Center (In Mandarin) |
| 8/25/2016 | Beaverton MOWP Meal Site (Brief presentation and in person survey distribution/collection) |
| 8/26/2016 | Asian Health & Services Center (In Cantonese) |
| | Asian Health & Services Center (In Korean) |
| 8/30/2016 | Asian Health & Services Center (In Vietnamese) |
| 8/31/2016 | El Centro Cultural de Washington County (Latino Focused in Spanish) |

**Focus Group Questions**

1. What would you like to see in your community that would make it a better place for older adults to live?
2. Older adults sometimes feel isolated, lonely, or depressed. How do you think the community helps older adults with these feelings?
3. How do you feel the nutrition needs of older adults are being met in your community?
4. Sometimes older adults have difficulty staying in their homes as they age. What would you say you need to be able to remain in your home? Examples might be home modifications or financial assistance.
5. Subgroup questions, as applicable
   How do you feel the needs of veterans are being met in your community?
   How do you feel the needs of the LGBT community are being met?
   How do you feel the needs of the Latino community are being met?

How do you feel the needs of the Asian community are being met?

6. Is there any additional information that you would like to provide regarding the needs of older adults in your community?

**Survey Distribution**

WCDAVS Website/Media Release/Facebook Page
WVDAVS Staff
Washington County Internal Horizons Website
Area Agency Advisory Council
APD
AARP Oregon
Asian Health & Services Center
Community Action
El Centro Cultural de Washington County
Forest Grove Elks Lodge
Health Share Adult Mental Health Providers
Hillsboro Community Senior Center
Indian Health Board
MOWP Meal Sites and Home Delivered Meal Recipients: Hillsboro, Forest Grove, Beaverton, Sherwood
Native American Rehabilitation Association NW
Native American Youth and Family Center
OPI Priority List
PFLAG of Washington County
Q Center
Ride Connection
Sage/Friendly House
Sherwood Faith in Action
SPIN Network: Postings on the Westside Referral Network, Home Instead Senior Care Washington County and Right Fit Senior Living Solutions Facebook Pages

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

WCDAVs successfully accomplished a number of goals and objectives included in the 2013-2016 Area Plan. Below are the stated goals from the 2013-2016 Area Plan and then successes and challenges follow in *italics*.

<u>Goal 1: Outreach, Information and Assistance</u>

Increase access to and knowledge of information, assistance, and services for seniors, people with disabilities, veterans and the general community, through increased volunteer recruitment, outreach and public education.

Objective 1: Increase outreach to minority/isolated/rural communities

Work with Asian Health & Family Services to develop outreach to this community. *WCDAVS amended the ongoing contract with Asian Health & Family Services to include information about outreach and assistance. There was also a small pilot project regarding outreach and assistance to the Latino community*

*through El Centro Cultural de Washington County. WCDAVS staff also attended culturally specific health fairs in an effort to better serve these populations. WCDAVS has also contracted with Elders in Action to do the recruitment for volunteers. Elders in Action facilitates the Project REACH Program and Special Advocate Program to reach more older adults.*

- Develop plan to network with businesses /organizations to serve underserved populations. *WCDAVS participated in partnerships through Washington County THRIVES with the local business community.*

Goal 2: Healthy Living

Increase opportunities to achieve optimal health and well-being for baby boomers, older adults and individuals with disabilities through strategies focusing on improvement in multi-generational health, illness prevention and chronic disease management.

Objective 1: Develop partnerships to increase access to the number of programs promoting healthy living. Develop relationships with other agencies such as county, non-profit and private to offer healthy living programs. *WCDAVS was successful in accomplishing a Continuing Care Transitions Program across the metro area which has been in place for three years. Home visitors see older adults who have been recently hospitalized to provide services to reduce re-admittance to the hospital.*

Objective 2: Develop and implement health promotion and access.

- Work with CCO's, hospitals and other partner agencies to increase health care access. *WCDAVS has continued to work with the local CCO's and other healthcare providers in the area largely as part of Washington County's Community Health Improvement Plan (CHIP) Access to Care Committee.*

Objective 3: Promote health and well-being through a focus on improved nutrition. Work with senior nutrition provider to provide health food choices. *WCDAVS participated in the revision of the statewide nutrition standards for nutrition providers.*

Goal 3: Community Centers/Focal Points

Redefine senior centers as multi-generational community focal points offering increased opportunities for citizens in all geographic areas in Washington County to access information, education and a variety of programs and services designed for baby boomers, older adults and individuals with disabilities.

Objective 1: Provide leadership in development of new center in the Reedville/Aloha area.

- Lead efforts to form a task force to examine feasibility of new center. *WCDAVS initiated a planning process with community partners that resulted in an additional meal site in the Reedville/Aloha area at the Edwards Center which serves older adults and people with disabilities.*

Objective 2: Provide leadership to create a task force charged with examining current senior centers and identifying needed changes to update and create a new program model.

- Network and recruit leaders from cities, park and recreation departments and MOWP to serve on the task force.
- Explore local and national models for multi-use facilities to identify best practice models.
- Develop preliminary plans for creating new program model.
  *WCDAVS convened a task force and conducted a feasibility study regarding this issue. The task force prioritized a library project over continuing to work on the community center project. An additional challenge was a lack of funding to support the creation of a community center in the area.*

Goal 4: Veterans

Enhance the overall level of services to the veterans' community through strategies to increase advocacy, outreach and innovative services to Washington County veterans and their survivors.

Objective 1: Develop an outreach plan to educate veterans in Washington County and empower them in addressing their unmet needs. *WCDAVS implemented a program where a trained volunteer provided information to all the assisted living facilities in our community. There was also an expansion of off-site outreach in Tigard, Forest Grove and at Portland Community College.*

Objective 2 Network with community organizations to identify ways to raise community awareness and support for veterans issues. *WCDAVS has made efforts to provide information to the media through a radio interview. Staff have attended farmers markets to raise awareness. WCDAVS has also reconnected with Elks Lodges and Veterans of Foreign Wars groups in an effort to raise awareness and improve outreach*.

**Appendix E Emergency Preparedness Plan**

WCDAVS Emergency Preparedness Plan and all associated necessary information can be found at: http://www.ocem.org/Plans.cfm

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

**Meals on Wheels People Meal Centers in Washington County**

Elsie Stuhr Center
5550 SW Hall Blvd.
Beaverton, OR 97005
Meal Site Manager: Vicki Adams
Phone: 503-643-8352

Forest Grove Senior Center
2037 Douglas St.
Forest Grove, OR 97116
Meal Site Manager: RayAnn Warncke
Phone: 503-359-4818

Hillsboro Meals on Wheels People Center
545 SE Baseline St.
Hillsboro, OR 97123
Meal Site Manager: Elly Ritchie
Phone: 503-924-6858

North Plains Senior Center
31450 NW Commercial St.
North Plains, OR 97133
Meal Site Manager: Angie Boyd
Phone: 503-647-5666

Sherwood Senior Center
21907 SW Sherwood Blvd.

Tigard Senior Center
8815 SW O'Mara St.

Sherwood, OR 97140
Meal Site Manager: Thressa Calkins
Phone: 503-625-5644

Tigard, OR 97223
Meal Site Manager: Jay Gilbertson
Phone: Phone: 503-620-4613

Juanita Pohl Center-Tualatin
8513 SW Tualatin Rd.
Tualatin, OR 97062
Meal Site Manager: Julio Lopez
Phone: 503-692-6767

Edwards Center
4375 SW Edwards Pl.
Aloha, OR 97007
Meal Site Manager: Dan Hill
Phone: 503-642-1581

**Appendix G OPI Policies and Procedures**

See attached.

**Appendix H Partner Memorandums of Understanding (See attached)**

MOU with Aging and People with Disabilities
MOU with Washington County Assessment and Taxation
MOU with Health Share and tri-counties
MOU with Washington County Human Services Division
MOU with Washington County Sheriff's Office (currently in renewal process)

**Appendix I Statement of Assurances and Verification of Intent**

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

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

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

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

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

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

A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access to those older Native Americans to programs and benefits provided under the Area Plan;
B. An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under Title VI of the Older Americans Act; and
C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

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

9/28/2016
Date

Marni Kuyl
Director, Washington County Health and Human Services
Acting Director, Washington County Disability, Aging and Veteran Services

9-22-2016
Date

Marge Sommers
Advisory Council Chair

9/28/2016
Date

Sia Lindstrom
Sr. Deputy County Administrator, Washington County Health and Human Services; Washington County Disability, Aging and Veteran Services
Legal Contractor Authority

# SERVICE MATRIX and DELIVERY METHOD

**Instruction:** Indicate all services provided, method of service delivery and funding source. (The list below is sorted numerically by service matrix number.)

☒ **#1 Personal Care** (by agency)

Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Home Instead Senior Care
1400 NE 48th Avenue, Suite 107
Hillsboro, OR 97124 "for profit agency

Marquis At Home
4560 SE Internationa Way
Milwaukie, OR 97222 "for profit agency"

Comfort Keepers (BNS)
19365 SW 65th Avenue, #205
Tualatin, OR 97062 "for profit agency"

Comfort Keepers (Bahandi)
1225 NW Murray Rd., Suite101
Portland, OR 97229 "for profit agency"

Always At Home
15405 SW 116th Avenue
Tigard, OR 97224 "for profit agency"

Note if contractor is a "for profit agency"

☒ **#1a Personal Care** (by HCW) Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ **#2 Homemaker** (by agency)

Funding Source: ☒ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Home Instead Senior Care
1400 NE 48th Avenue, Suite 107
Hillsboro, OR 97124 "for profit agency"

Marquis At Home
4560 SE Internationa Way
Milwaukie, OR 97222 "for profit agency"

Comfort Keepers (BNS)
19365 SW 65th Avenue, #205
Tualatin, OR 97062 "for profit agency"

Comfort Keepers (Bahandi)
1225 NW Murray Rd., Suite101
Portland, OR 97229 "for profit agency"

Always At Home
15405 SW 116th Avenue
Tigard, OR 97224 "for profit agency"

Store To Door
7730 SW 31st Avenue
Portland, OR 97219

Maid Perfect PDX
21939 SE Yamhill St.
Gresham, OR 97030 "for profit agency"

Note if contractor is a "for profit agency"

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

☒ **#3 Chore** (by agency)

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Hard Hat Handyman "for profit agency"
1554 South Beech St.
Cornelius, OR 97113

M.D. Watson Construction
17520 SW Sugar Plum Ln.
Beaverton, OR 97007 "for profit agency"

Smooth Transitions
13225 SW Shore Dr.
Tigard, OR 97223 "for profit agency"

Note if contractor is a "for profit agency"

☐ **#3a Chore** (by HCW) Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☒ **#4 Home-Delivered Meal**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Meals on Wheels People
7710 SW 31st Avenue
Portland, OR 97219
Note if contractor is a "for profit agency"

☒ **#5 Adult Day Care/Adult Day Health**

Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Gentog, LLC
11535 SW Durham Rd., Suite C5
Tigard, OR 97224 "for profit agency"
Note if contractor is a "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):

Note if contractor is a "for profit agency"

