Area Plan for Aging and Disability Services

2021 - 2025

The Area Plan, developed by Senior and Disability Services, directs planning efforts for present and future aging and long-term care services for older adults and adults with physical disabilities. The plan covers a four-year strategic planning period.

Senior and Disability Services, a division of Lane Council of Governments

1015 Willamette Street Eugene, Oregon 97401

Lane Council of Governments (LCOG)

Senior & Disability Services (S&DS)

Area Agency on Aging and Disability Services, Lane County

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Special Acknowledgements

Advisory Councils & Special Committees

Senior Services Advisory Council

Disability Services Advisory Council

Planning and Budget Committee

Area Plan Work Groups

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TABLE OF CONTENTS

SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A-1 INTRODUCTION

OVERVIEW OF SENIOR & DISABILITY SERVICES

Lane Council of Governments (LCOG) is one of the oldest councils of governments in the nation. LCOG is a voluntary association of general and special purpose governments in Lane County. LCOG serves as a regional planning, coordination, program development and service delivery organization. LCOG helps area cities, Lane County, educational districts, and special-purpose districts reach their common goals.

Since LCOG's creation in 1945, the agency has participated in a wide variety of projects and programs for local governments. Today, LCOG serves 35 members including Lane County, all 12 cities within the county, and education, public utilities, and other special districts. The governing body of LCOG is the LCOG Board of Directors, comprised of local elected and appointed officials designated to represent member governments.

Among its many responsibilities, LCOG is the designated Area Agency on Aging and Disability Services (AAA) in Lane County. Within LCOG, AAA operational responsibilities and services for older adults and adults with disabilities relies on Senior & Disability Services (S&DS). S&DS is LCOG's largest division, with an annual budget of approximately $34.7 million and over 200 full and part-time staff.

As the designated AAA in Lane County, S&DS administers and supports community-based care services, advocates for older adults and adults with disabilities, develops community-based long-term care services. S&DS is responsible for administering funds from sources such as the Older Americans Act to implement service delivery. In addition, S&DS is contracted by the State of Oregon, Department of Human Services (DHS) to administer Medicaid eligibility and Adult Protective Services. S&DS coordinates services with other local agencies to help provide a robust array of quality options for consumers.

S&DS has two full-service offices located in Eugene and Florence. These offices have staff that provide nearly all the services available from the agency. An additional four small outstations provide limited S&DS services in South Lane, Junction City, Oakridge, and Veneta.

The Senior Services Advisory Council (SSAC) and the Disabilities Services Advisory Council (DSAC) are two of the S&DS citizen advisory councils. Both these councils provide several critical functions. The Councils advise and provide guidance to S&DS on planning activities, service, and program implementation, monitoring and recommendations for service providers and providing crucial information on the needs and concerns of older adults and adults with disabilities in Lane County. The SSAC is composed of up to 23 members, of which at least 50% must be age 60 and older. The DSAC

is composed of up to 15 members, of which at least 50% must experience a disability. Emphasis is placed on achieving balanced representation of rural, urban, and minority members as well as members with diverse backgrounds.

S&DS TARGET POPULATIONS

S&DS strives to develop and provide a wide variety of services to meet the needs of older adults age 60 and older and adults with physical disabilities age 18 and older in Lane County. Emphasis is placed on serving persons in economic and social need, including frail, vulnerable, functionally impaired, socially isolated, underserved, minority and economically disadvantaged persons. S&DS also provides services for caregivers of older adults and adults with disabilities.

AREA PLAN DEVELOPMENT

Per State and Federal regulations, S&DS is required to help create and maintain a comprehensive and coordinated service delivery system to meet the needs of older adults and adults with disabilities in Lane County. To facilitate this goal, S&DS develops an Area Plan on Aging and Disability Services every four years. The Area Plan is a multi-year document that serves two purposes: (1) To plan services and service delivery based on community needs; and (2) To serve as a compliance document which provides the basis for the State of Oregon contract with LCOG for the delivery of services to older adults and adults with disabilities.

For additional information, questions, or comments regarding the Area Plan contact:

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The Aging and Disability Resource Connection
Local: 541-682-3353
Toll Free: 1-800-441-4038
Email: ADRCLane@lcog.org
Visit the website: www.adrcoforegon.com

To visit or contact one of our local office locations:

Eugene Office
1015 Willamette St.
Eugene, OR 97401
Phone: 541-682-4038

South Lane Office
Community Center
770 East Gibbs Avenue
Cottage Grove, OR 97424
Phone: 541-682-4038

Florence Office
3180 Highway 101
Florence, OR 97439
Phone: 541-902-9430

Junction City Outstation
Viking Sal Senior Center
245 West 5th St.
Junction City, OR 97448
Phone: 541-998-8445

Oakridge Outstation
The Uptown Building
48310 E. 1st Street
Oakridge, OR 97463
Phone: 541-782-4726

Veneta Outstation
Fern Ridge Service Center
25035 W. Broadway Ave.
Veneta, OR, US, 97487
Phone: 541-935-2262

A-2 MISSION, VISION, VALUES

The Mission Statement of S&DS is:

TO ADVOCATE FOR SENIORS AND PEOPLE WITH DISABILITIES AND PROVIDE THEM QUALITY SERVICES AND INFORMATION THAT PROMOTES DIGNITY, INDEPENDENCE, AND CHOICE.

To accomplish this mission, S&DS believes in the following guiding principles:

Consumer choice and independence: Consumers should receive quality and up to date information on available service options. With the right information and support, they may make informed decisions regarding their own care and independence.

Consumer advocacy and involvement: Consumers should act as their own advocate whenever possible. Consumers, community members and organizations should shape the system and services that best address consumer needs.

Protection of vulnerable adults from abuse, neglect, and exploitation: Consumers should have access to resources that help them avoid abuse and exploitation as well as resources for timely and appropriate assistance in responding to allegations of abuse.

Family and other natural supports as a foundation of care: Natural supports should be the first step in assisting older adults and adults with disabilities for care needs.

Caregiving is an important and honorable activity: Caregivers, both paid and unpaid, should be valued and supported by their communities. Paid caregivers should be appropriately compensated. All caregivers should have access to training, support, and respite.

Strong local community awareness of long-term care issues, services and supports: Community awareness provides the basis for an effective network of care for consumers. In times of scarce

resources, service organizations must support one another and collaborate, not compete, to assure a strong service system.

Access for all consumers: Consumers who are aging or living with a disability should have a reliable, single access point to services and information, such as through the Aging and Disability Resource Connection (ADRC). Services, information, and facilities should be physically, culturally, and financially accessible, with appropriate design and sensitivity to consumers of all abilities, languages, cultures, and financial situations.

Diversity and Equity: We embrace a diverse workforce and recognize the importance of full inclusion to our programs and services, regardless of race, ethnicity, gender identity, or sexual orientation.

Public policy that allows for funding flexibility: We value flexible public policy that allocates funds to local communities to meet local needs.

Opportunities for healthy aging: We promote community programs which provide activities and exercise, educational programs, health-related newsletters, and access to free or low-cost screening and prevention services.

Age and disability friendly communities: We support a community that is committed to helping citizens to age in place and that is accessible and welcoming to individuals with disabilities.

A-3 PLANNING AND REVIEW PROCESS

S&DS COMMUNITY NEEDS ASSESSMENT

S&DS used a variety of methods to identify the needs of the target populations served. Between June 25, 2019 and December 19, 2019, S&DS surveyed Lane County adults age 60 and older, adults with disabilities age 18 and older, regarding their needs in the community. Surveys explored views about housing, in-home support needs, transportation, health and nutrition and caregiving. A total of 1,215 useable surveys were returned. Simultaneously, while the surveys were being distributed throughout Lane County, several focus groups were conducted to gather more in-depth analysis of local needs specific to rural and underserved communities. Additional research was conducted in key areas to further understand community needs and trends along with US Census data, State of Oregon data, other community needs assessments, and population forecasts. For detailed information on this process and full results representing the scope of need in Lane County, please review the 2019 S&DS Community Needs Assessment located at https://www.sdslane.org/DocumentCenter/View/7562/2020-SDS-Community-Needs-Assessment

PLANNING GOALS AND OBJECTIVES

A series of workgroups composed of S&DS staff, Advisory Council members, , Tribal members, Tribal liaisons, Latinx community members, and professionals drafted a series of proposed goals and objectives. The focus of the goals and objectives are for discretionary funding and related S&DS

services emphasizing those in the greatest economic and social need. Workgroups used information such as current programming, county demographics, availability of services in the community, and the Community Needs Assessment to draft goals and objectives.

The Planning and Budget Committee, a standing committee of the two S&DS Advisory Councils, reviewed the drafted workgroup proposals. Based on funding requirements and findings from the Community Needs Assessment, the Committee reviewed recommendations on agency goals, objectives and future services found in this Area Plan. A Public Hearing was held public comment on the 2021-2025 Area Plan. Due to Covid-19, the Public Hearing was conducted via GoToMeeting and conference call. Accommodations were made for the hearing impaired and language interpreters with a 48-hour notice prior to the public hearing. Upon 48-hour notice, large print and other formats of the draft 2021 - 2025 Area Plan were made available. Final prioritization and recommendations were presented to the Senior Services Advisory Council and Disability Services Advisory Councils for additional review and recommendations. The final step in this process was the final review and approval by the LCOG Board. The Area Plan, along with the Community Needs Assessment, is shared with other community entities to help coordinate, collaborate, and align county wide planning efforts that impact our populations.

A-4 PRIORITIZATION OF DISCRETIONARY FUNDING

OLDER AMERICANS ACT

Title III-B: Support Services and AAA Administration:

1. Federal Priority Services:
    a. Access Services: transportation, including assisted transportation; outreach; information and assistance; options counseling; and case management. Due to limited funding, volunteer mileage reimbursed for the Rural Escort assisted transportation program has remained less than the federal mileage reimbursement rate.
    b. In-home Services: home care; personal care; friendly visiting; telephone and in-person reassurance; chore; coordination of in-home volunteers for reassurance/friendly visiting; and in-home support services such as caregiver respite. The Reassurance programs are projected to begin services again in December 2020.
    c. Legal Services.
    d. Other Services: Financial Assistance, funded through Low Income Home Energy Assistance Program (LIHEAP), a Lane County program. LIHEAP has a waitlist for services and prioritization is determined by the county in accordance with federal guidelines. LIHEAP takes into consideration date of application; those previously served and maintains a balance of 25 percent rural consumers served.

Title III-C-1: Group/Congregate Meals and AAA Administration.

Title III-C-2: Home-Delivered Meals (Meals on Wheels) and AAA Administration. The Meals on Wheels (MOW) program uses a risk assessment tool and is geographic area specific. This risk tool includes factors such as income, age, health, daily living needs, and nutritional risk factors.

Title III-D: Health promotion and disease prevention services: Currently S&DS supports the evidence-based programs Living Well with Chronic Conditions, Living Well with Chronic Pain, and Living Well with Diabetes developed by Stanford University's Patient Education Research Center. Workshops and classes are offered in both metro and rural locations with prioritization on expanded rural and underserved populations representation.

Title III-E: Family Caregiver Support Services and AAA Administration. S&DS' current plan for the use of III-E funds calls for the provision of the following services to eligible individuals and families: information, assistance, counseling, respite, and supplemental services. As of 2016, the Family Caregiver Support Program is prioritized using a Family Caregiving risk assessment tool. This risk tool includes factors such as income, age, health and cultural or linguist needs.

Title VII-A: Elder abuse prevention services. Using these funds along with community donations, S&DS supports activities such as adult abuse community education events and targeted training for professionals, such as Adult Foster Home Providers.

TYPE B AAA FUNDS (a blend of federal and state funds, including Medicaid, Food Stamps, and other state funds): These funds are utilized for eligibility determination, benefits issuance, long-term care services and supports, case management, Adult Protective Services, the licensure and monitoring of adult foster care homes, and AAA Administration.

OPI AND OPI PILOT STATE GENERAL FUNDS:

Currently, there are two Oregon Project Independence (OPI) programs, one for adults age 60 and older and a pilot program for adults with disabilities ages 19-59. OPI can be used for a variety of in-home services, such as: Home Care, Personal Care, Chore, Health & Medical Equipment, Meals on Wheels, Case Management and AAA Administration. The OPI program has experienced inconsistent funding throughout the program's existence. Due to funding instability and reduction, the 60 and older OPI program (not the Pilot program) is experiencing a waitlist. The current waitlist is at the maximum capacity of 50 potential consumers and is currently closed. When OPI program capacity exists, the waitlist is prioritized based on a State of Oregon DHS OPI risk assessment tool followed by length of time on the waitlist.

MONEY MANAGEMENT PROGRAM STATE GENERAL FUNDS

In Fiscal Year 2014, S&DS received new State General Funds to administer the Oregon Money Management Program (OMMP) which was a volunteer-based service. S&DS previously operated a small-scale money management program and, with the hiring of dedicated OMMP co-coordinators, these funds allowed the agency to greatly enhance the level of service provided as well as build new

program capacity. OMMP does experience a short-duration waitlist for new consumers due to volunteer match availability. The waitlist is prioritized based on a risk assessment which includes social and financial duress criteria, length of time on the waitlist, volunteer match compatibility, geographical region, and APS involvement.

HEALTH PROMOTION, DISEASE PREVENTION STATE GENERAL FUNDS

Health Promotion, Disease Prevention State General Funds continue to operate. These funds were used to support Stanford University's chronic-disease self-management 'Living Well' program suite. In addition, S&DS launched Powerful Tools for Caregivers in 2018. Powerful Tools is a training program to give family caregivers better tools to handle the challenges of caregiving for adults suffering from stroke, Alzheimer's, Parkinson's, or other conditions.

ADRC & EMPLOYER RESOURCE CONNECTION GRANTS

Special ADRC grants for No Wrong Door and Mental Health programming are utilized by S&DS for Options Counseling, ADRC staffing and dementia listing improvements, and were used for PEARLS programming. S&DS also receives funding for the Employer Resource Connection (ERS) program which provides OPI and Medicaid consumers help with Home Care Worker related issues such as selecting a Home Care Worker, setting a schedule and how to handle common problems that may occur.

WAITLISTS FOR SERVICE AND PRIORITIZATION

Programs experiencing waitlists are indicated in their respective sections above. In addition to length of time on waitlist, both the Family Caregiver (FCG) Program and the Older Americans Act (OAA) MOW Program prioritize their wait lists based on scores from in-home risk assessments and geographic area. Risk or "social need" is based on a combination of physical, cognitive, and mental function (determined through daily self-care activity need, economic need (relationship to poverty level), isolation (physical, geographic, rural, social, family), age, emergent health and mental health conditions (i.e. recent hospital discharge, depression, medication usage, nutritional needs), and, in the case of the FCG Program, the risk levels of both the caregiver and the care recipient. The FCG waitlist is also maintained to assure a minimum 25% of supported caregivers reside in rural communities.

FUTURE FUNDING CHANGES

In the event of future funding reductions in any program area, waitlists would be maintained as appropriate and alternatives to service reductions would be reviewed. S&DS seeks recommendations from its Advisory Councils and other relevant community entities, dependent on the type of services and funding impacted, during times of funding change. Historically, S&DS has looked to other programs to continue service delivery and prevent service closure whenever possible. In the event of future funding increases, priorities would be reviewed to potentially increase service levels and the

numbers of consumers served or determine if additional complementary services could be offered. Recommendations from Advisory Councils and the community would be sought.

PROGRAMMATIC IMPACTS OF COVID-19

On February 11, 2020, the World Health Organization (WHO) officially announced the name for the virus that was causing the 2019 novel coronavirus outbreak called COVID-19, short for coronavirus disease 2019. Covid-19 is a new disease that has not been previously seen in humans causing mild to severe symptoms that appear within 2-14 days after exposure. On March 11, 2020, the WHO declared COVID-19 a pandemic.

In March 2020, to respond to the Coronavirus (Covid-19) pandemic, Lane Council of Governments has established an Emergency Operations Committee (EOC) to update staff and the public (as necessary) on its operations. Members of the EOC include: LCOG Executive Director, Government Services Division Director, Senior & Disability Services Division Director, Fiscal Unit Manager, Chief Technology Officer, Human Resource Manager, Administration Operations Assistance, EOC Communications Officer, Senior & Disability Services Division Deputy Director, and Human Resources Senior. The EOC discusses Covid-19 impacts and makes decisions to best serve consumers and staff. The EOC updates all S&DS staff daily regarding Covid-19 and employee resources. S&DS prioritized staff and consumer safety by creating a teleworking policy which was an internal collaboration ensuring that staff had the appropriate technology, infrastructure, and supports to sustain working remotely. Furthermore, S&DS worked with the State of Oregon to establish modified lobby hours and encourages consumers to call before coming to the building to minimize contact and maintain social distancing.

S&DS staff continue to work remotely with limited staff that are working from the office. S&DS established sanitization policies, a mandatory facial covering policy while inside the building, internal contact tracing, and other procedures to maintain the safety of staff and consumers that access the building. S&DS established a daily meeting among their leadership team to discuss programmatic impacts and search for emerging opportunities to be a collaborative partner in the community as agencies were responding to the pandemic. Though not all programs were severely impacted by Covid-19, S&DS wants to highlight the impacts of Covid-19 had on consumers in programs and how S&DS modified practices to reflect a fluid response to changing conditions.

The Aging & Disability Resource Center (ADRC) skillfully accomplished fielding an increasing number of calls. From when the pandemic began impacting S&DS operations in mid-March, the ADRC assisted 293 unduplicated consumers, fielded 323 calls, and made 490 referrals by the end of March. The ADRC assisted an increased number of unduplicated consumers, calls, and referrals as the pandemic continued. From April 2020 to June 2020, the ADRC assisted 175% more unduplicated consumers, fielded 197% more calls, and made 186% more referrals due to Covid-19 impacts on our population.

As of March 16, 2020, in response to the increasing COVID-19 concerns regarding the aging population, S&DS closed all Café 60's communal dinning operations and built a meals-to-go model. Café 60's continues to provide hot meals "to-go" at specific locations during specific times to ensure that consumers continue to receive hot meals that they were accustomed to through the Care 60 program. S&DS could see a decrease in Café 60's participants long term. All Meals on Wheels routes continue to operate with volunteers however volunteers; however, volunteers are not making direct contact with meal recipients, in order to minimize health risks for all parties. To maintain volunteer and consumer safety, a "knock and drop" approach has been instituted that allows volunteers to continue to check on our consumers while retaining appropriate social distancing measures. Meals remain available to older adults who are unable to prepare meals for themselves and lack a support system to assist with meal preparation. S&DS responded by applying for and securing two Meals on Wheels America (MOWA) Covid-19 Response Fund grants which focused on purchase of additional frozen meals, shelf stable meals, reusable masks, and no-touch thermometers. Through both the MOWA grants combined, S&DS distributed over 21,000 additional meals to community members in response to Covid-19.

With schools in Lane County transferring their educational curriculum to an online format for the remainder of the school year, S&DS has witnessed a need for our non-respite related services regarding our Relatives as Parents Program (RAPP). S&DS forged ahead and successfully secured a United Way of Lane County COVID-19 Community Response Fund grant. This grant focused on assisting grandparents purchasing needed items for their grandchildren such as clothing, school supplies, technology for school, bedding, and horse therapy.

S&DS continues to monitor the pandemic through communication with the state, county, and local governments within Lane County. As of the publishing of this document, S&DS continues to encourage staff to telework, have select staff work inside the building, have modified lobby hours, continue sanitization, and facial covering policies. The safety and wellbeing of consumers and staff will continue to drive the decisions of S&DS regarding Covid-19.

The SSAC and DSAC Councils went from in-person meetings to strictly remotely starting in March 2020. Through discussion with the councils, S&DS continues to currently hold all council meets via conference call. S&DS holds space on each agenda for the S&DS Director to provide emergency related updates and field questions. As of the publication of this document, all council meetings continue to be strictly held remotely via conference call.

SECTION B – PLANNING AND SERVICE AREA PROFILE

B-1 POPULATION PROFILE

According to long-range population forecasts prepared by the Population Research Center at Portland State University (PSU), in 2020 Lane County had an estimated 381,365 people, 110,596 of which are age 60 and older. According to 2014 – 2018 American Community Survey (ACS) five-year estimates:

- 25% of Lane County is age 60 and older; of these, 6% is of a minority population compared to 12% of the overall Lane County population
- 7% of those 60 and older live below poverty
- 19% of the Lane County adult population experience a disability
- In Oregon, 32% of adults age 18-64 and older with a disability live below the Federal Poverty Level (FPL)

Of those 60 and older:	
Live in poverty	9.6%
Live alone	25.4%
Female	53.5%
Male	46.5%
Grandparent raising grandchildren	0.8%
Any minority	6.4%
Minority living in poverty	1.0%
Hispanic/Latino	2.3%
Native American	0.6%
Native Hawaiian/Pacific Islander	0.1%
Asian	1.2%
African American	0.5%
2 or more races	1.8%
Limited English proficiency age 65 and older	4.4%

For additional demographic information, please review the 2020 S&DS Community Needs Assessment located at https://www.lcog.org/DocumentCenter/View/7562/2020-SDS-Community-Needs-Assessment?bidId=

Over the next 20 years, the Lane County older adult population is forecasted to increase from 27 percent of the total population to about 30 percent. The population forecasts at PSU projected the 60 and older population in Lane County is forecasted to grow from 100,754 in 2019 to about 110,596 in 2020. Upon PSU certifying population estimates in 2020, the estimated number of the population who is 60 and older in Lane County is 110,569. At the same time, the share of the total population that falls into the 60 and older category is forecasted to grow from about 28 percent in 2020 to 30 percent in 2030. According to the PSU forecasts, growth of the older population will begin to slow after 2030, which is in line with the overall population growth. After 2030, the older population is forecasted to remain at 29 percent of the total population through 2044. By 2044, the 60 and older population will have grown to about 123,538; about 23 percent over 2019 levels.

Along with this fast pace growth, S&DS anticipates the number of older adults and adults with disabilities from minority or underserved demographics to increase. The two largest minority populations represented in Lane County are in the Hispanic and Asian communities. Over the next four years, S&DS will refine targeted outreach to these populations, as well as to the Native American

community. In addition to ensuring that materials in alternate languages and fast and reliable verbal translation services are available, S&DS will seek to collaborate with local agencies to cultivate impacts with these populations. S&DS expects to include partnering with community agencies, conducting specialized outreach campaigns and inclusive messaging.

