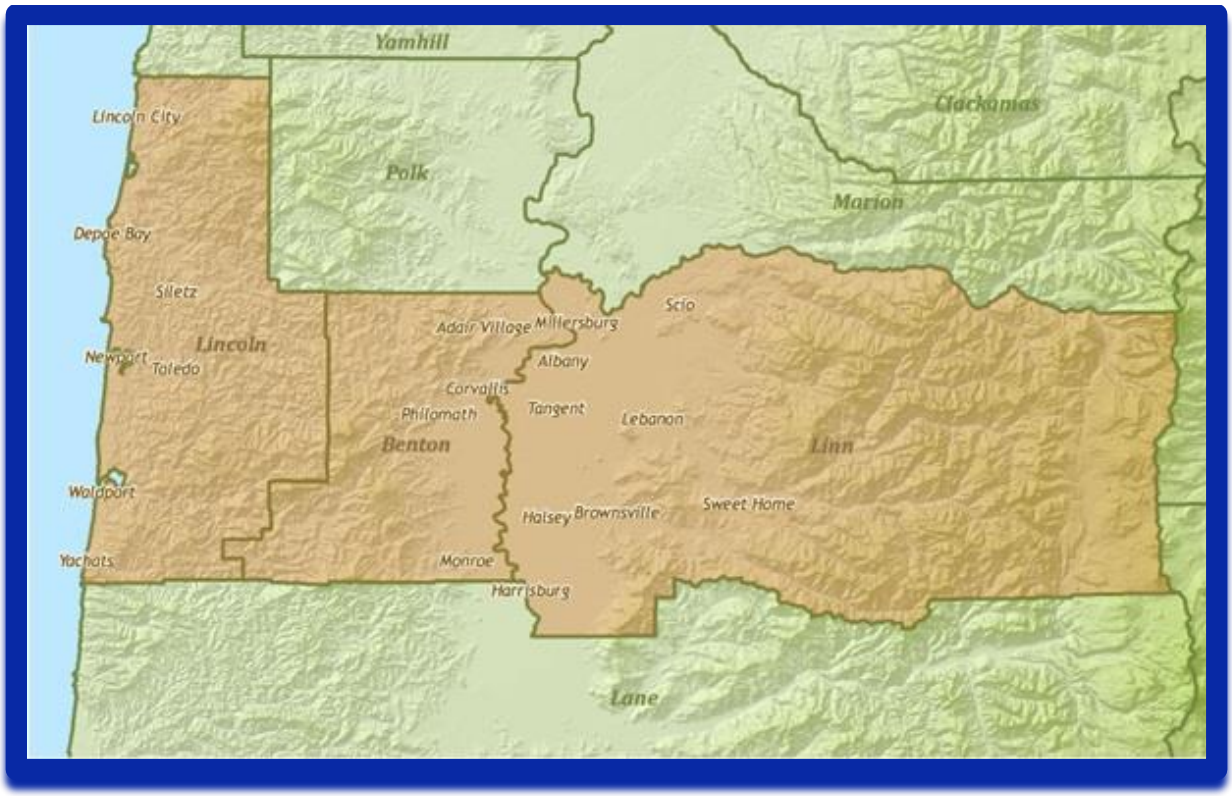
Oregon Cascades West Council of Governments

District 4 Serving Linn, Benton, and Lincoln Counties



Area Plan: January 1, 2017 – December 31, 2020

AREA AGENCY ON AGING AND DISABILITY SERVICES

LINN, BENTON, AND LINCOLN COUNTIES

FRED ABOUSLEMAN

OCWCOG Executive Director

DAVE TOLER

Senior and Disability Services Director

Special Acknowledgements

Disability Services Advisory Council

Senior Services Advisory Council

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Section A: Area Agency Planning and Priorities

A-1 Introduction

Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS) is the designated Area Agency on Aging (AAA) and the designated Type B Transfer organization for the Oregon Department of Human Services (DHS) administering the Supplemental Nutrition Assistance Program (SNAP), Oregon Health Plan (OHP), and Long-Term Services and Supports (LTSS) programs for Linn, Benton, and Lincoln Counties. The organization also staffs the Benton County Veteran Services Office on behalf of the County.

OCWCOG is a voluntary intergovernmental entity of 21 cities, three counties, the Confederated Tribes of the Siletz Indians, and a port district. Geographically, OCWCOG spans from the crest of the Cascade Range to the Pacific Ocean and includes all of Linn, Benton, and Lincoln Counties. OCWCOG, on behalf of its member governments, carries out a variety of local, state, and federal programs.

SDS provides or administers a wide range of services through the Older Americans Act (OAA) funds, Oregon Project Independence (OPI) funds, Medicaid Program Administration funds, and a variety of services operated or enhanced through grants and fundraising activities. All of our services and programs are focused on serving our Region's older adult population, adults with long-term physical disabilities, and veterans.

Our Region has two population centers of over 50,000 residents, while the U.S Department of Housing and Urban Development (HUD) designates two of the three counties in our Region as rural, Lincoln and Linn. A major priority for SDS is to ensure that more rural residents can access the services they need to live as independently as they choose.

Through its *Meals on Wheels* program, SDS administers eleven meal sites throughout the Region, with most of these meal sites located in very rural communities.

SDS takes a holistic approach to serving the Region. Strong partnerships with the regional Coordinated Care Organization (CCO), Intercommunity Health Network (IHN), the county health departments, Samaritan Health Services, and several local nonprofits are critical to achieving this approach.

SDS is a member of the IHN Regional Planning Council (RPC) as well as the RPC's Management Group. The RPC is an advisory panel representing key partners for the CCO in the Region. SDS is contracted by the RPC to coordinate the Citizens Advisory Council for IHN.

OCWCOG works closely with Samaritan Health services through the Hospital to Home Program (H2H) to ensure that individuals discharging from hospitals or rehabilitation centers have a smoother transition back home or into another community setting.

OCWCOG is also involved with the LTSS provider community. Staff work with licensed facilities, community-based agencies providing supportive services, and an in-home provider network to assist in delivering the highest quality services to our citizens.

SDS is committed to ensuring that consumers and the public play a meaningful role in helping to determine the service priorities for the Region, as well as a strong advocacy role in the Region and the State. Over the last three years, SDS has dedicated staff toward the recruitment, retention, and support of the OCWCOG Disability Services Advisory Council (DSAC) and Senior Services Advisory Council (SSAC). Both Advisory Councils have played a key role in developing this OAA's *Area Plan* 2017-2020's agency partner survey and helped define program priorities for SDS. The Advisory Councils have also led a successful effort in establishing a closer partnership with the Confederated Tribes of Siletz.

In order to ensure that SDS can serve the entire Region effectively, SDS has three offices within Linn, Benton, and Lincoln Counties. All offices provide full access for persons with disabilities.

Albany Senior and Disability Services
1400 Queen Avenue SE, Suite 206
Albany, OR 97322
541-967-8630 Voice and ADRC
800-638-0510 Toll free
541-924-8402 TTY
541-812-2581 Fax

Corvallis Senior and Disability Services and Veterans Services
301 SW 4th Street
Corvallis, OR 97333
541-758-1595 Voice
800-508-1698 Toll free
541-758-3126 TTY
541-758-3127 Fax

Toledo Senior and Disability Services
203 North Main Street
Toledo, OR 97391
541-336-2289 Voice and ADRC
800-282-6194 Toll free
541-336-8103 TTY
541-336-1447 Fax

Our offices provide information and/or services to all adults aged 60 and older, and people with disabilities under the age of 65. SDS office structure and procedures are consistent throughout the Region. Residents can access all of the information and resources via a phone call to the Aging and Disability Resource Connection (ADRC), which serves as the front door for all of the SDS resources in the Region. The phone number to reach the ADRC is 541-967-8630 (for Benton and Linn Counties) and 541-336-2289 (for Lincoln County).

In addition to the Senior and Disability Programs, the OCWCOG also serves the Region through the following programs:

Economic Development: OCWCOG provides federal and state funded region-wide economic strategy planning, staffing for grant and loan programs, and project level technical assistance. OCWCOG also provides staffing for projects within the Region. OCWCOG is the federally designated Economic Development District for Linn, Benton, and Lincoln Counties, as well as Lane County.

Transportation: OCWCOG staffs state and federally authorized region-wide and sub-regional transportation planning agencies including the Albany Area Metropolitan Planning Organization, Cascades West Area Commission on Transportation, and Corvallis Area Metropolitan Planning Organization. The organization manages the regional Medicaid Transportation Brokerage through a DHS contract providing non-emergent medical transportation for residents of the region. Additional transportation activities include Pedal Corvallis, a bikeshare program in Corvallis; Drive Less Connect, a statewide campaign to reduce single occupancy vehicle commuting and transportation in the Region; and Safe Routes to School, a program that works directly with school districts to design safer walking and bike-riding paths home for students.

Community Development: OCWCOG provides staffing to assist communities to plan and implement public improvements. OCWCOG staff assists communities, especially smaller communities, with specialized tasks for which they do not have in-house expertise. Examples of work include geographic information systems (GIS) mapping, and planning and interjurisdictional collaboration among communities.

Technology Services: OCWCOG provides staffing to deliver comprehensive, organization-wide information technology management. Services include network implementation, software and web site development, computer and phone maintenance, consulting, and project management for OCWCOG departments and by contract to member governments and other agencies.

General Administration: OCWCOG General Administration provides all human resources, financial, and general agency management services, with the exception of legal services. General Administration also manages member services for all of its member governments.

Copies of the *Area Plan*, in its entirety, may be found at all City libraries throughout the tri-Counties. Questions and comments on the *Area Plan* may be addressed to Dave Toler, Senior and Disability Services Director, 541-812-6008 or dtoler@ocwcog.org.

A-2 Mission, Vision, Values

SDS' mission is to enhance the independence, dignity, choice, and individual well-being for all aging people and people with disabilities in our Region. SDS holds a vision of serving as the regional experts in aging and disability services, and supporting the regional population to maintain health, wellness, and access to programs when needed.

SDS work is guided by several key values.

1. Service equity. SDS strives to serve all who may need our services, including all ethnic, racial, gender, or sexual orientations. It is also critical that the services OCWCOG provides are delivered in a manner that is sensitive to racial, gender, cultural, and sexual orientation so that all members of the community feel welcomed and comfortable when they access services.
2. High quality services. SDS seeks to establish high customer satisfaction and excellent outcomes, as measured by the appropriate evaluation tools for each and every program. In some cases, SDS needs to further develop appropriate evaluation tools to better inform staff of the quality of the program.
3. Innovation. Innovation guides the type of programs provided, the way those programs are delivered, and how programs are funded to ensure sustainability. SDS recognizes the changing world and the need to respond appropriately to those changes, ensuring services for aging and disability services remain relevant and effective community collaboration. SDS' mission to enhance the independence, dignity, choice, and individual wellbeing for all aging people and people with disabilities is only achievable through strong community partnerships throughout the Region.
4. Challenging and rewarding workplace. A challenging and rewarding workplace guides SDS program design and implementation. OCWCOG understands that a high-performance workforce relies on a workplace that encourages creativity, critical thinking, and 360-degree decision-making.

Combating abuse and neglect is a major priority for our organization. SDS is an active member of local Multi-Disciplinary Teams (MDT) within our tri-county Region and the Vulnerable Adult Support Team (VAST) in Linn and Benton Counties. These teams consist of local law enforcement, District Attorney Representatives, County Mental Health programs, Legal Aid Services of Oregon, and other community partners. These groups meet monthly to staff complex Adult Protective Service (APS) cases that challenge us to protect older adults and people with disabilities. These meetings also provide an opportunity for SDS to build stronger relationships with community partners.

Throughout all SDS processes, SDS staff embrace and value a diverse workforce and recognize the importance of full inclusion to all of our programs and services, regardless of race, religion, ethnicity, gender, or sexual orientation.

A-3 Planning and Review Process

The planning process used for the development of this *Area Plan* has been underway since the completion of the last plan in 2013. The needs assessment for this *Area Plan* , conducted over the last four years, is based on a combination of community outreach, input from SDS direct services staff, the DSAC, the SSAC, OCWCOG management, and statistical analysis of our Region's older and disabled population.

SDS staff took three steps to achieve meaningful community input when evaluating need, and developing goals and objectives for this *Area Plan*. Our first outreach was in the form of consumer and community partner surveys. In all consumer survey distributions, individuals living in rural areas, as well as ethnic and cultural minorities in the Region, were included.

The *Area Plan* also focuses our community outreach on underserved populations and worked with members of the Confederated Tribes of Siletz and the regional lesbian, gay, bisexual, and transgender (LGBT) community. Community members were invited to join OCWCOG for discussion regarding improved service equity, and senior and disability related issues. The community forums were advertised in local newspapers, on social media, and on community bulletin boards. Complete summaries of survey, community forums, and focus group data are included (Appendix C).

Staff utilized a variety of data sources to provide information about our Region and current services being delivered. The sources include: U.S. Census Bureau, DHS service, regional demographic reports, OCWCOG's 2012 Work Program and Budget, and the American Community Survey. A complete list of resources can be found at the end of this document.

DSAC and SSAC played an integral role in the development of this *Area Plan*. A subcommittee of the Advisory Councils developed the questions that were used in the Community Partner Survey that was conducted in early 2016.

Advisory Council members helped plan and participated in, community forums and focus groups. The Councils reviewed and voiced their perspectives concerning the general direction of the plan and specific issues during the Council meetings. Staff also utilized both Councils on multiple occasions during the editing and review process. In November 2016, the DSAC, SSAC, and the OCWCOG Board of Directors reviewed the *Area Plan*.

The writing of this *Area Plan* is a cooperative body of work developed by the SDS's management team. This team met regularly throughout the development process to discuss the direction and progress of the *Area Plan*. Program managers, supervisors, and direct service staff were consulted throughout the development and editing of narrative, goals, and objectives.

Included below is a list of community surveys, forums, and focus groups that were conducted to support this planning process.

Surveys

- *Family Caregiver Support Program Consumer Survey*, 2014
  Survey was conducted to understand the program participant's feelings about a newly implemented process for paying for respite services and their satisfaction with the program in general. Information was gathered through one-on-one phone calls with program participants. Ultimately, there was a 67% response rate. Detailed results of this survey are described in Section C: Issue Area 1: Family Caregivers.
- SDS Consumer Survey, 2014
  Survey was sent via paper mail to individuals served within our tri-county Region. The survey was sent to receive consumer feedback on the satisfaction rate and suggestions for improvements from the consumer perspective. The 1,075 completed surveys represented an 18% response rate.
- *Community Partner Survey*, 2016
  Survey was sent via Survey Monkey© to a comprehensive list of community partners in our Region. A partner survey was sent to provide those organizations that SDS works with on a regular basis, a chance to offer their perspective on what SDS was doing well and what could be improved upon. SDS wanted to understand which programs were being used most often. The 62 completed surveys represented a 24% response rate.

SDS Focus Groups

The focus groups were organized to solicit opinions from selected community partners. They were asked to help us by providing specific ideas and suggestions related to service equity, working with underserved populations, and services for older adults and people with disabilities.

- *Corvallis*, 2016
  - 11 LGBT community members and advocates attended along with the SDS Director, the Community Programs Manager, and the OAA Case Manager. (See Appendix D for minutes)
- *Siletz*, 2016
  - 10 Confederated Tribes of Siletz members, staff, and elders attended along with the SDS Director, the Community and Program Support Coordinator, and the Lincoln County Program Manager. (See Appendix D for minutes)

A-4 Prioritization of Discretionary Funding

A small amount of SDS' budget is considered flexible spending or discretionary. Title III-B discretionary funds refer to money available after meeting the minimum Title III-B expenditure requirements. SDS engages in fundraising and grant writing, along with collaborating in community partnerships to maximize discretionary funding. Due to continuous declines in federal funding for programs, it is paramount that SDS develop strong partnerships in the Region to leverage limited resources go as far as possible toward serving those in need of assistance.

Prioritization of discretionary funding and fundraising is led by a basic philosophy that SDS emphasize services for those most vulnerable in our Region. In addition, input from Advisory Councils, consumers, and staff is critical to determining this prioritization.

DSAC and SSAC provided direct input on determining the priorities for discretionary spending. Discretionary spending priorities were set as follows:

- *Meals on Wheels* (*MOW*): current service level along with restoration of frozen meals on weekends
- Behavioral/Mental health supports
- Information and Assistance/Options counseling
- Family Caregiver Support Program (FCSP): respite, supplemental services, and training for caregivers
- Care Transitions: Hospital to Home Program (H2H) - A complete description of this program has been included in Section C-4.
- Expansion of the Money Management Program

Title III-B: Support Services and AAA Administration

The list below illustrates areas in which Title III-B funding is currently allocated and the percentage of the funding allocated to each area.

- Administration and Program Coordination – 10%
- Advocacy – 3%
- Legal services – 10%
- In-Home services – 9%
    - Personal care and chore services
    - Respite
    - Adult day care
    - Home repair and modification
    - Case monitoring
    - Coordination of in-home volunteers
- Access services – 68%
    - Information and assistance
    - Screening
    - Case management
    - Interpreting/translation services
    - Newsletter
    - Information for caregivers of elderly and those serving children
    - Assistance in gaining access to caregiver services
    - Public outreach/education
    - Transportation and assisted transportation
    - Geriatric assessment
    - Telephone reassurance
    - Friendly visiting

Other III-B Services

- Counseling
- Options Counseling
- Registered Nurse services
- Money Management Program*
- Public Outreach

*SDS has a *Money Management Program* that serves our tri-county Region offering a free *Bill Pay Assistance Program*. The program matches trained volunteers with residents to assist with the organization of bills, bank statements, and reconciling accounts with a representative payee program where Money Management staff pay bills, balance checkbooks, and provide and manage personal incidental funds. We can also complete paperwork for residents and submit the annual representative payee reports required by the U.S. Social Security Administration (SSA).

Title III-C: Nutrition Services

Title III-C allows for the provision of both home-delivered meals and congregate dining opportunities throughout the entire Region, as well as the expertise of a dietician, compliance with dietary guidelines, and nutrition education.

C-1: AAA Administration and Congregate Meals
C-2: AAA Administration and *Meals on Wheels*

The *Meals on Wheels* (*MOW*) program, especially home delivered meals, is a high priority for the Region. Historically, the primary funding source for MOWs has been the OAA. However, given that this has been a relatively flat or declining funding source for more than ten years, the program must attract other funding sources in order to sustain at its current level into the future.

These local funds include grants and donations from the community. A resource development plan has been developed with the goal of closing a historical budget gap by July 1, 2018. The development plan includes expansion of individual donations, greatly expanding business sponsorships, and increasing support from governmental jurisdictions across the Region.

Title III-D: Health Promotion and Disease Prevention

The list below illustrates areas in which Title III-D funding is currently allocated:

- Prescription medication education
- Information and counseling related to Medicare Part D
- Evidence based programs:
    - Care Transitions Intervention, Hospital to Home (H2H)
    - Powerful Tools
    - Program to Encourage Active and Rewarding Lives (PEARLS) – mental health program

Care Transitions Intervention and H2H is a priority for OCWCOG. These programs are funded by Title III-D funds, in cooperation with a grant from the Samaritan Health Services Foundation.

Title III-E-Family Caregiver Support Services and AAA Administration
The list below illustrates areas in which Title III-E funding is currently allocated:

- Information and assistance to family caregivers (including grandparents raising grandchildren)
- Counseling and organization of support groups
- Respite
- Supplemental services

SDS prioritizes these services and works collaboratively with community partners to co-sponsor training and workshops for caregivers. SDS has secured grant funds to expand respite services for family caregivers in our Region over the last year and will continue to seek additional funds.

Title VII-A: Elder Abuse Prevention
The list below illustrates areas in which Title VII-A funding is currently allocated:

- Co-organizer of local Multidisciplinary Teams (MDT) and Vulnerable Adult Services Teams (VAST), which meet monthly in all three counties
- Media campaign on elder abuse awareness
- Co-sponsorship of events with community partners about elder abuse prevention

In cooperation with the DSAC and SSAC, SDS will develop media outreach with a theme toward increased community awareness of adult abuse in our communities.

A-5 Conclusion

With priorities set for discretionary spending, it is the intent of SDS to continue focusing on the most economically and socially challenged segment of our communities. All programs prioritized above are free of charge and historical data confirms that these programs primarily benefit more at-risk individuals and families.

Section B: Area Agency Planning and Service Area Profile

B-1 Population Profile

As an Area Agency on Aging (AAA), OCWCOG needs to bear in mind current demographics and emerging trends in order to serve this Region's population in an effective and efficient manner over the next four years. The following information is intended to create a profile of the Region, the demographics, and potential needs.

Characteristics of Seniors Living in Linn, Benton, and Lincoln Counties

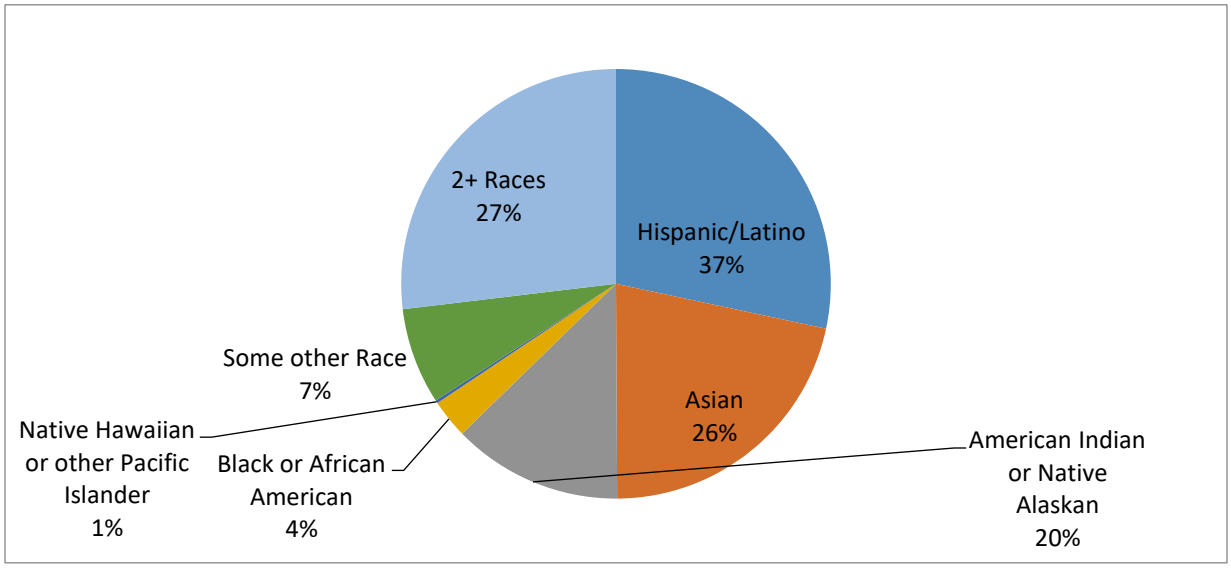
Age
Reported by the 2010-2014 American Community Survey, there were 59,475 older adults age 60+ in the tri-county Region. This accounts for 24% of the total population of these counties. Population trends continue to point to a robust increase in the proportion of older residents in the Region.

Gender
In all three counties, 60+ females outnumber their male counterparts by at least 10%.

Race and Ethnicity
The U.S. Census Bureau categorizes "minority" as any person who identifies as African American, Hispanic or Latino, Asian American, Native Hawaiian or Pacific Islander, American Indian or Native Alaskan, Some Other Race, or Two or More Races. According to this definition, the 2010-2014 American Community Survey reported that 5.6% of our tri-county area's 65+ population is categorized as minority.

Characteristic	Oregon	Benton County	Lincoln County	Linn County
Total Population	3,900,343	86,034	46,138	118,270
60+ population	839,946 21.5%	16,750 19.5%	15,434 33.5%	27,291 23.1%
60+ Female	451,915	8,893	8,330	14,385
60+ Male	388,031	7,857	7,104	12,906
65+ White	547,186	10,784	10,239	18,545
65+ Hispanic/Latino	15,694	213	145	302
65+ Asian	13,753	276	136	90
Characteristic	**Oregon**	**Benton County**	**Lincoln County**	**Linn County**
65+ American Indian or Native Alaskan	4,037	34	119	145
65+ Black or African American	5,387	25	13	30
65+ Native Hawaiian or other Pacific Islander	639	0	5	0
65+ Some other Race	3,667	68	34	67
65+ 2+ Races	7,604	160	175	291
65+ Total Minority	50,781	776	627	925
55+ Siletz Tribal Elders	793	10	217	14
Native American Tribes represented in with Title VI Programs	9	0	1-Siletz Total Pop 5,080	0
65+ Speak only English	541,816	10,577	10,458	18,618
65+ Speak language other than English	40,457	770	263	550
65+ Speak language other than English & speak English “very well”	19,430	556	173	346
65+ Speak language other than English & speak English “well”	7,326	96	48	76
65+ Speak language other than English & speak English “not well”	7,273	94	33	76
65+ Speak language other than English & speak English “not at all”	6,428	24	9	52
Veteran total	150,472	3,400	4,943	2,907
Total Population Living Below Poverty Level	16.7%	22.6%	17.1%	19.5%
Characteristic	**Oregon**	**Benton County**	**Lincoln County**	**Linn County**
65+ Living Below Poverty Level	46,860	878	1,499	681
65+ Living Below Poverty Level & Minority	8,248	92	71	81
Adults with Disabilities	508,577	8,332	9,023	18,113

Older Adults Ethnic Minorities in Linn, Benton, and Lincoln Counties

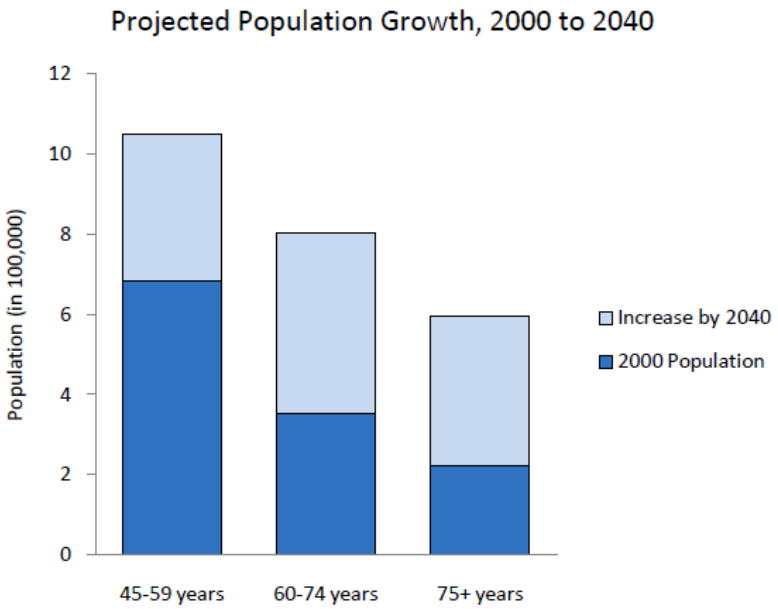


Senior Population Growth

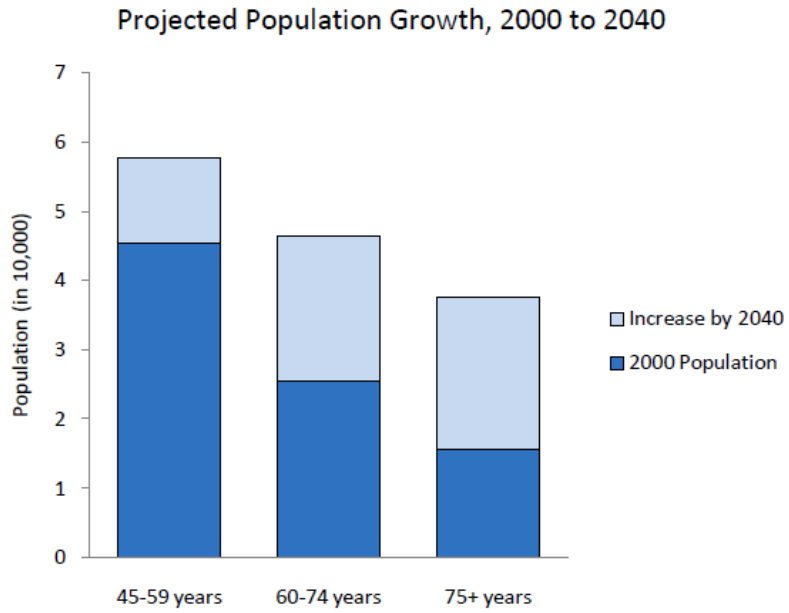
The population of older adults in the U.S. is predicted to increase greatly over the next 30 years. This is due in large part to the Baby Boomer generation entering their older adult years. Population of adults between the ages of 60 and 74 years of age in Oregon is predicted to increase from approximately 350,000 in 2000 to 800,000 in 2040. The population of adults 75+ in Oregon is predicted to increase from approximately 200,000 in 2000 to 600,000 in 2040.

In Linn, Benton, and Lincoln Counties, the population of adults between the ages of 60 and 74 years of age is predicted to increase from approximately 25,000 in 2000 to 45,000 in 2040. In the same three counties, the population of adults 75+ is predicted to increase from approximately 15,000 in 2000 to 35,000 in 2040. By 2040 the population of individuals 75+ in our Region will grow to twice what it was in 2000. The following graphs depict this anticipated population growth.

Oregon



Linn, Benton, and Lincoln Counties



Along with this population growth, the need for LTSS and medical needs will increase. In Benton County, the number of individuals projected to have LTSS needs is predicted to rise from 4,424 in 2010 to 6,514 in 2020 to 7,797 in 2030. Projected increases in the number of seniors receiving Medicaid funded LTSS and other Medicaid assistance goes from 793 in 2010 to 1,168 in 2020 to 1,398 in 2030.

In Linn County, the number of individuals projected to have LTSS needs is predicted to rise from 7,665 in 2010 to 9,844 in 2020 to 12,146 in 2030. Projected increases in the number of seniors receiving Medicaid funded LTSS and other Medicaid assistance goes from 1,374 in 2010 to 1,764 in 2020 to 2,177 in 2030.

In Lincoln County, the number of individuals projected to have LTSS needs is predicted to rise from 4,102 in 2010 to 5,739 in 2020 to 7,037 in 2030. Projected increases in the number of seniors receiving Medicaid funded LTSS and other Medicaid assistance goes from 735 in 2010 to 1,029 in 2020 to 1,261 in 2030.

B-2 Target Population

This list of priority target populations has been developed by combining State required focal populations and those identified by the needs assessment process. Each of the groups identified below represent individuals with unique needs and barriers that may prevent them from accessing services, are at higher risk for health issues, are at a higher risk to be isolated, and will require focused efforts by our AAA to assist them in getting their needs met. This list is not intended to provide a ranking priority. The target populations include:

- Individuals who are low-income and/or members of a minority group
- Older adults and adults with disabilities who live in rural areas and are at-risk for isolation
- Hispanic and limited English speaking
- Adults, age 18 and older, with disabilities
- Older adults who identify as LGBT
- Native Americans
- Individuals with behavioral health challenges, including dementia-related diseases
- Older and disabled Veterans

Oregon's poverty rate averages eight percent overall. In our Region's rural areas, the poverty rate is anywhere from eight to 14 percent. Many SDS brochures are produced in both English and Spanish and are provided to the public in the office and at community events and presentations.

OCWCOG participates in planning efforts, workgroups, community forums, and coalitions that represent and develop programs and policy for target populations. Through these partnerships, SDS staff identify individuals in our Region who are vulnerable, isolated, and financially in need. Some of these groups include the MDT, VAST, self-sufficiency, local senior centers, the Linn-Benton Senior Resource Network, the Homeless Connect program, and the Heart-to-Heart Homeless Coalition, which plans a homeless fair annually with community service groups. This homeless fair is cosponsored by OCWCOG to provide information and assistance.

Through Memorandums of Understanding (MOU) and contracts with partner and volunteer agencies, these organizations agree to refer consumers who are identified as low income, minority, at-risk for isolation, or whom are generally underserved due to their socio-economic status to our ADRC for information and assistance.

The majority of our Region's service area is categorized as rural, and that these areas are more economically challenged, rural citizens will continue to be a major target population for SDS. By working with health clinics, churches and an array of volunteer programs, we strive to identify and serve older adults and individuals with disabilities living in rural areas.

1. Our meals program has 11 meal sites throughout the tri-County Region, the majority of which are located in rural areas to meet the growing needs of seniors who are homebound and at risk for isolation.
2. Another way SDS combats the challenges associated with living in rural areas is by providing medical and non-medical transportation for low-income seniors and younger disabled consumers. These consumers receive transportation through special transportation grant funding in Linn, Benton, and Lincoln Counties. SDS and OCWCOG's Community and Economic Development Department coordinate this work.

A growing population of Hispanic and limited-English speaking individuals reside in our Region. These are vulnerable populations which Information and Assistance staff, including Options Counselors, will focus on while planning outreach and services. One goal is to expand outreach in Newport to Centro de Ayuda, a cultural help center for the Hispanic population in the Region's coastal service area. SDS's Options Counseling staff has taken Spanish translated ADRC and Options Counseling information to Centro de Ayuda and makes regular contact with its Executive Director. Additionally, SDS staff conducts outreach activities across the Region to schools, businesses, healthcare clinics, partner agencies, churches, and volunteer organizations. Many local churches have staff and/or volunteers providing advocacy and support for minority parishioners, with whom OCWCOG provides information and coordinates services for minorities. The SDS main office in Albany has a bilingual receptionist.

OCWCOG SDS is a Type B Transfer Agency, which serves both seniors and people with disabilities. SDS has staff in Albany and Toledo, as well as Corvallis, to meet the needs of a large, younger disabled population in Benton County. The Corvallis office also includes our Benton County Veterans Service Officer. Due to the proximity to Oregon State University, the Corvallis SDS staff is able to engage and increase its visibility with younger disabled adults. As a result, our Medicaid and ADRC staff has familiarized themselves with the needs of younger citizens, which connects our organization to community resources with which we would not otherwise interact.

In 2009, the Benton County Health Department sponsored transgender training for medical professionals on the heels of a 2009 Benton County survey that identified health risks such as depression, post-traumatic stress disorder (PTSD), and anxiety in LGBT individuals. *The Friendly House*, a LGBT focused Portland organization reports:

> LGBT older adults face challenges that their heterosexual counterparts do not. For example, the effect of historical and present-day social stigma and prejudice often cause LGBT older adults to not seek care or services when needed. This stigma can also leave LGBT older adults and seniors isolated or having to face the impossible decision to go back into the closet to seek care, services, or housing. Whereas many older adults and seniors turn to families for care or support, LGBT older adults are more likely to live alone or have inadequate family support networks. Lastly, LGBT older adults and seniors face unequal treatment under laws, programs, and services. All together these challenges make it more difficult for LGBT older adults to achieve three key aspects of successful aging; financial security, good health and health care, and community support and engagement.

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) asserts in their Strategic Plan 2008-2012, that older adults who identify as LGBT may be five times less likely to access needed health and social services because of their fear of discrimination. This illustrates the importance of developing outreach and service delivery methods that alleviate such fear and are culturally sensitive to this growing population.

In the summer of 2016, OCWCOG SDS hosted a focus group comprised of local members of the LGBT community. The focus group highlighted issues that the LGBT felt are important for SDS to consider. Many in the LGBT community are unaware of the variety of services that may be available to them through their local ADRC. It is important that facilities and home caregivers have the training they need to ensure that they are sensitive to the needs of the LGBT community. It was mutually agreed that SDS would strengthen its ties to the LGBT community by sponsoring more events that target the LGBT community.

Along with population priorities designated by the OAA, SDS focuses on Native Americans, who are a part of the Confederated Tribes of Siletz Indians. The Confederated Tribes of Siletz has a major presence in Lincoln County and has tribal members living in Benton and Linn Counties. Lincoln County is also home to tribal members of the Coos, Lower Umpqua, and Siuslaw Tribes. A primary focus of our organization is to partner in activities with the Confederated Tribes of Siletz through the ADRC, Family Caregiver Support Program, and Senior Meals Program. We currently provide congregate meals in Siletz.

Through the development of our ADRC, SDS is preparing to provide information, assistance, and Options Counseling to a growing number of Baby Boomers over the next four years. It is imperative that staff organize SDS services to accommodate the older adult population increase expected over the next 30 years.

Older adults and adults with disabilities, who are facing mental health challenges are also a high priority population for OCWCOG. Perhaps one of the most consistent messages that came out of the surveys and focus groups was the need to address a growing mental health epidemic in the Region, including dementia-related diseases.

Dementia-related diseases are the fastest growing chronic diseases in the nation and yet the health care system is woefully inadequate to address this crisis. While dementia-related diseases are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), generally mental health providers reject treating these conditions. Meanwhile, on the physical health side, few providers are trained on these diseases and consider them as more behavioral health issues and refer people to mental health providers.

In 2016, OCWCOG SDS received a contract for the area's Older Adult Behavioral Health Specialist positions funded by the Oregon Health Authority. The primary objective of these positions is to facilitate a more coordinated health care system for older adults and people with disabilities who need mental health services.

The systemic problems that consumers confront in seeking mental health services are multiple including the lack of providers for Medicare insured people, lack of coverage for Medicare and Medicaid recipients, a delivery system that is culturally insensitive to this population, and a social stigma that is exacerbated in the older generation.

Through the DSAC and SSAC, SDS is making mental health a priority for advocacy.

B-3 AAA Administration and Services

Service System
With a mission to enhance the independence, dignity, choice, and well-being of aging people and people with disabilities across the Region, SDS ensures universal access to a wide spectrum of LTSS. Core functions include administering the Medicaid program and a variety of non-Medicaid funded programs and services.

For the consumer, the ARDC is the doorway to all information and services under the LTSS umbrella. The following identifies the individual services, or service components, that our AAA provides with OAA funding as well as funding from local sources.

OAA and Other Support Services:

1. *Information and Assistance/Referral* – Help individuals, families, and community members connect with needed services, as well as providing information on community resources through the ADRC.

2. *Options Counseling* – Options Counselors help to facilitate planning for individuals and families so they are aware of all service options available to meet their unique situation. This program does focus on those at risk for having to leave their home related to a healthcare crisis or on-going care needs. The Options Counselors complete an assessment of need, provide resource education and counseling, and facilitate client-centered action planning with consumers and their families during a face-to-face visit, usually in the home. Options Counselors assist in creating a client driven action plan, provide short-term assistance, and follow-up with individuals and families.

3. *Legal Assistance* – Utilizing OAA funding, SDS contracts with community partners across the Region to provide 400 hours of legal aid services to persons 60 years of age and older. Consumers call Legal Aid Services of Oregon to make appointments with an attorney. In Linn and Benton Counties, consumer appointments are scheduled one day every month at senior centers in Albany, Corvallis, Lebanon, and Sweet Home. Appointments can also be scheduled at the Albany office of Legal Aid Services of Oregon, in consumers' homes, at nursing homes, or telephone appointments, as necessary. In Lincoln County, appointments are made at the Newport office of Legal Aid Services of Oregon, or at the consumer's home.

4. *Congregate Meals* – The MOW program provides a hot, nutritious mid-day meal along with social and educational activities at 11 meal sites throughout the Region. This program helps prevent isolation and malnutrition in older adults, while they congregate to share meals and continue to feel involved in their community. Recipients are asked for a voluntary donation.

5. *Home-Delivered Meals* – The MOW program provides nutritious, hot meals to homebound older adults and people with disabilities. Due to budget restraints, frozen meals are no longer provided for weekends and holidays. In addition to the nutritional and health value of the program it also addresses isolation, a major social determinant for the health and safety of vulnerable individuals. With each meal delivery comes a friendly smile from a community member checking in on the participant. In the case of forecasted inclement weather, frozen meals and/or freeze dried meals are sent to all consumers in advance. Volunteer telephone trees are used to call all home delivered meal consumers and inform them when there will be no hot meal deliveries and ask if they have any special needs or concerns to report.

6. *Nutritional counseling/education* – As a part of the MOW program, SDS provides nutritional education to our program participants. This is done as a means to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health information. The information on nutrition is delivered to program participants, caregivers in a group, or individual setting overseen by a dietician or individual of comparable expertise.

7. *Elder Abuse Prevention* – SDS continues its campaign to prevent abuse before it begins. Along with the utilization of brochures and flyers in English and Spanish, educational events are organized to raise the consciousness of the public and potential abusers relating to elder abuse. For this planning period, SDS will be focusing on media campaigns that raise awareness about adult abuse in our Region.

   SDS adult protective service staff participate in a monthly MDT meeting in each of the respective counties. This team consists of each counties District Attorney's Office, local law enforcement agencies, legal aid attorneys, and other critical community partners. Time is spent staffing critical individual cases, reviewing adult protective service referrals for prosecution, along with discussing community concerns and strategizing abuse prevention options.

8. *Family Caregiver Support Program* (FCSP) – The FCSP assists unpaid family caregivers by providing supports to ease family caregiver stress and increase coping skills. The goals of this program are to assist family caregivers to successfully meet the challenges of their care giving roll and stabilize care given within the home through continued support, while forestalling placement in a higher level of community care.

   Respite care is provided to family caregivers, general support and information, connection to local support groups, counseling, homemaker services, supplies, and assistance devices. One example of respite care provided is transportation and attendance to the Grace Adult Daycare Center in Benton County.

   Grandparents and relatives who are age 55 and older, raising a blood related child, are also eligible to receive assistance through the program. Provision of scholarships for after school and/or outdoor programs/camps are examples of the supplemental services provided to grandparents in the program.

   The FCSP provides caregiver training to caregivers and their families to support and enhance the care giving role. *Powerful Tools for Caregivers* is an educational class series supported by the FCSP's in our Region. Our FCSP coordinators are trained to facilitate these classes.

9. *Oregon Project Independence* (OPI) provides case management and in-home care services for individuals who are not Medicaid eligible (except for food stamps and the Qualified Medicare Beneficiary program), and are 60 years or older, or younger adults with a physical disability. Services are authorized based on individual consumer needs and may include in-home care, adult day care services, respite, and nursing services.

10. *Advocacy* – SDS provides opportunities for consumer advocates to work with SDS staff, and local and State policymakers, on public policy and program issues. The AAA also works with policy issues and represents the interests of older adults and people with disabilities, as well as their caregivers at local, state, and national levels.

11. *Registered Nurse Services* – Contract services for registered nurses are provided through OAA funding. Contract Nurse Services are intended to provide consultation with consumers and caregivers about medication management, chronic disease management, offer resources for caregiver training, and assist with making contact with their primary care physician as needed.

12. *Money Management Program* – The Money Management Program assists with financial tasks for seniors who need support with their personal finances (i.e. banking, transactions, paying bills, taxes) and are at-risk in the community.

13. *Volunteer Services* – OCWCOG provides an array of opportunities for community members, including older adults and people with disabilities to stay involved in their community. Volunteers participate in decisions that affect them at a state and local level, and provide input regarding needed services and programs. Volunteer experiences also include: meal site volunteers, drivers for home delivered meals, Retired Senior Volunteer Program (RSVP) volunteers throughout the Region, and participating on the DSAC and SSAC.

14. *Retired Senior Volunteer Program* (RSVP) – RSVP's mission is "meeting critical community needs while providing life-changing opportunities for seniors." Under the Corporation for National and Community Service's Senior Corps (Senior Corps), RSVP recruits, trains, and provides volunteer recognition for volunteers, 55 and over, who are interested in National Service. It also provides volunteer liability coverage, uniforms, and mileage reimbursements.

