Attachment 11

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RPQ No. R11-10422
DISTRICT CENTER SERVICES

APPENDICES

1. Geographic Service Area Boundaries and Policy
2. Standards for Single Entry Case Management
3. Performance Measures
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5. Adult Protective Service Roles and Responsibilities
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APPENDIX 1

Multnomah County
Department of County Human Services

AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

GEOGRAPHIC SERVICE AREA BOUNDARIES AND POLICY

Background
ADSD provides a wide variety of services to elderly (age 60+ years) and people with disabilities (18 – 64 years) through five Medicaid Branch Offices, five District Centers, and specialized offices for Nursing Home residents, Public Guardian and Conservators, Protective Services, and Adult Care Homes. Geographic boundaries are necessary to ensure efficient delivery of service. ADSD values easy access for anyone needing aging or disability services and thus any site can be the public's initial point of contact. Defined boundaries allow equitable funding formulas, consistent planning and program evaluation.

Policy
ADSD Service Area and District Center boundaries coincide, based upon the following descriptions. Where the boundary between either ADSD Areas or District Center areas is a street or highway, the boundary lies in the middle of the thoroughfare. Each District Center service area fits entirely within one ADSD Service Area.

All interagency, inter-division and inter-department case assignments follow the ADSD Boundary Policy.

ADSD Service Area and District Center Procedure
The five ADSD and District Center service areas are:

- East
- Mid-County
- North/Northeast
- Southeast
- West

Each District Center service area is associated with the ADSD Branch Office in which it is located. No District Center area will lie within two ADSD Service Areas.

The specialized ADSD offices are responsible for providing services County-wide. Employees assigned to a specific ADSD Branch Office take assignments for that ADSD Service Area, unless they are assigned by their supervisor to serve multiple areas.

AGING AND DISABILITY SERVICES DIVISION
GEOGRAPHIC SERVICE AREAS AND BOUNDARIES

EAST SERVICE AREA

Bounded on the **West:** From the line extending from the Columbia River South on SE 162nd Ave. to the southern county border
East: Multnomah – Hood County Boundary (east on I-84 past Bonneville Dam)
North: Columbia River
South: County Boundary

MID-COUNTY SERVICE AREA

Bounded on the **West:** From a line extending from the Columbia River South on SE 82nd Ave. to the southern county border
East: From the line extending from the Columbia River South on SE 162nd Ave. to the southern county border
North: Columbia River
South: County Boundary

NORTH/NORTHEAST SERVICE AREA

Bounded on the **West:** Willamette River
East: From the intersection of SE 82nd Ave and E Burnside Street; **Then** north to the county border
North: Columbia River
South: E. Burnside Street from the Willamette River, east to its intersection with SE 82nd Ave.

SOUTHEAST SERVICE AREA

Bounded on the **West:** Willamette River
East: From the intersection of SE 82nd Ave and E Burnside; **then** south to the county border
North: E. Burnside Street from the Willamette River, East to intersection with SE 82nd Ave;
South: County Boundary

WEST SERVICE AREA

Bounded on the **West:** County Boundary
East: Willamette River
North: County Boundary
South: County Boundary

APPENDIX 2

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

STANDARDS FOR SINGLE-ENTRY CASE MANAGEMENT

The following Standards for single-entry case management apply to all case management services and functions administered through the Aging and Disability Services Division (ADSD). Case Management functions are in effect when:

- An individual needs service planning and coordination, and/or
- The agency must authorize the purchase of publicly funded services for the individual.

ADSD and district senior centers are to develop procedures to implement these standards within six (6) months of training on the Standards. Compliance with these Standards is expected; any deviation should be documented.

PREAMBLE

The aging and disability services system in Multnomah County is a coordinated system promoting the well-being and independence of the elderly and persons with disabilities. The system is based on the following principles:

1. The Aging and Disability Services System is Client-Focused.
   The primary function and purpose of the aging and disability services system is to provide services to those elderly and disabled who are in need. The Older Americans Act recognized the nation's responsibility toward the well being of **all** of its older citizens, regardless of their capacity. Consequently, ADSD requires its District Centers to serve adults over the age of 60 regardless of their capacity and to the extent that resources are available. These services can be provided through the case management system or by linking the person to another needed service.

2. The Aging and Disability Services System is a Single-Entry System.
   Facilitating people's access to services and helping people obtain services through other agencies is the responsibility of each participating agency. Participating agencies have an active role in making sure that an individual reaches the appropriate resources. At a minimum, the agencies provide information on services available and facilitate people's access to those services. Communication and coordination with other service Providers are key elements in a single-entry system.

3. The Aging and Disability Services System is Neighborhood Oriented. Responsiveness to the social, cultural, and economic characteristics of the people to be served is expected of the system and its participating agencies. Participant agencies function within the standards of the countywide aging and disability services system and adjust their actual services and service delivery procedures to the characteristics of the individual districts for which they are responsible.

DESCRIPTION OF TERMS

The standards for the Multnomah County aging and disability services system are based on the following concepts:

1. Assistance Request. Assistance request refers to a request for help from an individual or other person or agency on behalf of that individual. The help being requested may be for service planning, prior-authorized services, counseling or problem solving (e.g. help with identifying and deciding upon options for retirement living) or financial support.

2. Case Management. Case Management is a service to an individual who is experiencing difficult and/or multiple problems. Trained case managers screen the call for assistance, assess the need for services, determine financial eligibility, develop and implement a plan of care, evaluate or monitor the ongoing success of that plan, and reassess the needs of the client when indicated and on a regular basis. Case managers also serve as advocates to get the help their clients need. They may negotiate with other agencies to provide the needed services or they may order (prior-authorize) services funded through the aging and disability services system. Case management is a holistic service in that it attempts to find an array of services for the total needs of the client and is not restricted to services an agency provides. The elements of case management include:

    a. Assessment and Entry. Assessment and entry refers to the process of determining eligibility and initiating services for a person. It involves an initial screening to determine the appropriateness of the agency for the service request, a needs assessment to identify the problems the individual is having, and an eligibility determination to assure that the agency can legally provide the services to that individual.
    b. Case Planning. Case planning refers to the process of identifying the services needed by the client, writing a plan, and implementing that plan.
    c. Ongoing Case Monitoring. Ongoing case monitoring refers to the continuing management of "cases" (that is, clients and their service plans). It includes advocacy with other agencies to get services for their clients; counseling and problem solving with the client, family, friends, neighbors, service Providers and others to resolve problems; evaluation of services to assure their quality and appropriateness for the client's needs; and reassessment of the client's needs and financial eligibility.

3. Client

A person who requests assistance becomes a client of the participant agency when their request has been screened and the request seems appropriate for the participating agency. A case management client is:

a. A person who has multiple and/or complex problems requiring assessment, service planning and monitoring, who is unable to provide these for him/herself, and who has no family/friends to carry out the case management functions; and/or

b. A person who has a need for services offered through the agency when those services must be purchased (authorized) by staff of that agency.

4. Financial Eligibility. Financial eligibility refers to an income-based criterion established by a funding program to determine whether an individual may receive services through that specific program. The financial eligibility criterion is based on the individual's income level, but also may be affected by other factors such as assets, fixed expenses, medical expenses, family support, etc. Determining financial eligibility for services is required by law for the Title XIX (Medicaid), General Assistance and Oregon Supplemental Income Payment, and Oregon Project Independence programs. Income is considered for Title III (Older Americans Act) services, but no one may be denied a Title III service on the basis of income.

5. Information and Referral. Information and referral is a service provided to individuals to help them locate desired resources and/or answer questions they may have. It consists of two primary functions:

   a. Information. This involves the answering of questions posed by an inquirer. A skilled information and referral Provider will be able to elicit unstated questions or concerns of the inquirer and provide the appropriate information.

   b. Referral. This involves the information and referral Provider contacting a service Provider on behalf of the inquirer and assuring a linkage is made. Usually the referrer will need to collect basic information from the inquirer and carry out a preliminary assessment of the inquirer's problems in order to evaluate available service options and select the appropriate resource. A follow-up call to the inquirer to determine whether the inquirer's needs were met is part of the service. If the needs were not met, the referral process is started over.

6. Outreach. Outreach is a specific service conducted by trained persons from the district senior centers to locate isolated seniors and let them know the types of assistance available in the community. Outreach is also part of the underlying philosophy of the aging and disability services system, in that the system is responsible for actively seeking and helping seniors in need.

7. Participant Agency. Participant agency refers to an agency which provides case management services to elderly and/or persons with disabilities in

cooperation with the Aging and Disability Services Division (ADSD). Current participant agencies are the nine district senior centers and ADSD.