☒ **#7 Congregate Meal**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Meals on Wheels People
7710 SW 31st Avenue
Portland, OR 97219
Note if contractor is a "for profit agency"

☒ **#8 Nutrition Counseling**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Meals on Wheels People
7710 SW 31st Avenue
Portland, OR 97219
Note if contractor is a "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):
Ride Connection
9955 NE Glisan St. Portland, OR 97220
Portland, OR 97220
Note if contractor is a "for profit agency"

☐ **#10 Transportation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#11 Legal Assistance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Oregon Law Center
230 NE 2nd Avenue, Suite F
Hillsboro, OR 97124
Note if contractor is a "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):
Meals on Wheels People
7710 SW 31st Avenue
Portland, OR 97219
Note if contractor is a "for profit agency"

☒ **#13 Information & Assistance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#14 Outreach**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#15/15a Information for Caregivers**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#16/16a Caregiver Access Assistance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Asian Health & Service Center
3430 SE Powell Blvd.
Portland, OR 97202
Note if contractor is a "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):

Note if contractor is a "for profit agency"

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "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):
Rebuilding Together
12550 SW 3rd St.
Beaverton, OR 97005

Hard Hat Handyman
1554 South Beech St.
Cornelius, OR 97113 "for profit agency"

M.D. Watson Construction
17520 SW Sugar Plum Ln
Beaverton, OR 97007 "for profit agency"

Note if contractor is a "for profit agency"

☐ **#30-4 Respite Care (IIIB/OPI)**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "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):
Home Instead Senior Care
14780 SW Osprey, Suite 295
Beaverton, OR 97007 "for profit agency"

Home Instead Senior Care
1400 NE 48th Avenue, Suite 107
Hillsboro, OR 97124 "for profit agency"
Note if contractor is a "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):
Courageous Mourning, LLC
15510 Boones Ferry Rd., Suite 248
Lake Oswego, OR 97035 "for profit agency"
Note if contractor is a "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):
Active for Life
448 S. 1st Avenue
Hillsboro,OR 97123 "for profit agency"

McCann's Pharmacy
15685 SW 116th Avenue
King City, OR 97224 "for profit agency"

Amazon.com "for profit agency"
Note if contractor is a "for profit agency"

☐ **#40-2 Physical Activity and Falls Prevention**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#40-3 Preventive Screening, Counseling and Referral**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ #**40-4 Mental Health Screening and Referral**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ #**40-5 Health & Medical Equipment**

Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):
Active for Life
448 S. 1st Avenue
Hillsboro,OR 97123 "for profit agency"

McCann's Pharmacy
15685 SW 116th Avenue
King City, OR 97224 "for profit agency"

Amazon.com "for profit agency"
Note if contractor is a "for profit agency"

☒ **#40-8 Registered Nurse Services**

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Home Instead Senior Care
1400 NE 48th Avenue, Suite 107
Hillsboro, OR 97124 "for profit agency"

Marquis At Home
4560 SE Internationa Way
Milwaukie, OR 97222 "for profit agency"

Comfort Keepers (BNS)
19365 SW 65th Avenue, #205
Tualatin, OR 97062 "for profit agency"

Comfort Keepers (Bahandi)
1225 NW Murray Rd., Suite101
Portland, OR 97229 "for profit agency"

Note if contractor is a "for profit agency"

☐ **#40-9 Medication Management**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#50-1 Guardianship/Conservatorship**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒ **#50-3 Elder Abuse Awareness and Prevention**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#50-4 Crime Prevention/Home Safety**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#50-5 Long Term Care Ombudsman**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#60-1 Recreation**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "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):

Note if contractor is a "for profit agency"

☒ **#60-4 Volunteer Recruitment**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Elders in Action
1411 SW Morrison, Suite 290
Portland, OR 97205
Note if contractor is a "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):

Note if contractor is a "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):

Note if contractor is a "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):
Courageous Mourning LLC
15510 Boones Ferry Rd, Suite 248
Lake Oswego, OR 97035 "for profit agency"

Asian Health & Service Center
3430 SE Powell Blvd.
Portland, OR 97202
Note if contractor is a "for profit agency"

☒ **#70-5 Newsletter**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#70-8 Fee-based Case Management**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "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):

Note if contractor is a "for profit agency"

☐ **#70-10 Public Outreach/Education**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#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):

Note if contractor is a "for profit agency"

☐ **#72 Cash and Counseling**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#73/73a Caregiver Cash and Counseling**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "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):

Note if contractor is a "for profit agency"

☐ **#80-4 Financial Assistance**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☐ **#80-5 Money Management**

Funding Source: ☒ OAA ☒ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

☒#**Volunteer Services**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):

Note if contractor is a "for profit agency"

Area Plan Budget, Worksheet 1
Washington County Disability, Aging & Veteran S
BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Pla

**Place cursor at Select and choose AAA.**
**Repeat for Budget Period.**

# Budget by Service Category

copy this column

| (3) | (4) | | | | | (9) OAA | | | | | | (10) | (11) | (12) | (13) | (14) | (15) | (16) | (17) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Matrix | SERVICE NAME | (5) | (6) | (7) | (8) | T III B | T III C-1 | T III C-2 | T III D | T III E | T VII | OAA Total | NSIP | OPI | Other State-provided Funds | Other Cash Funds | Total Funds | Estimated Cost Per Unit | Comments Explanation |
| **ADMINISTRATION** | | | | | | **$230,288** | **$0** | **$0** | **$0** | **$0** | **$0** | **$230,288** | **$0** | **$0** | **$0** | **$0** | **$230,288** | | |
| 20-1 | Area Plan Administration | C = Contract | | | | $49,230 | | | | | | $49,230 | | | | | **$49,230** | | |
| 20-2 | AAA Advocacy | | | | | $46,109 | | | | | | $46,109 | | | | | **$46,109** | | |
| 20-3 | Program Coordination & Development | D = Direct Provision | Estimated Units | Unit Definition | Estimated Clients | $134,949 | | | | | | $134,949 | | | | | **$134,949** | | |
| **ACCESS SERVICES** | | | | | | **$252,343** | **$0** | **$0** | **$0** | **$0** | **$0** | **$252,343** | **$0** | **$93,579** | **$103,939** | **$0** | **$449,861** | | |
| 6 | Case Management | D | 2500.00 | 1 hour | 150 | $45,048 | | | | | | $45,048 | | | | | **$45,048** | $18.02 | |
| 9 | Assisted Transportation | C | 1000.00 | 1 one-way trip | 46 | | | | | | | $0 | | $27,533 | $9,509 | | **$37,042** | $37.04 | |
| 10 | Transportation | | | 1 one-way trip | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 13 | Information & Assistance | D | 13783.00 | 1 contact | 13783 | $128,646 | | | | | | $128,646 | | | $17,542 | | **$146,188** | $10.61 | |
| 14 | Outreach | | | 1 contact | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 40-3 | Preventive Screening, Counseling, and Referral | D | 400.00 | 1 session | 400 | | | | | | | $0 | | | $59,407 | | **$59,407** | $148.52 | |
| 40-4 | Mental Health Screening & Referral | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 60-5 | Interpreting/Translation | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 70-2 | Options Counseling | D | 400.00 | 1 hour | 400 | $47,120 | | | | | | $47,120 | | $66,046 | $10,650 | | **$123,816** | $309.54 | |
| 70-5 | Newsletter | D | 6.00 | 1 activity | 4500 | $26,793 | | | | | | $26,793 | | | | | **$26,793** | $4,465.50 | |
| 70-8 | Fee-Based Case Management | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 70-10 | Public Outreach/Education | D | 244.00 | 1 activity | 8000 | $4,736 | | | | | | $4,736 | | | $6,831 | | **$11,567** | $47.41 | |
| **IN-HOME SERVICES** | | | | | | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$625,911** | **$20,922** | **$0** | **$646,833** | | |
| 1 | Personal Care | C | 8000.00 | 1 hour | 159 | | | | | | | $0 | | $262,262 | $7,055 | | **$269,317** | $33.66 | |
| 1a | Personal Care - HCW | | | 1 hour | | | | | | | | $0 | | | | | **$0** | | |
| 2 | Homemaker/Home Care | C | 10000.00 | 1 hour | 159 | | | | | | | $0 | | $296,497 | $4,855 | | **$301,352** | $30.14 | |
| 2a | Homemaker/Home Care - HCW | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 3 | Chore | C | 10.00 | 1 hour | 10 | | | | | | | $0 | | $3,520 | $140 | | **$3,660** | $366.00 | |
| 3a | Chore - HCW | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 5 | Adult Day Care/Adult Day Health | C | 400.00 | 1 hour | 10 | | | | | | | $0 | | $28,054 | $6,773 | | **$34,827** | $87.07 | |
| 30-1 | Home Repair/Modification | C | | 1 payment | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 30-4 | Respite (IIIB or OPI funded) | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 40-5 | Health, Medical & Technical Assistance Equip. | C | 249.00 | 1 loan/payment | 123 | | | | | | | $0 | | $20,642 | $2,039 | | **$22,681** | $91.09 | |
| 40-8 | Registered Nurse Services | C | 170.00 | 1 hour | 66 | | | | | | | $0 | | $14,936 | $60 | | **$14,996** | $88.21 | |
| 60-3 | Reassurance | | | 1 contact | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 90-1 | Volunteer Services | D | 103000.00 | 1 hour | 1000 | | | | | | | $0 | | | | | **$0** | $0.00 | |
| **LEGAL SERVICES** | | | | | | **$16,000** | **$0** | **$0** | **$0** | **$0** | **$0** | **$16,000** | **$0** | **$0** | **$9,871** | **$0** | **$25,871** | | |
| 11 | Legal Assistance | C | 246.00 | 1 hour | 70 | $16,000 | | | | | | $16,000 | | | $9,871 | | **$16,000** | $65.04 | |
| **NUTRITION SERVICES** | | | | | | **$0** | **$335,073** | **$384,081** | **$0** | **$0** | **$0** | **$719,154** | **$206,567** | **$0** | **$0** | **$0** | **$925,721** | | |
| 4 | Home Delivered Meals | C | 180921.00 | 1 meal | 1310 | | | $384,081 | | | | $384,081 | $103,283 | | | | **$487,364** | $2.69 | |
| 7 | Congregate Meals | C | 68230.00 | 1 meal | 1971 | | $335,073 | | | | | $335,073 | $103,284 | | | | **$438,357** | $6.42 | |
| 8 | Nutrition Counseling | C | 1150.00 | 1 session | 1150 | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 12 | Nutrition Education | C | 1915.00 | 1 session | 1875 | | | | | | | $0 | | | | | **$0** | $0.00 | |