B-2 TARGET POPULATIONS

The OAA requires AAAs to prioritize services to individuals with the greatest economic and social needs, low income minority individuals, and those living in rural areas. S&DS is committed to providing the highest level of quality services to meet the growing needs of these targeted populations. S&DS accomplish this through outreach, community education, coordination, collaboration, and implementation of appropriate services and programs with an emphasis on the following target populations:

- Residents in rural areas
- Low-income older adults, including low-income minorities
- Native American residents
- Limited English-speakers
- Those at risk for institutional placement
- Adults with physical disabilities
- Adults with Alzheimer's disease or related dementias
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Asexual or Allied (LGBTQIA+) older adults

B-3 AAA SERVICES AND ADMINISTRATION

S&DS provides a wide array of programs and services that help promote independence, dignity and choice for older adults and adults with disabilities. Please see Attachment C (Service Matrix and Delivery Method) for funding source and service delivery method per service. S&DS programs and services include:

1. *Adult Foster Care*: S&DS licenses adult foster care homes located throughout Lane County and monitors the care they provide consumers. Adult foster homes are licensed to care for up to 5 people per home. S&DS also provides ongoing local foster home provider training.

2. *Adult Abuse Prevention*: S&DS provides a variety of services designed to prevent abuse, neglect, and exploitation of vulnerable adults. These services include public education, outreach, abuse investigation and participation in a wide variety of local and statewide efforts.

    a. *Abuse Multi-Disciplinary Team (MDT)*: This MDT coordinates efforts to resolve complex community protective services and abuse issues. The team consists of a variety of community organizations focused on vulnerable adult safety. Members range from the District Attorney's

Office and local Police Department, to Lane County Developmental Disabilities Services.

b. *Adult Protective Services (APS)*: S&DS staff respond to abuse allegations regarding adults age 65 and older and adults age 18 and older with disabilities. APS staff works closely with law enforcement, licensed facilities, and the justice system.

3. *Advocacy*: Advocacy is conducted at both the individual consumer and agency level. For consumer advocacy, please see 'Senior Connections' in this section. At the agency level, the S&DS Advisory Councils, with LCOG Board approval and staff support, advocate for legislation, funding, and system changes at the local, state, and federal level.

4. *Aging & Disability Resource Connection (ADRC):* The ADRC, through the integration of aging and disability services systems, provides personalized assistance to help consumers learn about and navigate through available community service options. The ADRC is designed as a highly visible and trusted place the public, regardless of income, may utilize for unbiased, reliable information on the full range of community long-term support options. Locally, the ADRC includes:

    a. *Information & Assistance*: The ADRC serves as the first stop for consumers, family members and friends, as they seek to find resources for those who are aging or are experiencing a disability. It is designed to streamline access to information about available long-term care services. Referrals are made to programs and organizations that may meet the individual's specific need. Assistance is provided in accessing or connecting to services when needed or requested.

    b. *Online Resources*: An online database of resources is available through www.adrcoforegon.org. The database is regularly maintained to ensure up-to-date information and contacts. Extra focus has been placed on access to dementia related services.

    c. *Options Counseling*: Trained Options Counselors provide one-on-one assistance to assess the consumer's situation and needs, to tailor options for services. Options Counselors also facilitate decision making on long-term care options, including supported living in the community. Home visit assessments are available to help navigate local, state, and federal programs and services. Extra focus has been placed on training staff to provide dementia related services. Consumers may be care recipients, caregivers, or family members.

    d. *PEARLS*: PEARLS (Program to Encourage Active and Rewarding Lives) is a time-limited and participant driven program offered to consumers with home-based services. Through trained professionals, the program teaches depression management techniques to older adults with minor depression through one-on-one sessions in the participant's

home. As of August 2020, the state has terminated the contract for this program. PEARLS funding was cut at the State level in August 2020.

5. *Facilities Case Management*: S&DS staff monitors the care of Medicaid consumers in Residential Care Facilities, Assisted Living Facilities and Nursing Homes. Residential Care Facilities and Assisted Living Facilities provide 24-hour care in a licensed facility. Nursing Homes offer group living in a hospital-like setting.

6. *Health Promotion Programs*: S&DS offers a variety of evidence-based health promotion programs, including Living Well with Chronic Conditions, Chronic Pain, and Diabetes. These three evidence-based programs were developed by Stanford University's Patient Education Research Center. The six-week workshops are designed to help participants learn how to manage their health conditions. Participants learn about nutrition, exercise, how to talk with their health care team and more from certified and trained volunteer leaders. In 2018, S&DS launched two new pilot programs, Walk with Ease and Powerful Tools for Caregivers. Walk with Ease is a 9-week group walking course that includes stretching and strengthening exercises. Powerful Tools for Caregivers is a 6-week program designed to help the family caregiver learn skills to better handle the challenges of caregiving for adults suffering from stroke, Alzheimer's, Parkinson's, or other conditions.

7. *Long-Term Care Medicaid Case Management*: S&DS staff work closely with consumers and their families to establish a care plan with a focus on keeping individuals safe and independent in their own homes for as long as possible. Once in place, Case Managers keep in touch with the consumer, caregivers, service providers and family members to verify that the plan continues to meet the consumer's needs.

8. *Medicaid and the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps)*: S&DS staff determine eligibility for these federal programs for older adults and adults with disabilities in Lane County. Eligibility is based on income, assets, and other factors. In 2020, S&DS served more than 18,900 Lane County residents through Medicaid & SNAP.

9. *Money Management*: Certified, trained volunteers or S&DS staff help participants with managing their finances and may serve as representative payees for federal benefits such as Social Security, Veterans Benefits and Railroad Retirement.

10. *Oregon Project Independence (OPI):* OPI provides limited in-home services to people 60 and older who need a little help to continue living independently in their own homes. The goal of OPI is to promote quality of life and independence by preventing inappropriate or premature placement into a nursing home. OPI services are offered on a sliding fee and are dependent on available funding and include personal care and housekeeping in-home care, help with durable medical equipment, emergency response devices and Meals on Wheels. In 2015, S&DS was selected by

the Oregon Department of Human Services (DHS) as a pilot area to expand OPI services to adults with disabilities ages 19 – 59. As of publication of this document, the Pilot Program has continued to be authorized and funded by the Oregon State Legislature. Results of the Pilot Program will be analyzed by the Legislature to determine program availability in the future. A waitlist for the 60 and older program exists.

11. *Senior Connections*: Coordinators assist older adults age 60 and older and their caregivers with services to continue living independently in their own homes. This program is specifically for older adults that do not qualify for or choose not to utilize Medicaid services. Senior Connections is primarily funded through the Older Americans Act (OAA). Programs and services include:

    a. *Advocacy*: Staff and volunteers advocate on behalf of the needs of consumers to ensure they receive the best care possible. Staff assist consumers to work through barriers and connect to other resources in the community that best meet their needs.

    b. *Case Management*: Information, assistance and referrals for care coordination are provided one-on-one. This includes assisting older adults in activities such as assessing needs, developing care plans, and authorizing, arranging, and coordinating services with providers. Follow up and reassessment is provided as needed and services are renewed annually.

    c. *Family Caregiver Program*: Staff provide information and assistance, respite care, supplemental services, and training resources for anyone caring for a family member or friend age 60 and older. This also applies to anyone age 55 and older who is the unpaid primary caregiver for a child under the age of 18 or adult child with a disability. There are no current waitlists for this program. When there is a waitlist it is capped at a maximum of 25 potential consumers.

    d. *Low Income Home Energy Assistance Program (LIHEAP) (Financial Assistance):* This federally funded seasonal program helps low-income consumers pay for primary or secondary heating costs once a year. LIHEAP is available during early winter. Additional financial assistance may be provided through two local emergency funds, one in partnership with a local non-profit and the other administered by S&DS through donation funds. Waitlists exist for this federally funded program.

    e. *Rural Medical Escort Program*: Staff coordinate assistance and transportation for older individuals who have difficulty (physical or cognitive) using regular vehicular transportation. This is a volunteer- based door-through-door service. Volunteers are supervised by staff.

    f. *Senior Companion Program (Reassurance)*: Trained older adults age 55 and older that meet low-income guidelines receive an hourly tax-exempt stipend and some meal and mileage reimbursement to provide friendly visiting, transportation, and assistance to vulnerable older

adults. This program is provided by the Lane Community College (LCC) Successful Aging Institute for S&DS consumers. Volunteers are supervised by staff. There are no current waitlists for this program. When there is a waitlist it is maintained by geographic service area.

g. *Transportation Assessments (RideSource):* Under a contract with Lane Transit District (LTD), S&DS staff assess older adults and adults with disabilities for RideSource and American's with Disabilities Act ride eligibility. RideSource provides transportation services within the Eugene/Springfield area for individuals not able to ride the LTD fixed-route bus system due to their functional physical, mental, cognitive, or emotional capacity.

12. *Senior Legal Program*: Consumers age 60 and older with non-criminal legal issues may receive no-cost legal consultation with pro-bono or staff attorneys. This program is offered by the Lane County Legal Aid and Oregon Law Center who is under contract with S&DS. Community education on legal issues is also provided.

13. *Senior Meals Program*: This program provides nutritious meals and serves as a social outlet, reducing isolation and providing a valuable safety check for consumers. Almost 27 percent of the Senior Meals Program budget comes from extensive fundraising. All meals served are prepared in the LCOG Central Kitchen in Eugene. Senior Meals Programs include:

    a. *Café 60:* These communal dining settings serve hot, nutritious lunchtime meals in nine Lane County communities. Locations include Eugene, Springfield, Creswell, Coburg, Cottage Grove, Florence, Junction City, Oakridge and Veneta. Meals are offered on a donation basis to those 60 and older and their spouses.

    b. *Meals on Wheels* (MOW): The Senior Meals Program delivers meals and regular safety checks to homebound people in eight Lane County Communities through a robust network of volunteers. Meals may be hot or frozen, depending on availability and consumer needs. MOW participants are unable to prepare meals for themselves and lack a support system to assist with meals. S&DS partners with FOOD for Lane County for Eugene meal delivery, while S&DS provides meal delivery in Springfield and rural Lane County. Waitlists for this program exist, are route specific and are maintained by geographic service area.

B-4 NON-AAA SERVICES, SERVICE GAPS AND PARTNERSHIPS TO ENSURE AVAILABILITY OF SERVICES NOT PROVIDED BY THE AAA

S&DS is committed to integrating systems and supporting services offered throughout the community. S&DS does not look to compete or replace existing services offered in the community, but rather supplement and fills gaps in the service delivery system. S&DS evaluates and seeks new opportunities for partnerships and collaboration between systems and community partners. A consistent finding between the S&DS Community Needs Assessment and other partner assessments is that consumers

find the overall service delivery system divided and disconnected. To address this finding, S&DS is increasingly collaborating with partner systems to help break down silos with the goal of providing streamlined and seamless service delivery whenever possible. These efforts include serving on the local Coordinated Care Organization's board, attending various community meetings, and providing an inclusive environment for community partnership engagement.

The following parallel or complimentary community resources and services are provided in Lane County but are not administered by S&DS. S&DS partners with many of these to enhance and provide services. Additionally, through the ADRC and local outreach, S&DS educates consumers and the community on the availability of all services. This list is not intended to be exhaustive, but to provide a broad overview of local community resources. To search for a comprehensive list of community resources with contact information, please visit the ADRC website at www.adrcoforegon.org or call 1-800-ORE-ADRC.

Adult & Community Centers

- Campbell Senior Center, Eugene
- Cottage Grove Senior Center
- Fern Ridge Senior Center, Veneta
- Florence Senior Center
- Hilyard Community Center
- Peterson Barn Senior Center, Eugene
- River Road Park and Recreation District, Eugene
- Viking Sal Senior Center, Junction City
- Willamalane Adult Activity Center, Springfield
- Willamette Activity Center (Oakridge Senior Lounge)

Alzheimer's Disease and other Dementias Support

- Alzheimer's Association
- Alzheimer Family Support Group
- ElderHealth and Living
- Living with Alzheimer's: For Caregivers
- Memory Loss Solutions

Case Management *(Fee for Service)*

- Cornerstone Services, Inc
- ElderCare Resources, Inc
- In-Home Elder Care, Inc
- Maxim Healthcare Services
- Morgan Consultants, LLC

- New Horizons In-Home Care

Disability Services and Programs

- Employment services provided by Goodwill, Alternative Work Concepts, Lane Community College
- Full Access Brokerage
- Lane Independent Living Alliance (LILA)
- Lane County Developmental Disabilities Services
- Mentor Oregon
- Recreation services provided by the City of Eugene Adaptive Recreation and Special Olympics
- Supporting Access to Independent Living (SAIL) Housing
- Supportive Employment Services
- The Arc of Lane County

Education & Counseling Programs

- Alzheimer's Association
- Downtown Languages
- Elderhostel
- Lane Community College Successful Aging Institute
- Osher Lifelong Learning Institute, University of Oregon

Employment and Volunteerism

- Alternative Work Concepts
- Experience Works
- Goodwill
- Retired Service Volunteer Program (RSVP)/ United Way of Lane County
- Senior Companion Program of the Lane Community College Successful Aging Institute
- St. Vincent de Paul
- Vocational Rehabilitation
- WorkSource Lane, Employment Department

Family Caregiver Supports

- Caring for the Caregiver Support Group
- Family Caregiver Support Program
- Respite Providers (16)

Financial & Energy Assistance

- Lane County Veterans Services

- LIHEAP
- Siuslaw Outreach Services
- Social Security Administration
- Tax-Aide (AARP)

Health & Wellness

- Hearing Loss Association of American, Lane County Oregon Chapter
- Lane Community College Dental Society
- Lane County Mental & Behavioral Health
- Lane County Public Health
- National Alliance on Mental Illness (NAMI) of Lane County
- Volunteers in Medicine
- Whitebird Health & Dental Services
- Young Men's Christian Association (YMCA)

Housing

- Adult Foster Homes (102)
- Assisted Living Communities (15)
- Homes for Good (Housing Authority and Section 8 Housing, formerly HACSA)
- Independent Retirement Communities (25)
- Nursing Facilities (13)
- Over 55 Communities (20)
- Residential Care Communities (36)
- Supporting Access to Independent Living (SAIL) Housing

Information & Assistance Services

- 211Lane call center and on-line database services contracts with 211Oregon to provide Information & Assistance for all Lane County residents
- Community Healthcare Resource Guide
- Lane County Senior Network
- The Lane Senior Guide

Nutrition

- Community Sharing, Cottage Grove
- FISH, Inc. Eugene
- Food for Lane County
- Love Projects, Veneta & Elmira
- Oakridge Food Box

Transportation Services

- Diamond Express, Oakridge
- Lane Transit District (LTD)
- LinkLane, Eugene Metro to coast
- Rhody Express, Florence
- RideSource, Eugene Metro
- South Lane Wheels, Cottage Grove

Vulnerable Adults, Limited English Speaking and Title VI Populations

- Amigos Multicultural Services Center
- Basic Rights Oregon (LGBTQ)
- Centro Latino Americano
- Downtown Languages
- Huerto de la Familia
- National Resource Center on LGBT Aging
- Pride Foundation Oregon (LGBTQ)
- Title VI (of the Older Americans Act) service providers, including: Coquille Indian Tribe; Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians; Cow Creek Band of Umpqua Tribe of Indians; and the Confederated Tribes of Siletz Indians

SECTION C – FOCUS AREAS, GOALS AND OBJECTIVES

S&DS engages clients with programs using a person-centered service methodology by providing consumers with accurate, unbiased information and an array of service options both within S&DS and in the community. This approach empowers and guides the consumer to participate in their service and care plan decisions. S&DS seeks to improve and support service equity within its programs and service delivery. S&DS promotes a person-centered approach to service delivery through engagement with community partners and members of diverse communities, collaboration with stake holders, providing services in a culturally and linguistically responsive manner, reviewing and improving program accessibility, and utilizing data to help guide agency actions. Throughout this section, references to person-centered supports and service equity, either directly or indirectly, demonstrate S&DS' commitment to further these values in its day-to-day operations and overall guiding principles.

The following focus areas have been identified as statewide issues for Area Agencies on Aging to address and develop goals and objectives for 2021 – 2025. S&DS currently collects and maintains a wide variety of data that will assist the agency to both measure and track goal efforts. For goals that may require new data collection, assigned program units will determine tracking methodology in consultation with S&DS management. S&DS management will, at a minimum, monitor progress quarterly. Data collected will be used not only to measure outcomes but to also adjust and refine goals over the 2021 – 2025 timeframe.

C-1 INFORMATION AND ASSISTANCE SERVICES AND AGING AND DISABILITY RESOURCE CONNECTION (ADRC)

ADRC IN LANE COUNTY

As the aging population continues to grow over the next 20 years, access to high quality, accurate service information is crucial for the aging and disability network. The ADRC is a vital community link that provides information, assistance, and referral to consumers of both public and private community and long-term services. The S&DS Community Needs Assessment found the majority of survey respondents were unfamiliar with the ADRC.

ADRC in Lane County provides general information and assistance for accessing community resources. This includes both public and privately funded long-term services and supports. ADRC staff conduct screenings for S&DS case management long-term services and initial eligibility determinations for SNAP and Medicaid for those age 60 and older and adults with disabilities. Trained Options Counselors provide one-on-one intensive information and referral consultation. Referrals are provided for non-S&DS services and supports.

In administering high quality and accurate information and assistance, another goal of the ADRC is to provide consumers with a person-centered, holistic service approach. ADRC staff focus on reviewing not just the initial contacted need but all the consumer's needs. ADRC staff place the consumer at the controls of service referral, allowing the consumer to make the decision on next steps. Having a person-centered approached to ADRC services maximizes independence and personal choice.

S&DS support quality assurance and quality improvement by offering in person consumers a customer service survey that is then shared with management to identify opportunities to make improvements. We encourage our staff to make recommendations for process improvements using lean philosophy keeping consumers and their experiences as our primary focus. S&DS collects the data on phone calls (total number of calls, number of calls answered, average hold times and average talk time) to determine if more attention is needed to make adjustments to improve our services for our consumers.

In Fiscal Year 2020, the ADRC in Lane County answered 18,047 calls, served 5,540 unduplicated consumers, and made a total of 12,249 referrals. In 2019 S&DS implemented a new phone system that further refined the S&DS phone triage system and call tracking reports. The ADRC is staffed Monday through Friday, 8am to 5pm. Referral sources include family members, friends/neighbors, social service agencies, medical professionals/hospitals, and self-referrals. The top 5 referral sources documented in Fiscal Year 2020 were S&DS, Homes for Good (formerly HACSA), Springfield Community Service Center, transportation services, and Food for Lane County.

OPTIONS COUNSELING

The S&DS ADRC Options Counseling Program provides facilitated decision-making regarding long-term care options for adults age 60 and older, adults with disabilities, veterans, caregivers, and family

systems. Options Counseling may include community-based or facility-based supports that are provided by natural supports, private pay, or subsidy. Options Counseling depends on the priorities of the consumer and caregiver. Options Counseling is typically short term, up to three months, based on the goals identified by the consumer. This service is provided through home visits and phone consultation.

S&DS provides Options Counseling through trained Senior Connections Area Coordinator staff at all S&DS locations. Staff members are state certified in Options Counseling within six months of hire, receive dementia-capable services training within a year of hire, are nationally certified in information and assistance practices through the Alliance of Information and Referral Systems and maintain annual professional development training. Furthermore, S&DS Options Counselors participate in state and national pilot training programs, including certification in person-centered practices.

PARTNERSHIP DEVELOPMENT

Over the next several years, S&DS plans on integrating more community partners and strengthening existing relationships with community partners. This will include improved information sharing, training, and shared work on mutual goals. With more ADRC community partners, coupled with on-going ADRC outreach, S&DS expects ADRC brand and name recognition to improve over the next several years.

SUSTAINABILITY

Financial sustainability continues to be a challenge as the ADRC grows and call volume increases. S&DS, working with ADRC partners and other entities, continues to seek additional funding streams to maintain and expand ADRC services. S&DS currently leverages existing Medicaid funding for the ADRC which has helped augment ADRC call staff. S&DS continues to seek additional sustainable funding sources to build capacity in programming and service provisions.
S&DS continues to review work operations for efficiencies and process improvements to maximize resources and staff availability. S&DS provides information and data supporting the value of the ADRC to local elected officials and works with the aging and disability network to promote ADRC work at the legislative level. The reduced ADRC standards requirements and plan to centrally maintain the ADRC resource website recently shared by the State Community Services and Supports Unit (CSSU) will also assist with the ability of S&DS to sustain the local ADRC. ADRC data collection remains with the State of Oregon's RTZ systems software program called GetCare, as the primary tool for data collection, reporting, and management.

CHALLENGES

The ADRC in Lane County currently faces several challenges. The 2019 Community Needs Assessment S&DS conducted found that most survey respondents did not know what the ADRC is or what the ADRC does. This has caused a disconnect to consumers that could use the ADRC services because they do not know what services and supports the ADRC offers. ADRC in Lane County has worked significantly to create and maintain community partnerships to help create a robust connection

to the ADRC. The ADRC is dedicated to consumers by focusing on ease of use, program understanding, and connection to needed services.