8. Primary Case Manager. The primary case manager is the staff person assigned responsibility for a client. The primary case manager may call on specialists to carry out specific functions of case management (e.g. assessment of needs or financial eligibility determination), but the primary case manager is the contact for the client and is responsible for assuring that the client gets served in a timely manner. The intent is to have as few people working with the client as possible. The ideal is for the primary case manager to be the only individual to have personal working contact with the client. As part of this concept, the primary case manager is staff of either an ADSD branch or a district senior center. Only one staff member is designated primary responsibility at a time. The Aging and Disability Services Division stresses the primary case manager concept but allows for transfer of that responsibility on a temporary basis to another individual as circumstances dictate. The goal, however, is to have as much continuity for the client as possible.

9. Prior-Authorized Services. Prior-authorized services refers to assistance given to people to help them carry out activities of daily living, which is paid for through ADSD and which may be purchased only by authorized representatives of ADSD (i.e. ADSD case managers and staff of the district senior centers). Prior authorized services include home care, personal care, substitute living arrangements and nursing home placements.

10. Short-Term Intervention Clients. Short-term intervention client refers to a person who receives one or two discrete services from a district senior center or ADSD Branch. This type of client does not need ongoing case management. Examples include: someone who has a one-time medical expense or needs help obtaining a Social Security disability payment. The short-term intervention client receives help from the participant agency, but much of the documentation and follow-up that are part of case management are not required.

11. Single Entry. Single entry is a process by which an individual, through one contact to any participating agency, gets linked up to appropriate services. It involves the participant agency taking responsibility for responding to an inquiry or request for assistance and essentially walking a client through the assessment and entry process.

STAFF QUALIFICATIONS

Staff hired to carry out the case management service functions are expected to be qualified. Special qualifications include:

1. Ability to relate to clients;
2. Skill in casework techniques, i.e. interviewing, listening, assessing, planning, developing resources, and implementing plans;
3. Skill in clearly communicating, both orally and in writing;

4. Knowledge of community resources, medical terminology and service implications of medical diagnoses.
5. Knowledge of program eligibility requirements and ability to apply them in specific situations.

I. SCREENING AND REFERRING INQUIRES FOR ASSISTANCE

This section refers to the initial contact made by the inquirer regarding service planning, prior-authorized services, or financial assistance. It includes general inquiries for information, requests for assistance, information on which agency or program is the appropriate resource, and referrals for further action. It does not refer to information and referral type inquiries or to inquiries for non-ADSD programs administered by an agency, e.g. LIEAP. It differs from information and referral in that the inquirer has indicated a need for assistance or a desire to obtain services from the participating agency. An inquirer may be either an individual or an agency calling on the individual's behalf.

A. STANDARDS

1. The participant agency will respond to an inquiry within one working day (or eight (8) hours). "Response" refers to action initiated to resolve whatever questions or concerns were expressed in the inquiry.

    a. A response may include notification to the inquirer on the status of the inquiry if the information or assistance will not be available within the one-day time frame.

    b. If an application is being made for prior-authorized services, a response may be a call to determine the urgency of the request, or an appointment scheduled at the time of the initial contact for a visit at a later date. (Refer to section II on "assessing needs" for timelines for client visits.)

2. The participant agency will actively assist the inquirer in obtaining the desired information and/or services.

    a. Inquirers requesting services provided through the participant agency will be screened for eligibility and appropriateness for case management and followed up with an assignment to a primary case manager within one working day if the request appears to be appropriate. (This does not apply to service requests from another participant agency where a primary case manager has already been assigned).

    b. Inquirers requesting services not provided through the participant agency or prior-authorized services, for which the inquirer is clearly ineligible, will be either given information on or referred to other appropriate resources. Referral to other agencies includes direct contact between the participant agency and the other resources on behalf of the inquirer. Information about other service agencies without further assistance by the participant agency is provided when

the inquirer appears able to manage his/her own affairs, and assistance by the participant agency would not be helpful but considered as interfering or unnecessary.

3. When the participant agency refers the inquirer to another agency, it will minimize the amount of duplicate assessment and information gathering the other agency will need to do. The goal is to have basic client information collected only once.

   Client confidentiality policies will be maintained. Only information necessary for service delivery should be exchanged. Written client information will be obtained from the client.

4. When the participant agency has made an appointment with another agency on behalf of an inquirer the participant agency will follow up to determine that the appointment has been kept and the need has been addressed. This follow-up on referrals will be within five (5) working days.

   (Follow-up is not required when the individual, another agency, or family member/friend is functioning as case manager and the participant agency has provided information on services available through other agencies.)

B. RECOMMENDED PROCEDURES

1. Screening Requests for Service Planning, Prior-Authorized Services and/or Financial Assistance

   a. Ascertain the nature of the request (what is being requested) and its appropriateness for the agency (does the participant agency provide those services; does the inquirer appear eligible for services).

   b. Determine the appropriate agency.

   c. If the participant agency is not the appropriate agency, direct the inquirer to another resource. If the inquirer seems to be confused, angry, frustrated, or otherwise unable to follow through, call the other agency for the inquirer to obtain help from the agency. If the inquirer expresses a preference to follow through by him/herself, provide the inquirer with the pertinent information on the other agency.

   d. If the participant agency is the appropriate agency to provide the assistance requested, assign a case manager who will be responsible for assessing needs and getting services to the inquirer. This case manager is called the "primary case manager."

   e. If a request has been made for a specific service, which can be provided without assigning a case manager (e.g., transportation), arrange for the service but do not assign a case manager.

2. Sharing Information on Assistance Requests

a. Collect as much information on/from the inquirer as needed to determine the appropriateness of the assistance request. This information usually includes:
    - Name
    - Address
    - Birthdate/age
    - Income level
    - Presenting problem
    - Significant others
    - Social Security number

b. If the assistance request appears inappropriate for the agency, indicate this to the inquirer and request approval to give the information to an appropriate agency.

c. If approval is granted by the inquirer, call an appropriate agency and give them the information on the inquirer.

d. If the other agency is the appropriate one for the inquirer (i.e. it opens the case), send a copy of the screening form for their files.

e. If a referral is being made to the participant agency by another service Provider on behalf of an individual, request any written information on the client that is available and can be shared. Screening forms with common elements should be used by agencies providing case management.

3. Following Up Referrals

a. If a request for prior-authorized services or financial assistance results in a referral to another agency (i.e., an appointment was made for the individual), follow up the referral to determine whether the inquirer received the assistance requested. The person making the referral should either follow up with a call to the inquirer within five (5) working days or request and expect notification within five (5) working days from the agency to which a referral was made as to the status of that referral.

b. If the service request has been made by another service Provider, notify that Provider within five (5) working days as to the status of the referral.

c. Record the prevalence of inappropriate referrals. A follow-up call is important to evaluate the quality of the referral. If a referral was inappropriate or resulted in dissatisfaction, investigate the problem and take whatever corrective active may be indicated. Examples of corrective actions include:
    - Terminating service referrals to a particular agency;
    - Notifying the agency's management that referrals are being neglected;

- Revising the participant agency's screening practices to collect more appropriate information with which to improve the referral process.

II. ASSESSING NEEDS

This section refers to the evaluation of the client's physical, mental, social, financial and environmental conditions as they relate to the ability of the individual to function on a daily basis.

A. STANDARDS

1. The needs assessment will be a holistic appraisal of the functional needs of the client. This will include the psychological, social, health, financial and environmental conditions of each client as needed for care planning. When appropriate an evaluation by a specialist may be required as part of the assessment.

2. The needs assessment will provide an overview of the needs of the client. It will not be limited to areas in which the participant agency or ADSD offers services.

3. The needs assessment will include a face-to-face contact with the individual, preferably where the person is currently residing.

4. A face-to-face needs assessment will be held within five (5) working days of a service request. When the need for a response is imminent (e.g., hospital discharge), the assessment will occur as soon as possible but no later than three (3) working days from the initial request. When the client's condition demands immediate attention the visit will occur within one (1) working day. (See protective services mandates for timelines in abuse/neglect situations.) These timelines may be adjusted to particular circumstances identified during the services request, with adjustments and reasons documented.

5. The needs assessment will be carried out by trained persons under the direction of a primary case manager.

B. RECOMMENDED PROCEDURES

1. Collect data available on the client from all relevant sources, (e.g. client, screeners, referral source, etc.)

2. Make an appointment to go out to visit the client.

3. Arrange for specialists to visit, if a need is indicated. Specialists who may be needed include a registered nurse, social worker, mental health specialist, financial eligibility worker, and other case managers.

    a. Use other specialists' assessments, when possible, as a base for more in-depth evaluation.

b. All specialists who contact the client separately from the primary case manager will tell the client that they are acting in the case manager's behalf.