| (3) | (4) | | | | | OAA | | | | | | | (11) | (12) | (13) | (14) | (15) | (16) | (17) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Matrix | SERVICE NAME | (5) | (6) | (7) | (8) | T III B | T III C-1 | T III C-2 | T III D | T III E | T VII | OAA Total | NSIP | OPI | Other State-provided Funds | Other Cash Funds | Total Funds | Estimated Cost Per Unit | Comments Explanation |
| | | Contract or Direct Provide | Estimated Units | Unit Definition | Estimated Clients | | | | | | | | | | | | | | |
| **FAMILY CAREGIVER SUPPORT** | | | | | | **$0** | **$0** | **$0** | **$0** | **$157,479** | **$0** | **$157,479** | **$0** | **$0** | **$9,524** | **$0** | **$167,003** | | |
| 15 | Information for Caregivers | C/D | 150.00 | 1 activity | 150 | | | | | $64,199 | | $64,199 | | | $9,524 | | **$64,199** | $427.99 | |
| 15a | Information for CGs serving Children | | | 1 activity | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 16 | Caregiver Access Assistance | C/D | 800.00 | 1 contact | 400 | | | | | $52,047 | | $52,047 | | | | | **$52,047** | $65.06 | |
| 16-a | Caregiver Access Assistance-Serving Children | | | 1 contact | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 30-5 | Caregiver Respite | C | 395.00 | 1 hour | 25 | | | | | $7,279 | | $7,279 | | | | | **$7,279** | $18.43 | |
| 30-5a | Caregiver Respite for Caregivers Serving Children | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 30-6 | Caregiver Support Groups | C | 220.00 | 1 session | 45 | | | | | $15,910 | | $15,910 | | | | | **$15,910** | $72.32 | |
| 30-6a | Caregiver Support Groups Serving Children | | | 1 session | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 30-7 | Caregiver Supplemental Services | C | 36.00 | 1 payment | 20 | | | | | $3,103 | | $3,103 | | | | | **$3,103** | $86.19 | |
| 30-7a | Caregiver Supplemental Services-Serving Children | | | 1 payment | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 70-2a | Caregiver Counseling | C | 160.00 | 1 session | 100 | | | | | $12,928 | | $12,928 | | | | | **$12,928** | $80.80 | |
| 70-2b | Caregiver Counseling-Serving Children | | | 1 session | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 70-9 | Caregiver Training | C | 400.00 | 1 session | 175 | | | | | $2,013 | | $2,013 | | | | | **$2,013** | $5.03 | |
| 70-9a | Caregiver Training - Serving Children | | | 1 session | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 73 | Caregiver Self-Directed Care | | | 1 client served | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 73a | Caregiver Self-Directed Care-Serving Children | | | 1 client served | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| **SOCIAL & HEALTH SERVICES** | | | | | | **$173** | **$0** | **$0** | **$4,144** | **$0** | **$3,674** | **$7,991** | **$0** | **$0** | **$0** | **$0** | **$7,991** | | |
| 40-2 | Physical Activity & Falls Prevention | | | 1 session | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 40-9 | Medication Management | C | 10.00 | 1 session | | | | | $1,861 | | | $1,861 | | | | | **$1,861** | $186.10 | |
| 50-1 | Guardianship/Conservatorship | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 50-3 | Elder Abuse Awareness and Prevention | D | 7.00 | 1 activity | 337 | | | | | | $3,674 | $3,674 | | | | | **$3,674** | $524.86 | |
| 50-4 | Crime Pervention/Home Safety | | | 1 activity | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 50-5 | LTC Ombudsman | | | 1 payment | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 60-4 | Volunteer Recruitment | C | 25.00 | 1 placement | 25 | $173 | | | | | | $173 | | | | | **$173** | $6.92 | |
| 60-10 | Recreation | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 71 | Chronic Disease Prevention, Management & Ed | | 15.00 | 1 session | | | | | $2,283 | | | $2,283 | | | | | **$2,283** | $152.20 | |
| 72 | Self-Directed Care | | | 1 client served | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 80-1 | Senior Center Assistance | | | 1 center served | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 80-4 | Financial Assistance | | | 1 contact | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 80-5 | Money Management | | | 1 hour | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 80-6 | Center Renovation/Acquisition | | | 1 center acqrd/renovated | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 900 | Other (specify) | | | | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 900 | Other (specify) | | | | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 900 | Other (specify) | | | | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| 900 | Other (specify) | | | | | | | | | | | $0 | | | | | **$0** | $0.00 | |
| | | | | | **GRAND TOTAL** | **$498,804** | **$335,073** | **$384,081** | **$4,144** | **$157,479** | **$3,674** | **$1,383,255** | **$206,567** | **$719,490** | **$144,256** | **$0** | **$2,453,568** | | |

**Area Plan Budget, Worksheet 2**
**Washington County Disability, Aging & Veteran Services (WCDAVS)**
**BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Plan Year 1**

# 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)** | **Admin. Cash Match** | **Admin. 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** |
| County | $46,740 | | $101,827.55 | | $11,907.50 | | $160,475 | $0 |
| Contractors | | | | $86,243 | | $23,493 | $0 | $109,736 |
| Volunteers | | | | $29,000 | | | $0 | $29,000 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| | | | | | | | $0 | $0 |
| **Column Totals:** | **$46,740** | **$0** | **$101,828** | **$115,243** | **$11,908** | **$23,493** | **$160,475** | **$138,736** |

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

**Notes/Comments**

**Area Plan Budget, Worksheet 3**
**Washington County Disability, Aging & Veteran Services (WCDAVS)** **Medicaid/OAA/OPI Staffing Plan**
**BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Plan Year 1**

| ADMINISTRATIVE POSITIONS | | | | | Breakout of funding sources | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) | (14) |
| Position Title | FTE Worked | Annual Salary (excludes OPE) | Annual OPE | Total Salary + OPE | OAA Funds | OPI Funds | Other Funds | Medicaid Funds Regular Allocation | Medicaid Funds Local Match | Medicaid Matched by Local Funds | Total |
| 11951.Senior Program Coordinator | 0.60 | $52,192 | $25,408 | $77,600 | $36,977 | $40,623 | | | | | $77,600 |
| 11952.Accounting Assistant II | 0.90 | $46,185 | $25,327 | $71,512 | $34,076 | $37,436 | | | | | $71,512 |
| 12641.Disability, Aging & Veteran Services Supervisor | 0.30 | $31,023 | $14,046 | $45,069 | $21,476 | $23,593 | | | | | $45,069 |
| 12982.Program Coordinator | 0.45 | $35,466 | $15,668 | $51,134 | $24,366 | $26,768 | | | | | $51,134 |
| | | | | $0 | | | | | | | $0 |
| | | | | $0 | | | | | | | $0 |
| | | | | $0 | | | | | | | $0 |
| | | | | $0 | | | | | | | $0 |
| ADMINISTRATIVE TOTAL | 2.25 | $164,866 | $80,449 | $245,315 | $116,894 | $128,421 | $0 | $0 | $0 | $0 | $245,315 |

| DIRECT SERVICES POSITIONS | | | | | Breakout of funding sources | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Position Title | FTE Worked | Annual Salary (excludes OPE) | Annual OPE | Total Salary + OPE | OAA Funds | OPI Funds | Other Funds | Medicaid Funds Regular Allocation | Medicaid Funds Local Match | Medicaid Matched by Local Funds | Total |
| 11948.Program Coordinator | 1 | $78,815 | $34,827 | $113,642 | $113,642 | | | | | | $113,642 |
| 11951.Senior Program Coordinator | 0.4 | $34,795 | $16,940 | $51,735 | $51,735 | | | | | | $51,735 |
| 11952.Accounting Assistant II | 0.1 | $5,132 | $2,813 | $7,945 | $7,945 | | | | | | $7,945 |
| 11955.Disability and Aging Services Supervisor | 1 | $84,871 | $36,076 | $120,947 | $42,331 | $42,332 | $36,284 | | | | $120,947 |
| 11957.Disability and Aging Services Coordinator | 1 | $63,130 | $30,575 | $93,705 | | $23,427 | $70,278 | | | | $93,705 |
| 12637.Program Specialist | 1 | $50,441 | $27,960 | $78,401 | $47,038 | | $31,363 | | | | $78,401 |
| 12638.Program Specialist | 1 | $55,258 | $28,953 | $84,211 | $50,526 | | $33,685 | | | | $84,211 |
| 12640.Disability and Aging Services Coordinator | 1 | $58,236 | $29,566 | $87,802 | | $70,241 | $17,561 | | | | $87,802 |
| 12641.Disability, Aging & Veteran Services Supervisor | 0.55 | $56,875 | $25,752 | $82,627 | $82,627 | | | | | | $82,627 |
| 12670.Administrative Specialist II | 1 | $48,866 | $27,637 | $76,503 | $57,378 | | $19,125 | | | | $76,503 |
| 12982.Program Coordinator | 0.55 | $43,350 | $19,161 | $62,511 | $45,462 | | $17,049 | | | | $62,511 |
| 13091.Disability and Aging Services Coordinator | 1 | $54,542 | $28,806 | $83,348 | | $66,677 | $16,671 | | | | $83,348 |
| 13108.Disability and Aging Services Coordinator | 0.4 | $23,294 | $5,037 | $28,331 | | | $28,331 | | | | $28,331 |
| 13141.Disability and Aging Services Coordinator | 1 | $52,595 | $28,404 | $80,999 | | $80,999 | | | | | $80,999 |
| 13202.Disability and Aging Services Coordinator | 1 | $62,062 | $30,355 | $92,417 | $9,242 | $55,452 | $27,723 | | | | $92,417 |
| 13216.Program Specialist | 0.75 | $42,917 | $26,262 | $69,179 | $6,918 | | $62,261 | | | | $69,179 |
| 13692.Administrative Specialist II | 1 | $40,194 | $25,849 | $66,043 | $33,021 | $16,511 | $16,511 | | | | $66,043 |
| 13693.Administrative Specialist II | 1 | $40,194 | $25,849 | $66,043 | $33,021 | $16,511 | $16,511 | | | | $66,043 |
| 13694.Disability and Aging Services Coordinator | 1 | $51,945 | $28,270 | $80,215 | | | $80,215 | | | | $80,215 |
| 13746.Disability and Aging Services Coordinator | 0.7 | $36,362 | $19,790 | $56,152 | | | $56,152 | | | | $56,152 |
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| | | | | $0 | | | | | | | $0 |
| **Note: These figures include budgeted OPI Pilot figures | | | | $0 | | | | | | | $0 |
| | | | | $0 | | | | | | | $0 |
| PAGE 1 DIRECT SERVICES TOTAL | 16.45 | $ 983,874.00 | $ 498,882.00 | $ 1,482,756.00 | $ 580,886.00 | $ 372,150.00 | $ 529,720.00 | $ - | $ - | $ - | $ 1,482,756.00 |

| DIRECT SERVICES POSITIONS | | | | | Breakout of funding sources | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Position Title | FTE Worked | Annual Salary (excludes OPE) | Annual OPE | Total Salary + OPE | OAA Funds | OPI Funds | Other Funds | Medicaid Funds Regular Allocation | Medicaid Funds Local Match | Medicaid Matched by Local Funds | Total |
| | | | | $0 | | | | | | | $0 |
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| | | | | $0 | | | | | | | $0 |
| ADMINISTRATIVE TOTAL | 2.25 | 164,866.00 | 80,449.00 | 245,315.00 | 116,893.58 | 128,421.42 | 0.00 | 0.00 | 0.00 | 0.00 | 245,315.00 |
| PAGE 1 DIRECT SERVICES TOTAL | 16.45 | $983,874.00 | $498,882.00 | $1,482,756.00 | $580,886.00 | $372,150.00 | $529,720.00 | $0.00 | $0.00 | $0.00 | $1,482,756.00 |
| PAGE 2 DIRECT SERVICES TOTAL | **0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **GRAND TOTAL** | **18.70** | **$1,148,740.00** | **$579,331.00** | **$1,728,071.00** | **$697,779.58** | **$500,571.42** | **$529,720.00** | **$0.00** | **$0.00** | **$0.00** | **$1,728,071.00** |