    RSVP's local focus is *Healthy Futures*, a federally defined measure to help keep seniors aging in place independently. This grant metric bodes well at OCWCOG as the RSVP offices are located within its SDS Department, who shares the organizational goal of helping local seniors age in place as the local AAA.

RSVP volunteers provide homebound seniors with access to healthy foods, free durable medical equipment, and senior companionship. RSVP also certifies paraprofessional volunteers that offer unbiased financial assistance and Medicare counseling through its *AARP Tax-Aide* and Senior Health Insurance Benefits Assistance (SHIBA) programs.

15. *Foster Grandparent Program* (FGP) – Volunteers from the FGP serve as mentors and tutors to disadvantaged children in local schools and community programs. Under the Senior Corps Program, the FGP recruits, trains, and provides volunteer recognition for volunteers, 55 and over, who are interested in National Service by serving as a mentor and academic tutor to local youth. It also provides a tax-exempt hourly stipend, volunteer liability coverage, tutoring training, uniforms, meals, and mileage reimbursements. FGP's local focus is increasing academic gains in literacy outcomes, especially among English Language Learners.

16. *Hospital to Home* (H2H) – H2H is a person-centered care transitions program that assists individuals to be more successful in their transition from hospital to their community. The result is healthier communities and lower readmission rates to the Region's hospitals.

16. *Transportation* – The AAA provides access to medical and non-medical transportation for low-income seniors and disabled consumers. Special Transportation Grant Funding in Linn, Benton, and Lincoln Counties is applied for on an annual basis to offer bus tickets to use for those without access to a car and vouchers for gasoline to travel to medical appointments.

17. *Private Admission Assessments* (PAA) – Federal and State law entitles non-Medicaid nursing facility residents to be informed of choices in living arrangements and care options in the community. SDS staff visit these residents and their families, and share information to assist in understanding and choosing alternative placements or supplemental care for meeting their needs.

18. *Program Coordination and Development* – SDS staff provides administrative function support required to implement planned services, negotiate and maintain required contracts, and records for all SDS contracts and funding obligations.

Title XIX Funded Services

The following services are provided through a combination of community partners and OCWCOG, to individuals age 65 and older and persons with disabilities under the age of 65, who qualify based on income and resource criteria and impairment. Except for adult foster homes, OCWCOG has no authority over assisted living, residential care, or skilled nursing facilities.

1. *In-Home Care* – OCWCOG helps with recruiting, hiring, and paying an in-home provider who is employed by the person receiving assistance or hiring an in-home care agency who provides the caregiver. In-home care workers help with light housekeeping, meal preparation, bathing, and other personal care needs to enable individuals to remain in their own homes.

2. *Adult Foster Care* – This care setting provides 24-hour care in a private home that is licensed for up to five residents. The AAA is responsible for conducting licensing activities for these settings on a regular basis.

3. *Residential Care Facilities* – This care setting provides room and board with 24-hour supervision and is licensed for six or more residents. These facilities aid with physical care needs, medication monitoring, and some planned activities. The AAA works with the State to insure quality care in these facilities.

4. *Assisted Living Facilities* – This care setting provides private apartments with meals, housekeeping, and physical care, as needed. These facilities are licensed for six or more residents. The AAA works with the State to insure quality care in these facilities.

5. *Adult Foster Home Licensing* – OCWCOG inspects and monitors adult foster care facilities to ensure they meet State standards for licensing. SDS provides a current list of available facilities and openings on its website

6. *Adult Protective Services* (APS) – SDS's APS investigates complaints of abuse, neglect, or exploitation of older adults and people with disabilities. APS takes appropriate action to protect those living in the community, and reduce risks in their living situation.

7. *Pre-admission Screening and Diversion/Transition* – SDS has a team of trained professionals who assess the needs of older adults and people with disabilities to determine if there is a need for nursing facility care. Screeners take an active role in identifying alternate placements and resources needed to successfully divert and transition older adults and people with disabilities from nursing facility placement. Individuals and their families are assisted in obtaining care that is most appropriate for their needs.

8. *Nursing Facilities* – People who are highly impaired functionally may qualify for nursing facility care. Nursing facilities provide skilled care, rehabilitation, and end-of-life support. Licensed nursing staff is required on site 24-hours per day. The Staff work with each facility and the State to insure quality care for the residents our consumers.

9. *Case Management* – SDS provides a professional assessment of unique needs for each consumer. Case managers work with consumers, and their families, to identify the most appropriate level of care and follow through to assure that care plans are maintained. The SDS staff conducts the assessment, creates a care plan, and reassess on an annual basis to determine if care needs have changed. Staff determines eligibility for services through the Medicaid program.

10. *Food Benefits* – SDS staff determine eligibility for the Supplemental Nutrition Assistance Program (SNAP) and issues monthly benefits to those eligible.

11. *Health Plan Coverage* – SDS' Eligibility staff enroll Medicaid eligible consumers into a medical insurance plan including the Oregon Health Plan (OHP) and a variety of Medicare Savings Plans. In addition, staff provide consultation to Medicare recipients for their Part D (prescription drugs) coverage in accordance with the Medicare Modernization Act.

12. *Special Needs Equipment and Adaptation* – SDS provides medical devices or modifications to promote independence, access, and safety in the home and community for people with disabilities and older adults.

13. *STEPS* – This program is designed for Medicaid and OPI consumers who choose to employ their caregiver. The STEPS program provides education and counseling to ensure the client-employer can be a successful employer with their caregiver.

Please see Attachment C - "Service Delivery Matrix" for more information

B-4 Community Services Not Provided by the AAA

As a Type B Transfer AAA, OCWCOG's SDS has the responsibility to administer the OAA, OPI, and Medicaid LTSS. OCWCOG has had success in piloting new programs, reorganizing existing services to meet community needs, and has a strong commitment to increasing fundraising and grant writing to supplement critical services, such as the MOW Program.

A look forward to this planning period forebodes the strong possibility of significant budget shortfalls facing the Oregon legislature in the 2017-2019 biennium. Unsustainable costs of the Public Employees Retirement System (PERS) will likely continue to erode budgets in 2019-2021. In addition, the U.S. Congress continues to underfund the OAA.

With the rising cost of doing business, the growing proportion of the aging and disabled population in the Region, and the lack of resources from the State and Federal government, real challenges are posed for SDS to sustain services for our communities.

This set of dynamics calls for building strong partnerships with other community organizations. By pooling our resources, we can better ensure that our communities continue to receive the services they need in an environment of increasingly limited public resources.

Partner Programs
Below are program areas where OCWCOG partners to ensure additional services are available throughout the Region. This is in part a statement of what our community needs and a statement of what SDS believes is possible within limited State and Federal resources.

1. *Transportation* – The OCWCOG Community and Economic Development department administers the Medicaid-funded transportation brokerage, *Cascades West Ride Line* for the Region. Between January and December of 2015, *Ride Line* provided 157,221 rides to medically related appointments. These rides were provided to more than 6,500 individual Medicaid consumers. In the first eight months of 2016, 127,873 trips have been provided with the expectation that the number of trips will surpass last year's total. It is anticipated that the number of rides and consumers will increase over the next four-year period.

2. *Senior Companion Program* – Senior companions are helping hundreds of frail elderly and younger disabled neighbors stay in their homes with familiar surroundings for as long as safely possible. OCWCOG is a volunteer station for our regional Senior Companion Program. Their volunteers provide companionship and friendship, provide transportation to medical appointments, the grocery store and social events, and help with other personal errands and tasks for SDS consumers allowing them to live independently and with dignity.

3. *Hospice Programs* – Hospice programs support end-of-life care that emphasizes control of pain and other symptoms, as well as providing emotional, spiritual, and psychological support, so that patients may spend their remaining life in dignity and comfort. Hospice agencies in our Region partner with OCWCOG in many ways including working closely with case managers, working with consumers facing end of life issues, and with our FCSP staff supporting caregivers with training and support.

4. *Community Action Program* (CAP) – OCWCOG works closely with the CAPs in the Region to link consumers with housing, transportation, and food resources. CAP's are also a critical resource for energy assistance, especially during the cold season.

5. *Independent Living Centers* (ILC) – ILC's are 501(c)(3) non-profit organizations administered by persons with disabilities. They are non-residential, community-based centers where people with disabilities can receive assistance with an array of independent living services from people who have had similar experiences living with a disability. The centers serve people with all types of disabilities and, with some exceptions, do not charge for their services.

   Benton and Linn Counties do not have an ILC funded by State or Federal funds. Over the years there have been attempts to create a core group of advocates as well as a funding base to support a program, but the gap remains. In Lincoln County, a small nonprofit, *Progressive Options*, works to provide a limited service to people with disabilities. SDS staff in Lincoln County work to coordinate on service issues and requests for help. When the DHS funded *Employment Initiative* was available, SDS staff was able to assist with additional services such as preparing resumes, interviewing skills, and job searches. This is a gap for those with disabilities who have difficulties finding support and advocates.

6. *Health Care Providers* – Most of the consumers served by SDS are confronted with varying levels of physical and/or behavioral health issues. Health care utilization data across the nation illustrates that the largest users in the health care system are individuals who are dual eligible for both Medicare and Medicaid. The dual eligible consumers are our older and most economically challenged segment of our communities and therefore can often have complex health issues.

   The better SDS can coordinate and partner with health care providers, the more likely we will be able to accomplish the triple aim of better health, more accessible health care, and lower cost care.

Service Gaps

OCWCOG recognizes the need to better support housing and transportation but does not receive any significant funding to address these issues. Service gaps identified:

1. *Housing* – While community partners do provide a limited amount of rental assistance to older adults and adults with disabilities, the demand outnumbers the supply. There are many who reach out to SDS searching for more affordable housing or assistance to pay for their current housing. In many cases SDS recognizes that consumers do not receive the help they need.

2. *Transportation* – While transportation for medical appointments and other health care related activities has become prevalent for low income individuals, transportation for other critical purposes including banking, shopping, physical activity, work/volunteering, and social interaction are often unavailable.

3. *Mental Health* – Many Medicare recipients have little to no access to mental health services. Services for Medicaid recipients can also be limited. Those with dementia-related diseases find it particularly difficult to access effective services. Most mental health providers will not treat for dementia diseases and often lack the training necessary to provide effective treatment. In addition, physical health providers are often also not trained for dementia diseases.

Section C: Issue Areas, Goals and Objectives

The Oregon State Unit on Aging (SUA) has identified the Issue Areas for our region's target population. Issue Areas address national and state concerns and priorities identified in the Older Americans Act (OAA), the OAA State Plan and the State Agency's strategic plan.

C-1: Local Issue Areas, OAA and Statewide Issue Areas

1. Issue Area: Family Caregivers Support Program (FCSP)

Profile:
The FCSP assists family caregivers in their expanding roles by providing program components that will ease family caregiver stress and increase coping skills. Goals of the program are to: assist family caregivers to successfully meet the challenges of their care giving roles; stabilize care giving within the home through continued support; and forestall placement in a higher level of community care. There are currently 180 individuals in our Region enrolled in FCSP. FCSP coordinators do a home visit with all new consumers to discuss their needs and help identify resources that will ease family caregiver stress and increase coping while supporting their individual choice. At this home visit the coordinator collects info on the caregiver and care recipient, including ages, relationships, and diagnoses.

The FCSP caters to non-paid caregivers caring for individuals over the age of 60, grandparents over the age of 55 caring for a grandchild 18 years of age or younger, and adults of any age caring for an individual, of any age, with Alzheimer's or a related disorder. FCSP coordinators work with many community partners and other SDS programs to find solutions to what can seem like overwhelming situations. Our FCSP is often a resource for APS staff by helping support at-risk families caring for seniors and individuals with disabilities in our communities.

The designation of Program Coordinators for the FCSP in each SDS office has assisted in raising public awareness and visibility of the program, increased utilization of the program, and made it possible to offer a more coordinated set of community activities.

The FCSP has made a concerted effort to provide critical services at no cost. Taking care of a loved one can be challenging and without adequate support, caregivers may end up with compassion fatigue. Many family caregivers have clinically significant symptoms of depression. FCSP links caregivers with helpful support and resources to combat such serious concerns.

The FCSP targets low income and at-risk individuals. The program conducts community outreach to a variety of social service and Medicaid health care providers to ensure that they are aware of the FCSP. Referrals to the FCSP are received through the ADRC, from a variety of partner agencies, and members of the community.

FCSP Program Coordinators are certified *Powerful Tools for Caregivers* facilitators, an evidence-based support and education group that lasts six weeks, meeting once per week for sessions of two and a half hours. This gives caregivers the opportunity to gather with others in the community in similar situations. Over the course of this class, caregivers troubleshoot, learn coping techniques and skills, and form connections.

One objective of the FCSP is to help caregivers acquire the equipment, supplies, home repair, and adaptations needed to provide care to the best of their abilities. Generally, Program Coordinators try to link individuals with durable medical equipment providers to meet these needs. A portion of FCSP funds are allocated to help or share the expense of medical equipment and supplies such as wheelchairs, walkers, hospital beds, incontinence products, masks, cleansing cloths, or gloves. Funding can also be used to make minor home repairs or modifications such as wheelchair ramps, handrails or bath bars, emergency response systems, and pay for MOW, as well as equipment and services which make caregiving more efficient and successful.

The FCSP often partners with community agencies to host educational and motivational activities for caregivers. OCWCOG SDS hosts multiple *Family Caregiver Recognition Day* events in celebration of National Caregiver Month, held annually in November. At these celebrations caregivers receive support, resources, and recognition. Grandparents, and other relatives raising grandchildren, are invited to an annual seminar which provides information focused on raising grandchildren and the option of a weekend retreat, *A Gift of Time*, which provides respite care.

The seven core elements of the FCSP were considered when planning the program.

1. *Information services and group activities* is accomplished by knowledgeable Program Coordinators who consistently provide educational information and brochures for community services relevant to each consumer.

2. *Specialized family caregiver information* is addressed during the first face-to-face visit with a Program Coordinator and on an as needed basis thereafter.

3. *Counseling* can be paid for with program funding and is referred out on an as needed basis. Program Coordinators are available to help caregivers navigate their health insurance options to help pay for services.

4. *Training* is provided on an individual basis or in group training as needed. Program Coordinators are also interested in helping caregivers get specific training they need. Caregivers have participated in a variety of trainings from CPR to *Powerful Tools for Caregivers* to Alzheimer's care training.

5. *Promotion of support groups*, in partnership with the Samaritan Health Services, our Lincoln FCSP Coordinator facilitates two Caregiver Support groups. FCSP connects clients with support groups to share experiences and problem solve with others in their community going through similar experiences. Such support groups help individuals realize that they are not alone.

6. *Respite care services* provides caregivers a break, whether in or away from the home, it increases the quality of care they are able to provide. Through this program, respite care providers are able to provide personal care, meal prep, transportation, and companionship. Benton County is home to one of the few adult day services in Oregon, the *Grace Center*. This is a service and facility strongly encouraged and supported by FCSP Coordinators. Our AAA contributes funding to the *Grace Center* and conducts annual evaluations to ensure the best care for consumers. For grandparents caring for minors, respite care has come in the form of paying for summer camp or similar activities for their grandchildren.

7. *Supplemental services* include a wide range of activities, such as payment of monthly monitoring fees for an emergency response system, home delivered meals, assistance buying school clothes, and caregiver massages.

In a 2013 study, AARP estimated there are about 40 million family caregivers in the U.S. providing an estimated 37 billion hours of care to an adult with limitations in daily activities. The estimated economic value of their unpaid contributions was approximately $470 billion, more than all Medicaid spending in the nation.

Problem/Needs Statement:
A Caregiver Support Survey was mailed to participants in 2010 and a phone survey was conducted in 2014 of participants in the FCSP in Linn, Benton, and Lincoln Counties. Results from the survey showed that people appreciated assistance with paying for respite and having someone to call to get resource information and emotional support. Fifty-seven percent of those who received respite care commented that they needed a longer break. Since the survey, this has become a focus area in the program. Caregivers were given a chance to comment on what they experience mentally and emotionally throughout the caregiving process. These answers ranged broadly from joy to exhaustion, and everything in between. When asked, what is most helpful to caregivers, the vast majority prioritized respite care and encouragement/emotional support at the top of their list.

Because the FCSP Coordinators meet directly with the individuals they serve, initially and then on an as needed basis, consumers can describe exactly what they need. SDS recognizes that families with different backgrounds or styles of living have a wide variety of needs. The flexibility of the FCSP allows each caregiver to get individualized assistance. Program Coordinators are able to assist caregivers with a one-time change or set-up ongoing assistance, such as respite care or emergency response services. The program strives to help each consumer be successful within the structure of their beliefs and culture.

When providing services through the FCSP, Program Coordinators work hard to provide culturally relevant services. As identified in 2011, U.S. Census Bureau data highlighted in *Section B: Planning and Service Area Profile*, 354 individuals 60+ in Linn, Benton, and Lincoln Counties report speaking a language other than English and speaking English "not well" or "not at all". This equals less than one percent of our 60+ population. To better serve individuals with limited English proficiency, SDS produces materials in Spanish. Bilingual staff and translation services are also available when necessary. Our Lincoln County FCSP Coordinator regularly coordinates with the Elder's Program of the Confederated Tribes of Siletz Indians. Tribal members are invited to attend all family caregiver activities.

Lincoln and Linn Counties are classified as rural counties by the U.S. Census Bureau; because of this, family caregivers are at higher risk for isolation. The National Institute of Aging reported in 2004 that female family caregivers are 2.5 times more likely than their non-caregiving counterparts to live in poverty and five times more likely to receive Supplemental Security Income (SSI). Outreach to rural senior centers, community bulletins, and information spread through the Home Delivered Meals program helps identify isolated caregivers who may benefit from enrolling in the FCSP.

FCSP Coordinators are working toward the goal of reaching out to underserved grandparents caring for grandchildren through partnerships with DHS, schools, organized summer programs, and local child focused agencies.

As with many SDS programs, this program creates change on an individual, community, and state level. The Program Coordinators serve on the State of Oregon Family Caregiver Advisory Board and the State Relative as Parents Advisory Board. Attending the Advisory Board meetings allows Coordinators to gather new resources, make network connections, and hear ideas to utilize in our community program.

The largest limitations to FCSP are limited budget and low staffing. Along with many SDS programs, coordinators stretch the budget by partnering with community organizations and encouraging caregivers to pursue other avenues of support, which can be paired with that of the support received from the FCSP.

One gap in service is support for seniors caring for children who are not blood relatives. For example, SDS has one case involving a grandmother caring for three grandchildren, one blood related and the other two half siblings of the first. To stay within the mandates of the FCSP, she is only allowed to receive assistance for one of her three grandchildren. This also becomes a problem when considering non-traditional families.

Goals & Objectives

Issue Area: Family Caregivers					
Goal #1: Increase enrollment and involvement of grandparents raising grandchildren in Lincoln County FCSP.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Provide additional outreach to seniors raising grandchildren	a. Outreach to these populations through local media including newspaper, magazines, and radio	FCSP Coordinators	1/17	12/20	
	b. Network with local organizations specializing in working with at risk children including: DHS, Self-Sufficiency, Child Welfare, local school districts, CASA, YMCA, the Boys and Girls Club, and other afterschool activity programs		6/17	12/20	
	c. Further educate 2-1-1 and the ADRC call specialists about FCSP to increase promotion and referral from these services		1/17	12/20	
2. Continued development of grandparents raising grandchildren support groups	a. Continue to market existing group in partnership with Old Mill Center to grandparents who are already on FCSP and encourage additional enrollment	FCSP Coordinators	8/17	12/20	
	b. Develop an additional group for grandparents raising grandchildren in east Lincoln or Linn County		1/18	12/20	

	c. Support partner agencies with funds for respite and supplies		7/17 12/20	
	e. Gather educational information and compile support group topics		1/17 12/20	
Goal #2: Provide recognition to caregivers.				
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe: Start Date / End Date	Update
1. Continue Community Caregiver Celebrations	a. Research and book educational and supportive presentations	FCSP Coordinators	1/17 12/20	
	b. Include relaxation techniques and practices into the celebration		1/17 12/20	
	c. Continue building relationships with community members to strengthen partnerships		1/17 12/20	
Goal #3: Increase involvement in the FCSP minority populations and LBGT community.				
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe: Start Date / End Date	Update
1. Outreach to Hispanic population	a. Partner with Centro De Ayuda	FCSP Coordinators	7/17 12/20	
	b. Partner with Self Sufficiency and DHS through regional meetings		1/17 12/20	
	c. Partner with local churches		1/18 12/20	
2. Outreach to the LBGT Community	a. Partner with Friendly House, a SAGE Affiliate in Multnomah County	FCSP Coordinators	7/17 12/20	
	b. Strengthen partnerships with LGBT Focus group initiated in 2016		1/17 12/20	

	c. Research and contact organizations working with our target population		1/18 12/20	
3. Increase community presentations to targeted populations	a. Attend local Latino Festivals in all three counties.	FCSP Coordinators	1/17 12/20	
	b. Attend local Pride events		1/17 12/20	
	c. Work with the Siletz Tribe to be visible at their community events		1/17 12/20	

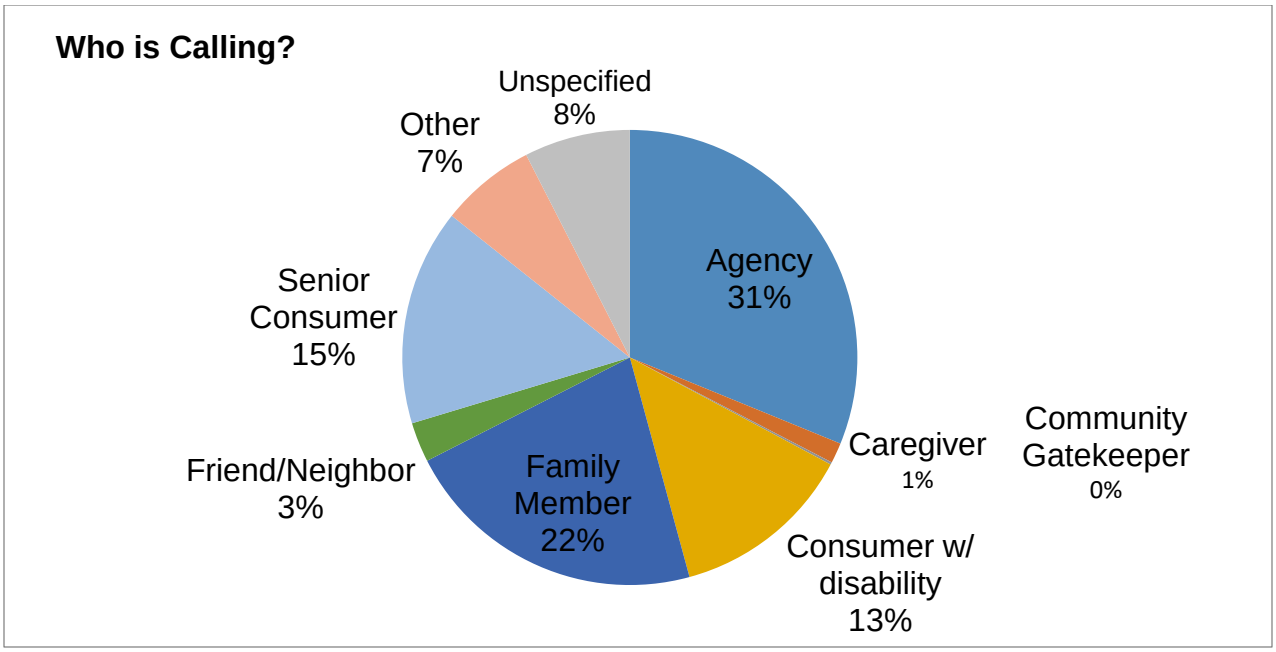
2. Issue Area: Information and Assistance Services and ADRC

Profile:
OCWCOG is a fully functioning ADRC, the public gateway to all aging and people with disabilities information and services. The ADRC offers the public a one-stop phone and in-person, "shopping" experience for SDS services. OCWCOG has committed the necessary funding and staff to maintain an ADRC, including Information and Assistance, available Monday through Friday, eight hours a day, Options Counseling, Care Transitions services, and facilitating access to public and private LTSS.

ADRC Specialists provide assistance to callers and walk-in consumers concerning a wide range of services including: in-home assistance, care facilities, family and caregiver support, peer counseling, transportation, home-delivered meals, personal medication alerts, Medicare counseling, medical equipment, healthy living programs, legal services, and more. The ADRC was designed to streamline access to home and community supports and services.

In the first six-months of 2016, the ADRC received 4,769 calls in total, of which 3,242 were unduplicated individuals. The following table and chart describe who is calling the ADRC line.

Caller	Total	Percent
Agency	1,487	31
Caregiver	69	1
Community Gatekeeper	8	0
Consumer with a Disability	619	13
Family Member	1,036	22
Friend/Neighbor	135	3
Senior Consumer	733	15
Other	323	7
Unspecified	359	8



The table above shows how the ADRC has received contact from community members over the six-month period. The most common method of contacting the ADRC was by phone, followed by email, and in-person visits.

Method of Contact	Total	Percent
Email	646	14
Fax	89	2
Mail	36	1
Phone	3,812	80
TTY	2	0
In Person	114	2
Other	70	1
Unspecified	0	0

The following table breaks down ADRC contacts by purpose. The majority of contacts with the ADRC are looking for referrals.

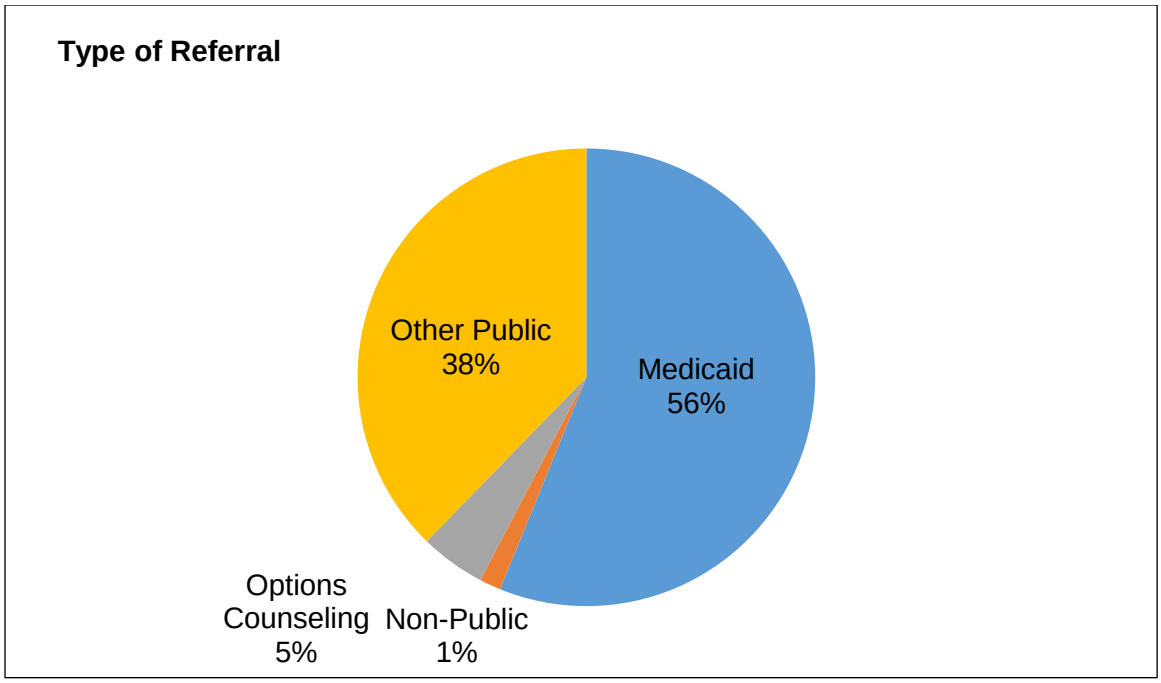
Type of Call	Total	Percent
Assistance	675	14
Information	648	14
Referral	3258	68
Unspecified	188	4

The following table displays ADRC contacts by referral source. This table provides information about which forms of outreach have been most effective and which should be expanded.

Referral Source	Total	Percent
1-855-OREADRC	102	2
AARP	0	0
ADRC	47	1
Alternative	21	0
Brochure	2	0
Family Member	77	2
Friend/Neighbor	118	2
Home and Community Based Services/Social Service	1,072	22
Hospital	349	7
Independent Living	1	0
Internet Website	38	1
Library	0	0
Doctor/Health Professional	255	5
MDS Section Q	0	0
Newspaper	0	0
Nursing	157	3
Radio	0	0
Rapid Needs	7	0
Self	1,417	30
Senior Center	32	1
Social Worker	114	2
Television	0	0
Other	138	3
Unspecified	377	8

The referral tables and chart above demonstrate where ADRC Specialists have referred contacts over the past six months. It is important to note that specialists do not only refer individuals to in-house services, but also to other community agencies. ADRC Specialists provide referrals to the service that best suits the needs of the caller.

Type of Referral	Total	Percent
Medicaid	2,006	42
Non-Public	54	1
Options Counseling	165	34
Other Public	1,347	28



Due to very limited funding, ADRC outreach efforts are far less than they could be. With no funding from the Oregon Legislature and decreased funding from U.S. Congress, via the OAA, for Information and Assistance, the OCWCOG has reached its capacity to field calls.

All contacts, including referral sources, are tracked in the ADRC call module. The call module database provides reliable and accessible information on areas needing improvement in marketing our services. In addition, the ADRC has an interagency agreement with the *211info* program operated in Portland. The *211info* program refers callers who are looking for resources or services related to older adults or people with disabilities to the ADRC for expert help and in-depth assistance.

ADRC Specialist staff makes up our Regional Call Center, serving Linn, Benton, and Lincoln Counties. The Information and Assistance staff are certified by the *Assistance and Information Resources System*, the nationally recognized accreditation for Information and Assistance work. New Specialist staff take the exam toward certification within a year of joining the ADRC unit. As well as assisting the State in the creation of their standards, OCWCOG has created additional standards the ADRC Specialists follow in an effort to provide consistent information and assistance across our Region.

The ADRC staff record all contacts in the RTZ call module and provide resource information from the resource database. Individuals are then referred to the appropriate program or community resource that fits their unique situation.

Often consumers who receive information and assistance may need a more in-depth exploration into their situation and the potential resources that may assist them in reaching their goals. In this case, they are referred to an Options Counselor. Options

Counselors are knowledgeable individuals available for face-to-face sessions, either in a community member's home or in one of our offices. These qualified professionals assist consumers in determining what care options best fit their specific needs. Together, consumers and Options Counselors assist the consumer making an informed decision about LTSS and meeting their personal goals. The SUA, Portland State University (PSU), and the AAA in the ADRC pilot sites developed a set of standards to provide consistent delivery to all consumers.

Options Counselors use the *Care Tool* software program to document Options Counseling consumer assessments and action plans. The *Care Tool* is also used to track all Options Counseling activities for state and federal reporting.

Options Counselors also play a role in transition support, and have a strong understanding of functional assessments and transition support services. At the initial contact and follow-up as needed, staff assesses the consumer's need for transition support and provides whatever information and referral is most appropriate.

OCWCOG also has an active Care Transitions Program, H2H, in partnership with the local healthcare system, Samaritan Health Services. The program is based on the Care Transitions Intervention (CTI) developed by Dr. Eric Coleman. CTI, an evidence-based model, has proven to reduce readmission to hospitals within a 30-day period for the same diagnosis. In 2016, OCWCOG began contracting with Samaritan's Albany General Hospital to provide H2H to their discharged patients.

SDS has an established referral process for PAA in all seven nursing facilities in the Region, through a contract with DHS to perform assessments and assist consumers in their transition from nursing home care. In addition, residents in nursing facilities who identify a desire to know about options for leaving the nursing facility and moving to a lower level of care are referred to the ADRC. Diversion Transition Case Managers or Options Counselors work with the facility, the resident, and families to assess care needs and start transition support and action planning.

As a Type B Transfer AAA, OCWCOG has the advantage of assisting ADRC callers to enroll in Medicaid and SNAP programs. Information and Assistance staff work closely with Medicaid Eligibility staff and Medicaid Case Managers so that ADRC consumers receive the right resources. Quality assurance and improvement measures are implemented through review of the call routing system data, the call module data, resource database entries, and ADRC standards developed and improved through monthly review and unit meetings with key staff.

Through the RTZ reporting system and accurate use of the standards for data entry, staff gather call summary data to identify trends in consumer needs (i.e. Medicaid, non-publicly funded services, Options Counseling, other public services), gaps in our local resources, and performance measures. All ADRC call data is entered and tracked in the RTZ system. Option Counseling activity, outcomes, and follow-up are entered solely through the *Care Tool*, and is added to *Oregon Access* for State funding reporting as

well. The data collected will include any referrals made for people seeking a return to the community from nursing facilities via the Nursing Facility Resident Assessment - Section Q referrals and Options Counseling activities that stem from these referrals.

SDS Program Managers and direct Supervisors review key data at the call center level to determine staffing needs and analyze the information at unit meetings in order to identify trends and areas requiring improvement.

SDS uses the ADRC call module 100% of the time in order to capture required data. The call module data helps maintain accurate and consistent internal reports, as well as reporting through our Statistical Analysis of Rates and Trends (SART) system.

SDS has key staff responsible for maintaining our resource database, outreaching to new community agencies, and updating existing community information. Staff has participated in training, onsite testing, and provided feedback for improvements on the call module, care tool, and resource database.

SDS will continue to work in recruiting area partners of the ADRC. Already, the ADRC enjoys consistent partnership with Linn County Mental Health, Benton County DD services, the Siletz Confederated Tribes, and Inter Community Health (CCO), all of whom regularly attend the monthly ADRC council meetings.

As a Transfer AAA, OCWCOG is able to utilize Medicaid funding to continue supporting this effort. In addition, OCWCOG is working with Health Care insurance/providers for additional funding.

Problem/Need Statement:
The ADRC is intended to be a N*o Wrong Door* experience that consumers can rely on with one phone call, internet contact, or stop to the office. Yet, there are still many instances when consumers who enter OCWCOG through one door are sent back with ADRC contact information for other issues. During this Area Plan period, it is SDS' intent to train all staff on the *No Wrong Door* approach and to effectively implement it throughout the organization.

There are programs within SDS, such as the Veterans Service Office (VSO) in Benton County, that are not well-connected to other SDS programs. Therefore, Veterans may not be getting useful information about services that may be of great assistance to them or their family. SDS will be working to establish effective referral protocols so that these veterans are fully aware of potential resources and programs.

ADRC lines are open 9:00 am – 5:00 pm, Monday - Friday.

Goals & Objectives

Issue Area: Information and Assistance Services, and ADRC.					
Goal #1: Ensure a *no wrong door* experience for all consumers.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Ensure that once consumers contact any SDS staff, they will not have to call another number to get assistance	a. Develop internal referral process for all SDS staff	Info and Assistance Supervisor	11/16	12/20	
	b. Provide training as needed to staff	Program Managers	11/16	12/20	
Goal #2: Ensure accurate database with 100% updating each year.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Maintain 100% ADRC consumer database annually	a. Task staff with updating database to ensure it is 100% updated each year	IA/IR Supervisor		12/20	
Goal #3: Ensure that veterans in the Veterans Service Office of Benton County are included in ADRC internal referral process.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Increase number of veterans in Benton County VSO that receive referrals and service from SDS	a. Develop internal referral process for VSO staff	Program Supervisor (IA/IR and VSO)	9/16	12/20	
	b. Provide training for VSO staff as needed	Program Supervisor (IA/IR and VSO)	10/16	12/20	

3. Issue Area: Elder Rights and Legal Assistance

Profile:
SDS recognizes that protecting the rights of older adults and people with disabilities, and preventing abuse, neglect, and exploitation is a large part of the responsibility of an AAA. Due to the seriousness of these issues, elder rights is a high priority. OCWCOG continues to develop and support programs that focus on public education and the rights of our senior and disabled population. SDS will continue to provide funding to legal services contractors that is above and beyond the level required.

SDS works with community partners to increase the public awareness of abuse, neglect, and exploitation. One way of accomplishing this is by partnering with monthly MDT meetings in Linn, Benton, and Lincoln Counties. During these meetings, each counties' District Attorney's office, local law enforcement agencies, legal aid attorneys, and other critical community partners are in attendance. Time is spent staffing critical individual cases, reviewing adult protective service referrals for prosecution, along with discussing community concerns and strategizing abuse prevention options. In addition, OCWCOG has an MOU between Legal Services and APS is in place to ensure effective coordination and cross referrals between partner agencies.

SDS works collaboratively with agencies such as the *Long-Term Care State Ombudsman Program*, county mental health programs and community crisis services. Training is periodically provided by SDS's APS team to various community organizations and nursing facilities on protective services and elder rights.

As a Type B Transfer AAA, SDS has the advantage of housing Information and Assistance, Medicaid Eligibility, Medicaid Case Managers, Family Caregiver Support Specialists, OPI Service Coordinators, and Adult Protective Services staff under one roof. Internal referral protocols between APS and all other programs have been established for many years. APS is an integral part of all SDS services.

Risk Intervention and APS services for older adults and people with disabilities are intended to assess the risk or the potential of harm, as well as investigate and resolve alleged abuse and neglect. APS is provided to vulnerable older adults and people with disabilities who are at risk because of self-abuse, or abuse caused by another, neglect or exploitation.

In an APS investigation, the Investigator interviews the alleged victim, the alleged perpetrator, and any other pertinent witnesses. After the investigation, the Investigator makes a determination as to whether the allegation is substantiated. In the event of substantiated allegations, the DHS, as well as local District Attorneys' offices, may become involved for additional action. Risk intervention, including case management services, are provided for persons who are reported "at risk" and continue to be vulnerable. Risk intervention activities include continued contact, reassessment, intervention, and the implementation of an individualized plan to reduce the risk of harm.

SDS is committed to the education of our staff as an effective way to address abuse and exploitation. Case Managers and APS staff attend regional and local trainings that speak to the critical issues leading to risk/harm to older adults and people with disabilities. The utilization of brochures and flyers in English and Spanish allows for outreach to limited-English speakers in the Region. Educational events are organized to raise the consciousness of the public relating to elder abuse.

OCWCOG is especially focused on efforts to prevent financial exploitation. Referrals often come through the ADRC Call Center, family or friends of consumers, community partners, or case management staff. SDS has developed relationships with local financial institutions to make their referral process more efficient and effective. Staff receives regular training on how to recognize and address financial exploitation.

In fiscal year 2015-2016, SDS APS staff conducted over 750 community and facility investigations of potential abuse or neglect of older adults and people with disabilities. The highest incidence of reports is financial exploitation.

SDS has a contract agreement with Legal Aid Services of Oregon, which includes funding beyond the required three percent of Title IIIB funding per year. OCWCOG has supported these services for more than ten years and plans to continue this practice. Each year the DSAC and SSAC members conduct a contract review, which provides opportunity to become familiar with these services and ensure accountability. This open communication allows for effective referral between organizations. A significant focus of our partnership with Legal Aid Services of Oregon is to address issues affecting residents living in long-term care facilities.

OCWCOG will continue its contract with Legal Aid Services of Oregon. The contract calls for a minimum of 400 hours of legal aid services to persons 60 years of age and older in Linn, Benton, and Lincoln Counties. Consumer appointments are scheduled for one day every month at senior centers in Albany, Corvallis, Lebanon, and Sweet Home. Appointments are scheduled at the Albany office of Legal Aid Services of Oregon, in consumer’s homes, at nursing homes, or telephone appointments as necessary. In Lincoln County, appointments are made at the Newport office of Legal Aid Services of Oregon or at the consumer’s home, if the individual is unable to travel to Newport.

Due to APS funding allocation methods, financial exploitation prevention and education are not funded. This creates a challenge toward providing the level of prevention and education needed in the community. SDS will be utilizing the limited OAA Elder Rights funding on a community outreach campaign educating the community about financial exploitation.

Problem/Needs Statement:
In terms of community awareness and understanding, elder abuse issues are 20-30 years behind domestic violence issues. Like domestic violence, elder abuse is a community problem. To effectively address abuse, communities must be aware of the problem and take an active role in preventing it from happening. The *Gatekeeper Program* did much to begin educating communities about elder abuse and the red flags that may indicate someone is being victimized. Unfortunately, the Oregon legislature cut all funding for the *Gatekeeper Program* for the 2015-2017 biennium.

Resources to support the APS unit are lagging with the increased volume experienced each year. SDS is working to adapt new processes to make the unit as efficient as possible. It is critical that investigation reports are completed and allegations are responded to in a timely manner.

OCWCOG is identifying other ways to educate the community about elder abuse. Like domestic violence, research shows that the more aware communities are about abuse, the more likely someone will intervene to prevent abuse.

During this planning period, SDS will be utilizing the small amount of Elder Rights funding received to support a public advertising campaign that will serve to heighten our community's awareness of abuse and what people can do to help prevent or stop it. The theme of this media campaign will be to convey that elder abuse is never right – even when it is a family matter.

Goals & Objectives

Issue Area: Elder Rights and Legal Assistance					
Goal #1: Ensure that investigations of abuse are completed in a timely manner.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Achieve a timely completed report rate of 90%	a. Provide sufficient staff and training	APS Supervisor	9/16	12/20	
	b. Track open investigations weekly		9/16	12/20	
Goal #2: Increase public education and awareness regarding older adult abuse, neglect and especially exploitation.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Develop strategies for the most cost-effective outreach	a. Research cost-effective means of outreach and identify priority	OAA Program Manager	1/17	12/20	
2. Implement outreach effort through local media	b. Expand ability to provide presentations in alternative languages	OAA Program Manager	1/17	12/20	
	a. Secure contract with media, including possible public transits ads	Program Manager	1/17	12/20	

4. Issue Area: Health Promotions

Profile:

An important outcome of many of the services provided or administered by OCWCOG's SDS department is stabilizing or improving health for older adults and younger adults with disabilities across the Region. Through better health, individuals retain their independence, choice, and dignity. Helping people to secure in-home and community-based assistance provides both physical and mental stability to individuals who would otherwise be hospitalized and/or referred to skilled nursing facilities. By providing the optimal level of assistance with Activities of Daily Living (ADL), consumers can live more independently for a longer period of time than they may have otherwise.

Along with assistance with ADL's, these consumers also have the support of a Case Manager who works with them to establish their personal goals and provides problem-solving support when challenges arise. Delivering prepared nutritious meals to the consumer's doorstep is another service that can help maintain or improve their health.

One critical social determinant of health that is often overlooked is isolation and loneliness. Several studies have shown that isolation and loneliness are most commonly found in older people, and younger adults with disabilities. According to the 2010 U.S. Census Bureau nearly 30% of people 65 and older live alone.

Isolation is not the same as loneliness. Isolation is an objectively measured phenomenon typically measured in terms of the number of interactions an individual has with other people on a daily or weekly basis. Loneliness is a subjective phenomenon measured by an individual's feelings. Isolation can often lead to loneliness, but not always. Isolation and loneliness can exacerbate both chronic diseases and behavioral health such as depression. During the next four years, SDS will be putting additional emphasis on helping to reduce isolation and loneliness.