4. Use necessary assessment tools to evaluate the total condition of the client. Supplementary forms to ADSD required forms (e.g. the PIB) should be included in the client's file.

5. Include the family, neighbors, other care Providers, and significant others in the assessment visit(s) if at all possible. The intent is to get as complete a picture of the client's ability to function as possible.

III. DETERMINING ELIGIBILITY

This section refers to the examination of specific circumstances to assure that the client meets eligibility criteria.

A. STANDARDS:

1. The participant agency will assume that inquirers referred for assessment and eligibility determination by the participant agency are eligible for services and are therefore considered clients or applicants unless and/or until ineligibility is proved.

2. The participant agency will apply mandated eligibility criteria, including such factors as age, income level, and service need. Priorities for service will also apply.
3. The participant agency will determine the most appropriate funding source for the client's service needs. Every effort will be made to assure that individuals are provided services for which they are eligible.

4. The participant agency will continue to address the client's/applicant's needs while financial eligibility is being determined. This may include referral to other agencies for short-term services.

5. The participant agency will review eligibility for ongoing clients within required timeframes.

B. RECOMMENDED PROCEDURES

1. Consider the extent of needs, value of family support, cost of medical care, etc. when evaluating the individual's financial eligibility.

2. Use appropriate eligibility manuals for more specific procedures and timelines.

3. Refer the individual to another resource if the person is ineligible, and facilitate access or provide follow-up, if appropriate, within forty-five (45) working days of

the assistance request. (Note: reflects maximum time frame for determination of Title XIX eligibility.)

4. Refer to another resource for services while the application is pending, if indicated. Resources to consider include risk intervention, OPI, district senior center services, etc. Referrals should be made within five (5) working days of the assistance request.

IV. DEVELOPING AND IMPLEMENTING CASE PLANS

This section refers to the processes of translating problems of an individual into a package of services and arranging for those services to be delivered.

A. STANDARDS

1. The case plan will address all needs of the client and include services that take care of at least the major needs of the individual, whether or not the participating agency provides those services.

2. The case plan will draw on relevant resources available in the community.

3. The case plan will define frequency and duration of service(s) to be provided.

4. The case plan will supplement the family and other support systems of the individual. The intent behind the case plan is to encourage independence and to maintain family support to the degree possible while advocating for a safe environment for the individual.

5. Each case plan will be individually developed to reflect the unique needs of the client.

B. RECOMMENDED PROCEDURES

1. Match the needs of the individual with the resources available.
2. Arrange for public payment as a last resort for services when private resources are inadequate or unavailable.

3. Organize family, neighbors, friends, volunteers or others to provide some of the services, if possible.

4. Arrange with other participating agencies to provide services.

    a. Share information on the client to facilitate record keeping and improve service delivery. This may include sharing portions of the client file, with the knowledge and consent of the client.

    b. Hold a joint staffing, if needed. A joint staffing may be appropriate if the other participating agency will be providing a number of services but not case management.

5. Schedule a date for reassessment.

V. MONITORING ONGOING SERVICES

This section refers to the staff work involved in maintaining services to the client. It includes providing advocacy and counseling to the client, monitoring his/her condition, working with significant others and other Providers to resolve difficulties, and formally reassessing the individual's needs.

A. STANDARDS

1. In addition to formal reassessments, the participant agency will establish and maintain a regular schedule for contacting each client. Contacts may include face-to-face visits or telephone calls or communication with Providers. Contacts regarding non-responsive clients (e.g. comatose nursing home residents) may be with Providers and/or significant others. The regular schedule will be based on the client's needs and preferences, but the expected time frame is once a month. Reasons for deviation from this schedule will be documented.

2. The participant agency will carry out a formal reassessment of each client, including a face-to-face contact, not less than every 12 months or more frequently as needed.

3. The participant agency is responsible for maintaining up-to-date case plans for clients.

    a. Services are to be appropriate for clients.

    b. Services delivered are to be of good quality.

    c. Natural support systems are to be maintained and encouraged where possible. Respite may need to be arranged.

    d. A regular schedule for contact with the service Providers to resolve problems and assure quality will be established and maintained.

    e. If the client's needs change markedly during the monitoring process, a reassessment will be initiated.

4. If prior-authorized services will no longer be provided to a client who still has service needs, the participant agency will attempt to arrange for the needed services from other sources. The goal is to maintain continuity in assistance for the client.

B. RECOMMENDED PROCEDURES

1. Include schedules for client and Provider contacts in the case plan.

2. Document each contact with the client and with the service Providers.

3. Document case staffing, if a specialist (e.g. nurse) or other staff members has contact with the client.

4. If a client is no longer eligible for services but still needs some care and/or monitoring, refer the client to other service Providers who may be able to provide the needed assistance. Follow up the referral within five (5) working days to determine if the client has kept the appointment and has received assistance.

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VI. TRANSFERRING CLIENT AMONG CASE MANAGERS

This section refers to the transfer of cases between participant agencies, between case managers in the same agency, and between the aging and disability services system agencies in different counties (Area Agencies on Aging).

A. STANDARDS

1. The participant agency will minimize the number of transfers of clients among its case managers. A transfer from an intake to an ongoing case manager will generally be made only when the client has stabilized in his/her new living situation.

2. The participant agency will provide for a transition period when it transfers a client.

    a. If the transfer is within the participant agency, the new primary case manager will be involved in the case planning as early as possible.

    b. If the case is being transferred to another participating agency, a transition period will be granted to all for joint case planning/staffing and transfer of relevant client information (with client permission). The goal is to minimize duplicate assessments and case planning.

    c. Responsibility for responding to the client and his/her service Providers remains with the initiating case manager until he/she has been notified that the new case manager has received the case.

    d. Documentation from the case file will be forwarded within five (5) working days to the new case manager.

3. The participant agency will notify the client and his/her service Providers of a pending case transfer prior to its enactment. If possible, the new case manager will be introduced in person (preferably) or through written communication.

4. The participant agency will work closely with similar agencies in other countries when transferring case in order to ease the transfer and assure continuity of services to the client.

B. RECOMMENDED PROCEDURES

1. Notify the recipient case manager or agency as soon as a client transfer is expected.
   Notification may be through a telephone call or letter.

2. Involve the new case manger in case planning, client and Provider visits, and review of case files, prior to case transfer.

3. Arrange for transfer of documentation to the new case manager. Send copies of current forms and recent (e.g. last three (3) months) service logs.

4. Notify the service Providers of the transfer.

5. Call the new agency (case manager) within thirty (30) working days to see that everything is satisfactory.

6. The new case manager should make a client contact (preferably a visit) as soon as possible but no later than five (5) working days. The case manager should make a second telephone contact if an on-site visit will not occur within the thirty days, with reasons for the deviation documented.

GUIDELINES FOR SCREENING APS REFERRALS

1. Obtain complete, relevant information regarding who, what, where, why, when and whether this might fit one of the three APS categories:

   a. NF abuse: Physical harm or neglect to any patient in a nursing home;

   b. Elder abuse: Physical harm, neglect or abandonment to anyone 65 or older by someone else (hospital abuse referrals are included here); and,

   c. Community Protective Services (CPS): Aged, blind or disabled person unable to protect own interests and harmed or threatened with harm due to self or others.

2. Take responsibility for getting the referral to the APS designee, that person's backup or any professional staff person in the correct geographical branch (map attached). As a mandatory reporter under the NF abuse and Elder abuse laws, <u>you</u> are legally responsible to assure that the time frames are met!

3. The receptionist's responsibility is to assist the caller by connecting the caller with someone who can help. Acceptable actions are to transfer the call to the appropriate protective service or backup worker in the branch, to transfer the call to the receptionist or screener in the correct branch, or to take the caller's name and phone number, and assure that an appropriate person calls them back (unless otherwise arranges, within 10 minutes or so).

4. An unacceptable response is "that would be the responsibility of X branch; their phone number is 123-4567." It is <u>never</u> acceptable for an ADSD employee to tell a protective service caller to call somewhere else.

5. The receptionist's job is not to screen the call, take information or otherwise attempt to resolve or provide I & R to a protective service caller; the critical function is to get the caller connected with a case manager or other professional staff member who can help.

6. It is never the case that no one is available to help. Each manager should outline for his or her receptionists who is backup, next backup and on and on. If for any reason, all staff in one office can't be reached, another ADSD office will provide backup. Managers must make arrangements for responding to protective service calls during all-staff events. 8:00 a.m. to 5:00 p.m., ADSD and all its programs and offices are to be open for business.

7. Staff should remember that protective service callers may be afraid, have limited time to make a phone call (e.g. while the abuser is out of the house), or be otherwise inhibited or reluctant to share information. An attitude of helpfulness and minimizing the bureaucratic run-around is critical when dealing with these callers.