**Area Plan Budget, Worksheet 4**

Washington County Disability, Aging & Veteran Services (WCDAVS)

BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Pla

| | (3) | (4) | (5) | (6) |
|---|---|---|---|---|
| **APD Position Titles** | **Number of FTE Employed** | **Area Agency on Aging Position Title (if applicable)** | **Medicaid Positions and Title (in addition to APD allocated positions)** | **Number of FTE Employed** |
| Admin Specialist 1 | | | | |
| Adult Protective Services Specialist | | | | |
| Compliance Specialist 2 (AFH Licen.) | | | | |
| Diversion Case Manager | | | | |
| Human Services Assistant 2 | | | | |
| Human Services Case Manager | | | | |
| Human Services Specialist 3 | | | | |
| Office Specialist 2 | | | | |
| Pre-Admission Screening | | | | |
| Principal Executive Manager C | | | | |
| Principal Executive Manager D | | | | |
| Principal Executive Manager E | | | | |
| Principal Executive Manager F | | | | |
| Transition Case Manager | | | | |
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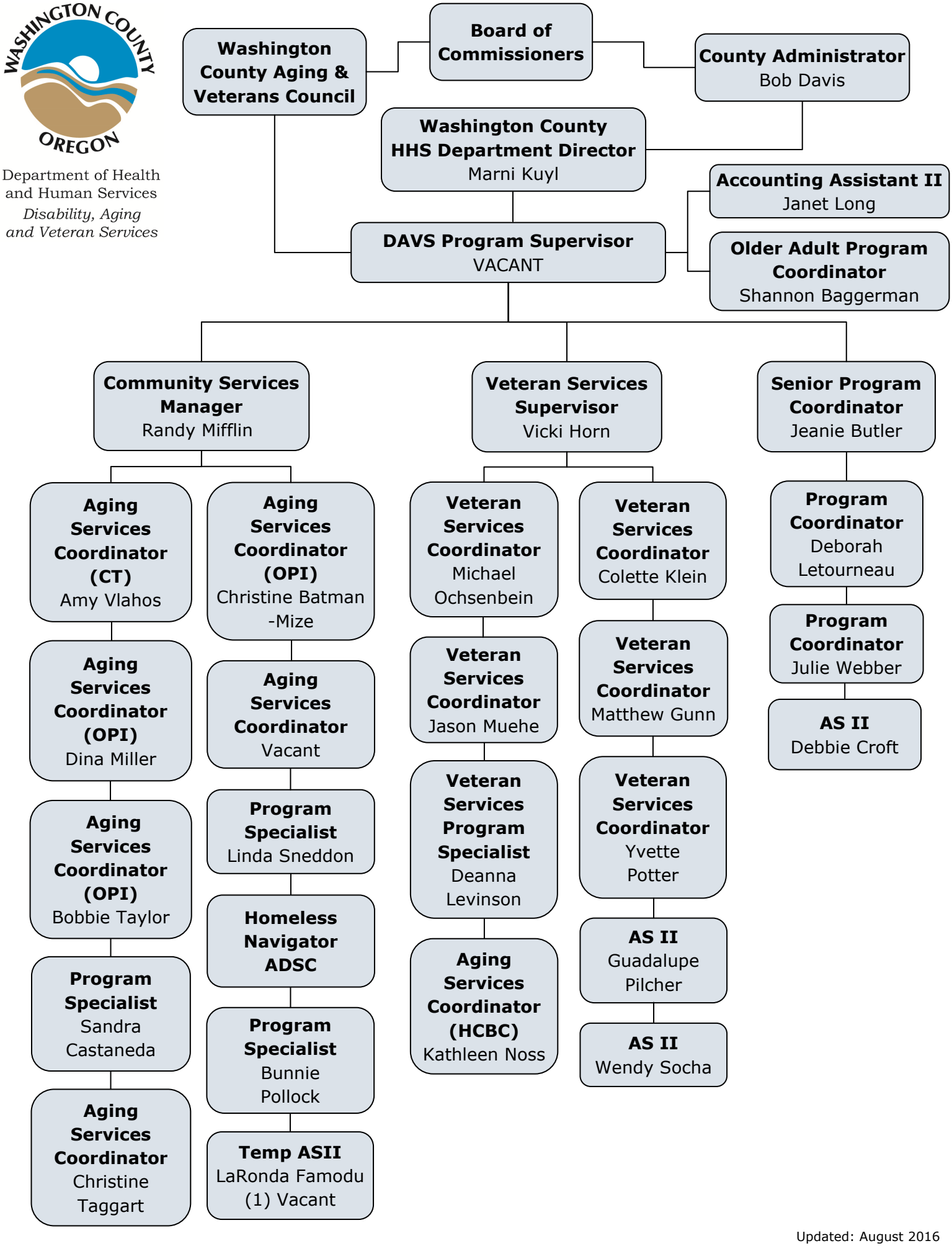
**Select AAA Name**

Community Action Program of East Central Oregon (CAPECO)
Community Action Team (CAT)
Community Connection of Northeast Oregon (CCNO)
Clackamas County Social Services (CCSS)
Central Oregon Council on Aging (COCOA)
Douglas County Senior Services Division (DCSSD)
Harney County Senior & Community Services Center (HCSCS)
Klamath & Lake Counties Council on Aging (KLCCOA)
Lane Council of Governments Senior & Disabled Services (LCOG)
Multnomah County Aging, Disability & Veterans Services Dept (MCADVSD)
Mid-Columbia Council of Governments (MCCOG)
Malheur Council on Aging & Community Services (MCOACS)
NorthWest Senior & Disability Services (NWSDS)
Oregon Cascades West Council of Governments Senior & Disabled Srvcs (OCWCOG)
Rogue Valley Council of Governments Senior & Disabled Srvcs (RVCOG)
South Coast Business Employment Corporation (SCBEC)
Washington County Disability, Aging & Veteran Services (WCDAVS)

**Select Budget Period**

BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Plan Year 1
BUDGET PERIOD: 7.1.2017 - 6.30.2018 Area Plan Year 2
BUDGET PERIOD: 7.1.2018 - 6.30.2019 Area Plan Year 3
BUDGET PERIOD: 7.1.2019 - 6.30.2020 Area Plan Year 4

Department of Health and Human Services
*Disability, Aging and Veteran Services*




Updated: August 2016

# What matters to you? We want to know!

***Please share your thoughts and concerns at an upcoming focus group.***

Like many organizations, Washington County Disability, Aging and Veteran Services (DAVS) is facing increased demands for services and shrinking public resources.

As part of our planning process for the next few years, **we want to know what issues are most important to older adults, veterans and people with disabilities**. We invite you to attend our upcoming focus group. No RSVP is required.

**Thursday, August 4, 2016**
**10:30–11:30 a.m.**
**Hillsboro Community Senior Center, Maple Room**
**750 SE 8th Ave.**

If you would like to provide input but are unable to attend the focus group, please visit our website at **www.co.washington.or.us/HHS/DAVS**. You can find a link to the focus group survey there.

WASHINGTON COUNTY OREGON

Department of Health and Human Services
*Disability, Aging and Veteran Services*

**Questions? Call 503-846-3081.**

# Qué es importante para usted? ¡Queremos saber!

***Por favor comparta sus pensamientos y preocupaciones en nuestro próximo grupo de enfoque.***

Al igual que muchas organizaciones, la oficina de Discapacidad, Envejecimiento y Servicios de Veteranos (DAVS) del Condado de Washington se enfrenta a un aumento de la demanda de servicios y la reduccion de los recursos publicos.

Como parte de nuestro proceso de planificación para los próximos años, queremos saber qué temas son los más importantes para los adultos mayores, veteranos y personas con discapacidades. Le invitamos a asistir a nuestro próximo grupo de enfoque. No se requiere registración.

**Miércoles, 31 de agosto de 2016**
**mediodía – 1:30 p.m.**
**Centro Cultural de Washington County**
**1110 N Adair St, Cornelius**

Si desea contribuir con su opinión pero no puede asistir a los grupos de enfoque, puede tomar la encuesta en línea **www.surveymonkey.com/r/DAVS**. La encuesta está disponible en inglés y español y está abierta hasta el 31 de agosto.

WASHINGTON COUNTY OREGON

Department of Health and Human Services
*Disability, Aging and Veteran Services*

## Preguntas? Llame 503-846-3081.

WASHINGTON COUNTY
OREGON

Department of Health and Human Services
*Disability, Aging and Veteran Services*

# Community Input Requested!

Washington County Disability, Aging and Veteran Services (DAVS) is seeking public input as we begin to develop our next area plan on aging.

Shrinking resources combined with increased demands for services makes it crucial to engage the community in the process.

The survey is available in English and Spanish and takes less than 15 minutes to complete.

**www.surveymonkey.com/r/DAVS**

The survey will remain open through August 31, 2016. For more information, call 503-846-3060.

WASHINGTON COUNTY
OREGON

Department of Health and Human Services
*Disability, Aging and Veteran Services*

# ¡Se pide participación comunitaria!

El departamento de servicios de Discapacidad, Envejecimiento y Veteranos (DAVS) del Condado de Washington está buscando la opinión del público ya que empezamos a desarrollar nuestro próximo plan de área para adultos mayores.

La disminución de los recursos combinados con el aumento de la demanda de servicios hace que sea crucial para involucrar a la comunidad en el proceso.

La encuesta está disponible en inglés y español y toma menos de 15 minutos en completarse.

**www.surveymonkey.com/r/DAVS**

Esta encuesta se mantendrá abierta hasta el 31 de Agosto del 2016. Para más información puede llamar a 503-846-3060.

**WASHINGTON COUNTY**
**OREGON**

August 10, 2016

## Washington County Disability, Aging and Veteran Services Seeks Community Input for Future Planning

Washington County Disability, Aging and Veteran Services (DAVS) is seeking public input as we begin to develop our next area plan on aging. Shrinking resources combined with increased demand for services makes it crucial to engage the community in the process.