SDS offers the *Program to Encourage Active Rewarding Lives for Seniors* (PEARLS) throughout the Region. PEARLS is an evidence based program that effectively helps individuals cope with low-to-moderate depression. The program is delivered in-home, thus knocking down several barriers associated with mental health services for older people and people with disabilities including transportation, social stigma, and group therapy. Local program data indicates that PEARLS is effective in decreasing the symptoms of depression.

Providing opportunities for social interactions and volunteerism is supported through the Retired and Senior Volunteer Program (RSVP) – American's largest volunteer network for individuals age 55 and over. RSVP's mission is to help citizens "reinvent their retirement" through service to the community. The program facilitates a large variety of volunteer and educational opportunities to older adults. Community engagement helps reduce isolation and loneliness.

Aside from programs to encourage more social engagement, OCWCOG supports several other health promotion programs for the Region. H2H is a program that assists individuals transitioning from hospital back home or other community based settings. H2H is based on the *Coleman Care Transitions Intervention* model and empowers individuals to take control of their health through positive decision-making. H2H has shown to significantly reduce the rate of readmission to hospitals within a 30-day period from hospital discharge.

With the limitations of Federal and State funding for health promotion programs, SDS was considering closing H2H. However, a contract with Samaritan's Albany General Hospital to provide the program to many of their patients leaving the hospital was agreed on in 2016.

SDS also contracts with Benton County Hospice to provide *Powerful Tools for Family Caregivers*, which provides peer support and a curriculum in a workshop format. Family care givers come away feeling more empowered to take care of themselves, as well as their loved ones. The goal of the program is for family caregivers to understand that the quality of care they can provide is greatly influenced by their own physical and emotional health.

The DSAC and SSAC have expressed a desire to see mental health as a high priority for SDS. Therefore, SDS is looking for ways to expand the PEARLS program and develop additional programs to reduce isolation and loneliness for older adults and younger adults with disabilities throughout our Region.

The referral protocols for staff and community partners for PEARLS, H2H, and *Powerful Tools for Family Caregivers* assures that these programs are primarily targeting more economically challenged, isolated, and at-rick individuals and families in the Region. All of these programs are provided at no cost to the consumer. OCWCOG will work with Siletz and LGBT communities in particular to market Powerful Tools and other Evidence Based Programs.

SDS is also looking at taking a leading role in statewide education about the serious service gaps that challenge individuals and families confronted with a dementia-related disease. This may include a series of summits that will eventually lead to a coalition of advocates seeking public policy changes needed to ensure that the health care and social service providers are effectively addressing this epidemic.

As a Transfer AAA organization, the largest referral source for OCWCOG's health promotion programs are Medicaid program case managers and eligibility staff. OCWCOG is further improving referrals for health promotion programs from Medicaid eligibility staff and Case Managers in all field offices. This will enable OCWCOG to make these programs available to the full spectrum of our communities including people of color and Native Americans.

OCWCOG will work to ensure that all Evidence Based Programs are following practices that maintain full fidelity. This is accomplished with regular monitoring of programs by trained staff and ensuring that all staff providing these services, including contractors, are properly trained for the program to ensure integrity.

Problem/Needs Statement:
Cancer and heart disease are the two most common causes of death for older adults in the Region. The fifth leading cause is dementia related diseases; it is estimated that in the next 20 years, these diseases will likely move to the third leading cause of death.

Type	**Our Region**			
Age	*60-69*	*70-85*	*85+*	*Total*
Cancer	393	680	320	1,393
Heart Disease	179	449	620	1,248
Stroke	36	171	196	403
Respiratory	87	189	108	384
Dementia Related	5	88	192	285
Diabetes	45	91	48	184
Hepatitis C	160	19	0	179
Accidents	21	52	66	139
Suicide	26	12	3	41

Source: Oregon Public Health, 2009

Two additional takeaways from this chart:

1. It is also important to note that accidents, usually falling, is the eighth leading cause of death. Given that these are to some degree preventable, SDS will be working with community partners to support fall prevention class series in the Region.
2. The 9th leading cause of death is suicide; by far the highest incidence of suicide occurs in the younger stage between 60-69 years.

A Serious Gap in Mental Health Services
Both the SSAC and DSAC have expressed a strong desire to see more mental health services accessible for older adults and younger adults with disabilities. In 2016, OCWCOG received a contract from Linn County to establish two Mental Health Services Coordinators serving the Region. Three primary goals of the program are to:

1. Provide geriatric mental health consultation to health and social service providers;
2. Provide education to the health/social service workforce about geriatric and disability behavioral health conditions, and best practices for serving those with behavioral health issues; and
3. Facilitate better coordination in the health care system to ensure better access to mental health services for older adults and people with disabilities.

The program has been very informative to SDS in identifying the gaps in service for this population and the barriers that need to be addressed.

For Medicare recipients, mental health care is difficult to access due to a shortage of providers who are covered by Medicare and a limited ability to bill for services through Medicare. In addition, traditional delivery systems that require consumers to travel to a mental health care facility pose both transportation and cultural barriers. Many older adults and those with disabilities have a difficult time with transportation, due to a variety of reasons. Culturally, many are not willing to participate in group therapy at a recognized mental health services facility.

Perhaps the most glaring disparity in mental health services is treatment for Alzheimer's and other dementia-related diseases. While dementia diseases are the fastest growing chronic disease in the U.S., mental health providers will not treat these conditions because Alzheimer's and other dementia-related diseases are not considered a mental health diagnosis. Meanwhile, many primary care providers lack the training about these diseases. The result is a lack of providers who can effectively serve those with dementia-related diseases.

OCWCOG's DSAC and SSAC have held informative meetings in 2016 on the mental health service barriers in the Region and have made this a high priority to address. SDS is in the preliminary planning stages of sponsoring a statewide *Dementia Summit* to be held in 2017. The purpose of the *Summit* will be to draw experts together to develop a foundation of knowledge on the issue to move toward building public policy recommendations that would be put forth to State and Federal legislators.

Goals & Objectives

Issue Area: Health Promotions					
Goal #1: Expand mental health services for older adults and people with disabilities.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Increase evidence based programs such as PEARLS and *Powerful Tools for Family Caregivers*	a. Increase PEARLs consumer load throughout Region	Program Director and Program Manager	1/17	12/20	
	b. Contract with County mental health officials to provide PEARLS to Medicaid recipients		1/17	12/20	
	c. Increase *Powerful Tools for Family Caregivers* classes to at least six per year		1/17	12/20	
Goal #2: Increase community engagement for older adults and people with disabilities.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Develop options for new programs that reduce isolation and loneliness	a. Research to identify evidence based programs that reduce isolation/loneliness	Program Director	6/17	12/17	
	b. Adopt EBPs that reduce isolation/loneliness		1/17	12/20	
Goal #3: Address service gap for dementia related diseases.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Increase understanding of impact dementia diseases are having on households/ community	a. Provide for venues where information about dementia and its impact are explained b. Sponsor a *Summit* of dementia experts to develop information on the issue	Program Director and Mental Health Services Coordinator	1/17 1/17	12/20 5/17	Other funding sources have been identifie d
2. Advocate for better treatment for dementia disease	a. Strengthen and expand the existing informal support group	DSAC and SSAC	1/17	12/20	

5. Issue Area: Native American Elders

Profile:
According to the U.S. Census Bureau, there are 470 seniors (60+) in our Region who identify themselves as Native American. There are two Native American Tribes living in the Region, including The Confederated Tribes of Siletz and The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw. While Oregon's senior service network typically considers 60 or 65 as the statistical entry into the older adult status, it is important to note that the tribes consider their elders 55+. This may result in the Tribes self-reporting more seniors than are reflected in the U.S. Census Bureau data. OCWCOG's SDS has a formal agreement in place with The Confederated Tribes of Siletz (The Tribes).

The Tribes is comprised of 17 statewide tribal groups with their tribal headquarters in Siletz. The Tribes' Elders Program is responsible for the administration of Federal and Tribal social services to their eligible Tribal members. The program offers socialization activities, nutrition services, in-home services, caregiver support services, financial benefits, and referrals to other local and Tribal resources. To be eligible for the Elders Program, Tribal members must be enrolled and have reached the age of 55.

The Tribes Elders' Program is a Title VI AAA serving their Tribal elder population. They receive OAA funding to administer programs directly through their Tribal organization. As outlined by the OAA, SDS is tasked with outreach to local Tribes, raising awareness of the services offered, and coordination of services to Tribal members.

The Tribes provide medical care for its members in a medical clinic in their offices located in Siletz. A large part of OCWCOG's partnership with the Tribe relates to Medicaid service billing.

The Tribes also provide their own adult protective services to Tribal members in their service area. However, OCWCOG has recently increased cooperation to work with the Tribes to ensure Tribal member's safety.

In June, 2016, an Elder Justice Forum was co-sponsored by the Tribes and OCWCOG.

In addition, SDS held a focus group at the Siletz Health Clinic in June 2016 to hear from Tribal members about the issues they are facing with aging and disabilities in their community. The number one concern was a lack of services for elders who did not qualify for Medicaid or some other OAA programs. Elder abuse was another key topic of concern from the focus group.

Problem/Need Statement:
Building stronger relationships with the Tribes is critical to achieving better services for the Tribal members. An Elder Justice Forum and a focus group began to establish stronger ties. Both parties agreed that more outreach to the Tribal members is a mutual goal. SDS has been successful in recruiting a representative from the Tribes to join the SSAC, helping to improve on-going communications between SDS and the Tribes.

SDS is working with the City of Siletz to continue providing a *MOW* meal site which serves meals twice a week. The kitchen was remodeled in early 2016, though staffing has been an issue for the site.

It was apparent from the focus group that more services are needed for Tribal members. A stronger relationship will enable additional creative solutions between SDS and the Tribes.

Goals & Objectives

Goal #1: Continue to build a strong relationship with the Confederated Tribes of Siletz for the benefit of our Region's senior and disabled population.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Improve Communication and Outreach Services with Tribal Elders	a. Establish quarterly meetings with Tribal leaders	OAA Case Manager	7/17	12/20	
	b. Recruit local Tribal governing members to join DSAC and SSAC	Program Manager	1/17	12/20	
	c. Establish location for ADRC brochures to be distributed regularly	OAA Case Manager	1/17	6/17	
2. Coordinate with local area Tribes to co-host semi-annual elder abuse forums	a. Work with Tribal staff to coordinate forums	Program Manager	5/17	12/20	
	b. Commit staff to participate in forums	OAA Case Manager	5/17	12/20	
	c. Assist with promotion of forums	OAA Case Manager	5/17	12/20	

6. Issue Area: Nutrition Services

Profile:
The SDS *MOW* program provides older adults, age 60 and over, 55+ Tribal elders, and people with disabilities, who are Medicaid consumers, a hot meal either in a dining room atmosphere or in their home.

The *MOW* program strives to provide services around the person's needs in many ways. First, there are 11 sites to allow participants to reduce the travel required to join a meal site. Secondly, *MOW* menus incorporate special diets such as low salt items. Third, regular surveys are implemented that help guide menus for the upcoming year based on consumer's tastes and preferences as indicated in the surveys.

There are 11 meal sites throughout our Region; each site has a dining room in addition to the home delivery routes. Home delivery provides hot, nutritious meals to the consumer's doorstep. Delivery days vary depending on the site, with some sites providing meals five days a week and others less often.

Home-delivered meals are more than just a meal; each meal delivery serves as a connection to the community. Consumers in the program know that they will not only have a nutritious meal, but also a short, friendly visit and safety check by a dedicated trained volunteer driver. Our mission is to provide fresh, hot meals as well as a connection for local seniors and people with disabilities, supporting independent living at home. For many homebound consumers, the volunteer driver is the only contact they have. Volunteer drivers have assisted in identifying and avoiding a wide array of emergency situations for homebound individuals.

In addition to the regular contacts with the volunteer drivers, *MOW* Coordinators and Case Managers engage the consumers during an initial assessment to determine eligibility and then again annually. These appointments give an opportunity to determine if additional support services may be appropriate for the consumer.

Another important benefit of *MOW* is the nutrition education for diners and home-delivered meals consumers. Monthly nutrition education articles are provided on the back of each month's menu. These articles are written by the food contractor's dietician and cover a wide variety of topics that relate to seniors and are culturally appropriate. In addition to these articles, we offer quarterly nutrition education seminars to our dining room consumers. The OAA homebound *MOW* consumers will also have nutrition education, provided during their initial and annual in-home reassessments.

Ensuring that *MOW* participants are made aware of other health promotion resources is also a key objective for the *MOW* program. Initial assessment and re-certification assessments include information about such resources. In addition, volunteer drivers are trained to identify signals that might call for other resources and referrals are immediately submitted to the Information & Assistance staff.

The dining venues are yet another opportunity to reduce isolation and loneliness of older adults. These venues provide a social opportunity to meet people and connect with their community.

Utilizing Title IIIC OAA funding, SDS' meal sites are in the following locations:

Linn County

Albany
Phone: 541-967-7647
Location: Albany Senior Center
489 Water Avenue NW
Serves: Monday - Friday at 11:30 am
Mailing Address:
P.O. Box 1270
Albany, OR 97321

Lebanon
Phone: 541-451-1139
Location: Lebanon Senior Center
80 Tangent Street
Serves: Monday - Friday at 12:00 pm
Mailing Address:
80 Tangent Street
Lebanon, OR 97355

Mill City
Phone: 503-897-2204
Location: First Presbyterian Church
236 West Broadway
Serves: Tuesday - Thursday at 12:00 pm
Mailing Address:
P.O. Box 84
Mill City, OR 97360

South Linn (Brownsville)
Phone: 541-466-5015
Location: Christian Church
117 North Main Street
Serves: Tuesday - Thursday at 12:00 pm
Mailing Address:
P.O. Box 658
Brownsville, OR 97327

Sweet Home
Phone: 541-367-8843
Location: Sweet Home Community Center
880 18th Street
Serves: Monday, Tuesday, Friday at 12:00 pm
Mailing Address:
P.O. Box 803
Sweet Home, OR 97386

Benton County

Corvallis
Phone: 541-753-1022
Location: Corvallis Senior Center
2601 NW Tyler
Serves: Monday - Friday at 11:50 am
Mailing Address:
2601 NW Tyler
Corvallis, OR 97330

Lincoln County

Lincoln City
Phone: 541-994-7731
Location: Lincoln City Community Center
2150 NE Oar Street
Serves: Monday, Wednesday, Friday
at 12:00 pm
Mailing Address:
2150 NE Oar Street
Lincoln City, OR 97367

Newport
Phone: 541-574-0669
Location: Newport Senior Activity Center
20 SE 2nd Street
Serves: Monday, Wednesday, Friday
at 12:00 pm
Mailing Address:
20 SE 2nd Street
Newport, OR 97365

Siletz
Phone: 541-270-7416
Location: Tribal Community Center
Government Hill
Serves: Monday and Wednesday
at 12:00 pm
Mailing Address:
P.O. Box 151
Siletz, OR 97380

Toledo
Phone: 541-270-7416
Location: Trinity Methodist Church
383 NE Beech Street
Serves: Friday at 12:00 pm
Mailing Address:
P.O. Box 151
Siletz, OR 97380

Waldport
Phone: 541-563-8796
Location: South County Community Center
265 Hemlock
Serves: Monday, Wednesday, Friday at 12:00 pm
Mailing Address:
P.O. Box 913
Waldport, OR 97394

The chart below displays the actual number of meals served by County over FY2015-2016. This data shows that *MOW* serves primarily home delivered meals, rather than congregate (dining room meals). It is reasonable to assume that with the increase in the general senior population, *MOW* counts will also increase through 2020.

County	Total MOW Meals	Total Congregate Meals	Total Meals per County
Benton	21,978	3,521	25,499
Linn	105,935	18,770	124,705
Lincoln	38,690	13,682	52,372
Totals	166,603	35,973	202,576

MOW offers consumers a choice of two different entrees each day. Each meal also has several sides, including vegetables, salads, freshly-baked breads or rolls, fruits, a variety of desserts, and milk. Meals are designed to provide individuals with no more than 30 percent calories from fat, averaged over a week's time. Gravies contain zero

fat, and tropical oils are not used in the meals. Each meal includes one third of the current Dietary Reference Intakes (DRI), as established by the Food and Nutrition Board of the National Academy of Science National Research Council. All menus are approved by a registered dietician. Specialty menus for diabetic individuals are available upon request.

There is a suggested donation of $3.50 per meal, although the actual meal cost is more than double that amount. At the close of the FY2016, the average donation for a home delivered meal was $.90. The average donation for a dining room meal is slightly higher at $1.28 per meal. Some consumers can donate for their meals and others are not.

The *MOW* program is a very cost effective service; each meal costs approximately $9.50/meal.

1. The mainstay of home-delivered meals is over 300 community volunteers throughout the Region. Simply put, *MOW* would not exist without these volunteers. The value of the hours spent by these volunteers reaches a total of over one million dollars annually.

2. OCWCOG's participation in a meal purchasing consortium keeps the costs low. SDS joined with Northwest Senior and Disability Services, based in Salem, and Lane Council of Governments, based in Eugene, to contract with Bateman for production of the meals. This partnership allows SDS to keep the price of each meal down, while maintaining high quality and nutrition.

In addition to serving consumers, SDS found a need to help feed seniors' animal companions. Eight years ago, our organization teamed up with the Lincoln County Humane Society to provide dog and cat food to homebound consumers in need. Because this service proved to be incredibly popular, in July 2010 it was duplicated at our Linn County meal sites when SDS partnered with SafeHaven Humane Society. Three years ago, *MOW* expanded again to provide this service in Benton County. Meal site managers are often told how much this service is appreciated due to homebound seniors being unable to get to the store on a regular basis.

The *MOW* program receives referrals from OCWCOG staff across its program areas, as well as local hospitals and other community partners.

MOW is a vital service that enables people to continue living in their homes, reduces stress, and can lead to better health. MOW is a very cost-effective and valuable asset to the Region.

Unfortunately, the decline in traditional Federal funding (OAA) over several years has created a very significant challenge for SDS. The *MOW* program has been operating in a fiscal deficit for several years and the organization can no longer sustain the financial losses. In addition, recruiting and retaining the volunteers who deliver the meals has also reached a critical point, particularly in the more remote areas of the Region.

Problem/Need Statement:
For decades, OAA funding fully supported *MOW* in our Region. However, over the last 10 years OAA funding has declined or remained stagnant, while the cost for meals, transportation, and staffing have risen every year. Today, OAA only provides about 70% of the revenue required to sustain *MOW*.

The DSAC and SSAC have expressed a strong preference for the *MOW* program to continue at its present level of service and that weekend frozen meals be restored from cuts that were made two years ago. To achieve this goal, *MOW* must embark on an endeavor to significantly increase funding from alternative sources.

In the summer of 2016, SDS developed a *Resource Development Plan* for *MOW*. The plan features five major strategies to close a $225,000 budget gap by July 1, 2018 including:

1. Significantly increase donations to *MOW* from individuals in the Region.
2. Develop business sponsorships for *MOW*.
3. Increase support from local governments for *MOW*.
4. Increase private foundation grant support for *MOW*.
5. Increase and stabilize volunteer base of *MOW*.

A key theme of the *Resource Development Plan* is that the success of the *MOW* program depends greatly on increased support from individuals, businesses, local government, and civic organizations throughout the Region. To assist in implementing the *Resource Development Plan*, SDS has contracted with a development firm to provide consultation for various aspects.

Improving the financial health of MOW is critical for the Region. The benefits of *MOW* are multifold:

1. Nutrition to ensure that consumers can maintain their health.
2. Social engagement for diners at the meal sites to help reduce isolation and loneliness.
3. Safety checks and social connection that volunteers provide when they deliver meals to consumers who are home-bound, thus assuring that consumers are not neglected.
4. Nutrition education to provide useful tips for our consumers to eat well, an important ingredient for maintaining health and independence.

Goals & Objectives

Issue Area: Nutrition Services					
Goal #1: Maintain the *MOW* program at its current service level, with a high priority on home-delivered meals.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Develop the financial resources to maintain program at current service level	a. Increase individual donations by at least 75%	Program Manager and Program Director	9/16	7/18	
	b. Develop business sponsorships to at least $30,000/yr.	Program Manager and Program Director	1/17	7/18	
	c. Increase local government contributions by at least 20%	Program Manager and Program Director	1/17	7/18	
	d. Secure private foundation grants for capacity building	Program Manager and Program Director	1/17	12/20	
2. Increase and stabilize volunteer base	a. Develop written and video materials for volunteer recruitment	Program Manager	1/18	12/20	
	b. Implement media campaign targeted to potential volunteers	Program Manager	6/17	12/17	
	c. Secure community donors to support volunteer recognition events	Program Manager	6/17	12/20	
	d. Provide volunteer coordination training for Meal Site Managers	Program Manager	1/17	12/20	

Goal #2: Enhance the dining program experience.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Increase dining participation by 20%	a. Develop partnerships with other community programs to co-locate with meal sites	Program Supervisor	1/17	12/20	
	b. Provide more enrichment activities during meal time	Meal Site Managers	6/17	12/20	
Goal #3: Maintain regional pet program for home delivered participants companions.					
Measurable Objectives	Key Tasks	Lead Position and Entity	Timeframe		Update
			Start Date	End Date	
1. Engage local humane societies	a. Continue partnering with the local humane societies in Lincoln and Linn Counties	Program Supervisor	1/17	12/20	
	b. Contact the Humane Society in Benton County to attempt to partner with them	Program Supervisor	1/17	6/17	

Section D: OAA/OPI Services and Method of Service Delivery

D-1 Administration of OPI

A. Describe how the agency will ensure timely response to inquiries for service.
The ADRC Resource Specialists in the call center respond “live” to initial inquiries made to the organization about services and resources. The Resource Specialist collects consumer data and provides information about programs that would meet their needs, and the eligibility criteria for such programs.

OPI serves consumers who are between the ages of 19 and 59 with a disability, 60 years or older, or under 60 years and diagnosed as having Alzheimer’s disease. People receiving OPI cannot be receiving Medicaid except for food stamps, Qualified Medicare Beneficiary, or Supplemental Low Income Medicare Beneficiary. If eligible, individuals can receive case management services through OPI. Sliding scale fees are explained at the screening level, but full explanation and calculation are left to the OPI Case Manager. If the consumer believes that OPI is the most appropriate program, their demographic information is entered in the call module and screening is created for the Case Manager in Oregon ACCESS (OA).

The Case Manager will make phone contact with the potential consumer and/or family member within 5-10 days, depending on the need of the individual requesting services. An appointment will be made for a home visit to complete a full CAPS assessment and all OPI and State standardized forms.

B. Explain how consumers will receive initial and ongoing periodic screening for other community services, including Medicaid.
The ADRC Resource Specialists in the Call Center screen and assist with all initial inquiries for services, program eligibility, and community resources. The Resource Specialists will connect callers to all appropriate resources/programs, including OPI, and narrate any referrals made in the ADRC consumer data base and OA screening.

During the initial home visit, the OPI Case Manager assesses for OPI eligibility and any other needed resources. Consumers receiving OPI services are continually monitored for any changes in their circumstances where they may need other community programs and services. The Case Manager also conducts an annual assessment, but monitors more frequently with phone calls and home visits as warranted based on individual consumer circumstances.

A minimum of three calls are generally made to OPI consumers:

1. Monitoring the initial service plan and how things are going.
2. Within three to six months of initial assessment and service planning to monitor and evaluate need for other services.
3. Prior to the annual review to prepare and plan for updates.

OPI Case Managers are provided the necessary training to ensure that they have a broad-based understanding of Medicaid programs and eligibility, and can confidently assess the consumers need when appropriate.

C. Describe how eligibility will be determined.
The CAPS assessment tool is used to determine functional eligibility during a face-to-face home visit with the consumer. The assessment is based on information gathered through observation and a consumer interview, often in collaboration with family members. The OPI Case Manager inputs all required information related to the consumer's ability to perform ADL and Instrumental Activities of Daily Living (IADL). The assessment tool then generates a Service Priority Level (SPL), which is the basis of program eligibility. Consumers with priority levels 1-15 are currently served under OPI.

The OPI Income/Fee Determination Record, OPI Risk Assessment Tool, and OPI Service Agreement are completed. Based on 2011 Oregon Legislative direction to establish statewide consistency for the program, SDS has adopted the use of standardized forms agreed upon by all AAA's.

If the consumer meets requirements of SPL 1-15, they are determined eligible and they are enrolled in the OPI program, based on the availability of funding. However, a State developed risk assessment weighs the amount of resources, natural supports, and physical function to determine the priority of need; in the event that funding is limited, a wait list may be created.

D. Describe how the services will be provided.
OCWCOG's SDS, Northwest Senior and Disability Services (NWSDS), and Lane Council of Governments (LCOG) have a tri-agency (nine-county) In-Home Services Contract with Addus HealthCare Inc. that began July 1, 1999. In our Region, the contract serves Benton and Linn Counties only. In addition to the contracted home care agency, the *Client Employed Provider Program* and Homecare Worker registry are discussed, including the benefits and costs of each option. The consumer decides which option to choose in hiring an in-home care provider; often in-home care workers are selected based on continuity and cost effectiveness.

The consumer plays an active role in determining how many hours per week/month they will need in the areas of personal care, home maker, and chore services to remain independent in their own home. The OPI Case Manager discusses other community resources and supports that will augment the service hours and develop a comprehensive in-home plan. Once determined, the Case Manager will complete a service plan in OA and process the plan through the appropriate channels for referral and payment for services.

E. Describe the agency policy for prioritizing OPI service delivery.
Consumers enter the system based on many factors:

1. Consumers arrive through referrals from partner agencies and the local healthcare system when they have experienced a healthcare crisis or their current supports are no longer adequate.
2. Individuals with the greatest risk factors often enter the system through APS. APS workers refer at-risk consumers to the ADRC Call Center and OPI Case Manager to assess for community resources and services that would reduce their risk of being placed in a setting other than home. These cases are often a priority.

All other consumers are assessed on a first come, first served basis. The assessment and conversation with consumers and/or their families determine how many hours and what kind of service will be most beneficial in supporting the independence of the consumer. However, Case Managers complete a risk assessment on all consumers to survey them for priority of need at the initial assessment. Funding is used to assist as many high-risk consumers as possible.

F. Describe the agency policy for denial, reduction, or termination of services.
For new consumers or consumers that are determined ineligible at review, the Case Manager will have a conversation to inform the consumer of the reduction, denial, or closure prior to sending out any paperwork. The Case Manager will send a written notice to the consumer, after their conversation. The Case Manager also completes the notice or reduction, and sends it to the home care worker or agency.

Upon termination of services, the OPI Case Manager will provide the consumer with information about other available community resources that may meet their ongoing need for assistance while still meeting the goals of promoting quality of life, reducing the risk of institutionalization, promoting self-determination, and optimizing a consumer's personal resources and natural support. The consumer also receives a copy of the organization's formal complaint process and their right to grieve adverse eligibility or service determinations. The Program Manager will be made aware of any denials, reduction, or terminations of services prior to the notice(s) being sent, as the complaint process directs consumers to the local Program Manager with questions or concerns.

G. Describe the agency policy for informing consumers of their right to grieve adverse eligibility and/or service determination decisions or consumer complaints.
At initial enrollment, the Case Manager informs the consumer of the grievance procedure, they are provided a copy of the SDS's Reduction/Closure Grievance Policy.

Additionally, SDS brochures about OPI is given to all new consumers, which notifies them of their right to file a complaint and the office contact information. Consumer complaints are directed to the OAA Program Manager who calls the consumer or family member directly and discusses the concerns. This may result in providing further clarification of policy, completing another assessment, or another course of action.

H. Explain how fees for services will be implemented, billed, collected, and utilized.

A calculation of income and medical expenditures are used to determine if a sliding scale fee will be applied for the cost of the OPI service hours assigned to consumers. This is discussed at the time of assessment during each consumer's initial home visit with their Case Manager.

For each consumer determined appropriate for OPI services, the OPI Case Manager completes an OPI Income/Fee Determination form and the fees are calculated based on the State issued fee schedule. If housekeeping or personal care services are provided through the agency contractor, the case manager sends a copy of the consumer service plan to Addus Healthcare to begin service and to inform them of the percentage to be billed to consumer.

A written approval is sent to the consumer, confirming the proportion of service cost which the consumer is to pay and the estimated monthly cost. The agency contractor sends out consumer billing letters and collects fees in accordance with the requirements of the agency contract.

Consumers receiving home care worker services and paying a portion of OPI service costs are billed by SDS staff who enter the fee percentage(s) into the OA billing system. In addition, a one-time $25 fee will be applied to all individuals receiving OPI services who have adjusted income levels at, or below, the Federal Poverty Level and have no fee for OPI services. All fees collected are submitted to SDS on a monthly basis and are applied to the overall budget and billing of OPI services submitted to the State.

When an OPI case is opened, the consumer is sent the Service Agreement form confirming the start of the OPI service and notifying them of their fee for service. The OPI Income/Fee Determination form is reviewed and updated annually at the service assessment review date.

Cost of Service Per Unit as of November 2016	
Client Employed Provider	$17.87
Agency – Home Care	$17.15
Agency – Personal Care	$19.29
Adult Day Services	$16.10
Emergency Response System	$41.45
Meals	$9.54
Registered Nurse Services	$60.00
Case Management	$64.00

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

Through the OA reporting and billing system, consumers are billed monthly and a one-time $25 fee when applicable. Administrative Support staff notifies the Case Manager if fees are delinquent; the contract agency does the same. If non-payment occurs, the Case Manager contacts the consumer and discusses the reasons for non-payment, and evaluates the hardship and/or reason, reminding them they must pay the fee within 10 days or risk closure.

Fees are mandatory, no matter how small. However, a Case Manager might request a fee be waived in a situation of undue financial hardship or an APS involvement. This would be rare and circumstances would be extenuating. The Program Manager would be consulted in each case where a waived payment is requested.

J. Delineate how service providers are monitored and evaluated.

Yearly monitoring and evaluation of contracted service providers is done by members of our Senior and Disability Services Advisory Councils. This is done by a panel that completes a face to face visit with providers and uses and uses a tool to identify any issues or weaknesses as well as highlight strengths.

D -2 Services Provided to OAA and/or OPI Consumers

SERVICE MATRIX and DELIVERY METHOD

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

X #2 Homemaker (by agency)

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Northwest Senior and Disability Services
P.O. Box 12189
Salem, OR 97309
Subcontractor:
Addus HealthCare, Inc
2401 S Plum Grove Road
Palatine, IL 60067
"for profit"

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

☐ **#3 Chore** (by agency)

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

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

X #4 Home-Delivered Meal

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Subcontractor:
Bateman Food & Nutrition
2655 Hyacinth Street NE
Salem, OR 97301
"for profit agency"

X #5 Adult Day Care/Adult Day Health

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Grace Center
980 NW Spruce Avenue
Corvallis, OR 97330
"for profit agency"

X #6 Case Management

Funding Source: ☐OAA ☒OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #7 Congregate Meal

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Subcontractor:
Bateman Food & Nutrition
2655 Hyacinth Street NE
Salem, OR 97301
"for profit agency"

☐**#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

☐**#10 Transportation**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #11 Legal Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

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

Legal Aide Services of Oregon
433 Fourth Avenue SW
Albany, OR 97321

X #12 Nutrition Education

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #13 Information & Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #14 Outreach

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #15/15a Information for Caregivers

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #16/16a Caregiver Access Assistance

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #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

X #30-4 Respite Care (IIIB/OPI)

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☒Contracted ☐Self-provided

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

Grace Center
980 NW Spruce Avenue
Corvallis, OR 97330

"for profit agency"

X #30-5/30-5a Caregiver Respite

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted X Self-provided

X #30-6/30-6a Caregiver Support Groups

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #30-7/30-7a Caregiver Supplemental Services

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted X 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

X #40-8 Registered Nurse Services

Funding Source: ☒OAA ☒OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Mary Mamer, RN
"for profit vendor"

X #40-9 Medication Management

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

Contractor name and address (List all if multiple contractors):
Provided at annual Living Well Expo in partnership with Samaritan Health Services, Oregon State University Pharmacy students, and Rice's Pharmacy (Corvallis)

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

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #**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

☐ #**60-4 Volunteer Recruitment**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #60-5 Interpreting/Translation

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☒Contracted ☐Self-provided

Contractor name and address (List all if multiple contractors):
Certified Languages International
4724 SW Macadam, Suite 100
Portland, OR 97239
"for profit agency"

X #70-2 Options Counseling

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #70-2a/70-2b Caregiver Counseling

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #70-5 Newsletter

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #70-8 Fee-based Case Management

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

X #70-9/70-9a Caregiver Training

Funding Source: ☒OAA ☐OPI ☒Other Cash Funds

☐Contracted ☒Self-provided

X #70-10 Public Outreach/Education

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

X #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

X #80-5 Money Management

Funding Source: ☒OAA ☐OPI ☐Other Cash Funds

☐Contracted ☒Self-provided

☐#**90-1 Volunteer Services**

Funding Source: ☐OAA ☐OPI ☐Other Cash Funds

☐Contracted ☐Self-provided

Area Plan Budget, Worksheet 1
Oregon Cascades West Council of Governments Senior & Disabled Srvcs (OCWCOG)
Select BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Plan Year 1

Budget by Service Category

(3)	(4)					(9) OAA						(10)	(11)	(12)	(13)	(14)	(15)	(16)
Matrix	SERVICE NAME	(5)	(6)	(7)	(8)	T III B	T III C-1	T III C-2	T III D	T III E	T VII	OAA Total	NSIP	OPI	Other State-provided Funds	Other Cash Funds	Total Funds	Estimated Cost Per Unit
ADMINISTRATION						**$50,000**	**$12,000**	**$8,000**	**$0**	**$15,000**	**$0**	**$85,000**	**$0**	**$17,387**	**$50,000**	**$25,000**	**$177,387**	
20-1	Area Plan Administration	C = Contract				$25,000	$12,000	$8,000		$15,000		$60,000		$17,387	$50,000	$20,000	**$147,387**	
20-2	AAA Advocacy					$25,000						$25,000				$5,000	**$30,000**	
20-3	Program Coordination & Development	D = Direct Provision	Estimated Units	Unit Definition	Estimated Clients							$0					**$0**	
ACCESS SERVICES						**$177,000**	**$0**	**$0**	**$0**	**$0**	**$6,671**	**$183,671**	**$0**	**$80,000**	**$100,000**	**$237,000**	**$600,671**	
6	Case Management	D	3000.00	1 hour	150							$0		$80,000	$100,000		**$180,000**	$60.00
9	Assisted Transportation			1 one-way trip								$0					**$0**	#DIV/0!
10	Transportation			1 one-way trip								$0					**$0**	#DIV/0!
13	Information & Assistance	D	8000.00	1 contact	4000	$115,000						$115,000					**$115,000**	$14.38
14	Outreach			1 contact								$0					**$0**	#DIV/0!
40-3	Preventive Screening, Counseling, and Referral			1 session								$0					**$0**	#DIV/0!
40-4	Mental Health Screening & Referral	C		1 hour								$0				$120,000	**$120,000**	#DIV/0!
60-5	Interpreting/Translation			1 hour								$0					**$0**	#DIV/0!
70-2	Options Counseling	D	2000.00	1 hour	300	$37,000						$37,000				$117,000	**$154,000**	$77.00
70-5	Newsletter			1 activity								$0					**$0**	#DIV/0!
70-8	Fee-Based Case Management			1 hour								$0					**$0**	#DIV/0!
70-10	Public Outreach/Education	D	125.00	1 activity	1000	$25,000					$6,671	$31,671					**$31,671**	$253.37
IN-HOME SERVICES						**$17,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$17,000**	**$0**	**$450,500**	**$211,076**	**$0**	**$678,576**	
1	Personal Care	C	250.00	1 hour	50							$0		$5,000	$5,000		**$10,000**	$40.00
1a	Personal Care - HCW	C		1 hour								$0					**$0**	#DIV/0!
2	Homemaker/Home Care	C	575.00	1 hour	65							$0		$10,000	$10,000		**$20,000**	$34.78
2a	Homemaker/Home Care - HCW	C	26000.00	1 hour	150							$0		$400,000	$175,000		**$575,000**	$22.12
3	Chore			1 hour								$0					**$0**	#DIV/0!
3a	Chore - HCW			1 hour								$0					**$0**	#DIV/0!
5	Adult Day Care/Adult Day Health	C	1120.00	1 hour	45							$0		$20,000	$10,000		**$30,000**	$26.79
30-1	Home Repair/Modification			1 payment								$0					**$0**	#DIV/0!
30-4	Respite (IIIB or OPI funded)	C	300.00	1 hour	2	$17,000						$17,000					**$17,000**	$56.67
40-5	Health, Medical & Technical Assistance Equip.	C	405.00	1 loan/payment	40							$0		$15,000	$10,000		**$15,000**	$37.04
40-8	Registered Nurse Services	C	20.00	1 hour	5							$0		$500	$1,076		**$1,576**	$78.80
60-3	Reassurance			1 contact								$0					**$0**	#DIV/0!
90-1	Volunteer Services			1 hour								$0					**$0**	#DIV/0!
LEGAL SERVICES						**$29,927**	**$0**	**$0**	**$0**	**$0**	**$0**	**$29,927**	**$0**	**$0**	**$0**	**$6,073**	**$36,000**	
11	Legal Assistance	C	370.00	1 hour	80	$29,927						$29,927				$6,073	**$36,000**	$97.30
NUTRITION SERVICES						**$12,650**	**$373,842**	**$192,658**	**$0**	**$0**	**$0**	**$579,150**	**$133,997**	**$70,000**	**$161,000**	**$170,000**	**$1,114,147**	
4	Home Delivered Meals	D	165000.00	1 meal	490	$12,650		$192,358				$205,008	$106,500	$70,000	$161,000	$110,000	**$652,508**	$3.95
7	Congregate Meals	D	35000.00	1 meal	430		$371,681					$371,681	$27,497				**$399,178**	$11.41
8	Nutrition Counseling			1 session								$0				$60,000	**$60,000**	#DIV/0!
12	Nutrition Education	D	2000.00	1 session	430		$2,161	$300				$2,461					**$2,461**	$1.23

Budget Date Printed: 9/26/2016 1 of 9

(3)	(4)					OAA							(11)	(12)	(13)	(14)	(15)	(16)
Matrix	SERVICE NAME	(5)	(6)	(7)	(8)	T III B	T III C-1	T III C-2	T III D	T III E	T VII	OAA Total	NSIP	OPI	Other State provided Funds	Other Cash Funds	Total Funds	Estimated Cost Per Unit
		Contract or Direct Provide	Estimated Units	Unit Definition	Estimated Clients													
FAMILY CAREGIVER SUPPORT						**$0**	**$0**	**$0**	**$0**	**$134,431**	**$0**	**$134,431**	**$0**	**$0**	**$0**	**$36,000**	**$170,431**	
15	Information for Caregivers	D	43.00	1 activity	2600					$2,050		$2,050				$2,000	**$4,050**	$94.19
15a	Information for CGs serving Children	D	30.00	1 activity	1000					$300		$300					**$300**	$10.00
16	Caregiver Access Assistance	D	1076.00	1 contact	152					$59,981		$59,981					**$59,981**	$55.74
16-a	Caregiver Access Assistance-Serving Children	D	100.00	1 contact	100					$5,000		$5,000					**$5,000**	$50.00
30-5	Caregiver Respite	C	3270.00	1 hour	50					$32,000		$32,000					**$32,000**	$9.79
30-5a	Caregiver Respite for Caregivers Serving Children	D	60.00	1 hour	5					$1,000		$1,000					**$1,000**	$16.67
30-6	Caregiver Support Groups	D	10.00	1 session	5					$500		$500					**$500**	$50.00
30-6a	Caregiver Support Groups Serving Children	D	20.00	1 session	12					$100		$100				$7,000	**$7,100**	$355.00
30-7	Caregiver Supplemental Services	D	96.00	1 payment	96					$15,000		$15,000					**$15,000**	$156.25
30-7a	Caregiver Supplemental Services-Serving Children	D	18.00	1 payment	18					$3,000		$3,000					**$3,000**	$166.67
70-2a	Caregiver Counseling			1 session								$0					**$0**	#DIV/0!
70-2b	Caregiver Counseling-Serving Children			1 session								$0					**$0**	#DIV/0!
70-9	Caregiver Training	C/D	144.00	1 session	24					$15,500		$15,500				$27,000	**$42,500**	$295.14
70-9a	Caregiver Training - Serving Children			1 session								$0					**$0**	#DIV/0!
73	Caregiver Self-Directed Care			1 client served								$0					**$0**	#DIV/0!
73a	Caregiver Self-Directed Care-Serving Children			1 client served								$0					**$0**	#DIV/0!
SOCIAL & HEALTH SERVICES						**$0**	**$0**	**$0**	**$25,263**	**$0**	**$0**	**$25,263**	**$0**	**$0**	**$0**	**$25,000**	**$50,263**	
40-2	Physical Activity & Falls Prevention			1 session								$0					**$0**	#DIV/0!
40-9	Medication Management			1 session								$0					**$0**	#DIV/0!
50-1	Guardianship/Conservatorship			1 hour								$0					**$0**	#DIV/0!
50-3	Elder Abuse Awareness and Prevention	D		1 activity								$0					**$0**	#DIV/0!
50-4	Crime Pervention/Home Safety			1 activity								$0					**$0**	#DIV/0!
50-5	LTC Ombudsman			1 payment								$0					**$0**	#DIV/0!
60-4	Volunteer Recruitment			1 placement								$0					**$0**	#DIV/0!
60-10	Recreation			1 hour								$0					**$0**	#DIV/0!
71	Chronic Disease Prevention, Management & Ed	D	720.00	1 session	20				$25,263			$25,263					**$25,263**	$35.09
72	Self-Directed Care			1 client served								$0					**$0**	#DIV/0!
80-1	Senior Center Assistance			1 center served								$0					**$0**	#DIV/0!
80-4	Financial Assistance			1 contact								$0					**$0**	#DIV/0!
80-5	Money Management			1 hour								$0				$25,000	**$25,000**	#DIV/0!
80-6	Center Renovation/Acquisition			1 center acqrd/renovated								$0					**$0**	#DIV/0!
900	Other (specify)											$0					**$0**	#DIV/0!
900	Other (specify)											$0					**$0**	#DIV/0!
900	Other (specify)											$0					**$0**	#DIV/0!
900	Other (specify)											$0					**$0**	#DIV/0!
					GRAND TOTAL	**$286,577**	**$385,842**	**$200,658**	**$25,263**	**$149,431**	**$6,671**	**$1,054,442**	**$133,997**	**$617,887**	**$522,076**	**$499,073**	**$2,328,402**	

Area Plan Budget, Worksheet 2
Oregon Cascades West Council of Governments Senior & Disabled Srvcs (OCWCOG)
Select Budget Period

Cash Match/In-kind Match

(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
SOURCE OF OAA CASH & INKIND MATCH FUNDS Be descriptive (e.g. Donated dining space @ SC)	Admin. Cash Match	Admin. Inkind Match	III B & C Cash Match	III B & C Inkind Match	OAA III E Cash Match	III E Inkind Match	TOTAL Cash Match	TOTAL Inkind Match
Money Management Contract			$25,000				$25,000	$0
H2H Contract with AGH			$70,000				$70,000	$0
OPI Pay In	$20,000						$20,000	$0
MOW Volunteer Hours			$60,000	$60,000			$60,000	$60,000
Legal Aid Contract Match		$6,073					$0	$6,073
Powerful Tools Community Trainers Hours						$7,000	$0	$7,000
Meals on Wheels Volunteer Mileage Donation				$50,000			$0	$50,000
Options Counseling Contract			$47,000				$47,000	$0
SSAC and DSAC Volunteer Hours		$5,000					$0	$5,000
Evidence Based Funds to support powerful tools					$20,000		$20,000	$0
Older Adult Behavioral Health Contract w/ Linn County	$120,000						$120,000	$0
Donated Space, Door Prizes and Food for FCSP Celebration						$2,000		$2,000
Old Mill Staff time to run Grandparent Support Group						$7,000	$0	$7,000
Column Totals:	**$140,000**	**$11,073**	**$202,000**	**$110,000**	**$20,000**	**$16,000**	**$362,000**	**$137,073**