8. Ask for feedback from the APS designee or investigator. Did you gather the correct information? Enough information? Did you refer them to the right place? The right person? How could you have done it better? What did you do especially well? ASK!!

9. If you can't do what you think you need to do in getting a referral to the right person, talk to your boss or talk to that person's boss. Do it in a positive way.

APPENDIX 3

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

Performance Measures

The Department of County Human Services is moving toward funding efforts that are evidence-based and have provable results. Accordingly DCHS requires its Contractors to report on performance measures. The performance measures for District Centers are as follows:

Program Goal #1:
To work to eradicate structural inequalities between minority and non-minority elders in Multnomah County by conducting targeted outreach and service of ADS contracted services to underserved cultural, racial and ethnic minority seniors.

Performance Measure #1:
District Center will serve at least twice the percentage of ethnic and racial minority seniors in their registered contracted services within a fiscal year as compared to the percentage of ethnic and racial minority seniors in Multnomah County. Population data will be based on the most current Census data unless there is another more accurate community data source. Data will be provided by ADS and updated as new data becomes available.

Program Goal #2:
To provide excellent service for needed activities and programs to seniors of Multnomah County.

Performance Measure #2:
District Center will score an average of 'good' or better on client satisfaction surveys administered by ADS to registered clients one to two months after receiving registered contracted services. Scores will be aggregated and reviewed by fiscal year. Analysis will be conducted to see if satisfaction rates vary for clients of different race, ethnicity, primary language status, gender and age.

APPENDIX 4

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

NUTRITION PROGRAM POLICY ASSUMPTIONS

2003

SECTION 1. OVERVIEW

A. Program Purpose

Aging and Disability Services Division (ADSD) contracts for nutrition services for the elderly of Multnomah County. This process is undertaken in compliance with the Federal Older Americans Act, and other State, County and local requirements. The successful contractor(s) shall have the option to renew the contract annually contingent upon procurement guidelines, availability of funding and successful performance.

The purpose of the Multnomah County Senior Nutrition Program is to address dietary inadequacy, and social isolation among older adults with a special focus on greatest social and economic need, frailty, and cultural and ethnic heritage. The congregate nutrition program helps meet the dietary need of older people by providing nutritionally sound meals served in a group setting or in sites which specialize in serving elders from specific ethnic communities (including Asian, Latino, and Native American.) Home delivered meals programs provide nutritious meals to older people who are homebound and unable to prepare meals for themselves. Outreach and transportation services provided in culturally appropriate ways are an integral part of increasing accessibility to nutrition services by those persons most in need of them. All nutrition programs function as "gateways" for participants to access other services provided by ADSD.

B. Enhanced Program Focus

The outcome that Multnomah County ADSD desires for nutrition services is to improve the health status, well being, and access to other services of individuals from all ethnic backgrounds as a result of their participation in the program.

In addition, ADSD is interested in selecting programs that propose effective methods to address the nutritional needs of elderly persons in a changing environment. The changing demographics in the older adult population and its ethnic cohort, recent changes in the health and long term care system, and increased knowledge of the positive impact of nutrition and exercise on health conditions all suggest the need for new and different service strategies to achieve the stated outcome.

SECTION 2. PROGRAM OUTCOMES

A. Investment in Nutrition as part of comprehensive support

ADSD is interested in investing in programs that materially improve the integration of nutrition into the comprehensive system of case management and community services provided through Multnomah County ADSD and its partners. This includes:

Integrating nutrition into case management

- Addressing nutrition in care plans
- Providing dietician access and consultation for case managers

Making nutrition part of risk management

- Providing nutrition risk assessments
- Managing nutrition risks with intervention, skills building, providing more meals per day, and monitoring.
- Improving nutrition scores for all participants

Putting culture first

- Increasing participation of individuals from cultural groups
- Targeted outreach
- Participants creating their own menus

Serving as a gateway and referral source to other LTC services

B. Performance targets

ADSD nutrition program Providers will use some or all of the following performance targets for participants. This is not an all-inclusive list. Providers may add others that they feel support the ADSD outcomes.

- Increased number and diversity of participants in nutrition programs.
- Increased number of participants from geographically isolated or under-served areas.
- Increased access by participants to culturally appropriate dietician consultation
- Increased access by case managers to dietary counseling
- Increased number of participants who have received a nutrition risk assessment
- Increased number of participant who have improved their nutrition risk factor.
- Increased number of participants who are physically active three times a week.
- Increased number of participants who consume five servings of fruits and vegetables each day.
- Increased number of participants who choose to participate in at least one other activity at the congregate site regularly.

SECTION 3. NUTRITION POLICIES

A. The following givens act as conditions on any contract expenditures:

- Participants must be 60 or over in age, or meet other eligibility requirements as stated in the Congregate Nutrition Program Standards and the Home Delivered Nutritional Standards of the NANASP, the National Association of Nutrition and Aging Service Programs. (Available from ADSD).
- Funding is targeted for residents of Multnomah County.

- Programs cannot require a fee of participants, but can accept client donations in a confidential manner. Donations must be used to enhance the nutrition program.
- Each meal served must meet one-third (1/3) of Recommended Dietary Allowances (RDA) as established by the Food Nutrition Board of the National Academy of Science National Research Council
- Programs must comply with SPDS Nutrition Program Standards.
- Programs must be willing to track client level data as required under (NAPIS) National Aging Program Information System, and submit it electronically to ADSD in a timely fashion.
- Programs must comply with applicable federal laws and provisions of the Older Americans Act; state health, sanitation, and safety codes, and meet ADSD Contract Terms and Conditions.

B. The following assumptions are required of Nutrition Providers:

- ADSD reserves the right to require the meal site operator(s) to co-locate a meal site with the Area Office of District Center, and create multicultural environment that would be in accordance with a plan to meet this goal and consistent with ADSD values around diversity.
- Nutritious, attractive high quality meals which are culturally and therapeutically appropriate are served.
- Services provided by staff are linguistically and culturally relevant to the participants.
- Frozen meals are able to be cooked in microwave and oven, easy to open, attractive and tasty.
- Programs provide options for up to two meals a day for seven days a week.
- Transportation needs of participants to and from congregate meal sites are addressed by the program, either through its own auspices or in partnership with a District Center, through a variety of approaches.
- A variety of meal types are offered.
- Hot, home delivered meals are served hot, are easy to open, attractive, and tasty.
- Meal services are connected to other programs: e.g., on-site food banks, nutrition education and counseling, physical activity, health promotion activities, social events, and other options to increase the time a participant is able to spend at the congregate site.
- Partnerships between Providers improve variety, interest, and cultural enrichment.
- Strategies to increase participation include collaboration or coordination with other entities such as public or senior housing agencies, churches or other places serving older adults.
- Programs make use of diversified funding or resources, e.g., in-kind contributions, volunteer contributions, or fund raising.

SECTION 4. SPECIAL NUTRITION PROGRAM INVESTMENTS

In addition to investing in Congregate Nutrition and Home-delivered Nutrition, ADSD may use part of the available funding to make a limited number of **discrete investments** in the following **performance target areas:**

- Development of reliable methods, developed through research or pilot projects, that are acceptable to participants, for improving ethnic participants' nutritional status, or for measuring nutritional status before and after participation—**Research and Development**.
- Increased awareness of and accessibility to nutrition services, through targeted outreach efforts and cultural/ethnic nutrition sites, by older adults from ethnic communities (currently including Native American, Japanese, and Kosher sites.) Such sites may deviate from certain program assumptions around number of days of service and NAPIS reporting. —**Targeted Outreach and Cultural Meal Sites.**
- Increased access for smaller and specialized nutrition programs to culturally and ethnically appropriate registered dietitian expertise—**Ethnic Dietitian Service.**

APPENDIX 5

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

ADULT PROTECTIVE SERVICE ROLES AND RESPONSIBILITIES

Role Clarification for Community Based Adult Protective Services and Case Management

As employees and contracted service Providers of Multnomah County Aging and Disability Services we are responsible to ensure the health, safety and welfare of all vulnerable adults regardless where they reside. As representatives of this agency and as mandatory reporters for abuse, this means that whenever we observe a vulnerable adult being mis-treated in the community we will ensure that he/she receives the necessary attention and intervention necessary for their safety.

This document is written to assist in the clarification of the role of each staff person within ADSD who come in contact with vulnerable adults residing in the community who are being mis-treated, abused, neglected and/or exploited.

Although this document attempts to clarify roles, the safety of the client will come first. Should there be a disagreement as to who is responsible to respond to a particular situation, it will be the responsibility of each staff person to ensure that someone responds appropriately and in a timely manner regardless of this protocol.