We will be conducting targeted focus groups at senior centers and meal sites throughout Washington County. We encourage you to join us for these interactive sessions in the month of August. The focus group dates and times can be found below:

| **August 22, 2016, 11:00 a.m. – Noon** | **August 24, 2016, 10:30 – 11:30 a.m.** |
|---|---|
| MOWP Hillsboro Meal Site<br>541 SE Baseline Street<br>Hillsboro, OR 97123 | MOWP Sherwood Meal Site<br>Marjorie Stewart Center<br>21907 SW Sherwood Blvd.<br>Sherwood, OR 97140 |
| **August 23, 2016, 11:00 a.m. – Noon** | **August 25, 2016, 11:00 a.m. – Noon** |
| MOWP Forest Grove Meal Site<br>2037 Douglas Street<br>Forest Grove, OR 97116 | MOWP Beaverton Meal Site<br>Elsie Stuhr Center<br>5550 SW Hall Blvd.<br>Beaverton, OR 97005 |

In addition, we have created a community survey which we invite you to complete. The survey takes less than 15 minutes and can be found in the attached documents.

The survey, available in English and Spanish, will remain open through August 31 and is targeted toward older adults and those who care for or work on behalf of them.

Thank you in advance for your participation!

Marni Kuyl, RN, MS
Robert Wood Johnson Executive Nurse Fellow
Director, Department of Health and Human Services

**Department of Health and Human Services – Disability, Aging and Veteran Services**
Mailing Address: 155 N First Avenue, MS-44, Hillsboro, OR 97124-3072
Physical Address: 5240 NE Elam Young Parkway, Suite 300, Hillsboro, OR 97124
Phone: 503-846-3060 ◆ Aging Fax: 503-846-3065 ◆ Veteran Fax: 503-846-3059 ◆ www.co.washington.or.us

**Oregon Project Independence**
**Local Area Rules – Washington County**

**Refer to OARs 411-032-0000 through 411-032-0044 for:**
**OPI Service Definitions, Goals, Administration, Authorized Services & Allowable Costs, Data Collection, Records & Reporting, Eligibility & Determination of Authorized Services, Fees for Authorized Service & Fees for Service Schedule**

**Refer to OARs 411-015-0006 through 411-015-0015 for:**
**Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), Assessments, Priority of Paid Services and Current Limitations**

## Eligibility 411-032-0020

The consumer, at assessment must meet service eligibility levels (1-18), as indicated on *current* OPI Service Level Matrix in order to receive in-home services.

The consumer cannot be receiving Medicaid benefits, *except* Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Qualified Medicare Beneficiary (QMB), or Supplemental Low Income Medicare Beneficiary Programs (SLMB).

Any individual residing in an Assisted Living, Adult Foster Home, or a Nursing Facility shall not be eligible for authorized services. *However, a person wishing to relocate from an institution to their place of residence to receive care will not be restricted if it is appropriate and not against medical advice (AMA).*

## Determination of Services 411-032-0020

The determination of OPI services is based on each consumer's financial, functional, medical, and social need for the services, shown by the service eligibility level as indicated through the Client Assessment/Planning System (CA/PS).

After the initial eligibility determination, the determination of continued OPI services is made at regular intervals but not less than twelve months. Informal assessments and consumer follow up will be as needed. A full financial assessment is not necessary at these informal intervals unless there is a significant change to income as indicated by the consumer.

## Priority of Service 411-032-0020

Priority for authorized services will maintain consumers already receiving authorized services as long as their condition indicates the service is needed.

If OPI budget constraints do not allow for the immediate start of in-home services then consumers will be placed on a priority list.

Prioritization of services will be based on the state standardized OPI Risk Tool (SDS 287J) that measures the risk for out of home placement. Consumers with the highest risk of out of home placement are given priority.

## Goals 411-032-0001

The goals of Oregon Project Independence are to:

(1) Promote quality of life and independent living among older adults and people with physical disabilities;
(2) Provide preventive and long-term care services to eligible individuals to reduce the risk for institutionalization and promote self-determination;
(3) Provide services to frail and vulnerable adults who are lacking or have limited access to other long-term care services; and
(4) Optimize eligible individuals' personal resources and natural supports

## Authorized OPI Services 411-032-0010

(A) Home care supportive services limited to the following:
    (i) Home care;
    (ii) Chore;
    (iii) Assistive technology device;
    (iv) Personal care;
    (v) Adult day services;
    (vi) Registered nurse services; and
    (vii) Home delivered meals.
(B) Service coordination
(C) Assisted transportation
(D) Money management
(E) Options Counseling

Many of these services are provided only as budget allows. Fees may be assessed on a sliding scale for any of these services except Service Coordination, Assisted Transportation, and Home Delivered Meals.

## Fees for Authorized Service 411-032-0044

Fees for service will be based on a sliding fee schedule to all eligible consumers whose annual income exceeds the minimum household income limit, as established by the State.

## One-Time Fee 411-032-0044

(a) A one-time fee is applied to all consumers receiving OPI authorized services who have adjusted income levels at or below federal poverty level. The fee is due at the time eligibility for OPI authorized services has been determined.
(b) A second attempt to collect the one time fee is not required.
(c) Consumers who identify a financial hardship may request that the one-time fee of $25 be waived.
(d) Consumers who wish to have the fee waived should contact the Community Services Supervisor in writing within 10 business days of receipt of the invoice to request a waiver. The invoice will include contact information and instructions on how to request a waiver.

Proof of financial hardship may be required by the Community Services Supervisor before approval.

## Issues of Consumer Non-Payment

OPI consumers who have been assessed a fee for service will be billed by Washington County each month after Home Care Worker vouchers have been processed and after agencies have billed Washington County.

If a consumer is more than 60 days past due, the staff person, who processes consumer bills and payments, will notify the OPI case aid and the appropriate Service Coordinator that they have sent a past due notice to client.

The letter being sent to the consumer will notify them of their past due amount and inform them that the case will be closed 30 days after the date of the letter if payment arrangements are not made.

If a consumer, who is still receiving services, wishes to make monthly payment arrangements for a past due bill then they will need to make at least the minimum monthly payment plus an additional $10.00 above this in order to work toward paying off the debt.

If the consumer wants to keep OPI services they need to contact the staff person stated in the letter they receive and arrange a payment plan, at which time a second letter will be sent for client signature that lays out the payment plan. Client needs to return the signed letter for client records.

If the client arranges a payment plan the contacted staff person will notify the Service Coordinator and OPI Case Aid that payment arrangements have been made.

If the consumer does not pay by the date listed in the original letter, or does not make payment arrangements, the Service Coordinator will discontinue the consumer's OPI services and send a closure letter to the consumer and in-home care provider. The past due amount will be sent to a collection agency.

If the consumer does not follow through on the payment plan as agreed, the staff person who handles billing will notify the Service Coordinator and OPI Case Aid so that client's case can be closed at that time. The Service Coordinator or OPI Case Aid will mail a closure letter to the consumer and in-home care provider.

If the consumer pays the past due amount after the OPI case has been closed they may reapply for services. If there is a priority list they will be added to the list based on priority level, as determined by their Risk Assessment Tool score, and new date of request.

## Consumer Assessment 411-015-0008

The assessment process will identify the consumer's ability to perform activities of daily living, instrumental activities of daily living (self-management tasks), and determine the consumer's ability to address health and safety concerns and their preferences to meet needs.

The purpose of assessing consumers is for the Service Coordinator to evaluate the current level of functioning of the consumer and how well they can manage in their *present* living situation, then determine what care needs are required to allow the person to remain safe in the least restrictive environment. The service plan must be cost effective in management of OPI's limited resources in order to serve the greatest number of consumers with service needs.

## Client Assessment/Planning System (CA/PS)

This computerized assessment tool in Oregon Access is a comprehensive and holistic evaluation system of a consumer's mental, social, and physical health. CA/PS is used for determining consumer need in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), and establishing services through setting up a Service Plan.

***Please see OAR 411-015-0005 through 411-015-007 for specific rules and definitions under each assessment area.***

## Required Forms

The following forms will be used during the OPI home visit and will be a part of the consumer's file. These forms will be updated at least annually, unless otherwise specified, through the service redetermination assessment. *Copies are included in the forms section.*

*OPI Service Agreement (SDS 0287L)*
*OPI Income/Fee Determination Record (SDS 0287K)*
*Oregon Health Authority Notice of Privacy Practices (MSC 2090)**
*Oregon Health Authority Notice of Privacy Practices Acknowledgement of Receipt (MSC 2092)**
*Workers' Compensation Agreement and Consent (SDS 0354)***
*Client-Employed Provider Program Participation Agreement (SDS 0737)***
*Washington County Disability, Aging & Veteran Services Release of Information*
*Risk Assessment Tool or RAT (SDS 0287J)****

* Initial Assessment Only
** As needed when HCW chosen
***RAT needs to be completed at initial screening (called initial in ADRC), at every reassessment (called annual in ADRC), and after six months that the consumer is on the priority list (called reassessment in ADRC).

## Setting up In-home Services

a. Upon completion of the assessment, In-Home Service Plans will be discussed. Authorized hours will be discussed with the consumer to develop a plan while being cost effective and consumer driven.

Homemaking hours are not to exceed 15 hours/month per individual, or 20 hours/month for 2 clients living in the same home, unless approved by Community Services Supervisor. Total in-home care hours will not exceed current Washington County maximum.

Personal care hours must be designated according to each task and consumer will be informed that hours may be reduced if they are not being utilized.

b. Consumers have the option of selecting a Home Care Worker (HCW) or an in-home care agency. Consumers will be sent a letter of

their approval following the assessment and notified that a provider must be selected within 30 days.

If consumers are having difficulty locating a provider within 30 days, they must inform their Service Coordinator and request an exception. If the exception exceeds 60 days, then the Community Services Supervisor must grant the exception.

c. Consumers wishing to hire privately for additional hours beyond what OPI is providing may arrange to do so. However, consumers who are hiring their OPI Home Care Worker privately for additional hours must put in writing the hours and day(s) of the week that HCW is providing services through OPI. A HCW Private Pay Release form will be sent to the HCW as a courtesy. This will be added to the consumer's file.

d. If a consumer's HCW takes a vacation or other emergency leave and consumer needs a fill in HCW to work for them, the Service Coordinator may use the 546SF to update the voucher system rather than having to do a whole new service plan. The 546SF must be scanned into the consumer file.

e. Consumer must be present in the home when an agency caregiver or home care worker is providing any in home service.

## Safety Plans

Safety plans may be requested by OPI staff if consumers are high risk or have unmet high care needs. Safety plans must address how additional care will be provided and what steps must be taken to ensure that consumer is safe with OPI involvement. If the Service Coordinator determines that a safe care plan is not possible with OPI involvement, natural supports and other community supports, then consumers will not be eligible. This will be based on the determination that the service needs are beyond the scope of what OPI can safely provide and the consumer is considered beyond the point of independence.

The safety plan will be signed by the Service Coordinator and consumer or their representative. If consumer or their representative agree to the safety plan and then fail to adhere to the safety plan, then services may be terminated.

All safety plans will be reviewed and approved by the Community Services Supervisor.

*Example of when a safety plan would be required:*
A consumer assessed at an SPL 3 lives with spouse who is the unpaid caregiver. Consumer is physically and/or cognitively unable to leave the home without assistance from another person; safety plan addresses that consumer will not be left alone on the property.

Safety Plan would state that paid caregiver will not be able to leave until unpaid caregiver returned.

Safety plan addressed the need that consumer is unsafe being left alone because in an emergency, they would not be able to get out of the home or call for help.