These issues have led to the following goals:

1. Increase, enhance, and sustain ADRC partnerships
2. Conduct a consumer driven ADRC program evaluation
3. Increase consumer connection to the ADRC
4. Increase Options Counseling presence in the community

GOALS AND OBJECTIVES – INFORMATION AND REFERRAL SERVICES AND ADRC

Goal #1: Increase, enhance, and sustain ADRC partnerships

Objectives

1. Participate in community outreach opportunities	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025	**Accomplishment or Update**
				Start Date	End Date	
	a	Research existing opportunities	ADRC Lead, Unit Manager	07/2021	07/2021	
	b	Make contact with person in-charge of the event	ADRC Lead, Unit Manager	07/2021	08/2021	
	c	Table at ADRC related community events	ADRC Lead, ADRC Team	07/2021	TBD	
	d	Boost information distribution between core partners regarding relevant community events and training	ADRC Lead, Unit Manager	07/2021	01/2022	
	e	Develop a sustainable partnership with at least 1 community partner each month	ADRC Lead, ADRC Team	01/2022	01/2023	
	f	Share ADRC resource spreadsheet with community partners	ADRC Lead	07/2021	06/2025	
		Key Tasks		Timeframe for 2021-2025		

2. Conduct external trainings on ADRC topics			Lead Position & Entity	Start Date	End Date	Accomplishment or Update
	a	Establish target audience	ADRC Lead, ADRC Team	01/2022	01/2022	
	b	Determine ADRC subject specific topics	ADRC Lead, ADRC Team, Unit Manager	01/2022	01/2022	
	c	Determine who will present the training	Unit Manager	01/2022	01/2022	
	d	Conduct outreach to external partners and community members	ADRC Lead, ADRC Team	07/2022	06/2025	
	e	Establish measurable outcomes of each training	ADRC Lead, Unit Manager, Program Manager	07/2022	07/2022	
	f	Conduct subject specific training at a minimum of twice a year	ADRC Lead, Unit Manager, Program Manager	07/2022	TBD	
3. Develop outreach to underserved populations		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Identify target audience, locations, and events	ADRC Lead, S&DS Outreach Team	07/2021	07/2021	
	b	Support portion of lead worker to outreach activities	Unit Manager, Program Manager	07/2021	09/2021	

	c	Create culturally sensitive outreach materials through alternative formats and languages	S&DS Outreach Team, Unit Manager, Program Manager	07/2021	09/2021	
	d	Conduct outreach activities quarterly	ADRC Lead, ADRC Team, S&DS Outreach Team	07/2021	TBD	
	e	Establish measurable outcomes of outreach effectiveness	ADRC Lead, Unit Manager, Program Manager	08/2021	08/2021	

Goal #2: Conduct a consumer driven ADRC program evaluation
Objectives

1. Administer a consumer response program evaluation	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Establish a target audience	ADRC Team, ADRC Lead, Unit Manager	01/2022	01/2022	
	b	Determine method of survey	ADRC Lead, Unit Manager, Program Manager	01/2022	01/2022	
	c	Determine survey questions	ADRC Team, ADRC Lead, Unit Manager	05/2022	07/2022	
	d	Determine survey dates of availability	ADRC Lead, Unit Manager	05/2022	05/2022	

	e	Establish survey distribution	ADRC Lead, Unit Manager, Program Manager	09/2022	10/2022	
	f	Analyze data	ADRC Lead, Unit Manager, Program Manager, Program Analyst	01/2023	02/2023	
	g	Conduct survey on a bi-annual basis	ADRC Lead, Unit Manager, Program Manager, Program Analyst	01/2023	TBD	
2. Use survey findings to inform ADRC Program	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End	
	a	Share results with community partners	Unit Manager, Program Manager, Program Analyst	01/2023	03/2023	
	b	Conduct an ADRC staff specific training regarding the results	ADRC Lead, Unit Manager	06/2023	10/2023	
	c	Use data to inform grants	Unit Manager, Program Manager, Program Analyst	05/2023	TDB	
	d	Use consumer needs to determine resources for ADRC	ADRC Lead, Unit Manager	05/2023	10/2023	

Goal #3: Increase consumer connection to the ADRC
Objectives

1. Develop internal protocols to prevent barriers to the ADRC	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Establish protocol for non-English speaking callers	ADRC Lead, S&DS Diversity Team	10/2021	01/2022	
	b	Sustain prioritizing veteran referrals to the veteran benefit specialist	ADRC Lead, VBS Staff, Unit Manager	07/2021	TBD	
	c	Review ADRC voicemail header	ADRC Lead, Unit Manager	07/2021	09/2021	
	d	Create and maintain an excel spreadsheet that tracks organizations/businesses that are not in RTZ	ADRC Team, ADRC Lead	07/2021	06/2022	
	e	Review RTZ Excel spreadsheet quarterly, contact businesses to add them to RTZ database	ADRC Team, ADRC Lead, Unit Manager	07/2021	TBD	
2. Enhance a person-centered and culturally sensitive		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Support a person-centered approach to each ADRC staff person	ADRC Lead, Unit Manager, Program Manager	07/2021	TBD	

approach to service	b	Support a culturally sensitive approach to service for each ADRC staff person	ADRC Lead, Unit Manager, Program Manager	07/2021	TBD	
	c	Participate in at least one annual training of cultural awareness activities	ADRC Team	07/2021	06/2022	

Goal #4: Increase Options Counseling presence in the community

Objectives

1. Develop community outreach opportunities	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Research existing opportunities	Senior Connections OC Team, Unit Manager	07/2021	08/2021	
	b	Make contact with person in-charge of the event	Unit Manager	01/2022	01/2022	
	c	Boost information distribution between core partners regarding relevant community events and training	Senior Connections OC Team, Unit Manager	01/2022	TBD	
	d	Table at ADRC related community events	S&DS Outreach Team, Senior Connections OC Team	01/2022	TBD	

	e	Develop 1 community outreach opportunity quarterly	Senior Connections OC Team, ADRC Team	01/2022	TBD	
2. Increase Options Counseling (OC) availability		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Cross train staff on OC	Senior Connections OC Team, Unit Manager	09/2021	TBD	
	b	Create diagram that demonstrates how ADRC and OC overlap	ADRC Lead, Senior Connections OC Team, Unit Manager	11/2021	03/2022	
	c	Create diagram that demonstrates how ADRC and OC do not overlap	ADRC Lead, Senior Connections OC Team, Unit Manager	11/2021	03/2022	
	d	Provide OC training to more individuals	Senior Connections OC Team, Unit Manager	01/2022	TBD	
3. Develop outreach to underserved populations		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Identify target audience, locations, and events	S&DS Outreach Team, ADRC Lead, Senior Connections OC Team, Unit Manager	09/2021	09/2021	

	b	Support outreach activities	S&DS Outreach Team, ADRC Lead, Senior Connections OC Team, Unit Manager, Program Manager	01/2022	TBD	
	c	Create culturally sensitive outreach materials through alternative formats and languages	Senior Connections OC Team, S&DS Outreach Team, S&DS Diversity Team	01/2022	06/2022	
	d	Conduct outreach activities quarterly	Senior Connections OC Team, S&DS Outreach Team, ADRC Lead	01/2022	TBD	
	e	Establish measurable outcomes of outreach effectiveness	S&DS Outreach Team, Unit Manager, Program Manager	01/2022	02/2022	

C-2 NUTRITION SERVICES

THE SENIOR MEALS PROGRAM

Since the inception of the Older Americans Act, great progress has been made towards reducing hunger and food insecurity of older adults. The Senior Meals Program has made a significant impact on hunger in Lane County through Café 60 congregate dining sites and the Meals on Wheels (MOW) program. While these programs have been successful in feeding older adults, the cost of providing meals has increased dramatically, while funding has remained stagnant or even decreased in some areas, creating challenges in the Program.

As the older population continues to dramatically increase, so does the demand for Senior Meals Programs, especially MOW. With people living longer, they also use services longer. This increased demand further taxes limited program resources; resources that have already been stretched to their limits to maintain existing services.

The 2019 S&DS Community Needs Assessment found almost 56 percent of respondents do not eat enough fruits and vegetables. Of these respondents, almost 31 percent do not have enough money to buy food to eat. The state of Oregon ranks the 20th hungriest state in the United States. In Lane County, 24 percent of people reporting food insecurity do not qualify for federal nutrition assistance. Many are living in food deserts, with little or no access to affordable and healthy food choices. The Senior Meals Program is a vital service helping many older adults in Lane County meet their food and nutrition needs.

S&DS Senior Meals Programs strive for diversity. As of Fiscal Year 2020, 6 percent of Café 60 consumers and 5 percent of MOW consumers belong to a minority group. Lane County Census data shows that 6 percent of adults age 60 and older belong to a minority group. The wide variety of cultural backgrounds, socio-economic factors, health and mobility differences, cognitive and mental health variations, along with personal preference, limits interest in a universal program approach.

To maximize consumer access, S&DS has chosen to locate congregate sites in geographically dispersed locations, with three in Eugene, one in Springfield and seven additional sites in rural communities. To provide consumer choice, S&DS also offers participants two different meal options at all locations. As S&DS forges toward future programmatic expansions, S&DS intends to create and sustain partnership opportunities that will allow to build culturally specific meal sites to serve additional consumers that have been historically underrepresented. S&DS will look for opportunities to improve services to underserved populations and culturally diverse communities through vibrant community partnerships, such as a new Eugene meal delivery partnership developed in 2015 with FOOD for Lane County.

SERVICE LOCATIONS & SCHEDULE

The chart below lists Café 60 dining sites and MOW staging locations along with service schedule. Note: Due to Covid-19 precautions, during Fiscal Year 2020 and 2021, LCOG S&DS Café 60 dining sites were limited to "to-go" meal service, and hands-free ("knock & drop") MOW delivery.

Town/Facility	Address	Service Schedule	Services	Average Participation
Coburg (United Methodist Church)	91193 N. Willamette St. Coburg, OR 97408	Wednesdays at Noon	Congregate	15
Cottage Grove (Riverview Terrace)	925 W. Main St. Cottage Grove, OR 97424	Tuesdays, Wednesdays, and Thursdays at Noon	Congregate & MOW	Congregate-18 MOW-45
Creswell (Cresview Villa)	350 S. 2nd St. Creswell, OR 97426	Mondays, Wednesdays, and Fridays at Noon	Congregate & MOW	Congregate- 7 MOW-30
Eugene (Northwest Neighbors)	1221 Jacobs Dr. Eugene, OR 97402	Monday through Friday at 11:30 AM	Congregate & MOW	Congregate-33 MOW-16
Eugene (Olive Plaza)	1135 Olive St. Eugene, OR 97401	Monday through Friday at 11:45 AM	Congregate & MOW	Congregate-50 MOW-3
Eugene (River Road)	1055 River Road Eugene, OR 97404	Tuesday and Thursdays at Noon	Congregate	Not open due to Covid-19
Florence (Senior Center)	1570 Kingwood Florence, OR 97439	Mondays, Wednesdays, and Fridays at 11:45 AM	Congregate & MOW	Congregate-11 MOW-73
Junction City (Viking Sal Senior Center)	245 W. 5th Ave Junction City, OR 97448	Mondays, Wednesdays, and Fridays at 11:30 AM	Congregate & MOW	Congregate 12 MOW-33
Oakridge (Church of the Nazarene)	48187 Highway 58 Oakridge, OR 97463	Tuesday and Thursdays at Noon	Congregate & MOW	Congregate-33 MOW-29
Springfield (Willamalane Adult Activity Center)	215 W. C St. Springfield, OR 97477	Monday through Friday at 11:30 AM	Congregate & MOW	Congregate-107 MOW-109
Veneta (Fern Ridge Service Center)	25035 W. Broadway Ave. Veneta, OR 97487	Monday through Friday at 11:30 AM	Congregate & MOW	Congregate-21 MOW-31
Eugene MOW (FOOD for Lane County)	770 Bailey Hill Road Eugene, OR 97402	Monday through Friday at Noon	MOW only	295

FOOD PRODUCTION AND DELIVERY

LCOG is a partner in an interagency consortium with NorthWest Senior & Disability Services (NWSDS) and Oregon Cascades West Council of Governments (OCWCOG) to procure food services for congregate and home delivered meals programs in a seven-county area. NWSDS operates as the lead agency. The consortium is in year two of a five-year agreement with Bateman Senior Meals to operate three central kitchens which are located in Salem, Newport and Eugene. The consortium's pooled meal volume results in reduced unit prices.

The Eugene central kitchen produces and delivers food in bulk to LCOG's 11 service locations as well as FOOD for Lane County (FFLC), the MOW delivery agency for Eugene. Under this contract, Bateman plans the menu; hires, trains and supervises all kitchen staff; purchases raw food; prepares food according to standardized recipes; delivers it in S&DS trucks to meal sites; and maintains the kitchen equipment and trucks. Food is then served or packaged by S&DS staff and volunteers. MOW is delivered by S&DS volunteers in Springfield and outlying communities and by FFLC in Eugene.

LOCAL PARTNERSHIPS

S&DS could not operate its Senior Meals Program without community partners. Current partners include:

FOOD for Lane County: S&DS contracts with FFLC for MOW Home Meal Delivery in Eugene. FFLC is a 501(c)(3) non-profit entity. The contract includes OAA consumer assessment, volunteer management, participation in fund raising, and site operation.

Willamalane Adult Activity Center: Willamalane provides Café 60 dining space, a kitchen for MOW staging and Café 60 service, office space, custodial maintenance, and limited reception services for a monthly charge.

Homes for Good (formerly HACSA): Homes for Good provides space for Café 60 dining rooms, kitchens, and office space in Creswell, Cottage Grove, and at the Eugene Northwest Neighbors location at no charge.

City of Junction City: The City of Junction City provides space for the Café 60 Dining Room, kitchen, and office space for a monthly charge.

River Road Park & Recreation District: In this partnership, the River Road Park & Recreation District pays for the River Road Café 60 dining Site Coordinator while LCOG provides food and supplies.

FUNDRAISING

The Senior Meals Program conducts an aggressive, year-round direct mail fundraising campaign under the Senior Meals Program brand in outlying communities. An additional direct mail fundraising campaign is conducted under the MOW brand, in conjunction with FFLC, in the Eugene/Springfield shared market. In Fiscal Year 2020, all these efforts grossed approximately $432,805 in local charitable gifts. While direct mail fundraising campaigns have proven successful over the years, opportunities through social media development are likely to provide additional resources and venues for fundraising. LCOG S&DS also conducted the first annual A Race for the Rest of Us fundraiser for the Senior Meals Program and MOW. A Race for the Rest of Us had 122 participants and raised $4,629 for the Senior Meals Program. LCOG S&DS will continue to conduct this fundraiser on an annual basis.

Due to Covid-19, S&DS secured two Meals on Wheels America (MOWA) COVID-19 Response Fund grants totaling $97,100. The first MOWA COVID-19 Response Fund grant S&DS received was for $25,000. These grant funds were used to purchase 3,605 additional frozen meals for our MOW participants. S&DS focused on our Springfield participant waitlist and S&DS served all the participants on that waitlist with these funds. The second MOWA COVID-19 Response Fund grant S&DS received was for $72,100. These grant funds were used to purchase three shelf stable meal boxes for every meal participant, reusable masks for every meal participant, and no-touch thermometers for our Café 60 congregate meal sites. S&DS purchased 3,089 shelf stable meal boxes which is equivalent to 15,455 individual meals.

NUTRITION EDUCATION

The Senior Meals Program provides nutrition education to all participants that receive meals. Senior Connections Area Coordinators provide MOW recipients nutrition education at the time of service enrollment and annually thereafter. This includes a three-page document titled *About the Senior Meals Menu*. This tool is used to further educate participants about menu options and ordering meals. It includes specific information for those with a diabetic diet or low sodium needs.

Nutrition Education is also provided quarterly at our congregate Café 60 meal sites and is presented by the Site Coordinator. Topics are selected by the Program Manager.

Menus are distributed monthly to congregate and MOW recipients. Menus contain a full page of written nutrition information developed by a dietitian. Nutritional counseling is not an S&DS offered service.

COORDINATION WITH OTHER SERVICES

The ADRC is at the forefront for information on aging and disability services in Lane County for consumers. Those inquiring about MOW and Café 60 are directed to the ADRC number where their potential needs are communicated, and community referrals are provided. Senior Connections Area

Coordinators perform in-home assessments for OAA MOW delivered in Springfield and outlying communities. Since the beginning of Covid-19, assessments have been conducted via phone. They also provide ongoing case management and access to other services. Case management and service assessments are conducted using a person-centered methodology, placing the consumer at the controls of their case planning activities. Area Coordinators are also the access point for consumers to the S&DS Family Caregiver, Money Management, Options Counseling, other AAA services and referrals to outside community resources. FFLC's contract includes OAA MOW assessment in Eugene and requires referral to ADRC for consumers who present with additional service needs.

CONSUMER CHOICE

Meal participants have a choice between two entrees each day, a choice of hot or frozen meals, and a choice of days of service. Detailed nutritional analysis of the daily menu is provided on request, at meal sites and online. Menu substitutions are offered for diabetics. Through the ADRC and S&DS staff, consumers may also receive information on other food resources available throughout the community to best meet their nutritional needs and preferences.

CHALLENGES AND BARRIERS

The congregate program is currently operating under a "meals-to-go" model due to Covid-19 and MOW continues to operate through dedicated volunteers and staff. As the MOW program is significantly larger than the congregate program, managing MOW requires the majority of Senior Meals Program staff time and promotional activities. S&DS has forged ahead and received over $97,000 in Covid-19 relief grant funds to support our Senior Meals Programs.

Strict Oregon nutritional requirements used to prepare meals satisfy some who are consciously working on their health but may not satisfy others who cannot find their favorite foods or cannot taste allowable foods. Bateman is continuously testing new menu options that meet nutritional standards and are appealing to a large audience.

Program growth is restricted by stagnant federal funding, unpredictable state funding, minimal local government support, and the availability of grant funding. At the same time, certain costs are non-negotiable, such as food inflation. There continues to be limited funding for capital investments or improvements to significantly expand and serve target underserved populations. Due to additional funding, MOW started serving meals to consumers in Springfield on wait lists

S&DS continues to focus on volunteer recruitment and appreciation. Any loss of volunteers, funding or partnership is felt deeply, with a significant impact on the program and consumers. S&DS does not own the facilities used for meal sites and relies on local organizations with adequate facilities to commit the space and time to operate the program in their communities. Lack of adequate, affordable, attractive community facilities creates additional barriers for continued congregate participation and MOW growth.

OPPORTUNITIES

The partnership with FFLC is opening doors and providing additional resources for the Eugene area MOW program. As this partnership continues, additional opportunities may develop that will improve the Senior Meals Program in Lane County. S&DS remains in collaboration and continues to move towards sustainable partnership growth.

S&DS maintains their membership in the MOW Association of America (MOWAA) who offers much needed market research, assistance with branding, and grant opportunities. They also assist with fundraising messaging and volunteer recruitment. MOWAA has a multi-year agreement with the Ad Council to develop a national campaign to recruit one million MOW volunteers nationally. S&DS is actively engaging in this campaign and is hopeful it will result in increased volunteer interest.

The issues identified have led to the following goals:

1. Continue quality MOW and congregate meal services county-wide via community and volunteer engagement/support.
2. Prioritize creating an accessible environment for underrepresented populations to increase participation in meals programs
3. Conduct a consumer driven Senior Meals program evaluation
4. Explore expanding MOW delivery areas to rural communities
5. Explore alternatives to current Nutrition Education efforts

GOALS AND OBJECTIVES – NUTRITION SERVICES

Goal #1: Continue quality MOW and congregate meal services county-wide via community and volunteer engagement/support.
Objectives

1. Continue direct mail fundraising for Senior Meals and MOW	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Maintain relationship with FFLC regarding fundraising efforts for MOW.	Program Manager	07/2021	TBD	
	b	Continue direct mail fundraising for Senior Meals and MOW.	Program Manager, Admin Support	07/2021	06/2022	
	c	Evaluate and expand fundraising web presence (i.e., social media, LCOG web pages, MOW Lane County web pages).	Program Manager, Community Program Analyst, Admin Support	01/2022	06/2022	
	d	Plan and implement donor appreciation efforts (once annually).	Program Manager, Unit Manager, Meal Site Coordinators, Admin Support	07/2021	06/2022	
	e	Explore sponsorship opportunities from private sector.	Program Manager, Deputy Director, Director, Fiscal Manager, Community Program Analyst	07/2021	06/2022	

	f	Plan and implement in-person fundraising events (e.g., A Race for the Rest of Us), at least once annually.	Program Manager, Community Program Analyst, Unit Manager, Director, Deputy Director	07/2021	06/2022	
	g	Explore new alternatives to generating increased program revenue.	Program Manager, Community Program Analyst, Director, Deputy Director	07/2021	06/2022	
2. Increase total number of volunteers program-wide by 10%		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Develop a Senior Meals specific volunteer recruitment campaign (e.g., web, print, social media, word of mouth).	Program Manager, Unit Manager, Community Program Analyst, Meal Site Coordinators	01/2021	04/2022	
	b	Work with Outreach team to identify how Senior Meals volunteer recruitment efforts fit into existing outreach efforts.	Program Manager, Unit Manager, Outreach team	01/2022	04/2022	
	c	Develop a sustainable volunteer recognition effort program wide.	Program Manager, Unit Manager, Meal Site Coordinators	07/2021	06/2022	
	d	Survey existing volunteers and solicit their support in highlighting Senior Meals &	Program Manager, Unit Manager, Meal Site Coordinators	09/2021	09/2022	

		MOW stories for volunteer recruitment efforts.				
3. Increase total number of volunteer hours program wide by 5%		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Develop a Senior Meals specific volunteer recruitment campaign (e.g., web, print, social media, word of mouth).	Program Manager, Unit Manager, Community Program Analyst, Meal Site Coordinators	01/2022	04/2022	
	b	Collaborate with Outreach team to identify Senior Meals volunteer recruitment efforts	Program Manager, Unit Manager, Outreach team	01/2022	04/2022	
	c	Develop a sustainable volunteer recognition effort program wide.	Program Manager, Unit Manager, Meal Site Coordinators	07/2021	06/2022	
	d	Survey existing volunteers and solicit their support in highlighting Senior Meals & MOW stories for volunteer recruitment efforts.	Program Manager, Unit Manager, Meal Site Coordinators	09/2021	09/2022	

Goal #2: Prioritize creating an accessible environment for underrepresented populations to increase participation in meals programs

Objectives

1. Emphasize Senior Meals efforts to	Key Tasks	Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)	Accomplishment or Update

serve Latinx community				Start Date	End Date	
	a	Evaluate what materials are currently in Spanish and determine a process for having English only materials translated.	Unit Manager	07/2021	09/2021	
	b	Evaluate and shift processes for connecting clients with Spanish speaking staff.	Unit Manager, Program Manager	07/2021	11/2021	
	c	Connect with local non-profits that serve the Latinx community and provide Senior Meals specific information.	Program Manager, Community Program Analyst, Director, Deputy Director	07/2021	11/2021	
	d	Conduct Senior Meals outreach with Latinx community	Unit Manager and S&DS Outreach Coordinator	07/2021	TBD	
2. Enhance efforts to prioritize the Native American community	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End	
	a	Communicate with S&DS Director and Outreach lead to determine where this prior area plan goal sits.	Program Manager, Unit Manager, Director, Outreach Lead	09/2021	06/2022	

	b	Create a list of county specific Native American contacts and reach out to them with info regarding Senior Meals	Program Manager, Unit Manager, Director, Outreach Lead	01/2022	06/2022	
	c	Collaborate with Native American communities on grants	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	07/2021	TBD	
3. Provide cultural competency and equity training to Senior Meals team.	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Conduct annual staff equity activity.	Program Manager, Unit Manager	01/2022	05/2022	

Goal #3: Conduct a consumer driven Senior Meals program evaluation

Objectives

1. Administer a consumer response program evaluation for the Native	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Establish target audience	Program Manager, Unit Manager, Community Program Analyst	07/2022	07/2022	

American Community	b	Determine method of survey	Program Manager, Unit Manager, Community Program Analyst	07/2022	07/2022	
	c	Determine survey questions	Program Manager, Unit Manager, Community Program Analyst	07/2022	09/2022	
	d	Determine survey dates of availability	Program Manager, Unit Manager, Community Program Analyst	07/2022	07/2022	
	e	Establish survey distribution	Program Manager, Unit Manager, Community Program Analyst	07/2022	09/2022	
	f	Analyze data	Community Program Analyst	11/2022	01/2023	
	g	Conduct survey on a bi-annual basis	Program Manager, Unit Manager, Community Program Analyst	07/2022	TBD	
2. Administer a consumer response program evaluation for the		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Establish target audience	Program Manager, Unit Manager,	07/2021	07/2021	