If you are uncertain as to who or how one should handle a specific issue or situation, consult with your supervisor or contact an APS worker for technical assistance.

The following section is the current approved REFERRAL and ON-GOING case management Policy. This section has been cut and pasted from the current ADSD APS procedure manual. This policy has been approved by ADSD.

The following matrixes will assist in defining the roles. The first matrix defines Case Management versus Adult Protective Services for referral and on-going case management. The second matrix further clarifies the roles between the various case management functions including Adult Protective Services.

Case Distribution Procedures

An internal APS referral and case management referral system has been developed to eliminate internal agency confusion as to the distribution of cases among APS investigation and intervention, APS case management, Medicaid Service case management, eligibility-only cases and district center case management.

The following matrix shows the APS referral and case management system.

Adult Protective Services	Abuse (based on the Administrative Rules, as follows) Abandonment Sexual Abuse Financial Exploitation Neglect (with intent to harm or if harm has occurred or been perpetrated by a third party or paid care giver) Physical Abuse Psychological Abuse Self neglect (when person does not have capacity to understand consequences)
Case Management*	Benign Neglect (without intent, causes no harm, is not perpetrated by third party or paid care giver) Self Neglect (When a person has capacity to understand the consequences of their actions) ***Medicaid, Oregon Project Independence (OPI), Older Americans Act (OAA)***

APS Intervention vs. Ongoing Case Management

APS Intervention

Based on Administrative Rule, as follows:

Adult Protective Services is limited to assessment and/or investigation and intervention as identified in rule (see below). Service ends when the identified problem has been resolved or a plan has been instituted that assures continuing care and protection for the individual.

1. Person has the right to refuse services if in the estimation of the Division; the person is able to make an informed choice.
2. Counseling
3. Service Brokerage (If qualifies for this service in another program, APS will refer)
4. Assist in obtaining medical, legal, housing etc. (If qualifies for this service in another program, APS will refer)
5. Provide Advocacy to ensure client rights
6. Obtain legal resources if client lacks capacity.

Ongoing Case Management

Once the initial intervention is completed by APS, a referral for case management services will be made based on eligibility for a specific program.

1. OAA (persons 60 and older)
2. OPI (persons 60 and older who qualify for services based on the CAPS assessment)
3. APS Case Management: if there is no other service or resource available to provide case management

   And, for Medicaid eligibility ONLY
   (Cases when the person does not qualify for Medicaid Waivered Services.)
4. Medicaid Waivered Service
   (case management for those persons who qualify based on the CAPS Assessment.

Additional Role Clarification Is As Follows

CASE MANAGER I	CASE MANAGER II	CASE MANAGER III	OPI/OAA CASE MANAGER	APS CASE MANAGER
Identifies care concerns, basic needs and abuse, neglect and exploitation	Identifies care concerns, basic needs and abuse, neglect and exploitation	Identifies care concerns, basic needs and abuse, neglect and exploitation	Identifies care concerns, basic needs and abuse, neglect and exploitation	Identifies care concerns, basic needs and abuse, neglect and exploitation
Refers Abuse, neglect and exploitation to APS	Refers Abuse, neglect and exploitation to APS	Refers Abuse, neglect and exploitation to APS	Refers Abuse, neglect and exploitation to APS	Provides Protection and Investigates Abuse, Neglect and exploitation
Assesses client needs to determine action plan	Conducts a holistic assessment to determine care plan	Conducts a holistic assessment to determine care plan	Conducts a holistic assessment to determine care plan	Conducts a holistic assessment to determine intervention and care plan
Refers to Medicaid Service Intake and/or APS those care concerns that require a more holistic assessment and care plan*	Develops a comprehensive care plan that addresses all identified care needs	Develops a comprehensive care plan that addresses all identified care needs	Develops a comprehensive care plan that addresses all identified care needs	Refers to Medicaid Services and or OPI/OAA case management for on-gong case management those situations that qualify for such services.
Locates and coordinates basic care needs for housing, transportation, food, medical and mental health care	Implements and monitors comprehensive care plan	Implements and monitors comprehensive care plan	Implements and monitors comprehensive care plan	Implements and monitors comprehensive care plan for those clients received from CM 1's or those persons who don't have another case management option.

Role Clarification for Community APS and Private Pay ACHP Clients Being Evicted Without Natural Support Systems

CASE MANAGER I	CASE MANAGER II	CASE MANAGER III	OPI/OAA CASE MANAGER	APS CASE MANAGER
				Provide Placement Services to those Private Pay Clients without family who meet the eviction criteria for the ACHP "less than 30 day eviction rule" See Facilities role clarification

THE DEFINITIONS OF ABUSE UNDER THE CPS RULE

Physical Abuse
Use of excessive force, physical assault, or physical contact with an individual including, but not limited to, hitting, slapping, biting, pinching, or shoving.

Sexual Abuse
Sexual contact that is forced, tricked, threatened, or otherwise coerced upon another person.

Neglect
The failure (whether intentional, careless or due to inadequate experience, training or skill) to provide basic care or services when agreed to by legal, contractual, or otherwise assumed responsibility.

Abandonment
The desertion or willful forsaking of an elderly person or the withdrawal or neglect of duties and obligations owed a dependent adult by a caretaker or other person.

Financial Exploitation
The illegal or improper use of another individual's resources for personal profit or gain.

Psychological Abuse

The use of derogatory names, phrases, or profanity, ridicule, harassment, coercion, threats, or intimidation toward an individual; or denial of civil rights, that results in emotional injury.

Self-Neglect

One's inability to understand the consequences of his/her actions or inaction that leads, or may lead, to harm or endangerment to him/her self or other persons. To substantiate self-neglect the following needs to be considered:

Refer all Abuse, Neglect and Exploitation Cases to the Central APS Number:

503-988-4450

APPENDIX 6

Multnomah County
Department of County Human Services
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DISTRICT CENTER SERVICES

Narration Standards

October 26, 2004

Quality narration is one of the primary methods by which the division demonstrates accountability for the services it provides. We must be able to show that we have acted in the best interest of each client, and have done what we can to protect their safety and welfare and to provide them with the assistance they need. In a complicated system, with multiple individuals potentially involved in a case, documentation of important case activity and decisions is essential to service planning, coordination and continuity. The ADSD Narration Standards are a cornerstone of our commitment to quality customer service. They provide a universal measure for the Division about what constitutes quality narration and our performance expectations for staff. Oregon ACCESS is the common narrative tool for ADSD and District Center staff to document essential case information about shared clients. All ADSD and DC staff are responsible for using Oregon ACCESS to narrate any client information that may impact care planning.

- Narration will be a chronological record of any contact or action that affects client benefits or situation. (If it's not narrated, it didn't happen).
- Narration will be objective, factual, and free from personal bias, comments, or emphasis. Quotations are only used for actual statements. Clients and their representatives have access to most case records, including narratives.
- Narration will be descriptive, concise and complete so that others can understand the case and worker actions. Each narration entry should include:
    - Who was seen, contacted, initiated the contact?
    - What was the purpose of the contact?
    - When & Where did the contact take place?
    - What changed?
    - What & Why were action taken? When are they effective?
    - What is the plan? What follow-up is needed?
    - How were decisions determined?
- Narration will be done at the time of contact or activity – or within at least 3 days. Narration may be a summary of a day's contacts.
- Narratives will be checked for proper grammar, spelling and punctuation, and should use sentence case and agency-accepted acronyms and abbreviations
- Any ADSD or DC staff working on an open ADSD case, who become aware of changes in the client's information or circumstances will document the information in the ACCESS narrative.

- Essential Elements as identified for each case status should be narrated at intake and reassessment.
- Instances of client involvement or the reason why the client is unable to participate should be documented.
- Narration will address each eligibility factor and the decision made and/or action taken. This will be done at application, re-determination and when changes occur. Each eligibility case must have a narrative entry at least annually.
- All mathematical calculations must be documented.
- Narration will not include any information on HIV/AIDS.
- Protective Service narration by Case Managers will be limited to documentation of the referral and the case assignment, if known. Specific details and the outcome of the referral will be excluded, according to Adult Protective Service Rules and Guidelines. Case Managers may obtain additional information regarding an investigation through use of the Protective Service module per ADSD policy. The case manager will document care planning issues caused by a Protective Service situation, without any comment regarding the allegation or alleged perpetrator.
- Protective Service and Public Guardian staff will narrate all formal referrals for their services. Protective Service and Public Guardian Screeners will narrate in the Access narrative that a referral has been received and, if assigned, who it was assigned to.
- Helpline staff will narrate all calls that may impact care planning, including After Hours referrals. If the call concerns an open case the information will be documented in the Access Narrative. If it is not open, it should be documented in the screening when there is one. When there is no access screening the client should be referred to the appropriate Service Screener.
- As much as possible, client medical information (diagnoses, medications, etc.) should be entered in CA/PS rather than the ACCESS narrative.