## Putting Services on Hold

If a consumer requests or needs their OPI services to be placed on hold they may do so. The circumstances in which a case can be put on hold may include family visitation, consumer going out of town, consumer in hospital or rehab, etc. However, after being on hold for 45 days the Service Coordinator may make the determination that the services need to be closed in order for consumers on the priority list to be added on to the program.

If a case closure is needed then the OPI Service Coordinator will send a letter to the consumer informing them of the case closure and giving the consumer a chance to respond. The case closure will be 10 business days from the date of the letter.

A consumer in the hospital or rehab facility may be able to have services on hold for a longer period of time. These situations, as well as other exceptions, should be approved by the Community Services Supervisor.

## Tracking High Risk Consumers

Some consumers may be considered by OPI Service Coordinators to be "high risk". The OPI Service Coordinator will mark the consumer as "High Risk" in the OPI Spreadsheet and complete a pink High Risk form which is kept in a central location. High Risk consumers are those that would need immediate follow-up in the event of a natural disaster.

*Some of the considerations in deeming a consumer as "high risk" may include:*

- Live alone and have limited family or social supports
- Unable to evacuate their home in an emergency
- Requires medical equipment that uses electricity (oxygen, dialysis, etc)
- Other variables deemed appropriate by the OPI Service Coordinator

## Denying, Reducing or Terminating OPI Services

Denial for Service: When an OPI Service Coordinator determines that an applicant for OPI services will not be provided a requested service, the Service Coordinator shall provide to the applicant, by mail, a written notice

of this decision. This notice shall state the specific reason(s) for this decision and shall describe the consumer's grievance rights, including deadline for submitting a grievance.

Reducing Service: If a consumer requests a reduction in hours, it should be noted in the narrative. A new Service Agreement showing the reduction in hours should be sent to consumer for signature. If the reduction in hours is the Service Coordinator's decision, the worker shall provide to the applicant, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the consumer's grievance rights, including deadline for submitting a grievance.

Terminating Services: If a consumer decides to end services, the reason should be noted in the narrative. Service Coordinator will send "Consumer Request to Withdraw" form for signature.

If Service Coordinator decides to terminate services, the Service Coordinator shall provide to the consumer, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the consumer's grievance rights, including deadline for submitting a grievance.

If consumer signs the OPI Fee Determination and OPI Service Agreement that shows a change or reduction in hours or fee, then the consumer is agreeing to these terms and therefore does not have a grievance.

## Grievance Procedure

If a consumer disagrees with a decision to deny, reduce, or terminate OPI services then they may utilize the following procedure:

1. They may request a reassessment of their needs by their OPI Service Coordinator. The OPI Service Coordinator must schedule a reassessment within 5 business days of the request unless an assessment has been done within the past 30 days. If the assessment has been completed within the past 30 days and there is no significant change, then the current assessment will be considered valid. Consumer may proceed to step 2.

2. The consumer may contact the Community Services Supervisor in writing within ten (10) business days of the date of the denial letter. If the consumer uses this approach, within five business days of the consumer's letter, the Community Services Supervisor will contact the consumer and discuss the decision and the review process. If the consumer still disagrees with the decision they may follow Step 3 below.

3. The consumer may file a written grievance within ten (10) business days of the conversation with the Community Services Supervisor. Their grievance should be submitted to: WCDAVS Director, 155 N. First Ave., MS 44, Hillsboro, OR 97123. If the consumer uses this approach the Director will schedule a grievance review meeting within ten business days of receiving the consumer's written grievance. The consumer and their representative, if any, will be notified in writing, of the date, time and location of this meeting. The consumer's rights at this meeting will be set forth in the meeting notice. If the consumer needs any special accommodations at this meeting they will need to let the Director know at least 5 business days before the meeting.

If the consumer grieves the decision to terminate their OPI services, they will continue to receive this service until the outcome of the formal grievance is known.

**Memorandum of Understanding**
**Between**
**Washington County Disability, Aging & Veteran's Services**
**Area Agency on Aging**
**And**
**Department of Human Services**
**Senior & People with Disabilities, Washington County**

**Purpose**

The Washington County Disability, Aging & Veteran's Services Area Agency on Aging, hereinafter WCDAVS, and Oregon Department of Human Services, Division of Seniors and People with Disabilities in Washington County, hereinafter SPD, 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**

**SPD agrees to:**

- Provide training to WCDAVS personnel and volunteers regarding services and eligibility criteria established and/or administered by SPD on an as needed basis to ensure WCDAVS staff have basic programmatic knowledge for Information and Referral.
- Refer individuals to WCDAVS for assessment, case management, veteran benefits and/or service delivery as deemed mutually appropriate by SPD and WCDAVS personnel via denial/withdrawn spreadsheets developed during the intake process.
- HSS1 SNAP Outreach individual will coordinate efforts with the BEC in order to include all core benefits.
- Refer non-Medicaid clients requiring Medicare benefits assistance to WCDAVS SHIBA program. For Medicaid clients requiring Medicare benefits assistance, refer to SPD MMA specialists who will consult with SHIBA as needed.
- Provide a knowledgeable representative who will attend the WCDAVS monthly Advisory Council Meeting to provide an update of the current SPD operations and policies.

- Provide a knowledgeable representative who will attend the BEC Steering Committee meetings and provide information for the improvement of the BEC.

- Use a state-generated monthly report for re-determination for follow up as of June 1, 2011.

- Provide data if necessary indicating application/enrollment rates for clients of the

BEC.

- Work with WCDAVS Aging Services Coordinators and Veteran Services Coordinators to determine medical and financial eligibility for Medicaid waiver services for adults as quickly as possible.

- Consult with WCDAVS personnel and administration to address system(s) quality and effectiveness.

- Receive Universal Referral Form and Oregon ACCESS screenings from WCDAVS by fax, e-mail and through Oregon ACCESS and register them in the appropriate Medicaid category.

- Coordinate monthly meeting of State and County Managers to support information sharing and programmatic updates in each respective agency.

- Partner with WCDAVS in annual/biannual Employee Orientation to facilitate education of new State and County staff.

**WCDAVS agrees to:**

- Participate in training regarding services and eligibility criteria established and/or administered by SPD on an on-going basis.

- Provide training to SPD personnel regarding services and programs administered by WCDAVS on an as needed basis to ensure SPD staff has basic program knowledge for Information and Referral.

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

- Work with the SPD 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 SPD.

- Consult with SPD personnel and administration to address system(s) quality and effectiveness.

- Refer all potential Medicaid clients identified by the SHIBA program, Aging Services Coordinators, Veteran Services Coordinators or REACH to SPD for an eligibility assessment.

- Communicate receipt and ongoing status of referrals for all programs administered by WCDAVS upon receipts and at least monthly.

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 WCDAVS

6/21/11
Date

For SPD

6/20/11
Date

I: WCDAVS/CONTRACTS/SPD MOU 2010-11.doc
10/15/2010jb

CA 16-0199

# Memorandum of Understanding
# Between
# Washington County Disability, Aging & Veteran's Services
# Area Agency on Aging
# And
# Washington County Assessment and Taxation

## Purpose

The Washington County Disability, Aging & Veteran's Services Area Agency on Aging (hereinafter WCDAVS) and Washington County Assessment and Taxation (hereinafter WC A&T) agree that veterans, seniors and the disabled 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

### WC A&T agrees to:

- Provide training to WCDAVS personnel and volunteers in order to have basic programmatic knowledge for eligibility in property tax relief programs.
- Include information regarding the Benefits Enrollment Center (BEC) and how it relates to property tax relief programs in those statement mailings that have been determined that the information will be the most effective.
- Agree to have informational materials regarding the Benefits Enrollment Center available to the public at the Assessment and Taxation office.
- Provide a knowledgeable representative who will attend the WCDAVS quarterly BEC Steering Committee Meeting to provide an update of the current BEC/WC A&T partnership and to address system(s) quality and effectiveness.
- Provide reporting data which includes number of mailings/marketing materials distributed.

### WCDAVS agrees to:

- Coordinate training for staff and volunteers regarding services and eligibility criteria established and/or administered by WC A&T on an on-going basis.

- Provide training to WC A&T personnel regarding services and programs administered by WCDAVS as requested.
- Consult with WC A&T 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 upon signatures of all parties and will be effective through the grant period ending December 31, 2016. This agreement may be terminated by either of the parties by 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 WC HHS/DAVS

2-24-2016
Date

For WC A&T

2/19/2016
Date

**Sia Lindstrom**
Sr. Deputy County Admin

For Washington County CAO

3/2/2016
Date

CA 16-0825

# Memorandum of Understanding

This Memorandum of Understanding (MOU) is entered into by and between Health Share of Oregon (Health Share) and the Area Agencies on Aging and Disability in the Multnomah, Clackamas, and Washington County regions and the Multnomah and Clackamas districts of Oregon DHS-Aging and People with Disabilities (collectively "APD/AAAD").

## I. Purpose of the MOU

In order to maximize effective health outcomes, improve both the care experience and quality of life, reduce costs in both healthcare delivery and long-term care systems, and ensure shared responsibility for delivering high quality, person-centered care, the parties to this MOU plan to coordinate care and share accountability in the tri-county area for Medicaid beneficiaries, with a primary focus on those receiving Medicaid-funded LTSS. The parties to this MOU also desire to work together collectively to expand our mutual ability to address the social determinants of health, reduce health disparities, prevent or delay need for LTSS, and improve health outcomes for low income and at-risk seniors and adults with disabilities.

## II. Agreements of the Parties

Based on a good faith description of the roles and responsibilities and the commitment to coordinate care and share accountability, the parties to this MOU agree to participate in the following activities during the period from **July 1, 2016 through June 30, 2018:**