(12)	(13)
SOURCE OF MEDICAID LOCAL MATCH FUNDS	TOTAL
Dues, Donations, Fees	$170,000
Benton County Veterans Contract	$80,000
Column Totals:	**$250,000**

Notes/Comments

Area Plan Budget, Worksheet 3
Oregon Cascades West Council of Governments Senior & Disa
Select Budget Period

Medicaid/OAA/OPI Staffing Plan

ADMINISTRATIVE POSITIONS								Breakout of funding sources			
(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Position Title	FTE Worked	Annual Salary (excludes OPE)	Annual OPE	Total Salary + OPE	OAA Funds	OPI Funds	Other Funds	Medicaid Funds Regular Allocation	Medicaid Funds Local Match	Medicaid Matched by Local Funds	Total
Program Director	1.00	$92,528	$48,200	$140,728	$7,014		$7,014	$126,699			$140,728
Clerical Supervisor	1.00	$57,473	$39,865	$97,338				$97,338			$97,338
Contracts Coordinator	0.60	$32,261	$19,133	$51,395	$17,132		$17,132	$17,132			$51,395
Program Manager	3.00	$207,564	$152,418	$359,982	$42,765	$30,423	$7,014	$279,779			$359,982
Program Supervisor	6.00	$390,152	$239,006	$629,158				$629,158			$629,158
Community/Council Liaison	0.50	$21,269	$7,632	$28,901	$28,901						$28,901
			$0	$0							$0
			$0	$0							$0
ADMINISTRATIVE TOTAL	12.10	$801,247	$506,254	$1,307,501	$95,812	$30,423	$31,161	$1,150,105	$0	$0	$1,307,501

DIRECT SERVICES POSITIONS								Breakout of funding sources			
Position Title	FTE Worked	Annual Salary (excludes OPE)	Annual OPE	Total Salary + OPE	OAA Funds	OPI Funds	Other Funds	Medicaid Funds Regular Allocation	Medicaid Funds Local Match	Medicaid Matched by Local Funds	Total
Case Manager	35.89	$1,981,955	$1,253,373	$3,235,328	$110,615	$130,912	$269,579	$2,724,222			$3,235,328
Eligibility Specialist	20.4	$984,772	$653,542	$1,638,314				$1,638,314			$1,638,314
ADRC Specialist	4.65	$214,978	$37,035	$252,013	$112,708			$252,013			$364,721
APS Case Managers	6	$335,011	$213,838	$548,849				$548,849			$548,849
AFH Licensors	1.75	$87,229	$51,712	$138,942				$138,942			$138,942
Diversion Transition	3	$190,905	$119,562	$310,467				$310,467			$310,467
Trainer	1	$65,792	$39,171	$104,962				$104,962			$104,962
Administrative Assistant	5.075	$208,617	$123,810	$332,427				$332,427			$332,427
Clerical Specialist	6.75	$248,496	$181,895	$430,391				$430,391			$430,391
Meal Site Managers	5.3	$189,636	$125,518	$315,154				$315,154			$315,154
Meals Coordinator	1.25	$41,917	$32,967	$74,884				$74,884			$74,884
STEPS Coordinator	0.75	$31,083	$22,424	$53,508				$53,508			$53,508
H2H Coach	0.85	$50,647	$36,411	$87,058			$87,058				$87,058
Options Counselor	1.5	$77,176	$48,106	$125,282	$41,760.50		$83,521				$125,282
			$0	$0							$0
ADMINISTRATIVE TOTAL	12.10	$801,247	$506,254	$1,307,501	$95,812	$30,423	$31,161	$1,150,105	$0	$0	$1,307,501
DIRECT SERVICE TOTAL	94.17	$4,708,214.25	$2,939,362.62	$7,647,576.87	$265,083.27	$130,912.13	$440,157.61	$6,924,131.83	$0.00	$0.00	$7,760,284.83
GRAND TOTAL	106.27	$5,509,461.07	$3,445,616.53	$8,955,077.60	$360,895.37	$161,335.09	$471,318.15	$8,074,236.95	$0.00	$0.00	$9,067,785.56

XIX-OAA-OPI Staffing Plan

Area Plan Budget, Worksheet 4

Oregon Cascades West Council of Governments Senior & Disabled Srvcs (OCWCOG)

Select Budget Period

(3) APD Position Titles	Number of FTE Employed	(4) Area Agency on Aging Position Title (if applicable)	(5) Medicaid Positions and Title (in addition to APD allocated positions)	(6) Number of FTE Employed
Admin Specialist 1	5.08	Administrative Assistant		
Adult Protective Services Specialist	6.00	APS Case Manager	Trainer	1.00
Compliance Specialist 2 (AFH Licen.)	1.75	AFH Licensor	Clerical Supervisor	1.00
Diversion Case Manager	3.00	Diversion Transition Case Manager	ADRC Specialist	4.65
Human Services Assistant 2	3.00	In Home Assistant	Meal Site Manager	1.10
Human Services Case Manager	35.89	Case Manager	Contract Coordinator	0.20
Human Services Specialist 3	20.40	Eligibility Speciailist	Options Counselor	1.00
Office Specialist 2	6.75	Clerical Specialist		
Pre-Admission Screening				
Principal Executive Manager C	6.00	Program Supervisors		
Principal Executive Manager D				
Principal Executive Manager E	3.00	Program Manager		
Principal Executive Manager F	1.00	Program Director		
Transition Case Manager				

Allocated Medicaid Staff Date Printed: 9/26/2016 1 of 9

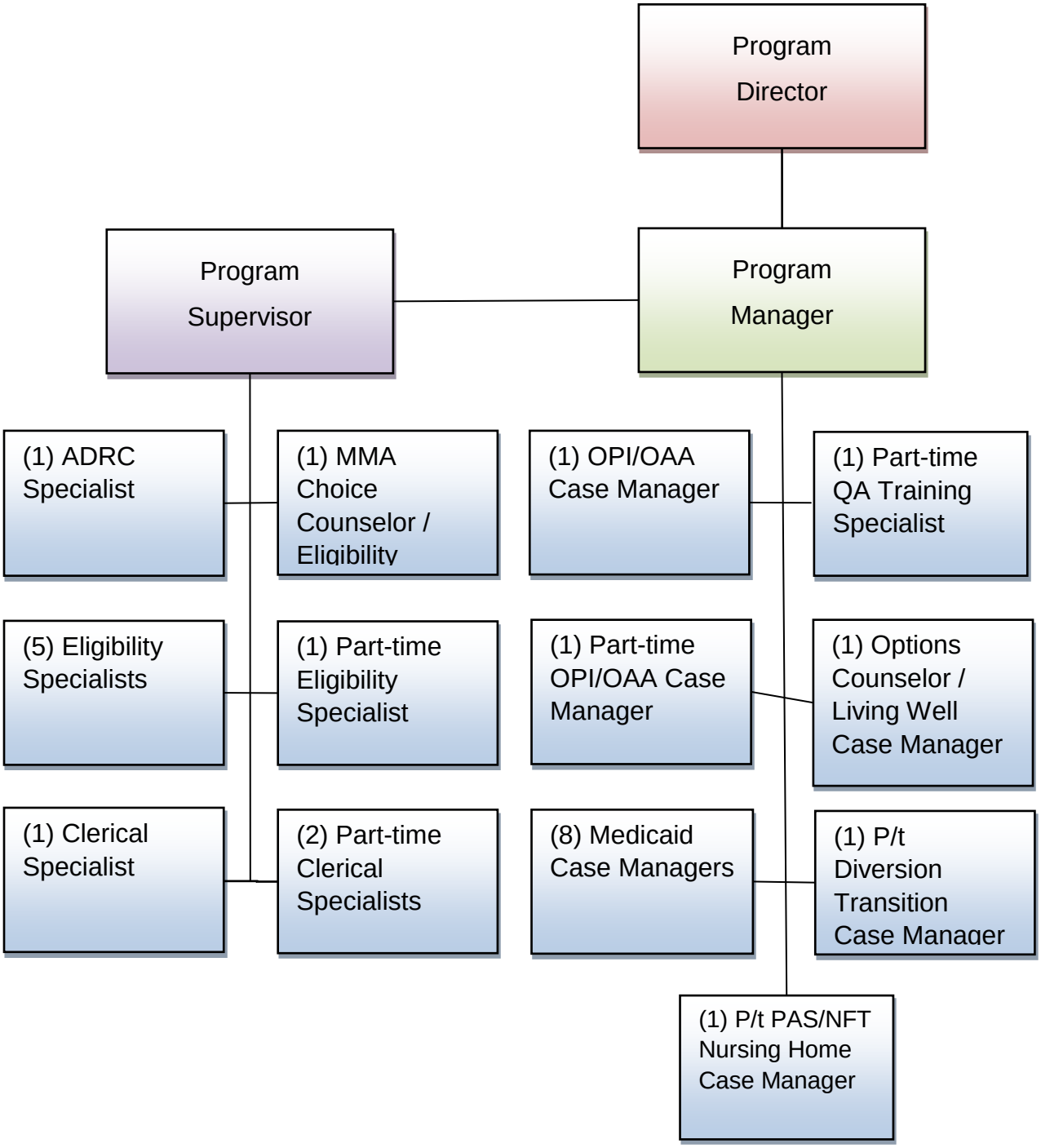
Select AAA Name	Select Budget Period
Community Action Program of East Central Oregon (CAPECO)	BUDGET PERIOD: 7.1.2016 - 6.30.2017 Area Plan Year 1
Community Action Team (CAT)	BUDGET PERIOD: 7.1.2017 - 6.30.2018 Area Plan Year 2
Community Connection of Northeast Oregon (CCNO)	BUDGET PERIOD: 7.1.2018 - 6.30.2019 Area Plan Year 3
Clackamas County Social Services (CCSS)	BUDGET PERIOD: 7.1.2019 - 6.30.2020 Area Plan Year 4
Central Oregon Council on Aging (COCOA)	
Douglas County Senior Services Division (DCSSD)	
Harney County Senior & Community Services Center (HCSCS)	
Klamath & Lake Counties Council on Aging (KLCCOA)	
Lane Council of Governments Senior & Disabled Services (LCOG)	
Multnomah County Aging, Disability & Veterans Services Department (MCADVSD)	
Mid-Columbia Council of Governments (MCCOG)	
Malheur Council on Aging & Community Services (MCOACS)	
NorthWest Senior & Disability Services (NWSDS)	
Oregon Cascades West Council of Governments Senior & Disabled Services (OCWCOG)	
Rogue Valley Council of Governments Senior & Disabled Services (RVCOG)	
South Coast Business Employment Corporation (SCBEC)	
Washington County Disability, Aging & Veteran Services (WCDAVS)	

Appendices

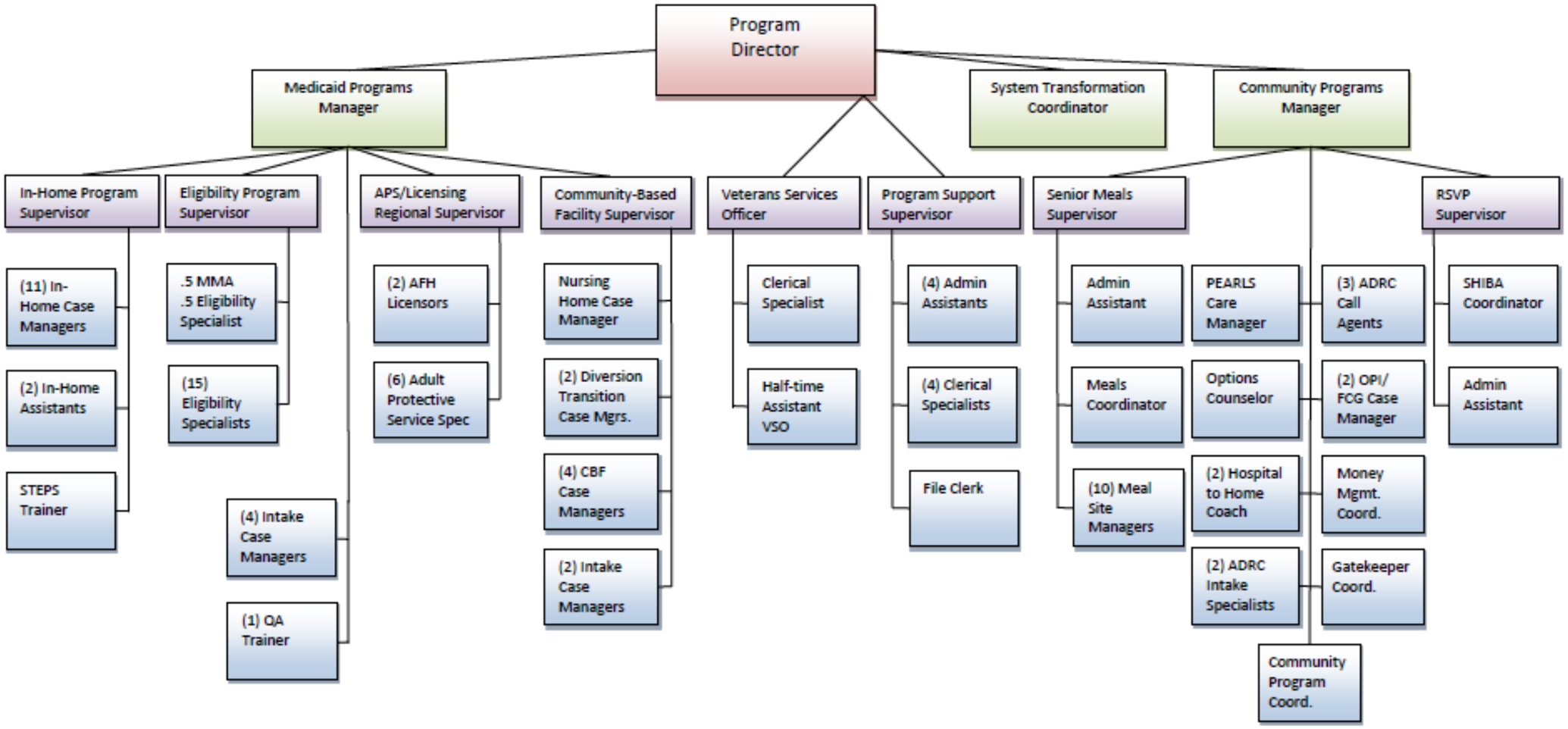
Appendix A

Organizational Charts

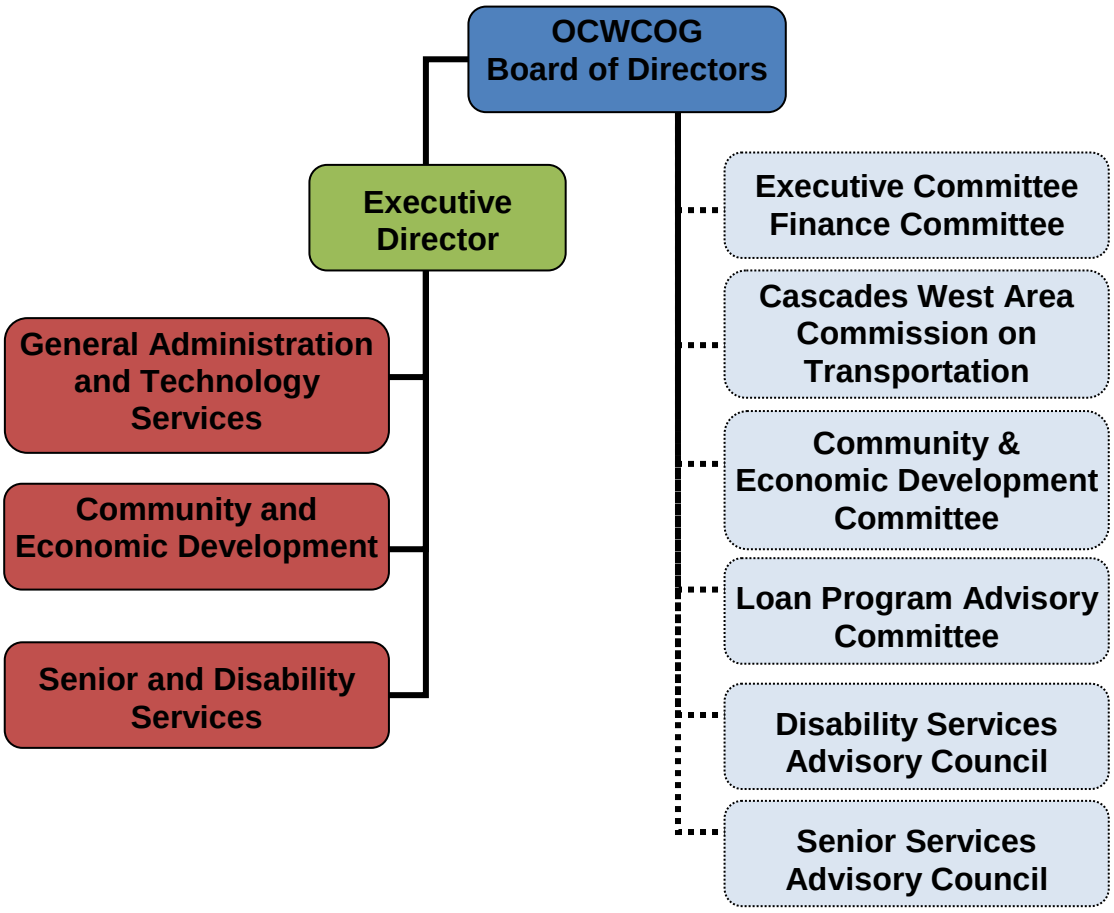
Senior and Disability Services - Toledo



Senior and Disability Services – Albany/Corvallis



OCWCOG Board of Directors



Appendix B

DSAC and SSAC Advisory Councils and Governing Body

OCWCOG's Board of Directors

Name and Contact Information	Representing	Date of Term Expiration
Anne Schuster, Commissioner	Benton County	12/31/18
Bill Currier, Mayor	Adair Village	12/31/18
Biff Traber, Mayor	Corvallis	12/31/18
Ron Thexton, City Councilor	Monroe	12/31/18
Rocky Sloan, Mayor	Philomath	12/31/16
John Lindsey, Commissioner	Linn County	12/31/16
Sharon Konopa, Mayor	Albany	12/31/18
Don Ware, Mayor	Brownsville	12/31/18
Ken Lorensen, City Councilor	Halsey	12/31/16
Sarah Puls, City Councilor	Harrisburg	12/31/16
Bob Elliot, City Councilor	Lebanon	12/31/16
Jim Lepin, City Councilor	Millersburg	12/31/18
Debbie Nuber, City Councilor	Scio	12/31/18
Jeffrey Goodwin, Mayor	Sweet Home	12/31/16
Loel Trulove, Mayor	Tangent	12/31/18
Bill Hall, Commissioner	Lincoln County	12/31/18
Robert Kentta, Siletz Tribe	Tribal Treasurer	12/31/18
A.J. Mattila, Mayor	Depoe Bay	12/31/16
Chester Noreikis, City Councilor	Lincoln City	12/31/16
Dean Sawyer, City Councilor	Newport	12/31/16
Walter Chuck, Projects Manager	Port of Newport	12/31/17
Dave Button, City Councilor	Siletz	12/31/16
Jill Lyon, City Councilor	Toledo	12/31/16
Dann Cutter, City Councilor	Waldport	12/31/16
Ron Brean, Mayor	Yachats	12/31/18

Disability Services Advisory Council Membership, July 2016

Name	Representing	Date of Term Expiration
Bill Hall, Lincoln County Commissioner	Lincoln	None
Rusty Burton	Linn	2018
Mike Volpe	Benton	2018
Jann Glenn	Lincoln	2018
Edythe James	Linn	2017
Lee Lazaro	Benton	2017
Suzanne Brean	Linn	2018
Pete Rickey	Linn	2017
Jan Molnar-Fitzgerald	Lincoln	2017

Senior Services Advisory Council Membership, July 2016

Name	Representing	Date of Term Expiration
Mike Volpe, DSAC Liaison	DSAC	None
Bill Hall, Lincoln County Commissioner	Lincoln	None
Suzette Boydston	Linn	2017
Mark McNabb	Benton	2017
Bill Turner	Lincoln	2017
Catherine Skiens	Linn	2018
Anne Brett	Benton	2018
Doris Lamb	Lincoln	2018
Curtis Miller	Linn	2017
Janet Shinner	Lincoln	2017
Lee Strandberg	Benton	2018
Danita Marlow	Linn	2017
Bob Daley	Benton	2017
Suzanne Lazaro	Benton	2018

Appendix C

Public Process

To assist in developing the *2017-2020 Area Plan*, OCWCOG Senior & Disabilities Services implemented a comprehensive planning process that began in 2104 and concluded in September, 2016.

This planning process included:

1. A Consumer Satisfaction Survey and Report
2. Regular updates and solicitation from SSAC and DSAC from March, 2016-September 2016
3. A Special SSAC/DSAC *Area Plan* Meeting - members assisted SDS in designing a Community Partner Survey
4. Four Community Forums - in Albany, Corvallis, Lebanon, and Newport
5. Community Partner Agency Survey - completed in Spring 2016
6. Two Focus Groups - Native Elders held at Siletz and LGBT held in Corvallis
7. Public Hearing - held in September 2016; advertised in accordance with public hearings rules (several newspapers, radio stations, etc.)

Oregon Cascades West Council of Governments
Senior & Disability Services
Consumer Satisfaction Final Report

Prepared by Katie Stevens

Survey Design

In August the 2014 Consumer Satisfaction Survey was initiated by Oregon Cascades West Council of Governments (OCWCOG) and Senior and Disability Services (SDS) to satisfy federal regulations and more importantly to determine consumers' current level of satisfaction with OCWCOG and SDS as well as the current issues our consumers face in their daily lives. To fully understand the issue the Oregon Cascades West Council of Governments Area Plan, budget plans, and previous surveys were utilized to accomplish three goals: (1) to determine past and potentially current issues our clients face; (2) to determine consumer satisfaction in the past and; (3) to guide survey design.

Survey design had in the past asked questions only about our consumers' level of satisfaction with OCWCOG and SDS' service, but a thorough analysis of the documents suggested there may be ongoing issues in our consumers' daily lives that could be documented for future planning and initiatives. These issues may affect our consumers' opinions surrounding OCWCOG and SDS' service as well. The newest iteration of the survey design includes a section on consumers' level of satisfaction with our service as well as a section on issues they may be facing in their daily lives. Older survey iterations documented four primary issues for our consumers in (1) affordable & safe housing, (2) food insecurity, (3) healthcare, and (4) transportation. These primary issues as well as other small, yet frequently documented, issues

drove the additional questions in the survey i.e. issues with caregivers, opinions surrounding staff responsiveness and knowledge, and knowledge of the Aging and Disability Resource Connection (ADRC). The additional questions make it easier for OCWCOG and SDS to understand our consumers' lives, which means our organization is better equipped to handle and prepare for the issues they may face as the issues have previously been documented.

Methodology

Senior & Disability Services contracts with the state of Oregon and the federal government to provide Medicaid services to 12,000 older adults and people with disabilities and those records are kept by the Department of Human Services (DHS). Senior & Disability Services' administrative assistants were able to retrieve that list from DHS. To reduce cost it was decided to send 5,000 surveys to these individuals, thus the researcher went through the master list and removed every third or second name in a rotating fashion. For example, the researcher would remove the third name down then the second name down and then the third name down in a consecutive order. This strategy lent a random order to the individuals on Medicaid who received the Consumer Satisfaction Survey.

The methodology which was utilized during the 2014 Consumer Satisfaction Survey had two main goals in that the research team wanted a representative sample from each county, gender, and age group as well as a high return rate. To accomplish these goals Senior & Disability Services sent out 6,000 surveys. The breakdown of individuals who received surveys in the mail included 5,000 surveys to individuals on Medicaid, while 800 went to individuals who receive home-delivered meals, and 200 surveys went to individuals who receive Oregon Project Independence Benefits; contained within the survey were boxes to check if individuals

drove the additional questions in the survey i.e. issues with caregivers, opinions surrounding staff responsiveness and knowledge, and knowledge of the Aging and Disability Resource Connection (ADRC). The additional questions make it easier for OCWCOG and SDS to understand our consumers' lives, which means our organization is better equipped to handle and prepare for the issues they may face as the issues have previously been documented.

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were currently or had in the past received Oregon Project Independence Benefits or meals from the Meals on Wheels program. In addition the Consumer Satisfaction Survey contained questions surrounding gender, age, name, address, and phone number as well as questions about Senior & Disability Services and questions surrounding challenges (transportation, healthcare, food insecurity, access to information, and affordable and safe housing) these consumers face in their daily lives[1].

Response Collection

As the Consumer Satisfaction Survey Coordinator I wanted to utilize an online survey as well as a mail survey to have lower costs in terms of resources and time, but it became clear that the online survey may be under-utilized. The online survey had already been created so it became the primary online data collection and analysis tool. Each of the 1,075 returned surveys were entered manually into Qualtrics, the aforementioned online data tool, and recorded as being complete. While the majority of the surveys were filled out completely and with comments many of the consumers did not leave contact information. The 193 respondents who did leave contact information had almost always checked the box contained within the survey to be contacted. Those requests for contact will be given to the appropriate caseworker and manager for follow-up. As of today all of the returned surveys have been recorded in Qualtrics and the data has been downloaded into an Excel file.

[1] For a copy of the survey please see Appendix A.

Results

Overall, the results of the Consumer Satisfaction Survey demonstrate that the consumers of services from Oregon Cascades West Council of Governments and Senior & Disability Services are overwhelmingly satisfied with the services provided. However, there were several issues and there was one defining negative characteristic of our service that consumers wrote about in the space provided to discuss issues. The main complaint that 33% of consumers noted was with our caseworkers' unresponsiveness; consumers noted lengthy call back times and in some cases completely nonresponsive caseworkers. Finally, the results match our organization's expectations surrounding the demographic information, challenges, and satisfaction of our consumers.

Demographics

The demographic information matched with expectations. Of the 1,075 respondents there were 637 respondents who identified as female and 307 respondents who identified as male (See Figure 1a). The skewed response rate may be due to a variety of factors including the researched hypothesis that females respond to surveys at a higher rate than their male counterparts, but also because when there was a couple who were both on Medicaid in the master list the researcher chose to send it to the female due to the aforementioned hypothesis. The sample proportionally represented the county populations with more respondents identifying their residence in Linn County, then in Lincoln County, and then from Benton County. It is no surprise that Linn County had the most respondents as the county has the largest population at 118,765; 16.8% of those individuals are 65 years of age or older (US Census, 2013). Even though Lincoln County has a lower population at 46,350 under Benton County at 86,591, Lincoln County has a significantly

larger older population at 23.8% than does Benton County at 13.7% (US Census, 2013). The survey respondents' most popular age groups were between 50 – 89 years of age (See Figure 2a). 79% of the 951 respondents who answered the age question say they fall in this age group.

Figure 1a:

#	Answer		Response	%
1	Male		307	33%
2	Female		637	67%
	Total		944	100%

Figure 2a:

#	Answer		Response	%
1	18 - 29		40	4%
2	30 - 39		45	5%
3	40 - 49		77	8%
4	50 - 59		168	18%
5	60 - 69		259	27%
6	70 - 79		203	21%
7	80 - 89		124	13%
8	90 - 99		32	3%
9	99+		3	0%
	Total		951	100%

Return Rate(s)

One of the methodological goals, a high return rate, was achieved during response collection. The response rate achieved from the Consumer Satisfaction Survey was 18%. As you may remember Senior & Disability Services sent 5,000 surveys to individuals on Medicaid, 800 surveys to individuals who have or who are currently receiving meals from the Meals on Wheels program, and 200 surveys to consumers who receive Oregon Project Independence benefits. Due to the survey design where it was asked if individuals received home delivered meals or Oregon Project Independence Benefits we can deduce the return percentages for each group of consumers (See Figure 1b & 2b). Medicaid clients responded at the lowest rate of return at 17%

as 850[2] out of 5,000 returned the survey. Individuals who have or currently are receiving home-delivered meals from the Meals on Wheels program responded at a rate of 20% as 162 out of 800 returned the survey. Finally, the Oregon Project Independence beneficiaries responded with the highest rate at 32% as 63 out of 200 OPI clients returned the survey.

Figure 1b:

Do you receive home delivered meals?

#	Answer		Response	%
1	Yes		162	15%
2	No		899	85%
	Total		1,061	100%

Figure 2b:

Do you receive Oregon Project Independence (OPI) benefits?

#	Answer		Response	%
1	Yes		63	6%
2	No		996	94%
	Total		1,059	100%

Services

Oregon Cascades West Council of Governments (OCWCOG) and Senior & Disability Services (SDS) made contact with 99% of the survey respondents via phone (65%) or in person (34%) with 1% of respondents reporting they contacted the organization through the OCWCOG website (See Figure 1c). On average the majority of survey respondents answered they agree or strongly agree that they are happy with the help they received from Senior & Disability Services (See Figure 2c). Further, the majority of survey respondents agreed or strongly agreed that the staff people they work with are knowledgeable and responsive (See Figure 2c). In addition, 99%

[2] This number is assumed as these consumers did not answer that they receive either home-delivered meals or Oregon Project Independence benefits.

of the survey respondents felt they are treated courteously when they contacted Senior & Disability Services (See Figure 3c). 96% of the respondents believed they were helped in a reasonable amount of time and 95% of survey respondents thought they had received the information they needed (See Figure 4c). Finally, 93% of the consumers rated their contact with Senior & Disability Services as Good to Excellent, which indicates that a mere 7% rated our service as Fair or Needs Improvement (See Figure 5c).

Figure 1c:

At the time of your last contact with Senior & Disability Services, how did you make contact with us?

#	Answer		Response	%
1	In person.		348	34%
2	Via the phone.		666	65%
3	Via the website.		10	1%
	Total		1,024	100%

Figure 2c:

How are we doing?

#	Answer	Average Value	Total Responses
1	I am happy with the help I received from Senior & Disability Services.	1.63	917
2	The staff people I work with are knowledgeable and responsive.	1.64	966

Figure 3c:

Were you treated courteously?

#	Answer		Response	%
1	Yes		999	99%
2	No		11	1%
	Total		1,010	100%

Figure 4c:

Were you helped in a reasonable amount of time?

#	Answer		Response	%
1	Yes		965	96%
2	No		45	4%
	Total		1,010	100%

Figure 5c:

Did you get the information you needed?

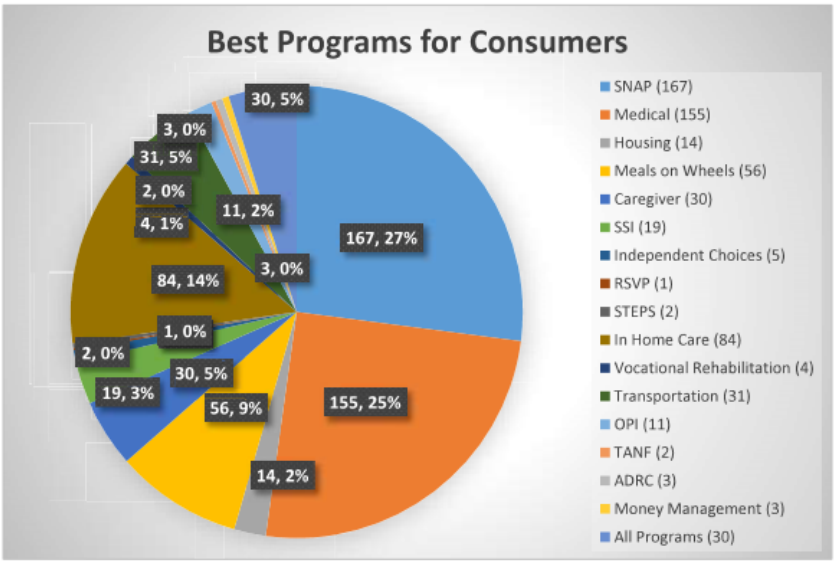
#	Answer		Response	%
1	Yes		954	95%
2	No		55	5%
	Total		1,009	100%

Consumer Services

The 2014 Consumer Satisfaction Survey was designed with a question for consumers to write in the programs that work best for them. Due to the nature of the question there were many different responses, thus the responses were placed into bigger categories such as medical, transportation, or housing. If categorization was not feasible then those individual responses were recorded. The categories or programs included housing, SNAP, Meals on Wheels, caregiver, medical, SSI, Independent Choices, RSVP, OHP, STEPS, In Home Care, Vocational

Rehabilitation, transportation, OPI, Money Management, the ADRC, TANF, or a response that all programs were working.

Figure 6a:



As seen in Figure 6a the programs or services consumers identified as being the best were the Supplemental Nutrition Assistance Program, Medical services, In Home Care, Meals on Wheels, Transportation, their caregivers, SSI, Housing, OPI, Independent Choices, Vocational Rehabilitation, the ADRC, Money Management, TANF, STEPS, and RSVP. 30 survey respondents reported that all of their programs work well for them. In addition, several consumers wrote in specific caseworkers who have made their interactions with Oregon Cascades West Council of Governments and Senior & Disability Services a pleasant experience.

Consumer's Daily Challenges

A review of the Oregon Cascades West Council of Governments Area Plan and past surveys indicated four primary areas that the survey respondents and consumers of service noted as providing challenges in their lives. As previously mentioned those areas were transportation, affordable and safe housing, healthcare, and food insecurity. It was not immediately obvious that access to information was also an issue, but it became apparent that the consumers of services do have difficulty accessing information as well as still facing challenges in the four aforementioned areas. The consumers' difficulty in accessing information may be due to a perceived lack of responsiveness on the part of Senior & Disability Services' caseworkers. This is potentially problematic because 666 out of 1,075 survey respondents indicated they made contact with Senior & Disability Services by phone the last time.

To document and better understand the daily challenges these consumers face a Likert Scale questionnaire[3] was developed to ascertain the consumers' level of satisfaction or dissatisfaction. Each of the six questions is coded with answers from one to five where one equals "strongly agree", two equals "agree", three equals "neutral", four equals "disagree", and five equals "strongly disagree". A score closer to one means that the survey respondents, on average, believed they are happy with the services Senior& Disability Services provides, that they are happy with transportation, healthcare, housing, and their caregivers, and that Senior & Disabilities Services staff are knowledgeable and responsive (See Figure 1e). Questions (See Figure 1d) were asked surrounding consumers' knowledge of the Aging and Disability Resource Connection (ADRC), access to transportation, housing, and healthcare, and whether consumers

[3] The Likert Scale questionnaire was coded with numerical values 1 through 5 where 1 equals "strongly agree", 2 equals "agree", 3 equals "neutral", 4 equals "disagree", and 5 equals "strongly disagree". These numerical values created an average score for each question. For example, if a question had an average score of 1.58 that would indicate that most people answered "strongly agree to agree" with a few dissidents.

were satisfied with their caregivers (if applicable). 789 out of 1,075 or 73% of survey respondents were not aware of nor had ever used the ADRC. The ADRC can potentially be a wealth of information for anyone who desires more information about a variety of issues. The consumers who responded to the survey "agreed" with an average of 2.01 that they do have adequate transportation in their community that meets their needs. The survey respondents also agree with an average answer of 1.58 that their housing is safe and meets their needs. Further, consumers believed, at an average score of 1.60 that they had access to adequate healthcare. Finally, with a strong average score of 1.68, the consumers believed their caregivers are trained well.

Figure 1d:

How are we doing?

#	Answer	Average Value	Total Responses
1	I have access to adequate transportation in my community that meets my needs.	2.01	944
2	My current housing situation is safe and meets my needs.	1.58	993
3	My caregivers are trained well.	1.68	779
4	I have access to adequate healthcare.	1.60	972

Figure 1e:

Statistic	I am happy with the help I received from Senior & Disability Services.	I have access to adequate transportation in my community that meets my needs.	The staff people I work with are knowledge able and responsive.	My current housing situation is safe and meets my needs.	My caregivers are trained well.	I have access to adequate healthcare.
Min Value	1	1	1	1	1	1
Max Value	5	5	5	5	5	5
Mean	**1.63**	**2.01**	**1.64**	**1.58**	**1.68**	**1.60**
Total Responses	917	944	966	993	779	972

Cross Tabulations

A contingency table, better known as a "cross tab" is a type of table in a matrix format that displays the frequency distribution of the variables contained within the matrix. Several cross tabs have been run on the survey data to demonstrate how age and gender may affect a survey respondent's answers. In these cross tabulations there is little difference in terms of age and gender in how the survey respondents answered the questions, even though there are significantly less male respondents. Similarity in answers lends credibility to the collected data; the similarity indicates the survey population is homogenous, an expected characteristic within the survey population.

In this cross tabulation frequency of gender and these five questions were compared:

1. At the time of your last contact with Senior & Disability Services, how did you make contact with us?
2. Were you treated courteously?
3. Were you helped in a reasonable amount of time?
4. Did you get the information you needed?
5. How would you rate your contact with Senior & Disability Services?

COLLECTIVE GENDER RESULTS

Senior & Disability Services consumers have overwhelmingly positive beliefs about the service Senior & Disability Services' provides.

99% thought they were treated courteously.

96% thought they were helped in a reasonable amount of time.

95% believed they received the information they needed.

93% rated their contact with Senior & Disability Services as Good to Excellent.

When gender and the question concerning organization contact are compared it is clear that 99% of the time the consumers prefer to contact the organization by phone or in person as only nine individuals reported they contacted the organization through the website. Of the individuals who answered both the gender question and the question concerning contact, 290 were male and 613 identified as female for a total of 903. Overall, males are more likely to make contact in person while females are more likely to make contact by phone. This data indicates that Senior & Disability Services should continue to rely on its staff and phone protocols to address the needs of its consumers.

When asked, 289 males and 599 females, 99% of the female and male survey respondents agree that when they make contact with Senior & Disability Services they are treated courteously; nine total, three male and six female, or 1% of survey respondents thought they were not treated courteously. Further, 96% of the 289 males and 602 females who responded to the question concerning service time believed they were helped in a reasonable amount of time. 2.5% of males and 5.1% of females thought they were not helped in a reasonable amount of time, thus a collective 4.2% of the consumers who identified their gender believe they were not helped in a reasonable amount of time. Thirdly, 95% of the consumers thought they received the information they needed when they contacted Senior & Disability Services. Of the 890 respondents who identified a gender and who answered the information question 48 or 5.3% believed they did not receive the information they needed. Finally, 94.5% of males and 93.3% of females rate their contact with Senior & Disability Services on a scale of good to excellent. Collectively, this data indicates that Senior & Disability Services creates a courteous environment for the consumers that may need improvement in the areas of

service time and informational resources, however, it should be noted that with increasing caseloads and limited new staff hires that if the organization helps 93 - 95 of every 100 consumers to their satisfaction then Senior & Disability Services is completing the work with the result of exceptional consumer satisfaction.

Gender Cross Tabulation[6]

		What is your gender?			
		Male	Female	Mean	Total
At the time of your last contact with Senior & Disability Services, how did you make contact with Senior & Disability Services?	In person.	117 40.34%	188 30.67%	1.62	305 33.78%
	Via the phone.	171 58.97%	418 68.19%	1.71	589 65.23%
	Via the website.	2 0.69%	7 1.14%	1.78	9 1.00%
	Total	290 100.00%	613 100.00%	-	903 100.00%
Were you treated courteously?	Yes	286 98.96%	593 99.00%	1.67	879 98.99%
	No	3 1.04%	6 1.00%	1.67	9 1.01%
	Total	289 100.00%	599 100.00%	-	888 100.00%
Were you helped in a reasonable amount of time?	Yes	282 97.58%	571 94.85%	1.67	853 95.74%
	No	7 2.42%	31 5.15%	1.82	38 4.26%
	Total	289 100.00%	602 100.00%	-	891 100.00%
Did you get the information you needed?	Yes	277 95.19%	565 94.32%	1.67	842 94.61%
	No	14 4.81%	34 5.68%	1.71	48 5.39%
	Total	291 100.00%	599 100.00%	-	890 100.00%
How would you rate your contact with Senior & Disability Services?	Excellent	148 49.83%	292 47.71%	1.66	440 48.40%
	Very Good	91 30.64%	199 32.52%	1.69	290 31.90%
	Good	42 14.14%	80 13.07%	1.66	122 13.42%
	Fair	10 3.37%	14 2.29%	1.58	24 2.64%
	Needs Improvement.	6 2.02%	27 4.41%	1.82	33 3.63%
	Total	297 100.00%	612 100.00%	-	909 100.00%

[6] It should be noted that while a large number of the surveys were filled out to completion a significant number of surveys were not; most notably survey respondents either did not return or answer the questions surrounding gender and age. This creates a cross tabulation with fewer numbers in each "total" box because to count in the cross tabulation the respondent had to provide an answer to each question.

When age and the question concerning organization contact are compared it becomes clear that 99% of the time the consumers, of any age, prefer to contact the organization by phone or in person as only nine individuals (1%) reported they contacted the organization through the website. Phone contact was the most popular option as 65% of consumers made contact through the phone; slightly less than double the rates of in person contact. In person organizational contact was second as 34% of survey respondents reported they made contact with Senior & Disability Services in person the last time. This data indicates that phone and in person contact should continue to be a priority for Senior & Disability Services.

When age and service-related questions were asked of the survey respondents 884 (99%) respondents of all ages reported they feel they are treated courteously when they make contact with Senior & Disability Services. 10 respondents aged between 50 – 89 felt they were not treated courteously; due to the popularity of this age group within the population it is expected to have a number of negative responses. Secondly, 857 (95%) thought they were helped in a reasonable amount of time by staff and services while 39 individuals felt they were not helped in a reasonable amount of time. Thirdly, 846 (94%) survey respondents believed they received the information they needed, however 49 individuals felt they did not receive the information they required. Finally, 93.4% of consumers rated their overall contact with Senior & Disability Services on a scale of good – excellent. The age cross tabulation indicates that Senior & Disability Services treats their consumers courteously, but could improve their service time and informational resources. As with the gender cross tabulation it should be noted with increasing caseloads and limited new staff hires that if the organization helps 93 of every 100 consumers to their satisfaction then Senior & Disability Services is completing the work with the result of exceptional consumer satisfaction.

In the second cross tabulation frequency of age and these five questions were compared:

1. At the time of your last contact with Senior & Disability Services, how did you make contact with us?
2. Were you treated courteously?
3. Were you helped in a reasonable amount of time?
4. Did you get the information you needed?
5. How would you rate your contact with Senior & Disability Services?

The consumers of Oregon Cascades West Council of Governments services and specifically of Senior & Disability Services are on the whole extremely happy with the services they receive and the staff they encounter. The cross tabulations show us there are no significant differences in the survey responses between people of varying ages and genders. This homogeneity of the survey population is clearly seen when age and gender are compared with the survey questions as the response percentages are almost exactly the same.