Note: Protocols related to documenting ongoing involvement of Protective Service MDT and Public Guardian staff in active ADSD and DC cases will be developed at a later date.

Essential Narrative Elements Ongoing Case Management

- Changes in client circumstance, care plan or Provider status
- Contacts, including who and why, new information received or provided, and decisions or agreements made
- Referrals or other case actions, including Protective Service, MDT, Public Guardian referrals
- Correspondence or forms mailed or received in the office
- Actions that affect mainframe screens, and their effective dates
- Anything else Case Manager deems important to care plan or for others who might be viewing the case

ACRONYM LIST

Following are some common acronyms that may appear in the RFPQ

AAA	Area Agency on Aging

ACCESS	Automated Client Capture & Storage System
ACHP	Adult Care Home Program
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AFC/AFH	Adult Foster Care/Adult Foster Home
ALF	Assisted Living Facility
APS	Adult Protective Services
APD	Aged & Physically Disabled
A/R	Applicant/Recipient
CAF	Children, Adults and Families (state division of DHS)
CA/PS	Client Assessment/Planning System
CAWEM	Citizen/Alien Waived Emergent Medical
CBC	Community Based Care
CHIP	Children's Health Insurance Program
CNA	Certified Nurse Aide/Assistant
DD	Developmental Disabilities
DHS	Department of Human Services (state)
DME	Durable Medical Equipment
DSAC	Disability Services Advisory Council
EBT	Electronic Benefits Transfer
e.g.	For example
EI	Employment Initiative
ENCC	Exceptional Needs Care Coordinator
EPD	Employed Persons with Disabilities
FHIAP	Family Health Insurance Assistance Plan
FCHP	Fully Capitated Health Plan
GA	General Assistance
HAP	Housing Authority of Portland
HC	Home care
HCW	Home Care Worker
I & A / I & R	Information & Assistance/Information & Referral
i.e.	That is
IT/IS	Information Technology/Information Systems
LTC	Long Term Care
MCO	Managed Care Organization (also MHC: Managed Health Care)
MDT	Multi-Disciplinary Team
MH	Mental Health
MHO	Mental Health Organization
MOW	Meals on Wheels
MRS	Monthly Reporting System
MRT	Medical Review Team
NOC	Network of Care
NSLA	Nonstandard Living Arrangement
OA	Oregon Acess
OAR	Oregon Administrative Rule
O4AD	Oregon Association of Area Agencies on Aging & Disabilities (also N4A)
OFSET	Oregon Food Stamp Employment Transition Program
OHP	Oregon Health Plan
OPI	Oregon Project Independence
OSIP/OSIPM	Oregon Supplemental Income Program/Medical

OSIP-AB, AD, OAA	Oregon Supplemental Income Program /Aid to the Blind, Disabled, Aged
PAS	Pre-Admission Screening
PC	Personal Care
PCCM	Primary Care Case Manager
PCP	Primary Care Provider/Physician/Practitioner
PIF	Personal Incidental Fund
PMDDT	Presumptive Medicaid Disability Determination Team
QA/QC	Quality Assurance/Quality control
QMB	Qualified Medicare Beneficiary
RCF	Residential Care Facility
ROI	Release of Information
SPD	Seniors & Persons with Disabilities (state)
SHIBA	Senior Health Insurance Benefits Assistance
SLF	Specialized Living Facility
SMB	Special Medicare Beneficiary
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSB	Social Security Benefits
SSD/SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TPR	Third Party Resource
VA	Veteran's Administration (federal)
VRS	Vocational Rehabilitation Services (state)
WEBM	Welfare Eligibility Benefit Menu

Screening Protocols for Clients with Multiple Access Screenings

Assumptions:

- There will only be one screening per client
- Branches will respond in a timely manner when they are requested to inactivate a screening

When you receive a screening and one already exists the following steps should be taken:

- If the screening is active in another branch, contact the branch where the screening is located and request that it be inactivated; review the screening for any errors in information, and add the updated information to the Access narrative in bold font.
- Narrate new screening information in the Access Narrative
- Inactivate the screening when the screening has been completed
- When multiple screenings are found:
  - ✓ Cut and paste the old narrative(s) into the new screening and enter "consolidated from past screenings"

- ✓ When extra screenings are located, enter "Do not use/invalid screening" under "Other" in "Benefits Requested" section of the screening form, and inactivate these
- ✓ Identify and use only the screening without the "invalid" notation

- When PS staff receive an incomplete screening (e.g. a screening lacking client's personal information) they should add to the screening as additional information is obtained and consolidate screenings as necessary.

Essential Narrative Elements Reassessment

- Assessment date and location:
- Individuals present and/or providing input:
- Significant events since prior assessment, not previously narrated:
- Summary of major changes to ADL's, if any, and new Survival Priority Level (include general statement regarding the change in condition):
- Status of, and/or changes to Care Plan. If client declines any services or plan is inadequate note discussion of risk and safety issues with client and/or others. Also, indicate client's capacity to understand risks.
- Follow-up needed (equipment and other needs identified; include responsible party):
- Program status at reassessment, pay-in requirement, and computer actions taken:
- Monitoring Needs and Plan:

APPENDIX 7

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

DISTRICT CENTER SERVICES

SERVING DIVERSE POPULATIONS & INTERCULTURAL STRATEGIES

Policy Statement:

To assure *cultural/ethnic/racial* minority persons have equal access to all ADSD programs and services.

To serve *cultural/ethnic/racial* minority elderly and persons with disabilities through flexible programs adapted to the unique cultural, ethnic, or language needs of the individual.

To assure that an eligible person is not excluded from receiving services based on the individual's race, ethnic or cultural background.

To assure that all specialized programs will be multicultural in nature in keeping with policy recommendations by the Minority Services Task Force (1989).

Adopted Strategies: **In order to provide the greatest good for the most people, and to maximize use of available resources, the following strategies have been adopted:**

Assure that the "mainstream" programs of ADSD and Contractors are open and available to all populations by employing a workforce that is knowledgeable and sensitive to cultural and ethnic needs and includes individuals representative of cultures served who are bilingual and bicultural.

Create and maintain special ethnic outreach and access programs when it is evident that certain groups are not using the mainstream programs and services.

Build and/or fund specialized programs for cultural/ethnic populations when it is evident that for one or more cultural/ethnic groups the mainstream programs are 1) not being used, 2) insufficient to overcome actual or perceived barriers of language or culture, or 3) are not able to address diverse cultural issues appropriately.

Fund activities that will support cultural identity and foster effective relationships between minority persons and ADSD, when the above strategies are not successful.

Stakeholder Representation/Program Support:

Multi-ethnic Action Committee (MAC): an official advisory committee to ADSD to

ensure that elders and persons with disabilities who are also racial and ethnic minorities have equal access to quality and culturally appropriate services in Multnomah county.

Gay & Grey PDX (formerly Elder Resource Alliance): a special interest group focused on outreach to Gay, Lesbian, Bisexual, and Transgender (GLBT) seniors and increasing the awareness of the community to the needs of GLBT seniors through speaking engagements and training.

Elders in Action and the Disability Services Advisory Council: official advisory committees for older adults and persons with disabilities, respectively, provide advocacy and advise to ADSD regarding the needs and barriers to service for all older adults and persons with disabilities.

Desired Outcomes:

1. A diverse, skilled knowledgeable and sensitive culturally competent workforce.
2. Culturally appropriate and accessible services and programs

Intercultural Strategies for Aging and Disability Services September 2010

History: Initial Intercultural Strategies Plan developed with input from management May 2007 with assistance from Kristin Lensen, Consultant. Over the past few years ADS has presented progress to and sought feedback from MAC.

Areas of Focus and work plan processes were identified. Manager input used to develop a 2 – 3 year plan and 4 objectives. Objectives were either incorporated into ADS Leadership Team goals or addressed via program goals through committee work.

Update: Management met in August 2010 to renew agency commitment to pursue intercultural strategies, review progress, reaffirm areas of focus and develop goals and objectives for FY11.

Areas of Strategic Focus:

1. Identify, develop and provide the resources and tools necessary to prevent language differences from being a barrier to service access.

2. Develop and sustain active partnerships with diverse communities to learn how to reach different populations, serve people in a manner that meets their specific needs, and use practices and processes that assure all clients equal access to services.

3. Provide cultural-general and cultural-specific training so that staff and providers continuously improve their skills for working with people who are culturally different from themselves.