### 1. Interdisciplinary Care Coordination

| Description of Activity | Health Share & APD/AAAD Shared Accountability | State Measurement Parameters |
|---|---|---|

| | | |
|---|---|---|
| a) Health Share and AAAD/APD parties to this MOU have identified 2 teams which will share accountability for the interdisciplinary care coordination conferences (ICCCs) on mutual LTSS clients/members.<br><br>b) These 2 teams will include both a designated Health plan partner lead and an APD/AAAD lead. The frequency with which each team will hold ICCCs will be based on the total numbers of mutual LTSS clients/members with either high emergency department or in-patient utilization and/or other social determinant-based risk factors but will occur at least monthly.<br><br>c) The designated leads from both the Health plan partners and the AAAD/APDs will share accountability for preparing the ICCC requests and coordinated care plans. The ICCC requests will document baseline demographic, mental or behavioral health engagement, as well as risk, utilization, and cost data on each client/member taken to ICCC;<br><br>d) Each ICCC team will also share responsibility to document comparison data on all of the same factors for each | a) By July 31, 2016, the 2 teams will each review the data sources currently available, revise, as needed, the criteria used to stratify high needs cases, and document the process used to integrate data from AAAD/APD and health plan sources used in the stratification process. This information will be documented and presented for review and comment to the Tri county Joint Aging, Disability, and Health Systems Steering Committee.<br><br>b) By September 30, 2016, the health plan partner leads for each team will be identified and presented to the Tri County Joint Aging, Disability, and Health Systems Steering Committee. By September 30, 2016, the APD/AAAD lead for each team will be identified and presented to the Tri-County Joint Aging, Disability, and Health Systems Steering Committee.<br><br>c) Effective October 1, 2016, The Health plan partner leads will be accountable to complete and communicate, on or before the date of the ICCC, to the designated AAAD/APD lead the baseline risk and utilization measures from CCO or health plan data sources for each client/member addressed in an ICCC. The Health plan partner leads also will be accountable for distributing each ICCC care plan to all health system-affiliated members of each care team. The designated APD/AAAD lead will be accountable to complete | • % of CCO/APD/AAAD teams that are meeting on a regular schedule to coordinate care for high need members;<br><br>• % of CCO MOU partners and APD/AAAD districts that have integrated risk screening data to generate a list of prioritized high needs members to refer for care coordination;<br><br>• % of CCO individualized person-centered care coordination plans that document member or member representative preferences and goals;<br><br>• % of inter-disciplinary care teams that have a clearly-designated |

| | | |
|---|---|---|
| client/member in the succeeding quarter.<br><br>e) HealthShare, Health plan partners and APD/AAAD agree that the ICCCs shall be individualized and person-centered. The LTSS care team members to be included in each ICCC may include the APD/AAA case manager, intake, APS, and/or Multi-Disciplinary Team or community RN staff, contractors, facilities, care providers, and community partners. The Health plan care team may include the primary care providers or a designee, care management staff, mental health and substance use disorder providers, hospital discharge planner or care management staff, and any ancillary health providers, navigators or health resilience staff, or other consultants that may be appropriate. The teams will share responsibility to ensure that appropriate releases of information are obtained from the client/member as needed for any member of the care team who is not a HIPPAA-covered entity.<br><br>f) Two additional ICCC teams are under development. | and communicate to Health Share and the health plan partner leads the baseline demographic, service hours, level of service, dual eligibility status, and SPL for each client/member addressed in an ICCC. The APD/AAAD lead for each team will be accountable for distributing the coordinated care plan to the client, LTSS providers, and any other community providers on each care team. The designated AAAD/APD lead will analyze data trends on all ICCC s for each team and report on these to the Tri County Joint Aging, Disability and Health Systems Steering Committee on a quarterly basis.<br><br>d) Effective August 1, 2016, Health Share and each of the Health plan and AAAD/APD leads will meet quarterly to document outcomes and comparison data on degree of engagement in the ICCC, mental or behavioral health engagement, as well as risk, utilization, and cost factors on all clients/members addressed in an ICCC in the previous quarter.<br><br>e) Effective August 1, 2016, the designated Health plan leads will be responsible to identify, document, and share with all other members of the care team the names and contact information of all health-care related members of the client/members care team for each ICCC. The AAAD/APD lead will be responsible to | lead from CCO or other designated health care organization and from APD/AAAD; |

| | | |
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| | identify, document the names and contact information, and share with all other members of the care team all LTSS-related members of the client/member's care team for each ICCC.<br><br>f) By June 30, 2017, the remaining 2 HealthShare Health Plan Partners will work with AAAD/APD lead to develop and accept their full shared accountability for ICCCs. | |

**2. Transitional Care Practices**

| Description of Activity | Health Share & APD/AAAD Shared Accountability | State Measurement Parameters |
|---|---|---|
| a) Health Share and APD/AAAD will work together to identify and document the transitional care practices of health plan staff, primary care, hospitals, mental/behavioral health inpatient and residential providers, community contractors, and AAAD/APD.<br><br>b) Health Share and APD/AAAD will analyze available data on all of these practices to identify elements | a) By October 30, 2016, The Tri County Joint Aging, Disability, Health Systems Steering Committee will designate a Tri-County Transitions Work Group and charge it to identify and document transitional care practices of all elements of the Aging, Disability, and Health systems in the tri-county area. The group will meet at least monthly or more often as needed. Health Share will designate at least one person to serve on this work group, as well as encourage participation from its health plan partners. Health Share will encourage | • % of MOU partners that have mapped the transitional care practices in their areas;<br><br>• % of MOU partners that developed a procedure for coordinating |

| | | |
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| of transitional care that will improve with better communication and coordination.<br><br>c) Health Share, other health plan partners, and APD/AAAD will develop a collaborative action plan to improve communication and coordination of care in transitional practices. | its member network of providers and hospitals to designate liaisons to the Work Group as well. AAAD/APD will also designate at least two persons to serve on this work group.<br><br>b) By September 30, 2017, The Tri County Transitional Practices Work Group will draft and present to the Tri County Steering Committee a report to describe and map the transitional care practices in each area, as well as to identify gaps, areas of duplication, and barriers to coordination. The Work Group will submit its final report to the Steering Committee by December 30, 2017. The report will include recommendations to improve communication and coordination among all of the parties. The Health Share Transitions Liaison, with its participating Health Plan partners, will present this report to Health Share leadership by February 28, 2018. AAAD/APD Transitions Liaison will present this report to AAAD/APD leadership by February 28, 2018.<br><br>c) Health Share, with its Health plan partners, and AAAD/APD will develop a collaborative action plan to improve communication and coordination of care | and communicating around transitions of care |

| | | |
|---|---|---|
| | in transitional practices by April 30, 2018. | |

**3. Member Engagement**

| Description of Activity | Health Share & APD/AAAD Shared Accountability | State Measurement Parameters |
|---|---|---|
| Health Share and APD/AAAD ICCC leads agree to involve client/members themselves, as well as a support person of the client/member's choosing, and address member/client access to needed services, in the ICCCs whenever feasible and appropriate. | Effective August 1, 2016, Health Share and health plan partner leads will be responsible to document client/member preferences and goals and/or invite the client/member and a support person to attend the ICCC. If Health Share or its health plan partner requests assistance from the AAAD/APD lead, the AAAD/APD lead will provide assistance to document client preferences/goals and/or invite the client and a support person to participate in the ICCC. If either Health Share or its health plan partner or APD/AAAD receives input that it would not be appropriate to involve the client/member directly in the ICCC, this will be documented. For these clients, Health Share or its health plan partners and AAAD/APD will work together to document the client/member's preferences and goals in the 2 weeks prior to the ICCC and following the ICCC. Effective August 1, 2016, the AAAD/APD lead will track how often this occurs for each team and report to the Tri County | • % of members that are engaged in the care conference process prior to a conference<br>• % of time the care plan is reviewed with the consumer after the care conference |

| | | |
|---|---|---|
| | Joint Aging, Disability and Health Systems Steering Committee on a quarterly basis. | |

**4. Health Promotion and Prevention (Optional Domain)**

| Description of Activity | Health Share & APD/AAAD Shared Accountability | State Measurement Parameters |
|---|---|---|
| Health Share, its Health Plan partners, and AAAD/APD will work together to improve access to and utilization of evidence-based self-management education for Health Share client/members. Health Share, its health plan partners, and AAD/APD also will work together to strengthen referrals from the provider and health plan networks as well as to test and implement billing/payment mechanisms that will support both the continuation and expansion of community-based self-management education. Health Share, its health plan partners, and AAAD/APD will work together to develop a regional action plan to present to the Tri-County Joint Aging, Disability and Health Systems Steering Committee. | By September 30, 2016, AAAD/APD will host and lead a regional coalition to work on a) improve access to and utilization of evidence-based self-management education programs b) strengthen referrals from provider and health plan network and c) test and implement billing/payment mechanisms that will support both the continuation and expansion of these community-based self-management programs. By September 30, 2016, Health Share and/or its Health Plan partners will designate one or more liaisons to attend coalition meetings and participate in its work. By | No State measures at this time. |

| | | |
|---|---|---|
| | December 30, 2016, the Regional Coalition will present a report with recommended action plan, timetable and specific deliverables to the Tri County Aging, Disability and Health Systems Steering Committee. Upon endorsement of the plan by the Tri County Steering Committee, the Health Share liaison will present the report to Health Share leadership for consideration of the recommendations. | |

**5. Cross-System Learning (Optional Domain)**

| Description of Activity | Health Share & APD/AAAD Shared Accountability | State Measurement Parameters |
|---|---|---|
| Health Share, its health plan partners, and AAAD/APD will work together to foster opportunities for cross-system learning that will enhance communication, improve coordination, transitions, and provide opportunities for collaboration to improve access to and quality of services. | By November 30, 2016, AAAD/APD will assemble and lead or co-lead an inter-disciplinary coalition group in each county to develop an annual cross-system learning plan for the calendar year 2017. The plan will include an | No State measures at this time. |

| | | |
|---|---|---|
| | evaluation component to determine whether the cross-system learning sessions are enhancing communication, improving coordination, and providing opportunities for collaboration. Health Share and/or its Health Plan partners will designate one or more liaisons to the coalition. By January 31, 2017, the annual cross-system learning plan for each county will be presented to the Tri-County Joint Aging, Disability, and Health Systems Steering Committee. | |

## III. Terms and Conditions

a. Effective Date and Termination: The effective date of this MOU shall be July 1, 2016 regardless of the date on which each party has signed this MOU. Unless earlier terminated as provided below, the termination date shall be June 30, 2018.

b. Termination: This MOU may be terminated by mutual consent of both parties at any time. Any such termination of this agreement shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.

c. Amendments: Given the complexity of Oregon's health care initiative, it is understood that during the term of this MOU many details regarding the participating systems, the State's priorities, and funding mechanisms may be re-designed or altered. This MOU may be revised to reflect those changes as needed and as jointly agreed by the parties. All amendments must be in writing and signed by all parties.

d. Adherence to Law: Each party shall comply with all federal, state and local laws and ordinances applicable to this MOU.