Latinx community			Community Program Analyst			
	b	Determine method of survey	Program Manager, Unit Manager, Community Program Analyst	07/2021	07/2021	
	c	Determine survey questions	Program Manager, Unit Manager, Community Program Analyst	07/2021	09/2021	
	d	Determine length of time survey will be available for responses	Program Manager, Unit Manager, Community Program Analyst	07/2021	09/2021	
	e	Establish survey distribution	Program Manager, Unit Manager, Community Program Analyst	07/2021	09/2021	
	f	Analyze data	Community Program Analyst	11/2021	01/2022	
	g	Conduct survey on a bi-annual basis	Program Manager, Unit Manager, Community Program Analyst	07/2021	TBD	
3. Use survey findings to inform the		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	

Senior Meals Programs	a	Share results with community partners	Program Manager, Unit Manager, Community Program Analyst	12/2021	TBD	
	b	Use data to inform grants	Community Program Manager	12/2021	TBD	
	c	Use consumer needs to inform the Senior Meals program	Program Manager and Unit Manager	12/2021	TBD	

Goal #4: Explore expanding MOW delivery areas to rural communities
Objectives

1. Evaluate where current MOW boundaries lie in rural communities served.	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Review Senior Meals policies and where current boundaries lie.	Unit Manager, Program Manager	04/2022	09/2022	
	b	Engage rural meal site coordinators and volunteers about expansion brainstorm.	Unit Manager, Program Manager, rural Meal Site Coordinators	09/2022	01/2023	
2. Identify food pantries, non-profits, and other	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End	

resources in rural areas to explore partnerships	a	Create workgroup with Unit Manager and Meal Site Coordinators to establish list of resources and contacts.	Unit Manager, Meal Site Coordinators	01/2023	09/2023	
	b	Contact these agencies and share Senior Meals specific program details.	Unit Manager, Program Manager	08/2023	TBD	
3. Gather ideas for non-traditional service from staff and community members	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Create workgroup to brainstorm new ideas for meal service (i.e., pop-up meal sites, volunteers driving "long routes" every other week).	Unit Manager, Meal Site Coordinators, Advisory Councils	01/2024	05/2024	

Goal #5: Explore alternatives to current Nutrition Education efforts.
Objectives

1. Evaluate existing state of Oregon nutrition standards for delivery of information	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Contact -CSSU Policy Analyst at the state and set-up a meeting.	Unit Manager	01/2022	09/2022	

directives or restrictions.	b	Engage rural meal site coordinators and volunteers about expansion brainstorm.	Unit Manager, Program Manager, rural Meal Site Coordinators	09/2022	05/2024	
2. Create new content and methods of communication.	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End	
	a	Develop a varied approach (print, email, social media, etc.) of communication efforts.	Unit Manager, Program Manager	01/2024	03/2024	
	b	Using existing resources (MOWAA, State of Oregon, consortium/TRIO, FFLC), develop new content.	Unit Manager, Program Manager	06/2024	11/2024	
	c	Survey Senior Meals program participants regarding mediums they prefer as well as content.	Meal Site Coordinators, Unit Manager	01/2024	TBD	

C-3 HEALTH PROMOTION

S&DS HEALTHY LIVING PROGRAMMING

S&DS began using OAA Title III-D Disease Prevention and Health Promotion funds, as well as state of Oregon Health Promotion and Disease Prevention funds, to offset costs incurred from implementing Stanford University's Chronic Disease Self-Management Programs beginning in FY19. These programs are known locally as the Living Well program and the Arthritis Foundation program, Walk with Ease. The largest program implemented from this offering was Living Well, a series of six, evidence-based, peer-led workshops designed to provide participants with tools to better manage their chronic conditions and remain living as independently as possible. Additional programs implemented include Walk with Ease, Powerful Tools for Caregivers, and sessions designed to alleviate chronic pain and diabetes, as well as a mental health program in place to push back on anxiety and depression (PEARLS).

S&DS has strived to provide Living Well programming where consumers live, with special consideration for rural communities. Program attendance began to decline across all health promotion efforts due to the impacts of COVID-19. The Senior Connections unit continues to work closely and collaborate with program organizers as well as S&DS management to strategize on how to better engage prospective clients. The COVID-19 pandemic has resulted in a necessary cancellation of all Health Promotion classes which were being held in-person. S&DS continues to discuss ongoing programmatic expansions to adjust implementation during the pandemic.

Through the ADRC Mental Health grant funds, S&DS was providing the PEARLS depression management program. This program was targeted to at-risk home bound older adults with mild depression. Both Living Well and PEARLS are supported by state Health Promotions funds. Currently, the PEARLS program has been terminated across the state due to funding reductions.

PROGRAM GAPS

The S&DS Community Needs Assessment determined several programming gaps in Lane County, specifically in the areas of healthy eating and physical activity. S&DS is also acutely aware of the programming gap to the Latinx community. Over the next four years, S&DS will continue to adapt and strategize to better engage current and prospective clients. S&DS will explore the engagement opportunities through the existing Living Well infrastructure or through community partnerships.

PROGRAM SUSTAINABILITY

S&DS is vigilant about long-term program sustainability. S&DS receives some funding, along with strong support of the Living Well program, from the local Coordinated Care Organization, Trillium. Staff also participate in a variety of state and local workgroups that review alternate payment methodologies to reimburse programs for insured participants. New funding opportunities are being explored including opportunities to partner with more insurers.

COMMUNITY ENGAGEMENT

S&DS is involved in a variety of community initiatives designed to improve health outcomes for Lane County residents either through direct interventions or attention to social determinants of health, such as income, education, housing, and access to food. S&DS is actively engaged with the Lane County Community Health Improvement Plan (CHP). S&DS' involvement is primarily to advocate for older adults and adults with disabilities as the County invests in work to achieve CHP goals. S&DS maintains a close relationship with Lane County Behavioral Health. For several years, S&DS has partnered closely with the local Coordinated Care Organizations (CCO) in Lane County. S&DS has partnerships with Trillium and PacificSource, S&DS has Memorandums of Understanding (MOU) with both these CCOs to coordinate Medicaid funded long-term care services to reduce costs and to deliver high quality, person-centered care.

The issues identified have led to the following goal:

1. Administer a consumer Health Promotions & Evidence Based program evaluation
2. Conduct public education and training opportunities for Health Promotions Program

GOALS AND OBJECTIVES – HEALTH PROMOTION

Goal #1: Administer a consumer Health Promotions & Evidence Based program evaluation

Objectives

1. Conduct a current program consumer survey	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025	**Accomplishment or Update**
				Start Date	End Date	
	a	Establish a target audience	Health Promotion Coordinator	07/2021	07/2021	
	b	Determine method of survey	Health Promotion Coordinator, Unit Manager	07/2021	07/2021	
	c	Determine survey questions	Unit Manager, Program Manager	07/2021	09/2021	
	d	Determine length of time survey will be available for responses	Unit Manager, Program Manager	07/2021	09/2021	
	e	Establish survey distribution	Health Promotion Coordinator, Unit Manager	07/2021	09/2021	
	f	Analyst data	Community Program Analyst	10/2021	12/2021	
	g	Conduct survey bi-annually	Program Manager, Unit Manager, Community Program Analyst	7/2021 &7/2023	TBD	
		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		

2. Conduct a consumer survey of previous program participants				Start Date	End Date	Accomplishment or Update
	a	Establish target audience	Health Promotion Coordinator, Unit Manager	07/2021	07/2021	
	b	Determine method of survey	Health Promotion Coordinator, Unit Manager	07/2021	07/2021	
	c	Determine survey questions	Unit Manager, Program Manager	07/2021	09/2021	
	d	Determine length of time survey will be available for responses	Unit Manager, Program Manager	07/2021	09/2021	
	e	Establish survey distribution	Health Promotion Coordinator, Unit Manager, Program Manager	07/2021	09/2021	
	f	Analyze data	Community Program Analyst	10/2021	12/2021	
3. Use survey findings to inform future programmatic focus		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Determine program positives through consumer responses	Health Promotion Coordinator, Unit Manager	07/2021	12/2021	

	b	Determine program negatives through consumer responses	Health Promotion Coordinator, Unit Manager	07/2021	12/2021	
	c	Determine barriers to attending classes	Health Promotion Coordinator	07/2021	12/2021	
	d	Prioritize equity and access for consumers to Health Promotion funded programs	Health Promotion Coordinator	07/2021	2/2022	

Goal #2: Conduct public education and training opportunities for Health Promotions Program
Objectives

1. Conduct internal trainings on Health Promotions subjects	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Establish a target audience	Health Promotion Coordinator	07/2021	07/2021	
	b	Determine topics through collaboration with other units	Health Promotion Coordinator, Unit Manager	07/2021	08/2021	
	c	Collaborate with community partners	Health Promotion Coordinator, Unit Manager, Program Manager	07/2021	TBD	
	d	Determine who will present the training	Unit Manager	07/2021	09/2021	

	e	Establish measurable outcomes of training	Health Promotion Coordinator, Unit Manager	07/2021	08/2021	
	f	Conduct trainings twice a year	Health Promotion Coordinator	Continuous	TBD	
2. Conduct external trainings on Health Promotions subjects		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Establish target audience	Health Promotion Coordinator, Unit Manager	07/2021	07/2021	
	b	Determine training subjects	Health Promotion Coordinator, Unit Manager, Program Manager	07/2021	09/2021	
	c	Determine training objectives and outcomes	Health Promotion Coordinator, Unit Manager	07/2021	09/2021	
	d	Determine method of inviting public	Unit Manager, Program Manager	07/2021	09/2021	
	e	Establish measurable outcomes of training	Unit Manager, Program Manager	07/2021	09/2021	
	f	Send information to Latinx community partners twice a year	Unit Manager, Program Manager	07/2021	09/2021	

	g	Conduct trainings twice a year	Health Promotion Coordinator	Continuous	TBD	
3. Use survey findings to inform future programmatic focus		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Determine program positives through consumer responses	Unit Manager, Program Manager, Trillium	07/2021	01/2022	
	b	Determine program negatives through consumer responses	Unit Manager, Program Manager, Trillium	07/2021	01/2022	
	c	Determine barriers to attending classes	Health Promotion Coordinator, Unit Manager, Trillium	07/2021	01/2022	
	d	Prioritize equity and access for consumers to Health Promotion funded programs	Health Promotion Coordinator, Unit Manager	07/2021	01/2022	

C-4 FAMILY CAREGIVERS

FAMILY CAREGIVING

Informal and family caregivers include spouses, partners, children, other family members, and friends. Caregiving may include assistance with everyday household chores, such as cleaning and meal preparation, and assistance with personal care activities such as eating, bathing and mobility. These caregivers provide critical support that may help delay or prevent the need for a person to be admitted into a nursing facility or hospital.

Informal, unpaid caregiving is universally recognized as the foundation of long-term care. With the population continuing to age and demographics shifting due to the baby boomer generation the need for caregivers is likely to increase over the next few decades. This shift could cause an increased burden on caregivers.

Family caregivers are a benefit for the care recipient but creates a tremendous burden on the caregiver. For younger family members, caregiving may impact current employment, further employment opportunities, and career enhancement. That impact is felt through reduced hours or job loss and time and attention away from other family members. Not only do many caregivers suffer economically, but also emotionally, and they may face serious stress related health risks. Family caregivers are more likely to experience long-term medical problems and have weaker immune systems. They are also less likely to eat healthy meals or exercise regularly.

THE S&DS FAMILY CAREGIVER PROGRAM

The Family Caregiver Program (FCG) provides services for unpaid caregivers in Lane County. Services are available to caregivers supporting older adults, adults with dementia and older adult caregivers caring for related children or adult children with developmental or intellectual disabilities. Core elements of the FCG program include: Respite care, information services, specialized family caregiver information, counseling, training, support groups, and supplemental services. The local FCG program currently provides these core elements through:

- Paid respite services, which may be provided in-home or in a licensed facility. S&DS annually renews contracts with over 10 licensed agency respite providers to provide a diversity of respite options for the caregiver and care recipient.

- Respite stipends, which allow caregivers to choose their respite provider, such as an agency, registered home care worker, family member, trusted friend, or neighbor. The selected provider follows a care plan developed by the caregiver, care recipient, and Senior Connections Area Coordinator. This allows for increased consumer choice, flexibility in rural areas, culturally or linguistically appropriate options, and the ability to cluster services into a chosen timeframe.

- Cash and counseling services, which include direct payments for caregivers to provide a safe and nurturing home environment for the care recipient. Payments can support the purchase of adaptive equipment, durable medical equipment, incontinence products, minor home modifications, and similar improvements. When utilized in conjunction with the Relatives as Parents Program (RAPP), payments may also include school break camp fees, tuition for after school enrichment activities, back-to-school supplies, and similar enrichment activities.

- Options Counseling for caregivers, during which Senior Connections Area Coordinators facilitate decision making regarding long term care options, inclusive of community-based or facility-based care that is provided via natural supports, private pay, or subsidy dependent on what is important to and for the care recipient and caregiver.

- Referrals to appropriate community support groups provided by partner agencies, evidence-based programming and training for caregivers and care recipients, therapeutic counseling, and similar community supports. Currently, local support groups and training for caregivers are limited to disease specific care, such as group training programs for Alzheimer's disease and related dementias or Parkinson's disease.

- Caregiver education in the form of information and assistance, quarterly educational newsletters, and support to attend caregiver conferences and events. Support to attend conferences may include respite for the care recipient, conference fees, and mileage reimbursement. Through state Health Promotion and Disease Prevention funds, the caregiver training program and *Powerful Tools for Caregivers* is now offered.

PROVISION OF SERVICES TO UNDERSERVED CAREGIVERS

The FCG program prioritizes outreach to underserved caregivers. The program maintains a 25% rural and 75% urban balance of services to caregivers. Senior Connections Area Coordinators conduct outreach, assessments, and case management for caregivers at all S&DS offices and outstations. Senior Connections employs a bilingual (Spanish/English) Area Coordinator to provide culturally and linguistically appropriate family caregiver services for Latinx families and includes information about the capacity of each of the local respite agencies to provide Spanish-language care. State-provided program literature is provided in English and Spanish. Linguistic support for non-English and non-Spanish caregivers is provided through a translation service. Outreach to Native American caregivers is provided through relationships with the Tribes and the Annual Oregon Native Caring Conference. Outreach to caregivers within the LGBTQIA+ community is conducted in conjunction with S&DS LGBTQIA+ community outreach efforts.

SERVICE AND RISK ASSESSMENT

The FCG Program assessment for services includes a risk assessment for both the caregiver and care recipient. The risk assessment considers physical, cognitive, developmental/intellectual, and mental

disabilities; isolation; economic need; complexity of care for care recipients at risk of institutionalization; and multigenerational care amongst its measures. The Program has a close relationship with Adult Protective Services (APS), resulting in significant participation from caregivers and care recipients who are at risk for abuse or self-neglect.

Eligibility for the program is purposefully inclusive of an array of family systems, including related family, domestic partnerships, those not related by blood or marriage, and similarly supportive unpaid caregivers.

CHALLENGES

Many challenges impact the ability of the local FCG program to meet growing demand for these services. Identified gaps in the local FCG Program services include, but are not limited to:

- Outreach opportunities have been limited
- Need for support for caregivers
- Lack of diversity of respite care options, including adult day programming
- Need for support, training, and respite for caregivers of care recipients with complex care needs outside of dementia such as mental health, traumatic brain injury, developmental and intellectual disability and self-neglect
- Need for robust outreach to racial and ethnic minority caregivers, especially caregivers for whom legal documentation for one or more members of the family may be a problem

Over the next several years, the FCG program will strive to create new opportunities and improved partnerships. S&DS will strive to improve unpaid caregivers' quality of life by helping to reduce caregiving related stress and present caregivers with tools to sustain everyday life activities such as maintaining employment, raising children, and engaging in social activities.

These issues have led to the following goals:

1. Increase community awareness of FCG Program
2. Administer a consumer FCG program evaluation
3. Create effective FCG program processes

GOALS AND OBJECTIVES - FAMILY CAREGIVERS

Goal #1: Increase community awareness of FCG Program

Objectives

1. Create outreach program for FCG	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025	**Accomplishment or Update**
				Start Date	End Date
	a	Include FGC Area Coordinator in messaging	Unit Manager	7/2021	08/2021	
	b	Create media templates	Program Manager, Unit Manager, Community Program Analyst	7/2021	11/2021	
	c	Publish messages through media (e.g., PSAs, social media, etc.)	Program Manager, Community Program Analyst, Director	7/2021	11/2021	
	d	Use Metro TV for FCG outreach events	Director, Deputy Director, Program Manager, Community Program Analyst,	7/2021	TBD	
	e	Table at community events	Area Coordinator and Leads	7/2021	TBD	
	f	Create quarterly E-Newsletter	Program Manager, Unit Manager, Area Coordinators	7/2021	01/2022	

		Key Tasks	Lead Position and Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
2. Develop an internal understanding of FCG program	a	Train ADRC, Options Counseling, APS staff, and SSAC, DSAC on FCG	FCG Program Coordinator and Leads	7/2021	10/2021	
	b	Determine who will present the training	Unit Manager and Program Manager	7/2021	09/2021	
	c	Establish measurable outcomes of training	Unit Manger and Program Manager	7/2021	09/2021	
	d	Provide a minimum of one training a year	Unit Manager, Program Manager, Leads, FCG Program Coordinator	Continuous	TBD	
3. Develop an external understanding of FCG program	a	Establish target audience	Program Manager, Unit Manager, Area Coordinators, and Community Program Analyst	7/2021	09/2021	
	b	Determine training topics	Program Manager, Unit Manager, Community Program Analyst, FCG Program Coordinator	7/2021	09/2021	
	c	Determine training objectives and outcomes	Program Manager, Unit Manager, FCG Program Coordinator	7/2021	09/2021	

	d	Determine method for notifying public	Program Manager and Unit Manger	7/2021	09/2021	
	e	Establish measurable outcomes of each training	Program Manager and Unit Manager	7/2021	09/2021	
	d	Provide a minimum of two trainings a year	Unit Manager, Program Manager, Leads, FCG Program Coordinator	Continuous	TBD	
4. Increase RAPP awareness through community partnerships		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Research existing community partners	Area Coordinators	5/2022	07/2022	
	b	Make contact with existing partners	Program Manager, Unit Manager, Area Coordinators	5/2022	09/2022	
	c	Establish a point of contact with community partners	FCG Program Coordinator	5/2022	09/2022	
	d	Attend community partner events (e.g., at schools, YMCA, etc.)	Area Coordinators and Leads	1/2023	TBD	

Goal #2: Administer a consumer FCG program evaluation
Objectives

1. Conduct a consumer response	Key Tasks	Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)	Accomplishment or Update

program evaluation				Start Date	End Date	
	a	Establish target audience	Program Manager, Unit Manager, Community Program Analyst	1/2022	01/2022	
	b	Determine method of survey	Program Manager, Unit Manager, Community Program Analyst	1/2022	01/2022	
	c	Determine survey questions	Program Manager, Unit Manager, Community Program Analyst	1/2022	03/2022	
	d	Determine length of time survey will be available for responses	Program Manager, Unit Manager, Community Program Analyst	1/2022	01/2022	
	e	Establish survey distribution	Program Manager, Unit Manager, Community Program Analyst	8/2022	09/2022	
	f	Analyze data	Community Program Analyst	1/2023	01/2023	
	g	Conduct survey bi-annually	Program Manager, Unit Manager, Community Program Analyst	Continuous	TBD	

2. Use findings to inform FCG program	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End	
	a	Conduct internal training	FCG Program Coordinator and Leads	5/2023	09/2023	
	b	Conduct external training	FCG Program Coordinator and Leads	5/2023	09/2023	
	c	Share results with community partners	Community Program Analyst, Program Manager, Unit Manager	1/2024	03/2024	
	d	Use data to inform grants	Community Program Analyst	1/2024	TBD	

Goal #3: Create effective FCG program processes

Objectives

1. Create an efficient application process	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Establish gaps in application process	Program Manager, Unit Manager, FCG Program Coordinator	7/2021	11/2021	
	b	Create versions in different languages	Outreach Coordinator	7/2021	11/2021	

	c	Create a new application	Program Manager, Unit Manager, FCG Program Coordinator	7/2021	01/2022	
	d	Create simplified process and procedure	Program Manager, Unit Manager, FCG Program Coordinator	1/2022	06/2022	
	e	Create simple flow chart and procedure that links to appropriate forms	Program Manager, Unit Manager, FCG Program Coordinator	1/2022	06/2022	
	f	Develop online training tools for trainers and staff	Program Manager, Unit Manager, FCG Program Coordinator	1/2022	01/2023	
	g	Create centralized location for FCG materials, procedures, and communications	Program Manager, Unit Manager, FCG Program Coordinator	1/2022	01/2022	
2. Communicate with consumers on Respite expectations		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Establish a timeline of respite expectations for the consumer	Program Manager, Unit Manager, FCG Program Coordinator	9/2021	12/2021	
	b	Create a how-to-guide for sending in receipts	Program Manager, Unit Manager, FCG Program Coordinator	9/2021	12/2021	

	c	Create instructions on appropriate documentation	Program Manager, Unit Manager, FCG Program Coordinator	9/2021	12/2021	
	d	Draft letter to consumers with information	FCG Coordinator	5/2022	09/2022	
	e	Send information to consumers	Area Coordinators	9/2022	09/2022	
	f	Establish expectation of timeframe for follow-up with consumer	Program Manager, Unit Manager, FCG Program Coordinator	1/2023	01/2023	

C-5 ELDER RIGHTS AND LEGAL ASSISTANCE

OLDER ADULT AND ADULTS WITH DISABILITIES ABUSE IN LANE COUNTY

Abuse, regardless of type, tends to take place where the person lives, in their own home or in other community-based care settings and institutions. For home and community-based abuse, the majority of perpetrators are related to the victim; very few perpetrators are strangers. It is often someone close to the victim with a trusted relationship such as a family member, friend, caregiver, or neighbor.

Financial abuse and neglect of care by caregivers are on the rise and represent the two most common abuse types reported both in Oregon and locally in Lane County. Financial scams and fraud affect an estimated one-fifth of older adults nationally. In addition, sexual abuse is the most common abuse type for adults with disabilities, statewide. In Fiscal Year 2019, S&DS investigated 2,435 reports of suspected abuse. This was an 18 percent decrease over Fiscal Year 2018. Over 16.5 percent of the investigations were substantiated.

Prevention efforts are essential tools to help stem the tide of adult abuse and protect our most vulnerable community members. Educational, money management, and legal services programs are effective means of preventing abuse and provide stabilization after abuse has occurred.