4. Integrate intercultural strategies into staff work.

5. Recruit, develop, and retain a diverse workforce.

6. Recruit and retain a diverse pool of contractors and providers.

7. Facilitate equitable outcomes by addressing disparities for ethnic minority seniors and people with disabilities through policy and system wide strategies, developing opportunities for improving outcomes, and through planning, outreach, programming, and service delivery.

Objectives: Annual intercultural related goals and objectives are incorporated into the annual ADS Leadership Team goals. They are both captured under goal IV. "Clients who are members of non-dominant racial, ethnic, or cultural groups or have limited proficiency in English will have full access to resources and services that meet their diverse needs and preferences" and throughout the document as appropriate.

FY11 Intercultural Related Goals and Objectives:

- Develop a strategic plan for implementing equity-based planning, programming and service delivery as the foundation of our agency's mission and operations.

- Communicate progress on Intercultural Strategies plan with staff, providers, and department. Include purpose, desired outcomes, intended results, progress, and unintended consequences, both positive and negative.

- Build capacity to serve various ethnic populations living in Adult Care Homes; investigate innovative programming that addresses ethnic and cultural diversity needs/issues; identify and implement methods to make Adult Care Homes a viable option for serving ethnic populations, including special or limited licensing.

- Recruit providers to establish Cantonese and LGBT homes.

- Identify where bilingual skills are needed for improved client access and service; collaborate with HR and the Union to pursue options for addressing the need including recruitment of bilingual staff for expanded capacity.

- Involve consumers and community-based organizations representing ethnic/minority and LEP populations in improving access and service delivery through Multi-ethnic Action Committee involvement in key initiatives.

- MAC to review ADS policies in relation to their responsiveness to the needs of ethnic/minority and LEP groups and provide recommendations for changes to the ADS Leadership Team.

- Build a strategic business partnership with HR to develop and implement a workforce diversity plan. Enhance workforce diversity to mirror race and ethnicity status of population served by reviewing recruitment and retention strategies and recommending and implementing changes. Address recruitment, retention, promotion, and staff development practices.

- Ensure regular management conversations with staff regarding ongoing performance, professional development and training

- Engage in discussions regarding cultural differences into practice with teams and individuals.

- Provide cultural-general and cultural-specific training so that staff and providers continuously improve their skills for working with people who are culturally different from themselves: Building Partnerships Across Differences training.

- Continue development of tools and resources to either remove barriers or facilitate equal access to services; expand secret shopper program as way of gathering information on how we are doing.

- Parking Lot: Integrate intercultural strategies into staff work.

APPENDIX 8

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

POLICY ASSUMPTIONS FOR COMPUTER AND TECHNOLOGY SYSTEMS IN DISTRICT CENTER SERVICES
November 2010

Background

District Centers are required to use designated computer systems in the provision of services to clients and in accordance with standards set by Aging and Disability Services Division (ADSD), and the State Department of Human Services, Seniors and People with Disabilities Services Division (DHS SPD).

There are three State computer systems required to be used by all District Centers:

1. Oregon ACCESS (Automated Computer Capture and Storage System) contains the client assessment forms and other client information used by case managers and information and assistance specialists.
2. The State Mainframe System provides client information, food stamps and other service and client information systems used by case managers and information and assistance specialists.
3. The Information and Assistance Call Module System used by case managers and information and assistance specialists.

The following policy assumptions are intended to clarify ADSD's expectations as it applies to computers, software, system access, use of data from systems, and Information Technology problem resolution for District Center computers used to conduct County related business.

Policy Assumptions

ADSD is offering to assist the District Centers with Technology costs. ADSD will provide the following:

- Cost of required software, i.e. data collection tools for tracking client information

District Centers will supply their own:

- computers,
- office software
- internet connections and software required to access State systems
- maintenance and technical desk top support
- anti-virus software

District Centers are required to sign an interagency agreement regarding confidentiality, security and the use of State and County Systems; ensuring that District Center staff acquire and maintain RACF (Resource Access Control Facility) rights. Additionally,

District Centers will commit to sending staff to training provided by ADSD and the State.

Recommendation for Minimum Specifications for District Center Computers

The following County Desktop Workstation Hardware Standard may be used as a guide when purchasing computers.

Desktop Workstation Hardware

The Strategic Plan for Information Technology recognized that, in order to achieve its strategic goals, "the County must develop its information technology in such a way as to ensure connectivity, access, data sharing and integration and information usability." To accomplish this, the County must provide each worker with access to a desktop workstation that is capable of operating the standard desktop software, and that can be connected to a local area network and the County's wide area network. The County has adopted a "two-tiered" desktop hardware standard. Tier 1 outlines the minimum configuration for new acquisitions. Standards are set to meet not only meet current user needs, but also projected needs for the 5 year life cycle of the machine. Tier 2 is the minimum configuration to be reinstalled within the County, once replaced with a newer machine.

Standard

Tiers	Component	Desktop	Laptop
Tier 1 - Min. Buy	Processor Type	Intel Core i5	Intel Core i5 **
	Brand	Dell	Dell
	Processor speed	Minimum 3.2GHz	Minimum 2.5GHz
	Memory	2 GB (2 DIMM)*	2GB (2 DIMM)
	Monitor *(Preferred)*	17" Flat Panel LCD (1024 x 768 resolution)	14.1 WXGA
	Monitor *(Alternate)*	Contact IT for monitors other than the preferred 17" LCD	
	Video	256MB	256MB
	Network Card	10/100/1000GB.	10/100/1000GB
	Hard Drive	Minimum 160GB (7200rpm)	Minimum 160GB (5400rpm)
	Other	16x DVD +/-RW	8x DVD +/-RW
		Sound Card - Internal	
	Other		Computrace 3 Yr (tracking s/w)
Tier 2 Min. reinstall	Processor Type	1GHz	

Computer hardware specifications will be updated periodically as needed to meet software requirements.

Problem Resolution

District Centers will need to access their own resources for hardware issues and non-State software problems.

If a problem occurs with Oregon ACCESS or State Mainframe systems and any other connectivity issues, District Centers can request help from the State DHS Helpdesk at 1-503-945-5623.

Future Plans

ADSD, together with other Divisions within the Department of County Human Services (DCHS), is in the planning stage to implement a software program that will integrate and consolidate databases within DCHS. This single client tracking system will also allow for data input for Older Americans Act and Oregon Project Independence and other ADSD programs. ADSD will work with District Centers to allow for payment data to be directly entered into the system.

APPENDIX 9

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

Evidence-Based & Best Practice Healthy Aging Programs
March 2011

Evidence-based programs are proven programs that work. In order to be considered "evidence-based," programs must be extensively evaluated using a control/comparison group, with documented and published outcomes. Programs that are considered "best practices" have not undergone this rigorous evaluation, but are based closely on existing research on effective approaches.

The programs listed below are considered either "evidence-based" or "best practices" according to key national organizations including the Centers for Disease Control and Prevention, the Administration on Aging, and the National Council on Aging. Programs that are recognized as "evidence-based" by one or more of these national groups are marked with an asterisk (*).

A. Programs Actively Promoted in Oregon

***Living Well with Chronic Conditions (Stanford Chronic Disease Self-Management Program (CDSMP)** Living Well (Stanford University's Chronic Disease Self-Management Program, or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. The workshop provides support for normal daily activities and dealing with the emotions that chronic conditions may bring about. Chronic Disease Self-Management programs also include Tomando Control de su Salud, a Spanish-language, culturally appropriate version, and the Positive Self-Management Program (PSMP), a workshop for people with HIV.
For more information in Oregon: www.healthoregon.org/livingwell or 888-576- 7414. Or Stanford: http://patienteducation.stanford.edu

***The Arthritis Foundation Exercise & Aquatics Programs:** Offer low-impact exercises that can be done either sitting or standing (or in a warm-water pool for the aquatics program) to help relieve stiffness and pain and to build strength and stamina. Classes meet 2-3 times/week for at least eight weeks. The programs were developed by physical therapists specifically for people with arthritis or related conditions, but are also appropriate for other frail or deconditioned older adults. For more information: Contact the Arthritis Foundation Pacific Northwest Chapter, Johanna Lindsay at 206-547-2707, jlindsay@arthritis.org or the Oregon Arthritis Program: 971-673-0984.

***Matter of Balance (MOB):** A Matter of Balance Program is a nationally recognized evidence-based fall prevention program, and a Volunteer Lay Leader Model, adapted from Boston University Roybal Center by Maine's Partnership for Healthy Aging. MOB teaches practical coping strategies to reduce the fear of falling. This group-based course is led by trained lay leaders over 8 weekly 2-hour sessions. ThinkFirst Oregon and the OHSU Trauma Department offered free MOB training in Spring 2011 and may be able to offer subsequent training. For more information, contact Kayt Zundel at (503) 494-5353 or zundel@ohsu.edu, or, MaineHealth Partnership for Healthy Aging at www.MaineHealth.org/pfha or 207-775-1095.