COLLECTIVE AGE RESULTS

Senior & Disability Services consumers have overwhelmingly positive beliefs about the service Senior & Disability Services' provides.

99% thought they were treated courteously.

95% thought they were helped in a reasonable amount of time.

94% believed they received the information they needed.

93% rated their contact with Senior & Disability Services as Good to Excellent.

Age Cross Tabulation[7]

		What is your age?									
		18 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90 - 99	99+	Total
At the time of your last contact with Senior & Disability Services, how did you make contact with Senior & Disability Services?	In person.	12 31.58%	17 40.48%	23 30.67%	55 33.95%	68 27.42%	70 35.35%	49 42.98%	15 53.57%	1 50.00%	310 34.18%
	Via the phone.	26 68.42%	25 59.52%	50 66.67%	106 65.43%	175 70.56%	128 64.65%	64 56.14%	13 46.43%	1 50.00%	588 64.83%
	Via the website.	0 0.00%	0 0.00%	2 2.67%	1 0.62%	5 2.02%	0 0.00%	1 0.88%	0 0.00%	0 0.00%	9 0.99%
	Total	38 100.00%	42 100.00%	75 100.00%	162 100.00%	248 100.00%	198 100.00%	114 100.00%	28 100.00%	2 100.00%	907 100.00%
Were you treated courteously?	Yes	38 100.00%	41 97.62%	74 100.00%	160 98.77%	240 98.77%	190 98.45%	113 99.12%	26 100.00%	2 100.00%	884 98.88%
	No	0 0.00%	1 2.38%	0 0.00%	2 1.23%	3 1.23%	3 1.55%	1 0.88%	0 0.00%	0 0.00%	10 1.12%
	Total	38 100.00%	42 100.00%	74 100.00%	162 100.00%	243 100.00%	193 100.00%	114 100.00%	26 100.00%	2 100.00%	894 100.00%
Were you helped in a reasonable amount of time?	Yes	36 97.30%	41 97.62%	75 100.00%	152 93.83%	233 95.88%	187 94.92%	107 94.69%	24 96.00%	2 100.00%	857 95.65%
	No	1 2.70%	1 2.38%	0 0.00%	10 6.17%	10 4.12%	10 5.08%	6 5.31%	1 4.00%	0 0.00%	39 4.35%
	Total	37 100.00%	42 100.00%	75 100.00%	162 100.00%	243 100.00%	197 100.00%	113 100.00%	25 100.00%	2 100.00%	896 100.00%
Did you get the information you needed?	Yes	35 94.59%	41 100.00%	73 97.33%	154 93.90%	223 91.02%	181 93.78%	109 99.09%	27 100.00%	3 100.00%	846 94.53%
	No	2 5.41%	0 0.00%	2 2.67%	10 6.10%	22 8.98%	12 6.22%	1 0.91%	0 0.00%	0 0.00%	49 5.47%
	Total	37 100.00%	41 100.00%	75 100.00%	164 100.00%	245 100.00%	193 100.00%	110 100.00%	27 100.00%	3 100.00%	895 100.00%
How would you rate your contact with Senior & Disability Services?	Excellent	13 33.33%	19 45.24%	30 40.00%	79 48.47%	118 46.83%	96 48.48%	68 59.13%	16 57.14%	1 33.33%	440 48.09%
	Very Good	16 41.03%	15 35.71%	27 36.00%	52 31.90%	79 31.35%	62 31.31%	31 26.96%	7 25.00%	2 66.67%	291 31.80%
	Good	5 12.82%	7 16.67%	14 18.67%	20 12.27%	38 15.08%	24 12.12%	12 10.43%	4 14.29%	0 0.00%	124 13.55%
	Fair	0 0.00%	1 2.38%	3 4.00%	5 3.07%	8 3.17%	8 4.04%	1 0.87%	1 3.57%	0 0.00%	27 2.95%
	Needs improvement.	5 12.82%	0 0.00%	1 1.33%	7 4.29%	9 3.57%	8 4.04%	3 2.61%	0 0.00%	0 0.00%	33 3.61%
	Total	39 100.00%	42 100.00%	75 100.00%	163 100.00%	252 100.00%	198 100.00%	115 100.00%	28 100.00%	3 100.00%	915 100.00%

[7] It should be noted that while a large number of the surveys were filled out to completion a significant number of surveys were not; most notably survey respondents either did not return or answer the questions surrounding gender and age. This creates a cross tabulation with fewer numbers in each "total" box because to count in the cross tabulation the respondent had to provide an answer to each question.

Community Forums

In addition to conducting the 2014 Consumer Satisfaction Survey Oregon Cascades West Council of Governments and Senior & Disability Services chose to host four community events in the tri-county area for consumers and community partners to attend to share their opinions surrounding support services for older adults and people with disabilities in the local area. The community forums were held in Lebanon, Newport, Corvallis, and Albany in locations that were accessible to community partners and consumers. During the events five main topic areas were discussed; these five topic areas were identified from past surveys, the Oregon Cascades West Council of Governments Area Plan, and from the current Consumer Satisfaction Survey. The five topics included issues surrounding transportation, healthcare, housing, food insecurity, and access to information, however, individuals were encouraged to bring up other issues for discussion.

Collective Issues

Throughout the four community forums Oregon Cascades West Council of Governments and Senior & Disability Services hosted there were similar themes mentioned by attendees. The most prevalent issues surrounded prohibitive cost, difficulty in accessing affordable transportation, housing, and healthcare, and lack of outreach to the community. To account for potential differences between the different cities and regions each of the four community events was facilitated by two managers and the Consumer Satisfaction Survey Coordinator who documented the communities' input. In the next section, each site will be reviewed for the outstanding issues that were discussed during each community forum.

Albany

The community event Oregon Cascades West Council of Governments and Senior & Disability Services hosted at the Albany Senior Center on Monday, December 15, 2014 had the highest attendance. At this particular event there were three tables, which were facilitated by three employees of Senior & Disability Services whose notes have been combined into a cohesive list and categorized under the five topic areas of transportation, housing, access to information, healthcare, and food insecurity.

Food Insecurity:

1. Good quality food is expensive.
2. Individuals must choose between paying bills or purchasing food.
3. Supplemental Nutrition Assistance Program help is small and fluctuates based on complicated equations.
4. A number of community members never received lessons in how to prepare food.
5. A health diagnosis can make it difficult due to necessary dietary changes.
6. Diminished cognitive ability makes it difficult or impossible for individuals to cook.
7. It is difficult to cook for one person.
8. A meal creates a sense of camaraderie that is missing when people are forced to eat alone.
9. Information and outreach surrounding community meals for socialization would be ideal.
10. A number of individuals have a difficult time going to meal sites if they do not go with a friend or family member.
11. Education surrounding nutrition is important and under-utilized.

Transportation:

1. Routes are long.
2. It's hard for some individuals to sit and wait the required time.
3. The bus may not run the route in a timely manner.
4. Call-a-ride is cost prohibitive on fixed income.
5. Call-a-ride requires advance notice and does not have door to door service.
6. Dial-a-bus has limited hours of operation.
7. City infrastructure is missing sidewalk ramps or no sidewalks and there is a lack of audio in the Albany crosswalks.
8. There is a lack of information on what different businesses provide for seniors.
9. There is a lack of information in general.
10. Seniors and people with disabilities have a hard time getting in and out of vehicles.

11. There are safety concerns at some bus stops.
12. There is a perceived lack of literacy that makes it difficult for people to read bus schedules.
13. Lack of bus transportation on weekends.
14. It is difficult to travel between counties.
15. It can be intimidating to ride the bus.

Housing:

1. There is a lack of affordable housing in the community.
2. There is a three year wait to live in low income housing.
3. A housing voucher is only redeemable for 60 days and the individual will lose the voucher if they do not find housing.
4. The housing voucher does not cover the entire housing cost.
5. The only people who are eligible for vouchers are families, peoples with disabilities and seniors.
6. Individuals who own their own homes find they cannot afford to keep them due to taxes, insurance, and maintenance.
7. It is against the law for two HUD voucher recipients to share housing.
8. Companion animals are important to people.
9. Constant home inspections of low income apartment complexes make residents feel demeaned.
10. A service that included basic home maintenance (shoveling snow, repairs) for seniors would help senior stay in their own homes.
11. A list of Senior & Disability Services' programs could be published in the newspaper so everyone is aware of the services provided.

Healthcare:

1. Current healthcare programs and legislation are complicated, hard to understand, and lack explanation, which makes choosing a healthcare plan even more difficult.
2. Mental health care is nonexistent.

3. Paperwork is difficult to understand and complete.
4. Mental capacity can be a contributing factor in the understanding and completion of paperwork, plans, programs, and legislation.
5. High co-payments are not affordable on a fixed income.
6. Additional services should be covered by insurance, including chiropractors and exercise programs.
7. It can be difficult to navigate the complicated phone queues and voicemail systems.

Access to Information:

1. Outreach is needed so people know about the Aging & Disability Resource Connection (ADRC).
2. It would be nice to have a person doing outreach at the Senior Center each month for a couple of hours to disseminate information.

Corvallis

The community event Oregon Cascades West Council of Governments and Senior & Disability Services hosted on Friday, December 12, 2014 was comprised mainly of community partners. At this particular event staff decided on a round table discussion, which was facilitated by four employees of Senior & Disability Services whose notes have been combined into a cohesive list and categorized under the five topic areas of transportation, housing, access to information, healthcare, and food insecurity.

Food Insecurity:

1. Food banks have high demand.
2. Getting to the food bank in difficult.
3. Locations are not ideal, hard to find, and have limited hours.
4. The Gleaners and private residents could be more involved in produce distribution.
5. Community gardens may be under-utilized.
6. SNAP benefits do not last the entire month.
7. There are a small number of Meals on Wheels delivery drivers.
8. There is a small number of grocery delivery drivers.

9. Technology provides a bunch of remote ordering challenges.

Transportation:

1. Accessibility is a huge issue.
2. Dial-a-Ride must turn some individual's calls for services away.
3. Subsidized and inexpensive fares.
4. Many individuals rely on family or friends for transportation.
5. There is multi-county coverage up and down the coast as well as throughout the Valley, but it can take all day to travel from Corvallis to Astoria.

Housing:

1. There is a lack of affordable housing due to university-related issues in an increasing student population. The demand is greater than the supply of living units.
2. New housing units are not suited for families, seniors, or people with disabilities.

Healthcare:

1. The cost of healthcare is prohibitive.
2. Individuals lack knowledge surrounding policies, legislation, and rules for service.
3. The expansion of Medicaid means there are more people who need medical attention. In terms of medical and dental care there are few doctors who accept Medicare or Medicaid clients, which makes switching or finding a new doctor difficult especially with more individuals enrolled in the Oregon Health Plan.

Access to Information:

1. Senior & Disability Services website provides great printed information, but it may not be accessible to consumers due to technological barriers.
2. In general, more information dissemination is needed.

Lebanon

The community event Oregon Cascades West Council of Governments and Senior & Disability Services hosted on Wednesday, December 10, 2014 was comprised mainly of community partners. At this particular event staff decided on a round table discussion, which was facilitated by four employees of Senior & Disability Services whose notes have been combined into a cohesive list and categorized under the five topic areas of transportation, housing, access to information, healthcare, and food insecurity.

Food Insecurity:

1. River Center in Lebanon is over utilized.
2. Fresh vegetables and fruits are missing from food boxes.
3. It is difficult to transport groceries and an individual to and from the grocery store.
4. Cooking classes on how to cook less known vegetables would be welcome due to the prevalence of uncommon donated vegetables to the Gleaners.

Transportation:

1. City of Lebanon needs a city transportation system.
2. Dial-a-bus has restrictions on who is permitted to ride and the ride must be within city limits. Riders must also be able to carry their own goods.
3. Taxi services are expensive at 10 – 15 dollars roundtrip.
4. Linn Shuttle could have more stops where a park & ride situation could occur with reduced rates for seniors and people with disabilities.

Housing:

1. There are a good number of low income apartment complexes, but prices are increasing due to newer developments.
2. There are long waiting lists to live in HUD housing of between 18 – 24 months.
3. If you are removed from the HUD housing list you may be without housing.
4. There are no shelters for the homeless and limited transitional housing in Lebanon.

5. Finding new housing can be difficult.

Healthcare:

1. Development of the medical school in Lebanon has improved access to healthcare.
2. Medical specialists mostly have offices in Albany or Corvallis.
3. It is very difficult to find a doctor who is accepting new patients.
4. There is limited access so some people end up utilizing the urgent care because they cannot get in to see a doctor.
5. Veterans have to travel even further to Salem or Eugene and wait for more than 30 days for transportation.

Access to Information:

1. ADRC should be better promoted through radio, TV, brochures, and educational opportunities in the community.
2. Informational booths at county fairs and festivals would provide community outreach.
3. Bracelets with ADRC contact information could be a potential marketing strategy.

Newport

The community event Oregon Cascades West Council of Governments and Senior & Disability Services hosted on Thursday, December 11, 2014 was comprised of a mix of consumers and of community partners. At this particular event there were two discussion tables that were facilitated by three employees of Senior & Disability Services whose notes have been combined into a cohesive list and categorized under the five topic areas of transportation, housing, access to information, healthcare, and food insecurity.

Food Insecurity:

1. Meals on Wheels is a great program, but recipients must be 60 years of age or older to receive meals.

Housing:

1. There is a lack of livable, accessible, and affordable housing.
2. The HUD housing lacks managerial action in reference checking and maintenance.

3. The HUD housing provides unsafe conditions for tenants with a lack of smoke detectors, access points in case of emergency, and narrow, steep stairs as well as unsafe electrical connections.
4. Housing inspections are done infrequently and ineffectively.

Transportation:

1. Rideline is very useful, particularly in the winter, but riders must plan ahead and make appointments during a time frame of between 15 – 30 days prior to the ride.
2. Rideline's driver protocols are unclear.

Healthcare:

1. Scheduled transportation may be late and this lack of transportation can affect one's ability to make appointments.
2. Doctors move in and out of the community frequently.
3. Difficult to find a professional doctor.

Please check the appropriate box.		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am happy with the help I received from Senior & Disability Services.						
I have used the Aging and Disability Resource Connection (ADRC) and it has met my needs.	*Check the box if you do not know about the ADRC.* ☐					
I have access to adequate transportation in my community that meets my needs.						
The staff people I work with are knowledgeable and responsive.						
My current housing situation is safe and meets my needs.						
My caregivers are trained well.						
I have access to adequate healthcare.						

OREGON CASCADES WEST
Council of Governments

Senior & Disability Services Consumer Satisfaction Survey

Senior and Disability Services is the Area Agency on Aging (AAA) for Linn, Benton, and Lincoln counties. As the Medicaid long-term care agency for our region, we provide a wide variety of financial, medical and long-term care services for clients and their families. Our organization cares about our consumers' opinions surrounding issues with resources, service, and staff. We would appreciate your feedback so that Senior & Disability Services may improve our service.

Please open the brochure to start the survey.

You have the option to provide your contact information:

Name: _____

Address: _____

Phone Number: _____

Please check the box if you would like to be contacted: ☐

Please check the box if you receive home delivered meals: ☐

Please check the box if you receive Oregon Project Independence (OPI) benefits: ☐

1. At the time of your **last** contact with Senior & Disability Services, how did you make contact with us?
   a. In person.
   b. On the phone.
   c. On the computer.
2. Were you treated courteously?
   a. Yes.
   b. No.
3. Were you helped in a reasonable amount of time?
   a. Yes.
   b. No.
4. Did you get the information you needed?
   a. Yes.
   b. No.
5. How would you rate your contact with Senior & Disability Services?
   a. Excellent.
   b. Very Good.
   c. Good.
   d. Fair.
   e. Needs improvement.
6. I would like to see more information about community resources in the lobby of Senior & Disability Services.
   a. Yes.
   b. No.
   c. No preference.
7. Please tell us the program(s) that are working best for you?

   _____

8. If any of your answers to the survey questions was "unhappy," please let us know why in the space below.

   _____

   _____

   _____

Please continue onto the back page of the survey.

Appendix B: Comments on best programs.

Please tell us the program(s) that are working best for you?

1. HUD & SNAP
2. My health is bothering me all the time so it is nice not to have to worry about the rest.
3. Meals on Wheels. Caregiver Program.
4. SSI. Food Stamps.
5. The program I have now.
6. Medical: Samaritan Advantage Plus
7. OHP. Food Stamps.
8. CBHA. CMTI, TPLC.
9. All.
10. ICP or Home Care Worker.
11. SSI. Food Stamps. HUD.
12. MOW.
13. Independent choices.
14. Everything is ok!
15. None.
16. STEPS Program
17. Having caregivers, food stamps, health services.
18. OHP. Food Stamps.
19. Have friends and family to drive me around.
20. Meals on Wheels.
21. Samaritan Advantage. Food Stamps.
22. Food Stamps. Meals on Wheels.
23. In come care. Meals on Wheels.
24. Caregivers. Senior Volunteer.
25. Independent Living.
26. Senior & Disability Service.
27. All.
28. SNAP. Medicare.
29. Medicare Savings Program. In Home Care.
30. Medicare Savings Program. Care Provider.
31. Health Program; Medical. Food Stamps.
32. Vocational Rehab is excellent.
33. Home Visit: phone.
34. Caregiving.
35. In home care.
36. Ride Line.
37. Medical Insurance.
38. EPD. OHP.
39. Medical.
40. Food Stamps.
41. Medical.
42. Caregiver. Home Healthcare Nurse.
43. Dial Bus
44. Caregiver.
45. Home Care Worker
46. Medicaid. Daycare Grace Center.
47. In Home Care
48. Food Stamps. Social Security Medical Card.
49. OHP plus.
50. Meals on Wheels.
51. Home Health Care.
52. SNAP
53. Medicaid.
54. SNAP
55. All of them that I use.
56. All.
57. Food stamps.
58. Care Giver.
59. In Home Caregiving
60. Everything is okay.
61. OPI.
62. Help on medical expenses and rent.
63. SNAP.
64. SNAP. OHP.
65. Meals on Wheels
66. Meals on Wheels.
67. Classes.
68. Medical.
69. The few I have. Wants to be contacted about getting a walker. She can't see very well and needs more help.
70. They all work well for me.
71. Medical. Food Stamps.
72. SNAP.
73. SNAP.

74. OHSU Rides to Portland.
75. Food Stamps. Healthcare.
76. In-Home Assistance.
77. HUD.
78. In Home Care.
79. Homecare
80. Meals on Wheels.
81. Health Insurance. Food Stamps.
82. OPI.
83. OPI.
84. Food Stamps. Insurance Help.
85. OHP.
86. OHP.
87. Care Provider.
88. IHSS.
89. Food Stamps. TANF.
90. Home Care
91. Housing. Food Stamps.
92. All.
93. My care at Willamette Manor, all of it.
94. Medicare and Medicaid.
95. Food Stamps.
96. Meals on Wheels.
97. Meals on Wheels.
98. SNAP. Meals on Wheels.
99. Medical Insurance.
100. Medicaid. Food Stamps. Care Provider.
101. Meals on Wheels.
102. Food Stamps and Health Care.
103. Meals on Wheels. Physical Therapy.
104. Mennonite Village.
105. Medical Card. Food Stamps.
106. EPD.
107. Meals on Wheels.
108. Food Stamps.
109. RCO Brokerage/ Co-Opportunity INC.
110. Insurance. Drug Plans. Home Care Worker.
111. Meals on Wheels.
112. Medical. Food Stamps.
113. I have the Dr's and basic health care I need.
114. OHP.
115. Food Stamps. Health Care. Mental Health Care.
116. Health Care. In Home Care Givers.
117. Medicaid.
118. Meals on Wheels.
119. Food Stamps.
120. Case Management. Benefits.
121. Home Health Care.
122. SNAP. OHP Plus.
123. Senior Meals.
124. Meals on Wheels.
125. Meals on Wheels.
126. Meals on Wheels.
127. All of them so far.
128. Help in the home.
129. Food Stamps. Voc Rehab.
130. Special Needs.
131. Medical.
132. Food. Medical.
133. Food.
134. OHP. Food Stamps.
135. All.
136. Home Health.
137. All of them.
138. I am happy with all the programs.
139. Medical. Food Stamps.
140. Medicare. Medicaid. OHP. SNAP.
141. What programs?
142. Home Health
143. OPI.
144. Food Card. Disability. Medical.
145. None.
146. Caregiver. Meals on Wheels.
147. Contact by email only: catlover02us@yahoo.com
148. Meals on Wheels. Safety bars.
149. Evaluations
150. Food. Medical.
151. Helping understand paperwork and bills
152. Medical.
153. EBT.
154. SNAP. IHN. OHP.
155. Samaritan Health Services.
156. In home care assistance.
157. SNAP. IHN. OHP.

158. United Nations High commissioner for Refugees.
159. DHS.
160. Meals on Wheels. In Home Assistance.
161. Rideline. Medicare/Medicaid.
162. Food Stamps. Medical Services.
163. Ride A Bus.
164. In Home Respite.
165. 24 Hour In Home Caregivers.
166. Food Stamps.
167. LCMH.
168. Meals on Wheels.
169. Samaritan Advantage.
170. HUD. Caregiver. Power bill help.
171. In Home Care.
172. Caregiver.
173. Rideline Mileage Reimbursement.
174. Most of them are.
175. OHP. Disability.
176. Disability Case Manager.
177. Food Stamps.
178. Medicare and Medicaid.
179. Contact with social security, food stamps, and medical transport.
180. I have a good caregiver.
181. Dial a Bus. Meals on Wheels.
182. Food Stamps.
183. Food Stamps. OHP. Medicaid.
184. Home Help.
185. Having Caregiver.
186. Caregivers.
187. Caregivers.
188. Meals.
189. In Home Care.
190. Money Management.
191. Medical. Food Stamps.
192. Caregiver.
193. Medicaid.
194. Meals and housekeeping.
195. Food Stamps. OHP.
196. SNAP
197. ADRC.
198. Housing.
199. Medic Aide.
200. Health Care Services.
201. All.
202. OHP.
203. SNAP.
204. SNAP.
205. SNAP.
206. Independent Choices
207. Meals on Wheels.
208. Samaritan Advantage Special Needs Plan.
209. Caseworker.
210. Visiting Vicky Peterson Case Worker
211. OPI and FLS.
212. Assistance with Housekeeping.
213. Ride Line. My caseworker Lori Westling is awesome.
214. My caseworker Conan McAlister!
215. Meals on Wheels.
216. OHP Plus, Medicaid, Adult Foster Home, BCMH.
217. Food Stamps.
218. ICP - Extra Help. We are so grateful for the services we get it has saved my life.
219. In Home Care
220. Medical.
221. My SSID income.
222. Car Providing.
223. The rides are working good for me.
224. Steps. Meals on Wheels. Life Line.
225. The Rideline when they don't drop appts!
226. Caregiver.
227. Doctor visits - transport when needed.
228. SNAP. Health Care. Extra Help.
229. Meals on Wheels.
230. Meals on Wheels.
231. Affordable Assisted Living and Grace Center.
232. Caregiver.
233. All services are excellent and appreciated!
234. Caregiving. Food Stamps. Medicaid.
235. Live in Homecare worker.
236. Having a Worker

237. Home Care. OHP. Medicare.
238. In Home Care
239. I am very happy with Senior and Disability Services. Diane is wonderful.
240. Help with finances.
241. Care Giver.
242. Farmers Market Coupons help out a lot.
243. SNAP. SSI. OHP Plus.
244. Food Stamps. Medicaid.
245. Pills.
246. Food Stamps.
247. Home Care Assistance.
248. SNAP.
249. SNAP. Thank you for always being so kind and understanding.
250. In Home Care.
251. Home Care.
252. Dial a Ride/ Gas Vouchers/ Worker
253. Medical Mileage Reimbursement.
254. Food Stamps. Bus Tickets. Medical.
255. Medical. Food Stamps.
256. Samaritan Family Medicine.
257. Food Stamps. Medical Insurance.
258. SNAP. Utility bills help.
259. Dial a ride and food stamps.
260. Health Care. Food Stamps.
261. Resources Connections of Oregon
262. All are good.
263. Food Stamps.
264. Help with Medicare Part B, Prescription Coverage.
265. Medicare Part B Cost
266. OPI.
267. In home care.
268. In home care.
269. SSDI
270. Medicaid.
271. Food Stamps. Medical.
272. Work program.
273. In Home Caretaker Services
274. SSD.
275. In Home Care.
276. Medicaid is great!
277. Everything.
278. Medical Care. Food Stamps.
279. HUD
280. Information and money matters.
281. Food Stamps and Medical.
282. My Home Care Giver
283. Food Stamps.
284. Talking to my caseworker.
285. OPI. Medical.
286. Senior & Disabled Bus system is good in Lebanon where I live now.
287. Senior Companion/Driver.
288. Medical. Food Stamps.
289. None.
290. Food stamp Program.
291. Food Stamps.
292. In Home Care.
293. Medical. Food Stamps.
294. SSI. SNAP.
295. OPI.
296. Medical.
297. In home care. meals on wheels, food stamps, and farm program.
298. Food Stamps. OHP.
299. All.
300. Home Care.
301. All of them.
302. Caregiver of grandchild services resource.
303. Home Care.
304. Contact with case manager.
305. SSI. OHP. IHN. Food Stamps.
306. Live-in-provider assistance.
307. Money.
308. Medical. Food Stamps.
309. Oregon Trail. Trillium OHP Plus.
310. SDS. We want to say that Conan McCallister has been very helpful, kind and right there when you need answers or help! We appreciate him very much.
311. Health Insurance.
312. OHP.
313. Food Stamps. Mileage Reimbursement.
314. Medical. Food Stamps.
315. The lunch and classes.

316. Oregon Trail
317. Immediate care with my rep.
318. Food Stamps.
319. Food Stamps.
320. Medicaid.
321. Medicaid.
322. Meals on Wheels. Energy Assistant.
323. Medical.
324. Food Stamps. Medical.
325. In home care. Meals on Wheels.
326. All.
327. Meals on Wheels.
328. Health.
329. All. This is a nice way to know what people need and exchange opinions. Thank you for my great case worker Nancy.
330. Food Stamps. OHP.
331. OHP. Food Stamps.
332. Meals on Wheels.
333. OHP. Food Stamps. HUD.
334. EBT.
335. All services.
336. Help with paperwork.
337. Medicare. Food Stamps.
338. LIS Rider Program. Caregiver.
339. None.
340. Food Stamps. SSI.
341. Stay Home Care.
342. Food Stamps.
343. Food Stamps. OHP.
344. ICP.
345. OHP. Food Stamps.
346. All.
347. You folk give so much help it is hard to choose the best!
348. The Personal Touch.
349. OMAO. Disability Aid.
350. Food Stamps. Bus Rides.
351. Transportation. Medical.
352. Home Health Care.
353. Meals on Wheels.
354. Agriculture coupons. HUD.
355. Meals on Wheels. Home Caregiver.
356. None.
357. Home Health Services.
358. Homecare. (caregivers).
359. Everyone has been very helpful.
360. Home Care Services
361. In Home Care.
362. Senior Care.
363. ADRC.
364. Transport Reimbursement. Home Health Care.
365. Home Care.
366. No one question our need! We are already hurting, don't need more pressure.
367. Medical Programs.
368. Not sure which programs I have.
369. Housing and Medical.
370. Food Benefits.
371. Food Stamps. SSI.
372. Visits to SeaAire.
373. In Home Care-Giving.
374. Medical.
375. Food Stamps.
376. What I have works great! Compared to California I salute your efforts to be timely and effective.
377. Having a caregiver and Oregon Trail.
378. In home help.
379. SSI. Food Stamps. Medical.
380. Health and food programs.
381. OHP
382. Food and rent help.
383. Food Stamps.
384. Food and Medical.
385. Medicare. Meals on Wheels.
386. Community based care. Assisted Living.
387. In Home Care.
388. Food Stamps.
389. Food Stamps. Medical.
390. All of them.
391. TANF. Food Stamps.
392. Face to face.
393. HUD. SNAP. Medical. SSI. I am very happy with all of the services I receive for myself.
394. Wounds nurse.

395. OHP. Wound control. Medical transport.
396. OTAP energy assistance. Food Stamps. Medical.
397. Independent Choices; in home care payments.
398. Most of them.
399. Meals on Wheels. Rideline.
400. Medical.
401. Medicaid. Rides.
402. My caregiver and having life line.
403. In home care.
404. SNAP.
405. SNAP. OMB.
406. Caretaker.
407. IHN/CCO Plus, SNAP.
408. Caregiver at home.
409. Medicaid. Home care.
410. Meals on Wheels. Oregon Trail Card.
411. SNAP.
412. Food Stamps.
413. Phone Customer Service.
414. In home care.
415. Mental Health. HUD. Trail Card.
416. Food Delivery.
417. Food Stamps.
418. Food Stamps. Medicaid Rx.
419. My personal care here.
420. Jennifer Kettle has helped me a lot with Medicare.
421. In Home Caseworker.
422. SNAP. SSI.
423. Med. Food Stamps.
424. Everything.
425. Senior Companion. Home Help.
426. In home care provider.
427. Medical. Financial.
428. SNAP. SSI.
429. Home care.
430. Medicare. Food stamps. Energy assistance.
431. ICP.
432. Food Stamps. OHP.
433. Food Stamps.
434. Home help and Meals on Wheels.
435. Food Help.
436. Independent Living.
437. House cleaning senior services.
438. Long Term Services and Supports. SNAP. Medicaid. Medical Benefits.
439. Home Care. Meals on Wheels.
440. Care provider really helps.
441. In home care.
442. Use email! Where is my new application for SNAP benefits?
443. SNAP. Help with Medicaid.
444. Meals on wheels. Caregiver.
445. Home care help.
446. Oregon Food Trail.
447. Oregon Food Trail.
448. Disability.
449. SNAP. Medical.
450. Medical coverage. Food stamps. Heat assistance.
451. SNAP.
452. Medicaid.
453. SNAP. HEAT.
454. Food Stamps. Medical.
455. Money.
456. Food Stamps. Medical.
457. Food Stamps. Medicare.
458. Food Stamps. Seniors with disabilities.
459. OHP. Medicaid.
460. Meals on Wheels. In Home Care.
461. Medicaid.
462. Caregiving.
463. OPI. Meals. Grace Center.
464. Meals on Wheels.
465. Food Stamps.
466. All.
467. Medicaid.
468. Medicaid.
469. Emergency Medical Transportation.
470. Energy Assistance.
471. Health Insurance. Caregiver in home. Food stamps. Nurse.
472. Medicaid.
473. In Home Help.
474. Help on Meds.
475. Meals on Wheels.

476. Health and food sources.
477. SNAP. ICHP.
478. Medical.
479. EBT. SSD.
480. In Home Care.
481. SSI.
482. SNAP.
483. SNAP.
484. SDS. OHP. HUD.
485. Food Stamps. Medical.
486. OMB. SNAP.
487. Case management. SSI. Food Stamps.
488. SNAP. HUD.
489. Transportation and I'm happy I have the same worker as last year.
490. MOW but not always good.
491. In home care.
492. Insurance. Food stamps.
493. Meals on Wheels.
494. Food Card.
495. OPI.
496. My caseworker is wonderful.
497. Medical and disability checks.
498. Medical and Food Stamps.
499. Medical and Food Stamps.
500. Response time.
501. Food Stamps.
502. Meals on Wheels.
503. Food Stamps. OHP. In Home Care.
504. ICHP.
505. Having a worker. Home health care and transport for my medical appointments etc.
506. Most all.
507. Fair.
508. Food Stamps.
509. Counseling. Doctor, Nurse.
510. Support Group.
511. Food Stamps.
512. Ride Line.
513. Food Stamps. Medicaid.
514. SSI.
515. At home caregiver.
516. Having a person to care for me so my wife can run errands.
517. Voc Rehab/ Social Communication Clinic
518. SNAP. LIEP.
519. In home care provider services
520. Food.
521. The housing heat and the services that I use.
522. Mental Health.
523. Meals on Wheels
524. Food Stamps.
525. Info and Food Stamps.
526. In Home Care
527. ADRC.
528. My in home care and prompt call back.
529. Homecare.
530. Linnhaven Rent Stipon
531. Help with home services and access to a driver and the meals he provides.
532. That pays for workers so i can stay home.
533. SNAP. Help for part B SSI.
534. Home Care.

Appendix C: Consumers Negative Comments

1. If you answered that you are unhappy to any of the above questions, / please tell us why here.
2. QID4
3. Nope, so far they have been AWESOME. Thanks.
4. She needs help after a major surgery.
5. You refuse to allow me to choose the individual I desire to be my home care worker due to political bigotry.
6. How do people live on 14.00 dollars a month for food stamps?
7. My caseworker is awesome (Maureen). Paperwork and receptionist information not as great.
8. Frustration with paperwork getting lost. Blames front desk workers who may have lost the paperwork.
9. He doesn't know what OPI is and wants to know.
10. Dental insurance could be better.
11. Not sure my caseworker Robin Stakes takes very good care of me.
12. The food stamp program is insufficient. Utility allowance given is very off preventing discrepancy in amount of food stamps eligible for.
13. Need more outreach about available programs and resources.
14. Called numerous times with no call back.
15. Do not get call backs and process is slow.
16. People leaving and no one to help. No call backs. No follow up. Very bad. I can see why people fall through the cracks!
17. We are satisfied.
18. Would like to talk about getting a cell phone.
19. I do not care for the mileage reimbursement. They are very hard to work with at times.
20. Richard's worker Vici Fox told me I had no right to eat/using my husband's money to live on. I had a stroke before she scolded me. How dare she say to me after 32 years of marriage?
21. Need some way to get help with vision/glasses other than the Lions Club.
22. You provide transport?
23. Food Stamps is not enough.
24. I need to know how to get a dr for the eyes. I need new glasses.
25. They take too long to get back, if ever.
26. Most of the staff are very good, but one can give them all a bad name. New case manager told her she didn't need some medicines that her doctor told her she needed.
27. Did not get my food stamps because the worker has not sent my paper work.
28. Doesn't qualify for the "Dial a Ride" bus.
29. Programs for construction help. (ramp)
30. We would like more information about transportation. We do not drive.
31. Caseworker takes a long time to get back on matters/ food program. No comment. I've been waiting for somebody to call me back - going on 2.5 months may be because I'm Hispanic. We still being discriminated which is very sad because we have working hard - lost everything and I have to struggle for every little thing and I'm very tired to fight anymore and afraid of retaliation.

32. There should be more housing available for 55 over. Something affordable, convenient with a store near. Many do not drive. Age and health will not allow to walk.
33. Very happy.
34. Am in foster home, but am on assisted living #4 but can't find available in Corvallis where my mom and friend is. I need help desperately to get in an "assisted living" place in Corvallis ASAP. Can you help to find me one?
35. Not enough caregivers available in Lincoln City and Otis. Do more outreach and advertising and speed in careful processing.
36. I would like more help in finding resources to weatherize my home for winter.
37. Healthcare is too expensive. No access to a vehicle.
38. I called the Toledo office for help and was given the run around and ended up without answers.
39. I am unable to get to Toledo. I often do not have any contact with my caseworker she doesn't return my calls.
40. Ellen Eager was scheduled to come to house, she was sick and DSO forgot to call us. I called three hours later.
41. I feel I need more hours for help through caregivers.
42. I never met Rachel, after my husband went into Lydia's House in June. She didn't respond to my calls. Her message always said it could take 2 days for return calls. Still don't know who Bruce's new caseworker is.
43. Problem with my previous social worker, would not listen to my needs.
44. Slow response to inquiries. Lack of information even when requested. Lack of support provided. Feel I am in adversarial position,
45. Would like our workers to treat us like they treat their own family members.
46. I think your caregivers need more or better training in dealing with people and their partners.
47. I wasn't told of my eligibility for additional food stamps when I turned 60.
48. Takes forever to get answers.
49. No help after surgery during recovery, no 24/7 nurse line to call, no help with needed surgery. Live alone and no one to advocate or talk to who can help, nor who cares.
50. I needed to do thing via online, but the representative tried to convince me coming into the office would be easier - it's definitely not easier for me.
51. Some are disrespectful or dismissive and take forever to return calls.
52. Made a phone call to new caseworker asking for gas voucher. Never had my call returned.
53. Is there fundings to help buy a MH for our use? My mother and I are both disabled! As we pay too much for rent!
54. I have called asking for help several times. Each time I was told "we don't do that". These were basic questions. What DO they do?
55. Workers need to be better at returning phone calls.
56. My caseworker borders on rude and makes me feel like I'm wasting her time.
57. I need mobile dentistry and pediatry care that will visit Corvallis Manor.
58. I wasn't happy when they lost my application and I had to go there and fill out a new one.
59. Staff put her on the wrong insurance plan.
60. Have not been able to get an appointment for energy assistance for two years. This year is worse. Can't even get to a human being.

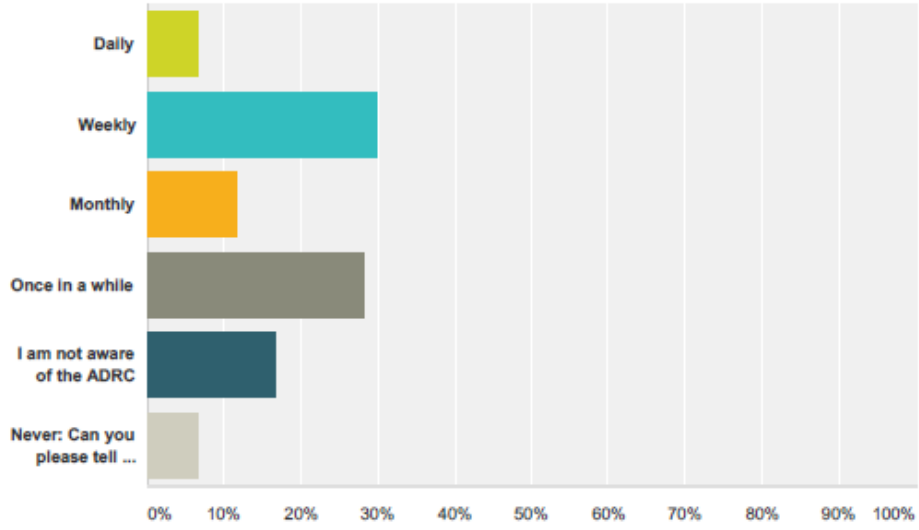
61. Need housing.
62. Need eyeglasses.
63. Needs help with housing concern.
64. Housing concern.
65. SSI.
66. I made two phone calls to Rideline registering my post surgery weeks ahead of surgery. Called and confirmed it again on 9-15 at 4:35. That is when OHSU confirmed my surgery time. No one called me back. No one showed. I called the morning of my surgery 9-22. left at 7:00. I told them I needed to leave by then to make it in time. Their excuse for not picking me up was that it was a personal line. Each time I called I got a recording confirming it was Rideline (Lisa). I drove on Geary m medication in the dark to make it in time. They would nto release me I had to call my son out of a NEW JOB to release me. You seriously should be able to log med trips at Cascade Rideline online. It takes a lot of money.
67. Only gave a "very good" because my last two case workers didn't do their jobs and screwed my son out of two years of funds we will now never see. My new caseworker, new to the job, actually looked at my son's case and put down the correct code so we at least got 2014 pay to date.
68. Wants to be contacted about additional programs he may be eligible for.
69. This letter is to inform you about my meals on wheels. The driver that brought my meals Monday, Tuesday, and Wednesday is a black man. I caught him pissing twice on my place. He could go to Waterloo Park which has at least seven bathrooms. Then he started going over to 6th ST to Don Conrad's place and pissing under a row of fir trees. I told Don. That's when I called Lebanon Senior Center and told them what the driver did. He is still working there but they stopped my meals for those three days. October 23, 2014
70. Her house needs repairs and is almost in foreclosure.
71. Too much turnover in caseworkers also untrained in home helpers. They need some medical training.
72. Would like to have access to other doctors besides only Lincoln City or Corvallis
73. Had to pay for dentures and teeth removal myself. Made payments for four years yet was not given any leeway towards food stamps actually lost $1.00
74. Special Thank you to Nannette Bengal and her staff. Very helpful. Thank you!
75. Case managers are hard to get ahold of. They don't answer their phone or call back within days.
76. Current housing has leaky roof and cracked foundation.
77. I would like to receive food stamps for me and the kids. I'm under poverty level but they say I make too much for SSI. But I pay rent and all utilities, I have three kids. I need food stamps.
78. My caregiver hours were cut. I need to have more.
79. Some of the food taste like shit especially the tomato sauce ones!
80. It takes too long to get response back on the phone.
81. Called worker three times. Never returned call.
82. I did not hear from caseworker till four days later.
83. DHS People are really rude.
84. Problem with a Rideline driver Mike. Unsafe driver. Should look into it.
85. It took forever to finally talk to a human.

86. My caseworker is incompetent. I would like a different one.
87. Wants to know why they did not get agricultural produce help this year.
88. Sharon Maughn is a very good caseworker. Thank you.
89. I did receive a mailing re: SNAP interview/update due. Told me to come to the office so I did; only to learn I'd be contacted by phone - confusing and a wasted trip -- took me about an hour at lunch time.
90. It is impossible to get any info or anything at all from the blond receptionist. Much more efficient to use phone.
91. After 6 months I have still not met my mother's caseworker. She is never available and always on leave.
92. No car and bus service only Monday through Saturday. No evenings or Sunday. Mainly curtails social activities. Also, do not use a computer, so I may not always find out about various events or resources that others who do or who go in person to your offices can see for themselves - mailers would be nice.
93. Would like eye glass expense and medical co pay and additional changes by state funding if possible.
94. I had some questions and I wanted someone to come out and see me since I have a speech problem.
95. Need housing. Hard time fine a place to live.
96. I wish meals on wheels didn't cost me hours. My caregiver does a great job of making groceries stretch but it has become increasingly difficult over the last few months because of the cost at the stores.
97. I would like to go swimming in Lincoln City for therapy.
98. I move around living in my camp trailer. I would like to find a apartment or small house to live in Philomath area. Please help! I just had Aortic Valve Replacement 6 weeks ago. Living alone.
99. I never have the same case manager I get tossed from person to person.
100. How do I get food boxes for the holidays?
101. As far as I can tell he is claiming that someone in his household is sexually abusing his daughter. We need to follow up. I will take this to Scott tomorrow.
102. I'm overall satisfied with the care I receive from senior services.
103. Disappointed in food stamp reduction. Not enough money to buy food for the whole month.
104. I just wish there was more aid at health places ex.) Pool and exercise programs to be made more affordable for people like me.

Community Partner Survey:
March 2016

Q1 How often do you provide information to people about the ADRC and Senior and Disability Services programs, or call the ADRC yourself to make referrals?