S&DS PREVENTION EFFORTS

S&DS implements and supports many abuse prevention efforts in Lane County. In addition to operating the local Adult Protective Services (APS) unit, which responds to and investigates allegations of abuse, S&DS staff provide training and public education. S&DS educates the community on abuse types and how to report suspected abuse and collaborates with other organizations to provide abuse prevention education with emphasis on financial exploitation. In June 2020, to raise awareness during Elder Abuse Awareness Month, APS hosted a virtual event called *COVID-19: Scams, Fraud, and Elder Abuse*. This training focused on recent scams and fraud tactics as a result of COVID-19. The training also provided information on the types and signs of elder abuse and how to report elder abuse.

APS receives reports of abuse or neglect directly from the Long-Term Care Ombudsman (LTCO) program which are processed through the screening and triage system. APS makes referrals to the LTCO office regarding issues that do not meet APS criteria but do involve concerns about resident rights and quality of life for individuals living in residential facilities. APS also collaborates with LTCO office whenever possible on issues related to long term care residential facilities.

APS staff also serve in local and state multi-disciplinary teams and workgroups. These efforts focus on abuse prevention, detection, and intervention. A few current topics being closely reviewed locally include availability of public guardianship, identification of gaps or issues in the system, work with the financial industry to improve detection and response to financial exploitation, and collaboration to

address other emerging issues. S&DS conducted a workgroup which included representation from APS staff, the local Senior Legal Services provider, and local elder law attorney program. The workgroup recommended the exploration of additional guardianship options in Lane County. S&DS is already working with state and local entities on this topic area.

S&DS operates the Oregon Money Management Program, a volunteer-based program that provides bill pay and representative payee services to adults 60 and older and adults with disabilities. This service fills a critical need to help safeguard vulnerable adults' finances from financial abuse and exploitation. Services are targeted to those with low income and low resources. Many volunteers are bilingual in a variety of languages, conducting services in a linguistically and culturally appropriate manner to referred consumers.

S&DS provides financial support and collaborates with the local Senior Law Program operated by the Oregon Law Center (formerly Lane County Legal Aid and Advocacy Center). The Senior Law Program is an integral key stakeholder and partner on all elder abuse intervention and prevention work, including financial abuse and guardianship improvements. This program also provides free legal consultation on non-criminal legal issues to older adults through pro bono attorneys and program staff. Additional assistance may be targeted to those with the most economic and social need. The types of cases handled by Senior Law Program staff focus on public benefit income maintenance, health care issues, long-term care issues, and basic needs such as nutrition, housing, and utilities. The Senior Law Program provides materials in Spanish and has on-site bilingual staff that may assist consumers.

S&DS is excited for the potential to add a Rapid Access Network to our prevention efforts. A Rapid Access Network is a community wide partnership of agencies that provide essential services to individuals in crisis with the goal of coordinating resources and service delivery to improve outcomes. A Rapid Access Network would allow all agencies working with individuals in crisis to have knowledge of who is actively supporting the individual. This network provides opportunities to collaborate on current and future needs of the most vulnerable at-risk populations, improving outcomes, and reducing risk for individuals served. Additionally, the opportunity to connect individuals in crisis with services and resources is often lost due to the delay that occurs in the traditional intake or request processes. A Rapid Access Network would facilitate the necessary resources to be deployed effectively and timely when they are most needed, rather than referring vulnerable individuals to cumbersome intake processes.

APS REFERRAL ENTRY POINTS

All suspected abuse reports are referred directly to S&DS APS screening, including calls received through the ADRC, partner agency reports, and reports received by email or fax. The APS dedicated phone line is staffed during normal business hours. After hours, messages may be left on this line which directs callers to contact 911 for emergencies. Screeners evaluate each report for further APS staff investigation. If a victim reports abuse, screeners conduct safety planning along with an initial interview. As S&DS operates the APS unit in Lane County, internal streamlined referral protocols

exist for staff to report suspected abuse through an internal electronic referral system. S&DS staff are trained mandatory reporters.

The issues identified have led to the following goals:

1. Administer public education and training opportunities regarding abuse and prevention
2. Strengthen community partnerships and collaboration opportunities
3. Establish guardianship advocacy and resource opportunities

GOALS AND OBJECTIVES – LEGAL ASSISTANCE AND ELDER RIGHTS PROTECTION ACTIVITIES

Goal #1: Administer public education and training opportunities regarding abuse and prevention

Objectives

1. Conduct internal trainings on APS topics	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Establish target audience	APS Managers and lead	7/2021	07/2021	
	b	Determine topics through collaboration with other units	APS Managers	7/2021	07/2021	
	c	Develop culturally competent training materials	APS Managers and lead	7/2021	07/2021	
	d	Determine who will present the training	APS Managers	7/2021	07/2021	
	f	Conduct trainings at a minimum of twice a year	APS Managers and lead	Continuous	TBD	
2. Conduct external trainings on APS topics		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Establish target audience	APS Managers	7/2021	07/2021	
	b	Determine training topics	APS Managers	7/2021	07/2021	
	c	Determine training objectives and outcomes	APS Managers	7/2021	07/2021	

	d	Determine method for notifying public (adding recordings to LCOG website)	Community Program Analyst	8/2021	08/2021	
	e	Conduct trainings at a minimum of twice a year	APS Managers	Continuous	TBD	

Goal #2: Strengthen community partnerships and collaboration opportunities
Objectives

1. Explore possibilities of establishing a Rapid Access Network	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025 (by Month & Year)		Accomplishment or Update
				Start Date	End Date	
	a	Research existing programs	APS Managers	7/2021	09/2021	
	b	Make contact with existing programs	APS Managers	7/2021	09/2021	
	c	Facilitate meeting with key stakeholders, advocates, and other parties	APS Managers	7/2021	10/2021	
	d	Identify lead agency	APS Managers	7/2021	11/2021	
	e	If program develops or existing structure can be modified, support the program through agency responsiveness, on-going development, and maintenance	APS Managers	1/2022	TBD	

2. Develop reciprocal training partnerships		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Identify community partners	APS Managers	7/2021	08/2021	
	b	Determine training objective and outcomes	APS Managers and comm partners	7/2021	08/2021	
	c	Conduct reciprocal trainings at a minimum of twice a year	APS Managers	Continuous	TBD	

Goal #3: Establish guardianship advocacy and resource opportunities

Objectives

1. Advocate for public guardianship		Key Tasks	Lead Position & Entity	Timeframe for 2021-2024		**Accomplishment or Update**
				Start Date	End Date	
	a	Research existing programs nationwide	APS Managers	7/2021	08/2021	
	b	Make contact with guardianship partners to increase knowledge of resources for lay guardians and identify potential training opportunities.	APS Managers	7/2021	09/2021	
	c	Write letter to state legislature	Community Program Analyst and Director	10/2021	TBD	
	d	Create an internal training on guardianship processes.	APS manager/lead	7/2021	10/2021	

	e	Have a designated point person attend Working Interdisciplinary Networks of Guardianship Stakeholders (WINGS) Committee	APS Manager	7/2021	08/2021	
2. Establish opportunities for funding		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Research existing programs nationwide for guardianship and crisis/emergency resource funding	APS managers and Community Program Analyst	7/2021	08/2021	
	b	Establish a list of potential funding sources	Community Program Analyst	1/2022	01/2022	
	c	Collaborate with other agencies on guardianship and crisis/emergency resource funding	APS Managers	1/2022	TBD	
	d	If opportunities arise, apply for funding resources	Community Program Analyst	Continuous	TBD	

C-6 OLDER NATIVE AMERICANS

S&DS SERVICE DELIVERY AREA

According to the American Community Survey, 530 Native Americans age 60 and older reside in Lane County. Four Tribes provide services for their respective Lane County members: The Coquille Indian Tribe; The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI, Title VI grantee); The Cow Creek Band of Umpqua Tribe of Indians (Title VI grantee); and the Confederated Tribes of Siletz Indians (Title VI grantee). Each of the four Tribes' primary centers is located outside of Lane County and the S&DS service delivery area. Outstations exist in Lane County for CTCLUSI and the Confederated Tribes of Siletz Indians.

All four Tribes provide services for Tribal Elders. Services include socialization activities, nutritional programming such as congregate meals, in-home care, caregiver support and financial and health benefits. All Tribes also have a wealth of other general programming available to Tribal Elders.

COORDINATION WITH LOCAL TRIBES

S&DS is committed to supporting the Tribes and Tribal members in Oregon and Lane County. Over the next four years, S&DS intends to enhance the cultivation of relationships and collaboration opportunities with the Tribes in Oregon and Lane County to better coordinate services, share information, and provide services in more culturally responsive ways. S&DS has started this process by participating in quarterly meeting with Tribal partners and AAA workgroups statewide. S&DS will strive to expand the partnerships with the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians which has two outstations located in Lane County. S&DS plans on developing relationships with these outstations that involve regular communication and information sharing, with targeted focus about the ADRC. S&DS relies on Tribal members to help guide partnerships and services that may develop over the next four years.

A significant challenge with S&DS establishing or improving relations with the Tribes is that no major Tribal Centers exist in Lane County for the Coquille Indian Tribe, The Cow Creek Band of Umpqua Tribe of Indians or the Confederated Tribes of Siletz Indians. With Lane County not having Tribal Centers creates barriers to effective collaboration and communication. In addition, S&DS must reach out to Tribal centers located in other AAA service delivery areas, which may cause communication confusion. One way to potentially work through this barrier is to partner with the primary AAA's in those areas to create effective referral and communications channels without S&DS being the primary conduit. S&DS continues to work with the tribal community to open up lines of communication to ensure that tribal consumers with case management services are coordinating with tribal liaisons to provide better case management services. S&DS identifies the potential for better coordination with these efforts. As stated above, any services or supports developed in this manner will be determined by the Tribes and Tribal members. Tribal community members and tribal liaisons were instrumental in developing the goals and objectives in this section. This workgroup focused on goal around additional

coordination and establishing tribal contacts at S&DS to bridge the barriers between S&DS and the Tribal communities.

These issues have led to the following goals:

1. Increase engagement with local Tribal communities and Tribal representatives
2. Improve service connectivity with local Tribes

GOALS AND OBJECTIVES – OLDER NATIVE AMERICANS

Goal #1: Increase engagement with local Tribal communities and Tribal representatives

Objectives

		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
1. Coordinate with Tribal liaisons	a	Establish lines of communication for a point of contact	Community Program Analyst and S&DS Outreach Coordinator	7/2021	08/2021	
	b	Establish lines of communication for meeting needs	Community Program Analyst and S&DS Outreach Coordinator	7/2021	08/2021	
	c	Streamline processes to forms and paperwork for each liaison	Community Program Analyst and S&DS Outreach Coordinator	7/2022	07/2023	
	d	Build effective partnerships	Community Program Analyst and S&DS Outreach Coordinator	7/2021	TBD	
	e	Focus on warm hand-offs to service providers	Community Program Analyst and S&DS Outreach Coordinator	7/2021	11/2021	
	f	Have a designated S&DS staff participate in Trillium's Native American Advisory Council	Director, Deputy Director, Program Manager	7/2021	08/2021	

	g	Attend events (in-person and virtual)	Community Program Analyst and S&DS Outreach Coordinator	7/2021	TBD	
	h	Dedicate FTE specifically to Older Native American activities	Director, Deputy Director, Program Manager	7/2021	07/2022	
2. Educate Tribal members and representatives on S&DS services		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Collaborate with tribal liaisons	Community Program Analyst and S&DS Outreach Coordinator	7/2021	09/2021	
	b	Establish target audience	Community Program Analyst and S&DS Outreach Coordinator	8/2021	08/2021	
	c	Determine service topics	Community Program Analyst and S&DS Outreach Coordinator	8/2021	09/2021	
	d	Determine method of delivery	Community Program Analyst and S&DS Outreach Coordinator	8/2021	09/2021	
	e	Establish measurable outcomes	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	8/2021	09/2021	

	f	Provide culturally sensitive materials (e.g., brochures, etc.)	Community Program Analyst and S&DS Outreach Coordinator	8/2021	10/2021	
	g	Provide a minimum of one education opportunity per year	Program Manager, Unit Manager, S&DS Outreach Coordinator	8/2021	TBD	

Goal #2: Improve service connectivity with local Tribes

Objectives

1. Create an internal road map for services	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Inventory services offered by both AAA and Title VI agencies	S&DS Outreach Coordinator	1/2022	02/2022	
	b	Establish services single point of contact	S&DS Outreach Coordinator	7/2021	08/2021	
	c	Create expectations for timelines of services	S&DS Outreach Coordinator	1/2022	02/2022	
	d	Create internal access to living resource document	Program Manager, Unit Manager, S&DS Outreach Coordinator	4/2022	06/2022	
	e	Invite Tribal community feedback	Community Program Analyst and S&DS Outreach Coordinator	3/2022	06/2022	

	f	Create internal file for living document	Program Manager, Unit Manager, S&DS Outreach Coordinator	4/2022	06/2022	
2. Create an external road map for services between S&DS and Tribal Communities		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Inventory services offered by both AAA and Title VI agencies	S&DS Outreach Coordinator	1/2022	02/2022	
	b	Establish services single point of contact	S&DS Outreach Coordinator	7/2021	08/2021	
	c	Create expectations for timelines of services	S&DS Outreach Coordinator	1/2022	03/2022	
	d	Create external access to living resource document	Program Manager, Unit Manager, Community Program Analyst	4/2022	06/2022	
	e	Invite Tribal community feedback	Community Program Analyst and S&DS Outreach Coordinator	3/2022	06/2022	
	f	Create internal file for living document	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	4/2022	06/2022	
		Key Tasks		Timeframe for 2021-2025		

3. Focus on Older Native American needs			Lead Position & Entity	Start Date	End Date	Accomplishment or Update
	a	Establish a point of contact	Community Program Analyst and S&DS Outreach Coordinator	7/2021	08/2021	
	b	Continue to openly communicate	Community Program Analyst and S&DS Outreach Coordinator	7/2021	TBD	
	c	Identify needs through shared survey results and other means	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	7/2021	TBD	
	d	Use needs assessment to inform grants	Program Manager, Unit Manager, Community Program Analyst	7/2021	TBD	
	e	Collaborate on grants to fund specific needs	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	7/2021	TBD	

C-7 UNDERSERVED POPULATIONS

S&DS is committed to providing a safe, inclusive, and welcoming environment for any consumer, regardless of race, ethnicity, sexual orientation, and gender identity. S&DS recognizes that minority and LGBTQIA+ community members experience inequities and disparities throughout service delivery systems, including the aging and disability service systems. During the 2021 – 2025 Area Plan time frame, S&DS plans to increase partnership development with the Latinx community and on LGBTQIA+ aging issues.

LATINX OUTREACH

According to the American Community Survey, 2,034 Hispanic older adults age 60 and older reside in Lane County and represent its largest minority community. Many speak limited or no English. Health disparities and inequities continue to exist for minority populations, such as access barriers to medical care, social programs, and a lack of culturally responsive services.

While S&DS currently employs Spanish-English bilingual employees in each program area, a coordinated outreach strategy needs to be conducted to optimize service delivery. Over the next four years, S&DS intends to build better relationships and collaboration with local agencies that serve the Latinx community. Outreach efforts will not only share information on S&DS services, but also find partnership opportunities to better serve this population in culturally appropriate ways. S&DS intends to review service delivery methods for culturally responsive improvements.

LGBTQIA+ OUTREACH

During the S&DS Community Needs Assessment, approximately 11 percent of the 1,215 survey participants reported identifying as LGBTQIA+. While society is growing more accepting of the LBGTQIA+ community, disparities and discrimination still exist. LGBTQIA+ older adults lived through times of extreme discrimination. The community would often have to hide their sexual identity. The consequences of being open about a LBGTQIA+ identity could have meant facing financial and social repercussions, rejection by family, or violence and abuse. LGBTQIA+ individuals may be less likely to access services due to fear of discrimination, the lack of acceptance, or lack of information on LGBTQIA+ friendly agencies and facilities.

Currently, while there are many informal social networks, such as support groups and school associations, in Lane County, no formal systems or entities exist that focus on LGBTQIA+ issues. S&DS is dedicated to providing culturally sensitive services by its own staff and providing targeted education and community awareness activities to its service partners. S&DS plans to continue building on this work by continuing to provide LGBTQIA+ aging awareness trainings and participation in statewide LGBTQIA+ aging committees.

ADDITIONAL OPPORTUNITIES

S&DS has begun working with the newly formed Lane Equity Coalition. The purpose of the Coalition is to build and sustain a community-wide effort to reduce barriers which prevent equal access and opportunity and to increase equity by identifying and reducing disparities. The Coalition was formed out of the local Lane County Community Health Improvement Plan. S&DS will be actively engaged in this Coalition along with many other community partners. Through this work and S&DS internal processes, S&DS will monitor the need for tailored outreach efforts to underserved populations in Lane County. These efforts may be customized to specific geographical areas or the S&DS service delivery area as a whole and may be completed in collaboration with other partners. The S&DS staff-driven Equity and Inclusion Committee was formed to address internal processes and find educational opportunities that engage staff at all levels in equity work and cultural awareness.

The issues identified have led to the following goals:

1. Increase Community Partnerships with Latinx Community
2. Build sustainable trust within Latinx community
3. Increase community engagement for those who identify as LBGTQIA+

GOALS AND OBJECTIVES – EQUITY AND UNDERSERVED POPULATIONS

Goal #1: Increase Community Partnerships with Latinx Community

Objectives

1. Develop Latinx community partnerships	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Identify new community partners in Latinx community	S&DS Outreach Coordinator	7/2021	08/2021	
	b	Make contact with new partners	S&DS Outreach Coordinator	9/2021	10/2021	
	c	Establish a point of contact with community partners	S&DS Outreach Coordinator	9/2021	11/2021	
	d	Attend community partner events (in-person and virtual)	S&DS Outreach Coordinator	9/2021	TBD	
	e	Develop living document listing community partners	S&DS Outreach Coordinator	11/2021	05/2022	
	f	Create external access to living resource document	S&DS Outreach Coordinator	1/2022	05/2022	
	g	Create internal access to living resource document	S&DS Outreach Coordinator	1/2022	05/2022	
2. Strengthen Existing Latinx		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	

community partnerships	a	Identify existing community partnerships	S&DS Outreach Coordinator	7/2021	08/2021	
	b	Make contact with existing partners	S&DS Outreach Coordinator	9/2021	09/2021	
	c	Establish point of contact with each community partner	S&DS Outreach Coordinator	9/2021	09/2021	
	d	Create an open line of communication	S&DS Outreach Coordinator	9/2021	TBD	
	e	Focus on soft referrals from community partners	S&DS Outreach Coordinator	9/2021	12/2021	
	f	Establish internal points of contact for soft referral clients	S&DS Outreach Coordinator	9/2021	10/2021	
3. Conduct service education and training in the community	a	Invite community partners to train staff on various topics	Program Manager, Unit Manager, S&DS Outreach Coordinator	11/2021	TBD	
	b	Collaborate with community partners on education and training topics	Program Manager, Unit Manager, S&DS Outreach Coordinator	11/2021	TBD	
	c	Invite community partners twice a year to participate in a service education or training	Program Manager, Unit Manager, S&DS Outreach Coordinator	Continuous	TBD	

Goal #2: Build sustainable trust within Latinx community

Objectives

1. Develop internal understanding of Latinx community	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Invite a community partner to deliver a cultural humility training twice a year	Director	Continuous	TBD	
	b	Invite a community partner to deliver a trauma informed training regarding the Latinx community twice a year	Director	8/2021	TBD	
2. Develop an external understanding of Latinx community		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Determine target audience	Program Manager, Unit Manager, S&DS Outreach Coordinator	1/2022	01/2022	
	b	Determine training topic	Program Manager, Unit Manager, S&DS Outreach Coordinator	1/2022	01/2022	
	c	Determine community partners to co-facilitate	Program Manager, Unit Manager, S&DS Outreach Coordinator	1/2022	01/2022	

	d	Determine method of training delivery	Program Manager, Unit Manager, S&DS Outreach Coordinator	1/2022	01/2022	
	e	Determine method for notifying public	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	1/2022	01/2022	
	f	Establish measurable outcomes of training	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	1/2022	01/2022	
	g	Provide a minimum of one training per year	Program Manager	1/2022	TBD	
3. Increase opportunities for staff participation	a	Dedicate staff FTE for Latinx community activities	Director, Deputy Director, and Program Managers	7/2021	07/2022	
	b	Establish event participation opportunities	S&DS Outreach Coordinator	7/2021	TBD	
	c	Establish engagement opportunities in the community	Program Manager, Unit Manager, Community Program Analyst, S&DS Outreach Coordinator	7/2021	TBD	
4. Increase participation in the Equity		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	

and Inclusion Committee	a	Establish target audience	Equity and Inclusion Committee	7/2021	07/2021	
	b	Determine barriers in participation	Equity and Inclusion Committee	7/2021	07/2021	
	c	Create measurable outcomes to overcome participation barriers	Equity and Inclusion Committee	8/2021	08/2021	
	d	Establish a consistent meeting schedule	Equity and Inclusion Committee	8/2021	TBD	
	e	Establish Committee Officers	Equity and Inclusion Committee	8/2021	TBD	
	f	Create engagement opportunities in the community	Equity and Inclusion Committee	11/2021	TBD	

Goal #3: Increase community engagement for those who identify as LBGTQIA+

Objectives

1. Conduct educational trainings with community partners	Key Tasks		Lead Position & Entity	Timeframe for 2021-2025		**Accomplishment or Update**
				Start Date	End Date	
	a	Identify target audience	S&DS Outreach Coordinator	7/2021	07/2021	
	b	Identify point of contact at community partner agency	S&DS Outreach Coordinator	7/2021	07/2021	

	c	Identify training host and location	S&DS Outreach Coordinator	8/2021	09/2021	
	d	Collaborate with community partners for training logistics	S&DS Outreach Coordinator	8/2021	09/2021	
	e	Collaborate with LBGTQIA+ community on training topics	S&DS Outreach Coordinator	8/2021	09/2021	
	f	Participate in a minimum of 2 trainings annually	Program Manager, Community Program Analyst, S&DS Outreach Coordinator	7/2021	TBD	
	g	Continue consistent communication with community partners for increased opportunities	S&DS Outreach Coordinator	7/2021	TBD	
2. Build internal processes for inclusivity		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Create and implement cultural humility training for new employees	Director	9/2021	TBD	
	b	Conduct an internal evaluation of SAGE training effectiveness	Community Program Analyst	11/2021	06/2021	
	c	Internally audit S&DS forms for consistent inclusive language	Community Program Analyst	7/2021	06/2022	

	d	Apply for LBGTQIA+ friendly agency designation	Director and Community Program Analyst	7/2021		
3. Conduct strategic outreach to LBGTQIA+ community		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Identify target audience	S&DS Outreach Coordinator	7/2021	07/2021	
	b	Create messaging	S&DS Outreach Coordinator	7/2021	09/2021	
	c	Create media templates	Community Program Analyst and S&DS Outreach Coordinator	8/2021	09/2021	
	d	Post messages through media (e.g., PSAs, social media, etc.)	Community Program Analyst	9/2021	09/2021	
	e	Table at community events	S&DS Outreach Coordinator	7/2021	TBD	
	f	Dedicate staff FTE to outreach activities	Director, Deputy Director, Program Manager	7/2021	07/2022	
4. Build and participate in LBGTQIA+ friendly community activities		Key Tasks	Lead Position & Entity	Timeframe for 2021-2025		Accomplishment or Update
				Start Date	End Date	
	a	Partner with LBGTQIA+ agencies to enhance their events	S&DS Outreach Coordinator	7/2021	09/2021	

	b	Support partner agencies with LBGTQIA+ community events	S&DS Outreach Coordinator	7/2021	TBD	
	c	At a minimum, host 1 LBGTQIA+ event yearly	Director and Community Program Analyst	7/2021	TBD	

C-8 COMMUNITY RELATIONSHIPS

The S&DS Community Needs Assessment identified several other gaps or issues affecting older adults and adults with disabilities in Lane County. These gaps included emergency preparedness, evacuation assistance, access to primary medical care, homelessness, availability of income, and lack of affordable housing. S&DS is supportive of county wide efforts addressing these issues but is not currently contributing its limited financial resources to these areas. However, S&DS, recognizing the importance of these gaps and issues, will advocate for its consumers, older adults, and adults with disabilities. This will be accomplished by participating in community meetings, committees, and other collaborative work. By being a reliable and effective voice for the most vulnerable members of our community, S&DS hopes to engage local community organizations and entities to work towards meaningful solutions in these areas.