***T'ai Chi: Moving for Better Balance:** Developed by the Oregon Research Institute in Eugene, this simplified, 8-form version of T'ai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Classes meet 2-3 times/week for at least three months. Program outcomes include decreased falls, and a decrease in fear of falling. For more information: Dr. Li Fuzhong at the Oregon Research Institute can be reached at www.ori.org or 541-484-2123.

B. Other Programs Offered in Oregon

Arthritis Foundation Tai Chi Program: Designed for people with arthritis, this 12-movement Sun-style Tai Chi program was developed by Paul Lam and is supported by the Arthritis Foundation. For more information www.arthritis.org/tai-chi.php.

Better Bones & Balance: Based on research at Oregon State University's Bone Research Laboratory, this strength and stepping exercise class is designed to reduce the risk of osteoporosis-related fractures. Outcomes include improved strength, balance and mobility, and reduced bone loss. Training is offered through Linn-Benton Community College. For more information, email Shirley.lockhart@linnbenton.edu.

***EnhanceFitness (EF):** EnhanceFitness, developed by the University of Washington in collaboration with Senior Services, is a group exercise program for older adults focusing on stretching, flexibility, balance, low impact aerobics, and strength-training. Classes meet 3 times per week and are led by a certified fitness instructor. For more information: www.projectenhance.org.

SAIL (Stay Active & Independent for Life): A strength and balance fitness class developed in Washington for older adults that includes education on preventing falls. The classes meet three times/week for an hour. Exercises can be done seated or standing and include moderate aerobic, strength, and stretching exercises. For more information, contact the Washington State Department of Health, Office of Health Promotion, 360-236-3736.

Strong Women: A group strength-training exercise program developed at Tufts University and designed for midlife and older women. Outcomes include increased strength, improved bone density, improved health and self-confidence. For more information: http://jhcpan.nutrition.tufts.edu/programs/strongwomen/.

Strong For Life: Developed by Boston University, this home-based exercise program increases strength, balance, and overall health. Volunteer coaches instruct frail homebound participants on how to exercise using an exercise video and monitor their performance. For more information: http://web.bu.edu/hdr/products/stronglife/index.html.

C. Programs Not Currently Offered in Oregon

Active Choices: A program developed by Stanford University to help older adults meet their physical activity needs. Each participant is assigned a trained activity coach who helps him/her build an individualized exercise plan. The Active Choices coach provides monthly phone support to monitor progress, modify exercise strategies as needed, and provide exercise tips. ("Active Choices" and "Active Living Every Day" were jointly disseminated/researched under the name Active for Life.) For more information: http://hprc.stanford.edu/pages/store/itemDetail.asp?118.

***Active Living Every Day (ALED)** This program was developed by the Cooper Institute and Human Kinetics. It is a 20 week (modifiable to 12-week), self-paced course to help people with sedentary lifestyles become and stay physically active. The course can be offered in a group or one-on-one format, and focuses on behavior change to help sedentary adults adopt and maintain physically active lifestyles. ("Active Choices" and "Active Living Every Day" were jointly disseminated/researched under the name Active for Life.) For more information: www.humankinetics.com/ppALP.

Eat Better Move More: A 12-week program developed for congregate meal program participants, and usually led by individuals with a nutrition background. Weekly 30 minute sessions provide basic activity and nutrition education and encourage participants to be physically active and eat a more healthy diet. A 4 second 12-week series is available for sites that have completed the first series. For more information: http://nutritionandaging.fiu.edu/You_Can/index.asp.

***EnhanceWellness (EW):** EnhanceWellness is an individualized, community-based wellness intervention for older adults at risk of functional decline. A nurse and social worker work with the individual to develop a plan, and support and encourage that individual to achieve the goals of his/her plan. The program was developed by the University of Washington in collaboration with Senior Services. For more information: www.projectenhance.org.

***Fit and Strong:** Developed by the University of Chicago, this physical activity program for older adults with arthritis is designed to be offered three times/week for 8 weeks. Each session includes a 60-minute exercise program and a 30-minute education and group problem-solving session to help participants develop ways of incorporating exercise into their daily lives. For more information: www.fitandstrong.org.

Healthy Changes: Trained volunteer group leaders and a defined curriculum assist older adults in the day-to-day self-management of Type 2 diabetes by focusing on diet and physical activity during weekly group meetings. Developed by the Providence Center on Aging in Portland, in collaboration with NCOA, A Healthy Changes toolkit has been developed to assist local organizations to implement this on-going program. For more information: www.healthyagingprograms.org/content.asp?sectionid=30&ElementID=11.

Healthy Eating: Healthy Eating for Successful Living in Older Adults, developed by the Lahey Clinic in collaboration with other Boston-area organizations, is both an education and support program to assist older adults in self-management of their nutritional health. The workshop is conducted over 6 weekly 2 ½ hour sessions with a peer leader and a RD/nutritionist resource person. For more information www.ncoa.org/Downloads/ModelProgramsHealthyEating.pdf.

Healthy Eating Every Day: This program was developed by the Cooper Institute and Human Kinetics. It is a 20 week course to help people with sedentary lifestyles become and stay physically active. The course can be offered in a group, one-on-one, or on-line format, and focuses on behavior change to help adults establish balanced and healthy eating habits. For more information: www.humankinetics.com/ppALP.

***Healthy IDEAS**: Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations.

This case manager-led program typically lasts for 3-6 months. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston. For more information: http://careforelders.org/default.aspx/MenuItemID/290/MenuGroup/Initiatives+%26+Tools.htm.

Healthy Lifestyles: A 2 ½ day workshop for people with disabilities addressing a variety of health promotion topics. Developed by OHSU's Office on Disability & Health, and offered through OHSU and state Independent Living Centers. For more information: www.ohsu.edu/oidd/cca/hlid/index.cfm.

***Healthy Moves**: "Healthy Moves for Aging Well" was developed by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program is offered one-on-one to homebound frail, high-risk sedentary older adults. The program was designed to be supported by case managers as an additional service of their community-based case management program. For more information: www.picf.org.

Medication Management: The Medication Management Improvement System (MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention is designed to enable social workers and nurse case managers to identify and resolve certain medication problems that are common among frail older adults. For more information: www.homemeds.org.

***Stepping On**: Developed at the University of Sydney, Australia, this program is designed to improve fall self-efficacy, encourage behavior change, and reduce falls. It is a seven week, two-hour/week, program sessions, with a follow-up occupational therapy home visit. [No website for this program.]

APPENDIX 10

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFPQ No. R11-10422

Nutrition Guidelines for District Senior Center Meals and Snacks Served Outside of Meals*

The nutrition guidelines listed below will help ADSD promote good health and a sustainable food system in Multnomah County. Good nutrition is an important key to healthy aging and senior centers can help older adults make wise choices about the food they eat by offering healthy options and nutrition education. These guidelines are intended to provide direction for incorporating healthier fare, which will be a gradual process, and are not aimed at restricting or reducing the amount of food that is available to older adults at these sites. To that end, ADSD will offer assistance, support and guidance to centers as they implement changes in line with these recommendations.

(Source: Proposal for Nutrition Guidelines for City Contractors, San Francisco)

- Senior Centers shall implement nutrition guidelines or a wellness policy that promotes healthy eating and physical activity. A wellness team at the Senior Center shall be responsible for developing and promoting the policy. The guidelines will inform food and beverage decisions including the type or amount of food or beverage served, distributed, purchased or sold at Senior Centers.

- Senior Centers shall feature and encourage participants to eat more fruits and vegetables. If or when unhealthy food items are served (including donated foods such as donuts, pastries etc.), Senior Centers will offer an adequate number of healthy options, such as fruits, vegetables or whole grain products. Healthy foods will be placed alongside unhealthy foods so that they are accessible.

- Food items served at Senior Centers shall, to the extent possible, be prepared from fresh, locally grown and healthy ingredients. If possible, foods offered will not have unnecessary preservatives, hormones or antibiotics.

- Senior Centers shall promote and integrate information and education about healthy eating into activities and programs.

- Senior Centers will limit the availability of unhealthy food options. In particular, unhealthy food options will be restricted prior to mealtimes or exercise activities.

*These guidelines are broad in nature and similar to the City of San Francisco's Nutrition Goals for City Contractors.
Sources: Ecumenical Ministries of Oregon Guidelines for Healthy Fellowship Food in Faith Communities; Healthy School Food Policies: A Checklist: Version 1.5, Center for Food and Justice; Proposal for Nutrition Guidelines for City Contractors, San Francisco.