Answered: 60 Skipped: 2

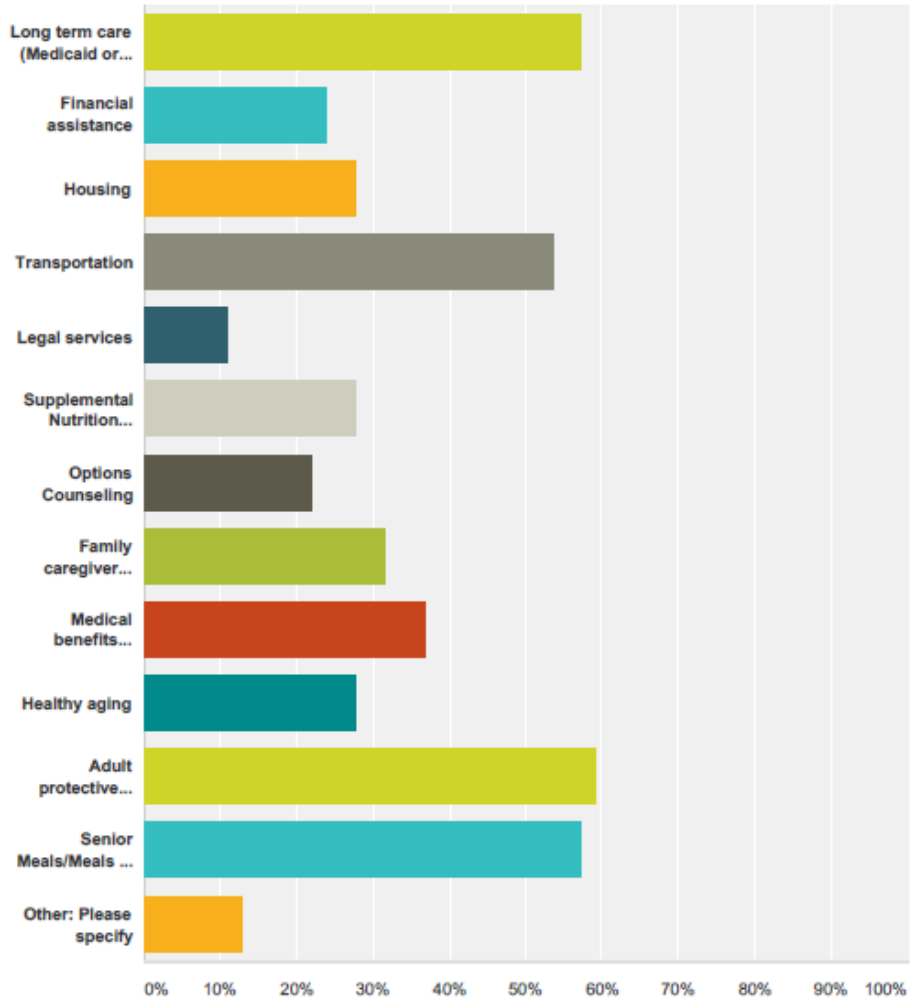


Answer Choices	Responses	
Daily	6.67%	4
Weekly	30.00%	18
Monthly	11.67%	7
Once in a while	28.33%	17
I am not aware of the ADRC	16.67%	10
Never: Can you please tell us why?	6.67%	4
Total		60

#	Never: Can you please tell us why?	Date
1	Not part of the Building Division services.	3/30/2016 9:14 AM
2	I am replying for Ten Rivers Food Web. We are a non profit with over a dozen years of experience working to assure that citizens in Linn, Benton, and Lincoln counties have access to locally grown/ regionally available quality, nutritionally dense foods. It would probably be good to work with your agency to get information and services out to Seniors and the Disabled.	3/25/2016 10:17 AM
3	I just learned of their existence.	3/7/2016 9:51 AM
4	I'm not aware of ADRC, and I don't even know what ADRC stands for.	3/2/2016 5:10 PM

Q2 Please mark which services you feel you have sufficient knowledge of to provide a quality referral for: (please check all that apply)

Answered: 54 Skipped: 8



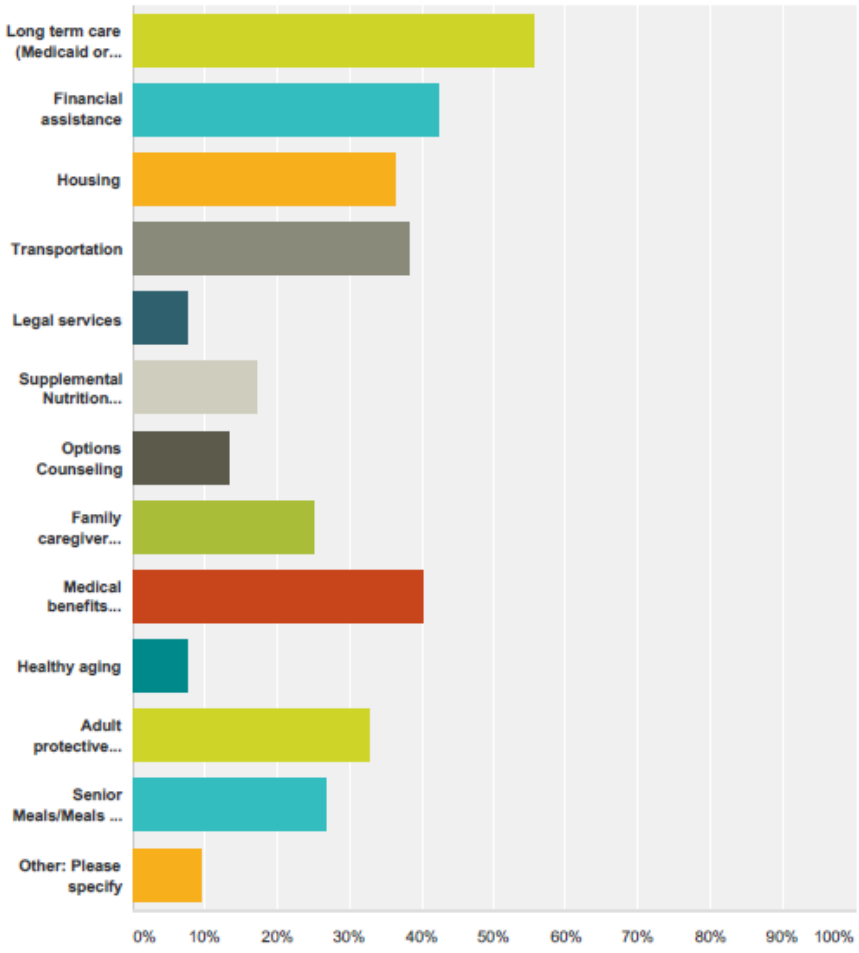
Answer Choices	Responses	
Long term care (Medicaid or Oregon Project Independence)	**57.41%**	31
Financial assistance	**24.07%**	13
Housing	**27.78%**	15
Transportation	**53.70%**	29
Legal services	**11.11%**	6

Supplemental Nutrition Assistance Program - SNAP (Food stamps)	**27.78%**	15
Options Counseling	**22.22%**	12
Family caregiver support	**31.48%**	17
Medical benefits (Oregon Health Plan, Medicare Savings Plans, Medicaid)	**37.04%**	20
Healthy aging	**27.78%**	15
Adult protective services	**59.26%**	32
Senior Meals/Meals on Wheels	**57.41%**	31
Other: Please specify	**12.96%**	7
Total Respondents: 54		

#	Other: Please specify	Date
1	Plant based nutrition for Seniors and those impacted by diseases like diabetes, obesity, cardiac related illnesses, etc.	3/25/2016 10:20 AM
2	Food Programs	3/4/2016 3:34 PM
3	long term community care nursing	3/4/2016 11:06 AM
4	Mental/behavioral health services	3/4/2016 11:03 AM
5	How to become active with the Disability Services Advisory Council and the steps that are required to become a member.	3/2/2016 12:48 PM
6	None	3/1/2016 12:12 PM
7	We can touch on other topics and get the public connected with knowledgeable staff, but aren't experts ourselves.	3/1/2016 11:33 AM

Q3 What supports and programs do you feel are most commonly asked about when you or others contact the ADRC call center? (select three)

Answered: 52 Skipped: 10



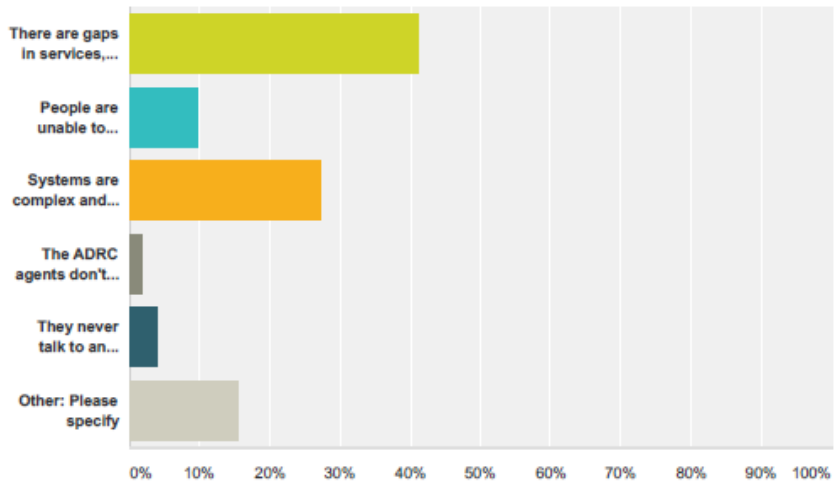
Answer Choices	Responses	
Long term care (Medicaid or Oregon Project Independence)	55.77%	29
Financial assistance	42.31%	22
Housing	36.54%	19
Transportation	38.46%	20
Legal services	7.69%	4

Supplemental Nutrition Assistance Program - SNAP (Food stamps)	**17.31%**	9
Options Counseling	**13.46%**	7
Family caregiver support	**25.00%**	13
Medical benefits (Oregon Health Plan, Medicare Savings Plans, Medicaid)	**40.38%**	21
Healthy aging	**7.69%**	4
Adult protective Services	**32.69%**	17
Senior Meals/Meals on Wheels	**26.92%**	14
Other: Please specify	**9.62%**	5
Total Respondents: 52		

#	Other: Please specify	Date
1	I've never contacted the ADRC (it'd be great to say on every page of this service WHAT it stands for, so that I can learn), but I've marked which ones I've had community members approach me about.	3/2/2016 5:13 PM
2	" My mom is old and needs help and I don't know where to start"	3/1/2016 3:51 PM
3	I think that I have only referred one client to the ADRC, and that was to speed up getting the client a case manager.	3/1/2016 1:17 PM
4	n/a	3/1/2016 12:12 PM
5	We refer people to the Senior Center (next door) for information on these services, or we call them ourselves to get the most current information.	3/1/2016 11:57 AM

Q4 What do you think is the greatest underlying cause when people call the ADRC or request services through Senior and Disability Services, but don't feel like they have their needs met?

Answered: 51 Skipped: 11

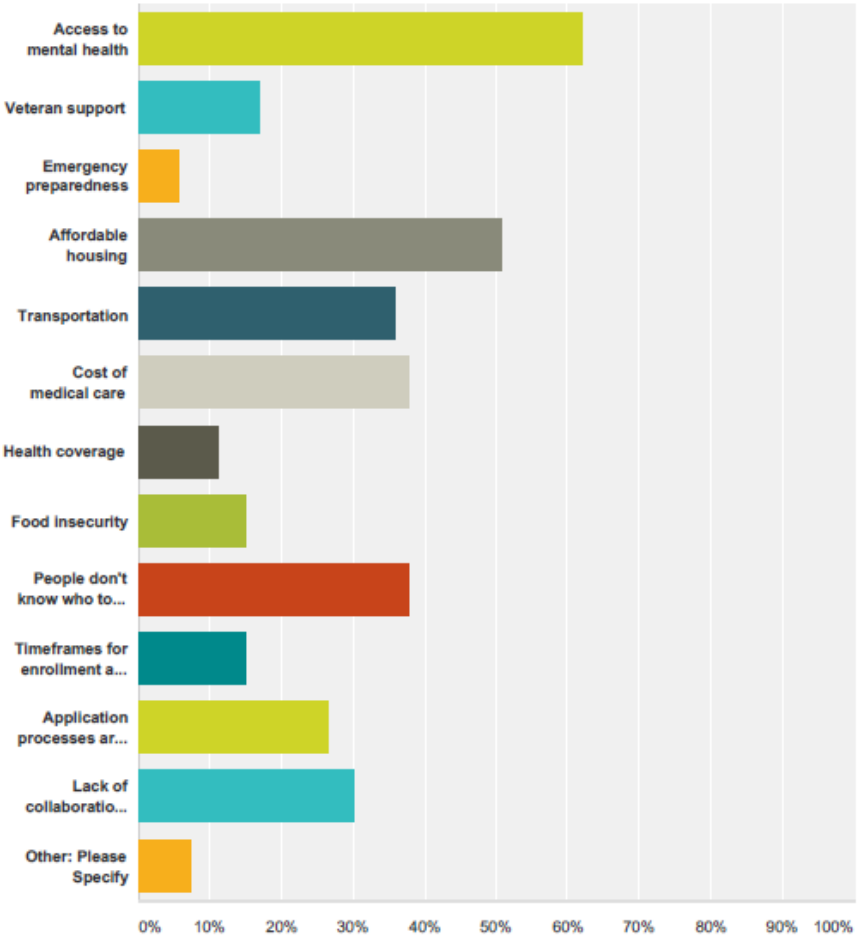


Answer Choices	Responses	
There are gaps in services, resources, and funding for the issue the customer is calling the ADRC about	41.18%	21
People are unable to identify their needs when speaking with an agent	9.80%	5
Systems are complex and people are unable to manage hurdles, such as filling out applications	27.45%	14
The ADRC agents don't know about all the resources available in the region	1.96%	1
They never talk to an agent because of the ADRC call center being closed or long call wait times	3.92%	2
Other: Please specify	15.69%	8
Total		51

#	Other: Please specify	Date
1	My guess would be the last one.	3/4/2016 3:35 PM
2	Sorry, I've not worked w/ ADRC, so I don't know.	3/2/2016 5:14 PM
3	I cannot speak to this. When I have called I always get my questions answered.	3/2/2016 1:03 PM
4	Have not had any comments back about the services.	3/2/2016 9:08 AM
5	Vulnerable folks become disenchanted when they are "guided" to answer questions related to ADRC reporting requirements. When bureaucracy colonizes the service experience, it ceases to be client-centered. Citizens sense this, and ditz the process.	3/1/2016 7:26 PM
6	I have had no feedback from clients who contacted the ADRC.	3/1/2016 1:18 PM
7	Don't know	3/1/2016 12:12 PM

Q5 What are the largest issues or gaps regarding resources or supports in our region? (Please choose three)

Answered: 53 Skipped: 9



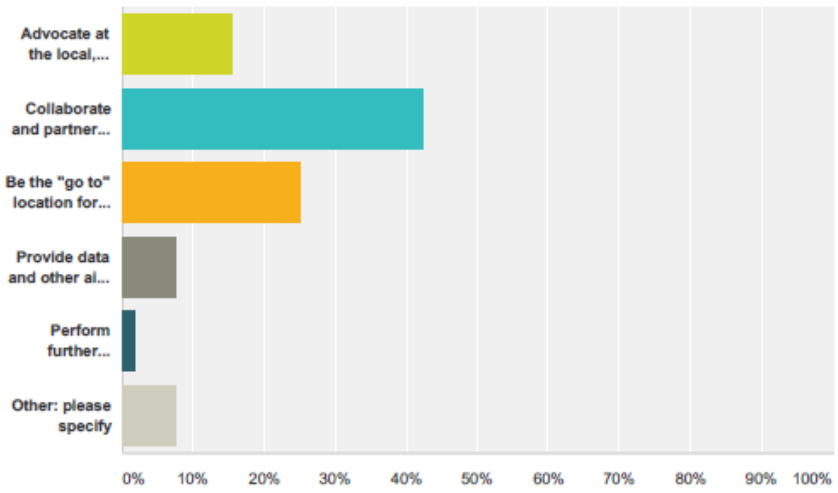
Answer Choices	Responses	
Access to mental health	62.26%	33
Veteran support	16.98%	9
Emergency preparedness	5.66%	3
Affordable housing	50.94%	27
Transportation	35.85%	19
Cost of medical care	37.74%	20

Health coverage	**11.32%**	6
Food insecurity	**15.09%**	8
People don't know who to call for assistance	**37.74%**	20
Timeframes for enrollment are too long	**15.09%**	8
Application processes are difficult	**26.42%**	14
Lack of collaboration between partners	**30.19%**	16
Other: Please Specify	**7.55%**	4
Total Respondents: 53		

#	Other: Please Specify	Date
1	Employment for sex offenders	3/28/2016 10:07 AM
2	Huge and widening gap between SDS and Mental Health services. Neither side can provide services for mentally ill people with ADL needs.	3/10/2016 8:18 AM
3	Many people can't afford cars and must take the bus or walk or bike. This makes it difficult to go to multiple places in one day. We need to make sure services are located close together and that there are plentiful bus routes and safe walking and biking routes.	3/2/2016 5:15 PM
4	We need more social services/advocates for seniors and others who don't have family/friends to help them look into, follow up, become aware of certain resources and/or gain help, many times to help them keep living independently.	3/1/2016 11:41 AM

Q6 What is the most important way the ADRC and Senior and Disability Services can help alleviate the gaps you identified in question 5?

Answered: 52 Skipped: 10

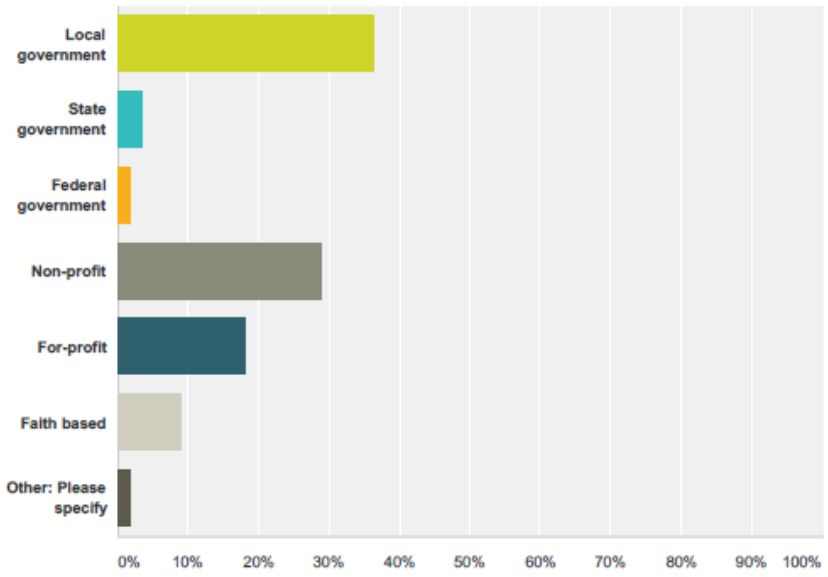


Answer Choices	Responses	
Advocate at the local, state, and federal level	15.38%	8
Collaborate and partner with other agencies	42.31%	22
Be the "go to" location for knowledge of the resources that are available	25.00%	13
Provide data and other aid such as grant writing assistance to support innovative programs	7.69%	4
Perform further marketing and outreach	1.92%	1
Other: please specify	7.69%	4
Total		52

#	Other: please specify	Date
1	Review access criteria and intake process for a more timely response to community needs.	3/28/2016 8:16 AM
2	Change eligibility requirements for help, in both SDS and all county MH agencies to include people with physical/mental disabilities and older adults with mental illness. The gap is deadly for those in it. ADL and housing services for this population must be made available by either SDS or MH; the rule books need to be changed to be more inclusive.	3/10/2016 8:20 AM
3	The Medicaid process needs to be simplified. and more education for family members on the process and what is expected. The state and federal govt. needs to fix this whole system.	3/1/2016 4:00 PM
4	Frankly, the OCWCOG is one of the most disfunctional organization that I have seen.	3/1/2016 1:20 PM

Q7 How would you categorize the organization you work for?

Answered: 55 Skipped: 7

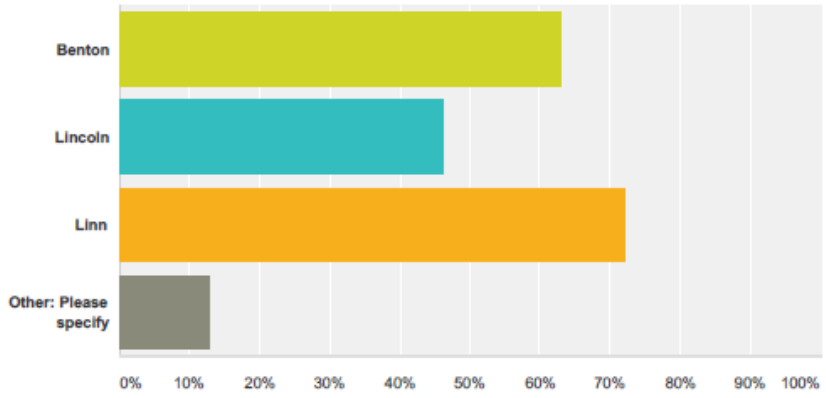


Answer Choices	Responses	
Local government	36.36%	20
State government	3.64%	2
Federal government	1.82%	1
Non-profit	29.09%	16
For-profit	18.18%	10
Faith based	9.09%	5
Other: Please specify	1.82%	1
Total		55

#	Other: Please specify	Date
1	Adult Foster Care	3/29/2016 1:34 PM

Q8 What county or counties does your organization serve? (select all that apply)

Answered: 54 Skipped: 8

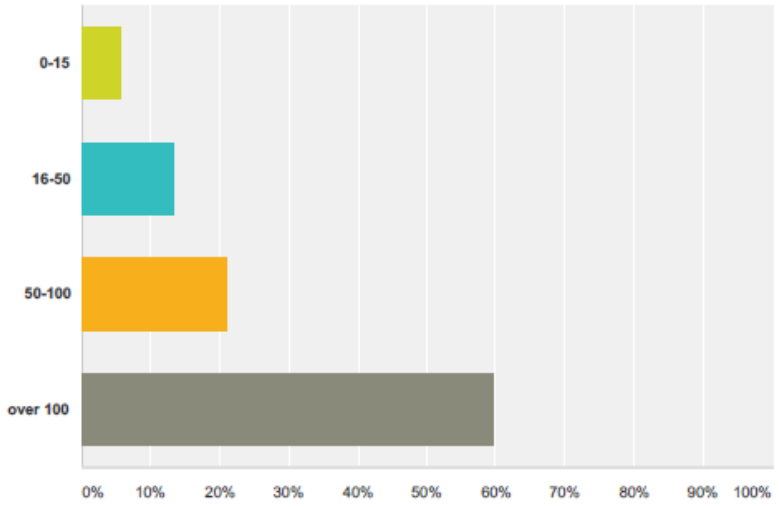


Answer Choices	Responses	
Benton	62.96%	34
Lincoln	46.30%	25
Linn	72.22%	39
Other: Please specify	12.96%	7
Total Respondents: 54		

#	Other: Please specify	Date
1	also North Albany and Jefferson	3/28/2016 10:10 AM
2	Marion and Polk as well	3/25/2016 10:57 AM
3	Polk	3/8/2016 2:02 PM
4	Marion Polk	3/8/2016 11:03 AM
5	Polk	3/2/2016 8:20 PM
6	Polk	3/2/2016 4:16 PM
7	We are an assisted living open at all levels. We have had admissions from out of state.	3/2/2016 1:16 PM

Q9 How many consumers does your organization serve monthly?

Answered: 52 Skipped: 10



Answer Choices	Responses	
0-15	5.77%	3
16-50	13.46%	7
50-100	21.15%	11
over 100	59.62%	31
Total		52

Area Plan Meeting Minutes:

April 18, 2016

SSAC/DSAC/ADRC Members Present: Mike Volpe, Lee Strandberg, Anne Brett, Bob Daley, Chris Barnes, Mary Scott, Suzanne Lazaro, Tim Malone, and Jann Glenn.

Guests: Carolyn Fry and Cathy Savage.

Staff: Dave Toler, Lisa Bennett, Ann Johnson, Mary Kay Fitzmorris, Randi Moore, and Terri Sharpe.

1) Welcome and Introductions:
   - Lisa Bennett called the meeting to order at 10:07 a.m. Introductions were made including guests.

2) Review of *Area Plan* Survey Results:
   - At the last Ad Hoc *Area Plan* Committee meeting the Committee formulated questions for the survey which the agency emailed to over 290 community partners with a return rate of 61%. The basic results of the survey were distributed with the ability to cross-reference any of the questions to obtain additional information if the Committee sees fit. Also covered were the State's instructions and mandates for the *Area Plan*. The Needs Assessment part of the Plan is near completion with a timeline of April 15th. There are plans to meet with two focus groups, the LBGT community and the Siletz Tribe, with the potential of a third focus group, the Spanish speaking population. Mental health issues will not have their own focus group but will be weaved in throughout the Plan.
   - The focus of today's meeting is to synthesize and prioritize the information from the survey, with a deadline of May 1st.
     1. Survey Question 1 gauged who is aware of the ADRC with results showing, even with heavy use, many others are not aware of the resource. The Committee agreed, knowing who uses the ADRC (nonprofits, government…), would be useful information.
        - Lee Strandberg asked if there is a plan in place linking SDS to clinic managers in the area, to enable them to educate the health care facilities on connecting patients they cannot serve to SDS. Lee will provide the name of the person in charge of overseeing all the Samaritan clinics in the three counties to Dave and look into setting up a meeting between them and Dave. Dave agreed.
        - Anne Brett's concern is the patient's follow up in contacting the ADRC once the information is handed to them. She feels they need a person to help them through the process of contacting the agency.
        - Mike Volpe asked if the survey addresses whether the seniors are seniors with disabilities. Randi said no but reports could be pulled from the ADRC call center, however, the data is from consumers where the

survey was directed at community partners. Mike feels this is important information to be addressed.

- Bob Daley suggested rather than addressing clinic managers they should address the RN Care Coordinators in the clinics who are the ones focusing on the difficult over burden cases. Lee agreed that this would be the way to go. Bob will find out the name of the lead RN Care Coordinator and find out when their monthly meetings will take place.
- Lee also suggested distributing brochures through the *Meals on Wheels* program for medical supplies. Dave stated that there is a question of proprietary. Carolyn Fry suggested having an assessment in their home might be better for them and they can then tell the person what it is they need.
- Carolyn inquired whether SDS does presentations on their services to case managers so they have the information when making referrals. Randi stated that they did a lot of marketing and outreach when they started the program but they do have to work on doing it regularly and consistently for ongoing success. Lee suggested having someone from the agency go out to all service clubs in the three counties and giving a canned presentation every year. Dave said this would be expensive; they need to find a balance between oral presentations and written materials and know who to get the written materials to. Mike inquired whether a SSAC or DSAC person could do the presentation. Dave said that it could be done with the right person.

2. In regards to Question 2 there were no surprises from the response. Anne asked why they don't hear about Options Counseling anymore. A few years ago, there was a big push and wonders why it's not sustained to get the most out of it. She would like to see an overall organizational strategy of when something is started then it gets carried through with a note of accomplishments. There should be a program advocate that continues to do outreach. Dave stated that Options Counseling is still being funded at $50,000 annually which pays for two part-time staff people for the three counties. They could not meet the demand if they did a full-blown education campaign marketing the program. Suzanne suggested changing the name of the program since it is so generic or putting a description of the program in parenthesis. Dave said the name is branded by the State but they could do more education.
   - Dave thinks they need to do a better job in targeting the information to their community partners and breaking down the information to find out who and who doesn't know who they are. Bob said there is a fine balance in knowing how much outreach the program and budget can sustain.
   - Lee suggested reaching out to law enforcement to enable them to target people who would benefit from our services. They could go through the County Commissioners and the Mayors to access the Chief of Police and the Sheriffs in each of the counties. Mary Kay stated that in Lincoln County one of her APS investigators will go in at

shift change and conduct training. Lee would like to do a trial run and set up a meeting with Commissioner Anne Schuster, Mayor Biff Traber, Sheriff Scott Jackson, the police chief, COG's Executive Director Fred Abousleman and Dave to discuss what the agency does and what everyone's needs are. Dave agreed.
    - Discussion revolved around different organizations and people that should be contacted for outreach. Dave suggested everyone sending him a prioritized list of who to address for presentations that will be of most value. Presentations will be by invitation only and list should be of manageable size where it's realistic so they can do it within the next year.
3. Question 3 addressed the most common asked-about programs: Long term care, Financial Assistance and Medical benefits. Carolyn inquired whether people are asking for mental health since it shows in Question 5 that there is a gap in mental health. Randi stated that they know it's a gap so they don't ask for it. Tim Malone stated it is well beyond a gap, geriatric mental health is not available. Discussion revolved around the mental health issue so Lisa suggested setting up an Issues and Advocacy meeting within the next couple of months to continue the discussion on mental health. She'll work with Tim on the agenda. Lee suggested inviting Kim Whitley, Operating Officer from Samaritan Health Plans and Dr. Mike May, Vice President of Samaritan Mental Health.
4. Question 4. Anne is interested in who responded to Question 4 and specificity to Comment 5 under "other". It was also suggested softening the way questions are asked. Bob feels after the first choice the remaining choices are something an Options Counselor could help them with. Randi explained when a caller talks about multiple issues with in depth need then an Options Counselor will reach out to them. They usually respond the same day and conduct a home visit within a week.
5. Question 5 asked what the largest issues of gaps regarding resources or supports in our region were with the largest response being access to mental health. At the Issues and Advocacy (I & A) meeting on mental health, Bob would like to know what the role of SDS is in addressing mental health needs, what's within the scope of this agency and what will be referred out. Suzanne would also like to know where they advocate for funding for mental health. She would like Lisa to invite a staff person, from the office of Senator Jeff Merkley, to the I & A meeting.
6. Question 6 asked what the most important way the ADRC and SDS can help alleviate the gaps that were identified in question 5 with the leading answer being collaborate and partnership. Carolyn asked if SDS has the cost figures of not providing their services. She feels if we can show the Legislators hard numbers proving it is less costly to the system in the long run by providing SDS services it would have a stronger pull. Dave agreed but said it is hard to quantify intervention. Lee told Carolyn if she identifies the research topic and writes five to ten research questions he will do the Pub Med research. Anne believes there is less emphasis on numbers and

more on the philosophy behind what we do and we need to appeal to the philosophy in getting the legislators and executives to rise to the challenge of being social leaders. Dave said they will be testing that hypothesis with the *Meals on Wheels* program over the next year.

7. Question 7-9; how would you categorize the organization you work for; what area does your organization serve; and how many consumers do you serve monthly, were mainly to find out who is answering the survey and the different populations.

- Dave is interested in targeting outreach from the data gathered. Anne asked if they can find any organization, over a 100 people, which did not respond to the survey. Dave said they can find out how many organizations did not respond but cannot tell who they are; they are anonymous.
- *Action: the Ad Hoc* Area Plan *Committee will provide to Lisa a prioritized list for targeted outreach for the promotion of the ADRC for the Area Plan. They will either provide contact information or make the initial contact themselves.*
- *Action: Bob will find out the name of the lead RN Care Coordinator and find out when their monthly meetings will take place.*
- *Action: Lee will present the concept of a meeting between Commissioner Anne Schuster, Mayor Biff Traber, Sherriff Scott Jackson, Lieutenant Cord Wood, COG's Executive Director Fred Abousleman and Dave to those mentioned above. Dave will send to Lee a paragraph of what the meeting will entail and if there is consensus, Lee will facilitate a meeting.*
- *Action: Lisa will set up an Issues and Advocacy (I & A) meeting within the next couple of months to continue the discussion on mental health. She'll work with Tim on the agenda. Lee suggested inviting Kim Whitley, Operating Officer from Samaritan Health Plans and Dr. Mike May, Vice President of Samaritan Mental Health. Bob would like to know what the role of SDS is in addressing mental health needs, what's within the scope of this agency and what will be referred out. Suzanne would also like to know where they advocate for funding for mental health. She would like Lisa to invite a staff person from the office of Senator Jeff Merkley to the meeting.*
- Dave summed up that they had a good outcome in looking at the survey. At the next meeting, he will go over the focus areas, past accomplishments and new goals. Dave will be looking for feedback on new proposed goals or goals they are missing. Anne suggested sending feedback when they send in their contributions to the prioritized target list but would like to see comments that anyone else may have. Dave will send as attachment as a reminder.

3) Adjournment

- The *Area Plan* Meeting was adjourned at 11:47 pm.

The Meeting Minutes were recorded by Terri Sharpe.

Focus Group Questions: The Confederated Tribes of the Siletz Indians

June 6, 2016

1.) What types of assistance do you see as most frequently requested by Siletz Tribal members, regarding the needs of Elders and people with disabilities?

2.) Senior and Disability Services tries to identify gaps in services for the communities we serve. Transportation, food insecurity, and mental health services are areas that are frequently identified as areas where there are needs that aren't being met. Do you feel that there would be different issues identified if we consider gaps in service for members of the Tribe?

3.) Do you think that Tribal staff and/or members are aware of the services available through Oregon Cascades West Senior and Disability Services?

4.) Equal access to our services, as well as cultural differences, are important to our organization. Do you have suggestions of how we might do better outreach or otherwise better serve members of the Siletz Tribe?

5.) Would having Senior and Disability Services staff located in Siletz be of value to you?

6.) Are there ways we can improve so that your members can more readily access our programs?

Focus Group Notes: The Confederated Tribes of the Siletz Indians

June 6, 2016

Location: Siletz Community Health Clinic Meeting Room

Attendees: Elaine Smith, Tribal Health Committee; Gloria Ingle, Tribal Council; Everetta Butler, Tribal Elder; Cyndee Druba; Tribal Health Advocate Staff; Brett Lane, Tribal Housing; Jessica Garcia, Tribal Housing and Tribal Member; Elizabeth John, Tribal Elder; Pat Darcy, spouse of Tribal Elder; Mike Darcy, Tribal Elder; Francisca Rilatos; Tribal Member and Tribal Housing

SDS Staff: Dave Toler, Director; Lisa Bennett, Community and Program Support Coordinator; Mary Kay Fitzmorris, Program Manager, Lincoln County Service Area

The meeting began with introductions from everyone.

Lisa Bennett thanked everyone for attending and provided an overview of what the meeting is about. SDS (Senior and Disability Services) would like to serve Tribal Members better and more effectively and we are seeking opportunities and information for doing so.

Dave Toler provided an overview of services, including ADRC, Options Counseling, in-home case management, and eligibility determination.

Jessica Garcia noted that many members feel they are ineligible for services, so they don't apply.

A member stated that there needs to be more help for people who aren't low income. Some members felt that assistance with cleaning and household tasks is really needed.

Continued support of the Meals Program is very important. Members feel it has tremendous support for social reasons, as well. There were other comments regarding the desire to include dessert, change the menu options more, and have better diabetic options.

Help is needed during short transitional periods, such as when Tribal Members get out of the hospital. This would help people recover more quickly, so that they can get back to doing things themselves.

Tribal members have stated that they feel like they receive too much paperwork in the mail.

One person commented that she had never had problems getting services as needed.

In terms of cultural differences, Gloria Ingle commented that Tribal people like to gather with food; food should be included in meetings, informational sessions, etc.

A member commented that the Tribe should coordinate better with others who provide health and wellness services, such as the hospital diabetes program.

Dave described the Living Well program, and offered to host some classes here locally.

Gloria stated that the Tribe spends over $2 million on Elders, not including public health. She went on to say that usually in Indian Country, it is a family member who is providing the care, but they should get training to do so.

A good resource, per Gloria, is NICOA, National Indian Council on Aging, and they should be utilized. Priorities should be caregiver services, nutrition, healthcare services, and transportation.

Jessica Garcia stated that there is a fear from Tribal members that when they apply for any kind of services, that they will be denied. Having a staff person to come out to do outreach to let people know about the programs could be really helpful.

Jessica also noted that there is a big gap in the area of Elder Abuse – who do they call? She would like to see pamphlets developed for the Tribe, and make the issue more well-known. Mary Kay Fitzmorris said that all abuse investigations are very confidential; we can't divulge what's being done. In some cases, a person needs to be deemed incompetent in a court of law, then a guardian is designated. Dave Toler noted that in cases of a caregiver not doing the job, an investigation can be made. Attendees liked the idea of having a forum locally regarding Elder Abuse – talking about "what is abuse?" The forum would include an Adult Protective Services Investigator, and possibly someone from the District Attorney's office. Jessica wanted people to learn how and when to report. Elaine Smith said that some situations can be tricky because Housing and other departments may be involved – when can they evict people who are financially abusing an Elder? Jessica says that at times they can evict people, but more often there is a lot of social work that happens first. Mike Darcy noted that the Sheriff's office should be involved with any meetings that we have regarding abuse. Mary Kay noted that SDS does not receive many referrals from Tribal members regarding abuse. Ruby Moon says that at this time, the Tribe is unwilling to take on an Adult Protective Services role, so SDS needs to be utilized. She wants to empower people to feel that they should report. Jessica noted that drug/alcohol abusers at times may be evicted from Tribal housing and may want to move in with grandparents, leading to potential abuse. Ruby said that she would like a flyer with contact information, and descriptions of what abuse is. Cyndee Druba shared that she had made a report in the past and had a quick response.

Gloria and Jessica stated that they feel there is a major issue with lack of housing, and that it is not just a local problem.

Several people felt that an outreach person from SDS is needed and that it should be a Tribal member, in order to facilitate a better comfort level, and therefore better communication. One person felt that it would not make a difference whether or not it

was a Tribal member. Dave stated that sharing resources to develop such a position might be a good option. Gloria suggested talking with Brenda, the General Manager for the Tribe, to find out about what steps to take, as “we are a sovereign nation.” Having someone present to talk about potential benefits, health, finance, and legal options, would be beneficial.

Ruby noted that she has been attending monthly Advisory Council meetings, and has found that invaluable in improving communications between the Tribe and SDS.

Elaine said that the Tribe couldn’t help her build a ramp, and asked if SDS could help with something like that. Dave said that it is often income-based. Lisa noted that the ADRC, Aging and Disability Resource Connection call center also has many resources from community organizations that may help with things like building ramps.

Cyndee said that there is a big gap for people transitioning out of the hospital – help with bathing, meals, etc. Meals are only available on Mondays and Wednesdays. Gloria agreed that this is a huge need. Elaine wants the Tribe to train CNAs, Certified Nursing Assistants. Ruby said that they are working on that.

Everetta Butler noted that honesty of caregivers has been a problem for her. She has contacted her case manager about it and is still concerned. Manager Mary Kay Fitzmorris will meet with Everetta after the meeting to discuss in further detail. Dave asked Everetta if she had considered using an in-home care agency. Everetta said that she had never heard of it.

Ruby said that chore services are available through the Tribe, specifically, through the Elders’ program.

Brett Lane stated that in-home care workers should be drug-checked. He is considering bringing up the issue with State Representative David Gomberg.

Attendees felt that in general, better screening of caregivers is needed.

In terms of the question asked on the handout regarding cultural differences, Pat noted that Tribal members aren’t all that different than others. Their needs are often the same.

Written comments were few, but included the need for better mental health services and for more chore services, such as housekeeping. Some members need help with chores, and those services should be available to more Tribal members.

Some members felt that is would be helpful to put a more positive spin on things – what we can do versus what we can’t.

One person suggested that establishment of an Elder center would be beneficial.

The meeting was adjourned, and a meeting focusing on abuse was planned for the near future.

Focus Group Notes: LGBT Consumers and Allies

June 30, 2016

Discussion Topics

People in the LGBT community don't know who Senior and Disability Services/ADRC are and how to access services from us:

- Market to advocacy agencies
    - Valley Aids and Information Network
    - Corvallis Area Lavender Women
    - Coastal Aids Network
    - LGBT friendly faith based organization
    - Galenthea
- The community and consumers we serve need to know that we are LGBT friendly
    - ADRC brochure have LGBT support info
    - Brochures have a diversity clause
    - LGBT friendly business identifying decals for SDS and long term care facilities
    - Ensure SDS/ADRC staff are trained and culturally competent when working with LGBT people
    - What is someone who calls about HIV supports going to hear when they call the ADRC?
- What gaps in service would we identify for LGBT consumers
    - Housing
    - Transportation
    - A lack of programs knowing about each other

Continued Collaboration and Next Steps for consideration

Provider certification for being LGBT trained and friendly

Viewings of the movie "Gen Silent" Throughout the region

Ongoing conversations and relationship building

Meeting Again

Early September to discuss and plan hosting a viewing of Gen Silent in Corvallis

- Viewing in the fall with hope we would have university support and participation (October)
- Considered viewing locations such as churches or library (potentially more inclusive)
- Randi will try to book a location
- Try to find time so others can join who work (6PM)
- Would we want someone to facilitate a conversation?
- Promotion of the event in the community

Appendix D

Report on Accomplishments from 2013-2016 *Area Plan* Update

1. *Develop emergency and disaster planning activities with each of the Counties in our Region:* Goal partially achieved: SDS has established working relationship with County emergency services for Linn and Benton Counties. SDS continues to work on internal processes for emergency planning for staff and for our consumers. Key staff participates in 'vulnerable population' workgroups in each County. OCWCOG has an emergency plan in place for how to continue operations in an event of an emergency. This plan is continuously reviewed and revised as appropriate.

2. *To improve the ADRC visibility and function in the Linn, Benton and Lincoln Counties*: Goal discontinued: ADRC is at maximum capacity, so no longer marketing aggressively in communities.

3. *Improve the outreach program in our Region:* Goal achieved: Several improvements have been made in the number of presentations and meetings that our Staff has attended in the community.

4. *Improve FCSP:* Goal achieved: there has been increased community networking around FCSP recognition and resource fairs around the Region. OAA Case Managers continue to market FCSP through presentations to community partners and the public.

5. *Maintain up-to-date procedure manuals and convert manuals to all to intranet based documents*: Goa partially achieved: A revamp of the organization website was completed to make it more contemporary and user-friendly. Internally, Staff are working on a shared drive where policy manuals, procedures, and processes will be stored for easy Staff access. SDS has an Internal Operations Committee that works on creating consistent procedures across our Region, as well as multiple internal workgroups that meet periodically to ensure the monitoring and upkeep of such procedures.

6. *Maintain a well-trained Staff to insure quality services for growing client population:* Goal partially achieved: SDS continues to identify training needs as policies and Staff change. We have training curriculums in place for each unit of work, and are currently building out a shared drive where policy manuals, procedures and processes will be stored. OCWCOG continues to request more frequent statewide trainings to insure Staff is consistently trained as policy and Statewide processes change.

7. *Increase efficiency of Staff and computer systems to provide the highest quality of services for the least cost:* Goal Achieved: Each Eligibility Worker now has a dual monitor system, which has increased the efficiency in their work. In an effort to provide accessibility and ease to our clients. SDS currently works with the Client Application Processing Interface (CAPI) to process online applications. An increased amount of consumers are using this as a way to apply for benefits because of its high convenience level.

In all of our region, Case Managers complete eligibility tasks for service consumers, which has proved to provide elevated customer service to our consumers. Linn and Benton Counties recently implemented a similar shared Eligibility Caseload model.

8. *Continue long- and short-term planning for SDS to meet the needs of these populations now into the future:* Goal Achieved: OCWCOG distributed and evaluated Staff, community partner, and client surveys. Community forums were held in each of SDS's three Counties to solicit information about the needs and solution ideas in each community. Focus groups were held in Corvallis and Siletz to gather new ideas and collaborate with community partners in the planning process. SDS Managers meet periodically to discuss how our organization can better meet the needs of our communities.

9. *Increase funding for senior programs to help meet the demands for services:* Goal partially achieved: Senior meals staff secured grants and outreaches for community donations to support the program. In addition, SDS has received grants for ADRC operational improvements, expanding the RSVP services with grants, and work continues to bring additional donations to the programs.

10. *Maintain and develop new contract relationships to assist offering more services to seniors by utilizing community partners*: Goal Partially Achieved: SDS maintains contract relationships with Legal Aid Services of Oregon and Grace Adult Day Center, as well as MOUs with 211, Interfaith Volunteer Caregivers, and Samaritan's Senior Companion Program.