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

D-1 ADMINISTRATION OF OREGON PROJECT INDEPENDENCE (OPI)

As S&DS is a Type B Medicaid Transfer Agency, internal intake and eligibility determination follow the same process as Medicaid and other state funded long-term care service programs. For new S&DS consumers, OPI applicants enter the S&DS service system through the ADRC. ADRC staff conduct an initial needs screening followed by an in-home intake appointment. Note: Due to Covid-19 the in-home portion of the intake appointment is being conducted by phone by S&DS staff. The intake is conducted by a trained case manager, knowledgeable in all long-term care in-home service programs, so that each consumer's eligibility is reviewed for all available service programs, not just OPI. Program eligibility is determined within 45-days. S&DS case managers follow State of Oregon Department of Human Services (DHS) rules, regulations, standards, and practices for determining eligibility and service priority levels. Recipients then receive an annual in-home review. During this annual review, both OPI eligibility, service need, and eligibility for other programs, such as Medicaid are evaluated. Outside of the annual review, consumers receive on-going case management services as needed. Consumers may contact their case manager at any time to discuss changes, receive information, referrals to community resources, screening for other programs such as Medicaid, or obtain consumer advocacy assistance.

S&DS uses DHS Service Priority Level guidelines to prioritize OPI services. Depending on available funding, the service priority levels served may change, along with services or level of service provided which includes maximum allowed in-home hours. In addition to funding considerations, the input of the S&DS Advisory Councils is used to determine program changes necessitated by budget or other program impacts. Whether this results in a change to hours, services, or Service Priority Level, this depends on the nature of the change and input from the Advisory Councils. Currently, OPI is available to consumers that have a Service Priority Level (SPL) 16 or lower.

Funding for OPI and the OPI Pilot program is separate and distinct. Depending on the amount of each budget, variations in availability and level of service between the two may occur. For example, funding is available for durable medical equipment for the OPI Pilot program, but only in limited situations for the OPI program. OPI Pilot program consumers may receive up to 19.5 hours per month of in-home care. When OPI experiences a waitlist, a standard DHS OPI Risk Assessment Tool form is utilized to prioritize new OPI consumers. Those with the highest risk and the greatest need, based on these tools, receive priority. A waitlist is currently in effect for the OPI program.

If OPI services are denied, the applicant receives a denial letter informing them of the reasons along with their appeal rights. If OPI services are reduced or closed, the consumer receives a letter at least 10 days prior to the proposed action. This letter contains the reasons for the action and the consumer's appeal rights. To review the S&DS OPI appeal process and other local policies, see Appendix G.

OPI in-home services for personal care, homecare, and chore services are provided either through a State Home Care Worker (HCW) or through a contracted in-home agency. Home-delivered meals are delivered by FOOD for Lane County in Eugene and by S&DS in Springfield and rural Lane County. Health and Medical Equipment available consists of emergency response systems, medication dispenser devices, and one-time purchases of low-cost durable medical equipment. Emergency response systems and medication dispenser devices, along with on-going monitoring, are provided by contract with for-profit entities. Durable medical equipment, dependent on available funding, is purchased as needed, on a limited basis through a variety of vendors depending on the item, consumer choice and price. If an item exceeds $500, three quotes are received to find the lowest cost option.

Contract agencies (see section D-2 for a list of all AAA services and current contract agencies) for in-home services and home-delivered meals are monitored annually through site visits. Site visits may entail the review of case files, employee records and practices, fiscal practices, and discussion of any findings or issues that may occur. All contract agencies are monitored through monthly fiscal audits of billings and unit reporting. Additionally, contract agencies administered by a third party, such as Addus Health Care, receive additional monitoring by the administering agency. Customer satisfaction surveys are conducted periodically to ensure contract services are meeting consumer needs and expectations. Many contractors also conduct their own internal customer satisfaction surveys.

Individuals denied, reduced, or closed are provided ADRC information to receive information on other available community services that may assist with supporting the person's independence and quality of life. They may also utilize Options Counseling to further explore their options in depth with a trained, knowledgeable expert. Exploring these other resources outside of OPI also builds on the strengths a consumer and their family may already have, such as natural supports and optimization of personal resources. As applicable, staff assess consumers for other S&DS program eligibility such as Medicaid, SNAP, and OAA services. S&DS has a conflict of interest policy on file which is available upon request. S&DS staff strive to connect the individual with a variety of resources to support continued independence and reduce the risk of institutionalization when a consumer is found ineligible or has OPI services reduced.

Unit cost per service is as follows (as of July 1, 2020):

Agency Personal Care: $21.85 per hour
Agency Homecare: $21.85 per hour
Home-Delivered Meals: $9.54 per meal (As of April 1, 2020, $11.75 per meal due to COVID-19 response)
Health & Medical Equipment: Price per unit varies, with an average cost of $28.05 in Fiscal Year 2020
Case Management: $39.52 average per hour based on staff salary, benefits, and associated costs.

OPI operates on a sliding fee scale. The process and calculation of fees is determined by DHS using a standardized DHS OPI fee determination form. S&DS charges and collects fees for personal care, homecare, and chore services, whether the consumer has a State Home Care Worker (HCW) or an agency providing care. For consumers opting for a State HCW, fees are assessed based on actual State

HCW hours. Program income is reinvested in the local OPI program to stretch services to more consumers. Fees may be waived based on ability to pay, hardships, and other extenuating circumstances as determined by a case manager or as staffed with management. Consumers that do not pay their fee are reviewed quarterly and are contacted by a case manager. If good cause is not determined for failure to pay, the consumer may have their services terminated with a 10-day notice. Consumers are sent a warning letter providing them an additional month to pay the fee or make other arrangements with S&DS prior to closure. All closure notices provide information on the consumer's appeal rights.

Please see Oregon Administrative Rules 411-032-000 through 411-032-0050 for additional detail on OPI state regulations.

D-2 SERVICES PROVIDED TO OAA AND/OR OPI CONSUMERS

The following table reflects Oregon Department of Human Services, Community Services and Supports Units service classifications. Each service listed indicates if it is an S&DS offered service, OAA or OPI funding source, if it is a contracted service, and contractor information, as applicable. In cases where the AAA provides OAA services directly, the approved Area Plan serves as the waiver. Case Management related services for consumers and caregivers, Information & Assistance, and Meal Site Supervision are self-provided as integral to AAA administration or would not be practical to separate from the overall AAA administrative functions. Food service production of hot and frozen meals, while not a separately defined service category, is contracted out to Bateman Community Living. Home-delivered meals in rural areas of Lane County are distributed out of rural meal sites as a matter of economy and efficiency. Where practical in the Eugene metro area, home-delivered meals are contracted to FOOD for Lane County. Contracts for food production, home-delivered meals, legal assistance, reassurance, and in-home services are procured through competitive requests for proposals every five years.

☒ **#1 Personal Care** (by agency)

Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address:
NorthWest Senior & Disability Services (Public Agency)
P.O. Box 12189
Salem, OR 97309

Subcontracted to:
Addus HealthCare (For Profit Agency)
1142 Willagillespie Rd, #20
Eugene, OR 97401

☒ **#1a Personal Care** (by HomeCare Worker) 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:
NorthWest Senior & Disability Services (Public Agency)
P.O. Box 12189
Salem, OR 97309

Subcontracted to:
Addus HealthCare (For Profit Agency)
1142 Willagillespie Rd, #20
Eugene, OR 97401

☒ **#2a Homemaker** (by HomeCare Worker) 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:

☐ **#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:
Food for Lane County (FFLC) (Not for Profit)
700 Bailey Hill Road
Eugene, OR 97402

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#6 Case Management**

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☒ **#7 Congregate Meal**

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

☐ **#8 Nutrition Counseling**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#9 Assisted Transportation**

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:
Lane Transit District (LTD) (Public Agency)
3500 East 17th Avenue
Eugene, OR 97403

☐ **#10 Transportation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#11 Legal Assistance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:
Lane County Legal Aid/Oregon Law Center
101 East Broadway Suite 200
Eugene, OR 97401

☒**#12 Nutrition Education**

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☒Self-provided

Contractor name and address:
Food for Lane County (FFLC) (Not for Profit)
700 Bailey Hill Road
Eugene, OR 97402

☒**#13 Information & Assistance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☒**#14 Outreach**

Funding Source: ☐OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:
Lane Transit District (Public Agency)
3500 E. 17th Ave
Eugene, OR 97401

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐**#20-2 Advocacy**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#30-1 Home Repair/Modification**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#30-4 Respite Care (IIIB/OPI)**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#30-5/30-5a Caregiver Respite**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:
Addus HealthCare
1142 Willagillespie Rd
Eugene, OR 97401
For Profit Agency

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☐OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

☒**#40-5 Health & Medical Equipment**

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:

Rate agreement for Emergency Response Systems and Medication Dispenser Devices with:

Phillips Lifeline (For Profit)
111 Lawrence Street, MS29
Framingham, MA 01702

Assured Independence (For Profit)
3125 Colby Avenue Suite B
Everett, WA 98201

Critical Signals Technologies
27475 Meadowbrook Road
Novi, MI 48377

Durable Medical Goods/Equipment purchased from various vendors, if over $500, a 3 bid/quote process is utilized.

☐**#40-8 Registered Nurse Services**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#40-9 Medication Management**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#50-5 Long Term Care Ombudsman**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#60-1 Recreation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒**#60-3 Reassurance**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address:

☐**#60-4 Volunteer Recruitment**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐**#60-5 Interpreting/Translation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒**#70-2 Options Counseling**

Funding Source: ☐OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐ **#70-5 Newsletter**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#70-8 Fee-based Case Management**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☐ **#70-9/70-9a Caregiver Training**

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#71 Chronic Disease Prevention, Management/Education**

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

☐ **#72 Cash and Counseling**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐ **#80-1 Senior Center Assistance**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

☒ **#80-4 Financial Assistance**

Funding Source: ☐OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

☒ **#80-5 Money Management**

Funding Source: ☐ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

☐ **#Volunteer Services**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

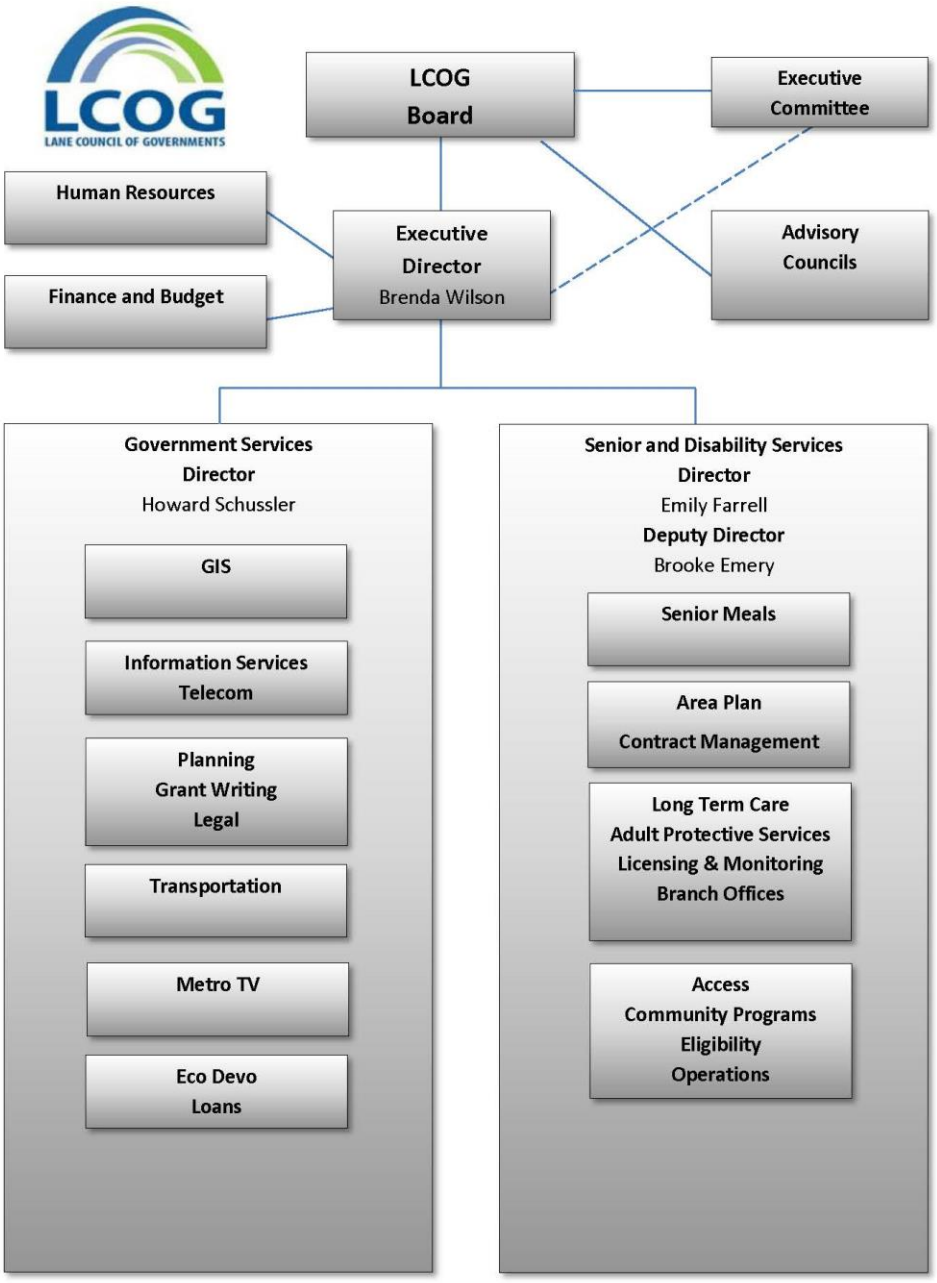
☐ Contracted ☐ Self-provided

SECTION E – AREA PLAN BUDGET

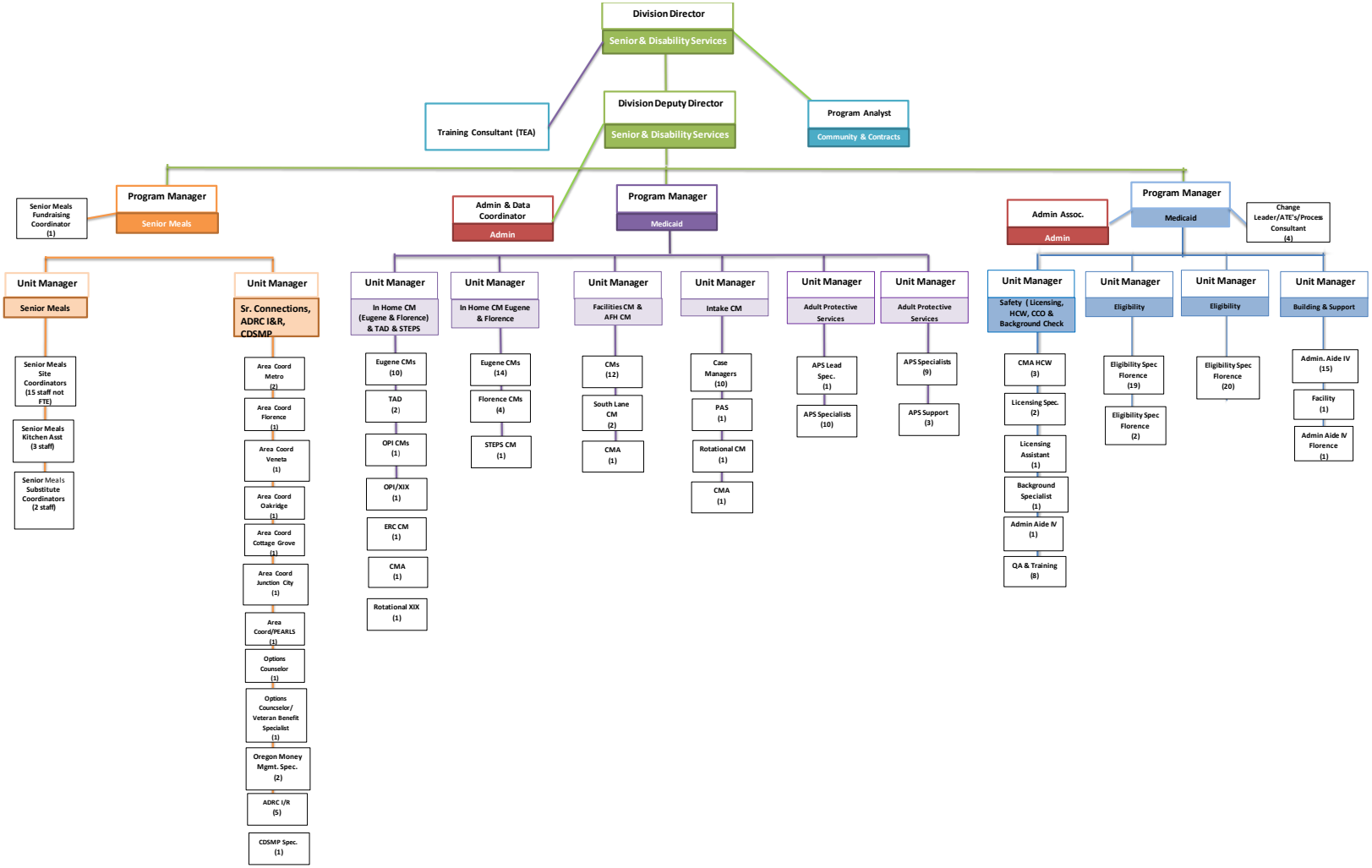
(Separate Attachment)

APPENDIX A – ORGANIZATIONAL CHARTS

LANE COUNCIL OF GOVERNMENTS ORGANIZATIONAL CHART



SENIOR & DISABILITY SERVICES DIVISION ORGANIZATIONAL CHART



APPENDIX B – ADVISORY COUNCILS AND GOVERNING BODY

2021 DISABILITY SERVICES ADVISORY COUNCIL (DSAC)

- John Ahlen
- Joe Basey
- Melanie Carlone
- Hoover Chambliss
- Lana Junger
- Tina Powell
- Peggy Thomas
- Dennis Weirich
- Lucy Zammarelli
- Kim Davidson-Ruby
- Robert Phillips
- Elaine Eiler-Mough
- Jeanne Barter
- Amy Scott (SSAC Liaison)
- Kay McDonald (SSAC Liaison)

2021 SENIOR SERVICES ADVISORY COUNCIL (SSAC)

- Julie Austin
- Ruth Beardsley
- Judy Dashney
- Rod Holst
- Suzanne Huebner-Sannes
- Kay McDonald
- Tom Mulhern
- Diane Rogers
- Amy Scott
- Barbara Susman
- Andy Fernandez
- Beth Brooks
- Jody Cline
- Judith Moman
- Hoover Chambliss (DSAC Liaison)
- Lana Junger (DSAC Liaison)

LCOG BOARD

- City of Coburg: Ray Smith
- City of Cottage Grove: Jeff Gowing
- City of Creswell: Amy Knudson
- City of Dunes City: Bob Forsythe
- City of Eugene: Randy Groves

- City of Florence: Vacant
- City of Junction City: Beverly Fleck
- City of Lowell: Don Bennett
- City of Oakridge: Kathy Holston
- City of Springfield: Leonard Stoehr
- City of Veneta: Thomas Cotter
- City of Westfir: Matt Meske
- Emerald People's Utility District: Patti Chappel
- Eugene Water and Electric Board: Sonya Carlson
- Fern Ridge Library District: Steve Brock
- Heceta Water PUD: Vickie Kennedy
- Junction City RFPD: Don Lighty
- Lane Community College: Lisa Fragala
- Lane County: Heather Buch
- Lane Education Service District: Sherry Duerst-Higgins
- Lane Library District: Vacant
- Lane Transit District: Don Nordin
- Port of Siuslaw: Vacant
- Rainbow Water and Fire District: James McLaughlin
- River Road Park and Recreation District: Wayne Helikson
- School District 19: Todd Mann
- School District 4J: Mary Walston
- School District 40: Lacy Risdal
- School District 45J3: Alan Baas
- School District 52: Alan Laisure
- School District 68: Vacant
- Siuslaw Library District: Susy Lacer
- Siuslaw Valley Fire and Rescue: Vacant
- Western Lane Ambulance District: Bob Sneddon
- Willamalane Park and Recreation District: Greg James

APPENDIX C – PUBLIC PROCESS

The Community Needs Assessment process included hardcopy paper surveys, online surveys, and community focus groups. Surveys were widely distributed across Lane County. Focus groups were targeted for rural and underserved communities. The S&DS Planning and Budget Committee, comprised of members from the Senior Services Advisory Council and Disability Services Advisory Council, was involved in this process. This included assistance with survey development, results interpretation, and on-going feedback and guidance. A full description of the S&DS Community Needs Assessment process, a list of survey distribution points, and focus group dates and locations are located in the S&DS Community Needs Assessment which may be accessed at https://www.sdslane.org/DocumentCenter/View/7562/2020-SDS-Community-Needs-Assessment.