*(Signatures on following page)*

**Signatures and Contacts**

**For Department of Human Services, Aging and People with Disabilities, Central Office,**

Authorizing Signature

By: _____

Title: _____ Date: _____

**Designated Contact Person is:**

Naomi Sacks, LTSS SIM Analyst, Advocacy & Development Unit

Naomi.e.sacks@state.or.us 503-385-7168

Email Phone

**For Health Share of Oregon**

Reviewed by: _____ Date: _____

Authorizing Signature

By: _____

Title: _____ Date: _____

The designated Health Share contact person is:

| Name | Title |
|---|---|
| Barbara Carey<br>Email: barbara@healthshareoregon.org | Senior Manager Compliance, Quality Assurance<br>Phone: 503-416-4962 |

**For Multnomah County Aging, Disability, and Veterans Services Division**

Authorizing Signature:

By: _____

Title: _____ Date: _____

The designated contact person is:

| Jan McManus | LTSS Innovator Agents |
|---|---|
| Name<br>Janet.mcmanus@multco.us or<br>Email | Title<br>503-988-2853<br>Phone |

**For Washington County Disability, Aging, and Veterans Services**

Authorizing Signature:

By: _____ Tia Lindstrom

Title: Senior Deputy County Administrator Date: 7/14/2016

**Signatures and Contacts**

**For Department of Human Services, Aging and People with Disabilities, Central Office,**

Authorizing Signature

By: _____

Title: _____ Date: _____

**Designated Contact Person is:**

Naomi Sacks, LTSS SIM Analyst, Advocacy & Development Unit

Naomi.e.sacks@state.or.us 503-385-7168

Email Phone

**For Health Share of Oregon**

Reviewed by: Barbara Carey Date: 7/5/16

Authorizing Signature

By: _____

Title: CEO Date: 6/30/2016

The designated Health Share contact person is:

| | |
|---|---|
| Barbara Carey<br>Email: barbara@healthshareoregon.org | Senior Manager Compliance, Quality Assurance<br>Phone: 503-416-4962 |

**For Multnomah County Aging, Disability, and Veterans Services Division**

Authorizing Signature:

By: Peggy J Brey

Title: Director of ADSVD Date: 6/27/16

The designated contact person is:

| | |
|---|---|
| Jan McManus | LTSS Innovator Agents |
| Name<br>Janet.mcmanus@multco.us or<br>Email | Title<br>503-988-2853<br>Phone |

**For Washington County Disability, Aging, and Veterans Services**

Authorizing Signature:

By: _____

Title: Senior Deputy County Administrator Date: _____

The designated contact person is:

The designated contact person is:

| Jeanie Butler | Senior Program Coordinator |
|---|---|
| Name | Title |
| jeanie_butler@co.washington.or.us | 503-846-3082 |
| Email | Phone |

**For Clackamas County Social Services Division**

Signature Authority:

By: _____

Title: Director - Clackamas County Social Services Date: 6-30-16

The designated contact person is:

| Brenda Durbin | Director |
|---|---|
| Name | Title |
| brendadur@co.clackamas.or.us | 503-655-8641 |
| Email | Phone |

Oregon Department of Human Services, Aging and People with Disabilities
Clackamas County APD

Signature Authority:

By: Genevieve Sundet

Title: District Manager Date: 6/30/2016

The designated contact person is:

| | |
|---|---|
| Genevieve Sundet | District Manager |
| Name | Title |
| genevieve.m.sundet@state.or.us | 503-971-6079 |
| Email | Phone |

Washington County APD

Signature Authority:

By: _____

Title: _____ Date: _____

The designated contact person is:

| | |
|---|---|
| Jessica Soltesz | District Manager |
| Name | Title |
| Email: jessica.m.soltesz@state.or.us | phone |

By: _____

Title: _____ Date: _____

The designated contact person is:

| | |
|---|---|
| Genevieve Sundet | District Manager |
| Name | Title |
| genevieve.m.sundet@state.or.us | 503-971-6079 |
| Email | Phone |

Washington County APD

Signature Authority:

By: Jessica Soltesz

Title: District Manager Date: 7/5/16

The designated contact person is:

| | |
|---|---|
| Jessica Soltesz | District Manager |
| Name | Title |
| Email: jessica.m.soltesz@state.or.us | Phone 503-330-2975 |

# Memorandum of Understanding
# Between
# Washington County Disability, Aging & Veteran's Services
# And
# Washington County Mental Health

## Purpose

The purpose of this agreement is to provide basis for a cooperative relationship between Washington County Disability, Aging and Veterans Service's (DAVS) Aging and Disability Resource Connection (ADRC) and Washington County Mental Health (WCMH). This agreement establishes roles and responsibilities related to assessing and triaging calls, providing information, referral services and crisis intervention.

## Roles

DAVS/ADRC:

The ADRC provides information and assistance to seniors, people with disabilities, veterans and caregivers in assessing their needs and linking them to appropriate services. This service is provided by Information and Assistance/Referral Specialists and Options Counselors Monday – Friday, 8:00 a.m. to 5:00 p.m.

WCMH:

WCMH is responsible for mental health system oversight and development of safety net services. This includes providing crisis intervention and treatment services through a network of contracted providers. WCMH also operates a managed Medicaid plan for mental health services through its partnership with Health Share of Oregon, a coordinated care organization (CCO).

## Scope of Agreement

### DAVS/ADRC agrees to:

When ADRC staff receives a call relating to behavioral health or addictions services, they will attempt to determine if the caller is a resident of Washington County and if the individual is covered by one of the following:

- Oregon Health Plan (OHP)/Open Card
- Health Share of Oregon CCO
- Family Care CCO
- Private Insurance (Kaiser, Providence, etc.)

Based on this information, ADRC staff will connect the individual to the entity responsible for managing their mental health services. In the situation where the consumer is OHP Open Card, Heath Share of Oregon CCO or uninsured, ADRC staff will transfer the individual to WCMH for further information, assessment and referral for treatment.

Callers with private insurance or Family Care CCO will be referred to their covering organization. If ADRC staff is unable to determine the funding source of the individual, they may transfer the person to WCMH for further evaluation or resources and needs.

Should the caller appear to be in distress or presenting with symptoms that make it difficult to communicate, ADRC staff may transfer the individual to WCMH or arrange for the Washington County Crisis Team to make contact with the individual.

If the caller seems to be an imminent threat to themselves or others, ADRC staff will call 911

ADRC staff will document the minimum data from the call into RTZ and summarize the call including who the call was transferred to in the narrative

**Washington County Mental Health Services agrees to:**

Washington County Mental Health Services will transfer calls relating to services for older adults, people with physical disabilities and veterans to the ADRC at X3060. These services include but are not limited to:

- Long-term care options counseling
- Assessment for in-home care
- Assistance with Medicaid or Medicare benefits enrollment
- Caregiver or respite resources
- Transportation
- Home delivered or congregate meals
- Legal assistance
- Adult day care
- Veterans services and benefits

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 WCDAVS

Date 1/9/2015

Washington County Mental Health Svcs

Date 1/9/15

# Washington County
# Contract Review Committee Worksheet

**Contract #** CA 13-0489
Assigned by Purchasing

Blanket Purchase Order Number N/A -JE

*Types:* **CA** - County Administrator Executes **BCC** - Board of Commissioner Executes

***NOTE: Please review all instructions on the back of this worksheet before you begin processing.***

1. Department Ship To: HHS - DAVS — 2. Date: 6/3/13

3. Department Bill To. HHS — 4. Administrator/Ext: Jeff Hill/ 3080

5. Type of Contract:
- ☐ (I) Intergovernmental Agreement ☐ (G) Purchase of Goods ☐ (C) Construction
- ☐ (P) Personal/Professional Services ☐ (L) Lease Agreement ☐ (T) Trade Services
- ☐ (A) Amendment/Change Order (list original contract number: _____)
- ☒ (O) Other MOU

6. Minute Order Number _____ Bid/RFP # _____ NIGP Category # _____

7. Description of Contract: Sheriff's Office to provide trainings to identify at risk older adults

8. Contractor, Lessor, Supplier Name: Washington County Sheriff's Office WISARD Supplier# 17655

9. ☐ MBE ☐ WBE ☐ DBE ☐ ESB (as certified by State of Oregon-Office of Minority, Women & Emerging Small Business)

10. Effective Date: 7/1/13 — 11. Termination Date 6/30/15

| | | | |
|---|---|---|---|
| 12. Original Contract Amount: | $10,400 | 16. ☐ Retainage: | $____ |
| 13. Total of Previous Amendments: | $____ | 17. ☒ Expenditure | $____ |
| 14. This Amendment: | $____ | ☐ Revenue | $____ |
| 15. Total Amount of Contract: | $10,400 | 18. Chargeable Program #: | ____ |

19. Source of Funds: state funds — 20. Payment Terms (monthly installments, progress payments, etc.): per invoice

21. Remarks:

**Check Off List for Attachments in Order of Appearance:**
- ☐ 2 copies of the Board agenda item and minute order number for this agreement (if one is applicable.)
- ☐ 2 copies of Insurance Certificates naming the County as additional insured, or include Attachment C with each contract.
- ☐ A minimum of three (3) copies of the contract, all with original contractor's signature(s).
- ☐ 2 copies of either the quote sheet OR justification selection memo
- ☐ One copy of the Invitation to Bid document OR RFP document.
- ☐ One copy of the contractor's Proposal (RFP) or contractor's Response (Bid.)
- ☐ A performance and payment bond (if applicable).

Contract Administrator certifies that no changes have been made to the attached County standard contract. _____
Contract Administrator's Signature

22. Signature Route:

| | | | |
|---|---|---|---|
| | 1. Department Head: | [signature] | Date 6/3/13 |
| | 2. Purchasing Supervisor: | [signature] | Date 6/4/13 |
| | 3. County Counsel: | [signature] | Date 6/13/13 |
| | 4. County Administrator's Office: | [signature] | Date 6/12/13 |

RECEIVED
JUN - 4 2013
County Counsel

Rev 1/1/12

CA 13-0489

MEMORANDUM OF UNDERSTANDING
*Washington County Sheriff's Office*
*and*
*Washington County Health & Human Services*
*Disability, Aging & Veteran Services*

July 1, 2013 through June 30, 2015

# Washington County Gatekeeper Program

## AGREEMENT

The purpose of this MOU is to clarify the duties and responsibilities of the Washington County Sheriff's Office (WCSO) and Washington County Health & Human Services (HHS) Disability Aging & Veteran Services (DAVS) related to the Gatekeeper Program.

## MISSION STATEMENT

The Gatekeeper Program is an outreach effort to identify, refer and respond to at-risk older adults living in our community. The Gatekeeper Program trains employees of businesses and organizations that have regular contact with the public to watch for warning signs that an older adult may be at risk. Due to their regular contact with people in the community, Gatekeepers are uniquely positioned to observe such warning signs and refer the at-risk person to Disability, Aging and Veteran Services for a follow-up contact to check on the individual's safety and well-being.

## TERM

The term of this MOU shall be from July 1, 2013 through June 30, 2015, unless otherwise amended. This MOU may be extended by mutual written agreement signed by WCSO and HHS.

## ROLES AND RESPONSIBILIES

The Washington County Sheriff's Office agrees to:

- Deliver three (3) trainings per quarter to community groups and individuals who may have contact with the elderly in the normal course of their jobs to recognize certain danger signals and to appropriately report their concerns to DAVS.
- Provide 10% in-kind match for Older American Act funds.
- Submit quarterly reports to DAVS identifying expenditures, match, number of presentations delivered, and the names of the organizations receiving the trainings.

The Washington County Disability Aging & Veteran Services Division agrees to:

- Reimburse the Sheriff's Office quarterly after receipt and approval of quarterly reports up to a maximum of $5,200.00 per year, not to exceed $10,400.00 for the biennium.

**CONSIDERATION**

In the event funding for the OAA Programs is reduced, changed, eliminated, or otherwise modified, or if funding from federal, state, or other sources is not obtained, then DAVS may terminate this Memorandum of Understanding, in whole or in part, effective upon delivery of written notice to WCSO, or at such later date as agreed upon by both parties, and WCSO agrees to abide by any such decision.

The undersigned agencies agree to all terms and conditions set forth in this Memorandum of Understanding.

Pat G 6-20-13

Signed Date
Pat Garrett, Sheriff
Washington County Sheriff's Office

6/12/2013

Signed Date
Sia Lindstrom, Sr. Deputy County Administrator
Washington County Health & Human Services / Disability, Aging & Veteran Services