11. *Continue to partner with LCOG and NorthWest Seniors and People with Disabilities in contracting for In-Home Services and Senior Meals:* Goal Achieved: SDS jointly uses kitchen facilities and food providers for the MOW food service contract. SDS has a joint in-home service contract to provide care to all consumers in our joint Regions. Partnerships with our sister agencies continue to be positive and productive relationships.

12. *Advocate for maintaining and improving upon a comprehensive system for seniors and people with disabilities*: Goal Achieved: SDS makes presentations throughout the community, before City Council meetings, at Commissioner meetings, or before Chambers of Commerce meetings. At the State level, Staff educates and advocates on behalf of seniors and people

with disabilities directly to Legislators, and requesting that Legislators present to SDS Staff and Advisory Councils. Nationally, advocating is provided by National Association of Area Agencies on Aging (N4A) and *Meals on Wheels Association of America* (MOWAA), and other national organizations. This is an ongoing challenge for Staff, Managers, and Program Director.

13. Maintain ongoing interagency coordination and communication between Senior & Disability Services and other groups and agencies that serve seniors: Goal Achieved: SDS continues to use the ADRC resource database, update information as appropriate, participate in community resource fairs, and conduct presentations in the region. Staff works especially close with other organizations serving seniors in our communities such as Interfaith Volunteer Caregivers and senior centers.

14. *Create public awareness for Senior Services and the services OCWCOG offers to seniors in the Region:* Goal Achieved: Presentations were made regularly in the community to provide information about the ADRC and services SDS offers to the public. ADRC Specialists receive phone calls, faxes, emails, and letter inquiries from individuals in the community and are responsible to provide information on services OCWCOG provides, as well as referrals to community agencies. The ADRC of Oregon website has been created and maintained with resources available to our Region. This site is shared with anyone who contacts our office with questions.

Appendix E

Emergency Preparedness Plan

As a Council of Governments, OCWCOG has an Continuity of Operations Plan and Emergency Protocols manual, *COOP*, see page 149.

SDS is the go-to agency for some of the most vulnerable adults and those with a disability in our Region. With this in mind, Staff actively serves on the Linn-Benton Vulnerable Populations Committee, and has for nearly 10 years. The Committee consists of partner agencies, emergency response teams (law enforcement and fire), consumers, Samaritan Health Services, and other City and County representatives, who have written an area-wide emergency plan in order to prioritize and meet the special needs of the most vulnerable adults in the area. The *Linn-Benton Vulnerable Populations Emergency Plan* is included in on page 181.

Every local nursing facility and assited living facility is noted on an emergency response priority list and “map” by the Linn-Benton Vulnerable Populations Committee. The adult foster care homes are also listed and given high priority as they are smaller, private homes, often without back up generators or located in rural areas.

SDS Staff has begun to participate in the Local Emergency Planning Committee, which is coordinated by the State Emergency Response Commission. Included in this Committee are hazmat facilities, healthcare providers, law enforcement and fire department officials, and local emergency management designees. Through these efforts, Staff anticipates the development of a more coordinated approach to planning for assistance for consumers in case of emergencies. Additionally, though this Committee, Staff will reach out to consumers to encourage and enable them to plan effectively in their residences.

The OCWCOG COOP outlines an assessment of potential hazards, chain of command, communictions during an event, and information regarding coordination with emergency response agencies, relief organizations, and any other entities that have responsibility for disaster relief service delivery.

Consumers
An ongoing goal for Staff is to compile a list of the most vulnerable SDS consumers, updated quarterly by Program Supervisors. Although there is priority given to in-home clients in an emergency, risks are weighed by need for medications, oxygen, rural locations, availability of caregivers, and the overall physical and cognitive limitations of the consumers.

The COOP calls for the consumer list to be distributed quarterly to SDS Managers in a sealed envelope, to be opened only in the case of an emergency. The lists are kept with the Managers in the event they need them when the office is closed. Copies are also kept in a safe at each office location and local emergency response teams would have access to the lists in the event of an emergency.

OCWCOG's management team has also established contact with local emergency response teams based on our proximity in Benton, Lincoln, and Linn Counties. All fire, City police, and County law enforcement offices have the contact information of the eight SDS managers. Dependent on the type of emergency or disaster, consumer lists would be used to:

- Notify emergency response teams of those at highest risk, if stranded for more than three days;
- Contact consumers, families, and/or caregivers (if able) to check on their status and evaluate needs; and
- Contact consumers, families, and/or caregivers, after the emergency, has subsided to evaluate their status and needs.

Continuity of Operations Plan (COOP)

and

Emergency Protocols

Oregon Cascades West Council of Governments

1400 Queen Avenue SE

Albany, OR 97322

Updated: September 2016

Introduction

This document contains the Business Continuity Plan for Oregon Cascades West Council of Governments (OCWCOG). It is the document containing the information needed regarding decision-making and the agency's response to any disruptive or extended interruption of the organization's normal operations and services. This plan outlines an action plan appropriate for clients, employees, and visitors in the event of an emergency. This plan identifies natural and man-made emergencies that may impact our operations as well as the community. It details the response procedures that should be followed in case of an emergency.

Purpose

The OCWCOG Business Continuity Plan (Plan) is to be used as a guide whenever an event results in prolonged disruption of business at any of our OCWCOG worksites. Some examples of events that may cause a disruption of business are:

- Fire or other damage to the building
- Natural disasters such as earthquakes, flood or windstorm
- Chemical Event
- Temporary loss of a significant number of staff
- Damage or interruption to utilities, computer or telephone systems

Applicability and Scope

This Plan is based on a short-term (fewer than five business days) closure. If closure is for an extended period of time, all functions will resume operation as quickly as possible at a new and previously identified temporary location.

A copy of this Plan is to be maintained by all OCWCOG managers and at each worksite. A backup copy of this Plan will be kept offsite by the Executive Director, the Deputy Director, and the Program Directors.

All OCWCOG employees have received a copy of the OCWCOG Employee Office Safety and Protection Guide. This guide is to assist employees in dealing with the emergency at-hand and the safety of building occupants. If the building cannot be used, the OCWCOG Business Continuity Plan will be used.

The succession of events in an emergency are not predictable, hence, published support of operational plans will serve only as a guide and checklist, and will require modification during an event to meet the requirements of the emergency. Flexibility and rationality are keys to successfully managing an emergency. Our organization stresses human safety above material loss at all times.

The following people have been designation as the OCWCOG Continuity Planning Team.

Continuity Planning Team	
Mary Kay Fitzmorris	Toledo
Mary Newman	Corvallis
Lydia George	Albany
Randi Moore	Albany
Brenda Mainord	Albany

Guiding Principles and Assumptions

- Every incident will be different, both in severity and in length of impact. The response needs to be flexible and meet the needs of the incident.
- Safety of staff and clients is the first goal, though efforts will be made to minimize damage to property.
- Responses will be made in cooperation with local emergency authorities and organizations according to the Linn-Benton Vulnerable Populations Emergency Plan. Assistance will be available from outside our tri-county area through mutual aid agreements with County, State and Federal emergency services.
- Documentation of the event and all steps taken, decisions made, and funds expended are very important.
- Every event is stressful on all employees. If the response is likely to last more than a couple of days, plans should be made to rotate staff to allow for periods of rest.
- A major disaster event will likely affect the lives of many Linn, Benton and Lincoln County agency employees limiting, or preventing, them from performing shelter and care activities.
- A major disaster will likely result in loss of utilities, communication systems, and transportation systems making evacuation to mass care facilities difficult and may limit which mass care facilities can be used.

- Experince has shown that a high percentage of evacuees will seek lodging from friends or relatives rather than go to facilities during minor events or localized conditions.
- Additional services, including the care of special needs groups and crisis counseling, will be required from our agency.
- Many residents, especially those with special medical needs, may assume there will be local resources available to rescue them. Medically-fragile clients may not have access or transportation to regular services such as dialysis, oxygen or chemotherapy.
- Patients who normally receive home healthcare services may need to be accompanied by a caregiver to a shelter. In such cases, the caregiver should be transferred with the evacuee and permitted to remain with that person as the caregiver is able.

SECTION

1

Activation of Plan

Decision Process

The Executive Director, or successor if the Executive Director is not available, will make the decision whether or not to implement the COOP. Communication of decisions will flow from the Executive Director to the Program Directors. Program Directors will be responsible for communicating to their unit Managers or designated staff and on down to their assigned staff. Section 2 of this Plan further describes the agency communication protocol.

Orders of Succession

Succession for the Agency will take place in the event the Executive Director is unavailable, debilitated, or incapable of performing his or her legally authorized duties, roles, and responsibilities.

Successors
Lydia George, Deputy Director
Sue Forty, Finance Director
Dave Toler, Senior and Disability Services Director
Phil Warnock, Community and Economic Development Director

Succession of each Department for the purpose of continuing operations is as follows:

PROGRAM	PRIMARY STAFF PERSON	FIRST BACK UP PERSON	SECOND BACK UP PERSON
Senior & Disability Service	**Dave Toler**	Randi Moore/Mary Kay Fitzmorris	Marci Howard
CED	**Phil Warnock**	Brenda Mainord	Theresa Conley
Tech Services	**Lydia George**	Troy Grover	Third Party Vendor
Human Resources	**Eric Wolke**	Lydia George	Rebecca Gibbons-Yardley
Finance	**Sue Forty**	Lydia George	CWCOG Board Treasurer

Each Program Director will also have a succession plan for each office. The Program Directors will communicate this plan with their Unit Management Team.

Employees are encouraged to have individual and family emergency plans. Being prepared themselves will keep them better equipped to help others in the event of an emergency. It is recommended to keep a five-day kit, stocked with food, water, blankets and other supplies.

SECTION 2

Communications

Oregon Cascades West Council of Governments is registered with the Linn-Benton ALERT Emergency Notification System and with the Reverse 9-1-1 alert system in Lincoln County. If an event has been reported, the Executive Director will contact the appropriate county's Emergency Management program through the Sheriff's office to verify. A list of Emergency Resources can be found in the Appendices of this document.

Once the event has been verified, the following communications plan will be used:

Employees

During an event, we will assess which means of communication are still available to us, and use the means closest in speed and form to the means that we have used in the past to communicate with the staff.

All OCWCOG managers, including the Facilities Maintenance Coordinator and the Network Operations Specialist, are required to maintain a cell phone for emergency contact purposes. Human Resources (HR) provides an updated emergency after-hours contact list to each person required to maintain a cell phone.

The Human Resources Manager will also provide an updated employee contact list to unit managers on a monthly basis.

Communication decisions will flow from the Executive Director to the Program Directors. Program Directors will be responsible for communicating to their unit Managers or designated staff and on down to their assigned staff.

The Executive Director will serve as the Public Relations Officer at an emergency scene. Only the Public Relations Officer (or a representative designated by the Executive Director) will provide statements to media personnel. Not all employees will have all of the pertinent information; therefore, employees will be instructed not to release any information to media personnel, and to provide "no comment" when approached for information by any member of the media.

The on-site Supervisors have been designated as Building Evacuation Supervisors. The Evacuation Supervisors will assist employees as needed during an evacuation, and will take a head count of all employees in the building at the time.

External internet based communications will be posted by HR or Technology Services staff. OCWCOG is registered with FlashAlert News Wire, which notifies all television, radio stations, and newspapers within the Albany/Corvallis, Eugene/Roseburg, and Portland/Salem (includes Lincoln City and Newport) of any business continuity information that needs to be communicated to OCWCOG employees. The HR Manager

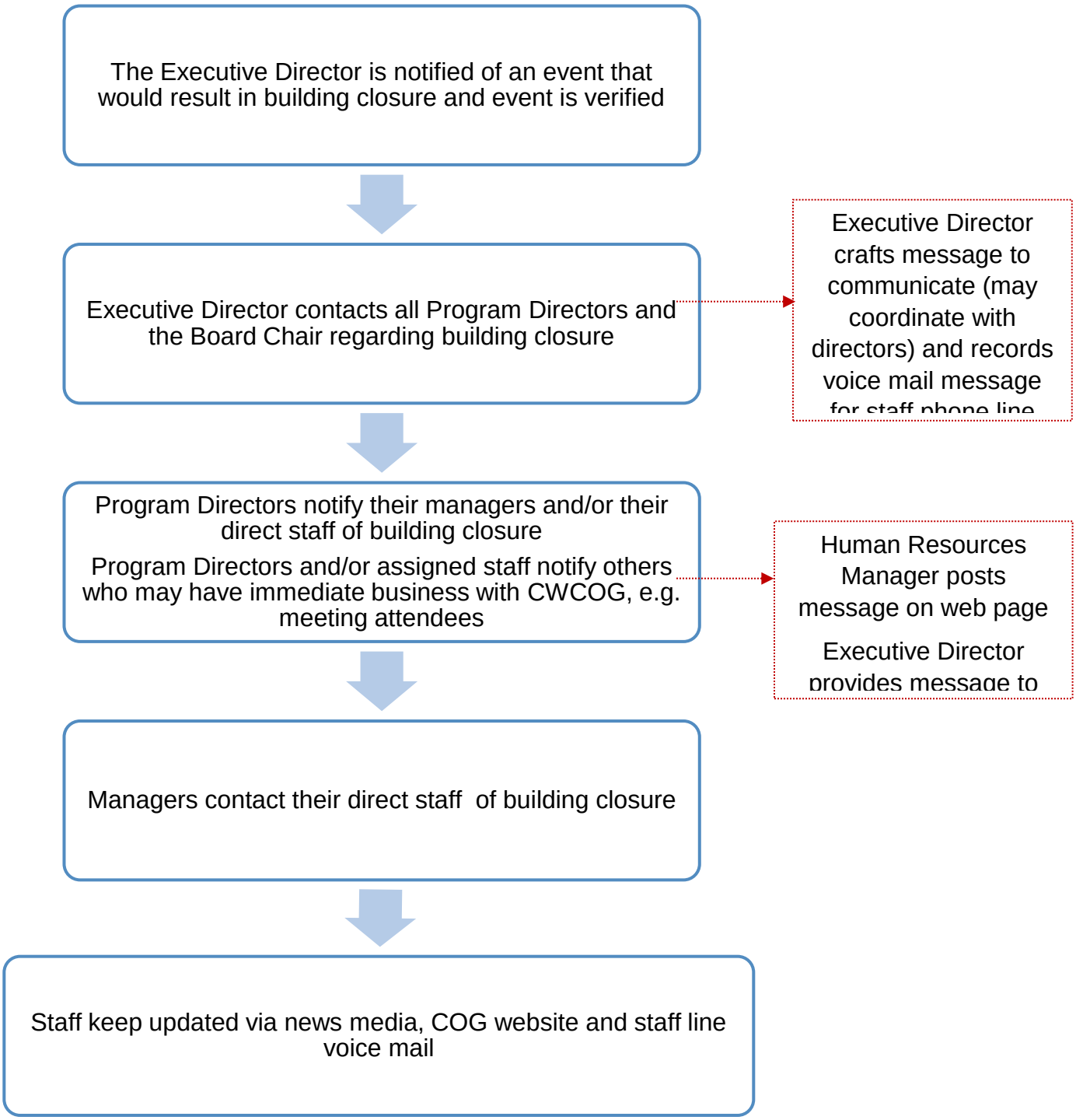
is responsible for providing the necessary information to FlashAlert News Wire. If the HR Manager is not available, another assigned OCWCOG Continuity Planning Team member will contact FlashAlert.

If phone service to the affected worksite has not been obstructed, voicemail instructions will be recorded on the following Staff Information Lines:

Albany/Corvallis Staff Line	**541-924-8434**
	1-888-777-5960
Toledo Staff Line	**541-336-2289**
	1-800-354-1095

If an event should result in a building closure, the following chart illustrates the agency flow of communication.

Agency Flow of Communication



Communications to OCWCOG clients/customers and other people we do business with is as follows:

Clients/Customers

In the event that any of the OCWCOG buildings are closed to the public, information will be posted on the external website by HR or Technology Services staff. Information will also be communicated to the public via FlashAlert News Wire, which notifies all television, radio stations, and newspapers within the OCWCOG service areas. The HR Manager, in coordination with appropriate department Directors will be responsible for posting information on FlashAlert News Wire.

If feasible, information and instructions for our consumers will be posted by the OCWCOG Primary Responders on the outside doors of each affected worksite.

Shared Resource Organizations

In the event that any of the OCWCOG buildings are closed to the public and/or business services suffer interruption, other agencies should be notified and kept informed. The appropriate Program Directors, or assigned staff, will be responsible for communicating the status of OCWCOG operations with them. Shared resource organizations are found in the Appendices of this document.

SECTION

3

Disaster Detection and Determination

Should there be an event that would potentially cause any of the COG buildings to be inaccessible, a primary responder will be responsible for assessing the building and reporting to the Executive Director. Designated Primary Responders are as follows:

Albany Building: **Facilities Maintenance Coordinator** and/or assigned back-up

Toledo Building: **Senior & Disability Services Program Manager** and/or assigned back-up

Corvallis Building: **Senior and Disability Services Director** and/or assigned back-up

Each Primary Responder will have an assigned backup should they be unavailable to assess their assigned building.

Each building has a Vendor Reference Manual that will provide contact information of building contractors. A list of primary vendor contacts is provided in the Appendices of this document.

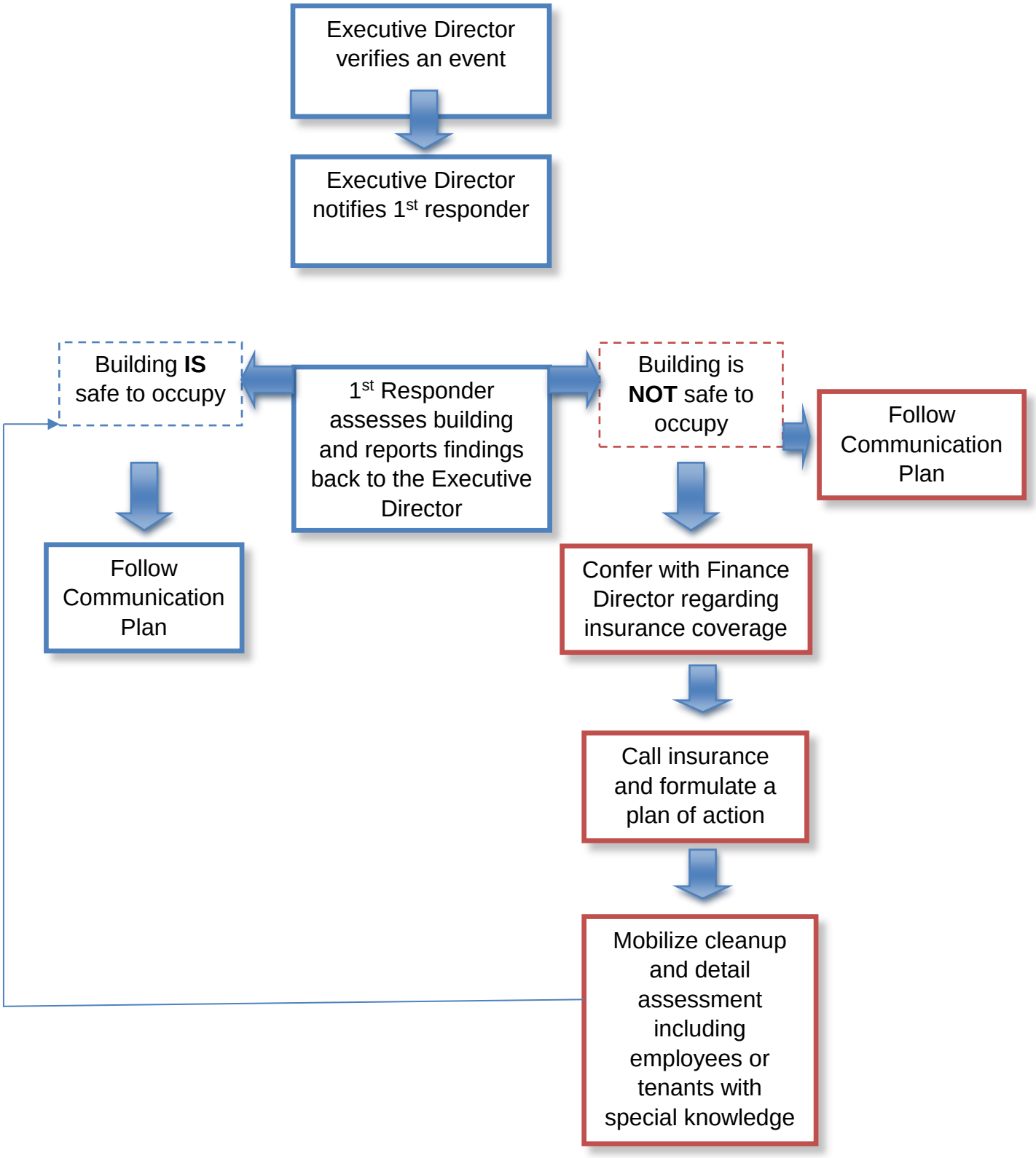
Should an event happen that could potentially compromise any of the OCWCOG facilities, the Executive Director will verify the event and then contact the appropriate Primary Responder, for that building. The Primary Responder will assess the building using an assessment check-off list to determine damage and/or safety concerns and report back to the Executive Director.

If the building is found safe to occupy, staff will follow the Communication Plan outlined in Section 1 of this manual.

If the building is not safe to occupy, staff and tenants will be notified per the Communication Plan. The Primary Responder and/or the Facilities Maintenance Coordinator will confer with the Finance Director regarding insurance coverage. The Facilities Maintenance Coordinator will contact the insurance company to formulate a plan of action to mobilize cleanup and detail. A copy of City County Insurance Services' Claim Procedure can be found in the Appendices of this document. The Facilities Maintenance Coordinator will notify the appropriate vendors, and employees and building tenants who have the expertise needed to regain building operations.

The following flow chart illustrates detection and determination.

DISASTER DETECTION AND DETERMINATION FLOW CHART



Types of Hazards

Electrial Fire Hazards

Electrical system failures and the misuse of electrical equipment are the leading causes of workplace fires. Fires can result from loose ground connections, wiring with frayed insulation, or overloaded fuses, circuits, motors or outlets.

To prevent electrical fires, employees should:

- Replace worn wires.
- Use appropriately rated fuses.
- Do not use extension cords as substitue for wiring improvements.
- Use only aproved esxtension cords.
- Check wiring in hazardous locations where the risk of fire is especially high.
- Check electrical equiptment to ensure it is properly grounded or double insulated.
- Ensure adequate spacing while performing maintenance.
- Do not overload curcuits with office equiptment.
- Turn off nonessential electrical equiptment at the end of each workday.
- Keep storage areas and walkways clear.
- Do not let trash and recycling accumulate.

General Fire Prevention and Procedures

Fire prevention is everyone's responsibility. Unsafe practices shall not be tolerated. The following safe practices are required of all staff members.

- Flammables and combustibles will not be stored near heaters, electrical appliances or other potential sources of ignition.
- Smoking is prohibited in public places and places of employent, which means smoking is prohibited in all OCWCOG buidings and within fifty (50) feet of a service line that extends out of doors.
- Do not block potential escape routes.
- Any gasoline, kerosene or cleaning solvents which must be stored inside, must be stored in an approved container with identifying information readily visible.

Administrators shall present basic fire prevention training to all employees upon employment, and shall maintain documetation of the training. Portable extinguishers shall be maintained in fully charged and operable condition. Maintenance staff will provide upkeep of fire alarms and sprinkler systems throughout our facilites. All persons in their respective buildings need to know how to get out of the building in the event of a fire or other emergency. Fire exits should be clearly marked, identifiable and continually up kept by maintenance staff. In the event of an emergency, stairs should be used as preference to elevators.

Medical Emergencies

Major mecial emergencies can include an array of conditions such as a fall, burns, choking, heart attack, poisoning, severe bleeding or stroke.

How to respond:

- Quickly assess emergency situation.
- Check for any additional immediate danger.
- Seek professional medical help as soon as possible.
- Avoid moving an injured person unless absolutely necessary.
- Wait until medical help arrives.
- Do not provide first aid or CPR unless you have been trained.

Natural Disasters

Hurricane

High winds, flooding and flying debris resulting from hurricanes can be extremely dangerous. Hurricanes typically affect coastal areas such as Lincoln County, but can also inflict damage far inland. A hurricane watch is issued when threat hurricane conditions are expected within 24-36 hours. A hurricane warning is issued when hurricane conditions are expected within 24 hours or less. The hurricane season typically lasts from July through November.

How to Respond:

1. It is essential that all employees stay indoors throughout the entire hurricane. During the peak of the storm for maximun protection, it is suggested that employees close doors and remain In hallways and/or spaces farthest from windows.
2. Employees should remain away from dangerous areas, such as glass windows.
3. Do not attempt to open windows or doors to see what is happening outside.

4. Employees should report all accidents, inuuries, broken windows, or excessive water to a supervisor.
5. Telephone calls should be made only in case of emergency.
6. Keep in mind that everything is calm when the eye of the strom passes overhead. Do not venture outside, as the second half of the storm will follow shortly.
7. Do not use fire stairs to go to an adjacent floor where the elevator will be shut off. Do not go outside.

Tsunami

A tsunami can cause major damage and loss of life along coastal areas, such as Lincoln County. Traveling at speeds of up to 500 miles per hour, a tsunami wave can be among the most powerful destructive forces on Earth. These waves typically occur as a result of earthquakes giving little or no warning for nearby shorelines.

How to Respond:

1. Listen to broadcasts that keep citizens up to date of potential tsunami situations. National Oceanic and Atmospheric Administration weather radios are especailly helpful in sending out immediate warnings and instructions. Local news stations are typically quick to respond and get the message out to the people in their listening area.
2. Listen carefully to instructions and follow them in order to remain as safe as possible until the all clear has been issued for your area.
3. Move away from the shoreline and seek higher ground and stay there. Tsunamis are not a single wave, but are instead a series of waves that are unpredictable. Do not return to low ground until the all clear signal has been given.

Earthquake

One of the most destructive phenomena of nature is an earthquake. An earthquake is a sudden, rapid shaking of the Earth, caused by the breaking and shifting of subterranean rock as it relases strain that has accumulated over a long period. This is followed by aftershocks.

How to Respond:

1. React quickly, but stay calm.
2. Move away from windows. Duck and cover or stand securely in a doorway to avoid falling debris.
3. Do not use elevators or stairs until identified as safe.
4. Expect fire alarms and sprinklers to activate.

Flood

Floods are the most common hazard for our tri-county area. Flooding can happen gradually or in an instant. Flash floods usually occur within a few minutes or hours of excessive rainfall or sudden rush of water held by an ice jam. Flash floods often have a dangerous wall of roaring water carrying rocks, mud and other debris. Overland flooding, the most common type of flooding, typically occurs when waterways such as rivers or streams overflow their banks as a result of rainwater. It can also occur when rainfall or snowmelt exceeds the capacity of underground pipes, or the capacity of streets and drains designed to carry flood water away from urban areas.

How to Respond:

1. Turn off main switches or valves if instructed to do so. Disconnect electrical appliances. Do not touch electrical equipment if you are wet or standing in water.
2. Keep a safe distance from flooded water. Avoid walking through moving water. Any amount of flooded water can cause a fall. If you have to walk through water, walk where the water is not moving. Use a stick to check the firmness of the ground in front of you.
3. Do not drive into flooded areas. If floodwaters rise around your car, abandon the car and move to higher ground if you can do so safely. You and the vehicle can be swept away quickly.
4. Do not camp or park your vehicle along streams, rivers, or creeks, particularly during threatening conditions.

Severe Winter Storm

A winter storm watch means severe weather is possible. A winter storm warning signals that severe winter weather is expected. A blizzrd warning signals severe weather with substantial winds is expected. A Traveler's Advisory means that conditions may make driving unsafe. In some instances during extreme weather or other emergency conditions OCWCOG may close operations. SDS will notify employees if evacuation is necessary.

Bomb Threat

Anyone who recieves a bomb threat should adhere to the following procedures in the order shown.

1. The person receiving the threat should remain calm and attempt to obtain as much information as possible from the caller.
2. Call 911. Give your name, location and telephone number. Inform the responder of the situation, reporting the exact words of the threat including information you may have as to the location of the threat, time of the threat and time you received the call. Emergency personnel will handle the evacuation if necessary upon their arrival.
3. Do not evacuate the building and do not sound the alarm, but wait for further instruction. Authorities will be responsible for necessary evacuation of buildings.
4. If you should spot something our of the normal that appears suspicious, report it to your supervisor. Under no circumstances should you touch, tamper with, or move objects that look out of place or confront persons acting suspicious.
5. Immedicately cease the use of all wireless transmission equipment.
6. Record conversation if at all possible.
7. If the buiding is evacuated, move as far from the building as possible.
8. Keep the street, fire landings, hydrants and walkways clear to emergency vehicles and crews.
9. Do not return to the building until told to do so by emergency personel.

SECTION 4

Essential Functions

Essential functions are those organizational functions and activities that must be continued under any and all circumstances.

OCWCOG has identified the following functions as essential and are those that cannot suffer interruption for more than 12 hours.

Priority	Essential Functions
1	Telecommunications/Voice Mail
2	Computer and Remote Access
3	In-home client health and safety check
4	Medical transportation through RideLine
5	Adult Protective Services

Each program has established protocols for emergency situations.

Technology Services

In the event the network has been compromised, the following protocol will be used in order to retain network services as quickly as possible:

- If the Albany building is not accessible, Technology personnel are to report to the Corvallis office in order to carry out their assigned functions to get the network operational.
- Should the Corvallis office also be inaccessible, the Technology Services Director will contact the Philomath Police Department in order to set up an offsite office. The Network Operations Specialist will report to the Toledo office.
- The first priority for Technology Services is to establish phone communications followed by remote access to the agency network through an operational office. Secondary tasks will involve restoring agency data and critical services such as the Transportation Brokerage, Springbrook, and Oregon Access.
- Photos of the server room equipment and its location are included as a part of this Plan. Should emergency personnel be able to access the building, the Technology Services Director, or designee, will remove critical equipment, such as hard drives and backup tapes, if feasible.

- The State Department of Human Services (DHS) will be contacted to allow staff to access Oregon Access and other State programs from alternate locations.

A list of pertinent Technology Services Vendor information is provided in the Appendices of this document.

Telephones/Voice Mail

All phone and fax lines can be forwarded to locations where a telephone line exists. This includes forwarding to cell phone numbers. Phone lines can be forwarded immediately through an Internet control interface that Technology Services staff has access to or by calling the phone provider. In the event the Internet is not functioning and a phone provider has to be called, expect up to 72 hours before the forwarding takes effect, although the published agency numbers can typically be forwarded within 4 hours. The published numbers are:

Albany: 541-967-8720 (GA), 541-967-8630 (SDS), 541-967-8551 (CED)

Corvallis: 541-758-1595

Toledo: 541-336-2289

In addition, toll-free numbers can be forwarded to different phone numbers by calling the phone provider. Agency voicemail is provided by one server located in the Albany office. In the event this server is inoperable, the phone provider can provide voicemail service on the published phone lines within 72 hours.

Computer and Remote Access

The majority of the OCWCOG management team has been set up through Technology Services with remote access to the agency network. In the event the building(s) is not accessible, and the network has not been compromised, the Program Directors and Managers with remote access, can access emails and critical files and information stored on the network from their home or another location.

Computer connectivity priorities have been established as follows:

Priority	Program
1	OBBS (Brokerage)
2	Senior and Disability Services
3	ADRC
4	Veteran’s Services
5	General Administration
6	LMS (Lending)

In-Home Client Health and Safety Check

A list of the most vulnerable of OCWCOG's clients is updated quarterly. This list consists of individuals who will not be able to function without aid during an emergency. This list is distributed to each of OCWCOG's managers in a sealed envelope to open only in the case of an emergency. Copies are also kept in a safe at each office location.

Senior Meals

Meal Sites are equipped with non-perishable foods for use when adverse weather or other emergencies prevent timely delivery of hot meals.

Meals on Wheels recipients are provided with emergency meal boxes stocked with non-perishable foods. These are to be used in the event of an emergency if volunteers cannot safely deliver hot meals.

SECTION

5

Vital Records Management

Critical records of the agency have been identified in order for the continuation of business. Records required for business success, legal reasons, regulatory agency, and/or to support recovery efforts are listed to the extent possible. How records are stored and how they may be accessed are as follows:

Federal Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Program Management				
Receipt of Fed Funds				
Federal Grants	Electronic	Feds		
CFDA Numbers	Electronic			
SBA Loans		CWFS		
USDA/RDF 133&4				
EDA/RLF		LMS & Auditors		
EEOC Reports	Electronic	Department of Labor		
I-9's	Hard copy			

Emergency Operations Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Emergency Continuity of Operations Plan (COOP)	Hard copy and electronic	All Program Directors		
Staff contact and assignment information	Hard copy and electronic	Program Directors and Management Team		X
Orders of succession and delegations of authority	Hard copy and electronic	Included in COOP		
Agency Insurance Information	Hard copy	Barker Uerlings & CIS		
Policy, procedural and systems manuals	Hard copy and electronic			
List of credit card holders to purchase needed supplies	Electronic	US Bank		

Rights and Interest Records

Vital File, Record or Database	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Alternate Location	Hand Carried to Alternate Location	Backed up at Third Location
Agency Bylaws	Hard copy & electronic			
Articles of Agreement	Hard copy and electronic			
Articles of Incorporation	Hard copy in fire proof file cabinet			
Board Resolutions	Hard copy and electronic			
State & Federal Employer Identification Number Authorization	Hard copy in fireproof safe			
Audit Reports	Hard copy and DVD in fire proof safe			
Adopted Budgets	Electronic			
Payroll and Accounts Receivable	Electronic	Springbrook		
Personnel Files	Hard Copies			
Client Records	Electronic	State of Oregon DHS		
COG Inventory	Hard copy and electronic			
Titles, deeds, and contracts	Hard copies in fire proof safe			

SECTION

6

COOP Planning Responsibilities

All OCWCOG managers are designated as Emergency Relocation Team (ERT) personnel. The team members are responsible for ensuring that the elements of this Plan are activated and followed by providing leadership in a calm manner to enable the continuation of mission critical functions.

OCWCOG recognizes the importance of taking care of family first in order to be available to then serve the agency. Employees must be sure that their family is safe and secure prior to reporting to work. Employees should develop a personal “go kit” that includes the items their families will need if they have to evacuate or shelter in place. As well, employees should have an office “go kit” that includes the employee’s contact information.

The following table reflects COOP responsibilities for the agency:

Responsibility	Position
Update COOP plan annually	Deputy Director, Program Directors, and HR Manager
Update telephone rosters monthly	HR Manager
Review status of vital files, records, and databases	Deputy Director, Finance Director, other Program Directors as appropriate
Conduct alert and notification tests	HR Manager in coordination with the Program Directors
Develop and lead COOP training	HR Manager
Plan COOP exercises	HR Manager in coordination with the Program Directors

SECTION

7

Test, Training, and Exercises

Training will be provided to all OCWCOG managers, and key personnel, in order to ensure consistent application of the Plan, when a crisis occurs, for continuity of operations.

- The Continuity Planning Team and key personnel will test the Plan to confirm whether or not procedures, processes, and systems function as intended.
- Managers will train their staff to ensure that all personnel know what to do, how to do it, and when it should be done during an emergency.

Designated managers will complete an After-Action Report regarding any emergency incidents. The Continuity Planning Team will review and analyze the data from the After-Action Reports to determine if there are any areas of improvement needed for the OCWCOG Business Continuity Plan.

COOP Plan Maintenance

The Continuity Planning Team will meet annually to review this document, Continuity of Operations and Emergency Protocol, for necessary updates and revisions. Key evacuation routes, roster and telephone information, as well as maps and room/building designations of alternate locations will be updated as changes occur.

EMERGENCY RESOURCES

Linn and Benton County

Linn Co. Sheriff *Emergency Management*	**541-967-3901**
Benton Co. Sheriff *Emergency Management*	**541-766-6864**
Linn County Public Health *Albany* *Lebanon* *Sweet Home*	 **541-967-3888** **541-451-5932** **541-367-3888**
American Red Cross	**541-926-1543**

Lincoln County

Lincoln Co. Sheriff *Emergency Management*	**541-265-0651**
American Red Cross	**541-265-7182**
Reverse 9-1-1	**9-1-1**

State of Oregon

AGENCY	PHONE
DHS Public Health Division	**971-673-1222**

Radio Stations

KRKT	**541-917-0212 early am** **541-926-8628 office** FAX 541-928-1261	Albany	990 AM/1240 AM 1340 AM 106.3 FM 99.9 FM
KSHO KGAL	**541-926-8683** FAX 541-451-5429	Albany	920 AM 1580 AM
KHPE KWIL	**541-926-2431** FAX 541-926-3925	Albany	107.9 FM 790 AM
KLCC	**800-922-3682** **541-463-6000**	Eugene	89.7 FM
KBCH	**541-994-2181**	Lincoln City	1400 AM
KNPT KYTE	**541-265-2266**	South Lincoln Co.	1310 AM 102.7 FM
KFIR	**541-367-5115**–Steve (after 4:30am)	Sweet Home	720 AM
KORC	**541-563-5100** FAX 541-563-5116 Email: bet8@korcam820.com	Waldport	820 AM

Vulnerable Populations Emergency Plan

An Annex to the

Linn-Benton County Emergency Operations Plans

August 2012

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RECORDS OF REVISIONS

Revision to the Emergency Operations Plan (EOP) Vulnerable Populations Plan will occur based on the following:

- Changes to the County Emergency Operations Plan
- As a consequence of the lessons learned from events or exercises
- As a consequence of new federal, state, or local guidelines and mandates

Revision Number	Date of Revision	Text Revised	Individual Initiating Revision
1	June 2012	Plan Created	A. Vendetti
2	7/13/2012	8.1.2 & 8.1.3 Edited	AV / A. Cornell
3	7/17/2012	Plan-wide Edits	AV/ J. Fleischbein
4	7/19/2012	Plan-wide Edits	A. Vendetti
5	7/24/2012	Plan-wide Edits	AV/ E. Rau
6	7/27/2012	Plan-wide Edits	AV/ LBVPC
7	8/06/2012	Public Health Edits	AV/ J. Fleischbein
8	8/14/2012	Concept of Operations Edit	A. Vendetti
9	8/20/2012	Plan-wide Edits	A. Vendetti
10	8/22/2012	Plan-wide Edits	A. Vendetti
11	8/23/2012	Plan-wide Edits	A. Vendetti

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TABLE OF CONTENTS

1. PURPOSE

The Linn-Benton Counties Vulnerable Population Plan addresses specific emergency needs and assistance that members of vulnerable populations in the counties may have before, during, and after an incident.

This plan addresses specific requirements for vulnerable populations in the areas of transportation, mass care, emergency assistance and human services that are generally addressed in Emergency Support Function #1 – Transportation, Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services, and ESF # 8 – Public Health and Medical Services found in each of the county's Emergency Operations Plans.

In addition to information in the Linn and Benton County Emergency Operations Plans, this plan also identifies:

- Resources that may be needed for the special needs population during an emergency
- Available support services within the community.
- Possible sources of alternate services and resources if the need is greater than the availability
- Alternate methods to communicate emergency information to people with disabilities, limited English proficiency, and to members of diverse cultures.

2. DEFINITIONS

This plan identifies and defines the following four terms:

- Vulnerable populations
- Special needs populations
- Special medical needs populations
- At-risk populations

The term "vulnerable populations" will be used primarily throughout this document; however, other terms will be referred to as appropriate. The definitional framework for special needs populations allows planners to plan for a predictable and specific set of functional support needs. This framework also establishes parameters for resource allocation. This definition satisfies a key recommendation from the U.S. Department of Homeland Security (DHS) Nationwide Plan Review, which calls on the federal government to develop a consistent definition of the term "special needs."

Vulnerable Populations

According to the National Association of County and City Health Officials (NACCHO), vulnerable populations are defined as, *"a range of residents who may not be able to comfortably or safely access and use the standard resources offered in disaster preparedness, relief, and recovery."* Addressing the specific needs of these populations may require detailed planning. Vulnerable populations may include, but are not limited to, people with or those who are:

- Sensory impairments (blind, deaf, hard-of-hearing)
- Cognitive disorders
- Mobility limitations
- Limited English comprehension or non-English speaking
- Elderly
- Geographically or culturally isolated

- Medically or chemically dependent
- Homeless

Special Needs Populations

Special needs populations can be described as a subset of vulnerable populations. The National Response Framework (NRF) defines special needs populations as *"populations whose members may have additional needs before, during, and after an incident,"* including but not limited to:

Transportation

Includes individuals who cannot drive due to a particular disability or who do not have a vehicle and will require transportation support for successful evacuation. Support may include but is not limited to:

- Making accessible vehicles available (e.g., lift and/or ramp equipped or vehicles suitable for transporting individuals who use oxygen)
- Providing information on how/where to access mass transportation in the event of an evacuation

Communication

Includes individuals who have limitations that interfere with the receipt of and response to information. These individuals will need to receive information in methods they can understand and use. Certain communication limitations may hinder or prevent them from performing particular actions, including but not limited to the following:

- Hearing verbal announcements
- Seeing directional signage
- Understanding how to get assistance due to hearing, vision, speech, cognitive, or intellectual limitations, or limited English proficiency

Medical Care

Includes individuals who require assistance and are not self-sufficient or do not have adequate support from caregivers, family, or friends. These individuals require the support of trained medical professionals. Assistance may include but is not limited to:

- Managing unstable, terminal, or contagious conditions that require observation and ongoing treatment
- Managing intravenous (IV) therapy, tube feeding, and vital signs
- Accessing dialysis, oxygen, and suction administration
- Managing wounds
- Operating power-dependent equipment to sustain life

Supervision

Before, during, and after an incident, some individuals may lose the support of caregivers, family, or friends or may be unable to cope in a new environment. Certain individuals, that may have particular conditions, will require supervision to make decisions affecting their welfare. These individuals include, but are not limited to, the following:

- Those with dementia
- Those with Alzheimer's disease
- Those with psychiatric conditions (e.g., schizophrenia or depression)
- Unaccompanied children
- The elderly

Maintaining Independence

Individuals in need of support that enables them to be independent in daily activities may lose this support during an emergency or disaster. By supplying needed support/devices, the County can assist individuals in better maintaining their independence. Support resources may include:

- Lost or damaged durable medical equipment (e.g., wheelchairs, walkers, scooters, catheters, ostomy supplies, etc.)

The NRF definition of special needs provides a function-based approach for planning and seeks to establish a flexible framework that addresses a broad set of common function-based needs, irrespective of specific diagnosis, statuses, or labels (e.g., children, the elderly, transportation disadvantaged). This function-based definition reflects the capabilities of the individual, not the condition or label. Resources available in Linn and Benton Counties, along with planning considerations based on specific factors and associated functional needs of those with special needs, are addressed in Appendix B, Resource Matrix.