The goals and objectives developed in this S&DS Area Plan for Aging and Disability Services were created in collaboration with Council members, professionals, community members, and S&DS staff. The S&DS Planning and Budget Committee reviewed drafts, provided comment, and recommended approval. Final steps in this process included notifying the public, providing a specified period for comment submission, holding a public hearing, final review, and approval by both S&DS Advisory Councils, and lastly, concluding with approval by the LCOG Board. S&DS used the following locations and community sites to provide information on the draft Area Plan public hearing:

Bethel Branch Library
Campbell Senior Center
Cottage Grove Public Library
Cottage Grove Senior Center
Creswell Library
Eugene Public Library
Fern Ridge Library
Florence Senior Center
Hilyard Community Center
Junction City Library
Lowell City Library
Oakridge Public Library
Petersen Barn Community Center
River Road & Santa Clara Library
River Road Park and Recreation
Sheldon Branch Library
Siuslaw Public Library
Springfield City Library
Viking Sal Senior Center
Willamalane Adult Activity Center
Willamette Activity Center
Mid Lane Cares

The draft S&DS Area Plan was also available by request. The Area Plan public hearing was held on November 20, 2020, via conference call and GoToMeeting. Notice for public comment and the public hearing was posted on social media, sent to community partners, and published in the Register Guard newspaper which has distribution across the S&DS service delivery area.

APPENDIX D – FINAL UPDATES ON ACCOMPLISHMENTS FROM 2017 – 2020 AREA PLAN

The following encompasses the updates of final accomplishments related to Focal Areas in the 2017 – 2020 S&DS Area Plan.

Family Caregiving

The primary goal for Family Caregiving was to increase program awareness and engage with key partners such as AARP. Awareness and education were targeted at our SSAC, DSAC, and Advocacy Councils. Through the awareness and education regarding the program, our SSAC council included the Family Caregiving Programming into their legislative priorities.

ADRC

The primary goal for the ADRC was to better serve consumers through the ADRC and its services. This included working towards robust internal protocols and data tracking to ensure call wait times were lower, phones were staffed adequately during peak hours, and a dedicated staff assigned to daily duties. Another accomplishment was having a lead worker specifically assigned to outreach activities. S&DS continues to work on improving and enhancing the ADRC database, as well as engaging all ADRC core partners in furthering the work of the ADRC.

Elder Rights

Elder Rights goals focused on continued support for guardianship assistance and conducting a targeted multi-media public education campaign regarding abuse prevention and detection. S&DS began participating in and supporting local guardianship through the High-Risk Team. The multi-media public education campaign included videos, public service announcements (PSA), and local bus advertisements to focus on Elder Abuse Awareness Month. These advertisements included contact information for our Adult Protective Services (APS) unit as well as our ADRC to ensure the public knew how to contact us regarding elder abuse.

Health Promotion

Goals in health promotion revolved around supporting improved health outcomes in Lane County. S&DS dedicated a staff member for Health Promotions programming which allowed for more workshops in the urban and rural communities. S&DS has established a robust MOU with the local Coordinated Care Organizations, Trillium and PacificSource, detailing shared work and efforts.

Older Native Americans

Goals for older Native Americans focused on creating a partnership with the tribal communities and providing caregiver information. This included collaboration with local Tribal Elders and providing caregivers scholarships to the Native Caring Conference. The Senior Connections Unit continues to

work on collaborative efforts with the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians.

Nutrition

Nutrition goals revolved around increasing program revenue through fundraising. S&DS focused on fundraising by hiring a dedicated coordinator to facilitate these activities. The program began recognizing donors who contributed over $250 to the program. This recognition was seen in the newsletter accompanied by thank you letters to those donors. The Senior Meals Program established an online portal through the S&DS website to accept online donations.

APPENDIX E – LCOG S&DS EMERGENCY PREPAREDNESS PLAN

Assessment of Potential Hazards

As the AAA in Lane County, S&DS is charged with providing a full range of direct and indirect services to members of the Lane County community. These services include senior meals (MOW and Congregate Meals); transportation assistance, in-home services, case management, legal assistance, financial assistance under the Low Income Home Energy Assistance Program (LIHEAP), among other services. These services have been proven to be a key factor in supporting older adults and adults with disabilities.

S&DS is located mainly inside the Schaefers Building in Downtown Eugene, at 1015 Willamette Street, Eugene, OR 97401. The majority of S&DS staff is housed at Schaefers, which has three floors and a basement. There are also two S&DS satellite branch offices in Florence and Cottage Grove, additional Senior Connections outstations in Veneta, Junction City, and Oakridge, and Senior Meals sites in Eugene, Springfield, Florence, Cottage Grove, Veneta, Creswell, Oakridge, and Junction City. LCOG's Executive Director, human resources staff, and fiscal staff are located two blocks from the Schaefers Building at LCOG's main office, 859 Willamette Street, Eugene, OR 97401.The S&DS Continuity of Operations Plan (COOP) was developed to ensure services continue to be provided to clients in the event of an internal disaster or in conjunction with the S&DS Emergency Operations Plan for large-scale events. It outlines actions to be taken by management and staff to secure its own facilities and personnel. If necessary, it provides guidelines to relocate to an alternate facility and reconstitute as quickly as possible to meet the needs of the community requiring supports and services.

S&DS leadership is aware of the Lane County Oregon Hazard Mitigation Action Plan (October 2014) and the Eugene-Springfield Multi-Jurisdictional Natural Hazards Mitigation Plan and Emergency Operations Plan (2014), which contain thorough information and assessment of potential local hazards, including natural disasters (such as earthquake, tsunami, flooding and forest fires) and other non-natural events such as hazardous materials incidents. All of these incidents could impact S&DS consumers. For detailed information regarding hazards in Lane County, refer to these documents.

Purpose Statement

S&DS has a responsibility to maintain critical operations and provide disaster services in times of crisis. Though no plan can anticipate all the situations and conditions that may occur during an emergency, the purpose of the COOP is to provide policies and protocols to be followed in times of internal and external disaster. S&DS has identified Essential Functions that must be performed to keep the division viable. Essential Functions are those tasks that must be performed at a minimum for client care and business financial stability.

External events considered in this plan are those events that occur outside the influence or control of our division. These events have the potential to impact staff, citizens, or communities within our county. These events may affect our ability to conduct normal day-to-day operations.

An internal event is limited to circumstances which only impact S&DS personnel, equipment, or facilities, and may or may not be the result of an external event. This type of an event may also affect our ability to conduct normal day-to-day operations.

The COOP and our Emergency Operations Plan may be utilized simultaneously. It is the policy of S&DS to continuously review and update both plans through scheduled activities such as training and drill exercises. COOP planning is simply "good business practice".

Plan Activation

This COOP is applicable to a wide range of potential emergencies or threats regardless of cause. These include, but are not limited to:

- Pandemic influenza or another pandemic
- Natural disasters (earthquake, tornado, fire, flood, winter weather event)
- Accidents
- Technological failures
- Violence or criminal behavior
- Events related to foreign or domestic acts of aggression
- Mass staff turnover, internal strife, labor disputes, etc.

The COOP can be activated based on the potential scope of the incident. The LCOG Executive Director and S&DS Division Director, in consultation with the Administrative Management Team (AMT) and advisors will determine whether COOP activation is necessary and will oversee the activation of any portion of the COOP.

Administration Management Team (AMT)

The AMT is tasked with making assessments concerning disaster related actions and provide input in determining a course of action. This team will be designated with Incident Command positions that will be defined in the full COOP. Additional positions can be added as needed. The following is the chain

of command, with the authority to activate the plan, with those lower in the chain of command taking authority when those higher are not available, and then transferring control once those higher become available:

- Executive Director, LCOG
- Director, S&DS
- Deputy Director, S&DS
- S&DS Program Managers (3)
- S&DS Unit Managers (11)

An S&DS Response Team will be created, with active defined roles.

The S&DS Director has been designated as the Incident Commander on-site at the Schaefer's Building. The S&DS Director shall be the ranking S&DS officer on site at any given time and shall be responsible for the initiation and coordination of an S&DS response during an emergency situation. If the S&DS Director is not available, the Deputy Director, followed by one of the three S&DS Program Managers will perform this role. The LCOG Executive Director, or their designee, will assign this duty.

As part of S&DS Director's duties, the Incident Commander will:

- Assess and triage the incident
- Ensure an accurate accounting of S&DS personnel on the scene
- Activate a Response Team
- Determine the activities of the Response Team
- Assign duties
- Ensure constant communication with the Response Team and S&DS employees
- Plan for the next phase of the response
- Plan for and authorize the deactivation of the response
- Serve as the Public Relations Officer while at the scene, being the only person who will provide statements to media personnel (all other S&DS employees will not provide any information)
- Coordinate with the LCOG Executive Director and other LCOG staff housed at the LCOG main office (859 Willamette Street, Eugene, OR)

- Defer to the LCOG Executive Director for any of these duties, should the LCOG Executive Director determine that necessary

Plan Maintenance

The COOP is to be reviewed and updated at least annually, reflecting the changes in state statutes, S&DS staffing, contractual issues, and emergency management procedures.

Authority to Implement

The S&DS Division Director has the overall authority for the plan as it applies to the S&DS Division of LCOG and will coordinate with various other key personnel to oversee implementation, maintenance, evaluation, and revisions of the plan. Other key staff may include, but are not limited to:

- Deputy Director
- Program Managers
- Fiscal Manager
- Unit Managers
- Leads

Concept of Operations

The COOP will be activated when routine operations are unsafe or become disrupted. Operational changes may require employees to perform additional duties in support of Essential Functions as directed by supervisors. An employee may be asked to work in a different location, for a different supervisor, and perform different tasks on an emergency basis. Non-essential functions will be deferred until time or circumstances permit.

Concept of Operations consists of the following sub-tasks:

- Objectives
- Assumptions
- Essential Functions
- Order of Succession
- Emergency Delegation of Authority
- Communication Plan
- Warnings or External Notifications
- Internal Notifications

Objectives

The COOP helps ensure a viable capability exists to continue Essential Functions when the plan is activated. The objectives of this plan are:

- Protect clients, staff, facilities, equipment, records, and other assets.

- Ensure the continuous performance of the Essential Functions and operations during an emergency
- Reduce disruptions to operations
- Provide for a time-phased implementation of the COOP to mitigate the effects of the emergency and shorten the crisis response time
- Identify and designate principals and support staff to be assigned or relocated
- Facilitate decision-making for execution of the COOP and the subsequent conduct of operations
- Achieve a timely and orderly recovery from the emergency and resumption of all services as soon as possible

Assumptions

Threats or confirmed emergencies can adversely impact normal operations either through disruption of services, access to facilities, or both. The primary impact of a disaster will be one that affects employees who perform critical operations.

General assumptions include:

- Emergencies and threatened emergencies will differ in priority and impact from one event to another
- Structural integrity of facilities may have been compromised
- Loss of equipment may occur
- Mutual aid with other AAAs located outside the area affected by the emergency or threat may be available as necessary to help provide Essential Functions

In this plan, we assume that employee absenteeism in any disaster will increase due to:

- Personal injury/illness or incapacitation of staff or family members
- Inaccessibility of clinical locations and medical service providers
- Employees under home quarantine or isolation as a result of state ordered lockdown or shelter in place conditions
- Employees caring for children due to schools and childcare being closed
- Employees quarantining out of safety concerns

Essential Functions

Essential Functions are those activities that must be performed under any circumstances to ensure the welfare of consumers and the financial stability of the organization. Essential Functions are prioritized based on life-threatening, health, urgent business and other considerations.

S&DS has accounted for the need for policy and decision-making authorities in determining the Essential Functions and personnel needed in each area. See the Emergency Delegation of Authority Section.

Essential Functions are defined and prioritized by the LCOG Executive Director or S&DS Division Director. Listed below is a guide for routine operation/functions that are essential and will not be suspended or discontinued where possible. Non-essential functions may be deferred, as authorized in the COOP, by the Director or designee.

Essential Functions may include, but are not limited to the following:

- Coordinating emergency access for hospitalization or emergency care of consumers
- Ensuring access to emergency electricity for ventilators, etc.
- Meal delivery and access for current clients
- Coordinating/facilitating transportation for evacuated consumers
- Ensuring coordinated business functions-billing, AR, payroll to maintain continuity of operations and operational funding
- Maintaining confidential client records
- Identifying alternate facility operations

Each enumerated Essential Function is comprised of individual tasks that are required to complete such function. These tasks can be used to identify staffing, equipment required, spacing for relocation, and single points of failure. Single points of failure are defined as either the loss of personnel or equipment with no redundancy that would prevent this function from being completed.

Identifying essential tasks can help determine immediate replacement costs needed to complete the function, number of personnel required to ensure the continuation of the Essential Functions, spacing requirements if relocation is required and identification of non-essential staff.

Order of Succession

The Order of Succession for each staffing level (listed below) is, at a minimum, maintained by two members of S&DS staff to ensure continuity of Essential Functions. To ensure Essential Functions will be sustained throughout all staffing level in S&DS, focus will be emphasized to cross-train other employees who assume responsibilities for key employees if they are unable to work for an extended period of time. In the absence of staff in key positions, this chain of succession shall be implemented. The chain of command is distributed to all members of S&DS.

Emergency Delegation of Authority

All authorities specific to each position are transferred to the emergency designee unless otherwise specified. When a succession occurs, the duties and authorities of the position are transferred to the incoming appointee, as the authority rests in the role being assumed unless otherwise stipulated.

Some emergency authorities cannot be anticipated in advance and may change based on the context of each emergent situation. Any modifications or new delegations of authority needed in a given situation will be authorized by the LCOG Executive Director, S&DS Division Director, or designee as needed during the emergency. It is possible that in certain extreme conditions delegation of authority may need

to be assumed if communication with the normal point of authority is disrupted and waiting would result in direct harm to individuals in need of support and services. In this instance, the authority may be exercised, and the appropriate persons notified once communication is re-established. At all steps of delegation, a chain of notification is essential to ensure smooth transition and continuity. All members of the succession list should be notified of delegation of authority so that operations continue without interruption. If the Director and succession of command are unavailable, the senior available manager shall assume duties of the Director in the interim period.

Communication Plan

The Incident Commander will implement a Communications Plan, which includes the following:

- Identify key audiences. Determine who needs to be informed of the situation, and in what order (both on- and off-site)
- Communicate with staff at the LCOG main office, satellite offices and other locations, as needed
- Send out information to the Flash Alerts system, update LCOG website, take additional actions as needed (as per the LCOG Inclement Weather Plan)
- Send communication to DHS via AAA emergency closures email per Action Request Transmittal APD-AR-21-002 to the following email at AAA.Closures@dhsoha.state.or.us and include the following information:
    - Name of AAA
    - Reason for closure
    - Estimated time AAA will be closed
    - Contingency plan(s) for how consumers will be served during the closure, including case management, APS, AFH Licensing and HCW vouchers
    - Any other pertinent information; and
    - Contact information for person in charge during the closure

Warnings or External Notifications

The LCOG Executive Director and S&DS Division Director will request that their names and contact information be added to the notification and warning lists of each of the county emergency management departments, emergency communications/dispatch centers, public health departments, and other response organizations in our County area.

The LCOG Executive Director and S&DS Division Director are responsible for receiving available emergency communications and for contacting the Emergency Manager of the County for follow up, if appropriate.

Upon learning of a confirmed or potential emergency situation that may affect staff or facilities, the LCOG Executive Director and S&DS Division Director are responsible for making appropriate internal notifications.

External warning communications *systems that may provide information to the LCOG Executive Director, S&DS Division Director, or designee as needed during the emergency* include hardline telephones, cellular telephones, television networks, public radio, emergency radio systems used *throughout* the County, weather alert networks and the internet

Internal Notification

S&DS has an internal list of all employees with their contact information, which is maintained with HR. In the event of a catastrophic emergency where direct contact of employees may be necessary, the calling tree plan follows the supervisory chain. Supervisors are expected to maintain current contact information in the event a calling tree is initiated.

S&DS employees are encouraged to contact their supervisors by phone, access the LCOG website for office emergency updates, access the Flash Alert system, watch local news, and access the county website for additional information in the event of an emergency.

Local Partnership Coordination

S&DS has been developing, and will continue to develop, working relationships with local emergency management personnel and agencies. Although LCOG is not a formal member of the Community Organizations Active in Disaster (COAD) group started by the Lane Preparedness Coalition, S&DS will continue to be involved through email and meetings to advocate for our consumers and have awareness of the plan in the event of an emergency. S&DS' role will be to ensure that emergency groups know about our vulnerable population in the community.

The ability of S&DS to successfully continue to provide services during an emergency will depend to a large degree on the ability of S&DS offices, meal sites, and consumer facilities to continue their own operations. There are three S&DS office locations that provide case management, SNAP, medical & information assistance: Eugene, Cottage Grove and Florence. In an emergency, where one or more locations are closed, including outstations, the other locations may provide service coverage. In the event all three S&DS offices and the main LCOG office are non-operational, S&DS will coordinate with State level DHS department officials, other Area Agencies on Aging and local partners such as the DHS self-sufficiency office, County offices, and community centers for service and business continuation.

S&DS also provides a critical role in outreach and contact with consumers to identify their status on health and safety during emergencies. During the 2020 wildfires, for example, S&DS called all consumers in impacted areas to identify whether they were safe or evacuated, identify where they evacuated to, and what supports they needed. S&DS then forwarded lists of consumers we were unable to reach to the State APD office and County EOC, along with daily updates of efforts taken. Names of those individuals we were unable to make contact with were then sent to the County Search and Rescue office for further assistance ensuring those consumers were safe. By providing this service, S&DS was able to actively assist the County EOC in freeing up resources to be directed specifically to fire management and recovery, instead of tracking residents of the evacuation zones.

The lists of consumers that should be evaluated for every emergency to identify whether contact is appropriate or necessary includes:

1. Current Consumers under active Case Management
   - High Risk Consumers
   - Facilities Consumers of any risk level
   - In-home Consumers of any risk level
2. Current OPI Consumers
3. Current consumers receiving services from Senior Connections
   - Options Counseling
   - Money Management Consumers
   - Other consumers?
4. Current Consumers receiving services from Senior Meals Programs
5. Consumers in the Eligibility process, or awaiting Eligibility determination

S&DS will keep and maintain a list of names and addresses of the highest risk and vulnerable consumers that receive in-home long-term care services based on their care plan. This list will be updated a minimum of twice a year so that it may be provided to local emergency management agencies in the event of a disaster. Emergency management will be the first responders in the event of an emergency and/or disaster.

The S&DS Senior Meals Program also relies heavily on community partnerships for site location and operation of Meals on Wheels and Café 60 sites. The S&DS Senior Meals Program will close Café 60 congregate sites when it is unsafe for participants to attend. Meals on Wheels service will be maintained for vulnerable consumers where possible after considering the safety of consumers and volunteers. The decision on suspension of service or temporary closure will be made by the S&DS Division Director and Deputy Director, with input from the OAA Program Manager for coordination with the Senior Meals Program Unit Manager, local Site Coordinator, and community partners. Emergency service information will be posted on Flash Alert for the local media to broadcast. Additionally:

- Congregate Meal Sites: Each emergency is different and affects each location in the county differently. While a Meal Site will generally be closed if the local School District closes school for the day during inclement weather, if the local school district is already closed due to summer recess, vacation schedules, or other reason, a separate decision on operation or closure may be made as necessary by the S&DS Division Director and Deputy Director, with input from the OAA Program Manager for coordination with the Senior Meals Program Unit Manager, local Site Coordinator, and community partners.
- Meals on Wheels: Emergency Meal Boxes will be distributed to every Meals on Wheels consumer in November, in advance of the winter inclement weather season. These boxes contain instructions to save the shelf-stable food for use when volunteers are unable to deliver meals. Sites will receive sufficient boxes to supply consumers who start service between

November and February, due to the likelihood of winter inclement weather concerns during this time.

- Rural Sites: Rural Site Coordinators will receive a two-day supply of bulk food for storage in their community to distribute to Meals on Wheels participants in case of Site and Kitchen closure. These meals can be distributed when volunteer assistance is available and in coordination with local community partners.
- Metropolitan Sites: If Eugene/Springfield School Districts are not in session or closed, the S&DS Division Director and Deputy Director, with input from the OAA Program Manager for coordination with FOOD for Lane County and Central Kitchen Manager, will determine whether the Central Kitchen will prepare hot Meals on Wheels for delivery.

S&DS consumers may also receive disaster assistance provided by local entities and Food and Nutrition Services as coordinated with state, local and volunteer organizations which may supplement the services provided and availably by S&DS.

APPENDIX F – LIST OF DESIGNATED FOCAL POINTS/SERVICE LOCATIONS

S&DS services may be accessed at the following locations:

Eugene Office
(Full Service)
1015 Willamette St.
Eugene, OR 97401
Phone: 541-682-4038

South Lane Office
(Limited Service, OAA)
Community Center
700 East Gibbs Avenue
Cottage Grove, OR 97424
Phone: 541-682-4038

Florence Office
(Full Service)
3180 Highway 101
Florence, OR 97439
Phone: 541-902-9430

Junction City Outstation
(Limited Service, OAA)
Viking Sal Senior Center
245 West 5th St.
Junction City, OR 97448
Phone: 541-998-8445

Oakridge Outstation
(Limited Service, OAA)
The Uptown Building
48310 E. 1st Street
Oakridge, OR 97463
Phone: 541-782-4726

Veneta Outstation
(Limited Service, OAA)
Fern Ridge Service Center
25035 W. Broadway Ave.
Veneta, OR 97487
Phone: 541-935-2262

APPENDIX G – PARTNER MEMORANDUMS OF UNDERSTANDING

As S&DS is a Type B Transfer Agency, APD services are offered by S&DS, not through a separate state office. S&DS has a Memorandums of Understanding (MOU) with the local Coordinated Care Organizations, Trillium Community Health Plan and PacificSource Health Plans.

Memorandum of Understanding
Long Term Services and Supports between Trillium Community Health Plans CCO,
Lane Council of Governments Senior and Disability Services, APD District 6 and APD District 7

Medicaid-funded Long-Term Services and Supports (LTSS) are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTSS services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCO's and the LTSS system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long-term care services.

This is a non-binding agreement between Trillium Community Health Plans Coordinated Care Organization (TCHP-CCO), Lane Council of Governments (LCOG) Senior and Disability Services (SDS), APD District 6 and APD District 7 (APD). The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care, in the right place at the right time for beneficiaries across the LTSS system; based on the roles and responsibilities of each entity, recognizing the purpose is to ensure coordination between two systems to provide quality care, produce the best health and functional outcomes for individuals to prevent escalation of costs for both systems.

Based on the good faith description of the roles and responsibilities of the entities participating in the proposed agreement to coordinate care and share accountability for Medicaid funded long term care, Trillium Community Health Plans CCO, Lane Council of Governments and APD Districts 6 and 7 agree to participate in the following activities:

MOU Period: Jan. 1, 2021 - Dec. 31, 2024

CCO Name: PacificSource Community Solutions - Lane

Partner AAA District(s) Names/Locations: This is a non-binding agreement between PacificSource Community Solutions (Lane) ("PCS" or "CCO") and the Lane Council of Governments, Senior & Disability Services (the Area Agency on Aging for Lane County) ("AAA"); hereinafter referred to as AAA. AAA serves the following geographic location: Lane County, Oregon. AAA has agreed to serve Lane County through this Memorandum of Understanding (this "MOU"). The parties agree to conduct this work in accordance with Oregon Health Authority's ("OHA") CCO to LTSS MOU Guidance CY2020-CY2024 guidance document, as that document may be amended (the "OHA Guidance"). To the extent that there is any language in this MOU that conflicts with the OHA Guidance, the OHA Guidance will supersede the language in this MOU.

If more than one AAA office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU_X__

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s): PCS Care Management	**AAA Lead(s): Deputy Director, Community Program Analyst, Safety Unit**
CCO will clearly articulate: How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports ("LTSS"), for example through representation on the governing board, community advisory council, or clinical advisory panel. How affiliated MA or DSNP plan participates in the MOU work for full benefit dual eligible members.	**AAA will clearly articulate:** How AAA governance lead(s) for participation at the community level in the board/advisory panel for LTSS perspective/Care Coordination AAA will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s).

CCO-LTSS AAA MOU:

MOU Service Area: Lane County				
Shared Accountability Goals with AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) —monthly & annual {REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members	• All members are screened annually for health risks via the Health Risk Assessment. Members who have an identified risk are offered Care Management services. • In addition, members are identified via algorithms embedded within our medical management platform if they meet the definition of a Prioritized Population. Prioritized Populations include members who are engaged in LTSS and/or AAA services.	• AAA will provide the CCO with access to information needed to identify members with LTSS and high health care needs. • AAA will share key health-related information including risk assessments, service priority levels, and individuals LTSS care plans generated by LTSS providers and local AAA offices that will assist the CCO in completing a comprehensive individualized care plan for CCO members with	• PCS and AAA's staff will work together to identify individuals with high care needs or with the potential for high care needs that may be avoidable with proactive management by having timely communications regarding members that meet or may meet the high care needs criteria • AAA agrees to share with PCS information regarding in-home service clients that AA's case Managers	• # of members with LTSS that prioritization data was shared during each month/year • Annual average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted • # of CCO referrals to AAA for new LTSS service assessments (for persons with unmet needs)# of AAA referrals to CCO for ICC review • # of completed referrals for ICC review [monthly/year Total]

	• Members who are referred to Care Management are screened for the appropriate level of Care Management. If a member is part of an identified Prioritized Population they may screen into a higher Care Management type. • Comprehensive assessments are completed to determine member needs. If a member is identified as being involved in AAA services or needing LTSS services, PCS Care Management will bring this information to regular (at least monthly) Care Management meetings, or reach out to AAA staff sooner as needed. Names of members who will be discussed at monthly meetings will be provided via	intensive care coordination needs. • AAA will make referrals to the CCO for members with potential need for Intensive Care Coordination ("ICC")/risk assessments as AAA staff identify concerns or gaps or changes in health status.	believe to be at risk due to accepting a lower that authorized care plan, losing housing due to a notice for eviction or involuntary move out, or any other bio-psychosocial factor(s) influencing stability in their current environment. • PCS agrees to share information from community health assessments, relevant behavioral health information pertinent to care coordination, and individual risk assessments of those individuals and communities defined as high risk or a high utilizer with designated AAA staff.	

	email one week in advance (if possible). • PCS will factor in relevant referral, risk assessment and screening information from local AAA offices and LTSS providers. • PCS will ensure AAA staff have contact information for referring members to ICC risk assessment and PCS will have a process to track and follow-up on these referrals. • PCS will have a process to track referrals to AAA for LTSS Needs Assessments.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams PCS and AAA will establish interdisciplinary care teams, consisting of entities such as PCS, primary care providers ("PCP"), (LTSS)	• PCS will provide information to AAA, as requested, using PCS standard risk tools, such as the Member Insight Report, Pre-Manage/Emergency Department Information Exchange, and Truven risk scoring.	• AAA will identify members by using reporting provided by OHA to identify high needs shared members. • AAA, when applicable, will inform the member of collaboration with	• AAA and PCS will jointly identify high-risk members. AAA or PCS can request a plan of care meeting at any time. • AAA and PCS teams will meet, at a minimum, four times per year to address	• # of members with LTSS that are addressed/staffed via IDT meetings monthly • % of months where IDT care conference meetings with CCO and AAA occurred at least twice per month

providers, and AAA representatives as well as other agencies/service providers working with members. The interdisciplinary care teams ("ICT") will coordinate care and develop individualized care plans for mutual high needs members. All members on the ICT must maintain confidentiality.	• PCS, when applicable, will inform the CCO member of collaboration with AAA. When known, PCS will document any member goals and preferences. • Upon request, PCS will provide the plan of care to AAA. Plans of care may include identified problems, interventions, and outcomes as documented by Member Support Specialists, Nurses, and Behavioral Health Clinicians. • Following Integrated Care Management meetings ("ICM"), PCS will document the plan of care, disseminate to community partners associated with the member, and with AAA, and will retain for purposes of tracking activities under this MOU.	PCS. When known, AAA will document any member goals and preferences of care.	high needs members. AAA or PCS may request additional meetings as needed. • AAA and PCS will document care team members and identify a lead from each partner agency in the transition process map document. • AAA caseworkers and the PCS Care Management team will collaborate to determine who would be the most appropriate to have present at care team reviews to develop the plan of care. This may include the CCO member, LTSS facility staff, PCP, AAA, PCS Case Managers, Behavioral Health, and others identified in the member's care.	• Total annual IDT meetings completed by CCO and AAA teams • % of times members participate/attend the care conference (IDT) by month/year • % of members that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)
DOMAIN 3: Development and sharing of individualized care plans				

DOMAIN 3 Goals: Development and sharing of individualized care plans	• PCS's individualized person-centered care or treatment plans will include information about the supportive and therapeutic needs of each member, including LTSS services and supports needs. • Plans will reflect member or family/caregiver preferences and goals captured in AAA service plans as appropriate. • Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA and with LTSS providers and case managers as appropriate. • PCS will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA where	• AAA will share key health-related information including risk assessments, service priority levels, and individuals LTSS care plans generated by LTSS providers and local AAA offices that will assist the CCO in completing a comprehensive individualized care plan for CCO members with intensive care coordination needs. • AAA will actively engage members in the design, and where applicable, implementation of their LTSS service plan, in coordination with CCO where relevant to health care treatment and care planning. • AAA will contact the CCO when they have referrals for ICC or	• AAA and other community partners (as needed) will develop with PCS, individual care plans for designated members that reflect their preference and goals. Clients and/or representatives will be directly involved with this process as appropriate. • All parties will share who the lead person and main point of contact is from each entity, the main point for communication, and who will attend the ICT. • All parties will share changes in assessments or member conditions that require modification of the care plan.	• % of CCO person-centered care plans for CCO members with LTSS that incorporate/document member preferences and goals • % of CCO person-centered care plans for CCO members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties

	relevant to LTSS service planning. • PCS will identify opportunities to focus on preventive approaches, screenings and strategies to reduce unnecessary hospitalizations, Emergency Room ("ER") visits, and maintain or improve the health of members with LTSS. • PCS will track completed care plans for members with LTSS.	have identified gaps or concerns about the health care needs of members with LTSS.		
DOMAIN 4: Transitional care practices				
DOMAIN 4 Goals: Transitional care practices PCS and AAA will develop coordinated transitional care practices that incorporate cross system education, timely-information sharing when transitions occur, minimal cross-system	• PCS will seek opportunities to improve transitions, such as sharing authorization status and other information, to assigned caseworker when applicable. PCS will communicate by secure email or by telephone. • PCS will offer training to AAA staff at least once a year, and as	• AAA will seek opportunities to improve transitions and discuss resource options when available. AAA will communicate by secure email or telephone. • PCS staff will attend APD's annual community partner training. AAA will provide additional	• AAA and PCS will reference the transitional care practices map, which contains current contact information, roles, and responsibilities. AAA and PCS will update the map as needed. Methods of communication will be secure email or	• % of transitions where CCO communicated about discharge planning with AAA office prior to discharge/transition • % of transitions where discharge orders (e.g. DME, medications, transportation) were arranged prior to discharge/did not delay discharge • % of the CCO region to CCO region transfers

duplication of effort, and effective deployment of cross-system nursing and psycho-social resources at any time members experience a transition in their care setting.	additionally requested by AAA, to improve their understanding of referral and authorization processes. • PCS Care Management staff will maintain a log of these events for purposes of tracking activity under this MOU.	training to PCS staff, if requested, to improve their understanding of LTC processes.	telephone as often as needed. • AAA and PCS will identify any cross system resources such as Health Related Services requests that may aid in the member's care.	that communication was made to appropriate AAA office(s) # of debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement process approach) [Q1, Q2, Q3, Q4]
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5 Goals: Collaborative Communication tools and processes	• Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication • Ensure communication methods are detailed and specific to enable regular communication and information sharing across all required domains. • PCS will share how they are using Collective Medical hospital event notifications ("HEN")	• Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication • Ensure communication methods are detailed and specific to enable regular communication and information sharing	• PCS and AAA's work toward utilizing HIT that enables the members of the ICT to assess patient information that is accurate and up to date. • PCS and AAA will use secure systems when sharing information electronically. • PCS and AAA will conduct regular meetings (at least quarterly) to discuss collaborative communication tools and processes to	• # of CCO Collective HEN notifications monthly result in follow-up or consultation with AAA teams for members with LTSS or new in-need of LTSS assessments • # of CCO Collective SNF notifications monthly that result in follow-up or consultation with AAA teams for members with LTSS or new in-need of LTSS assessments • MOU includes written process documents (e.g. prioritization, IDT, care planning, transitions)

	within their organization, for example, to support Care Coordination and/or population health efforts. • PCS will share how they are integrating new Collective Skilled Nursing Facility ("SNF") notifications into care coordination and/or population health efforts and participate in opportunities for joint discussions with Collective and AAA teams on SNF event notifications. • PCS will work to link expansion of provider direct access to event notifications to care planning and care transition processes. As part of the Health Information Technology ("HIT") roadmap (improvement plan), the CCO will identify a strategy to partner with the LTSS system to	across all required domains. • AAA will share how they may be using any Collective HEN information. • Participate in discussions, as appropriate, on any AAA use or monitoring new SNF information (Post-Acute Care) in Collective HEN.	identify challenges or barriers to communication and opportunities for improvement of the process.	that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

	improve upon any existing efforts to share relevant information electronically.			
DOMAIN A: Linking to Supportive Resources				
DOMAIN A Goals: Linking to Supportive Resources	• PCS will share information about how to access Health Related Services requests (formerly Flexible Services). • PCS will share information about the social determinants of health platform "Unite Us" to offer closed-loop referrals for community resources.	• AAA will share what types of resources may be available to support members through DHS (ADRC, SNAP, counseling on Long-Term Care options, Older American's Act services, etc.) AAA will share process by which additional LTSS supports can be authorized (e.g. transportation, safety devices, funds for specific items, special needs, K Plan ancillary services).	N/A	N/A

CCO Name: Trillium Community Health Plan

Partner AAA Names/Locations: Senior & Disability Services
Lane Council of Governments
1015 Willamette Street
Eugene, Or. 97401

If more than one AAA/APD office in your CCO Geographic Region, Please X Whichever Applies: Single Combined MOU: X

CCO Lead(s): Kim Duerst - Director, Medical Management	**AAA Lead(s): Brooke Emery – Deputy Director**
Trillium's governance structure captures the needs of its members receiving Medicaid funded Long-Term Services and Supports (LTSS) through members who provide representation through the Board of Directors, Community Advisory Council (CAC) and Prevention Workgroup. Trillium's affiliated DSNP and MA plans participate in the LTSS MOU work for FBDE. All affiliated plans are within the same electronic platform which supports seamless management of the membership with ease of monitoring and reporting.	AAA Director participates at the community level by attending the Trillium Executive Committee and the Trillium Statewide Governance Board. AAA has an Advocacy Council made up of Advisory Council members. The Advocacy Council will continue to advocate for Medicaid services, LTSS, and Care Coordination in collaboration with the CCOs. This will be accomplished through education and training which results in letters, meetings, and conversations with local, state, and federal legislatures regarding these topics.

CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) —monthly & annual [REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
CCO and AAA will establish routine communication pathways to share information on mutual members that have been identified, and prioritize as having high needs to support timely access to referral (i.e. ICC or LTSS), and resources. Improved communication will	CCO conducts Health Risk Screenings (HRS) within 30 days of identifying a member with LTSS, or part of a prioritized population*, traditionally underserved **, or have a health condition or received a referral. (*older adult, hard of hearing, blind, or have other disabilities; complex or high health care needs, multiple or chronic conditions, SPMI, or receiving LTSS. ** @ risk for inpatient psychiatric hospitalization, receiving intensive mental health		Monthly - CCO and AAA will review # of LTSS members/consumers that completed risk screenings and discuss any issues/barriers to completions at routine	

support in decreasing duplicative effort, while identifying opportunities "to go upstream" with prevention and implementation of care coordination activities that reduce unnecessary ER visits or hospitalizations.	services, or transitioning from Oregon State Hospital) CCO will provide a list of members that could not be reached through all available means to AAA for assistance on other contact information CCO will provide monthly reporting that combines data from authorizations, and claims for physical/behavioral/dental and other key shared initiatives (Hot Spotter) to AAA. CCO will monitor HotSpotter report to identify opportunities for non LTSS members and	AAA will review list of unable to reach to determine if any other information is available for CCO outreach.	Monthly CCO and AAA will review # of members identified as high needs with LTSS. Also will capture # of members per route identified (risk screening/reporting/referral) for opportunities. Quarterly (and as appropriate) CCO and AAA will review # of members	# of members with LTSS that prioritization data was shared during each month/year - Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted

	make referral to AAA or ODDS for service assessment CCO will receive referrals from AAA telephonically or through CMreferral@TrilliumCHP.com for Intensive Care Coordination review and will have a case manager respond within 1 business day CCO will report monthly on members identified (referrals/reporting), screened and accepted/declined Intensive Care Coordination (ICC).	AAA will provide monthly report of members – (Includes assessment scores, SPL, service plan, case worker, and other prioritization data) to CCO to be included in HotSpotter report AAA will report out on status of referrals received at monthly meeting AAA will identify members who have a health condition or are considered a priority population to refer for ICC to the CCO.	referred to SDS/ODDS/MH agencies for new LTSS service assessments and # of members referred for service plan hour increase/change. Quarterly (and as appropriate) - CCO and AAA will review # of members identified as high risk. Of those # of members declined ICC and # of members AAA outreached post decline and accepted. Quarterly (and as appropriate) CCO will report on 1 business day response time (date/time received by	# of CCO referrals to AAA for new LTSS service assessments (for persons with unmet needs) # of AAA referrals to CCO for ICC review # of completed referrals for ICC review [Monthly/Year Total]

		AAA will review reporting of members that declined ICC and determine if outreach from AAA case worker may support member in accepting or identify a barrier to being able to participate.	date/time responded) % compliant	
DOMAIN 2: Interdisciplinary care teams				
CCO and AAA will establish and maintain on-going interdisciplinary care teams, consisting of representation from CCO, AAA, PCP, LTSS, Specialist and other agencies/service providers working	CCO will set up routine cadence of Interdisciplinary Care Team Meetings for at least twice per month. CCO will monitors for changes of condition, transitions of care and other opportunities for care plan updates. CCO will work with the member in identification of	AAA will participate in interdisciplinary care team meetings to support their member. AAA will request ICT meetings when identified as needed, especially during LTSS transitions of	Quarterly (and as appropriate) - CCO and AAA will meet to review # of members with LTSS due for IDT meeting, # of members that decline attendance and participation (and why) # of members ICT not routine by reason (transitions of care)	# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and AAA occurred at least twice per month

with the member. The interdisciplinary care teams will coordinate care and develop individualized care plans for identified high needs, mutual members. Identify processes and resources to support best practices to build care plans and integrated approaches for member supports.	their preferred Interdisciplinary Care Team members. This should include member, member rep, primary care, specialists, and AAA/ODDS/MH and community agencies working with the member. CCO will coordinate formal invitation and set up to the meeting. Capture of attendees/notes/CP update. CCO will encourage and support member engagement in the care planning process to ensure member preference and success of plan CCO will ensure review of preventive screenings, early intervention, management of chronic conditions and wellness are addressed as indicated at each care plan meeting.	care. (i.e. ICF to AFH, RCF to in home)	And review for opportunities to reduce duplication of actions and services	total annual IDT meetings completed by CCO- AAA teams % of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)
DOMAIN 3: Development and sharing of individualized care plans				

CCO and AAA are both required to ensure person-centered care planning processes are in place to address member's needs. The expectation is to reduce duplication of services, assessments and improving member experience and outcomes through more integrated approaches to care planning while maintaining member's self-defined quality of life, choice, control, and self-determination.	CCO's Intensive Care Coordinator will develop in a person centered process written Interdisciplinary care plan (ICP) with member participation and in consultation with any agencies and specialists caring for the member. Care plan should include member's preference on chronic disease management, preventative screenings, medication management, behavioral health assessments and wellness activities to support a successful plan. For members identified as ICC, notification of their status in ICC and the name and contact information of their assigned ICC care coordinator is provided within five days of completing the ICC assessment and care plan must be developed within 10 days of entering into the ICC program	AAA will provide consumer preference from CA/PS to ensure alignment with care plan	Quarterly (and as appropriate) - CCO and AAA will meet to review # of care plans that document member preferences and goals. # of care plans updated every 90 days for relevant parties. – (capture trigger)	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties

	CCO will provide support in determination of underutilization of routine medications or services through reporting. (i.e. no fills on chronic condition meds or lag fills on diabetes supplies) When underutilization is noted, TCHP CM will outreach practitioner to coordinate discussion. CCO will review and update the ICP at least every three months for members on ICC and at least annually for other members, or when condition/need requires CCO will support member's access to specialist through coordination assistance, if needed.			
DOMAIN 4: Transitional care practices				

CCO and AAA will develop coordinated transitional care practices that incorporate timely-information-sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of care coordination and connection to behavioral, psycho-social or social determinant of health resources at any time members experience a transition in their care setting. Identify resources to support evidence-based care transition best practices. Transitions include when member's	CCO monitors for transitions of care through Collective reporting for inpatient and emergency room. Members are outreached and assessed with each transition to ensure current and new needs are quickly addressed. CCO will collaborate on AAA transitions of care to support timely coordination of DME, medications and transportation before discharge date. CCO will monitor members that are relocating to another CCO region and collaborate with local AAA on a warm hand off to the receiving AAA agency. CCO will support member in navigating the social systems with referral to community health workers within the CCO to assist with housing, food	AAA will communicate and collaborate on transitions of care identified within LTSS/Home and Community Based Care supporting least restrictive consumer choice. This is managed through a Transition and Diversion team who review and update through assessment. They will reach out weekly to CCO staff to communicate consumers preparing for transition to ensure that discharge orders are in place. AAA will assist in warm hand off to a	Quarterly (and as appropriate) CCO and AAA will meet to review % of discharges communicated from CCO to AAA prior to discharge/transition % of discharges communicated from AAA prior to CCO discharge/transition. % of transitions where discharge orders were arranged before discharge and did not delay discharge. % CCO region to CCO region transfers that were communicated to the appropriate receiving AAA agency. CCO and AAA will hold debrief meetings when transitions were not smooth to discuss opportunities and lesson learned for quality improvement. (i.e.	% transitions where CCO communicated about discharge planning with AAA office prior to discharge/transition % transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge % CCO region to CCO region transfers that communication was made to appropriate AAA office(s) # of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement

need or wish to change settings of care, service levels, or have an event that changes health status or result in unexpected hospitalizations or emergency room visits.	insecurity, and other social determinant of health needs.	receiving AAA agency	medications, equipment, Home Health, caregiver)	process approach) [Q1, Q2, Q3, Q4]
DOMAIN 5: Collaborative Communication tools and processes				
The CCO and AAA MOU will support two way collaborative communication through agreed upon modalities at times of key events, changes in health status, service priority levels, or changes in location of LTSS service delivery, or other	CCO monitors hospital event and skilled nursing facility notification through Collective. CCO will ensure communication of transition to primary care provider and AAA agencies to collaborate in the reducing hospitalizations, support transitions and to trigger reassessment of needs, if a change of condition.	AAA Transition and Diversion team monitor hospital event and skilled nursing facility notifications through Collective and will notify CCO on members noted as having a change of condition or change to their service plan	Monthly CCO and AAA will review # of hospital and skilled nursing event notifications from Collective or other means that involved AAA for consultation or were recognized as a referral potential for a new LTSS assessment. # of members who return to hospital within 30 days (IP or ED)	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with AAA teams for members with LTSS or new in-need of LTSS assessments # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with

transitions in member's need or level of care.			# LTSS members who trigger for • All Cause Readmission • Avoidable emergency department utilization • Emergency department utilization among members with mental illness • Screening for depression and follow up. • Alcohol and Drug Misuse: SBIRT • Poor control A1c • Diabetes short term complication admission rates • COPD or asthma in older adults admission rate • Congestive health failure admission rate • Asthma in younger adults admission rate	AAA teams for members with LTSS or new in-need of LTSS assessments MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).
OPTIONAL DOMAIN A: Linking to Supportive Resources				

CCO and AAA will support exchange of resource information and referrals to ADRC to support	CCO will collaborate on AAA linking consumers to additional supportive resources to support a holistic and robust coordination approach	AAA will share what types of resources may be available to support members through DHS (ADRC, SNAP, Counseling on Long-term Care options, Older American's Act services, etc.) AAA will share process by which additional LTSS supports can be authorized (transportation, safety devices, funds for specific items, special needs, K Plan ancillary services)	Quarterly CO and AAA will review # of referrals made to DHS (ADRC, SNAP, Counseling on Long-term Care options, Older American's Act services, etc.) for additional resources	# of CCO quarterly referrals to AAA for new ADRC consumers for additional supportive resources # of CCO annual referrals to AAA for new ADRC consumers for additional supportive resources

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APPENDIX H – STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of July 1, 2021 through June 30, 2025, Senior & Disability Services, a division of Lane Council of Governments, 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, Senior & Disability 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 Senior & Disability 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 specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by Senior & Disability 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 of 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

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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. Senior & Disability 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.

March 10, 2021

Date

DocuSigned by:
13540AE4A4644D1...
Emily Farrell, Senior & Disability Services Division Director
Lane Council of Governments

March 9, 2021

Date

Diane Rogers, Chair
Diane Rogers, SSAC Advisory Council Chair

March 9, 2021

Date

Lana Junger, DSAC Advisory Council Chair

March 10, 2021

Date

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Brendalee S. Wilson, Executive Director
Lane Council of Governments
Legal Contractor Authority