Individuals in need of additional response assistance may include those who:

- Have disabilities
- Live in institutionalized settings
- Are elderly
- Are children
- Are geographically/culturally isolated
- Have limited English proficiency
- Are non-English speaking
- Are without regular and/or adequate transportation

Special Medical Needs Populations

Special medical needs populations are a subset of the special needs populations. According to the U.S. Department of Health and Human Services (HHS), special medical needs populations are defined as *"those individuals, typically living in the community and outside of a medical setting or environment, who need support to maintain an adequate level of health and independence during times of emergency."* Included in this category are individuals who, before, during, and after an emergency, are:

- Medically dependent on uninterrupted electricity for therapies
- Require continual or intermittent medical care/support from a healthcare professional
- Are not self-sufficient with the loss of usual support from caregivers

At-risk Populations

HHS defines at-risk individuals as those who, before, during, and after an incident, "may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation." In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities; live in institutionalized settings; are geographically/culturally isolated; have limited English proficiency or are non-English speakers; are without regular and/or adequate transportation; have chronic medical disorders; and have a pharmacological dependency.

The difference between the HHS definition and the NRF definition of special needs is that the NRF definition does not include the following:

- Pregnant women
- Those who have chronic medical disorders
- Those who have a pharmacological dependency

The HHS definition includes these three other groups because pregnant women are specifically designated as at-risk in the Pandemic and All-Hazards Preparedness Act and those who have chronic medical disorders or pharmacological dependencies are two other populations that HHS has a specific mandate to serve.

3. SITUATION

Linn and Benton Counties are set in the Willamette Valley. The counties are susceptible to the impacts of disasters, both natural (snow, wind, earthquakes, floods, wildfires, etc.) and manmade (hazardous materials, transportation, technological). Due to the large diversity in the population for the counties, it is important to plan for individuals who may not be able to easily act or understand directions given in the time of a disaster. More information about hazards that can affect each county can be found in their Hazard Vulnerability Assessment.

Vulnerable populations make up a large percentage of a community's population. Because of this large population it is important to plan on how officials and responders will reach out to these groups as well as how to best help them recover. Working with the community is important when planning for the vulnerable populations to utilize the wealth of knowledge, experience, and resources the community offers. A list of resources available for vulnerable population emergency planning can be found in Appendix I: Community Resource Matrix.

According to the 2010 Census Linn and Benton counties have a combined population of about 200,000 people. This population can be affected by a number of potential disasters. According to the American Community Survey (ACS) 5-year average for 2006-2011, over 20 percent of the population of the 2 counties has a disability. Some of these individuals may be self-sufficient, while other may need assistance completing tasks on a daily basis.

Young children, seniors and people with limited income also comprise significant vulnerable populations within Linn and Benton counties. Geographic/cultural isolation, limited access to motor vehicles, limited income, difficulty communicating and understanding English, extreme age, and limited income are also situations that can leave an individual more vulnerable in a disaster.

- Linn County
  - Disabled: 22.02%
  - Under 5 Years Old: 6.83%
  - Over 65 Years Old: 14.92%
  - Limited Income (Under 100% of the poverty level): 16.27%
- Benton County
  - Disabled: 13.06%
  - Under 5 Years Old: 4.38%
  - Over 65 Years Old: 11.52%
  - Limited Income (Under 100% of the poverty level): 19%

For more information refer to Appendix A: Social Vulnerability Analysis

4. ASSUMPTIONS

The following assumptions reflect the approach with which the counties will fulfill the role of accommodating and assisting vulnerable populations during emergency operations.

- Many county departments and local non-profit organizations provide a critical link to and have the expertise to serve their clients with special needs.
- Local public health departments may be able to facilitate access to resources and case management services. However, they will not be able to provide onsite medical supervision and 24-hour nursing and environmental coverage.
- Public health nurses and clinicians might not be trained, nor should be expected or assigned, to care for individuals with special medical needs.
- Resources will be limited and the County may not be able to meet the needs of special needs populations at all times.
- Local planners have access to their jurisdictions' demographic profiles.
- All partnering agencies are responsible for the development of agency-specific standard operating procedures (SOPs) that uphold their roles and responsibilities in supporting response to an emergency.
- Some home healthcare providers may not be able to serve their clients during an emergency/disaster.
- Patients evacuated from licensed nursing home or assisted living facilities to a shelter are the responsibility of the employees and management of that facility.
- In an incident that impacts the general population, staffing levels at skilled nursing facilities, assisted living facilities, and outpatient clinics will be affected.
- Medically-fragile clients may not have access to regular services (e.g., dialysis, chemotherapy).
- Patients who normally receive home healthcare services may need to be accompanied by a caregiver to a shelter. In such cases, the caregiver should be transferred with the evacuee and permitted to remain with that person as the caregiver is able.
- Those individuals who normally receive home healthcare services and who are unaccompanied during transfer and sheltering may require special attention.
- Some individuals with functional needs will self-identify the need for assistance during emergency situations; others will not.
- Many residents, especially those with special medical needs, may assume there will be local resources available to rescue them (e.g., first responders) and/or that the County will be able to provide specialized assistance to them in an emergency (e.g., pharmaceuticals, durable medical equipment, and special transport).
- Some populations with special needs may be less likely to have disaster plans and supplies due to limited cognitive, physical, and/or financial resources.
- Transportation will be an issue for some residents and visitors with special needs.
- Service animals may be utilized by some people, and accommodations for these animals should be considered when developing evacuation and sheltering plans. NOTE: Service animals are not considered pets since they perform functions to assist their owner in activities of daily living. In order to be permitted into a shelter with their owner, the service animal cannot pose a direct threat to other animals or individuals residing in the shelter.

- Vulnerable populations may need assistance with the following activities associated with emergency or disaster response and recovery, including but not limited to:
    - Preparation, receiving notification, evacuation, and transportation
    - Sheltering
    - First aid and medical services
    - Temporary lodging and housing
    - Transition back to the community
    - Clean-up
    - Other emergency- and disaster-related programs, services, and activities

5. PARTNERING AGENCIES

5.1. FEDERAL

- Federal Emergency Management Agency (FEMA)
- Department of Health and Human Services (HHS)
- Centers for Disease Control and Prevention (CDC)
- National Organization on Disability (NOD)
- National Commission on Children and Disasters (NCCD)

5.2. STATE.

- Oregon Emergency Management (OEM)
- Oregon Health Authority
- Oregon Vulnerable Populations Coalition
- 211info

5.3. REGIONAL

- Linn-Benton Vulnerable Populations Committee
- Hospital Preparedness Program Region 2
- Oregon Cascades West Council of Governments
    - Disability Service Advisory Council
- Community Services Consortium
- American Red Cross Oregon Pacific Chapter
- Linn-Benton Senior Resource Network

5.4. LOCAL

- Linn County Sheriff's Office
- Linn County Public Health
    - Linn County Mental Health
    - Linn County Developmental Disabilities
    - Linn County Child Welfare

    - Linn County Public Health Medical Reserve Corp.
- Benton County Sheriff's Office
- Benton County Public Health
    - Benton County Mental Health
    - Benton County Developmental Disabilities
- City of Albany
- City of Corvallis
- Mennonite Home
- Adventist Disaster Response
- Samaritan Lebanon Community Hospital
- Samaritan Albany General Hospital
- Good Samaritan Corvallis Regional Medical Center

6. LEGAL AUTHORITIES

Law / Regulation	Citation	Purpose
FEDERAL		
Robert T. Stafford Disaster Relief and Emergency Assistance Act	P.L. 93-288, as amended, 1988	Integrates special needs issues into all phases of emergency management
HHS, Pandemic and All-Hazards Preparedness Act	P.L. 109-417, 2006	Addresses special needs or "at risk populations" including children, pregnant women, senior citizens, and other individuals who have "special needs"
Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users, 2005 (SAFETEA-LU)	P.L. 109-59	Requires state and local agencies to address special needs populations in their long-range transportation plans and improvement programs
Individuals with Disabilities in Emergency Preparedness (2004)	Executive Order 13347	Strengthens emergency preparedness with respect to individuals with disabilities
Americans with Disabilities Act (ADA) of 1990	P.L. 101-336	Mandates that all public and private sector facilities come into and remain in compliance, provide reasonable accommodations, and be accessible both physically and programmatically
Older Americans Act of 1965 (OAA)	P.L. 89-73	Used to authorize funds to assist older Americans in the recovery process
Individuals with Disabilities	H.R. 5441 (PL 109-295), Section 689	Used to develop disability-related guidelines for use by those who serve individuals with disabilities in emergency preparedness and disaster relief

Law / Regulation	Citation	Purpose
Rehabilitation Act of 1973	34 C.F.R. § 104; 29 U.S.C. § 794; Section 504	Holds local governments responsible for oversight of equal access by everyone to any program, service, or activity that receives federal funding; protects qualified individuals from discrimination based on their disability
Equal Opportunity for Individuals with Disabilities	42 U.S.C. §12132; 42 U.S.C. §12102(2)(B) & (C)	No qualified individual with a disability shall be excluded because of a disability from any programs, services, or activities provided by state and local governments
Nondiscrimination on the Basis of Disability in State and Local Government Services	28 C.F.R. § 35.104	Defines disabilities and states that individuals with disabilities may not be excluded from public accommodations by commercial facilities
Requirements For States and Long Term Care Facilities	42 CFR § 483	Requires that institutions have their own plans and provide them to their respective regulatory agencies
Requirements for Care Facilities	42 CFR § 485	Requires facilities to have a plan in place in disasters, as well as train staff in use of the plan.
STATE		
Department of Human Services Developmental Disabilities Oregon Administrative Rules	OAR 411-360-0130(8) OAR 411-325-0230	Requirement that adult foster homes and 24 hour care facilities must have an established emergency plan
Oregon State Fire Marshal	ORS 443.465(1)(b)	Requires that treatment homes and care facilities have an emergency preparedness plan

7. COMMAND AND CONTROL

7.1. GENERAL

Linn and Benton Counties have each established a system for emergency management under the direction and control of their respective County Emergency Program Manager. Each county has their own Emergency Operations Plan which describes their emergency management system. It describes how the county's emergency decision-makers and management personnel coordinated to carry out emergency functions in any incident that requires ECC/EOC activation.

7.2. DIRECTION AND CONTROL

All emergencies and disasters begin locally and initial response is by local jurisdictions working with county emergency management agencies. It is only after local emergency response resources are exhausted or local resources do not exist to address a given emergency or disaster that state emergency response resources and assistance may be requested by local authorities through their county emergency management organization.

7.3. COUNTIES

Each county has an Emergency Operations Center or Emergency Coordination Center that will be activated during an emergency. The location of each center and its activation procedures are outlined in the Counties Basic Plan. The county EOC/ECC will be the coordinating organization during an emergency that affects the majority of the county. For those situations where only a city is affected by an emergency, the city will stand up their EOC/ECC to coordinate their response efforts and contact county emergency management to advice them of their situation.

7.4. MUNICIPALITIES

Each city may establish an emergency management agency and appoint an emergency program manager. Cities that do so shall notify the county of the individual responsible for emergency management activities in their respective jurisdictions. Any city not choosing to establish an emergency management agency may develop a cooperative intergovernmental agreement with the county, specifying the emergency management activities to be accomplished at each level. If a city takes no action to increase its emergency management capability, such area will be considered in county planning and county resources will be deployed under the direction of the County to respond should emergency conditions arise that threaten residents of that city.

If a city adopts its own plan, that city will also:

- Adopt the National Incident Management System as the foundation for incident response within its jurisdiction;
- Acknowledge that the city government is charged with the responsibility of ensuring that city disaster plans are kept current;
- Ensure that those persons within city and county government who are charged with managing emergencies are made aware of their respective roles; and
- Ensure that the city plan is coordinated with their respective county plans.

7.5. PRIVATE/ NONPROFIT SECTOR

Disaster response by local government agencies may be augmented by business, industry, and volunteer organizations. Schools, hospitals, nursing/care homes and other institutional facilities are required by Federal, State or local regulations to have emergency plans. The County Emergency Program Manager will also work with voluntary organizations in the provision of certain services in emergency situations, typically through previously established agreements. In the preparedness context, essential training programs will be coordinated by the sponsoring agencies of such organizations as American Red Cross, Salvation Army, faith-based groups, amateur radio groups, and Community Emergency Response Teams. The Emergency Management Organizations may also provide the public with educational/instructional materials and presentations on whole community preparedness.

8. CONCEPT OF OPERATIONS

8.1. GENERAL

The basic concept of emergency operations focuses on managing and using available resources for effectively and efficiently responding to all types of emergencies. For the purpose of Vulnerable Populations individuals, licensed facilities and non-profit organizations all play a role to assist emergency management organizations within the county to provide preparedness information and emergency planning training to minimize the need for emergency responders. This section of the plan outlines expectations and guides on what needs to be done to provide smooth response during an emergency. More information on local government and nonprofit groups can be found in Appendix B: 211 Resource List.

8.2. ORGANIZATIONAL STRUCTURE

Each county has an organizational structure that is outlined in their individuals Emergency Operations Plan. These structures will be used any time their EOC/ECC is activated for an emergency or disaster. Each county will train with partners to this Vulnerable Population Annex to ensure the partners understand the county organizational structure and where they fit. Training will provide partners with an expectation of they need to do to assist in making response to an emergency more effective.

Partners to this plan are also expected to develop, implement and train their staff on their individual organizational structure, to share this structure with the county emergency management organizations and with the other partners they will work with as a part of this vulnerable population plan

8.2.1. LOCAL EMERGENCY MANAGEMENT

Both Linn and Benton Counties, and cities within, have emergency management organizations which are responsible for the maintenance of their Emergency Operation Plan (EOP) and EOC/ECCs. Emergency Management Departments focus on the disaster lifecycle which includes mitigation, preparedness, response, and recovery. During emergencies in which the EOC/ECC is activated, Emergency Management will perform duties as described in their EOP. Examples of duties may include coordinating resources, liaisoning with agencies and organizations active in disaster response, and advising on emergency matters, along with other tasks outlined in the county EOP.

8.2.2. HEALTH SERVICES

Linn and Benton Counties' Health Services departments will be responsible for preventing disease and coordinating health and medical responses required to cope with disasters in its area, including vulnerable populations. Through their various departments, Health Services are able to reach some populations that may need special consideration during an emergency, and will help facilitate the critical network of other health care and social service providers that can continue to offer assistance. Many of the Health Services response actions can be found in ESF 8 of the county EOP. Health Services will also assist in collecting, evaluating and disseminating information for the public; manage all necessary ESF8 resource requests; and coordinate with hospitals, other county and state agencies and partnering organizations as needed.

8.2.2.1. LICENSING/CERTIFYING AUTHORITIES

Within both Linn and Benton Counties any public organization, such as public health or nonprofit organization, will have an emergency structure in place to provide emergency support to their clients prior to and immediately after emergency. This structure will follow the four phases of emergency management to ensure that the clients are provided information on preparedness, the development of an emergency plan, training and

exercising and how to conduct an after action evaluation to improve their emergency plan. County or city Emergency management organizations will provide resources to assist licensing or certifying authorities within their jurisdiction.

During an emergency it is expected by the county or city emergency management that any request for assistance from a licensed facility will come through the licensing or certifying authority or designee to the county or city EOC/ECC rather than from individual facilities.

8.2.3. FIRE/EMS

Fire and Emergency Medical Services (EMS) will have Standing Operating Procedures and will train on how to effectively respond to an emergency situation in which members of the vulnerable population community are involved. In many cases, dealing with special needs or vulnerable population individuals may take a different approach than in dealing with the general population. Fire and EMS providers are expected to work and train with licensed facilities and care providers to ensure each organization understands their needs and resources.

8.2.4. LOCAL LAW ENFORCEMENT

Local Law enforcement can include city, county, and state agencies. Law enforcement is responsible for the safety and security of the public. During disasters, law enforcement will support the evacuation of the public and assist other departments with safety of the public and transportation of supplies.

8.2.5. NON-PROFIT ORGANIZATIONS

Non-profit organizations who are a part of this plan will work within the organizational structure as outlined in the individual county emergency operations plan. In addition they will develop their own organization structural plans that will be shared with their employee's, volunteers and county and city emergency management organizations. They will be expected to train and exercise these plans on a regular basis.

8.2.6. LICENSED/CERTIFIED CARE FACILITIES

As required under the authority of each licensing agency and associated administrative rules or statutes, all licensed/certified facilities will have an emergency plan addressing emergencies most likely to affect their facility and clients. Information pertaining to what hazards may affect them can be found in either the county or city hazard analysis found in their local area. Licensed facility plans should be regularly reviewed for revision, and should require ongoing training and exercises to take place on a regular basis with staff. Each plan will be reviewed and approved by the licensing or certifying authority or designee who will review the plans as required for licensing or certification renewal. The licensing or certifying authority of designee may request technical assistance by contacting their county or city emergency manager. A list of facilities can be found in Appendix D: Licensed Facilities.

Emergency plans for all licensed or certified facilities should demonstrate consideration for initial and potentially extended periods in which emergency responders are not available. A template for care facility emergency plans can be found in Appendix E: Emergency Planning for Care Facilities.

8.2.7. EDUCATIONAL INSTITUTIONS

Educational institutions are public and private pre-schools, elementary, middle, high schools, and colleges and universities that are responsible for the education of a wide range of individuals. Educational institutions are required to have emergency plans in place and exercise them as outlined in their plans. During an emergency, it is expected that each educational institution will implement their plan and communicate with city or county Emergency Managers.

8.3. IMMEDIATE ACTIONS

As an immediate action to a recognized incident that involves the local vulnerable population, coordination between City and/or County emergency management and leadership responsible for Vulnerable Population should be convened to discuss roles and responsibilities. This might include, but is not limited to, the following agencies:

- County Public Health
- County Emergency Management
- City Emergency Management
- Fire & EMS
- Police Agency
- American Red Cross
- Oregon Health Authority
- Council of Government
- Community Services Consortium

8.3.1. ACTIVATION OF THE COUNTY EOC/ECC

Activation of the County EOC/ECC will be based on the initial situational assessment. If the County EOC/ECC is activated the procedures outlined in the county's basic plan will be followed. Consideration will be given to the following:

- Support ESF 8 in the EOC/ECC
- Manage resources necessary to support vulnerable population
- Coordinate staff and volunteer management for general and vulnerable population shelters
- Coordinate information collection and management between shelters and EOC/ECC
- Keep a log of actions
- Ensure that health and medical messaging is provided through media outlets as indicated in each counties communications plan.
- Develop safety messages in coordination with the Safety Officer, as necessary
- Coordinate with partners as needed

8.4. RESPONSE ACTIONS

This plan is organized by the functional areas identified in the "special needs" definition: transportation, communication, medical care, supervision, and maintaining independence.

Particular events, such as a severe floods or large fires, may require an evacuation. Others incidents, such as chemical releases, may require sheltering at a home, school, or place of work. Depending on the event, the area and duration of an evacuation or shelter-in-place order will vary. Many incidents will require a combination of evacuation and sheltering-in-place during the course of the event.

This section describes specific response activities to a range of potential hazards for which the County agencies will be responsible in the event of a public health-related incident involving special needs or vulnerable population individuals or facilities. Response actions will focus on the public health consequences of an incident, and associated recovery activities, as they pertain to vulnerable populations.

8.4.1. TRANSPORTATION

Evacuations depend on mobility, and people with certain disabilities may not be mobile enough to evacuate on their own or without assistance. In evacuation plans, public officials must consider the transportation needs of the community. People with disabilities that decrease mobility may need additional help evacuating. Afterwards, those with mobility limitation may require help returning home. Transportation options can be found in Appendix C: Transportation Alternatives.

Nevertheless, people will want to return to their normal activities after an emergency and may need to go to medical appointments (e.g., to receive dialysis). Officials should think about transportation needs before, during, and after an event and ensure that transportation is available. Mobility disabilities include, but are not limited to, the following:

- Physical
- Sensory
- Chronic
- Behavioral
- Cognitive

Responsibilities:

Local Emergency Management

Coordinate transportation assistance to individuals who live in the community and have no transportation alternatives, they will provide support to licensed facilities, up on request, to support their emergency plan. Emergency management is responsible for the following actions:

- Coordinate evacuation transportation
- Facilitate movement of the public in coordination with other transportation agencies
- Implement their County ESF 1 procedures as outlined in their Emergency Operations Plan
- Provide support to those facilities that are unable to carry out their transportation needs as identified in their emergency plan
- Provide transportation services for residents including those with special needs
- Process all transportation requests through the County EOC/ECC
- Provide transportation services for Linn and Benton residents with special needs such as pre-arranged, specialized curb-to-curb transportation service for individuals who cannot ride the bus due to physical or mental conditions

Health Services

Actions required of Public Health may include, but are not limited to, the following:

- Coordinate public messaging with lead PIO and consider the communication needs of the community
- Coordinate with ambulance services, when needed.

Fire/EMS

Responsible for the following actions:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols
- Coordinate transportation of the sick and injured with area hospitals or receiving facilities and other EMS agencies

- Provide personnel and resources to the incident as needed and as available
- Obtain additional or specialized support if required, from neighboring counties and state and federal agencies, through the County ECC/EOC, if it is operational
- Obtain mutual aid assistance for the evacuation of evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

Local Law Enforcement
Responsible for the following actions:

- Provide security to the community
- Provide security, transportation, and escort for medical supplies, equipment, and personnel
- Assist with evacuations and coordination of needed equipment as appropriate
- Determine the most viable transportation networks to, from, and within the emergency/disaster area and regulate the use of these transportation networks

Licensed/Certified Care Facilities
During an emergency each facility will:

- Develop, update, and train staff on their emergency plan and ensure they can carry out their responsibilities
- Will be responsible for coordinating transportation services for their clients
- Identify in their plan a primary and secondary location where their clients will be transported to if evacuation from the facility is necessary
- Document where clients are transported to
- Communicate with client's relatives or legal authorities about the new location of the client
- Communicate with the licensing/certifying authorities on the action they are taking

Educational Institutions
Responsible for the following actions:

- Coordinate the transportation of students, staff, and faculty, when needed
- Provide transportation resources to Local Emergency Management to be used for emergency operations
- Implement their plan to ensure the safety of their student, staff, and faculty
- ensure their emergency plans are up to date and staff are adequately trained to understand and carry out their identified responsibilities

8.4.2. COMMUNICATION

Community members may not be able to hear verbal messages, see directional signs, or, due to language barriers, understand communications. In addition, they may not understand how to seek help. Officials must communicate with all residents and/or visitors in ways that are easy to access and understand. Planners must also use communication methods that reach everyone in the community, utilizing both audio and visual resources. Community members may have the following disabilities or limitations related to communication:

- Hearing impairment
- Vision impairment
- Speech impediment or impairment
- Cognitive or intellectual limitation

- Limited proficiency in English

Responsibilities:

Local Emergency Management

Lead agency for communication. Responsibilities may include, but are not limited to, the following:

- Implementation of the Communications portion of their Emergency Operations Plan
- Manage information during a disaster/emergency so that the most up-to-date and correct information is used to inform the public
- Coordinate with all agencies involved with the incident so that one message is used for public information to avoid any conflicts of released information
- Access all available media outlets to ensure that message is disseminated

Health Services

Actions requested of state or local Public Health may include, but are not limited to, the following:

- Coordinate public messaging with County Emergency Management and consider the health and medical communication needs of the community when providing emergency information
- Suggest the usage of partners, when needed, to provide communication services for the deaf, hard of hearing, DeafBlind, or speech disabled
- Make available and suggest to partners the usage of the Language Line or other interpreter service vendors, when required, to provide interpreter services, allowing providers to communicate more effectively with their clients in a multicultural community
- Provide to partners and the community written materials that have been translated into multiple languages, and make these materials available on the County website when possible
- Provide communications that are available in a variety of formats and media so that they are accessible to all residents, particularly those with special needs

Fire/EMS

- Provide updates on the situation in the field to their DOC

Local Law Enforcement

- Provide updates on the situation to their DOC

Licensed/ Certified Care Facilities

During an emergency each facility will:

- Communicate needs and actions taken with their licensing/certifying authority
- Communicate with their client's relatives or legal representatives
- Communicate with off-duty employees

Educational Institutions

Responsible for the following actions:

- Coordinate messages to families or guardians of students
- Ensure a line of communication exists between school administration and staff/ faculty
- Report activities to the local EOC/ECC

8.4.3. *MEDICAL CARE*

Emergencies that require individuals or communities to evacuate or shelter-in-place can cause hardship for those with medical needs that require close management. To address these challenges, officials should work closely with health and medical agencies to ensure that the management of care has been arranged for individuals with special medical needs during an emergency. Information on medical oxygen supplies has been created and can be found in Appendix H: Oxygen Planning. Assistance may include, but is not limited to, the following:

- Managing unstable, terminal, or contagious conditions that require observation and ongoing treatment
- Managing IV therapy, tube feeding, and vital signs
- Providing dialysis, oxygen, and suction administration
- Managing wounds
- Operating power-dependent equipment to sustain life

The needs of special medical needs populations might not be met in shelters established for the general population; the level of services will not equal what the client receives in his or her home or place of care. General population shelters are considered an option of last resort for these clients; however, healthcare providers should ensure continued services during emergencies, including evacuation to local shelters, if appropriate. A list of supplies for a functional needs shelter can be found in Appendix F: Medical Supplies for Functional Needs Shelter and a list of medical supply vendors can be found in Appendix G: Medical Supply Vendors.

Responsibilities:

Local Emergency Management

- Coordinate request of resources to State
- Facilitate the transportation of supplies

Health Services

Actions requested of the Health Department may include, but are not limited to, the following:

- Report observed needs up the chain-of-command
- Facilitate the availability of medical supplies
- Partner with ESF 6 to help facilitate the case management of individuals with special medical needs that may enter shelters
- Collaborate with ESF 6, as requested, to help facilitate family reunification (e.g., use of the American Red Cross Safe and Well website or FEMA's National Emergency Family Registry and Locator System, which is activated to support Presidentially-declared disasters and mass evacuations)
- Assess behavioral health needs following disasters and coordinate to provide interventions to minimize harmful stress levels for both the general public and responder communities
- Provide guidance to partners and ensure that health and medical agencies have a backup plan if the need to shelter-in-place lasts longer than 72 hours

Fire/EMS

Responsible for the following:

- Coordinate the provision of emergency medical services, as needed
- Ensure that triage, treatment, and transport of disaster victims is carried out in accordance with established protocols

- Coordinate the transportation of the sick and injured with area hospitals or receiving facilities and other EMS agencies
- Provide personnel and resources to the incident as needed and as available
- Obtain additional or specialized support, if required, from neighboring counties and state and federal agencies, through mutual aid or county EOC/ECC
- Obtain mutual aid assistance for the evacuation of patients from affected hospitals, nursing homes, or other special needs facilities

Local Law Enforcement

- Report observed needs to their local DOC

Licensed/Certified Care Facilities

See Legal Authorities (Section 6) above for regulations, but according to the Oregon Health Regulations licensed facilities are required to:

- Develop a written plan for the protection and possible shelter-in-place or evacuation of residents
- Develop mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation results
- Work with local responders and Emergency Management to ensure effective coordination during an emergency

During an emergency each facility will:

- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community
- Develop mutual support agreements with other agencies designed to ensure continuing care of both client populations in case of emergency-related needs

Educational Institutions

Responsible for the following actions:

- Provide on-site medical support to students, staff, and faculty
- Coordinate with local EMS to provide medical assistance to students, staff, and faculty

8.4.4. SUPERVISION

Many people need help with activities of daily living and receive this support from family members or paid caregivers. In an emergency or disaster, these individuals may lose the support of their caregiver. Certain individuals, that may have particular conditions, will require supervision to make decisions affecting their welfare. These individuals include, but are not limited to, the following:

- Those with dementia
- Those with Alzheimer's disease
- Those with psychiatric conditions (e.g., schizophrenia or depression)
- Those with other mental disabilities
- Unaccompanied children
- The elderly

Supervision of their clients will remain the responsibility of the licensed/certified care facility whether they are transported to the alternate care facility defined in their emergency plan, a shelter established by the American Red Cross, a shelter established by a non-profit organization or a shelter established by a governmental organization.

For those individuals who had no care giver prior to the emergency or whose care giver is off-site and cannot fulfill their responsibilities due to the emergency, the shelter operators will be response to get medical supervision for those individuals coming into established shelters.

Each school, public or private, within the Counties is responsible for developing a school emergency management plan that is based on the unique architectural, geographical, and student population characteristics of the school. Most school districts have district-wide emergency management plans that are developed in collaboration with community partners (e.g., fire, police, and EMS).

Responsibilities:

Local Emergency Management

- Coordinate request of resources to State
- Facilitate the transportation of supplies

Health Services

Actions requested of the public health department may include, but are not limited to, the following:

- Facilitate the availability of medical supplies
- Provide guidance to health and medical care partners in the community to better prepare them to provide continuity of medical services to their clients; this can include providing referrals to other agencies or caregivers who are able to offer continued care during emergencies/disasters
- Consult with and provide guidance to schools on public health and medical-related issues for all incidents (e.g., pandemic influenza, toxic exposure, etc.)
- Collaborate with ESF 6, as requested, to help facilitate family reunification (e.g., use of the American Red Cross Safe and Well website or FEMA's National Emergency Family Registry and Locator System, which is activated to support Presidentially-declared disasters and mass evacuations)
- Assess behavioral health needs following disasters and coordinate to provide interventions to minimize harmful stress levels for both the general public and responder communities

Fire/EMs

- Report observed needs to their local DOC

Local Law Enforcement

- Report observed needs to their local DOC

Licensed/Certified Care Facilities

During an emergency each facility will:

According to the Oregon Regulations for the Licensure of Nursing Facilities, each nursing home facility is required to:

- Implement their written plan for the protection and possible shelter-in-place or evacuation of residents
- Implement their mutual assistance partnerships with other facilities to provide the support necessary when an incident occurs, whether or not evacuation results

- Prepare for the continuation of services during emergencies or disasters by developing a plan that addresses the provision of services to clients who will need assistance, including those clients residing in facilities
- Work collaboratively with their local health departments and their locality's emergency planning office in developing appropriate sheltering capability for special needs persons in their community;
- Implement their mutual support agreements with other agencies designed to ensure continuing care of client populations in case of emergency-related needs

Educational Institutions

Responsible for the following actions:

- Partner with Public Schools to ensure that school emergency plans include staff and children with disabilities (e.g., visual, hearing, mobility, cognitive, attention, and emotions) and special medical needs
- Maintain a list of children who are identified with the following:
    - A disability under section 504 of the Rehabilitation Act of 1973
    - An individual education plan (IEP) under the special education services
    - A special medical need and/or family or social needs
- Determine how students will be accounted for
- Coordinate with safety and health officials to ensure that the needs of students are met
- Take direction from first responders once onsite
- Develop evacuation procedures for ensuring the full participation of students and staff
- Ensure that there is more than one evacuation route that does not interfere with public safety vehicles and/or fire hydrants
- Ensure that the clinic staff/nurses have emergency medical information, supplies, forms (e.g. *Authorization for Medication* forms), medications, and a medication log
- Conduct shelter-in-place drills regularly
- Train clinic staff to prepare medications and first aid supplies for such emergencies and set up a place for providing first aid or giving medication

8.4.5. MAINTAINING INDEPENDENCE

Many individuals with special needs are not self-sufficient with the loss of adequate support from caregivers. They may require regular care from a medical professional or need assistance to carry out daily activities, such as getting dressed, eating, and bathing. Individuals may also use a variety of support equipment, such as wheelchairs and walkers, to assist with their daily activities. In an emergency, these people may lose the aid they need to function independently. Without support, their conditions may worsen. Emergency plans should include ways to support these individuals. By receiving needed support/devices, these individuals will be able to better maintain their independence. Such support resources that may be required include, but are not limited to, the following:

- Consumable medical supplies (diapers, formula, bandages, ostomy supplies, etc.)
- Durable medical equipment (wheelchairs, walkers, canes, scooters, etc.)
- Service animals
- Attendants or caregivers
- Pharmacy support

Emergency plans should outline how to obtain such resources. Special needs advocates can work with emergency managers to secure these resources from the state or local government, non-governmental organizations (NGOs), and the private sector. Supplying support to special needs individuals will enable them to maintain their pre-disaster levels of independence.

Responsibilities:

Local Emergency Management

Responsible for the following actions:

- Maintain a list of public and private sector resources that could be utilized during response efforts
- Provide for the identification and management of resources that may be utilized during emergency or disaster situations

Health Services

Actions requested of the public health may include, but are not limited to, the following:

- Facilitate the availability of medical supplies
- Coordinate with Linn and Benton EOC/ECC's to request needed resources and maintain an ongoing assessment of needs
- Work with health and medical care partners, NGOs, and other partners to ensure that supplies and other resources that may be needed during an emergency or disaster are available
- Coordinate public messaging with County or local lead PIO and consider the health and medical communication needs of the community when providing evacuation information

Fire/EMS

- Report observed needs to their local DOC

Local Law Enforcement

- Report observed needs to their local DOC

Licensed/Certified Care Facilities

During an emergency each facility will:

- Provide support to residents/clients who are risk of losing independence during disasters as outlined in their plan

Educational Institutions

Responsible for the following actions:

- Provide support to students, faculty, and staff who are risk of losing independence during disasters as outlined in their plan

8.5. DISPENSING

Dispensing will be done as outlined in each counties Point of Distribution (POD) plan.

8.6. EMERGENCY RESPONSE

Response during an emergency will be coordinated at the county level through its EOC/ECC using the National Response Framework, National Incident Management System (NIMS) and the Incident Command System (ICS). City EOC/ECCs will coordinate their response with their counties to ensure there is a clear understanding of response efforts, expectations and potential response requests. Individuals, licensed facilities, and licensure organizations have a role in being prepared for an emergency and those expectations are outlined below.

There are four phases of emergency management which when properly followed by emergency responders and those facilities or individuals who fall within this plan will ensure a smooth and effective response.

Preparedness – Consists of measures taken to build, sustain and improve the capability to prevent, protect against, respond to and recovery from incidents. Preparedness is a continuous process that includes planning, training and exercises. Emergency plans should be developed to outline what action will be taken during an emergency and should include training with staff or care takers as well as annual exercises to ensure the plans are workable. These efforts help to minimize the need for emergency responders by assuring individuals and facilities can take care of themselves.

Response – It is during this phase that the preparedness efforts, emergency planning and training will be put to the test. Individuals and facilities will activate their emergency plan at the level necessary. The expectations of local emergency management is that adequate efforts has gone into the preparedness phase that emergency responders will only be needed in the most severe situations and that the majority of individuals and facilities will be able to take care of themselves.

Recovery – Restoring individuals and facilities back to their normal operations in the shortest period of time is the objective of recovery. The foundation of a good preparedness effort coupled with response during an emergency will ensure that recovery will take place quickly and effortlessly with little or no impact on individuals or clients.

Mitigation – This phase allows us to look back and see what worked and what can be improved. Individuals and facilities need to look at their response and determine if their emergency plans need to updated, coordination with other agencies or care takers need to be changed or if additional training would be helpful.

Appendix F

List of Designated Focal Points

Services may be attained from SDS at any of the following locations:

Albany Senior and Disability Services
1400 Queen Avenue SE, Suite 206
Albany, OR 97322
541-967-8630 Voice & ADRC
800-638-0510 Toll free
541-812-2581 Fax

Corvallis Disability and Veterans Services
301 SW 4th Street
Corvallis, OR 97333
541-758-1595 Voice

Toledo Senior and Disability Services
203 North Main Street
Toledo, OR 97391
541-336-2289 Voice & ADRC

Senior Center Locations Include:

Linn County

Albany Senior Center
489 Water Avenue NW
Albany, OR 97321
541-917-7760

Lebanon Senior Center
80 Tangent Street
Lebanon, OR 97355
541-258-4919

Sweet Home Senior Center
880 18th Avenue
Sweet Home, OR 97386
541-367-4775

Benton County

Chintimini Senior Center
2601 Tyler Street NW
Corvallis, OR 97330
541-766-6959

Lincoln County

Confederated Tribes of Siletz
PO BOX 549 Government Hill
Siletz, OR 97380
541-444-9169

Lincoln City Community Center
2150 NE Oar Place
Lincoln City, OR 97367
541-994-2722

Newport Senior Center
20 SE 2nd Street
Newport, OR 97365
541-265-9617

Waldport Community Center
265 Hemlock Street
Waldport, OR 97394
541-563-8796

Appendix G

OPI Policies and Procedures

OPI Service Reduction/Closure Grievance Procedure

1. If service hours for an OPI client are reduced or closed, and the client disagrees with the action, they have the right to present information about their case to the agency.

2. Clients must request a grievance review within 10 days of receiving written notice of a decrease or closure in OPI service hours. If they do not request a grievance review during that time period, they have forfeited their opportunity to do so.

3. Clients have the right to present their information in person, with legal counsel, to the Program Manager of Senior & Disability Services, before services are terminated. Client's case will remain open until final determination is made.

4. The agency decision, although informal, must state the reasoning, facts and rules upon which the decision maker at the grievance review relied.

5. Service hour reduction/closure can proceed once the grievance review is completed and the denial upheld.

6. If, after the grievance process, the client still disagrees with the local agency's decision, the client has the right to request an Administrative Review by Senior and Persons with Disabilities (APD).

7. In the Administrative Review, APD will review the following issues:
   - Whether Cascades West Senior Services' service priorities are established in policy, are consistently applied and do not contradict State statute/rule;
   - Whether service determination is individualized;
   - Whether the client has been informed of the agency's service priorities, grievance policies and right to participate in a grievance review;
   - The notification process was complete and timely; and
   - The client has been offered the opportunity to explore service alternatives.

June 7, 2002; revised February 2016

OPI Procedure—General for New and Reassessments

Contact client for initial or reassessment, and schedule home visit.

Download CAPS assessment on laptop to do in home with client.

At home visit, complete:

- CAPS assessment to determine SPL 1-15 (to be eligible)
- Income/Fee sheet to determine a fee, if no hourly fee, explain one-time $25.00 fee
- Service Agreement-have client sign
- Worker's Comp Agreement (for all new clients); have client sign
- Risk Assessment (not in CAPS, in OPI F/drive folder)

Other things to consider in-home:

1. How many OPI hours will meet the client's need if they are eligible; discuss individual needs. Currently offering an average of 2-3 hours a week of in-home services provided by CEPs or agencies. More hours can be assigned based on supervisor approval, *MOW*, Lifeline, adult day services, and chore and nursing services are options consumers can choose with most consumers kept around a $300 a month service limit.
2. If not eligible, what other community resources might assist and make referral?
3. Are any other programs might be appropriate (Family Caregiver or XIX)?
4. Does the client need assistance finding or training a HCW?
5. All new clients consider STEPS referral—with goal to refer as many new clients as possible.
6. Does the client need Home Delivered Meals (see HDM procedure for referral and completing OAA tabs)?

After home visit, in the office:

- Complete details needed in CAPS assessment and Service Plan with hours assigned
- Complete service portion in benefits tab (green circle arrows); enter fee & % for new and update fee changes with reassessments
- Complete Task List and print 1 copy, mail to client; IHA will print & mail copy to HCW
- Print SDS 546 and give one to IHA and keep one in mini file
- *Income fee sheet:* send a copy to client and one for file
- Give copy to Jen with risk Assessment score on it; she will bill.
- *Service agreement:* send a copy to client; if no hourly rate, highlight $5.00 annual fee on form and provide a SASE for return mail with payment
- *Worker's Comp:* to mini file. Only needs done at first visit.
- *Risk assessment:* complete and keep in mini file.
- *CEP Participation Agreement: Signed and put in the file.*

(continue to next page)

- *Note: Any changes in HCW or hours, give IHA new 546 or email and they will send 4105 notice and new task list as needed.*

To record OAA/OPI activities:

- Open OAA tab - For initial client, enter info in OAA Summary
- Select Case Management drop down #6 and enter 4 units for h/v, assessment
- For each follow-up phone call made to client, add 1 unit with date of contact.
- Select HCW 2a for homecare and HCW 1a for Personal care units/hours
- On OAA Service tab enter start date. If you are opening HDM, put in this tab/area
- Narrate all actions taken in Oregon ACCESS

February 2013 Gale Blasquez, Updated 6/2016

Procedure for OPI Client Waitlist

- ADRC call center will identify possible OPI applicants.
- Call center staff will explain there is a waiting list, BUT…
- Refer to OC and enter client on OPI waitlist spreadsheet.
- OC will call and offer home visit and/or OC at some level.
- OC will complete OPI Risk Assessment.
- OC will enter Risk Assessment score in wait list spreadsheet.
- OC will communicate with OPI case manager about urgent needs, high scores, OPI openings, etc.
- OPI case managers will triage waitlist participants based on risk assessment results.
- When client is opened on OPI, OPI CM will delete client off OPI wait list spreadsheet.
- OPI case manager will let OC know when client is opened on OPI and OC will provide client file (including risk assessment form) to OPI case manager.

RM September 2013

Appendix H

Partner Memorandums of Understanding

As a Type B Transfer AAA, copies of Memorandums are not required to be included.

Appendix I

Statement of Assurances and Verification of Intent

Attachment A

SDS Acronyms

AAA	Area Agency on Aging
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Connection
APD	Aging and People with Disabilities
APS	Adult Protective Services
CAP	Community Action Program
CAPS	Client Assessment Planning System
CAPI	Client Application Processing Interface
CCO	Coordinated Care Organization
CED	Community and Economic Development
CNA	Certified Nurse Assistant
COOP	Continuity of Operations Protocol
CTI	Care Transitions Intervention
DHS	Department of Human Services (State of Oregon)
DRI	Dietary Reference Intakes
DSAC	Disability Services Advisory Council
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
FCSP	Family Caregiver Support Program
FGP	Foster Grandparent Program
GA	General Assistance
HCBS	Home and Community Based Services
HCW	Homecare Worker
HDM	Home Delivered Meals
HR	Human Resources
HUD	U.S. Department of Housing and Urban Development
IADL	Instrumental Activities of Daily Living
IHN	Intercommunity Health Network
ILC	Independent Living Center
LCOG	Lane Council of Governments

LGBT	Lesbian, Gay, Bisexual, and Transgender
LTSS	Long Term Services and Supports
MDS	Minimum Data Set
MDT	Multi-Disciplinary Team
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MOWAA	Meals on Wheels Association of America
N4A	National Association of Area Agencies on Aging
NICOA	National Indian Council on Aging
NWSDS	Northwest Senior and Disabled Services
OAA	Older Americans Act
O4AD-	Oregon Association of Area Agencies on Aging and Disabilities
OC	Options Counselor
OCWCOG	Oregon Cascades West Council of Governments
OHP	Oregon Health Plan
OHSU	Oregon Health Sciences University
OPI	Oregon Project Independence
ORS	Oregon Revised Statutes
PAA	Private Admission Assessments
PEARLS	Program to Encourage Active, Rewarding Lives for Seniors
PERS	Public Employees Retirement System
PSU	Portland State University
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance
RDAD	Reducing Disability in Alzheimer's Disease
RPC	Regional Planning Council
RSVP	Retired Senior Volunteers Program
SAFETEA-LU	Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users, 2005
SAGE	Service and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders
SART	Statistical Analysis of Rates and Trends
SDS	OCWCOG's Senior and Disability Services' Department

Senior Corps	Corporation for National and Community Service's Senior Corps
SHIBA	Senior Health Insurance Benefits Assistance
SNAP	Supplemental Nutrition Assistance Program
SPL	Service Priority Level
SSA	U.S. Social Security Administration
SSAC	Senior Services Advisory Council
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SUA	State Units on Aging
TANF	Temporary Assistance for Needy Families
The Tribes	The Confederated Tribes of Siletz Indians
VAST	Vulnerable Adult Services Team
VSO	Veterans Service Office or Officer